

Department of Health and Social Care - Hewitt review: call for evidence Written evidence submitted by the Institute of Health Visiting

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1. 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.

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 [documents](#) and summarised in infographics and a short film (links embedded):

- [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](#)
- [Infographic – ‘Who are health visitors and what do they do?’](#)
- [iHV film – ‘Health visiting in your community’](#)

2. Our key points

We provide evidence in relation to the health visiting service in England and its key contributions across multiple pathways for child and adult health within an integrated care system (ICS):

2.1. Empowering local leaders

2.1.1 Please share examples from the health and care system, where local leaders and organisations have created transformational change to improve people’s lives (250-word limit)

Health visitors are highly skilled Specialist Community Public Health Nurses, ideally placed to act as local leaders in ICSs, working collaboratively with others to facilitate a place-based response to improve health and reduce inequalities. All families have a health visitor, and their frontline practitioner intelligence provides an important ‘early warning signal’ of the most pressing threats to the health of our youngest citizens who are often hidden behind front doors and invisible to other services. Health visitors’ vital contribution to the success of ICSs requires strengthening to maximise their input across numerous clinical pathways for adults and children, physical and mental health needs, child development and safeguarding. Health visitors reduce health inequalities by: improving access, identification of need, experience and outcomes - summarised in the infographic, [“Who are health visitors and what do they do”](#) .

Whilst ICSs are in their infancy and their success awaits evaluation, there are good examples of local integrated programmes with health visitors to address key priority areas, including: [childhood obesity](#),

[perinatal and infant mental health](#), [oral health](#), [immunisations](#), [unintentional injuries](#), [minor illness management](#), [early language](#) and SEND (see iHV [pandemic case studies](#) and [case studies of best practice](#)), as well as advanced [‘whole system’ plans](#) for better integration in some areas. The most successful examples of integration have been seen in areas with strong local leadership, a [‘whole system’ approach](#) and an integrated response between agencies – this ensures all stakeholders understand what is required of them with agreed roles, responsibilities, governance and funding.

2.1.2 Do you have examples where policy frameworks, policies and support mechanisms have enabled local leaders and, in particular, ICSs to achieve their goals? (250-word limit) This can include local, regional or national examples.

Joint Forward Plans to achieve shared goals for babies and children in ICSs are currently being formulated and their success will depend on integration at all levels and sufficient resource to deliver all parts of integrated pathways. The benefits of an effective health visiting service accrue to numerous government departments and across a person’s lifetime. Therefore, complex system’s principles need to be applied across all aspects of health and care delivery, including workforce planning, funding and the development of measures that capture **input** and **impact** across the system.

The iHV [Vision for health visiting](#) provides an evidence-driven blueprint for health visiting and a framework for the service within ICSs. Health visitors provide an invaluable contribution across multiple public health priority areas and as a vital safety net to protect our most vulnerable citizens (particularly babies) who can easily slip through the gaps between services.

Integrated pathways need to be evidence-driven, with front-loaded funding across the whole pathway focused on both immediate and longer-term goals as an investment in future health, to ensure:

- All babies, children and families are supported to reduce health inequalities, and those at risk of poor outcomes are identified early
- A continuum of support for a continuum of need is provided to achieve shared goals for key public health priorities
- The current fragmented care and unwarranted variation across local authority areas is addressed.

The [‘early language integrated pathway’](#) provides a helpful framework and 4-step implementation plan that could be applied to other priority areas.

2.1.3 Do you have examples where policy frameworks, policies, and support mechanisms that made it difficult for local leaders and, in particular, ICSs to achieve their goals? (250-word limit) This can include local, regional or national examples.

ICSs present an opportunity to deliver greater collaboration within the healthcare system, however **we cannot expect a system which has been designed with the needs of adults in mind to work effectively for children without explicit requirements to do so**. A number of issues will hamper the success of ICSs if unaddressed:

- **Insufficient focus on babies, children and young people** who are not a sub-category of adults but represent 30% of the population with their own distinct health needs that are met through a wide range of services
- **Think systems** - Greater attention is needed to support integrated working across multiple funding streams, organisations and a complex array of legislation, lines of accountability, and output/ outcome measures
- **Workforce issues** - The system’s ability to support babies’, children’s and young people’s health is experiencing unsustainable strain from growing workforce pressures. The health visiting workforce has been cut by almost 40% since 2015 which has led to significant unwarranted variation in support for families. **It is not too late to change direction and**

pursue reforms, but the current situation is serious – the iHV will publish its latest national survey of health visiting on 18 January 2023: <https://ihv.org.uk/our-work/publications-reports/#>

- **Insufficient funding and ineffective data sharing/ analytics** hamper effective integrated working
- The result is that children in England have some of the worst health outcomes in Europe, with widening inequalities - this fragmentation of services particularly affects poorer children and those with long term conditions, or special educational needs and disabilities (SEND).

2.1.4 What do you think would be needed for ICSs and the organisations and partnerships within them to increase innovation and go further and faster in pursuing their goals? (250-word limit)

1. **Strong leadership** to represent children’s health in its broadest sense, not just the NHS’s remit
2. **Shared strategy** for children (across NHS, public health and social care)
3. **Shift towards prevention and early intervention** (including the first 1001 days) **with front-loaded spending** to support all people to lead healthy lives, thereby preventing costly ill health in later life
4. **Demand-driven workforce modelling, with sustainable funding** to give confidence when planning services for the longer term, deliver the Healthy Child Programme in full, and end the postcode lottery
5. **System’s thinking**: the benefits of an effective health visiting service accrue to numerous government departments and across a person’s lifetime. Complex system’s principles need to be applied across all aspects of health and care delivery, including workforce, funding and the development of measures that capture **input** and **impact** across the system
6. **Integrated care pathways** to ensure early identification of all children at risk of poor outcomes with effective support proportionate to need
7. **Mechanisms to capture and respond to children’s ‘voices’**: Lessons from research and inquiries, alongside ‘frontline practitioner intelligence’ should inform decision making, particularly for babies/ children who cannot speak for themselves
8. **Equity**: the narrowing of the focus of national targets cannot come at the expense of improving child health and reducing inequalities across England - the most pressing public health priorities do not vary substantially between local authority areas
9. **Evaluation and Accountability system** to support improvement and hold all system partners to account for shared outcomes.

2.1.5 What policy frameworks, regulations or support mechanisms do you think could best support the active involvement of partners in integrated care systems? (250-word limit)

Examples of partners include adult social care providers, children’s social care services and voluntary, community and social enterprise (VCSE) organisations. This can include local, regional or national suggestions.

ICSs should utilize existing mechanisms through Health and Wellbeing Boards (HWBs), and Joint Strategic Needs Assessments, to agree shared priorities and a Joint Forward Plan (JFP). It is essential that all partners are equally able to contribute to the JFP through forums to assess the health and wellbeing needs of their communities. In addition, the following components are required:

1. **Co-production with the people who use our services** to support the development of policy, regulation and service provision at every stage of every integrated pathway. Health visitors’ ‘frontline practitioner intelligence’ gathered through their work with individuals, families and communities across the full cross-section of society provides an

- important 'early warning signal' of the most pressing threats to families' health and wellbeing and should inform JFPs
2. **National support for implementation:** with systems in place to support the leadership, development, evaluation and implementation of approaches that most effectively drive improvements in health across the country, to inform wider system learning
 3. **National plan – it can't all be left to local decision making:** Whilst local areas understand the health of their population best, the most pressing threats to the nation's health apply to all local authorities and cannot be ignored by any ICS. National government needs to set and retain accountability for ambitious national 'health and wellbeing' goals for all children in England, with clear timescales for reviewing these, and mechanisms for holding ICSs to account when they are not meeting national guidelines, or targets, to improve health and reduce inequalities.

2.2. National targets and accountability

2.2.1 What recommendations would you give national bodies setting national targets or priorities in identifying which issues to include and which to leave to local or system level decision-making? (250-word limit)

The health of our nation's children is too important to be left to chance, or solely to local decision making. Whilst local areas understand the health of their communities best, the narrowing of the focus of national targets cannot come at the expense of improving child health and reducing inequalities across England - the most pressing public health priorities do not vary substantially between local authority areas.

End the postcode lottery of support that families face. England has widening health inequalities and escalating levels of population need, including parental stress and mental health problems that pose serious risks to children's future health, development and wellbeing. Lifelong health inequalities take root in early childhood - it is therefore vitally important that, amongst so many other pressing policy priorities, we do not overlook children's needs.

National goals and clearer expectations of support are needed: Through clearer commissioning guidance and service specifications for health visiting, with system enablers and levers to hold local authorities to account when they are not delivering services that align with the evidence in NICE guidance, or achieving targets to improve child health and reduce inequalities.

Current process outcome measures provide a perverse system disincentive to 'tick the box but miss the point'. ICSs need a [new kind of accountability](#). Complex system's principles need to be applied, with metrics to capture **input** and **impact** across the system, including: access, identification of unmet need, experience, outcomes, with **local projections and goals** to track the reduction in inequalities.

2.2.2 What mechanisms outside of national targets could be used to support performance improvement? (250-word limit)

Examples could include peer support, peer review, shared learning and the publication of data at a local level. Please provide any examples of existing successful or unsuccessful mechanisms.

Evaluation and a continuous cycle of quality improvement will be essential for success. [Sector Led Improvement](#) (SLI) is used by local government for self-assessment and peer-review to support service improvement that is independent of formal external inspections. SLI can help provide confidence to internal and external stakeholders, and the public, in the quality of provision and outcomes. It provides evaluation, challenge, and measurement of improvement as well as collaboration, learning and knowledge.

In 2019, The Association of Directors of Public Health London and London Councils Programme Board appointed Improving Performance in Practice and the Institute of Health Visiting to work with them to develop and apply a SLI tool for local authority public health commissioners of health visiting and school nursing services.

This involved a rapid evidence review to support the development of the SLI, and a data insight working group to determine key indicators for borough data profiles. The tool was designed to encourage collaboration and engagement across all stakeholders and involves recording of the justification/evidence for the assessment scores covering a broad range of quality assurance areas.

The [SLI review](#) was conducted across London from 2019 to 2022, with a pause between Spring 2020 to Spring 2021 and a change to the approach to allow for London boroughs to focus on the Covid pandemic. This work has been shared at National and Regional events with subsequent new commissions in the Midlands Region to apply this SLI tool with potential peer review with some London Boroughs.

2.3 Data and transparency

We recognise that the transparent use of data, both at a local and national level is key to reaching greater local control and accountability.

2.3.1 Do you have any examples, at a neighbourhood, place or system level, of innovative uses of data or digital services? (250-word limit)

Please refer to examples that improve outcomes for populations and the quality, safety, transparency or experience of services for people; or that increase the productivity and efficiency of services.

In 2019, the iHV was funded by the Health Foundation to lead a project in partnership with Southern Health NHS Foundation Trust to improve analytical capability in health visiting by:

- i. Enabling a better understanding of the challenges and opportunities within the field of health visiting analytics and the ways that health visitors would like to use data
- ii. Exploring whether we can make better use of data and analytics to support health visitors' work with vulnerable, "invisible children" and those with additional needs
- iii. Sharing our learning and insights from this project to develop analytical tools and easy-to-use dashboards that will help drive quality improvements to deliver more effective care to the children.

The [project report](#) sets out the key barriers and enablers, including issues with data quality, completeness and information sharing between agencies. At present the system relies on multiple electronic record systems and datasets, often using 'out of date' IT equipment, as well as small scale projects, that do not join up, alongside varying levels of staff training and capability. This duplicates costs and risks, and obstructs transfer of ideas and analyses between settings. A [practical guide](#) was

developed to support areas to improve analytical capability with details of an [innovative project to develop a data visualization tool](#) to inform clinical decision making, focused on shared data for vulnerable children.

2.3.2 How could the collection of data from ICSs, including ICBs and partner organisations, such as trusts, be streamlined and what collections and standards should be set nationally? (250 word limit)

National and local government should agree streamlined key national metrics. The lack of hard system levers to drive quality in local authorities, alongside insufficient funding, has led to the current unwarranted variation in service provision. Legislation of local authority functions is seen by many as punitive; instead, change needs to be driven by working across organisational boundaries, creating partnerships built on trust to achieve shared aims.

Think complex systems: articulating causal impact within a complex adaptive system, in which the factors that impact outcomes are varied and messy, 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, with metrics to capture **input** and **impact** across the system, including: access, identification of unmet need, experience, outcomes, with **local projections and goals** to track the reduction in inequalities. The impact of health visiting intervention on prevention and demand for other services is needed to determine wider system cost savings e.g. fewer A&E attendances and hospital admissions due to improved parental health literacy and vaccine uptake.

Shift from measuring to prove, to measuring 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, including service users' perspectives, need to be developed and embedded in service delivery.

2.3.3 What standards and support should be provided by national bodies to support effective data use and digital services? (250-word limit)

Based on the findings from a [Health Foundation project by the iHV](#), the following components are needed:

1. **Workforce skills:** To equip the workforce with the knowledge and skills to maximise the use of data and analytics in health visiting and improve data quality
2. **National and local leadership** of digital transformation and analytics in health visiting is needed to drive innovation, share best practice and support local quality improvement, including access to analysts
3. **Modelling** by providing 'good' examples of analytical capability to support system learning
4. **Health visitor input in the design/development process of IT systems and analytics** is needed to ensure systems are fit for purpose, providing efficient data entry and quick access to timely, easy to interpret, data
5. **Access to appropriate IT equipment** with analytical capability
6. **Data should be presented in visualisations** that present the information from a variety of sources that health visitors use to support their own clinical judgement. Artificial Intelligence (AI) tools for risk stratification, without clinical input, should not be introduced until there is

a sound evidence-based clinical decision-making tool for health visiting on which to base the AI algorithm

7. **National guidance** on data collection, record keeping and use of analytics in health visiting
8. **Interoperability/data sharing**
9. **Standardised national coding** convention
10. **Better use of data and analytics to evidence health visiting outcomes** across the system
11. **Manageable workloads** to ensure practitioners have sufficient time to engage in quality improvement using data and analytics in their practice.

2.4 System oversight

ICs are continuing to develop, and DHSC, NHS England and the Care Quality Commission (CQC) are still in the process of developing their working relationships with them.

We recognise that there is significant variation in maturity, capability and performance between different systems and partner organisations, including trusts. This will require an appropriate balance between autonomy, support, regulation and intervention. We are keen to explore whether there are any principles we can identify to help set that balance.

2.4.1 What do think are the most important things for NHS England, the CQC and DHSC to monitor, to allow them to identify performance or capability issues and variation within an ICs that require support? (250-word limit)

All babies, children and families should receive equitable and effective services that are proportionate to their level of need, regardless of where they live. **The health of our nation's children is too important to be left to chance, or solely to local decision making.** Whilst local areas understand the health of their communities best, the narrowing of the focus of national targets cannot come at the expense of improving child health and reducing inequalities across England - the most pressing public health priorities do not vary substantially between local authority areas (even taking account of their variations in size, demography, health challenges and configuration). Currently, unexplained variation between local authorities, including statistically matched areas, persist and are widening.

We should aim to minimise the variation in terms of access to services, support and treatment, recognising that there will need to be some degree of local variation in the way in which services are accessed and delivered; for example, between rural and urban areas. However, whether services to address all of the key public health priorities set by national government are provided, or not, should not be subject to local decision making.

[Limitations in the current CQC inspections](#) drive a **positive reporting culture which masks problems and provides false reassurance.** We recognize that there is no malicious intent, it is just a feature of the current approach that CQC has acknowledged. This needs addressing as it ultimately places children at risk of harm and poor health outcomes, with widening inequalities.

2.4.2 What type of support, regulation and intervention do you think would be most appropriate for ICs or other organisations that are experiencing performance or capability issues? (250 word limit)

Success will depend on implementation, with the development of behaviours and relationships that support collaboration modelled across the health and care system. These changes will take time to deliver results and will require structural changes (in particular to support the delivery of integrated services for children which have a different legislative framework and structure to adults).

We need to move beyond fragmented, short-term fixes and funding streams to build a ‘new system’ that is focused on the overarching long-term goal of improving health and reducing inequalities for all babies, children and families in England. This will require strong national and local leaders who are equipped with skills in implementation science, evaluation and complex system’s approaches, alongside a commitment to a longer-term view of health and wellbeing. [Listening to patients and communities](#) will also be key to improving services and understanding how efforts to join up care are progressing and whether they are achieving the desired goals of improved health and reduced inequalities.

It is important to recognise the limits of what legislation can achieve. Legislation of local authority functions to drive improvement is seen by many as punitive; change needs to be driven by working across traditional organisational boundaries, creating a culture and working relationships built on partnership and trust to achieve national and local shared aims. Sector-led approaches that build on local assets are needed (as discussed earlier) to drive improvements.

2.5 Additional evidence

2.5.1 Is there any additional evidence you would like the review to consider? (250 word limit)

See the [Hewitt review terms of reference](#) as a guide to what additional evidence may be relevant.

ICSs are being developed in deeply challenging times for babies, children and their families, with increased levels of need and widening inequalities, alongside political and economic instability and varied levels of health care performance. Health visiting faces a significant **workforce shortage**, with almost 40% fewer health visitors compared to 2015, and problems with recruitment, retention and career progression. Consequently, many families are not receiving the support that they need, and this is being intensified by a lack of capacity in other health and social care services who are also experiencing extreme pressures – with increased risk and detrimental impacts on child health and development.

We want ICSs to succeed. It is not too late to change direction and pursue reforms, but the situation is serious. The current rate of health visitor workforce attrition, with no national workforce plan to plug the forecasted gaps, is not sustainable and will jeopardise the delivery of England’s child health programme. The government categorised health visiting as one of six priority services in its [Start for Life Vision](#) for the first 1001 days. However, this commitment is at risk without investment and a plan to rebuild the health visitor workforce. There is also [a significant risk](#) that the current context makes it harder for the original vision of much better-integrated care across the system to be fulfilled.

The [iHV Vision](#) provides a blueprint for health visiting within an integrated system. The latest [iHV State of health visiting report](#) will be published on 18 January 2023.