Department of Health and Social Care – Major Conditions Strategy: Call for evidence
Written evidence submitted by the Institute of Health Visiting

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1.0 About the Institute of Health Visiting

The Institute of Health Visiting (iHV) is an independent charity, professional body and centre of excellence for health visiting, established to strengthen the quality and consistency of health visiting for the benefit of all children, families and communities.

2.0 Cardiovascular disease

Cardiovascular disease (CVD) is a general term for conditions affecting the heart or blood vessels. It is one of the main causes of death and disability in the UK, and includes coronary heart disease, strokes, peripheral arterial disease and aortic disease. Atrial fibrillation (an irregular, and sometimes fast heartbeat), high blood pressure and high cholesterol are all risk factors for CVD. Evidence suggests taking action on these 3 risk factors will significantly reduce the number of strokes, heart attacks and other types of CVD.

Question

In your opinion, which of these areas would you like to see prioritised for CVD? (Select up to 3 -**iHV responses in purple)**

- **Preventing the onset of CVD through population-wide action on risk factors and wider influences on health (sometimes referred to as primary prevention)**
- **Stopping or delaying the progression of CVD through clinical interventions for individuals at high risk (sometimes referred to as secondary prevention)**
- **Getting more people diagnosed quicker**
- Improving treatment provided by urgent and emergency care
- Improving non-urgent and long-term treatment and care to support the management of CVD.

Question

How can we successfully identify, engage and treat groups at high risk of developing CVD through delivery of services that target clinical risk factors (atrial fibrillation, high blood pressure and high cholesterol)? (Please do not exceed 500 words)

We provide evidence in relation to the health visiting service and its key contributions preventing, identifying and treating problems for babies, children and families before they reach crisis point. Our four key points:

1) **Getting it right at the start of life:** Overall, as a nation, we are becoming less healthy. Lives are being cut short and more people are living with multiple, co-existing conditions and health inequities that are largely preventable and take root in early childhood. Without a change of direction, the government will need to budget for soaring treatment costs of cardiovascular disease in adulthood. To change the story, we need to change the beginning of the story with a concerted focus on 'creating health' in the earliest years – prevention is better than cure. Spending on the health of our nation's children needs to be seen as the smartest long-term investment in our nation's future, rather than a cost – and cannot be judged solely on cashable savings in one or two years.
   We have more evidence than any other generation that the building blocks of future health are laid in the earliest years of life. There is also strong evidence that exposure to certain environmental influences during critical periods of development (pre-conception, pregnancy and early childhood) can have significant consequences on an individual's short-and long-term health, increasing the risk of CVD.
2) **Health visitors are in a privileged position, providing a systematic way to reach all babies, children, and families,** including those who do not currently experience easy access to services and have the worst health outcomes. UNICEF-UK describes them as the 'backbone of the early years, the safety-net for all families' – their role should be maximised in the Major Condition Strategy (MCS).
3) **Managing complex problems requires a skilled workforce -** Health visitors have specialist training in public health and 'health creation', built on a foundation of nursing/ midwifery - trained to work across physical health and mental health; for babies, children and adults; child development, social needs and safeguarding. Their skills in partnership working with individuals and communities are important as there is good evidence that simply telling people to 'eat less and exercise more' doesn't work. Instead, there is strong evidence that the strategy must address both the wider determinants of health and provide personalised support for individuals that takes account of the context in which they live to improve health and reduce risk factors. The iHV and Kings College Centre for Parent and Child Support are currently piloting training for health visitors using the Family Partnership Model – 'Let's talk heart health' that supports practitioners to use their time most effectively to support families to reduce CVD risk.
4) **A health visitor workforce plan is needed:** When sufficiently resourced, the health visiting workforce is ideally placed to support the MCS – this requires a national workforce plan with investment to reverse more than 40% cuts to the workforce since 2015. Investing in an existing service is cheaper and quicker than implementing a new untested service.

3.0 Chronic respiratory diseases

Chronic respiratory diseases (CRDs) affect the airways and other structures of the lungs. Some of the most common are chronic obstructive pulmonary disease (COPD), asthma, occupational lung diseases and pulmonary hypertension. Respiratory diseases contribute to around 8,000 preventable deaths in the under 75s in England each year, and the UK has the highest prevalence of asthma in the world at around 9 to 10% of the adult population.

Question

In your opinion, which of these areas would you like to see prioritised for CRD? (Select up to 3)

- **Preventing the onset of CRDs through population-wide action on risk factors and wider influences on health (sometimes referred to as primary prevention)**
- **Stopping or delaying the progression of CRDs through clinical interventions for individuals at high risk (sometimes referred to as secondary prevention)**
- **Getting more people diagnosed quicker**
- Improving treatment provided by urgent and emergency care
- Improving non-urgent and long-term treatment and care to support the management of CRD

4.0 Tackling the risk factors for ill health

The condition groups we are focusing on are often driven by preventable risk factors, with nearly half (42%) of ill health and early death being due to them. This includes tobacco, alcohol, physical activity and diet-related risk factors. Action on preventable risk factors is also central to our work on tackling health disparities, since people living in more deprived areas are more likely to partake in these behaviours.

Question

Do you have any suggestions on how we can support people to tackle these risk factors?

- **Yes**
- No

Question

How can we support people to tackle these risk factors? (Please do not exceed 500 words)
You might consider suggestions on how we could:

- make changes at a local level to improve the food offer and support people to achieve or maintain a healthy weight and eat a healthy diet
- identify and support inactive people to be more physically active
- support people to quit smoking, including through increasing referrals to stop smoking support and uptake of tobacco dependency treatment
- support people who want to drink less alcohol to do so.

When adequately resourced, health visitors can enable families to make achievable changes in all four modifiable risk factors through their universal reach and personalised support. There are several points in a life course where there are specific opportunities to positively influence these risks that should be maximised by health visitors:

- Critical periods of metabolic plasticity (early life, pregnancy).
- Times linked to spontaneous changes in behaviour (becoming a parent).
- Periods of significant shifts in attitude (peer group influences, diagnosis of ill health).

- **Smoking:** Alongside enacting the recommendations in the Khan Review (2022), due to the considerable adverse impacts of smoking on pregnancy outcomes and child health, the MCS should also focus on tobacco harm reduction before, during and after pregnancy and the promotion of smoke-free homes. Health visitors are uniquely placed to reach and engage individuals who are smokers, or at risk of becoming smokers, including those that often fall through the gaps between other services – they can provide direct support (most are non-medical prescribers), as well as connecting smokers to local 'quit smoking' services. There is good evidence that being supported by a healthcare professional leads to more successful quitting.

- **Unhealthy diets:** The government should reinstate the Obesity strategy and use the plethora of evidence to support system wide approaches that address the complexities in obesity reduction. Childhood obesity is socially driven and poverty limits food choices; it is therefore imperative that action is taken to address child poverty and make healthy food affordable. Making health changes is difficult. Health visitors can support individuals through: early intervention and prevention, improving families' access to benefits, and support for breastfeeding. To be effective, families need practitioners with the knowledge and skills to work in partnership with them to understand the details of their circumstances, build resilience and a personalised plan for change – this often requires working through individual's fatalistic thinking that health improvement changes are impossible. Staff who solely have technical competence at filling in a form, or giving out a leaflet, are much less likely to be effective.

- **Alcohol harms:** Tackling alcohol-related harm is an important route to reducing health inequalities across the life course in general and for babies and children in particular. There are well-evidenced links between harmful parental drinking and:
    - neglect and abuse
    - domestic abuse
    - eating disorders
    - alcohol dependence or addiction
    - suicide
    - foetal alcohol spectrum disorders.

  Talking about alcohol consumption requires sensitivity, skill and trusted relationships to accurately elicit need, that is often hidden, and broker engagement in support – health visitors are ideally placed to have these meaningful conversations with parents, to support behaviour change, as well as signpost to specialist alcohol treatment services and respond to child safeguarding concerns.

- **Physical inactivity:**
  Supporting physical activity in pregnancy and childhood can lay strong foundations for future behaviours and lifelong health and wellbeing. Health visitors can improve individual capacity, perceived safety, access to physical activity and parental activity levels, with consideration of the importance of tailoring advice during pregnancy and postnatally.

5.0 Supporting those with conditions

This part of the survey seeks to understand how we can improve outcomes for people with any of the major conditions, or a combination of them, across their life course.
For these questions, we ask for you to consider the following in your responses:

- how we can improve outcomes for people across the life course, from pre-conception, early years, childhood and young adulthood, into adulthood and older age
- how we can target population groups most in need - including addressing disparities in health outcomes and experiences by gender, ethnicity and geography
- what could be adopted and scaled quickly (that is, in the next 1 to 2 years) with impact
- what we can learn from local, national and international examples of good practice, and what wider factors are either enabling them to be a success or are blocking them from being even more successful
- if you've tried a particular approach with success, please indicate the cost and be as specific as possible about how the approach was implemented.

i) Suggestions for multiple conditions

Population measures: A cross-government strategy to reduce health inequalities by tackling the social determinants of health is needed, alongside an integrated **national child health plan** with shared ambitions for children across all government departments - this is too important to be left to chance.

Getting it right in the earliest years: To reduce the increase in multiple conditions in adulthood, efforts need to focus on laying strong foundations for health in the earliest years. This includes the provision of a universal offer of support that reaches all families, with more intensive support proportionate to need, delivered by health visitors who have the skills to recognise need in an undifferentiated population across the breadth of priorities in the Healthy Child Programme (HCP).

Universal reach: The identification of need is an essential first step in any early intervention programme and supports targeting of resources to those in greatest need. Health visitors provide **the only systematic way** to reach all babies and young children to ensure that their needs are recognised and they don't fall through the gaps between services - 'joining together the pieces of the jigsaw' to identify vulnerable children.

Health visitors improve short, medium and long-term health outcomes across three important life stages:

- **Building** healthy people: Alongside midwives, health visitors support women to prepare for a healthy pregnancy and reduce harm through high quality preconception and pregnancy care and the reduction of the four main risk factors for many major conditions: smoking, alcohol, unhealthy diets/ obesity, and physical inactivity. They also provide guidance on immunisations, contraception and pregnancy spacing and will be central to the national plans to improve health through genomics.
- **Being** healthy in childhood: Health visitors work with families to promote health in childhood and also play a key role in the identification of babies and young children with underlying health conditions, developmental delay and disabilities. They support parents to navigate the complex system of health, education and social care support to ensure that families receive the help that they need.
- **Becoming** healthy adults**:** Early action leads to cumulative savings across the life course and across the health and care system - this avoids or delays more costly late interventions that

will incur due to increasing numbers of people spending more years in poor health in adulthood.

Action is needed to end the significant variation in health visiting support across the country which is driven by loosely defined national commissioning guidance, cuts to the public health grant and a 40% reduction in health visitors. This variation is not justified - the key public health priorities do not vary considerably between areas. Whilst Start for Life investment is welcomed, it only reaches half of all local authorities and does not cover the breadth of the HCP (it only focusses on breastfeeding, infant and perinatal mental health and parenting) and leaves many important physical health priorities out of scope. Investment in the health visiting service could be adopted at scale quickly, with benefits accruing across health, education and social care.

ii) Suggestions for cardiovascular disease

CVD has its origins in early childhood and adolescence. It is driven by underlying social, economic, political, environmental and cultural factors, broadly known as 'social determinants'. Physical inactivity, unhealthy diets, exposure to alcohol and tobacco, and unhealthy environments are important risk factors and are often preventable. Advances in epigenetics in the last 20 years, identified that environmental factors, nutrition and stress in utero and early life may also lead to genetic alterations which have lifelong implications for adult-onset conditions, such as CVD.

The good news is that there is also strong evidence that reducing risk factors, starting in the earliest years of life, can make a big difference to lifelong health and wellbeing and the reduction of health inequalities. Reducing CVD is not simply a matter of changing individual behaviour in isolation; broader changes in social, economic, environmental and cultural contexts are also needed – when tackled collectively, these changes will not only benefit the individual, they also yield wider cumulative societal benefits, reducing the need for costly late intervention across multiple government departments.

Health visitors have unique access to families during pregnancy and the early years, providing timely opportunities for early intervention to help reduce the risk of CVD and identify individuals most in need to address disparities in health outcomes.

Making health changes is not straightforward – all families will have different needs. How we communicate matters, as smoking, alcohol, inactivity and unhealthy diets can sometimes be challenging or sensitive topics to cover with families. At face value, some families may seem resistant to change, or defensive, and refuse to engage. There is good evidence that parents are more likely to engage in CVD conversations that they feel are relevant, useful and positive for them, and with trusted professionals. They are less likely to engage and feel motivated to change when they feel criticised, hopeless and powerless. Telling people to 'eat less and exercise more' does not work for many families and simplistic advice giving can do more harm than good.

Health visitors are trusted by families - to strengthen their skills in CVD, the iHV is currently piloting 'Let's Talk Heart Health' CPD, developed in partnership with The Centre for Parent and Child Support at Kings, to equip health visitors in the Family Partnership Model for CVD prevention as part of their routine work with families. The approach takes account of the context in which families live to create a shared understanding of the relationships between key factors influencing CVD risk. They are then able to offer personalised advice to families to support change. Context is important – it would take 74% of household income for the poorest families to eat healthily and it's important that we don't blame families. But it's equally important that we avoid fatalistic thinking, that change is impossible. With widening health inequalities, doing nothing cannot be an option. Rebuilding the

health visiting service in England presents significant opportunities to reach and engage the most vulnerable families to tackle the rise in CVD.

iii) Suggestions for chronic respiratory diseases

Like CVD, respiratory conditions often have their roots in early childhood and are impacted by environmental factors. Improving air quality and tackling poverty would have the biggest impact across the population. Poverty is linked with poor quality housing - overcrowding, cold, damp and mouldy homes pose significant risks for chronic respiratory diseases that are entirely preventable.

Babies and young children are particularly susceptible to breathing difficulties – these put pressure on health services and sadly some children are dying unnecessarily. Cold homes can cause or worsen a range of other health issues including cardiovascular illness, musculoskeletal and rheumatological conditions, diabetes, dementia, mental health and childhood development. All predictions show that they will contribute to more premature deaths in the winter and the cycle is repeated every year. The rise in fuel poverty has exacerbated the situation, leaving more families struggling to afford to heat their homes. In a recent survey by the iHV (iHV, 2023), 91% of health visitors reported an increase in the number of families affected by poverty in the last 12-months. The End Fuel Poverty coalition estimated that 35% of households with young children (0-4 years) are living in fuel poverty.

Health visitors have a vital role to play in reducing inequalities due to chronic respiratory diseases, through a range of preventative measures focused on pregnancy and the earliest years of life:

- Reducing preterm birth through improved preconception and pregnancy care will reduce the incidence of chronic lung disease in preterm infants.
- Supporting parents to quit smoking and have smoke-free homes.
- Supporting parents to manage minor illnesses – at the iHV, we have worked with NHSE on a range of resources for health visitors to provide support for families with Strep A and other childhood respiratory conditions to reduce the burden on primary and urgent care.
- NHSE Core 20 plus 5 CYP – offers opportunities to strengthen how services work together to tackle asthma. This requires practitioners to:
    - Look beyond presenting symptoms/ immediate treatment.
    - Identify people facing multiple disadvantages who are often excluded and require a universal service like health visiting to reach out to them.
    - Thinking broadly – for example, in the height of the winter pressures, some areas co-commissioned ‘warm hubs’ where people could go to keep warm and access advice and support.
- Reaching families and connecting them to other health services and wider support – health visitors have a key role in advocacy and social justice as part of their NMC Code and have good knowledge of local services. They can support families to access benefits and connect them to wider support.
- Identifying families living in substandard housing, supporting them to make complaints and advocating on their behalf. Health visitors also connect families to charities that can help. An excellent partnership project between the Citizen’s Advice Bureau and health visiting teams in one local authority area achieved significantly increased uptake of support by families with young children who previously had low levels of engagement with the CAB.

6.0 Supporting those with conditions - supporting local areas to diagnose more people at an earlier stage

This part of the survey seeks to understand how we can improve outcomes for people with any of the major conditions, or a combination of them, across their life course. You do not need to respond for every condition - please just reply in the relevant box for where you have suggestions.
For these questions, we ask for you to consider the following in your responses:

- How we can improve outcomes for people across the life course, from pre-conception, early years, childhood and young adulthood, into adulthood and older age
- How we can target population groups most in need – including addressing disparities in health outcomes and experiences by gender, ethnicity and geography
- What could be adopted and scaled quickly (that is, in the next 1 to 2 years) with impact
- What we can learn from local, national, and international examples of good practice, and what wider factors are either enabling them to be a success or are blocking them from being even more successful
- If you've tried a particular approach with success, please indicate the cost and be as specific as possible about how the approach was implemented

Question
How can we better support local areas to diagnose more people at an earlier stage?

- You might consider suggestions to increase capacity available for diagnostic testing or identify people who need a diagnosis sooner.

i) Suggestions for multiple conditions

Health visitors lead the delivery of the Healthy Child Programme and are a highly skilled workforce of specialist community public health nurses who are equipped to work in partnership with parents and communities to identify problems early - they also connect families to other services and support for diagnosis as part of a multi-disciplinary team and "whole system" approach for the earliest years of life.

Through the **systematic** delivery of the Healthy Child Programme, health visitors are the only service that universally reaches all families with babies and young children. As such, health visitors play a crucial role in the **early identification** of children with undiagnosed health conditions, atypical or disordered patterns of development or with significant impairments likely to result in disability. It is therefore vital that the health visiting service is sufficiently resourced to deliver high quality face to face mandated health reviews to all families (this brings considerable benefits to babies, children and families, as well as the wider health, education and social care system).

Health visitors are often the first point of contact for families who have concerns about the way that their child is developing. They are a highly skilled workforce trained to spot nuance and deviations from the norm in child and family physical and mental health, child development, social needs and safeguarding. They are therefore ideally placed to spot problems early and facilitate effective support, either directly through enhanced health visiting provision or by referrals to other services.

Early identification of developmental disorders and health conditions is important to enable prompt diagnosis and tailored interventions, including supporting parents. Many parents report that they find the healthcare system complex to navigate and value support adjusting to their role as a "parent of a child with a disability or a complex health condition". The health visitor's in-depth knowledge of local support, referral pathways and relevant benefits can provide an important brokering role to ensure that babies and children receive the help that they need.

However, in reality there is significant variation in the level of support that health visitors are able to provide which can be curtailed by poorly defined local commissioning specifications and the impact of local cuts to health visiting services. It is therefore crucial that the Healthy Child Programme and health pathways for babies and children are centrally funded, in full and based on demand-driven workforce modelling, to end the variations in local priorities and postcode lottery of support that families face. The benefits of an effective health visiting service accrue to other parts of the healthcare system, as well as education and social care. A "whole-system approach" driven by national government is needed to rebuild the health visiting service to maximise its impact – this has the potential to quickly alleviate some of the pressures in other services, through national cross-departmental funding, rather than being solely reliant on the public health grant.

ii) Suggestions for cardiovascular disease

In addition to our previous CVD response, we provide evidence for investment in breastfeeding support as a means to reduce CVD risk. There is a plethora of evidence to suggest that decisions made regarding infant feeding can have a significant impact on both the child and the mother's future health outcomes. Breastfeeding has a significant role to play in reducing health inequalities and in improving the health of children and families, whilst benefitting our economic and global sustainability.

Despite wide acceptance and integration of this knowledge within our research and government policies, as a nation, we have one of the worst breastfeeding rates in the world and continue to experience a gap in translating this evidence into practice to improve our breastfeeding rates.

The evidence is clear that not breastfeeding your child can lead to an increased risk of: obesity in later life; Sudden Infant Death Syndrome (SIDS); otitis media; tooth decay and dental malocclusion in under ones; lower respiratory infections; diarrhoea and vomiting; childhood leukaemia; and death from necrotising enterocolitis (NEC) in preterm infants. The protection that breastmilk affords is due to its unique nutritional content and value, which is far superior to formula milk, despite misleading marketing claims. Human milk is designed for human babies, with the correctly balanced level of nutrition, for the correct stage of the infant's life. Its composition changes as the child develops and responds to negative pathogens that the mother might come in to contact with, through an immune response to protect the child.

Breastfeeding also supports close and loving relationships, which helps the baby's brain development and impacts on infant attachment. Early childhood is the period when children learn to manage emotions and build relationships, develop resilience against adversity and trust in others. Such relationships can also be protective of mental health and reduce the risk of perinatal mental illness that can compromise the mother's ability to respond to her infant's cues and engage in responsive interactions.

Breastfeeding is associated with a significant reduction in the risk of breast cancer, ovarian cancer and type 2 diabetes for women who have breastfed their baby. There are also economic benefits as breastmilk is free, therefore does not incur the additional financial cost of formula feeding.

In the UK, we have a strong bottle-feeding culture; by one week of age over half of all babies will have received formula milk via a bottle, and by six weeks this rises to three quarters of all babies. Recent investment in breastfeeding in 75 local authorities through the Start for Life Vision is welcomed. This needs to be extended to all areas, alongside specific investment in the health visiting service to improve breastfeeding support which would deliver significant cost savings to the NHS. 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 consultations.

7.0 Supporting those with conditions - enabling health and social care teams to deliver person-centred and joined-up services

This part of the survey seeks to understand how we can improve outcomes for people with any of the major conditions, or a combination of them, across their life course. You do not need to respond for every condition - please just reply in the relevant box for where you have suggestions.
For these questions, we ask for you to consider the following in your responses:

- How we can improve outcomes for people across the life course, from pre-conception, early years, childhood and young adulthood, into adulthood and older age
- How we can target population groups most in need – including addressing disparities in health outcomes and experiences by gender, ethnicity and geography
- What could be adopted and scaled quickly (that is, in the next 1 to 2 years) with impact
- What we can learn from local, national, and international examples of good practice, and what wider factors are either enabling them to be a success or are blocking them from being even more successful
- If you've tried a particular approach with success, please indicate the cost and be as specific as possible about how the approach was implemented
- How can we better enable health and social care teams to deliver person-centred and joined-up services?
- You might consider suggestions to improve the skill mix and training of the health and social care workforce.

Question

How can we better enable health and social care teams to deliver person-centred and joined-up services?

- You might consider suggestions to improve the skill mix and training of the health and social care workforce.

i) Suggestions for multiple conditions

Workforce changes need to be driven by the best available evidence of 'what works' to ensure that care is delivered by practitioners with the skills and knowledge to address the breadth of multiple conditions that have their roots in early childhood. There are a number of definitions of the term 'universal' and these must not be conflated:

- Health visiting is the only service that provides a systematic way to reach the whole population of babies, young children and their families, with undifferentiated levels of need. This is referred to as a **universal service**.
- From a commissioning perspective, within this **universal population**, it is important to have a clear understanding of the distinction between:
    - **A tiered approach to describing the needs of babies and children**
    - **A tiered approach to describing interventions** (universal, targeted and specialist 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 knowledge to elicit need and respond to deviations from the norm across a breadth of adult and child health issues, for physical health and mental health, child development, social needs and safeguarding. Health visitors are trained to do these assessments and their effectiveness is dependent on their skills to facilitate a style of practice

that is based on the following key messages from research on 'what makes health visiting successful':

- **Trusting relationships:** lead to better identification of need and improved uptake of health promoting messages. Eliciting need requires more than technical competence at filling in a tick box assessment – continuity and coordination are essential elements.
- **Identifying unmet need:** Many families, especially the most vulnerable, may not be aware of the extent of their own or their baby's/child's needs, or the services that could help them. Addressing this requires a universal service that is acceptable to parents and provides a systematic way of reaching all families, led by practitioners with the professional knowledge (across the breadth of needs) and autonomy to provide a flexible service, tailored to need, including signposting.
- **Needs change over time:** The earliest years are a dynamic period of change for many families. Successful healthcare requires mechanisms to respond to changing family circumstances over time. Services should be based on proportionate universalism with a universal offer to identify need, more intensive support proportionate to need, and visible, accessible support in the heart of communities. Intensive home visiting programmes can also improve outcomes for the most vulnerable families.
- **Making health changes is difficult:** Families need practitioners who can take account of their individual context to help them build resilience – this requires the right knowledge, skills, resilience and supervision to work in partnership with families and provide effective support.

From a policy implementation perspective, it is far easier to strengthen an existing service, such as health visiting, than create a new one.

ii) Suggestions for cardiovascular disease

Alongside health visitors' work with families to reduce the four main risk factors for adult CVD risk, they also work directly with babies and children to:

- Identify babies/ children above a healthy weight through routine growth monitoring at all universal contacts and between contacts at health visitor clinics that provide visible and easily accessible support in the heart of communities.
- As part of their targeted and specialist support, health visiting teams can provide direct weight management support and interventions to families. For example some areas offer bespoke healthy weight programmes delivered across 0-19 specialist public health nursing services, often making good use of the skills of the wider health visiting skill-mix team with excellent results – see Greater Manchester' s award winning Healthy Weight Project and the HENRY programme that is delivered in some areas as part of the health visiting service offer.
- Health visitors can also connect families to specialist tier 2 and tier 3 weight management services to reduce risks and prevent ill-health.
- Provide a 'safety-net' for babies and children living in families that do not engage, or disengage, with specialist support. It is well recognised that families that need the most support are often the least likely to engage with these services and have high rates of attrition. It is therefore vital that the health visiting service is sufficiently resourced to reach out to families in these circumstances to broker engagement in support and manage any escalating health and safeguarding risks to the babies and children in these families.
- The iHV has developed a comprehensive suite of CPD resources and training for health visiting teams to support their work in 'Healthy weight, healthy nutrition'. We are also piloting the 'Let's talk heart health' modules developed in partnership with the Centre for Parent and Child Support at Kings, that aim to move beyond simplistic advice giving which can often do more harm than good. Instead, the training focuses on 'how' we communicate and support families to make positive health changes – it equips health visitors with an adapted version of the evidence-based Family Partnership Model focused on CVD prevention and early intervention using strengths-based conversations and the 'Helper

Process' which is more effective at achieving lasting change. With government support, this has the potential to be easily rolled out at scale within existing health visiting services, avoiding the license fees of many of the targeted programmes on the market.

Through their unique universal reach into all families, health visitors are also in an ideal position to provide individuals and communities with information on the type and amount of physical activity that they should undertake and work with them, building on their strengths, to find practical ways to increase their physical activity that takes account of personal circumstances and resources, to improve their health.

8.0 Supporting those with conditions – use of research, data and digital technologies to improve outcomes for people with, or at risk of, developing the major conditions

This part of the survey seeks to understand how we can improve outcomes for people with any of the major conditions, or a combination of them, across their life course. You do not need to respond for every condition - please just reply in the relevant box for where you have suggestions.
For these questions, we ask for you to consider the following in your responses:

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- If you've tried a particular approach with success, please indicate the cost and be as specific as possible about how the approach was implemented

Question
How can we make better use of research, data and digital technologies to improve outcomes for people with, or at risk of developing, the major conditions?

A cross departmental strategy with short, medium and long-term goals for children, across 3 critical periods of development, is needed:

- **Building** healthy people– reducing risk factors in preconception, pregnancy and early childhood. Health visitors have a key role to play in harm reduction through their universal work with all families – benefits can be realised in the short term (for example, by improving preconception support for healthy weight, increasing uptake of folic acid and reducing smoking in pregnancy, providing support for perinatal mental health problems, and reducing the incidence of foetal alcohol spectrum disorders through targeted support).
- **Being** a child – for babies/children to be seen as citizens in their own right, in line with the WHO Nurturing Care Framework. Preventing, identifying and treating problems in childhood can avoid them escalating. Improved outcomes can be seen in the short term/ medium term in areas like infant feeding, immunization uptake, accident prevention, oral health, childhood obesity and child development.
- **Becoming** an adult, with the absence of disease. The WHO states that non-communicable diseases pose the greatest threats to our nation's health and the single biggest cause of preventable illness, disability and lives cut short. Tackling this requires a shift away from

selecting interventions in childhood based on quick 'cashable savings', to also include investment in long-term outcomes. Evidence driven interventions should include proximal outcome measures linked to reductions in the four main risk factors.

Agree key national metrics for children. The lack of hard system levers to drive quality in local authorities, alongside insufficient funding, has led to unwarranted variation in service provision – this needs to be addressed to ensure equity across the country as the key public health priorities do not vary considerably between areas– our children's health is too important to be left to chance.

Think complex systems: articulating causal impact within a complex adaptive system, in which the factors that impact outcomes are varied, is difficult. Simple reductive approaches using process outcome measures have been widely criticized for providing limited and misleading conclusions. Complex system's principles need to be applied across every level from national government to frontline services, with metrics to capture health visitor's **input** and **impact** across the system; including access, identification of unmet need, experience, outcomes, and local projections and goals to track inequalities. The benefits of an effective health visiting service accrue across multiple clinical pathways for children and in the health, education and social care system **– to maximise these benefits, a joined up cross-government department strategy for health visiting is needed.**

Measure to improve: process outcome measures provide limited information on service quality and create perverse system disincentives to 'tick the box, but miss the point' with statutory and mandatory functions prioritised to the detriment of early intervention and prevention services. Longer term goals which value health assets, with meaningful measures, need to be developed and embedded in service delivery.

Existing infrastructure could be enhanced to improve data sharing and interoperability, with a unique child identifier across all health, social care and education providers.

9.0 Cancer

The cancer call for evidence published in 2022 provided useful insights that will shape the development of the major conditions strategy. We have published what we heard in the cancer call for evidence, which can be found at the end of this survey.
However, if you wish to, we wanted to provide an opportunity to provide any further insights in this call for evidence.
How can we better support those with cancer?
You may wish to consider:

- How we can target population groups most in need – including addressing disparities in health outcomes and experiences by gender, ethnicity, and geography
- How we can support those living with cancer and other conditions
- How we can better support local areas to diagnose more people at an earlier stage
- How we can better support and provide treatment for people after a diagnosis
- How we can better enable health and social care teams to deliver person-centred and joined-up services

Suggestions for better supporting those with cancer (optional) Do not exceed 500 words:

Every opportunity should be taken to refocus clinical pathways towards prevention. At the moment, pathways for different cancers often begin with diagnosis and focus on treatment. Instead, we must shift the focus and resources towards preventing the condition occurring, diagnosing early and helping children living with cancer to stay well and manage their symptoms.

Through their universal reach to all families with babies and young children, and regular mandated health reviews as part of the Healthy Child Programme, health visitors have a crucial role to play in the early identification of childhood cancers. At the Institute of Health Visiting, we regularly run cancer awareness campaigns alongside national childhood cancer charities to raise health visitors' awareness of the key 'red flag' symptoms of childhood cancers. However, there is currently wide variation in the quality of health visiting provision in the UK – to be effective, it is essential that all mandated health reviews are completed face-to-face and delivered by practitioners with the knowledge and skills to spot nuance and deviations from the norm in child health and development (as mentioned previously, having technical competence to fill in a form is not sufficient and makes it more likely that these conditions will be missed, losing valuable time in the diagnostic pathway).

Between 30 and 50% of cancers can currently be prevented by avoiding risk factors and implementing existing evidence-based prevention strategies. Prevention is key to reducing cancer risks. Cancer risk can be reduced by:

- not using tobacco
- maintaining a healthy body weight
- eating a healthy diet, including fruit and vegetables
- doing physical activity on a regular basis
- avoiding or reducing consumption of alcohol.

Health visitors make a vital contribution across multiple public health priority areas, as well as clinical pathways that straddle both public health and the NHS. Eight years of budget cuts have led to a 40% reduction in the number of health visitors in England and despite health visitors' best efforts, hundreds and thousands of babies, young children and families are currently not getting the support that they need. Investment in health visiting will ensure that health visitors are able to meet the needs of babies, children and families to prevent, identify and treat problems before they reach crisis point, this includes liaising with primary care where there are 'red flag' cancer symptoms to facilitate urgent referrals to specialist services.

10.0 Mental health

The mental health call for evidence published in 2022 provided useful insights that will shape the development of the major conditions strategy. However, if you wish to, we wanted to provide an opportunity to provide any further insights in this call for evidence.

Question
How can we better support those with mental ill health? (Please do not exceed 500 words)
You may wish to consider:

- How we can target population groups most in need – including addressing disparities in health outcomes and experiences by gender, ethnicity, and geography
- How we can support those living with mental health and other conditions
- How we can better support local areas to diagnose more people at an earlier stage
- How we can better support and provide treatment for people after a diagnosis
- How we can better enable health and social care teams to deliver person-centred and joined-up service

A significant proportion of parents develop a perinatal mental health (PMH) problem either in pregnancy and/ or the postnatal period. Without treatment, these can have a devastating impact on

parents and their families with long lasting consequences. In 2014, it was estimated that PMH problems carry a total cost to society of about £8.1 billion per one-year cohort of births in the UK, the majority of which is due to the subsequent impact on the child – the cumulative costs are likely to be much higher now. The recent MBRRACE report (2023) highlighted that suicide remains the leading cause of maternal death in the first postnatal year (with the highest rates being between 6 weeks and 12 months after the birth – long after maternity services have ended their involvement with families).

There is a significant body of evidence which highlights that health inequalities will not be reduced sufficiently if we solely target our work towards the most disadvantaged. Instead, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage. Only families with the highest level of need currently access specialist perinatal mental health services which provide important, but costly, treatment for these individuals. Most perinatal mental health problems are managed in primary and community care. Cost-benefit analyses and systematic reviews of interventions to reduce the impact of perinatal mental health (PMH) problems have highlighted the important role of health visitors, particularly in accessing so-called 'hard-to-reach' groups and providing early intervention for PMH problems. It is imperative that there are sufficient HVs to ensure early identification of PMH problems and offer appropriate support and referral for parents at greater risk.

PMH problems can also affect the parent-infant relationship and impact on the baby's ability to form a secure attachment which is key for their future emotional health and wellbeing. By addressing PMH problems and promoting infant mental health (IMH), HVs can prevent emotional disturbances from taking root and escalating into mental health problems later in life. There should be support for parent/primary caregiver-infant relationships at all levels of need with investment in health visiting support for the majority of families, and access to specialised support in every area of the UK. Specialist health visitors in perinatal infant mental health (PIMH) have a unique leadership role in supporting effective integrated PIMH services; each Local Authority should commission at least one Specialist HV PIMH.

Further work is needed to review, develop and implement suitable assessment and observation tools/indicators across systems in PIMH, particularly around fathers' mental health and the parent/caregiver-infant relationship. Recommendations must be implemented to improve inclusion and PMH of fathers. To improve maternity experiences and PMH of women from minoritised ethnic groups, concerns identified in reports relating to attitudes, knowledge, and assumptions of healthcare professionals, must be addressed in line with their recommendations. Barriers to quality perinatal mental healthcare for LGBTQI+ people (such as discriminatory policies, service provision and language, and discrimination within healthcare delivery) must be addressed.