THE EARLY YEARS COMMISSION - CALL FOR EVIDENCE

DATE: 17th June 2020

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Written evidence submitted by the Institute of Health Visiting

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A. Introduction

1. The Institute of Health Visiting (iHV) was established as an independent charity and centre of excellence for health visiting in 2012, with the support of the Cabinet Office and Department of Health, to strengthen the quality and consistency of health visiting services for the benefit of all children, families and communities. Our Vision 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.

2. The iHV published a Vision for Health Visiting in October 2019 in support of the Government's call through Public Health England for stakeholder evidence to support their proposed refresh of the Healthy Child Programme. The Vision is built on the expressed needs and preferences of parents, as well as the best evidence of "what works" and a benchmark of current practice.

The Vision and underpinning evidence are set out in a suite of documents in the links below[1]:

- **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**
- **State of Health Visiting in England: Results from a survey of 1040 practising health visitors (February 2020)**

3. In this submission, we provide a summary of what we know about the ways that we can ensure that all children are supported to achieve the best start in life.

B. Summary:

4. Our work in this field of primary prevention and early intervention makes clear the following key points:

4.1 We have more evidence than any other generation on **the importance of the first years of life as a foundation for health, wellbeing, educational and economic success across the life-course.** What happens during this time matters - the effects of early disadvantage are cumulative and associated with health, economic and social inequalities which can pass from one generation to the next in the absence of effective measures to tackle these.

4.2 **Inequalities are not inevitable**. However, despite overall improvements in child health, the UK lags behind other countries on many key health outcomes; infant mortality reductions have stalled, our breastfeeding and obesity rates are amongst the worst in Europe and health inequalities are seen across all indicators. Inequality affects all of us: reducing social mobility and education attainment, our economic stability, and our perceptions of happiness, trust and engagement in community life.

4.3 We have enough evidence on "what works" to make a difference now. **Early identification of need and vulnerability, with effective early intervention**, play an important role in preventing and mitigating childhood adversities; supporting all children to achieve their potential and in helping children recover from the effects of early trauma.

4.4 A model of early years support based on the principles of **proportionate universalism**, which provide **a level of support for all children and their families, alongside additional targeted support for children at risk of poor outcomes**, has been shown to make sound economic sense. **"Prevention is better than cure".**

4.5 However, **this will not happen by chance,** it requires political will, with investment in support services for children, and a bold commitment to reduce inequality. A radical shift in government policy is needed to provide **sustainable funding for prevention and early intervention services for children** in England. In addition to this, in our view, all government departments who accrue the benefits of an effective health visiting service, reaching into all families, should collectively commit to support immediate investment back into public health with pooled ring-fenced budgets for high quality health visiting services with protection into the future.

5. Future policy needs to plan for the rebuilding of a society and healthcare system that has been significantly impacted by the major practical challenges of COVID-19. The secondary impact of the pandemic on children and families has been significant, with rising levels of vulnerability and a backlog of unmet need, against a backdrop of an already depleted prevention and early support service due to austerity. There will be no "return to normal".

5.1 The pandemic has shone a spotlight on the impact of widening inequalities and **how the needs of young children are often invisible** when set against a multitude of competing policy priorities. In particular, we share the concerns of others around the vulnerability of babies and young children who are at home, hidden from society and some living with significant adversity and abuse.

5.2 **The impact of "lockdown" is not evenly distributed,** with the most disadvantaged experiencing the most detrimental consequences due to compounding factors like overcrowded housing with lack of outdoor space, the impact of poverty on food security, and parental stress and anxiety. The impact on children is likely to be far-reaching – adversity and exposure to toxic stress are linked with poor social, educational, physical, and emotional health outcomes across the life course.

5.3 A recent paper from Jack Shonkoff[2] warns that:

> *"We cannot lose sight of the massive consequences of these threats to the health and development of our most vulnerable children and their families - now and for years to come… As we pull out all the stops to prevent broader infection, we must also remain vigilant in caring proactively for those who are especially vulnerable to the threat and consequences of social isolation."*

5.4 Currently much of the focus for children is on the needs of school-aged children and the identification of need once schools resume. Yet the needs of babies and young children are equally important and will remain invisible unless a **proactive plan is also put in place to identify the surge in need in this age group, with effective measures to support them.**

5.5 In our view this can only be achieved through a robust national support service, led by highly skilled practitioners, that reaches into all homes providing an accountable, publicly-funded, universal public health service and **a vital safety net for babies and young children**. Health visitors provide this role as an essential part of the country's support structure for children and their parents; the service is non-stigmatising and plays a crucial role in the early identification of babies and young children in need and at risk of poor outcomes. This has been clearly demonstrated by the sudden drop in referrals to early help, children's social care and specialist support in the early weeks of the pandemic when the health visiting service was significantly

limited by social distancing measures and the Government's prioritisation of community services[3]. **Finding vulnerable families with babies and young children is problematic without the universal health visiting service** which also coordinates support and works in partnership with others within an integrated "whole system" approach for the earliest years of life.

5.6 However, **the pandemic has exposed significant flaws in the way this nationally-funded health visiting service is prioritised and delivered, with unwarranted variation in the support that families receive based on where they live rather than their level of need**. The universal health visiting service, intended to identify and support vulnerable children, was already significantly depleted and fragmented when entering the pandemic. The findings from recent research on "The impact of COVID-19 on the ability of community-based practitioners to keep babies and young children safe" by Oxford University[4] highlights that:

i. Despite significant increase in need, large sectors of the HV workforce were redeployed
ii. Limitations on home visits meant that critical services were not delivered
iii. Cessation of universal visits meant that 'new' and 'increased' vulnerability was not identified/ not seen by anyone
iv. Significant delivery of services virtually with no preparation/training; no evidence regarding its use with these families; many families not able to receive care that way; most practitioners wouldn't use it with vulnerable families going forward
v. Changes have had a significant negative impact on the mental wellbeing of the workforce.

5.7 **A plan is needed to rebuild services after COVID-19**. This will require a policy commitment to "front load" support and investment in children in their first years of life, to strengthen universal and targeted support services in order to boost capacity to **manage the backlog of COVID-19 and address increased unmet need.** Addressing the secondary impact requires the same effort levelled at building the Nightingale hospitals and treating infected patients. The impact on children may be more hidden, but it is likely to be even more significant to the future health and prosperity of our country.

C. The Early Years Commission – Call for Evidence:

6. Improving outcomes for parents and children requires the growing body of evidence to be translated into policy and implemented in practice. This requires a "whole system" approach as it is unlikely that any single intervention or service will be sufficient.

7. Actions must be based on the best evidence of "what works" to reduce inequalities and improve child and family outcomes. We set these out as the 8 key elements of our Vision, built on the expressed needs and preferences of parents, as well as the best evidence of "what works", and use these as the basis of our responses to this call for evidence. For services to be:

a. Accessible
b. Personalised
c. Responsive
d. Fairer
e. Collaborative
f. Evidence-driven
g. Effective
h. Professional autonomy – workforce with the right skills

Q1- How can we ensure that parents and children receive the best possible physical and mental health support, particularly during the perinatal period? (see iHV Vision for references unless stated).

8. Accessible: Ensure all families with children (pregnancy to 5 years) have access to a preventative public health service, including those considered "hard to reach", or easily overlooked.

8.1 **Policies should recognise babies and young children as a particularly vulnerable and often overlooked group:** The Children's Commissioner estimates that in total 2.3 million children are living with risk because of a vulnerable family background. Within this group more than a third are "invisible" (i.e. not known to services) and therefore not getting any support. At the most extreme end of the spectrum, as in previous years, currently the highest rate of homicide for any age group is in babies under the age of 1. Unlike older children who will be seen regularly by professionals within school or early years settings, babies and younger children are at high risk of having their needs overlooked. As a result, problems risk becoming more entrenched and costly to treat.

8.2 **A coordinated approach to address 3 levels of vulnerability.** Childhood adversity is frequently determined by the co-existence of multiple risk factors at the level of the child, family, community and society. Public Health England, NHS England and the Department for Education have identified **three high level categories of vulnerability for children and young people (CYP)** to provide clarity and a common language during the COVID-19 response and as services rebuild:

- **i.** CYP who may be at higher risk due to **clinical reasons.**
- **ii.** Higher risk and have **statutory entitlement** for care and support. This includes CYP subject to child protection plans (Section 47 or Section 17), children with Special Educational Needs and Disabilities, and Children in Care.
- **iii.** Higher risk due to **wider determinants of health and other factors leading to poor outcomes.**

Health visitors play an important role within a comprehensive prevention 'system' of support which is needed to reduce the occurrence and impact of this adversity – this includes working as part of the Government's "Troubled Families" programme to provide "joined up" support to build resilient families.

Health visiting straddles all three types of vulnerability across a continuum of need, which increases the impact of the service, but also introduces complexity, with blurred lines of accountability and benefits accruing to partners who do not fund the service.

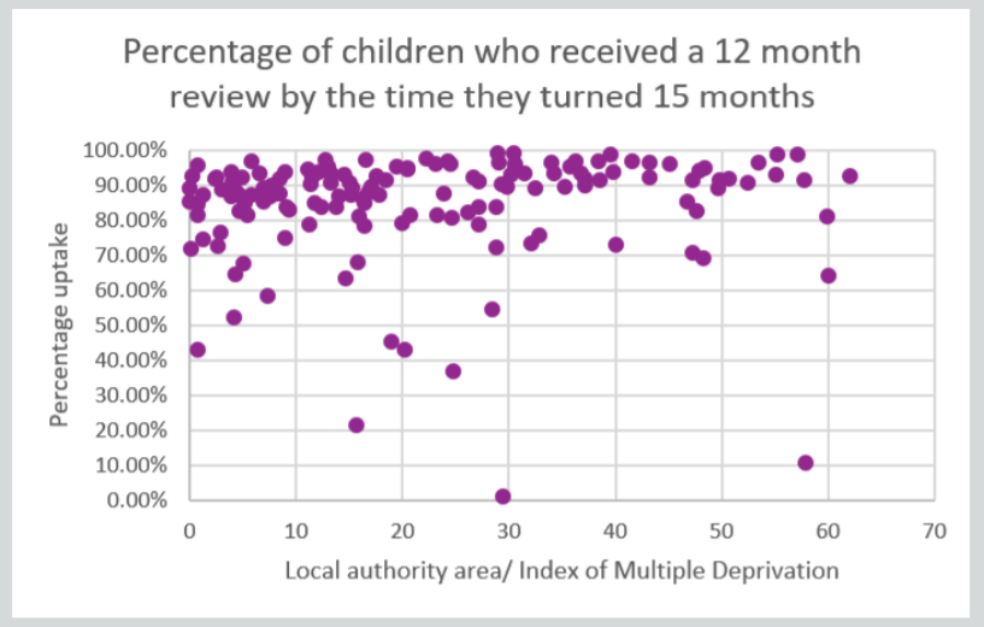
8.3 **Services should ensure they are accessible to all groups, particularly those individuals and groups who do not currently experience easy access to services**, and consequently do not experience the same health outcomes as the rest of the population. The most vulnerable families are known to find it difficult to focus on their child's needs and are often less motivated to seek out and use support services. Targeted interventions, by definition, leave many high-risk families ineligible for their services – universal services are therefore vital to ensure that vulnerable children are not missed.

8.4 **Safeguarding is a thread that runs through all levels of health visiting**, contributing to multi-disciplinary, multi-agency networks to protect children (and in some instances their parents) from abuse and exploitation, and to safeguard their health and wellbeing. Health visiting is non-stigmatising and has high levels of acceptability to the public. The Health Visiting Benefits Realisation review (2017) concluded that the universal health visiting service was important to both safeguarding and child protection "because it **safeguards all children**".

8.5 **Ensure sufficient "surge capacity" to meet the increased demand for support due to COVID-19 as well as the backlog of missed appointments.** Too many babies were vulnerable in the UK before this crisis. 53% of children in poverty in the UK are in a family with a young child.[5] Families' problems will have escalated during the COVID-19 crisis as a result of a range of stresses such as economic hardship, isolation and the stresses of lockdown. There is evidence of rises in domestic abuse,[6] and abuse and neglect of children are likely to have escalated behind closed doors. All of these issues put babies' wellbeing and development at risk. The significant economic impact of the crisis will persist long after lockdown, leading to an increase and deepening of child poverty.

8.6 Despite national mandation of the universal elements of the health visiting service, there is considerable **unwarranted variation in the services that families receive** based on where they live rather than their level of need. This is depicted in the graph below which shows uptake of the universal 12-month health review, with very poor provision in some areas. This variation in implementation represents a **significant quality issue for this important government policy**:

Figure 1: Uptake of the 12-month health visiting health review by local authority area Index of Multiple Deprivation[7]



9. Personalised:

9.1 **Not a "one size fits all" approach.** There is significant evidence that parents want a personalised service that is responsive to their individual circumstances and needs, with continuity of practitioner, rather than a "one-size fits all" approach.

9.2 **Strengths-based/ working in partnership with families.** Helping families improve outcomes for themselves and their children is complex and requires **significant practitioner skills and attributes**, alongside engagement by families. It should not be seen as a series of "tasks" to be delivered, but rather a process of working in partnership with families that requires a trusting relationship built over time. Mutual exploration of families' lives, their strengths and difficulties, informs and influences the way in which a shared understanding between parents and practitioners develops. Similarly, the capacity of parents and practitioners to negotiate shared goals and identify realistic strategies underpins their ability to bring about changes through well-planned implementation that result in specific, shared outcomes. In practice, the immediate and long-term impact of risk or resilience factors, as well as their interaction, are complex and

difficult to predict. Practice that builds on people's strengths has been found to be demonstrably more effective than approaches that emphasise problems, risks and the expertise of professionals.

9.3 **Continuity of practitioner.** Parents have described this as important - "knowing and being known personally by a health visitor". Services should aim to provide continuity of practitioner and personalised care, in line with the ambitions of the Maternity Transformation Programme and recent Select Committee recommendations. Yet continuity of carer in health visiting is not experienced by most parents in England - the current norm is that women are discharged from midwifery care at around 10 days after the birth of their child, without continuity of carer, when in reality their parenting journey has barely begun. It is widely recognised that the period from conception to age two represents a dynamic period of change and adjustment for many parents, with physical and emotional needs extending beyond the scope of maternity care, and with potentially life-long impact on the health and wellbeing of both infants and parents.

10. Responsive:

10.1 **Families need easy access to the right support when it is needed.** Movement between levels of support needs to be fluid, as needs change over time and may emerge throughout the early years – (see summary of the 4 levels of support provided by the health visiting service in Figure 2).

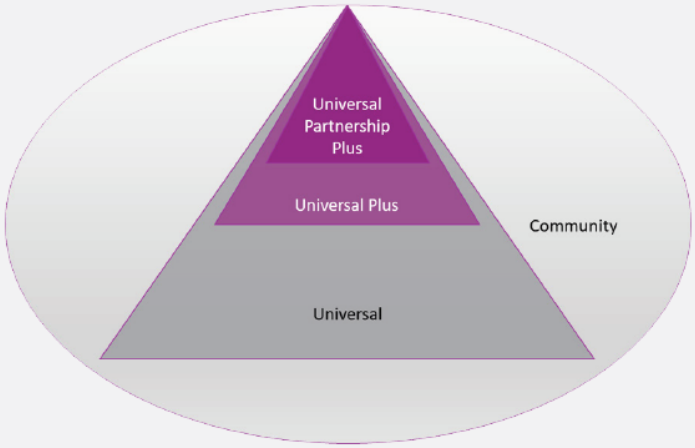
10.2 It is important to avoid the simplistic assumption that the level of support should be based on an initial "snapshot" assessment of need, as this is highly likely to be inaccurate. Some families do not disclose risks as they do not think it would lead to help, or provide socially acceptable, rather than truthful, responses, and some do not disclose due to fear of stigma or negative consequences such as loss of child custody.

10.3 Being able to intervene early, however, is **premised upon being able to identify those families where risks are present**, and there is mounting evidence that reliance on universal screening and first or minimal contact disclosure of sensitive risks is failing to identify those facing adversity and in need of additional support. There is evidence that a much greater disclosure and identification of need occurs in an established relationship when parents feel more comfortable to provide honest information and this may be weeks or months into a programme, like the Healthy Child Programme or more intensive home-visiting support programme.

10.4 A universal pathway of support offers systems and structures that standardise practice throughout the country and ensure that the health visitors' role is well defined and clear to families and wider agencies. The evidence suggests that by increasing the number of universal contacts, families develop trusting relationships with health visitors, which can lead to greater awareness of needs and timely support.

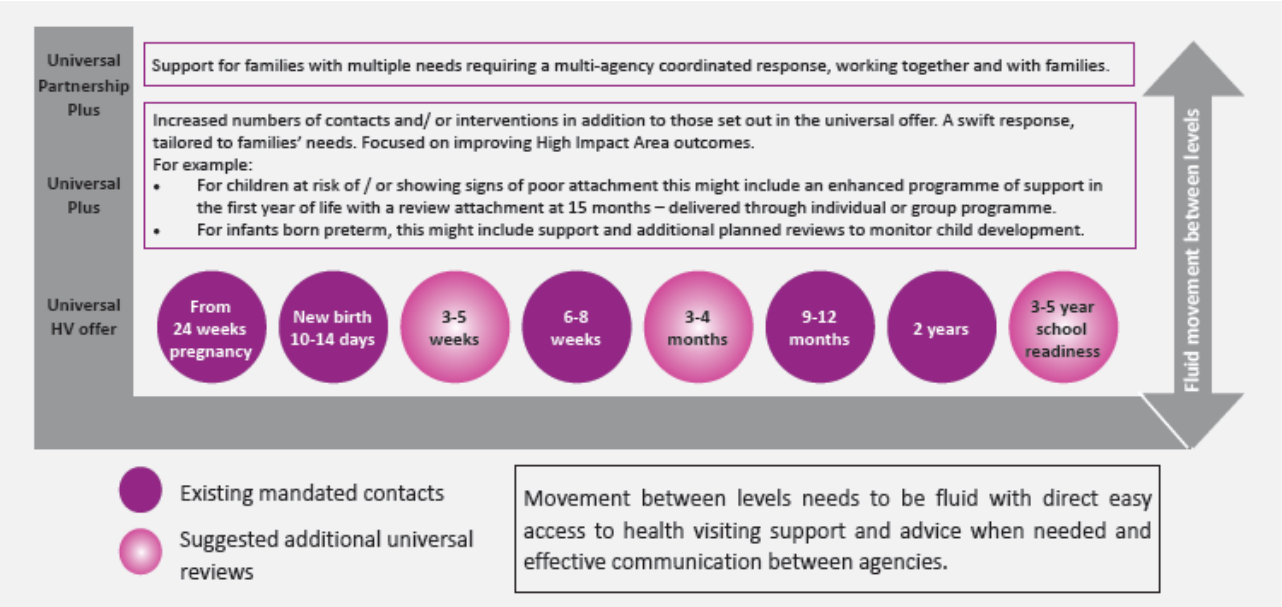
10.5 Easy access to health visiting support is crucial to ensure that the service is responsive to need, as and when it arises. Parents value drop-in clinics and groups that are both accessible and flexible to meet their needs. The service "workarounds" of COVID-19 have highlighted some benefits, as well as limitations, of non-face-to-face methods and new technologies providing personalised advice. The initial findings suggest that they provide a useful mechanism to increase choice and augment face-to-face contacts, however there are also considerable concerns about their use with vulnerable families and, in particular, the accuracy of needs assessment. Further research is needed to ensure that the primary ambition of the Healthy Child Programme to reduce inequalities is still achieved using these new technologies and that vulnerable children are protected.

Figure 2: Personalised support with 4 different levels of intervention proportionate to need



- **Community**: Health visitors work collaboratively with others to facilitate a place-based response to local need.
- **Universal**: Eight universal health visiting reviews provide a service for all and a safety net for children and families who might be "invisible" without this provision. Non stigmatising and acts as a gateway to other levels of support.
- **Universal Plus**: A swift response when families require specific expert help. To reflect the breadth of the health visiting contribution, we have based this particularly on 15 High Impact Areas.
- **Universal Partnership Plus**: Support for families with multiple or long-term, complex needs requiring a multi-agency coordinated response, working together and with families.
- **Safeguarding is a thread that runs through all levels of health visiting**. The health visiting service is recognised as important to both safeguarding and child protection "because it **safeguards all children**"[61].

Figure 3: A flexible health visiting service tailored to individual need and responsive to changing need over time



11. Workforce considerations: Professional autonomy – workforce with the right skills:

11.1 There are a range of services and supports available within communities that specifically focus on the early years and strengthening families so that they can provide positive and nurturing environments for their young children. **These services complement each other but have unique functions and contributions provided by practitioners with different skills that should not be overlooked in efforts to rationalise services**. The reductionist approach taken in some areas (reducing intervention into tasks to be completed, rather than taking a holistic approach that often requires considerable skill to address multiple competing needs) has increased fragmentation of support to families, lines of accountability and the risk that vulnerable children may fall in the gaps between services, leaving them with unmet needs.

11.2 The service pathways model presented in Fig.4 depicts how the role and position of different forms of support are conceptualised within the early childhood services landscape. This model was developed in Australia but has considerable overlap with the UK. It highlights the strong evidence to support both:

i. **Primary healthcare (in the UK this is provided by the health visiting service**)- the main functions are to identify need, broker engagement and provide direct support to families with a breadth of social, clinical and statutory vulnerabilities

ii. **Targeted support and child protection services** – once needs have been identified.

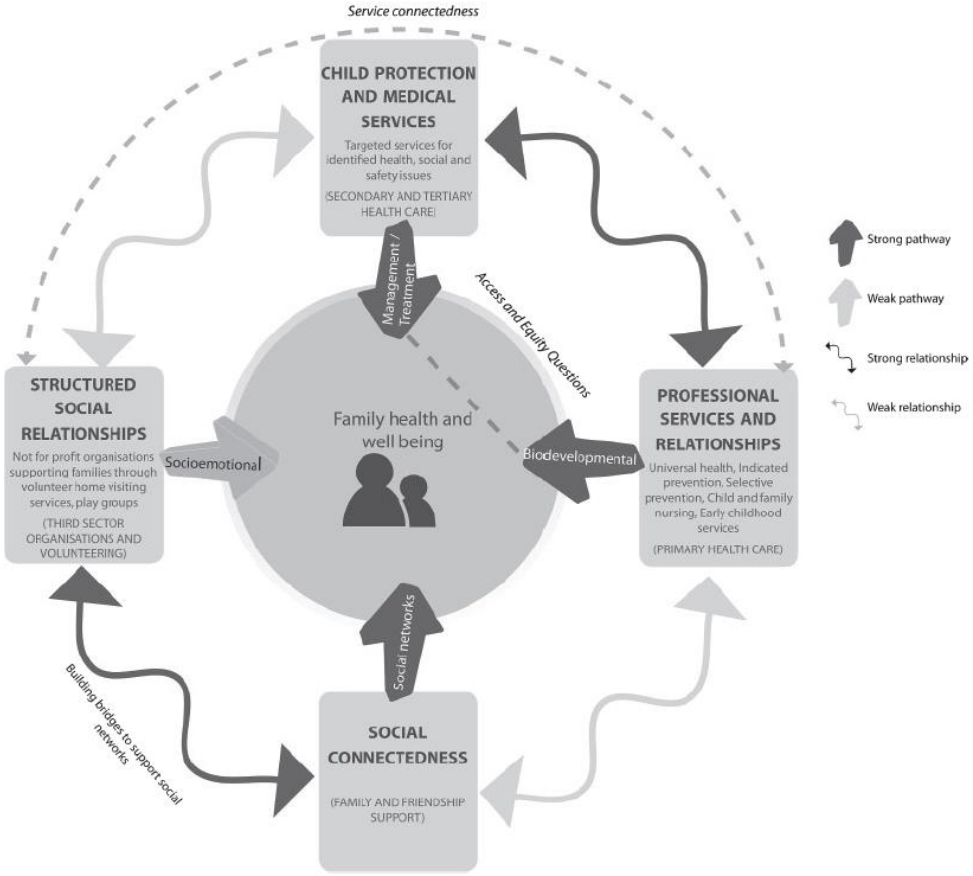
There is a strong relationship between the above services to improve outcomes. This support is augmented with:

iii. **A family's interpersonal support environment** represented as social connectedness. The supportiveness of personal social networks can buffer the effect of stress on wellbeing;

And

iv. **Structured social relationships are depicted as third-sector organisations supporting families.** The evidence suggests that programmes, such as home visiting by volunteers, help support the capacity of parents to construct supportive relationships within their family and local community. Whilst they bring benefits, there are untested assumptions that family engagement with not-for-profit organisations under the structured social relationships pathway will improve access and referral pathways for child protection and medical service/ clinical vulnerability. As these programmes are not delivered universally, they therefore cannot replace the role and function of services like health visiting - doing so may risk marginalising those families that have the greatest needs and do not readily disclose their vulnerabilities or engage in support, as well as families with needs outside the skillset of volunteers or 3rd sector workers (for example the clinical needs of children or parents in the perinatal period that require specialist community public health nursing skills like: faltering growth, perinatal mental health, early recognition of disability and chronic health conditions).

Figure 4: Pathways (child 0-5 years)[8]



11.3 **Health visiting** has been an important part of the service landscape for a very long time, both within the UK and in various guises of "Home Visiting" or "Family Nursing" internationally. Such programmes are delivered by highly-skilled professionals (e.g. Specialist Community Public Health Nurses in the UK, and child and family health nurses in other countries). Considerable research focus has been given to understanding the benefits of professional home visiting programmes for families of young children. Multiple reviews conclude that clearly defined professional home visiting services support positive maternal and child outcomes.

> *"Health visitors are an essential part of the country's support structure for young children and their parents – especially those who are struggling to cope. But they can only do this if they have the time and capacity to develop good, trusting relationships with families. I am very concerned that the huge pressure on health visitor services is making it harder for them to do this, meaning some vulnerable children are in danger of falling through the gaps."*
>
> **Anne Longfield, Children's Commissioner for England**

11.4 **Skills -** Health visiting practice is not simply skills to be learnt, or tasks to be completed, but encompasses a philosophy and way of working that makes health visiting a distinct public health profession focused on "health-creation", rather than illness treatment. Health visitors are trained to support the child within the context of their family and wider community, taking an ecological approach to enable parents to focus on the needs and priorities of their baby and family.

11.5 **Professional autonomy** is essential for enabling health visitors to provide a flexible service, tailored to individual need, adapting and changing in response to the dynamic nature of the environment.

11.6 **Supported by "Safer staffing"** – manageable workload. A 'health visiting service' should be one that is delivered and led by health visitors who are trained and qualified to the level of Registered Specialist Community Public Health Nurse and who work autonomously within a local service framework. With the cuts in recent years, health visitors in some areas are now accountable for caseloads of over 750 children. In contrast, NHS services are monitored against "Safer Staffing" levels, yet health services devolved to local government do not have this level of clinical governance. It goes without saying that it is impossible for a single practitioner to be safely accountable for the assessment and care of 750 children and their families

11.7 **Continuity of carer is important** and ensures that, as far as possible, a family sees the same health visitor. Parents want to avoid having to repeat "telling their story" and this is also strongly linked with increased identification of need and vulnerability. It is important that we avoid a system that is "health visitor led" in name only. Health visitors are professionally accountable for the assessments of health and care for all families on their caseload and any delegated activity undertaken within skill-mixed teams.

Q3. How can we support parents to develop the skills and maintain the relationships that support healthy child development during the early years period?

12. Relationship-based support: (In addition to the points covered in the sections above):

12.1 Parents play an essential role in babies' and young children's lives, providing them with the nurturing care they need to develop socially and emotionally. Becoming a parent is a time of adjustment and learning for most families. There is strong evidence that a system of support based on **proportionate universalism**, with a level of support for all families and increased support targeted at families with the greatest need, is the most effective means to reduce inequality and ensure every child has the best start in life.

12.2 This is particularly important during a pandemic and the time of rebuilding and recovery that will follow. For many children, their parents will be providing them with emotional support through this unsettling time. But some parents will find it hard to give their babies the care that they need and will not have the emotional and practical resources they need to buffer the impacts of the crisis for their babies. There is an urgent need to support babies and their families to prevent immediate and long-term harm. A wealth of evidence shows that exposure to significant stress in the womb or early life can have pervasive and lasting impacts on multiple domains of development.[9] The risks of early trauma and adversity can be mitigated with the right support. **Rapid action is needed so that babies do not become the "collateral damage" of actions to protect the nations' physical health, with long-term consequences for our children and our society.**

12.3 Supporting every child to achieve the best start in life with optimal child development is a central part of the health visitor's role; **health visitors work in partnership with parents** to promote child development, assess needs and identify problems or issues at the earliest opportunity, including signposting to specialist support if needed. Health visitors are also in a unique position to **promote learning in the home environment from antenatal through to school entry, building on the strengths within families and providing support and guidance when required and proportionate to the level of need.** This reduces the need for much more costly, and less effective, late intervention.

Q4. How do we provide the most effective and integrated early years services in local community spaces to give children the best start in life?

13. Support needs to be integrated and "Collaborative":

13.1 It is widely recognised that reducing inequalities requires a **whole-system, integrated approach as prevention and intervention cut across a range of stakeholders** working with children and their families. This is also affected by wider determinants of health like poverty, housing and government policy. The health visiting service is a central part of the "integrated system", maximising its impact by working universally with all families and collaboratively with partners.

13.2 **Clear leadership for children and families' public health is essential** to ensure plans are in place which are co-ordinated across the area and across those responsible for the wider determinants of health. Including health visitors in such planning will support the desired outcomes, as they hold important intelligence on the needs of local families.

13.3 **Collaboration relies on relationships, trust and autonomy:** Parents value health visitors as a point of contact (and referral to other health professionals); the service is non-stigmatising due to its universal reach. Health visiting teams work collaboratively with local communities and key partners like GPs to respond to families' priorities, mobilise assets within communities, promote equity and increase people's control over their health and lives.

13.4 **Integration, to ensure children do not fall in the gaps between services and improve outcomes, requires:**

- Integrated working across the healthcare system.
- Integration across other sectors – health, education, social care.
- Integration across the life-course – transitions.
- A learning culture and shared ambition, focused on children, to drive quality improvement. Currently, there are perverse system incentives which drive a positive reporting culture in order to preserve contracts – as a result, organisational silos may downplay any negative findings and resist sharing best practice or organisational learning with the wider system to preserve their advantage.
- Shared ambitions, clear lines of accountability and recognition of the unique contributions of different roles.

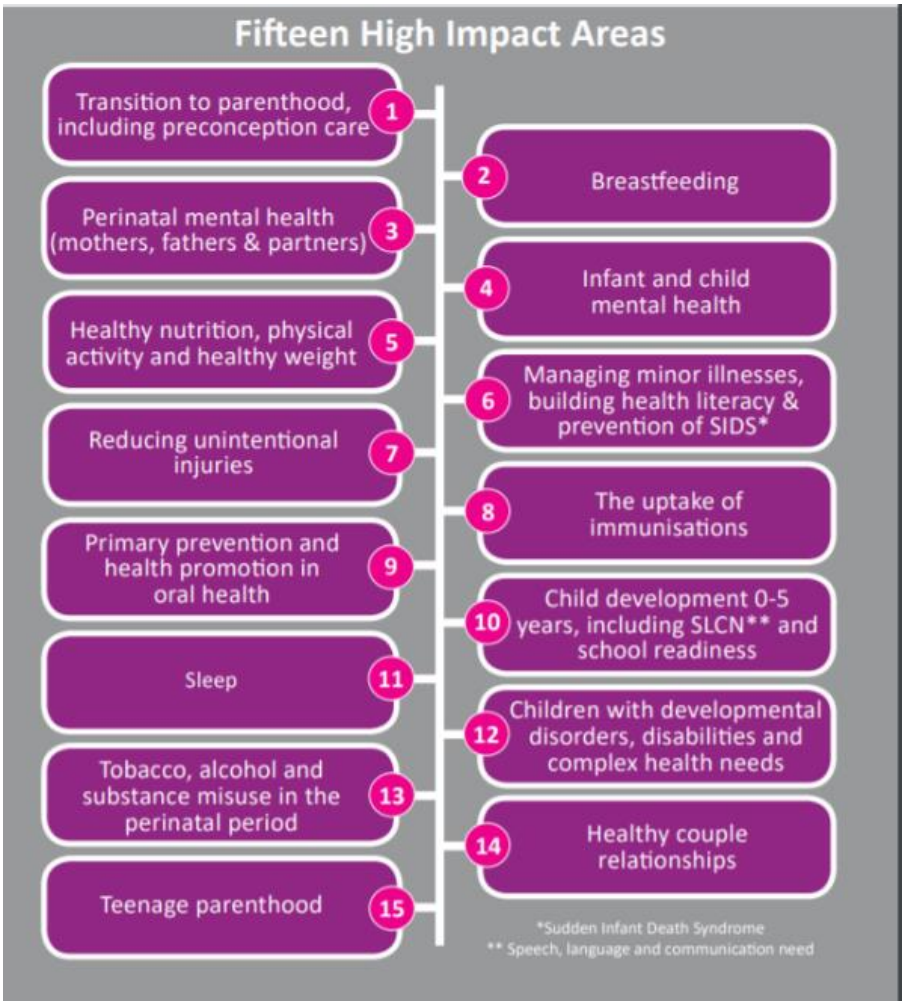
13.5 **A longer-term/ cross-departmental view of the benefits of investing in prevention and early intervention which accrue to numerous government departments.** Achieving the "best start in life" requires effective measures to tackle a breadth of issues linked to poor outcomes. The health visiting service should provide an important part of the solution to numerous current national priorities including:

- Improving early language development and the home learning environment; identifying and supporting families with children with Special Educational Needs or Disabilities (SEND); and safeguarding children from abuse and neglect (Department for Education (DfE));
- Supporting Troubled Families (Ministry of Housing, Communities and Local Government);
- Reducing parental conflict (Department for Work and Pensions);
- Improving parental health literacy to reduce unnecessary A&E attendance in children; improving immunisation uptake; supporting families at risk of, or experiencing, infant and perinatal mental health problems; reducing childhood obesity and poor oral health; and early identification and support for families with children with developmental delay and/or complex health needs (NHS England/ Department of Health and Social Care (DHSC));
- Support to help children living with alcohol-dependent parents (DHSC);

- Improving uptake of child benefit (HMRC), Healthy Start benefits (DHSC) and free education and childcare for two-year olds (DfE) by eligible families;
- Early support to reduce demand on general practitioners by parents with everyday parenting concerns such as feeding difficulties (DHSC).

13.6 The health visiting contribution to integrated clinical pathways are aligned to 15 High Impact Areas (see Figure 5) where they can make the biggest difference. In addition, safeguarding is a "golden thread" across all issues:

Figure 5: The health visiting 15 High Impact Areas



13.7 A strengthened health visiting service is integral to an effective collaborative system and improved outcomes for infants, children and their families. Conversely, a weak health visiting service has been likened to a "weak link in the chain" and increases the likelihood that children and families will be "missed", and the extra system burden associated with late identification and intervention.

Figure 6: Percentage of health visitors reporting they work with each of vulnerable groups (iHV survey, 2019):

Travellers	64%
Homeless families	77%
Looked After Children	91%
Families of concern	95%
Families with children subject to a Child protection Plan	93%
Teenage parents	90%
Refugees/ Asylum seekers	83%
Perinatal mental health	95%
Adults/ children with disabilities	93%
People with drug/ alcohol problems	94%
People who need interpreters	92%
Children with speech, language and communication needs	94%

The table above demonstrates that, within health visitors' work with *all* families, the many faces of vulnerability and disadvantage are mainstream to this work. The health visiting service is recognised as important to both safeguarding and child protection "because it **safeguards all children"**[10] This is because health visiting uniquely reaches out proactively to every family with a child under the age of five, in order to identify need and provide or facilitate support, across the full spectrum of need.

13.8 An innovation fund is needed to support the embedding of rapid cycle improvement methodology across all local authorities, to translate evidence into practice and support local innovation. In particular, an innovation fund is needed to evaluate "COVID workarounds" to ensure they achieve the intended outcomes of identifying children at risk of poor outcomes and reducing inequality.

Q6. How can central government work better together to develop effective policies on early years?

14. Policies need to ensure that they are "Fairer" for all children: A national cross-government ambition to reduce inequality is needed, with recognition that this can only be achieved through actions based on the principles of proportionate universalism:

14.1 Inequalities in health are not inevitable. They begin early in life and are reflected across the whole population. A preventative "upstream" focus is needed and **reducing health inequalities should be regarded as a key test of effectiveness.**

14.2 There is a significant body of evidence to support the case that **focusing solely on the most disadvantaged will not reduce health inequalities sufficiently**[11] [12]; indeed, it may stigmatise those most affected while missing the opportunity to reduce the social gradient across the whole population who are all negatively impacted to a greater or lesser extent.

14.3 To be effective, all areas need to provide a continuum of support for a continuum of need. **Actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage**[13] (i.e. both universal and targeted support).

14.4 A **salutogenic (health creating) approach**, rather than a pathogenic (problem treating) approach is needed. Focusing on how families can adapt and self-manage within their context to realise their own, and their child's, potential is effective. This recognises that:

- Practitioners and families cannot eliminate all risk factors or prevent all changes, instability and difficulties that families face

- The developing child cannot wait for family to be "cured" (for the family to have as absence of problems).

14.5 **In areas of higher deprivation, more families would need more support** based on the principles of proportionate universalism. This would need to be factored into the baseline with smaller caseload sizes in those areas.

14.6 **The Prevention Green Paper** summarises the ambitions above as, *"not about nannying, but empowering people to make the decisions that are right for them. It's about providing everyone with the chance to live happy, healthy lives… Children are also affected by the wellbeing of their parent or primary carer. Because these challenges occur from birth onwards, it's vital that families and their children who need extra support are identified early and receive tailored support. That way, we can prevent problems from arising in the first place, rather than dealing with the consequences".*

14.7 Currently, there are many policies that do not seem to take account of the logic of balancing economic, environmental, health and social outcomes. Too often departments appear to continue to focus on their own specific perspective and remit, "ploughing their own furrow". This is particularly the case in relation to spending on the early years of a child's life. Health, education, social care, local services and third sector services all collide in a patchwork of plans and funding programmes that are fragmented at every level of the system and ultimately lead to fragmented support for families. The case has been made for a wellbeing budget which makes a clear link between spend and the agreed societal outcomes. The evidence is clear that investing in the earliest years of life saves money in the long run. **It is precisely because the government is facing a tight fiscal settlement post-COVID that this "investment to save" is needed now, more than ever.**

Q7. How can local government and agencies work together to deliver innovative high-quality early years provision?

15. Services need to be "Evidence-driven"

15.1 Services need to be based on best evidence of "what works", with staff with the right skills to address the breadth of vulnerability, improve identification of need, broker families' engagement in support and deliver evidence-based interventions.

15.2 Services should focus on the breadth of issues outlined in the 15 High Impact Areas in our "Vision" for health visiting (Figure 5). These represent the most significant threats to individual and population health and are the areas where health visitors can make the greatest difference due to their universal reach and breadth of skills. Health visiting is a trusted "brand" that is non-stigmatising. Parents value health visitors' knowledge of parenting and childcare issues, their capacity to offer reassurance and support with specific issues such as postnatal depression, domestic violence and abuse, substance misuse, child development concerns and managing childhood illnesses, providing a continuum of support for a continuum of need.

15.3 Assessment should be completed over time and avoid a "tick box" approach. The aim is to gain a clear understanding of the individual family situation, assets and capabilities as well as their problems and difficulties within the wider personal, family and social context. This is a highly-skilled activity that aims to elicit needs that may not always be conspicuous or readily disclosed.

15.4 The aim is to achieve equity of outcome, not equal input. The overriding ambition to ensure that every child has the best start in life must drive decisions based on individual need; this is important to avoid a level of flexibility being misapplied to justify cuts to services or make assumptions about the needs of certain groups. Information on levels of unmet need and waiting lists should be collated to inform future service planning.

15.5 Support should be tailored to the needs of children and families (as outlined in the section above on personalised support). Many families who have inter-generational poor health and social outcomes may fall below statutory thresholds but need more support than universal services can provide. Therefore, greater attention needs to be given to what services are not providing and who is being missed to ensure equity of access. The universal health visiting assessment provides an important means to capture this information.

15.6 A continuous cycle of quality improvement is needed to develop, test, and scale new ways of working. To support engagement and reduce attrition, co-production of services is also important to identify barriers to service uptake and solutions to reduce the number of "invisible" children.

15.7 The voice of the service-user should be central to this quality improvement process. The benefits of working together and really listening to those who use our services are obvious and integral to designing services and systems that can improve quality of care and outcomes. If we do not work collaboratively, we risk developing programmes that are irrelevant, unhelpful, not feasible, ineffective, or even harmful. Services for the early years have much to learn from Maternity Voices Partnerships – these multi-disciplinary groups have brought together commissioners, providers and the women and families using the services, to positively shape the Better Births programme in maternity services. We recommend that a similar approach is introduced to health visiting and early years support services.

16. An "Effective" system of support is needed

16.1 Health visiting and early intervention face difficulties in articulating causal impact within a complex adaptive system in which the factors that impact outcomes are varied and messy. Simple reductive approaches for demonstrating impact within complex systems have been widely criticised for providing limited and misleading conclusions, with a call for changes to the way outcomes are measured in order to allow for meaningful accountability in service delivery.

16.2 Measurement for learning within complex adaptive systems relies on relationships, trust and autonomy in order to avoid a positive reporting culture which masks challenges and limits wider system learning.

16.3 Abstracted and simplified data from performance measurement should be considered alongside practitioners' own experience, qualitative feedback from other sources, including service user experience, to produce learning that can be used to adapt and improve practice.

16.4 The current national outcome measures for health visiting are largely process measures designed to prove compliance to external bodies. They have been criticised for only measuring a very small proportion of the scope of the health visitors' role and workload. They also provide very limited information on service quality, nor any information on the children and families who have not accessed the service.

16.5 The complexities of measuring impact in a complex adaptive system are widely recognised:

> *'This form of performance measurement [process measurement] actually encourages people to game the system. At best, they focus on the numbers that allow them to tick the box they are responsible for, with the result that it becomes harder to work across services or to take into account the variable and interrelated factors that affect outcomes on the ground".*[14]

What gets measured gets done – currently this means that the delivery of statutory and mandatory functions are protected to the detriment of early intervention and prevention services. The focus of outcome measures needs to shift from the "provision of services" and work towards longer term goals which value health assets, with cross-sector shared ambitions that matter to a community.

16.6 To reduce the provider burden of excessive process outcome measures, the Government should develop and set high level goals for children's population health with a clear line of accountability between national goals, ambitions or targets and regional systems.

16.7 Measure the impact of health visiting intervention on demand for other services and prevention of specific illnesses to determine wider system cost savings. For example, fewer A&E attendances and hospital admissions from increased breastfeeding and improved parental health literacy and reduced infectious illness from vaccine uptake.

16.8 The lack of hard system levers to drive quality in local authorities has, in many ways, led to the current unwarranted variation in service provision. Legislation of local authority functions to drive improvement is seen by many as punitive; instead, change needs to be driven with system incentives and by working across traditional organisational boundaries and silo working, creating a culture and working relationships built on partnership and trust to achieve shared aims.

Q8. If you could introduce one early years policy designed to bring about the greatest impact on a child's life chances, what policy would it be and why?

17. The COVID-19 pandemic has highlighted the weaknesses of the rather fragmented and short-term policies for babies and young children in recent years, particularly in England. **It is time for a bold shift in national policy which prioritises the needs of babies, young children and their families which are frequently hidden from sight.**

17.1 **Health visitors play an important role as part of this solution, providing invaluable universal support to all families and intensive support to those that need it the most. It is imperative that we have a national strategy to rebuild this important service.**

17.2 We set out our recommendations in detail in our Vision for Health Visiting (2019). In the light of the COVID-19 pandemic, the priorities include:

1. **Workforce:** A workforce plan for health visiting is urgently needed to ensure that the workforce has sufficient capacity to deliver the Healthy Child Programme in full and make good on the depletion of the workforce due to Public Health Grant cuts since 2015; redeployment due to COVID crisis actions; and ensuring a training pipeline by funding training places with a confident vision for a health visiting career.

2. **Funding:** Significant investment in the health visiting service is needed to ensure that the public health grant (or equivalent) supports delivery of the Healthy Child Programme in

full to all children through a universal evidence-based service that can identify and support the continuum of needs within a wider, integrated system.

3. **Quality:** A long-term, cross-government department, post-COVID strategy for children is needed, with clear lines of accountability to address widening inequalities and improve outcomes for all children, particularly in the First 1001 days. This will require greater integration both at national and local level to reduce the current unwarranted variation through a national refreshed Healthy Child Programme. Rigorous evaluation of COVID-19 workarounds are urgently needed and we recommend that an innovation fund is established to support the rebuilding of evidence-driven local services.

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