iHV representation to the Spending Review 2024

Fixing the foundations for health by rebuilding health visiting services

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.

Key points:

1. Our funding request aligns with the government's objective to reform health visiting services and train more health visitors (HVs), so parents and babies get the best possible support. We offer solutions to the challenges set out in the Darzi review, with a growing NHS backlog as demand for child health services increase and billions are spent annually on costly late intervention.

2. Increasing the number of health visitors will increase workforce capacity to deliver prevention and early intervention, benefitting health, education and social care. It will support the government's plans to create the healthiest generation of children ever and deliver its manifesto pledges for childhood immunisations, supporting families with minor illnesses, improving the quality of postnatal care, and the early identification and support for school readiness and special education needs and disabilities (SEND).

3. Our response is informed by our annual survey and stakeholder engagement. It is clear, that to improve our nations' health and reduce pressure on NHS services, much greater attention needs to be given to prevention, early identification of health needs and early intervention in the critical earliest years of life. Health visitors have a vital role to play as part of the "health" workforce, contributing to multiple clinical pathways through pregnancy, the perinatal period and 0-5 years (for babies, children and adults).

4. It is therefore vital that the "broken" state of health visiting is addressed, alongside the NHS, with action to reverse the loss of more than 40% of health visitors since 2015. The cuts to health visiting services have been a false economy, impacting on families' quality of healthcare and placing additional burdens and costs on other parts of the healthcare system.

5. The government has pledged to take action to improve public service outcomes. This includes developing a 10-year health plan to change and modernise the NHS, alongside transforming the system for supporting children and young people with SEND. The work of health visitors can support these overarching aims to deliver better outcomes and achieve financial sustainability by preventing, identifying and treating problems before they reach crisis point or require more costly late interventions.

6. In the context of a tight fiscal settlement, it is vital that any additional resources are focused on rebuilding the core health services that have been "broken" through years of funding cuts and short-term, often untested, "sticking plaster" policies that have left families without the joined-up healthcare support that they need during pregnancy, the postnatal period and early childhood.

7. It is far easier to rebuild and reform a tried and tested service, like health visiting, than invent a new preventative health workforce, with all the regulatory and training infrastructure needed for quality assurance and to protect the public. We welcome the government's commitment to "reform health visiting" and offer our ongoing support to deliver its manifesto pledges. This will require actions to improve workforce capacity, continuous professional development, recruitment and retention.

Key policy recommendations for health visiting:

Funding requests:

1. To address the loss of more than 40% of health visitors since 2015, and ensure all families receive health visiting support in line with the Healthy Child Programme, additional ring-fenced funding is needed for **1,000 extra health visitor posts each year for the next 3 years.**
2. To reform health visiting services and support workforce retention, salary uplift funding is needed for **689 specialist health visitor posts** (providing clinical leadership for government priorities, like perinatal mental health, immunisations and SEND).

Long-term investment, with ring-fenced funding, will help services to plan and build world-class services, ending the uncertainty of short funding cycles.

Governance:

3. **To update the Office for Health Improvement and Disparities' 0-19 Commissioning guidance** – providing greater clarity and system levers to ensure equity of health visiting provision throughout England, ending the current postcode lottery of support that families face during pregnancy, postnatally, and through the first five years of their child's life.

We welcome the government's commitment to train more health visitors and remodel workforce requirements set out in the NHS Long Term Workforce Plan. To increase the number of health visitors in England, funding to cover the costs of additional health visitor posts will also be needed (as set out in this submission).

We also recommend that health visitor workforce requirements are reforecast using demand-driven workforce modelling based on population need and the delivery of the national blueprint for health visiting as intended (set out in the Healthy Child Programme and Health Visiting model for England).

Costs (see Appendix 1):

1. Costs of 1,000 more substantive health visitor posts each year are £52.9m for year 1, £105.8m for year 2, and £158.7m for year 3.
2. Salary uplift costs for 689 specialist health visitor posts are £8.64m per annum (to cover salary uplift from band 6 to band 7).

Our policy recommendations will:

- Reduce NHS pressures and bring benefits that extend beyond the Department of Health and Social Care (DHSC) (see Appendix 2), with a strong economic case to reduce the costs of late intervention (see Appendix 3), by rebuilding health visiting services to provide effective healthcare support, prevention and early intervention for babies, young children, families and communities.

- Ensure that the health visiting workforce can support DHSC plans across multiple "health" pathways which extend beyond the NHS, requiring health visiting input. For example:

    i. By reforming the service to allow health visitors to administer routine immunisations to vulnerable and at-risk children, ensuring more are protected from infectious diseases
    ii. Increasing the number of health visitors so parents don't always end up having to seek help from the GP or A&E because they can't get the advice they need about their baby's health
    iii. Supporting the newborn genome screening programme.

- Strengthen health visitors' leadership capability to reform services by increasing specialist health visitor posts focused on key priority areas like perinatal and infant mental health, SEND and immunisations.

Key drivers for investment in health visiting:

The health visiting service in England needs to be urgently rebuilt to meet the increasing scale of need amongst babies, children, families and communities and reduce soaring costs of late intervention through prevention and early intervention (see our submission to the Darzi Review for supporting data, including health visitor workforce), with the current key drivers:

1. **Increased demand for support from the health visiting service** - practitioners cite the impacts of poverty, deteriorating child/ family health and pressures on children's social care as key drivers (see iHV State of Health Visiting report, 2024).

2. **Experience:** Families are calling for better healthcare support during pregnancy, the postnatal period and throughout childhood. A report by the First 1001 Days Movement sets out "Why Health Visitors Matter", with support from partners across the health, education, social care and voluntary sector.

3. **Workforce challenges:** The health visitor workforce has been cut by more than 40% since 2015. Alongside these losses, workforce challenges in children's social care and other health services further compound the pressure that is being placed on health visitors, with higher thresholds and long waiting lists leaving gaps in other services which health visitors are expected to fill.

4. **Weak commissioning guidance and system quality assurance***:* Prior to 2015, there was clear guidance for transition of healthcare between midwifery and health visiting (0-5) services. This is now left to chance and local decision making, with no standard operating procedure for perinatal /early childhood healthcare across the NHS and health visiting services. As a result, pathways are varied and fragmented, leaving too many families struggling to find the postnatal and early childhood healthcare support they need and would be expected in a modern healthcare system.

5. **Access:** Whilst millions of babies/ children are seen by health visiting services each year, many are not receiving their universal mandated reviews or getting the support that they need when health concerns are identified due to workforce shortages.

6. **Unwarranted variation in health visiting provision across England:** Families face a postcode lottery of health visitor support that is unjustified – the key public health priorities apply to all local authority areas and our children's health is too important to leave to chance.

7. **Role drift from health visitors' "health" functions, across numerous "health" pathways** during pregnancy, postnatally, and throughout the early years, as child protection and child safeguarding functions are prioritised by local government (see iHV State of Health Visiting report, 2024).

8. **Health visitor cuts create knock-on consequences and costs across the health, education and care system:** for example, soaring rates of A&E attendance for children 0-5 years over the last 10 years for conditions that would previously have been managed by health visitors, inadequate postnatal health care, late identification of SEND, fewer children "ready for school", falling immunisation rates, and a mental health crisis. These are all areas where health visitors can make a big difference and are core elements of the Healthy Child Programme that need to be prioritised. Failing to invest in prevention and early intervention is short-sighted and is fuelling soaring costs of late intervention (see Appendix 3).

9. With preventable disease posing the greatest threat to global health, countries across the world are recognising the value of public health nurses, with good evidence of impact (see recent paper

in the Lancet which describes health visitors [called public health nurses in Japan] as Japan's "hidden secret" for their health outcomes which are the best in the world!).

10. **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)), The First 1001 Days Movement, The National Network of Designated Healthcare Professionals for Children UK (NNDHP), Health Policy Influencing Group (HPIG), Maternal Mental Health Alliance (MMHA), the Royal College of Paediatrics and Child Health (RCPCH) and the Centre for Early Childhood led by HRH The Princess of Wales.

Health visiting is a vital infrastructure that needs to be protected:

11. **Why health visiting?** Health visiting 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 are often invisible to other services unless their parents reach out. When adequately resourced, the benefits of an effective health visiting service accrue to the NHS, primary care, education, social care and beyond (see Appendix 2).

    Health visitors' unique selling point (USP):

    - ***Reach*** – Health visiting is the only service that proactively and systematically reaches all families from pregnancy and through the first five years of a child's life, providing an opportunity to reach families with important health messages (for example, promoting immunisation uptake) and providing a vital safety-net for the most vulnerable. Health visitors are welcomed by families due to their legitimate health function. This brings considerable system benefit that must not be overlooked.

    - ***Range of skills*** – Health visitors have the skills to provide support for a breadth of physical health and mental health needs (for babies, children and adults), child development, social needs and safeguarding - getting it right first time, ensures that families get the right support, reducing pressures on other parts of the health and care system (see iHV infographic, "Who are health visitors and what do they do?").

    - ***Response*** – In contrast to the medical model which treats conditions at the point of diagnosis, health visiting is focused on "health creation", working in partnership with families, building on their strengths, taking account of their context, to prevent, identify and treat problems before they reach crisis point. Health visitors also play a crucial part in information sharing in child safeguarding – assessing needs in an undifferentiated population, collating and analysing information from multiple agencies to identify and manage risk and vulnerability for babies, children and families – particularly for families below the threshold for children's social care, or when new needs are identified.

12. The health visiting service has become highly politicized with successive governments choosing to invest and disinvest in the service over many years. This boom-and-bust cycle has led to huge variations in health visiting services across the country and destabilized the workforce, impacting on staff recruitment and retention. It has also impacted on the quality of healthcare that families with babies and young children receive during pregnancy, the postnatal period and 0-5 years. The government needs to find a way to protect and support this vital specialist nursing workforce from the harms of excessive political interference in the long-term, by restoring professional autonomy to enable health visitors to develop, innovate and deliver services to improve health and reduce inequalities. At a time when child health is deteriorating and inequalities are widening, the skills of these specialist public health nurses are needed more than ever.

Appendix 1:

Cost calculations:

1. We estimate the salary of a health visitor as the mid-point of the NHS Agenda for Change (AfC) band 6 (based on £ £39,405 for 2024/25. We account for the non-wage labour costs of 23.78% employer pension contributions and employer NI contributions (£4,182.09). Total cost per FTE=£52,957.60.
2. Salary uplift costs for existing band 6 health visitors to support increased pay as band 7 Specialist HV posts.
    a. We estimate the salary uplift of a health visitor based on the mid-point of the AfC band 6 (total band 6 wage cost listed in 1) = £52,957.60.
    b. and mid-point band 7 salary as £48,526 for 2024/25, with non-wage labour costs of 23.78% pension contribution and employee NI contribution (£5,440.79). Total cost per FTE band 7 HV=£65,506.27.
    c. Salary uplift calculation based on the difference between 2a and 2b = £12,548.67 per FTE.
    d. As local authority areas vary in size, the number of specialist posts needed will be determined via fair distribution based on population size, with a range of 3-6 specialist posts per area (specialty areas to be locally determined, for example Specialist Perinatal and Infant Mental Health[1] [2], SEND, Immunisations, etc…). Costings for specialist posts based on 153 LAs with 689 posts.

Figure 2: The costs of health visitor posts to increase substantive workforce establishment

	Year 1	**Year 2**	**Year 3**
Substantive Band 6 Health Visitor Posts (**3,000 posts over 3 years**; some year 1 posts will be RTP HVs*)	£52.9m	£105.8m*	£158.7m*
Salary uplift for 689 additional Specialist HV posts	£8.64m	£8.64m*	£8.64m*
Total	**£61.54m**	**£111.44m**	**£167.34m**
*pay awards for year 2 and 3 not included.			
** The government has committed to deliver the NHS Long Term Workforce Plan which also includes a commitment to remodel workforce requirements and reforecast. We recommend that this includes demand-driven workforce modelling based on population need and the delivery of the national blueprint for health visiting set out in the Healthy Child Programme and Health Visiting model for England. To offset an estimated 20% attrition rate, the number of health visiting training places will need to be reforecast to achieve an overall increase in the HV workforce (in 2021, Professor Conti at UCL estimated that there was a 5,000 shortfall in health visitor numbers. Due to changes in service configurations and further workforce losses, 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 "reform 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 discussions that we have had with officials in the Department for Health and Social Care, the Office for Health Improvement and Disparities, and the Chief Nursing Officer's team, to further develop the "conditions for success" for health visiting and the career pathway for health visiting from career entry to senior system leadership roles in clinical practice, service leadership/ management, facilitation of learning, research and policy.

[1] Homonchuk O, Barlow J. Specialist Health Visitors in Perinatal and Infant Mental Health. Department of Social Policy and Intervention, University of Oxford. 2022. Available from: https://bit.ly/40EFqHN

[2] Bauer A, Tinelli M, Knapp M. The economic case for increasing access to treatment for women with common maternal mental health problems. Care Policy and Evaluation Centre London School of economics and Political Science. 2022. Available from: https://bit.ly/3Ne8suG

Appendix 2: The benefits of an effective health visiting service accrue to DHSC and other government departments

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
Department for Education	Improving uptake of 2-year nursery offer for eligible children
	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/ supporting 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

Appendix 3: The economic case for investment in health visiting, preventative public health and early intervention

1. The Chancellor has said that the Spending Review will deliver economic stability with a clear plan to restore public spending control. It is precisely because the government faces a tight fiscal settlement that action needs to be taken to address the soaring costs of preventable problems that have their roots in early childhood. Failure to invest in prevention has been a costly mistake, with spending on late intervention spiralling out of control across health, education and social care.

The evidence is clear that investing in our nation's children represents the smartest of all investments, with spending in the earliest years yielding the greatest return on investment across the life-course. The current method of evaluating the cost of policy proposals based on cashable savings in the short term should not be applied to spending on children – instead, this needs to take a longer view, with spending treated as a capital investment in the human infrastructure that will lead our nation into the future.

2. To ensure that every pound is well-spent, the enormous current costs of "getting it wrong" need to be considered against the relatively small costs of prevention/ early intervention. For example:

- **The total cost of health inequalities in England** to the economy is estimated to be around £150bn per annum, equivalent to 7% of GDP[3].

- **The cost of "lost opportunity" for children in England** is £16.13bn 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[4].

- **Soaring rates of A&E attendance in children aged 0-4 years:** Nearly 2.6 million children aged 0-4 years attend A&E departments every year, with rates increasing in England by 42% in the last 10 years. Compared to all other age groups, babies under one have the highest rate of A&E attendance and potentially avoidable attendances. A review found 59% of babies who attended A&E in Northwest London did not need investigations, treatment, or hospital admission and were sent home after reassurance – costing an estimated £1.8 million per year in this one area of London alone[5].

- **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 £6bn per annum, this is forecast to rise to £9.7bn per year by 2050[6].

- **Perinatal mental illness** carries a total long-term cost to society of at least £8.1bn[7] for each one-year cohort of births in the UK. 20%[8] of women are affected by perinatal mental health problems and around half are not accessing support[9] [10].

- **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 year[11].

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[3] OXERA Consulting (2023) The economic costs of health inequalities in England: Prepared for The Times Health Commission. https://www.oxera.com/wp-content/uploads/2023/10/The-Economic-Cost-of-Health-Inequalities-FINAL-REPORT-2.pdf

[4] The Royal Foundation (2021) Big Change Starts Small. https://centreforearlychildhood.org/report/

[5] Institute of Health Visiting (2023) Understanding the rise in 0–4-year-old Emergency Department (ED) attendances and changing health visiting practice. https://bit.ly/471XYVB

[6] 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

[7] Bauer A., et al (2014) The costs of perinatal mental health problems. https://eprints.lse.ac.uk/59885/1/__lse.ac.uk_storage_LIBRARY_Secondary_libfile_shared_repository_Content_Bauer%2C%20M_Bauer_Costs_perinatal_%20mental_2014_Bauer_Costs_perinatal_mental_2014_author.pdf

8 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

[9] 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

[10] NCT Hidden Half campaign https://www.nct.org.uk/get-involved/campaigns/hidden-half-campaign

[11] https://www.gov.uk/government/publications/adult-oral-health-applying-all-our-health/adult-oral-health-applying-all-our-health