

iHV representation to the multi-year Spending Review 2021

Levelling up by delivering the Government’s pledge to prioritise the recovery of health visiting and the Healthy Child Programme¹.

Introduction:

1. 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. The iHV published a Vision for Health Visiting in 2019 which requires health visiting to play its fullest part within an integrated system to reduce health inequalities that arise in childhood and for our children to achieve health outcomes on a par with the best in the world. The Vision is built on the expressed needs and preferences of parents, as well as the best evidence of ‘what works’, presented in a suite of documents²:
 - [Health Visiting in England: A Vision for the future \(full report October 2019\)](#)
 - [Health Visiting in England: A Vision for the future \(Executive Summary\)](#)
 - [What do parents want from a health visiting service? Results from a Channel Mum survey \(January 2020\)](#)
 - [Health visiting - Good practice case studies - First Edition January 2020](#)
3. During the pandemic, health visitors have demonstrated³ that they are a modern, innovative and responsive workforce which has continued to support families through the most challenging times. However, the current state of health visiting in England is one of unwarranted variation, with insufficient resources to deliver the Healthy Child Programme in full. Since 2015 there has been significant disinvestment in health visiting, a decline in health visiting numbers⁴ and Public Health Grant allocations have fallen in real terms from £4.2 billion in 2015–16 to £3.3 billion in 2021–22⁵.
 - [State of health visiting in England: are babies and their families being adequately supported in England in 2020 to get the best start in life?](#)
4. In this submission, we offer solutions to the challenges that this country faces with a growing NHS backlog and billions spent annually on costly late intervention. As part of the First 1001 Days Movement, we join with partners calling on the Government for investment in health visiting to ‘**turn off the taps**’ by preventing problems happening in the first place, and intervening early, rather than ‘**mopping the floor**’ with less effective, costly late interventions.
5. We are calling for investment to deliver the Government’s Start for Life Vision⁶. This includes a **£500 million ringfenced uplift in the Public Health Grant over the next three years**. This will enable local

¹ Department of Health and Social Care (2021) The best start for life: a vision for the 1,001 critical days <https://www.gov.uk/government/publications/the-best-start-for-life-a-vision-for-the-1001-critical-days>

² Institute of Health Visiting (2019) Health Visiting in England: a vision for the future – suite of resources: <https://ihv.org.uk/our-work/our-vision/>

³ Institute of Health Visiting (2020) Making History: Health visiting during COVID-19 <https://ihv.org.uk/news-and-views/news/spotlighting-the-vital-safety-net-that-health-visitors-have-provided-for-babies-and-young-children-during-the-current-pandemic/>

⁴ Latest published data on the health visiting workforce indicates 7,555 WTE. (6,422 Full Time Equivalent (FTE) recorded on NHS HV workforce data August 2021; 1,133 FTE recorded on Independent Healthcare Provider workforce statistics published Feb 2021; **Percentage reduction in published workforce data= 33%**, compared to combined NHS and Independent workforce statistics Sep/Oct 2015 =11,266FTE)

⁵ Health Foundation statement retrieved from <https://www.health.org.uk/news-and-comment/news/public-health-grant-allocations-represent-a-24-percent-1bn-cut> on 19th May 2021

⁶ Department of Health and Social Care (2021) The best start for life: a vision for the 1,001 critical days

authorities to create strong and innovative health visiting services which provide a vital **infrastructure of support** to improve child health outcomes, reducing the burden on the NHS and children’s social care, and making the UK a “happier and fairer place”. We also support wider children’s sector calls to action.

Key policy recommendations for health visiting:

1. We are calling for a **£500 million¹ ringfenced uplift** in the Public Health Grant over the next three years which would enable growth in health visitor numbers and delivery of the Government’s pledge to prioritise **“the recovery of health visiting and the Healthy Child Programme.”¹**
2. We are calling on Government to invest enough to achieve a total of **5,000¹** additional health visitors over the next 5 years, with **3,000 in this spending review** period (see Appendix 1).
3. In addition to the extra health visitors, the £500 million includes funding to strengthen the **leadership capability** in health visiting. This would enable service leaders to drive excellence in health visiting practice through service innovation and strong integration with other services.
4. We strongly advise that **the budget for health visitors is ring fenced**, and system levers are used, to ensure that the fundamental core components of an effective health visiting service are available to all families, at a level proportionate to need regardless of where they live.
5. To ensure that the needs of babies, children and families are addressed in Integrated Care Systems, in ways that most effectively drive improvement in health, the Government should also invest in **‘ICS academies for child and family health’**, within selected early adopter sites. These academies will bring providers and commissioners of NHS services across a geographical area together with local authorities, Primary Care Networks and other local partners to collectively plan, test and refine health and care services to meet the needs of babies, children, families and communities. Improving integration represents a fundamental shift in health and care delivery and it will be important to have systems in place to support and evaluate the implementation of ICSs and inform wider system learning.

Our key policy recommendations will:

- Reduce the burden on the NHS and children’s social care, and bring benefits that extend beyond the Department of Health and Social Care⁷, by enabling all local authorities to build a robust infrastructure of effective support for families and address well-documented system failures to safeguard babies and young children.
- Strengthen health visitors’ capacity to support families directly and supervise skill mix teams, making best use of everyone’s knowledge, skills and competencies to improve outcomes.
- Ensure health visitors have manageable caseloads of children 0-5 years to deliver safe and effective care⁸ (see Appendix 2 for Safer Staffing).
- Enable local areas to flex their offer of support, based on the principles of proportionate universalism, to target resources to where they are needed most.
- Build on health visitors’ proven track record as an ‘innovative and modern’ workforce which has been at the forefront of implementing new technologies over many years (e.g. text

<https://www.gov.uk/government/publications/the-best-start-for-life-a-vision-for-the-1001-critical-days>

⁷ Department of Health and Social Care (2021) The Best Start for Life: a vision for the 1001 critical days.

<https://www.gov.uk/government/news/government-publishes-review-to-improve-babies-and-childrens-healthy-development>

⁸ 0-5 population 3.25m

messaging support, safe and effective use of virtual contacts and ‘blended models’ of support) as well as working innovatively with skill mix teams and local partners to ensure that families receive personalised support.

- Ensure that the health visiting workforce can support Department of Health and Social Care plans for the future (for example, supporting the newborn genomics screening programme).
- Strengthen health visitors’ leadership capability and help transform models of care within Integrated Care Systems.

The economic case for investment in preventative public health and early intervention

6. The Chancellor has said that the Spending Review will make people's lives better by levelling up across the UK, building infrastructures for growth with strong and innovative public services. The **evidence is clear that investing in an infrastructure for the earliest years of life represents the smartest of all investments**, building the human potential to advance ‘Global Britain’ and reducing inequalities, yet this currently receives insufficient attention. The pandemic has also laid bare the challenges facing our health and social care system which will require a new approach.

7. **We need to ensure that every pound is well-spent** - the cost of “getting it wrong” includes, but is not limited to, the following **spiralling costs to society**:

- The **cost to the NHS of health inequalities** has been estimated to be **£5.5 billion per year**⁹.
- The **cost of ‘lost opportunity’ in England is £16.13 billion per year**. This is an underestimate of the full costs and represents the “cost to society of the remedial steps needed to address issues that might have been avoided through action in early childhood”¹⁰.
- **An overwhelmed NHS**: Prior to the current pandemic, 2 million children aged 0-5 years attended A&E every year with rates increasing by 24% in the last six years (current rate is 655.3 per 1,000 and getting worse)¹¹. Most of these presentations are avoidable or preventable and will be for relatively minor or self-limiting illnesses and unintentional injuries. Consistent, explicit safety-netting advice to improve parental health literacy has been shown to reduce re-attendance. A **10% reduction in A&E attendance for under-5s would yield around £31.5 million a year**.
- **Childhood obesity**: is a strong predictor of adult obesity. 64% of the adult population in this country is currently overweight or obese with an estimated cost to the NHS of **£6 billion per annum**, this is forecast to rise to **£9.7 billion per year** by 2050¹².
- 20%¹³ of women are affected by **perinatal mental health problems and around half are not accessing support**^{14 15}. Perinatal mental illness carries a total long-term cost to society of at least **£8.1 billion**¹⁶ for each one-year cohort of births in the UK.

⁹ Public Health England (2019) Health inequalities: place-based approaches to reduce inequalities. London.

<https://www.gov.uk/government/publications/health-inequalities-place-based-approaches-to-reduce-inequalities>

¹⁰ The Royal Foundation (2021) Big Change Starts Small. <https://centreforearlychildhood.org/report/>

¹¹ PHE Fingertips (2021) Child and maternal health. <https://fingertips.phe.org.uk/profile/child-health-profiles/data#page/13>

¹² The Kings Fund (2021) Tackling obesity The role of the NHS in a whole-system approach.

<https://www.kingsfund.org.uk/sites/default/files/2021-07/Tackling%20obesity.pdf>

¹³ Public Health England (2021) Early years high impact area 2: Supporting maternal and family mental health

<https://www.gov.uk/government/publications/commissioning-of-public-health-services-for-children/early-years-high-impact-area-2-supporting-maternal-and-family-mental-health>

¹⁴ Best Beginnings, Home-Start UK, and the Parent-Infant Foundation (2020) Babies in Lockdown: listening to parents to build back better. <https://parentinfantfoundation.org.uk/our-work/campaigning/babies-in-lockdown/#fullreport>

¹⁵ NCT Hidden Half campaign <https://www.nct.org.uk/get-involved/campaigns/hidden-half-campaign>

¹⁶ Bauer et al (2014) Centre for Mental Health and London School of Economics: The costs of perinatal mental health problems. <https://www.centreformentalhealth.org.uk/sites/default/files/2018-09/costsofperinatal.pdf>

- Reducing the incidence of five illnesses protected by **breastfeeding would save** the NHS at least **£48 million a year, reducing** hospital admissions and GP consultations¹⁷.
- Dental decay and gum disease are the most common oral health conditions and are largely preventable with good habits learned in childhood. The cost to the NHS of treating oral health conditions is around **£3.4 billion** per year¹⁸.
- **Around 1 in 5 children will experience domestic abuse (DA)** with an estimated cost of over **£66 billion per year** in England and Wales.¹⁹ Due to its devastating impact, children are recognised as victims of DA in their own right²⁰.

8. The impact of the pandemic is not evenly distributed, with the most disadvantaged experiencing the most detrimental consequences, with rising levels of need. Adversity and exposure to toxic stress are linked with poor social, educational, physical, and emotional health outcomes across the life course. The actual impact of the pandemic on babies and young children is likely to be far-reaching and will not be known for some time due to delays in identification. Importantly, health visitors provide a vital infrastructure of support needed for the identification of vulnerable babies and young children.

9. Don't just take our word for it: The value of investing in health visiting has attracted **widespread support** from partners who are national experts in this field, including: The 'One Voice Partnership' (which includes the Royal College of Midwives (RCM), the Royal College of Obstetricians and Gynaecologists (RCOG), Sands, and the National Childbirth Trust (NCT))²¹, The First 1001 Days Movement²², The National Network of Designated Healthcare Professionals for Children UK (NNDHP)²³, Health Policy Influencing Group (HPIG)²⁴, Maternal Mental Health Alliance (MMHA) and the Royal College of Paediatrics and Child Health (RCPCH).

"As we recover from the pandemic, we have huge opportunities and challenges ahead and I am convinced that health visitors will play a key role in addressing the crucial issues of health promotion and early intervention amongst the families they work with."

Dr Camilla Kingdon, President Royal College of Paediatrics and Child Health (RCPCH)

"Health visiting is the foundation upon which specialist infant mental health services are built – they provide information and guidance... they screen for families that need more intensive support... and help to engage them in specialist provision, and they provide maintenance and consolidation of changes made. Healthy health visiting services make infant mental health services not only more effective and efficient, but possible."

A service lead in a parent-infant team (Parent-Infant Foundation, 2021)

¹⁷ Public Health England (2016) Commissioning infant feeding services: a toolkit for local authorities.

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/538344/Commissioning_infant_feeding_services_a_toolkit_for_local_authorities_Part_2_.pdf

¹⁸ <https://www.gov.uk/government/publications/adult-oral-health-applying-all-our-health/adult-oral-health-applying-all-our-health>

¹⁹ Rhys Oliver, Barnaby Alexander, Stephen Roe and Miriam Wlasny (2019) The economic and social costs of domestic abuse Research Report 107 Home Office <https://www.gov.uk/government/publications/the-economic-and-social-costs-of-domestic-abuse>

²⁰ Home Office (2021) Domestic Abuse Act 2021: overarching factsheet.

<https://www.gov.uk/government/publications/domestic-abuse-bill-2020-factsheets/domestic-abuse-bill-2020-overarching-factsheet>

²¹ One Voice Movement (2021) Letter on cuts to local public health budgets: <https://ihv.org.uk/news-and-views/news/ihv-welcomes-one-voice-letter-on-cuts-to-local-public-health-budgets/>

²² First 1,001 Days movement (2021) Turn Off The Taps Campaign: <https://ihv.org.uk/news-and-views/news/turnoffthetaps-campaign-to-invest-in-health-visiting/>

²³ NNDHP (2021) Letter on cuts to local public health budgets: <https://ihv.org.uk/news-and-views/news/ihv-welcomes-nndhp-letter-on-cuts-to-local-public-health-budgets/>

²⁴ HPIG (2020) Early Years Recovery Briefing <https://www.ncb.org.uk/sites/default/files/uploads/files/early-years-recovery-briefing.pdf>

Health visiting is a vital infrastructure, not an intervention:

- 10. Why health visiting?** Health visiting is more than a ‘task’, or an ‘intervention’ or even a service; when sufficiently resourced, it provides a vital infrastructure of support for all babies, young children and their families, improving health and safeguarding the most vulnerable who are unable to speak for themselves and often invisible to other services (see Appendix 5).
- 11. The health visiting ‘infrastructure’** is unique in its universal reach into all families - working ‘upstream’ in communities to prevent problems happening in the first place (‘health creation approach’), searching for health needs, and brokering families’ engagement in additional support when needed. **If positive outcomes are wanted, then investment is needed in an infrastructure which includes the core elements by which these outcomes are made.** This forms the basis of personalised care which is a key government ambition for health visiting²⁵. Professor Toby Lowe is a leading expert on complex system’s thinking and has produced work on ‘How health visiting creates positive outcomes’²⁶.
- 12. Health visitors:**
- **Are Registered nurses, or midwives**, who have completed **additional Specialist Community Public Health Nursing training** and are **regulated by the Nursing and Midwifery Council** (NMC) to ensure that families receive safe and effective care.
 - Are a professional workforce trained to support **babies, children, adults and communities** across a continuum of **physical health, mental health, social needs, child development and safeguarding** concerns, with a focus on ‘health creation’, as well as evidence-based support for identified needs.
 - Have the skills to work in a **strengths-based** way, supporting the ‘whole person’ within the context in which they live, which avoids families having to repeatedly ‘tell their story’. Most vulnerable families will have multiple co-existing needs which require coordination of care and support from a practitioner skilled in working with both children and adults, and across agencies within local communities.
 - Have a **high level of acceptability** with families as they are part of the ‘**health workforce**’ which reduces the stigma of asking for help, compared to children’s social care. Through **continuity of carer**, they build **relationships with families** and provide a vital **safety net for babies, young children** and families who can easily fall through the gaps between services when they disengage in interventions, or when a time-limited intervention ends.
 - Are therefore ideally placed to be the **default lead professional** for families with children 0-2 years and those not attending an Early Years setting.

Health at the heart of health visiting:

- 13. Health visitors are a safety-critical health workforce**, contributing important elements, including ‘case finding’, to numerous child and adult physical and mental **health pathways**. Their breadth of **clinical skills** needed for these specific areas of work should not be overlooked or replaced by skill mix staff without these skills. These skills are central to the **safe delivery** of numerous aspects of the Healthy Child Programme including:
- **Preconception care:** prevention of harm, including reducing smoking in pregnancy, support for alcohol and substance misuse, reducing genetic risk, support for healthy weight, and brokering engagement in antenatal care.

²⁵ PHE (2021) Health visiting and school nursing delivery model.

<https://www.gov.uk/government/publications/commissioning-of-public-health-services-for-children/health-visiting-and-school-nursing-service-delivery-model>

²⁶ Lowe T (2021) How health visiting creates positive outcomes. <https://ihv.org.uk/news-and-views/voices/how-health-visiting-creates-positive-outcomes/>

- **Perinatal mental health:** including identifying and supporting directly/ or referring for specialist support, parents with perinatal anxiety, depression, post-traumatic stress disorder, eating disorders, intrusive thoughts, psychosis and those at risk of suicide.
- **Postnatal care**²⁷: identifying and managing **common and serious health problems** in women and their babies, sexual and reproductive health and contraception advice.
- **Infant and child mental health:** helping parents and their infants form strong relationships.
- **Infant feeding:** including breastfeeding support and recognition/ management of problems including faltering growth, reflux, intolerances and allergies.
- **Managing childhood illnesses** and recognition of serious health problems – improving parental health literacy and nurse prescribing to reduce the burden on the NHS.
- **Accident prevention** and support for families following an accident.
- Improving **immunisation** uptake (adults and children); support for vaccine hesitancy.
- Failsafe for **newborn screening** programme: supporting parents through diagnosis (Note: the HV workforce will need to have sufficient capacity to support the NHS plans for newborn genomic screening).
- **Chronic conditions and disabilities:** Early recognition of these conditions is important as it speeds up the diagnosis and treatment which can make a significant and life-changing difference to outcomes and prognosis. Health visitors also have a role in care coordination and providing support for parents.

14. Whilst maximising the skills of a modern skill mix team will bring many benefits and help to relieve some of the current workforce pressures, it is important that delegation is done safely, in accordance with the legal requirements of the Nursing and Midwifery Council, in order to protect the public and the workforce (see Appendix 2). We welcome the ongoing opportunity to work with the Government to maximise the contributions of a skill mix team safely.

15. Key considerations: Health visitors will always remain responsible and accountable for the assessment, planning and supervision of care for all children on their caseload, even when they delegate work. In practical terms, there is clearly a safer staffing limit to the number of children that a single health visitor is able to be accountable for. Alison Leary, Professor of Workforce Modelling, sets out the added value of having an infrastructure of support for families planned and delivered by highly skilled Specialist Community Public Health Nurses²⁸. Without robust workforce modelling, efforts to save money in the short term can prove costly through less effective care; spending on clinical negligence is currently escalating, constituting a major threat to the sustainability of the NHS²⁹.

16. Adult health needs cannot be overlooked: Parental factors like mental health problems, substance misuse and domestic abuse can have a direct and devastating impact on child outcomes. It is imperative that the workforce supporting families has **high level skills to work effectively with adults** during times of distress and to support positive behaviour change.

17. Cost of late identification of children with complex conditions: Cuts to health visiting have had a direct impact on the timely referrals to specialist services with many reporting problems with late identification of children with complex health conditions, mental health problems and wider vulnerabilities. Cutting skilled professionals to spot the early signs of these conditions is a false economy as any short-term savings are quickly offset by increased delayed treatment costs and, for some children, the consequences are catastrophic (this is well documented for childhood liver disease, cerebral palsy, spinal muscular atrophy and childhood cancers). Using cerebral palsy as an example, cerebral palsy and associated neuro-disabilities are highly responsive to early intervention, when plasticity (ability to change) in the child's developing brain is at its greatest. Despite this, effective early intervention remains the exception, rather than the norm, in the UK,

²⁷ <https://ihv.org.uk/news-and-views/news/ihv-welcomes-one-voice-letter-on-cuts-to-local-public-health-budgets/>

²⁸ Leary A (2021) <https://ihv.org.uk/news-and-views/voices/dying-for-investment-health-visiting-a-safety-critical-workforce/>

²⁹ MDU (2021) <https://www.themdu.com/press-centre/press-releases/healthcare-leaders-call-for-action-on-clinical-negligence-claims-costs-to-aid-nhs-pandemic-recovery>

and families struggle to navigate complex pathways of care that often do not even meet the minimum standards set out in the NICE Guidelines for Cerebral Palsy³⁰.

“I’ve been doing research into cerebral palsy for 20 years... if we aren’t working with those at-risk infants in those first few years of life, we are missing a massive opportunity to shape a developing nervous system. But we can’t intervene early if we haven’t got the infants – if they haven’t been referred in and detected. At the moment, the average age of diagnosis of cerebral palsy is around 2 years, and in that time, not only may infants either not be getting any intervention or they might not be getting the most tailored intervention... And their parents are dealing with huge levels of anxiety and uncertainty and they are not being supported appropriately. Actually, we could do better ... Only about 50% of babies come from that difficult path, i.e. are born preterm. The other 50% come from babies who didn’t have that obvious difficulty or premature start. So if we only do high risk developmental surveillance, we’ll miss that other half of kids”.

Dr. Anna Basu, Clinical Senior Lecturer at Newcastle University and Honorary Consultant Paediatric Neurologist, Royal Victoria Infirmary, (APPG on Cerebral Palsy, Nov 2020).

“If we are going to improve pathways of care, improving diagnosis is a very important first step. Vital to that is assessment of motor skills in children... In my field, neuromuscular diseases, we are dealing with a problem of a significant delay in diagnosis... which is incredible, particularly when you think that these are progressive conditions that every day these children wait for a diagnosis, their muscles deteriorate. And the delay in diagnosis means that they have a delay in access to care.... What is going wrong? No matter how good a treatment or care pathway is, late diagnosis is a major determinant of outcome.... I strongly feel that we cannot assess motor development by using a questionnaire by asking parents to rate their child’s motor skills. We need to go back to hands-on motor skill assessment”.

Dr. Henriette van Ruiten, Consultant in Paediatric Neurology and Neuromuscular Diseases, Great North Children’s Hospital, (APPG on Cerebral Palsy, December 2020)

The benefits of an effective health visiting service accrue to DHSC and other government departments:

18. Figure 1: Examples of health visitors’ contribution to key cross-departmental priorities

	Department priority
Department of Health and Social Care	Reducing burden in the NHS / A&E attendance in under 5s through improved parental health literacy and support with managing minor illnesses/ reducing unintentional injuries
	Supporting parents/ infants through newborn screening (to include genome screening)
	Improving oral health
	Improving immunisation uptake
	Improving early identification and support for complex health conditions and disabilities to improve early uptake/ efficacy of treatment
	Improving uptake of Healthy Start scheme for eligible children
	Supporting infant mental health and attuned parenting
	Identification and intervention for perinatal mental health conditions
	Working with parental substance misuse: Identification/ brokering engagement in support
	Preconception care/ smoking in pregnancy/ reducing preterm birth, foetal alcohol spectrum disorders and congenital conditions
	Improving breastfeeding rates
	Teenage parenthood
	Reducing obesity
	Working with alcohol dependent parents

³⁰ <https://www.nice.org.uk/guidance/NG62/chapter/Recommendations#looking-for-signs-of-cerebral-palsy>

Department for Education	Improving uptake of 2-year nursery offer for eligible children ³¹
	Improving early language/ school readiness
	Identification and support for vulnerable children and those at risk of significant harm (statutory vulnerability - Child in Need/ Child subject to a CP Plan/ Looked After Children)
	Early identification of children with complex health conditions and disability, brokering engagement in support/ alerting SEND education team/ support school readiness
	Supporting parents of children with SEND (transition to parenthood, parental wellbeing, self-efficacy). For example, supporting parents with children with autism with least restrictive practice in the earliest years prevents entrenched patterns of behaviour which may require long-term forensic in-patient care in adulthood
Department of Work and Pensions	Reducing parental conflict
	Identification and support for domestic abuse
	Signposting families to relevant benefits
Department for Levelling Up, Housing and Communities	Supporting Families Programme – identification of eligible families and brokering engagement
	Homeless families
Home Office	Asylum seekers and refugees

Focusing on those with the greatest needs. Health visitors have a key role in the identification of vulnerable babies and young children to support prevention, early intervention and address hidden harm:

19. The important steps of eliciting need and brokering engagement in support are frequently overlooked by services which measure success from their ‘front door’ based on the misguided assumption that vulnerable families will ask for help when needed. **Babies cannot speak and some parents do not have the agency to reach out for help for when needed.** Babies and young children do not have the safety infrastructures that schools provide to older children, they therefore need **skilled professionals who are ‘looking out for them’, can spot their distress and step in to help.** This is why we are calling on the Government to invest in health visiting as a vital safety net for babies and young children.

“The health visiting cuts mean all the onus is on parents to have to reach out when it’s the hardest thing to do. You feel sick, shaky and talk yourself out of that call at least 20 times before you make it. Some never will!”

Parent quote

“Whilst many parents have the agency to reach out and ask for help when they are struggling, many don’t. Picture the 19-year-old first-time single mother, who is developing postnatal depression and is both frightened and detached from family and friends. Or the young father who is plagued by difficult emotions in the face of a crying baby and tired partner. It is not only babies and infants who have no understanding of their situation nor a direct line to public services... Health visitors, by spotting children and families in difficult situations, are vital to child and family wellbeing”.

Dr Peter Green Chair of The National Network of Designated Healthcare Professionals for Safeguarding Children

20. Populations with the greatest risk of maltreatment, such as parents with mental health or substance misuse problems, are known to have relatively low rates of enrolment in voluntary programmes³². 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, with high levels of attrition reported. In addition, 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.
21. Babies pay the ultimate price for the failings in the systems designed to safeguard and protect them. Pre-Covid, the Children’s Commissioner raised concerns about the number of invisible children, estimated to be more than a third of all vulnerable children³³ who are not known to services and therefore not getting any support.
22. **There is a clear imperative for change – we need to do better:** This year marks the 30th birthday of Victoria Climbié whose case hit the headlines and was a key driver for a radical shift in national policy to safeguard children. Yet the situation is now far worse, with 536 serious incident and child death notifications recorded last year, up 87 on 2019-20. 36% of these notifications related to children under the age of 1³⁴, and **the under ones remain at the highest risk of homicide compared to any other age group**^{35 36}.
23. Having skills to address the needs of both children and adults, alongside the **robust lines of accountability** for all children on their caseloads, reduces fragmentation and the likelihood that vulnerable children will fall through the gaps between services, which is highlighted as a significant risk factor in almost all Serious Case Reviews³⁷.
24. **Reaching minoritised groups:** This includes supporting individuals and groups who do not currently experience easy access to services (for example the Gypsy/ Traveller community, asylum seekers, families struggling with poverty, and individuals who are not registered with a GP). Health visitors are widely accepted by minoritised groups and there are numerous case studies outlining the effectiveness of their programmes of work in identifying need and improving health outcomes (see short film on HV work with homeless families and refugees³⁸).

Current state of health visiting:

25. Underinvestment in health visiting is a longstanding concern. Health visitors have worked incredibly hard during the pandemic but they are worried that they are only reaching the ‘tip of the iceberg’ of growing need³⁹, with widening inequalities. The cuts in services – which are still taking place - mean that many families no longer receive a good service and there is a “postcode

³² Institute of Health Visiting (2019) Health Visiting in England: a vision for the future. <https://ihv.org.uk/wp-content/uploads/2019/11/7.11.19-Health-Visiting-in-England-Vision-FINAL-VERSION.pdf>

³³ Children’s Commissioner (2019) Childhood vulnerability in England. <https://www.childrenscommissioner.gov.uk/report/childhood-vulnerability-in-england-2019/>

³⁴ Serious incident notifications (2021) <https://explore-education-statistics.service.gov.uk/find-statistics/serious-incident-notifications>

³⁵ Office for National Statistics (2021) Homicide in England and Wales: year ending March 2020. <https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/homicideinenglandandwales/yearendingmarch2020>

³⁶The Child Safeguarding Review Panel (2021) The Myth of Invisible Men: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1017944/The_myth_of_invisible_men_safeguarding_children_under_1_from_non-accidental_injury_caused_by_male_carers.pdf

³⁷ NSPCC – national repository of Serious Case Reviews. https://library.nspcc.org.uk/HeritageScripts/Hapi.dll/search?2?&LabelText=Case%20review&searchterm=* &Fields=@&Media=SCR&Bool=AND&

³⁸ Institute of Health Visiting (2021) A window into health visitors’ work with homeless families. <https://ihv.org.uk/news-and-views/voices/a-window-into-health-visitors-work-with-homeless-families-making-the-invisible-visible/>

³⁹ Institute of Health Visiting (2020b) State of health visiting in England <https://ihv.org.uk/wp-content/uploads/2020/12/State-of-Health-Visiting-survey-2020-FINAL-VERSION-18.12.20.pdf>

lottery” of support. Health visitors are operating with caseloads of 800-1000 children in some areas, services are designed so that there is a lack of continuity of carer, and opportunities to see families face-to-face for universal assessments are restricted. In these circumstances, even the most skilled professionals cannot work effectively. Many families are not even receiving their mandated checks with a health visitor, let alone able to access additional, timely support. The most recent data available on health visitor service delivery in England shows that in 2019/20 23% of one-year-olds had no 12-month health visiting review.

26. Latest published data on the health visiting workforce indicates 7,555 Full Time Equivalent (FTE) health visitors in England (6,422 recorded on NHS HV workforce data August 2021; and 1,133 recorded on Independent Healthcare Provider workforce statistics - Feb 2021). This represents a 33% reduction in published workforce data, when compared to 2015 (11,266FTE). We understand that there is an additional small unpublished health visiting workforce employed directly by some local authorities, however, the numbers are small and do not change **the headline message that the workforce cuts have been significant, and investment is urgently needed.**
27. Action needs to start now to avoid further workforce losses and there is an urgent need for **national health visiting workforce forecasting to support this.** Local areas have highlighted the workforce recruitment and retention challenges that they are experiencing to the iHV. We are aware of some local areas forecasting a 25% shortfall over the next 5 years. In addition, the planned closure of all NHS legacy pension schemes on 1st April 2022 is likely to increase the number of older health visitors taking early retirement next year.

Looking to the future:

28. When health visiting services are invested in, they can work in new, evidence-based and innovative ways to provide excellent services, especially to our most vulnerable families. It is now time to invest in workforce development and service innovation. The health visiting service is a modern, highly skilled workforce ready to embrace the opportunities available through Family Hubs and integrated working in ICSs, as well as building on the plethora of health visiting innovations. In particular, the profession is keen to continue to further develop, evaluate and refine their work to increase families’ choices through the effective use of new technologies where they can enhance care without compromising safety – health visitors have developed some excellent innovations where this is working well.
29. Increasing funding in the public health grant to enable 5000 new health visitors over the next 5 years, with leadership development, would provide the workforce needed to play its fullest part in tackling this nation’s challenges and supporting integrated models of care. The Government needs to find a way to protect this vital workforce into the long term so that its activities are no-longer at risk from policy changes by subsequent governments.
30. The deliverability of these proposals is relatively straightforward as they build on an existing service to maximise its impact, rather than developing a new service. The Institute is here to help.

Appendix 1:

Our recommendations will deliver on the Government’s pledge to ‘**rebuild health visiting**’. This will be achieved by:

- i. training 5,000 additional health visitors over 5 years (3,000 in this Spending Review),
- ii. a focused campaign to bring health visitors back into the profession after a time away, with the aim of attracting an additional 1,000 health visitors back into health visiting from year 1 and to offset estimated workforce attrition rates of 20%.
- iii. Increasing the workforce in these numbers would be enhanced by providing new routes into the profession, the current review of health visiting standards by the Nursing and Midwifery Council provides an opportunity for this and we have shared our draft proposals with the Early Years Review team.

Figure 2: The costs of health visitor workforce development

	Year 1	Year 2	Year 3
Substantive Band 6 Health Visitor Posts (3,000 posts over 3 years ; 5,000 over 5 years; plus 1,000 RTP HVs*)	£38m	£76m	£114m
Training student health visitors (band 5 salary)- 3,000 health visitor training posts over 3 years ; 5,000 over 5 years	£86.9m	£86.9m	£86.9m
Leadership	£0.8m	£1.6m	£2.4m
Total	£125.7m	£164.5m	£203.3m

* To offset an estimated 20% attrition rate, 6,000 additional health visitors will need to be trained or return to practice over 5 years to achieve an overall increase in the HV workforce of 5,000 over 5 years (national workforce forecasting is needed to test these assumptions).

Due to lag time in training additional health visitors (1-2 years depending on training route), the year 1 uplift in substantive post costs will cover return to practice (RTP), supporting qualified health visitors to return to practice (those who have been out of health visiting for a while and have lapsed their registration at the NMC will require a 3-month RTP course). Bringing trained health visitors back into the profession by understanding and addressing the reasons why they have left will also be an important first step.

The Government’s commitment to the ‘recovery of health visiting’ will require several approaches to improve workforce capacity and support the recruitment, retention and career progression for health visitors. We welcome the opportunity to continue the preliminary discussions that we have had with the Early Years team led by Dame Andrea Leadsom, Health Education England, NHSE/I and the Nursing Maternity and Early Years team at former Public Health England, to further develop routes into the profession through the Nursing Associate programme, as well as to explore options for accelerated HV programmes using Accreditation of Prior Experiential Learning (APEL) for graduates (Registered Nurse(RN), followed by SCPHN training).

Appendix 2: Safer staffing: Caseload size and skill mix teams:

Legal elements to consider when delegating work:

- The Nursing and Midwifery Council (NMC)^{40 41} set out expectations of registered nurses when they delegate work to others. Health visitors are bound by the NMC code.
- The NMC⁴² state that registered nurses need to make sure that everyone they delegate tasks to are **adequately supervised** and **supported** so they can provide safe and compassionate care. Therefore, health visitors can only delegate tasks and duties that are within the other person's scope of competence, making sure that they fully understand the instructions.
- Delegation can only take place when it is in the **best interests** of the person receiving the care and when a **holistic assessment of need** has been **undertaken by the nurse** who delegates the care.
- The registered nurse needs to confirm that the outcome of any delegated task meets the required standard.

Registered nurses (including health visitors) have **four** different lines of accountability:

- **To the public** – criminal prosecution-criminal offence
- **To the client** - civil claim- claim-compensation
- **To the employer** – civil action-breach of contract
- **To their professional body** (NMC) – Professional conduct hearing –Professional misconduct

- i. **“Safer staffing”** levels are needed to ensure that all health visitors have a manageable workload. It goes without saying that it is impossible for a single practitioner to be safely accountable for the assessment and care of 750 or more children and their families⁴³.
- ii. Skill mix teams bring considerable benefits by maximising workforce skills, and there are good examples of effective working models; however, it is important that case delegation is done safely to protect both the workforce and families.⁴⁴ Delegating responsibility for caseload management to more junior staff, without the level of training needed to work autonomously and develop/adapt plans of care, including clinical assessments and care, presents a significant risk, for which the health visitor remains accountable. In community nursing services such as health visiting, care is usually provided in the patient's home by a member of staff working alone, so staff are expected to work **autonomously** and make decisions⁴⁵. This highlights the importance of the HV assessing the family first to ensure it is safe to delegate the work.
- iii. If caseloads are **redistributed** to other workers (i.e. not delegated, but shifted wholesale from the health visitor and managed by skill mix workers), the health visitor will no longer be accountable for the assessment, care planning or review of the children and families, or supervision of the workforce. This raises significant governance issues and, in our view, undermines the safe delivery of the Healthy Child Programme which we urge the Government to consider carefully when workforce modelling.

40 Nursing and Midwifery Council (2018) The Code: Professional standards of practice and behaviour for nurses and midwives and nursing associates <https://www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/nmc-code.pdf>

41 Royal College of Nursing (2017) Accountability and Delegation. A Guide for the Nursing Team. <https://www.rcn.org.uk/professional-development/accountability-and-delegation>

42 NMC (2019) Delegation and accountability: SUPPLEMENTARY INFORMATION TO THE NMC CODE <https://www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/delegation-and-accountability-supplementary-information-to-the-nmc-code.pdf>

43 Conti, G; Dow, A (2021a) Using FOI data to assess the state of Health Visiting Services in England before and during COVID-19. UCL Department of Economics: London, UK. <https://discovery.ucl.ac.uk/id/eprint/10132710/>

44 Royal College of Nursing (2017) Accountability and Delegation. A Guide for the Nursing Team. <https://www.rcn.org.uk/professional-development/accountability-and-delegation>

45 Health Education England (2015) District Nursing and General Practice Nursing Service: Education and career framework. https://www.hee.nhs.uk/sites/default/files/documents/Interactive%20version%20of%20the%20framework_1.pdf

- iv. As highlighted in our recent meetings with the Early Years Team, we would welcome the opportunity to work with the Government to get this balance right, working with early adopter sites to evaluate the implementation and impact of different models of skill mix in practice using ‘test and learn’ methods, including co-production with service users. This would provide an essential next step to maximise the considerable benefits of skill mix teams, whilst also ensuring that the public is protected and the workforce is able to practice safely.

Local flex: caseloads based on proportionate universalism:

- v. Historically, the recommendation has been for a caseload of 250 children per health visitor (HV). This modelling was founded on an evidenced driven funding model developed by the UK Public Health Association⁴⁶, which immediately preceded the ‘Call to Action’⁴⁷ using proportionate universalism. This method is currently being used in Scotland and Blackpool where it is working well. Scotland offers 12 mandated visits in the early years and Blackpool offers eight. In England, most health visitors are currently unable to offer even 5 mandated contacts. The recently updated Health Visiting model for England recommends two additional universal contacts, however these are rarely implemented due to workforce capacity issues⁴⁸.
- vi. **The iHV supports the case for ‘local flex’ when determining the most effective caseload size, based on robust local workforce modelling.** All local authorities will contain areas of higher deprivation, alongside more affluent areas. As many vulnerability factors are socially correlated (although not entirely - vulnerable families exist in all postcodes), it makes sense to redistribute the workforce to provide an increased HV to child ratio in the areas of greatest disadvantage. For example, a local authority may choose to have caseloads of 100 children (0-5 years) per FTE HV in areas with the highest deprivation and caseloads of 400 children per FTE in the least deprived areas, the exact numbers will be subject to local workforce modelling. Therefore, our costings are based on an ‘average’ caseload of 250 children per FTE HV, with the expectation that a degree of local flex will be applied as described above.

[Note: the recommended caseload size for a Family Nurse Partnership nurse is 20-25 babies/ children; and ‘Starting Well’ (80 families per health visitor + family support worker). In 2009 the Laming Review recommended that those working in child protection should have no more than 13 cases. Most children’s services departments aim for 18-20 cases].
- vii. This HV caseload modelling takes account of the fact that some families will need much less support than others (for example, a mother of a 3-year-old child assessed as having universal needs may require very little support from the health visitor), and this is already built into these calculations for an ‘average’ caseload of 250 children. As needs change over time, having this 3-year old child and family on an ‘open’ HV caseload up to school entry avoids the need to do a new referral back into the HV service should a problem arise, it also reduces bureaucracy and the risk of families falling in the gaps between services which increases risk. We are aware that some areas now only have health visiting caseloads up to the age of 2 years which masks workforce cuts and introduces the governance challenges described.
- viii. Our calculation also allows time for supervision of delegated work which needs to be modelled into any of the government’s calculations as this is an essential part of workload delegation.
- ix. The funding model uses the Index of Multiple Deprivation (IMD) to support a graded caseload (Figure 3), based on evidence and professional consensus about the staff time required.

⁴⁶ UK Public Health Association (2009) Health visiting matters: re-establishing health visiting.

⁴⁷

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/383426/27_childrens_public_health_services_from_pregnancy_to_age_5.pdf

⁴⁸ Public Health England (2021) Health Visiting and School Nursing Service Delivery Model.

<https://www.gov.uk/government/publications/commissioning-of-public-health-services-for-children/health-visiting-and-school-nursing-service-delivery-model>

Figure 3:

IMD Score Decile	Suggested ratio of Full Time Equivalent HVs to 0-5 yrs
1. Most deprived 10%	1 to 100
2. 70 th to 90 th deciles	1 to 150
3. 40 th to 70 th deciles	1 to 300
4. Least deprived 30%	1 to 400

Appendix 3: Caseload sizes in Scotland and Blackpool

Region	Caseload size	HV core work	Skill mix type	Work undertaken by skill mix
Blackpool	100-400 per FTE (depending on need, the higher the need the lower the caseload numbers)	All Antenatal and early infancy contacts. UP, UPP and safeguarding work	Staff nurses Nursery Nurses	Latter part of HCP contacts which are delegated and supervised by a HV Sleep, diet, parenting, behaviour
Scotland NHS Board 1)	170 - 250	All 12 universal contacts UP, UPP and safeguarding work	Health visiting support workers, family nurturers,	Sleep, diet, parenting, play, development, behaviour
Scotland NHS Board 2)	160	All 12 universal contacts UP, UPP and safeguarding work	Nursery Nurses	When staff shortages NN will do some developmental checks but this is not what they are intended for. Sleep, diet, parenting, play, development, behavior
Scotland NHS Board 3)	250	All 12 universal contacts UP, UPP and safeguarding work	Nursery Nurses	Sleep, diet, parenting, play, development, behaviour, baby massage
Scotland NHS Board 4)	100-400 per FTE (depending on need, the higher the need the lower the caseload numbers)	All 12 universal contacts UP, UPP and safeguarding work	Early Years Workers	Sleep, diet, parenting, play, development, behaviour,
Scotland NHS Board 5)	250	All 12 universal contacts UP, UPP and safeguarding work	Early Years Workers	Sleep, diet, parenting, play, development, behaviour,
Scotland NHS Board 6)	150 Rural areas have more children where there is less deprivation but more time is needed for travel	All 12 universal contacts UP, UPP and safeguarding work	Nursery Nurse Health Care Support Worker	Sleep, diet, parenting, play, development, behaviour,

Appendix 4: 'ICS academies for child and family health':

Our recommendation:

To ensure that the needs of babies, children and families are addressed in Integrated Care Systems, in ways that most effectively drive improvement in health, the Government should also invest in '**ICS academies for child and family health**', within selected early adopter sites.

These academies will bring providers and commissioners of NHS services across a geographical area together with local authorities, Primary Care Networks and other local partners to collectively plan, test and refine health and care services to meet the needs of babies, children, families and communities. Improving integration represents a fundamental shift in health and care delivery and it will be important to have systems in place to support and evaluate the implementation of ICSs and inform wider system learning.

Through discussions with local authorities and leaders in emerging ICSs, it has been suggested that one of the most effective way to strengthen capability in the local system and support wider system learning is to make use of the existing regional Applied Research Collaborations⁴⁹ and develop a 'test and learn'/ ICS implementation support and evaluation Academy. This proposal is uncoded - a dedicated ring-fenced budget will support a selected number of regional 'early adopter' Academies, the outputs will inform ICS plans for children and wider system learning to support successful implementation at scale.

Appendix 5: Who are health visitors and what do they do? See infographics below

⁴⁹NIHR Applied Research Collaborations (ARCs) support applied health and care research that responds to, and meets, the needs of local populations and local health and care systems. <https://www.nihr.ac.uk/explore-nihr/support/collaborating-in-applied-health-research.htm>

Who are health visitors and what do they do?

They are a vital infrastructure, working in partnership with families, communities and professionals



infant - /'ɪnf(ə)nt/

from Latin infant - 'unable to speak'

Health visitors speak up for babies and their families

Who are health visitors?

- Registered nurses or midwives
- Have additional **registered** specialist training in public health
- Part of the 'health' workforce
- Work with all families from pregnancy to starting school
- "Eyes and ears" of the community
- Innovative workforce embracing digital technology



What do health visitors do?

- Give every baby the best start in life
- Support **thousands** of families every week
- Provide extra support when families need it the most
- Build on families' strengths
- Prevent** costly problems or spot them early
- Connect families to the right support and find solutions together
- Building a fairer society

Health creation is at the heart of health visiting

"As we recover from the pandemic, we have huge opportunities and challenges ahead...I am convinced that health visitors will play a key role in addressing the crucial issues amongst the families they work with."

Dr Camilla Kingdon, President of the Royal College of Paediatrics and Child Health



Physical Health

Child physical health

- Promoting health and wellbeing
- Coping with a **premature or sick** baby
- Infant feeding difficulties
- Faltering growth
- Identifying and managing common childhood illnesses
- Immunisations
- Newborn screening and genomics
- Childhood obesity
- Promoting oral health
- Complex health conditions** and disabilities such as liver disease and **neuro developmental disorders**
- Foetal alcohol spectrum disorders

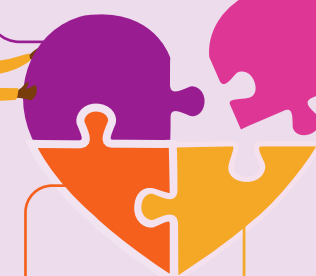
Adult physical health

- Common and **serious problems** in the postnatal period
- Pregnancy planning and sexual health advice
- Promoting physical activity, healthy weight and lifestyles - smokefree families



Social needs & safeguarding

- Building community connections**
- Reducing accidents
- Supporting vulnerable families**
- Domestic abuse
- Substance misuse



Child development

- Sleep
- Speech, language and communication
- School readiness
- Behaviour
- Promoting child development



Mental Health

- Promoting** good mental health and wellbeing of the whole family
- Identifying** 'red flags' and risk of suicide
- Assessment** of mental health
- Delivering evidence-based **interventions**
- Supporting healthy parent-infant and couple relationships

Public services are flooded with increasing needs. It's time to invest in health visiting to help to **#TurnOfftheTaps**



It's time to invest in health visiting because...

"My health visitor provided lots of information which was great because this was my first child and I felt I had no clue on a lot of things. She talked me through any questions, made sure I was ok without feeling like I was judged and made sure I knew I would always have help if needed for a wide variety of things"

A parent



"Health visitors have a holistic understanding of the infant experience and their development and can seamlessly interweave the key messages around infant mental health with other crucial public health messages...More universally, health visitors are best placed to identify those families requiring additional support...and are often our 'eyes and ears' in the community."

Consultant clinical psychologist



"If we aren't working with those at-risk infants in those first few years of life, we are missing a massive opportunity to shape a developing nervous system. But we can't intervene early if they haven't been referred in and detected.

Dr. Anna Basu, Consultant Paediatric Neurologist



"The health visiting cuts have resulted in the onus being on the parents to have to reach out when it's the hardest thing to do. You feel sick, shaky and talk yourself out of that call at least 20 times before you make it. Some never will!"

A parent



"Health visiting is the foundation upon which specialist infant mental health services are built – they provide information and guidance, they screen for families that need more intensive support and help to engage them in specialist provision...Healthy health visiting services make infant mental health services not only more effective and efficient but possible."

A service lead in a parent-infant team



Cuts have consequences

"The absence of a home visit means parents have been less likely to open up about difficulties, while health visitors haven't been able to identify developmental issues or safeguarding concerns so easily"

Homestart UK



"Health visitors, by spotting children and families in difficult situations are vital...They form core relationships with families without which our most vulnerable babies, children and young people would remain invisible to services, without the support that they need, and add to the tragedy of isolation and neglect that is the ongoing experience of so many..."

Dr Peter Green, Chair, National Network of Designated Health Professionals and Designated Doctor for Child Safeguarding NHS Wandsworth CCG



Investing in giving children the **best start for life** not only improves their **life chances**, but also reduces the **demands on public services**.

Public services are flooded with increasing needs.
It's time to #TurnOfftheTaps

