



Evidence for the Select Committee on:

**Early-years intervention and Adverse
Childhood Experiences (ACEs)**

May 14, 2018

Evidence for the contribution of health visiting to early-years intervention and Adverse Childhood Experiences (ACEs)

Key points

- Adverse childhood experiences (ACEs) are widely distributed in the population.
- Health visiting is a universal unsolicited service that reaches out to all families with young children providing context in which ACEs can be recognised and measures instigated for early intervention.
- Health visiting is important because it puts into effect programme design principles and mechanisms shown to be effective in improving outcomes for children.
- These mechanisms include a tiered approach or ‘proportionate universalism’ and key elements of governance and programme fidelity.
- There is accumulated evidence from health visiting research that the profession has an orientation to practice and core practices that enable needs to be identified and children and families helped in a timely and proportionate way, including facilitating access to specific forms of evidence based intervention.
- The health visiting workforce has been subject to dramatic swings from increased investment to disinvestment and fragmentation in England since 2011.
- The impact of the recent changes to commissioning of health visiting impairs the capacity of health visiting to lead and delivery the Healthy Child programme.
- Caseloads have increased dramatically with distorting effects on the intended preventative service model with intervention being less early and more late intervention.
- The most valued and effective element of health visiting is the quality of relationships with families, but this is diluted by lack of continuity of care / carer.
- The health visiting workforce in England is reducing dramatically owing to a combination in service reduction, increased substitution by less qualified and skilled staff and poor staff retention.
- Economic analysis of preventative child public health programmes suggests that the return on investment is high but that inexpensive services that do not meet quality standards are a waste of money.
- There are some exceptions to this general picture of decline in England and the other three home nations of the UK. There remains great potential to intervene early to mitigate ACEs and to promote positive early childhood experiences by fully implementing a health visiting service for all families.

1 Introduction

The Institute of Health Visiting (iHV) exists to be a Centre of Excellence, supporting the development of universally high-quality health visiting practice, so that health visitors can effectively respond to the health needs of all children, families and communities enabling them to achieve their optimum level of health, thereby reducing health inequalities.

While there are many influences on the health and life chances of young children, health visitors and the health visiting service are distinctive in proactively engaging with every family with a child under the age of five, regardless of any other setting or service that they may or may not access, with a focus on prevention and the promotion of optimum health and development. Such an approach allows for the early identification of risk as well as early intervention. Adverse childhood experiences such as exposure to mental illness, domestic violence or even substance abuse happens across the social gradient, as does child abuse. However if it's not looked for it may not be found before it has had a significant impact on the future wellbeing of affected children. We know from the work of Rose (2008) that proportionately these issues occur to a greater extent in the section of society not normally classed as being vulnerable as, although more diluted, the number of children in this cohort is significantly larger than in the conspicuously vulnerable group. It is the responsibility of well-resourced and trained health visiting services to seek such risk and vulnerability early.

The level of engagement with children and families is proportionate to needs rather than being targeted on one particular group. This approach is described by Sir Michael Marmot (2010) as 'proportionate universalism'. The language of Adverse Childhood Experiences (ACEs) is highly pertinent to health visiting services because ACE's because their impact is particularly powerful in the early years. The early years include the first '1001 critical days' (WAVE, 2013) from conception to age two when children are at their most vulnerable and yet where the return on investment on early intervention is most potent. The health visiting service therefore has a particularly important part to play.

Before outlining the contribution of HV to early intervention in the early years we wish to underline the importance of understanding the key terms. The 'Early years' from conception to school entry at age 5 (in England) is often defined in practice in terms of early years services or settings that commence at age two or three. UNICEF has noted that there can be a cultural blind-spot that fails to recognise that 'early means early' and commences in the prenatal period (for example, Lindland et al, 2016). This is of importance, because much research evidence is focused on operational definitions of early years that relate to early years education at nursery or kindergarten age.

Secondly, early intervention is a form of 'secondary prevention' that is, 'Early intervention is about taking action as soon as possible to tackle problems for children and families before they become more difficult to reverse' (Asmussen, 2016). Primary prevention, on the other hand, seeks out health needs and promotes health *before* problems occur. Clearly, there is a continuum of need and intervention and health visiting operates along this continuum (proportionate universalism). Of critical importance for the evidence of the effectiveness of 'early intervention' is that this too is early, which means that ACE's must be identified at an early stage.

The impact of ACEs is most severe when they are cumulative (notably when there are four or more ACEs affecting a child), but they do not occur spontaneously and simultaneously: rather they are notable for being widely distributed within the population and are relatively indiscriminating. However, much research (Asmussen, 2016) focuses largely on targeted interventions and groups rather than the wider population. How such specific interventions are linked to the wider population-based systems and how benefits are realised at scale is under-recognised in such research. Conversely, it is at the population level that the greatest gains are to be made according to Marmot, 2010. Hence, in what follows, we present evidence for the value of the impact of health visiting as a preventative service operating on the principle of proportionate universalism.

2 Why is the role of the health visitor then so important?

Marmot (2010) has demonstrated the health gains at population level to be achieved through improving health and reducing inequalities in the earliest years of life; and [Heckman](#) has depicted graphically the return on investment and the costs of failure. Moreover WAVE (2013) has demonstrated that 'early years' interventions are a rare opportunity to spend money in a way that delivers social and economic benefits at the same time' (p.101). Intuitively, it is easy to assume that interventions to mitigate ACEs should focus on the neediest or most extreme cases, often implied by the term 'targetting'. However, the 'prevention paradox', as outlined initially by Geoffrey Rose (2008), explains that the greatest impact will be achieved by addressing needs across the population as a whole in order to improve health as well as reducing the severity and number of cases with the greatest needs that make the greatest demands on public services over the long term. Put differently, 'targeted' interventions of known risk can be *guaranteed to fail* to identify the bulk of risk and health need in the population. Rather, effective prevention requires 'proportionate universalism' in the early years for which health visiting is a core component.

2.1 Evidence of 'programme mechanisms' to support the effectiveness of interventions

It is in the nature of research that it is most easily focussed on generating evidence about specific controlled interventions for defined groups. Therefore research rigour is related to exclusion in order to specify and control variables. For ACEs this needs to be balanced by evidence that can be applied to wider populations at scale and to generate evidence of how children and families can most benefit from specific evidence based interventions when they are available. Beyond the level of the 'intervention' we can posit the 'programme' or wider, systemic child public health approach. In England this is embedded in the multifaceted Healthy Child Programme (HCP, 2009) which is led by health visitors.

First we describe 'programme mechanisms' based on evidence of the design features that promote effectiveness:

2.1.1 A tiered approach

There is consensus that early years services should adopt evidence based practice and programmes. It needs to be remembered that this applies not only to specific interventions such as manualised parenting programmes, but also *the overall shape of the service offered*. According to the [Harvard Center on the Developing Child](#) 'Decades of brain science and developmental research suggest a three-tiered approach to ensure the health and well-being of young children' to which, in the Health Visitor Implementation Plan (Department of Health, 2011), the community level of service delivery is added to strengthen community capacity. These *four levels* (community, universal, universal plus, and universal partnership plus) are based on sound epidemiological analysis of health inequalities and 'proportionate universalism' (Marmot, 2010).

The Healthy Child Programme(HCP), the evidence for which has recently been reviewed (PHE, 2015), includes five child health and development reviews mandated by the commissioning of 0-5 services by local authorities.

The [six high impact areas](#) for public health outcomes in the early years are those for which there is evidence of sensitivity to health visiting interventions and for which the health visiting workforce is well equipped to deliver.

The *four* levels of service delivery, *five* mandated reviews and *six* high impact areas combine to form the [4/5/6 service model of health visiting](#).

2.1.2 Governance and programme fidelity

High quality programmes depend for their effectiveness on governance and **programme fidelity**. There are strong arguments in favour of criteria of programme fidelity being broadened to be more inclusive of the diversity of need (Davis, Axford and McDonald, 2012). ACEs do not occur spontaneously and in isolation, but in the context of the life situations of particular families and communities. Therefore, evidence from interventions for targeted ACEs/groups need to be considered alongside the wider ecology of childhood (Bronfenbrenner, 2005) alongside potential protective factors.

Programmes are most likely to be effective when embedded within a universal and responsive system of support that begins with an assessment of all new parents (Daro and Dodge, 2010: 79), ‘intervening briefly to address needs when risk is moderate, and connecting the family with targeted community resources to meet those needs for families having higher risk’ (Dodge et al, 2013).

Programme mechanisms cannot prescribe every detail of programme design. Given the well-known barriers to implementing evidence-based programmes, Penelope Mitchell (2011) it is better to identify their discrete elements and trust practitioners to combine them in tailored packages depending on the needs of the child, family and community in question.

Daro and Dodge (2010) have reviewed evidence based targeted home visiting intervention programmes in the USA. They conclude:

‘the relatively high costs of targeted interventions for high-risk families, such as those with multiple ACE’s ‘underscore the importance of identifying an efficient way to match families with appropriate levels of support. Achieving this level of efficiency is best done, not through an eligibility system based on demographically-based risk, but rather through a comprehensive assessment that identifies the specific needs of participants and refers them to the most appropriate service. Although the cost of such a system has not been well specified, the per participant cost for these assessments is substantially less than providing intensive home-based interventions’ (Daro and Dodge, 2010: 84).

In other words, they advocate that interventions are embedded within a universal personalised child public health service such as UK health visiting.

An example of based on these design principles and embedding these programme mechanisms is the Maternal Early Childhood Sustained Home-visiting ([MECSH](#)) programme being implemented in Australia, South Korea, the USA, the UK and the Channel Islands. In the UK, the programme has been implemented at scale in Essex, Plymouth and Lewisham and in regions of Somerset as part of a trial. It provides early evidence of positive outcomes although these do not specifically focus on ACEs (Kemp, Cowley and Byrne, 2017). What differentiates this from ‘usual care’ is the rigour of programme governance and fidelity with commensurate resourcing. Other examples are being developed through enhanced investment and governance in Big Lottery ‘[Better Start](#)’ sites and in Scotland an enhanced health visiting programme is being rolled out and evaluated to track outcomes. Regrettably, these examples stand in stark contrast to the inconsistent approach to delivering health visiting services in England, marked by severe disinvestment, thus weakening the mechanisms that support programme effectiveness.

2.3 Evidence for health visiting

A review of 25 years of research about health visiting practice, 'Why Health Visiting?' (Cowley et al, 2013) identified that a clear 'orientation to practice,' guides delivery of health visiting across the whole service spectrum from primary prevention to child protection. This analysis suggests that successful health visiting practice needs to be salutogenic (health-creating), in this case supporting positive childhood experiences of nurturing, responsive parenting; a person-centred approach where relationships are key, and to recognize the person-in-situation (human ecology), recognising the circumstances in which families with young children live.

This orientation to practice is put into effect by the complementary core skills of home visiting, needs assessment and relationship formation. Home visiting and needs assessment are key to the identification of ACEs in families that would not access other services and that cannot be targeted because they are (otherwise) unknown. Added to this, the research reviewed showed the critical importance of the **quality of health visitor – client relationships** to effective outcomes by health visitors promoting the health and social and emotional development of young children in the home and working with parents in the first '1001 critical days' (WAVE,2013).

In the UK, Barlow et al (2004) have investigated why vulnerable women refuse to take part in early intervention programmes that are developed to improve the lived experience of young children. It highlights that many intervention programmes evaluated by research studies have effectively deselected some of the most needy and vulnerable children and families from their 'targeted' intervention groups. The research highlights that achieving trust and engagement with such families is indeed challenging, requiring skill, persistence and professional resilience.

Health visitors use their universal access to families and relationship-based interventions to safeguard children including those not in regulated childcare settings. While there is evidence that home visiting is effective in prevention of escalation of risk for vulnerable children (PHE, 2015), universal access enables health visitors to directly observe the quality of interactions and impact on young children's health and development that would not otherwise become recognised until escalation has occurred. Identification of needs for additional support in respect of parenting, health or development is systematic through the full implementation of the HCP. The adoption of ASQ-3™ assessment used by health visitors at 2-2.5 years provides public health outcome measures as well as referral pathways contributing to 'early help' and to readiness for learning in school. This assessment is now supplemented by the ASQ-3SE to specifically focus on social and emotional development which is particularly sensitive to exposure to ACEs. Crucial is the combination of use of validated tools such as ASQ combined with professional skill, sensitivity and judgement to explore with parents or carers the context of the lived experience of children.

Research in Scotland (Scottish Government, 2015) on Growing up in Scotland found that satisfaction with health visitors was rated as particularly high by the most socially disadvantaged and isolated mothers of young children who were least likely to access and participate in group or centre-based programmes. This noted, the review by Cowley, et al, 2013 found that health visitors utilised 'service-journey skills' to support such families to make use of services that they would otherwise exclude themselves from. This capability is dependent upon these professionals having the autonomy to respond flexibly to parents' different circumstances and needs.

Research into the voice of users of health visitor services indicates the premium that families place on "feeling 'known' and listened to" by health visitors. (Donetto et al, 2013: 10). Equally, unsatisfactory encounters with professionals can impact upon parents' preferences and whether or not to engage with health visiting and other services in the future. Success factors include a

combination of practical and emotional support, continuity of relationships, involvement of service users in their services, provision of information, and coordination of services to support the 'service journey. This research on the generic success factors that are characteristic of effective health visiting is supplemented by specific research evidence that an effective programme is not enough but there are specific factors associated with poor attendance and engagement interventions targeted at vulnerable parents and their children. Moran et al (2004) advocate overall programme design accommodates different modes of delivery and therefore an ability to respond flexibly to the multiplicity of problems often facing the neediest families. This highlights the relevance of ecological theory (Bronfenbrenner, 2005) integral to health visiting's practice orientation, which explains the different layers of influence on the lives of individuals, suggesting that multicomponent programmes can reach distal social–community factors as well as proximal family–individual factors impacting on parenting roles and the experiences of children.

Related to this evidence is evidence that continuity and co-ordination are essential elements of team working by health visitors in an integrated service context. Furthermore the need is for a skilled, specialist and well supported health visiting workforce rooted in proactive sensitive family relationship-building. (See below)

3 The health visiting professional workforce:

An economic analysis of investment in early years prevention concludes that 'The essence of quality in early childhood services is embodied in the expertise, skills, and relationship building capacities of their staff. The striking imbalance between the supply and demand for well-trained personnel in the field today indicates that substantial investments in training, recruiting, compensating, and retaining a high-quality workforce must be a top priority for society' (WAVE, 2013). Investment in the workforce in England during the 'Call to Action (Department of Health, 2011) strengthened this asset available to commissioners of services. Subsequently, the Scottish Government are supporting an enhanced health visiting service and the Welsh Assembly is strengthening its investment through its Healthy Child Wales Programme.

Between 2011 and 2015, the Health Visitor Implementation Plan increased the number of HVs in England by almost 50% (4,000) after a long period of decline. The rationale for this investment is substantially that of the rationale for early intervention in the early years in general. However, in particular Lord Laming had called for government:

'to develop the health visiting workforce further, to provide leadership and expert practice for the HCP, and to use health visitors' specialist skills in supporting vulnerable families and making their contribution to safeguarding. He called for immediate action to increase the numbers, confidence and competence of health visiting staff' (DCF&S, 2009: 22).

In October 2015, the commissioning of health visiting services was transferred from the NHS to Local Authorities, and this coincided with a dramatic reduction in the numbers of health visitors in England.



Table 1: Demonstration of the loss of health visiting posts in the first two years after the move to local authority commissioning

NB: These losses have continued for the past 7 months although official figures aren't published yet suggesting that all the gain in posts during the call to action may already have been lost!

This was predictable, as the public health grant to local authorities was subjected to substantial cuts, and local authorities have dramatically reduced income from central government. Public health commissioners, surveyed by Public Health England as part of a consultation on the mandate of the five health and development reviews that form the spine of the English Healthy Child Programme (HCP), declared their intentions to scale back the cost of health visiting services through service redesign including changes to the skill and grade-mix of the workforce.

The iHV has surveyed its members on the 'State of Health Visiting' for the past 4 years and been able to demonstrate the impact of the cuts on services and staff wellbeing. The following comment is typical:

'We've been brought in-house [to local authority direct employment]. Morale is very low. The area I work in only has 50% of its recommended number of health visitors. Constantly pressured into meeting KPIs and management have lost focus of the child. HVs now been restricted in what we are allowed to do and have to justify why we are seeing families.'

4 Impact of recent changes to commissioning on service delivery

The Institute of Health Visiting (iHV) supports the view that the Healthy Child Programme (HCP) (DH/DfCSF, 2009) should have at its core health and development reviews where health visitors able to identify health and developmental needs in partnership with parents. Five of these reviews are presently mandated in England as a minimum, but unfortunately they have generally been invested in as the maximum universal service. The HCP is delivered on the basis of 'proportionate universalism' as propounded by Sir Michael Marmot (2010) which reflects the evidence that the health and development issues identified through these reviews, including ACE's are widely

distributed throughout the population and not confined to children or families with known risks. It is recognised that ‘targeted’ interventions of known risk can be guaranteed to fail to identify the bulk of risk and health need in the population; and that universal primary preventative services form the bedrock of a systematic approach to reducing health inequalities in terms of health and wider outcomes in childhood and beyond. While there is variation in the number of reviews in the UK four nations, the five prescribed in England is the lowest, and therefore should be regarded as a minimum, not a maximum. (In Wales there are 9 reviews; N Ireland, 7, with planned increase to 9; In Scotland there are 11, all carried out by qualified health visitors) unlike in England where the Institute estimates at least 50% are carried out by more junior members of the health visiting team after 6-8 weeks meaning that there is little opportunity for health visitors to identify ACEs in the whole population of infants and young children.

The most directly relevant responses from our November 2017 survey are as follows:

4.1 Delivering and leading the HCP

The HCP is a national programme of health prevention and health promotion. At its heart is a schedule of health and development reviews that should be provided to all families with children under five. This forms the basis for searching for and identifying health needs.

Our survey responses indicate that health visitors’ capacity to deliver all of the five mandated health and development reviews of the HCP in England is seriously reduced. These reviews are the minimum required by the HCP in England (there are more in the rest of the UK), yet they are being increasingly delegated to less qualified practitioners and / or not carried out.

4.2 Caseload sizes

Asked about caseload sizes 21% of health visitors said they are now again working with caseloads of over 500 children – the funding transferred from NHS to local government in 2015 was set at a recommended ‘minimum floor’ of one whole time equivalent health visitor for 300 children. A subset of London data suggested that 45% of health visitors in London are working with caseloads of 500-1000 children despite the extreme challenges and vulnerabilities found in urban caseloads.

The survey shows there is great variation in how caseloads are calculated and defined as local arrangements proliferate, departing from national norms. These reflect more targeting of work away from a universal primary preventative service, more delegation to less qualified staff, combined with increasing use of ‘corporate caseloads’.

The survey results indicate that health visitors are increasingly focused on the most vulnerable children and families at the expense of the five reviews and that the HCP is being implemented in an increasingly ‘targeted’ manner, against its fundamental design principles. The result is that health visitors cannot be confident that they are identifying ACEs or providing early primary prevention. 60% state their ability to make a difference is hampered by **‘focusing only on those most at risk [that] dilutes universal service’**; rather, they are managing risk with children and families with known needs.

4.3 Reality of health visitors working with the most vulnerable and a ‘targeted’ service

Health visiting is based on international evidence that the long-term return on investment in health outcomes is greatest when focused on early childhood preventative care based on ‘proportionate universalism’: that is, inclusive of **all** children and families, providing access to graded levels of additional support, early intervention or help, and where necessary, safeguarding and child

protection. This enables health visitors to use their assessment skills to identify and respond to ACEs as they emerge as well as when established.

We asked: **Do you deal with any of the following vulnerable groups in your work?** The responses indicate how successful health visitors are at engaging with children and families who are most vulnerable and often least confident to access support. These include travellers, homeless families, 'families of concern', families with a Child Protection Plan, pregnant teenagers, asylum seekers and refugees, perinatal mental health problems, disabilities, drug and alcohol problems. **These categories correspond closely to ACEs known to have negative impact on outcomes for children.**

4.4 Impact on preventative service model

Our evidence suggests that although meeting the mandated requirements for universal reviews is a significant challenge for health visitors, they nevertheless prioritise action to attempt universal coverage while strenuously attempting to respond effectively to vulnerable groups where there is a high prevalence of ACEs. However, the evidence suggests that the translation of the mandate of the five reviews into Key Performance Indicators (KPIs) as measures of service performance can have distorting effects that can subvert the intentions of the HCP to search for health needs across the whole 0-5 population. To be explicit, this means that children subject to ACEs are more likely to be remain unrecognised, and early intervention to be deferred to later intervention.

Key issues include the following:

4.4.1 Key issue #1: Quality of care for children and families

We asked about the impact of these changes on the quality of services as received by children and their families

It is not surprising that health visitors report that they can no longer offer continuity of relationships to their families – which is what families most value from the service according to research evidence (Donetto, et al, 2013) and as highlighted in PHE (2018) commissioning guidance.

The biggest **barriers to 'making a difference'** to families include:

- 'Lack of time' at appointments 44%
- Lack of continuity/ chance to get to know the family 49%
- Focusing only on those most at risk 62%

4.4.2 Key issue #2: Dilution of skill-base for delivering the HCP

We asked: Have you been restructured to reduce the number of health visitors since local authorities took over the commissioning of health visiting in October 2015?

50% replied 'Yes' and 15% replied No, but we have a reduced-size skill-mix team. Overwhelmingly, the many additional qualitative comments referred to loss of posts, under-recruitment and lower level skill-mix.

Whilst skill mix has been growing steadily in health visiting teams over the past 20 years, and very significantly in the past 2.5 years following the move to local authority commissioning, there is no evidence base to say that it is safe and can delivery the same outcomes as a highly trained health visitor who takes a holistic approach in their work with families. Rather from feedback from

members of the iHV is that many health visitors are now choosing to leave the profession due to the daily risks they feel they are facing trying to support families. To be effective health visitors need to know the families they look after, the current contact rather than outcome driven culture has rendered this impossible. However when there is a child death or other serious safeguarding incident they know that ultimately they are likely to be held responsible if the service they have been able to offer the family has been less than adequate. Whilst being told to delegate contacts to junior staff ultimately they remain responsible for the wellbeing of those children. When they challenge such delegation on safety grounds we are being told they have been told that if they want to keep their job they must comply with what is being asked of them by their managers.

'...it would appear the Band 5 community nurses are fulfilling the role of the HV with very limited in-house training and as quickly as possible. The only difference in roles is that HV's are covering safeguarding concerns. The HV role is being undervalued and I feel stealthily phased out.'

Research shows that what clients value most about health visitors is a trusted relationship over time that can provide authoritative support and advice in a way that is tailored to their family circumstances. It is especially valued by those who find group and centre-based services stigmatizing (Scottish Government, 2015).

- 42% can only offer continuity of care to vulnerable/child protection

Overall, these responses indicate that with increased case-loads, unmet need, and high thresholds for 'early help', health visitors are struggling to deliver their commitment to universal coverage of the mandatory reviews included in the HCP while also meeting needs within their caseloads. Increasingly, productivity is measured by the number of visits undertake rather than what takes place within them.

Survey responses provide evidence of enforced delegation to less well-trained and qualified staff that are determined by staffing levels and increased use of skill-mix without evidence to justify this (while health visitors are deemed by the Regulations to be professionally accountable for such delegation).

We asked about which of the mandated reviews (plus the NICE recommended visit to review perinatal mental health) were delegated and to whom. The responses are indicative of the attempt to focus on the transition to parenthood and early weeks for the skills of the qualified health visitor and the provision of continuity of care where possible. The most common member of staff to whom reviews were delegated are community nursery nurses and staff nurses.

However, in addition, a further request to members to provide feedback on the impact of the reduction of health visiting posts indicates implementation of skill and grade-mix for which there is no evidence base in relation to skill, competency or effectiveness. This has been highlighted as a gap in the otherwise substantial body of health visiting research reviewed by Cowley et al (2013), synthesising 25years of research evidence. In the last year, the iHV has led multi-stakeholder review of curricula for the education and training of health visitors and school nurses in the UK. There is no nationally agreed competency framework either for health visitors or skill-mix roles to deliver the HCP. On the other hand, it is worth repeating that the rationale for the increase in the number of qualified health visitors was based on the recommendations of Lord Laming's challenge to government:

'to develop the health visiting workforce further, to provide leadership and expert practice for the HCP, and to use health visitors' specialist skills in supporting vulnerable families and making their

contribution to safeguarding. He called for immediate action to increase the numbers, confidence and competence of health visiting staff' (DCF&S, 2009: 22).

Our evidence suggests that reductions in staffing and increased delegation are having precisely the opposite effect. The intention of Lord Laming's recommendations was not for health visiting to become a child protection service – a direction of travel strongly resisted by our colleagues who are Named Healthcare Professionals for safeguarding and child protection. Nevertheless, our survey responses indicate a distortion of the service model to one that is stretched between delivering the mandated reviews and holding risk for safeguarding cases while servicing the requirements of safeguarding procedures (e.g. case conference reports, on behalf of 'health' as a proxy for the wider healthcare system); and, as a corollary of this is, our responses indicate lack of opportunity to respond to unmet need (universal-plus level of service) identified through the mandated reviews and follow-ups. Rather, our survey results indicate that health visitors are increasingly focused on the most vulnerable children and families at the expense of full implementation of the five reviews and that the HCP is being implemented in an increasingly 'targeted' manner, against its fundamental design principles. 60% state their ability to make a difference is hampered **by 'focusing only on those most at risk [that] dilutes universal service'**; rather, they are managing risk with children and families with known needs. The result is that **health visitors cannot be confident that they are identifying needs or providing early primary prevention.**

This approach is also supported by WAVE Trust's concern for the mental health of pre-school children:

'The Healthy Child Programme (HCP) provides the framework for health visitor-led mental health promotion in pre-school children. Interventions may be at a universal or targeted level. Universal support to families in the HCP includes activities to promote the development of emotionally secure children and families by, for example, promoting the self-esteem of the parents, child-caregiver attachment and positive parenting practices. It also includes working specifically with women experiencing postnatal depression or domestic abuse, with children with behavioural problems, managing child abuse and bereavement. Providing it is done as a universal service, health visitors leading the programme [can] ensure the programme is delivered across many social and ethnic boundaries, and with excluded groups such as the homeless, travellers, asylum seekers and the families of prisoners, who face particular mental health challenges as a result of their life styles.'

(WAVE, 2013: 71).

Health visitors have developed their skills based on in-depth applied knowledge of attachment such as by adoption of the [Solihull Approach](#) and, more recently, use of tools such as [Newborn Behavioural Observation](#) (NBO) and [Baby Steps](#) to promote parental sensitivity and secure infant attachment. WAVE Trust (2013) advocates full implementation of the Healthy Child Programme and further enhancement by the use of such tools to assess and promote infant mental health. Embedding such approaches in practice provides the bedrock for identifying ACEs and establishing specialist services, for example to infant mental health services for reducing demand on CAMHS. *A robust universal service for preschool children affords the opportunity to identify children who may be at risk of developing such problems.* An example is through analysis of ASQ-3 SE which is completed as part of the two-year development assessment. There should then be the facility to refer for further pre-school intervention for child mental health based on these results.

5 Impact of cuts on staff health

Resilient and accountable workforce: Health visitors need to maintain **personal and professional resilience to remain courageous and compassionate** as well as proficient in unpredictable and uncontrolled environments. The support and supervision of health visitors, including a restorative function, is key to the quality of professional relationships, judgement and decision making (iHV, 2015; Munro review of child protection (Department of Education, 2011).

A recent small sample of health visitor feedback via social media (Voices from practice, March 2018 – unpublished) would suggest that staff sickness is very high leading to many experienced health visitors resigning their posts. More exact detail of this could be obtained from a request to employers.

Examples of health visitor feed back:

In my Midlands Trust they say there haven't been any cut, just no advertisements for posts and all vacancies held. FNP service has been decommissioned which is devastating and in an area of massive deprivation means our most vulnerable children are at increased risk of harm. Our local authority colleagues are also upset at this short-sighted change as they see more referrals heading their way for families in crisis and a lack of services to refer to for help. The HV Implementation plan seems so long ago now, it's much worse in practice with many less staff, larger caseloads, massive housing estates being built which attract families and have areas for 'social housing'. As a service we are at rock bottom, huge sickness levels due to stress and total service redevelopment. We will be out to tender again next year, who knows where we will be. People make comments about applying for jobs at the local supermarket, these seem less like jokes and more like a serious consideration of a way out.

'HVs are being left to sink with highly vulnerable caseloads that are unsafe and unmanageable with no support. As I said earlier, these concerns have been raised with the Trust and the unions but nothing changes. X deny anything is wrong and HVs are left feeling helpless and just leave the profession. I moved from X and joined Y - then won the Y contract and have taken over since January this year. They are doing the same to Y as they have done to X. i.e. not replace staff who leave, not covering sick leave etc. The sick rate is high as people can't cope.'

'Please help to be our voice, save our profession and tell the right people what is happening to us. All those poor children and families who need our help are suffering. I am personally looking to leave the profession as like most of my colleagues what's happening is having a detrimental impact on my own health & well-being.'

'Sadly, I have had enough and am leaving soon to become a parent and child foster carer, after only 4 years as a HV.'

'I have now left health visiting which was the saddest and most difficult decision, but I simply could not do a good enough job anymore due to lack of resources and lack of managerial support.'

'The LA have desperate problems meeting the safeguarding needs of children and I became burnt out working on one of the most deprived areas with increasing workload. I felt like a social worker and plugging the gap in services. The extent of accountability on me, the volume of problems, the seriousness of the safeguarding issues, the lack of services to refer to, the increasing "agile" working

practices, watching colleagues crumble and cry and the stress of all of this led me to agree redundancy as an escape.'

6 Economics of Health Visiting

In economical terms, to give one example, the Kings Fund predicting that the burden of mental illness will reach over £88 billion by 2026 (2008) and the annual cost of perinatal mental health calculated to be at least £8.1 billion a year, any service which impacts early to reduce individuals developing mental illness, by ensuring they are identified early and helped, or indeed that reduces referrals to GPs and secondary and tertiary services would seem to be very important. However the significant impact of early intervention to prevent the development of illness receives scant attention in the current green paper on children's mental health services. Work by the Centre for Mental Health and LSE have demonstrated that a well resourced health visiting service supporting mothers with postnatal depression is cost neutral against just one outcome, the mothers earning potential at one year post birth (Bauer et al, 2014). This does not account for her use of NHS and other services or impact of her depression on her child.

As you will be aware, James Heckman, Nobel Prize winning economist has determined that one dollar spent in the early years will save between 3 and 9 dollars on health, social and justice services.

The [Harvard Center for the Developing Child](#) (2007) also argues that the basic principles of neuroscience and the technology of human skill formation indicate that later remediation for highly vulnerable children will produce less favourable outcomes and cost more than appropriate intervention at a younger age.

The Harvard Center notes, 'The essence of quality in early childhood services is embodied in the expertise and skills of the staff and in their capacity to build positive relationships with young children' and, we would add, the expertise and skills to support parents to build such positive relationships. The Center goes on to state: 'The striking shortage of well-trained personnel in the field today indicates that substantial investments in training, recruiting, compensating, and retaining a high quality workforce must be a top priority' (p2).

Also pertinent to our finding on the state of health visiting in England is that, 'responsible investments in services for young children and their families focus on benefits relative to cost. Inexpensive services that do not meet quality standards are a waste of money. Stated simply, sound policies seek maximum value rather than minimal cost' (p2).

7 In Conclusion

Early intervention and working with families to tackle ACEs is the 'bread and butter' of health visiting but over the past 2-3 years the profession has been compromised to the point where it seems unlikely that they will be able to have any significant impact. Worse still, without the universal service being commissioned across England the majority of the more vulnerable children will remain unseen until their vulnerabilities require secondary interventions and are much harder to turn around.

Despite the reality of what is happening on the ground government policy work is still describing the role of the health visitor as being essential for early intervention to improve oral health, reduce speech, language and communication delays, improve breast feeding rates and reduce perinatal mental illness – all universal activities. DWP investment is shortly to go into strengthening the parental relationship to create a more positive environment for children to grow up in. These are

core activities for a universal health visiting service, but as has been demonstrated they require the health visitor to be able to provide universal services, build a trusting relationship with families offering continuity of care, to be able to conduct a holistic needs assessment of the whole family and to do so in the home environment where the impact of negative forces will be most conspicuous and greatest on the child.

The current situation is nothing less than very sad and worrying after the incredibly progress made during 2012-15 which left the profession excited about finally being sufficiently resourced to be able to demonstrate the impacts it can have. Without significant re-investment into public health with ring fencing of a much more robust universal health visiting service or indeed moving health visiting back into an NHS commissioning arena (something we don't fundamentally support) it feels that the current status of the profession will continue to deteriorate. The massive postcode lottery that has developed alongside 152 local authorities commissioning health visiting in 152 different ways will ensure an increase in health inequalities across the country and ACE's will be identified after they may have already destroyed a child's life course.

Fortunately the picture is not so bleak across the rest of the UK where every country is investing. In Scotland the health visiting role has been put back into statute and is being commissioned so the universal service consists of 11 home visits by a health visitor – none by other more junior members of their teams. Ironically the impetus for this was the evidence on ACE's and early intervention. In Wales the intention is that all families receive 9 core health visitor (no skill mix) contacts and 25% receive a more intense service known as Flying Start as they are deemed to be more vulnerable and Northern Ireland aspires to 9 health visitor universal contacts, currently average caseloads are 250 children but the intention is to recruit sufficient health visitors to reduce these to 180 children. It would be helpful to invest in research to compare outcomes for children in these countries to those for children living in England.

REFERENCES

Asmussen, K., Feinstein, L., Martin, J. and Chowdry, H. (2016) *Foundations for Life: What Works to Support Parent Child Interaction in the Early Years*. London Early Intervention Foundation.

Barlow, J., Sue Kirkpatrick, S., Stewart-Brown, S. & Davis, H. (2004) Hard-to-Reach or Out-of-Reach? Reasons Why Women Refuse to Take Part in Early Interventions. *Children & Society* Volume 19 (2005) pp. 199–210.

Bauer, A., Parsonage, M., Knapp, M., Lemmi, V. and Adelaja, B. (2014) *The Costs of Perinatal Mental Health Problems*. London: Centre for Mental Health.
<https://www.centreformentalhealth.org.uk/costs-of-perinatal-mh-problems> [Accessed 11.11.2016]

Bronfenbrenner U. (2005) *Making Human Beings Human. Bioecological Perspectives on Human Development*. Sage: London.

Cowley, S. et. al.(2013) *Why Health Visiting? A review of the literature about key health visitor interventions, processes and outcomes for children and families*. London. National Nursing Research Unit, Kings College.

Daro D, Dodge KA. (2010) *Strengthening home visitation intervention policy: Expanding reach, building knowledge*. In: Haskins R, & Barnett WS, eds. *Investing in Young Children: New Directions in Federal Preschool and Early Childhood Policy*. Washington, DC: Centre on Children and Families at Brookings: 79-88.

Davis, F.A., McDonald, L. and Axford, N. (2012) *Technique Is Not Enough: A framework for ensuring that evidence-based parenting programmes are socially inclusive*. Leicester. British Psychological Society.

Dept for Children, Schools and Families (2009) *Child Health Promotion Programme – Pregnancy and the first five years of life*. London, DfCSF.

Department of Health (2011) *Health Visitor Implementation Plan – A call to action*. London. DOH.

Dodge, K. A., Goodman, W. B., Murphy, R. A., O'Donnell, K., & Sato, J. (2013) Randomized Controlled Trial of Universal Postnatal Nurse Home Visiting: Impact on Emergency Care. *Pediatrics*, 132 (Suppl 2), S140–S146. <http://doi.org/10.1542/peds.2013-1021M>

Donetto, S., Malone, M., Hughes, J., Morrow, E., Cowley, S. & Maben, J. (2013) *Health visiting: the voice of service users - Learning from service users' experiences to inform the development of UK health visiting practice and services*. London: National Nursing Research Unit, King's College London.

Kemp, L., Cowley, S. and Byrne, F. (2017) Maternal Early Childhood Sustained Home-visiting (MECSH): A UK update. *Journal of Health Visiting*. August 2017. Volume 5 Issue 8

Knapp, McDaid and Parsonage (Eds) (2011) *Mental health promotion and mental illness prevention: The economic case*. London. Personal Social Services Research Unit (PSSRU), London School of Economics / Department of Health. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215626/dh_126386.pdf [Accessed 06.06.2016]

Lindland, E., Richter, L., Tomlinson, M., Mkwanzazi, N., and Watt, K. (2016) *Early Means Early: Mapping the Gaps Between Expert, Stakeholder, and Public Understandings of Early Childhood Development in South Africa*. A FrameWorks Research Report. Washington, DC: FrameWorks Institute.

https://www.unicef.org/southafrica/SAF_resources_mappingthegap.pdf [Accessed 16.08.2017]

Harvard Center on the Developing Child (2007a) *A Science-Based Framework for Early Childhood Policy: Using Evidence to Improve Outcomes in Learning, Behavior, and Health for Vulnerable Children*. http://developingchild.harvard.edu/wp-content/uploads/2015/05/Policy_Framework.pdf [Accessed 11.11.2016].

Harvard Center on the Developing Child (2007b) *Early Childhood Program Effectiveness* (InBrief). <http://46y5eh11fhgw3ve3ytpwxt9r.wpengine.netdna-cdn.com/wp-content/uploads/2015/05/inbrief-programs-update-1.pdf> [Accessed 11.11.2016].

Marmot, M. (2010) *Fair Society, Healthy Lives: Strategic review of health inequalities in England post-2010*. www.ucl.ac.uk/marmotreview [Accessed 17.08.2015].

Mitchell, P. F. (2011) 'Evidence-based practice in real-world services for young people with complex needs: new opportunities suggested by recent implementation science', *Children and Youth Services Review* 33, 207-216.

Moran, P., Ghate, D., & Merwe A. (2004) *What Works in Parenting Support? A Review of International Evidence*. Policy Research Bureau: London.

Public Health England (2015) *Healthy child programme: rapid review to update evidence*. London.PHE.

Rose, G. (2008) *Rose's strategy of preventive medicine*. Oxford. Oxford University Press.

Scottish Government (2015) *Tackling inequalities in the early years: Key messages from 10 years of the Growing Up in Scotland study*. Edinburgh. Scottish Government.
<http://www.gov.scot/Resource/0048/00486755.pdf> [Accessed 09.08.2016].

Tickell, C. (2011) *The Early Years Foundation Stage (EYFS) Review. Report on the Evidence*. London: Department of Education.

WAVE (2013) *Conception to age two: the age of opportunity*. London. Wave Trust.

WAVE (2015) *Building Great Britons*. London. Wave Trust.