# Department for Education - Working Together to Safeguard Children: changes to statutory guidance consultation.
# Written response submitted by the Institute of Health Visiting

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## 1.0 About the Institute of Health Visiting

The Institute of Health Visiting (iHV) is an independent charity, professional body and centre of excellence for health visiting, established to strengthen the quality and consistency of health visiting for the benefit of all children, families and communities.

## 2.0 Background

The iHV response has been formulated with support from UK members of the iHV Working Together Safeguarding Roundtable Event (n=34) which convened on 21 August 2023. The group considered the impact of the proposed changes to the statutory guidance on health visiting practice. Further practitioner intelligence, and views on the proposed changes, were also collated from direct emails that the iHV received from members during the consultation period.

In our response to the consultation, we have sought to provide constructive feedback on the proposals and to suggest areas that we think the Department for Education and the Department of Health and Social Care should explore further. Following a direct request from the Department for Education, our response is focused on questions 23, 24 and 25 that relate to the proposal that, alongside other professionals, health visitors could become lead practitioners for children subject to Child in Need – section 17 arrangements.

## 3.0 iHV responses

**3.1 Consultation question 23:** Do you agree that the proposed changes will help to improve the outcomes of children and their families who receive support under section 17 of the Children Act 1989?

- Yes
- No ✓
- Don't know

**3.2 Consultation question 24:** Do the proposed provisions for the role of the social worker qualified practice supervisor or manager ensure appropriate social work oversight?

- Yes
- No ✓
- Don't know

**3.3. Consultation question 25:** In your opinion, are there practitioners who should not be lead practitioners? Key considerations.

Babies and children categorised as 'Child in Need' under section 17 of the Children Act represent some of the most vulnerable individuals in our society. Our duty of care to safeguard them and promote their welfare is our overriding responsibility.

Decisions on the appropriateness of certain practitioners as 'Lead practitioners' need to take account of the following considerations:

i. **Workforce skills:** The role of 'Lead practitioner' is 'safety critical' work which carries a high risk of significant unintended consequences if badly managed. As such, it is essential that the practitioner who is designated as the Lead Practitioner has the right knowledge, skills and capacity to manage the complex situations and range of needs experienced by the children that fall within this remit. As the designation of section 17 is 'voluntary', the practitioner also requires high level communication skills to engage and work with their families to make positive changes. There is a large body of evidence that making health changes is difficult and the level of skill required to effectively engage, and support, families should not be underestimated. Parental factors often play a significant contributory part in the assessment of whether a baby or child is a 'Child in Need' – for example, the presence of domestic abuse, parental mental health problems, substance misuse and poverty are all associated with increased rates of 'Child in Need' cases. Lead practitioners should be experienced practitioners with skills to manage unexpected situations (this is a common feature of Child in Need case management), with professional autonomy to develop, evaluate and adapt plans of care. It is vital that practitioners have the skills to work directly with parents/ carers in this way – in our opinion, having skills in child development alone will not be sufficient; in addition, these skills are needed during the consultations with families, rather than by proxy through supervision sessions later (to ensure timely, safe and effective support, which is responsive to families' changing needs over time).

ii. **Governance and quality improvement:** It is imperative that the organisations that take on these roles have the right governance mechanisms in place to provide a high-quality service and discharge their duties under section 17 of The Children Act – this includes, effective senior leadership and accountability, supervision, risk management, quality assurance and complaints management.

iii. **Workforce capacity:** Any decisions on transferring statutory responsibilities from one professional group to another will need to take account of the workforce implications. In relation to health visiting, there are three key considerations:

- **Current health visitor workforce shortages** – Since 2015, the health visitor workforce has been reduced by more than 40% - a fall from 11,377 FTE health visitors in 2015, to 6,651[1] FTE health visitors in the latest data published this year. Despite health visitors' best efforts, these workforce cuts have had a significant impact on the level of support that health visitors have been able to provide to families[2].

[1] Following national modelling of optimum workforce numbers, in 2010 the government committed to increase the health visitor workforce by 4,200. By the end of the Health Visitor Implementation Plan 2011-15 – A Call to Action, in 2015, the iHV was informed by the national Health Visiting Implementation Plan Programme Board that they had reached their target and there were 11,377[1] Full Time Equivalent (FTE) health visitors in England. Published workforce data April 2023: 6,651 Full Time Equivalent (FTE) health visitors were recorded as employed in NHS and non-NHS organisations.

[2] Institute of Health Visiting (2023) State of Health Visiting, UK survey report: A vital safety net under pressure https://bit.ly/3DqvCrH

- **Caseload size** – Currently, Child in Need cases are managed by children's social care and by practitioners that have significantly smaller caseloads than health visitors. To ensure that the quality of support is not diluted, workforce modelling should aim for commensurate caseload sizes for other practitioners who take on the 'lead practitioner role'. This will require a significant increase in the number of health visitors in England.

- **Risk of role drift – shifting health visitors from their 'upstream' focus on prevention, identification and earlier intervention.** There is a risk that focusing health visitors' efforts on statutory Child in Need cases will further accelerate their role drift away from preventative public health and earlier intervention. Health visitors' "upstream" role is focused primarily on preventing, identifying and working with families to address problems before they reach crisis point. This takes pressure off children's social care and is particularly relevant for babies and young children who are our most vulnerable citizens and most reliant on the protection that the health visiting service affords them. Health visiting is the **only agency** that **proactively** and **systematically** reaches out to **all families** with babies and young children from pregnancy and through the earliest years of life **– this is a safety-critical function**. Further eroding this 'safety-net' strips out the mechanism to identify vulnerable babies and young children.

  There is strong evidence for universal services for babies and children that take a 'proportionate universalism' approach[3]. Inequalities in health begin early in life - they are not inevitable and are reflected across the whole population. There is a significant body of evidence to support the case that focusing solely on the most disadvantaged will not reduce health inequalities sufficiently[4,5]; 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. Instead, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage.

  The health visiting service aims to provide an accessible, evidence-based service for all children and their families based on this 'proportionate universalism' approach and in support of the Government's ambition that services should be *"universal in reach and personalised in response"*[6].

  At a time when national spending on late intervention and children's social care is spiralling out of control, investing in prevention and early intervention makes sound economic sense[7]. The highest returns on investment are seen in services that start in the earliest years of life. The effects of early disadvantage are cumulative and associated with inequalities, which can pass from one generation to the next in the

[3] Marmot, M., et.al. (2010) Fair society healthy lives: The Marmot Review. https://www.instituteofhealthequity.org/resources-reports/fair-society-healthy-lives-the-marmot-review/fair-society-healthy-lives-full-report-pdf.pdf
[4] Marmot, M., et.al. (2010) Fair society healthy lives: The Marmot Review. https://www.instituteofhealthequity.org/resources-reports/fair-society-healthy-lives-the-marmot-review/fair-society-healthy-lives-full-report-pdf.pdf
[5] Marmot, M., Allen, J., Boyce, T., Goldblatt, P., Morrison J., (2020) Health equity in England: The Marmot Review 10 years on. London: Institute of Health Equity. https://www.instituteofhealthequity.org/resources-reports/marmot-review-10-years-on/the-marmot-review-10-years-on-full-report.pdf
[6] Public Health England (2021) Health visiting and school nursing delivery model. https://www.gov.uk/government/publications/commissioning-of-public-health-services-for-children/health-visiting-and-school-nursing-service-delivery-model
[7] Conti, G., Melnychuk, M., Morris, S., & Pizzo, E. (2021a). The economic costs of child maltreatment in UK. Centre for Economic Policy Research https://cepr.org/active/publications/discussion_papers/dp.php?dpno=16397

absence of effective measures to tackle these. More recent evidence continues to show that the cost of failing to intervene early is enormous[8, 9].

Eroding the preventative role of the health visitor does not align with the recent Hewitt Review recommendations which highlight the need for a *'decisive shift upstream'*[10]. The Independent Review of Children's Social Care[11] also highlighted that "*children's social care picks up the needs of families which universal and other services cannot address. Therefore, getting the right support for families through universal services and, wherever possible, addressing issues before they escalate is critical".*

**iv.** **Funding:** There has been a 24% cut (£1bn real terms cut) to public health grant allocations since 2015/16[12]. These cuts affect local government spending on health visiting and are a key driver of health visitor workforce cuts across England. Similar funding challenges are being faced by children's social care, resulting in raised thresholds for access to care, leaving children's health services 'firefighting' the most severe cases of child protection issues at the expense of preventative public health[13].

Unless there is an associated budget to offset the full economic costs of delivering the proposed change (alongside efforts to address the workforce capacity issues described above), additional costs and burdens will be transferred to the health visiting service that is already stretched and under-funded. This will have a significant impact on the delivery of the Healthy Child Programme (HCP). As part of this consultation, the iHV has spoken to several Directors of Public Health who have raised serious concerns about the use of the public health grant to deliver services that were previously funded through children's social care budgets. They consider this to be in breach of the terms of the public health grant.

Delivery of the HCP has been mandated by the government. It is also intended by the government to be funded through the ring-fenced public health grant. The conditions of the Public Health ring-fenced grant to local authorities[14] make clear that:

- *"The grant must be used only for meeting eligible expenditure incurred or to be incurred by local authorities for the purposes of their public health functions as specified in section 73B(2) of the National Health Service Act 2006 ('the 2006 Act')".*

Those functions are specified as public health mandated functions which include the delivery of the Healthy Child Programme and:

- "*if payments are made out of the fund towards expenditure on other functions of a local authority or the functions of an NHS body, other public body, or a private sector or civil society organisation, the authority must be of opinion that those functions*

[8] Conti, G., Melnychuk, M., Morris, S., & Pizzo, E. (2021a). The economic costs of child maltreatment in UK. Centre for Economic Policy Research https://cepr.org/active/publications/discussion_papers/dp.php?dpno=16397
[9] The Royal Foundation Centre for Early Childhood (2021) Big change starts small. https://centreforearlychildhood.org/report/
[10] Patricia Hewitt (2023) The Hewitt Review – An independent review of integrated care systems https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1148568/the-hewitt-review.pdf
[11] MacAlister J (2022) The Independent Review of Children's Social Care: Final report. https://bit.ly/3ippA3L
[12] The Health Foundation (2021) https://www.health.org.uk/news-and-comment/news/public-health-grant-allocations-represent-a-24-percent-1bn-cut
[13] Hunter, W., (2023) 'National Blueprint needed for children's health'. Nursing in Practice https://www.nursinginpractice.com/latest-news/national-blueprint-needed-for-childrens-
[14] https://www.gov.uk/government/publications/public-health-grants-to-local-authorities-2023-to-2024/public-health-ring-fenced-grant-2023-to-2024-local-authority-circular

*have a significant effect on public health or have a significant effect on, or in connection with, the exercise of the functions described in paragraph 3".*

In particular:

a. *"the authority must be satisfied that, having regard to the contribution from the public health grant, the total expenditure to be met from the fund and the public health benefit to be derived from the use of the fund, the arrangements provide value for money".*

b. AND *"A local authority must, in using the grant have regard to the need to reduce inequalities between the people in its area with respect to the benefits that they can obtain from that part of the health service provided in exercise of the functions referred to in paragraph 3".*

In reality, the effect of the proposals in the consultation document (without sufficient funding and workforce to offset them) are that public health funding which is ring-fenced for the purposes outlined clearly in the conditions of grant will be used to offset children's social care. In other words, they will be used for purposes other than those mandated as conditions of the grant. Without addressing the underlying funding and workforce issues faced by health visiting services, we believe that it will be impossible for local authorities to divert this money and adhere to their duties to deliver mandated public health functions because those functions will be the functions that suffer most.

v. **Addressing the root causes of increased 'child in need' cases:** Health visitors are reporting[15] that the number of children living with risk and vulnerability has increased, but this is masked by increased thresholds for children's social care. Rather than falling levels of need, children living with significant vulnerability and risk now fall below this higher threshold, whereas in previous years they would have been supported by children's social care. There was widespread concern at the Institute of Health Visiting's roundtable event that the potential changes to the Working Together guidance may further increase social care thresholds, with the expectation that the health visiting service will pick-up the support for these vulnerable children.

Any changes to national guidance on 'lead practitioner' must address the root cause of the current crisis (namely increased numbers of children living with vulnerability, and reduced capacity in services to meet the scale of need).

Increased vulnerability is driven by multiple issues and many of these have been exacerbated by the COVID-19 pandemic and cost of living crisis. There is good evidence that addressing this thorny issue requires a 'whole system' response that includes tackling the wider determinants of health as well as the underlying workforce and funding issues faced by children's social care and the health visiting service.

It is essential that any changes improve support for families now, and in the future, and do not make things worse. The risk of 'lead practitioner' skills dilution and less effective support must not become the unintended consequences of a policy decision that is aimed at managing the increasing numbers of children living with vulnerability.

[15] Institute of Health Visiting (2023) State of Health Visiting, UK survey report: A vital safety net under pressure https://bit.ly/3DqvCrH

**3.4. Consultation question 25:** In your opinion, are there practitioners who should not be lead practitioners?

In response to the specific consultation question, the iHV is of the opinion that the following practitioners should not be lead practitioners:

- Those who do not hold a regulated professional qualification: such as early years workers and community nursery nurses. Whilst these practitioners bring many valuable skills to the children's workforce and contribute to improving child outcomes through their work with regulated professionals, they are not regulated by a professional body themselves. Regulation provides a means to protect the public and provide assurance of a practitioner's level of skill and competence to an employer, as well as other practitioners working with them in a multi-disciplinary team. For example, health visitors are regulated as a specialist branch of nursing by the Nursing and Midwifery Council which sets standards, holds a register, quality assures education and investigates complaints to protect the public. In health visiting practice, unregulated practitioners do not work autonomously. The qualified regulated professional (qualified health visitor) delegates duties to them and is responsible for assessing need, planning and reviewing care, managing unexpected issues as they arise, and case supervision – they are accountable for any delegated actions and must ensure that the delegated tasks are within the person's scope of competence.

- Registered Nurses or Registered Nursing Associates working in the community who **do not** hold an NMC-regulated qualification in specialist community public health nursing (SCPHN). Whilst these practitioners are regulated by the NMC, they have not completed the specialist community public health nursing training and they are not professionally regulated for this specialist field of practice. The SCPHN – health visitor, who has delegated duties to the Registered Nurse (staff nurse) or Registered Nursing Associate, is accountable for the plan of care and delegated actions (as listed in the bullet point above).

- The iHV **does not agree** that all health visitors with a SCPHN qualification should, by default, be the lead practitioner for Section 17 (S17) Child In Need (CIN) cases. Health visitors are part of the 'health' workforce. Becoming default lead professional for all S17 CIN cases would detract them from the primary focus of their work in 'upstream' preventative public health and early intervention that they have been trained for (as set out in section 3.3). Health visitors are also not trained as social workers and services do not have the infrastructure or resources to manage this by default. The case management role of families with complex social needs that arise in the period between 0-5 years are best managed by children's social care – they are equipped with the infrastructure to manage the governance of these cases, including managing out of hours concerns and emergency situations.

**3.5. Consultation question 25:** Exceptional cases where health visitors might be best placed to take on the lead practitioner role for Children in Need (section 17 cases)

The iHV considers that, in some **exceptional** cases (where workforce capacity and funding issues set out in section 3.3 are addressed), health visitors could be the lead for section 17 Child in Need cases. These are as follows:

- **Where the legal basis for the child being subject to S17 is solely for their health need.** For example, for a child (aged 0-5) with Special Educational Needs and Disabilities (SEND), it could be in their best interests that the health visitor is the lead practitioner. Each child would need to be assessed on a case-by-case basis as to which professional should be the lead practitioner (i.e., social worker, health visitor – or other practitioner, for example a physiotherapist or 'teacher for the deaf' may be more appropriate for some children with severe but discrete health needs). The need to improve the coordination of care for these families is well documented and health visitors are a highly skilled workforce that can support parents to navigate the complex systems of support.

  Within the Healthy Child Programme, health visitors already play a key role in:
  - Early identification of signs of developmental disorders and disabilities. This is important to support referrals for prompt diagnosis and tailored interventions/ support.
  - Supporting parents through the process of adjustment when they receive "different news". This includes supporting transition to parenthood for families who receive a diagnosis following antenatal screening (which is likely to increase with the introduction of the Newborn Genome Screening Programme) as well as those whose conditions are detected in the early years.
  - Helping families access wider support/ connecting them to other services in the community (such as uptake of Early Years provision, relevant disability and income-related benefits, specialist support groups and reducing parental conflict where applicable).
  - Supporting smooth transition to school and the school nursing service.

- **For proactive, targeted-selective intensive home visiting specialist nursing programmes:** These programmes target or 'select' families living with significant adversity or with characteristics that place them at greater risk of experiencing problems or worse outcomes. In some areas, health visiting services provide intensive home visiting programmes (for example, the Family Nurse Partnership Programme[16] for young parents, and the Maternal Early Childhood Sustained Home-visiting (MECSH)[17] programme for families living with significant adversity, or at highest risk of poor outcomes).

  The iHV Vision for Health Visiting[18] makes the case for a broader national approach to targeted intensive home visiting support and the delivery of intensive, health visitor-led home visiting programmes to address the needs of families at the greatest risk of poor outcomes, of which young parents form an important part. When sufficiently resourced, health visitors are ideally placed to deliver these evidence-based programmes to improve child health outcomes.

  Where applicable, section 47 responsibilities would remain with children's social care. Clear boundaries would need to be maintained to ensure that the thresholds for section 47 were not increased for these babies and young children. By working more intensively and proactively with these families - and maximising the unique and complementary skills of both health visitors and social workers - there is considerable opportunity to improve

[16]Family Nurse Partnership Programme https://fnp.nhs.uk/
[17] Maternal Early Childhood Sustained Homevisiting (MECSH) https://www.magonlinelibrary.com/doi/full/10.12968/johv.2022.10.5.200
[18] Institute of Health Visiting (2019) Health Visiting in England: A Vision for the future. https://bit.ly/3HnDpGd

outcomes for the most vulnerable children. There is good evidence from global intensive home visiting programmes that this will reduce wider system costs across the life-course.

- **Where health visitors work in robust multi-agency teams, such as**, Family Safeguarding Hubs[19] and Strengthening Families Models[20] it may be in the best interest of the child and family for the health visitor to be the lead practitioner on some S17 CIN cases. But again, this would need to be assessed on a case-by-case basis, with sufficient workforce capacity, resources, and a clear mechanism for escalation back to social care.

**The key considerations in section 3.3. would need to be addressed to implement these changes in practice – the iHV Roundtable members highlighted in particular:**

i. **Health visitors must have the requisite training and experience in terms of the legal duty under S17** if they are the lead practitioner. Health visitors are not trained in S17 CIN assessments which could pose safety risks to the child and family and to the health visitor as registrant of the Nursing and Midwifery Council (NMC).

ii. The **NMC should also consider any changes to the role of health visitor** brought about by the revised Working Together guidance.

iii. **Safety critical workforce planning, using demand-driven workforce modelling, with sustainable investment** into the health visiting profession will be essential. All areas will need sufficient funding to deliver the full national specification for the health visiting service set out in the Healthy Child Programme before additional roles and responsibilities are added to the profession.

iv. **Quality assurance mechanisms** to ensure the safe supervision and leadership for S17 CIN cases where health visitors are the lead practitioner. The National Child Safeguarding Practice Review Panel[21] highlighted the importance of effective leadership in safeguarding children and the need for local safeguarding expertise and oversight, including child in need cases (p.11). Therefore, the proposal to have a specialist social worker oversight should be widened to include health expertise as well, to ensure role, work and expectations of health visitors leading on child in need cases are fully considered and understood.

v. **Improved interoperability between health and social care IT systems.** If education, social care and health continue to work from different electronic record systems or cannot access vital information about a child and family, this creates a significant risk. Practitioners may miss crucial information, especially the lead professional who will be accountable and responsible for all aspects of care. Further work is needed to improve digital and analytical capability in health visiting[22], including data visualisations to ensure that important information on child vulnerability is not lost in unwieldy electronic record systems.

vi. **Manageable caseloads:** Using the logic model[23], if health visitors were to become default lead practitioners for S17 CIN cases, they would need to have a similar caseload size as social workers – these are capped at around 16 cases per full time equivalent social worker[24]. This would require **significant investment** into the health visiting profession. In the iHV annual

[19] Family Hubs Innovation Fund Evaluation Interim research report December 2022 Family Hubs Innovation Fund Evaluation: interim report (publishing.service.gov.uk)
[20] Supporting Families - 2021-22 and beyond Supporting Families - 2021-22 and beyond - GOV.UK (www.gov.uk)
[21] Child Safeguarding Practice Review Panel (2022) National review into the murders of Arthur Labinjo-Hughes and Star Hobson. [Accessed 20.08.2023] https://www.gov.uk/government/publications/national-review-into-the-murders-of-arthur-labinjo-hughes-and-star-hobson
[22] Institute of Health Visiting (2021) Moving beyond bean counting. http://bit.ly/3KWPJlZ
[23] Nuffield Trust (2019) How to develop and use logic models https://www.nuffieldtrust.org.uk/sites/default/files/2019-02/stephanie-kumpunen-and-muna-sheikh.pdf
[24] Gov.UK (2023) Reporting year 2022 Children's social work workforce https://explore-education-statistics.service.gov.uk/find-statistics/children-s-social-work-workforce

health visitor survey published in January 2023[25], only 6% of health visitors in England reported that they had the recommended average ratio of 250 children aged 0-5, or less, per FTE health visitor; compared to 69% of health visitors in Scotland. Worryingly, 30% of FTE health visitors in England had between 501-750 children; 17% between 751 and 1000; and 11% had more than 1000.

**A suggested alternative to health visitors being the lead practitioner for S17 CIN cases** is the Universal Health Visiting Pathway (UHVP) model in Scotland. This model designates health visitors as 'named health professionals' for all children aged 0-5. In the UHVP, health visitors provide eleven universal home visits to all families. Currently in England, children do not have a named health professional. The HCP in England only offers 5 mandated contacts but, due to significant workforce shortages (detailed in section 3.3), health visitors in most areas are not able to deliver the programme in its fullest form and there is wide variation in the quality of services across England. Currently 1 in 5 children are missing out on vital health and development reviews[26] which leaves many babies and children hidden from sight, as they are not seen universally by any other service until they start school.

The evaluation of the UHVP in Scotland[27] reported positive outcomes for babies, children and families:

- Increased coverage - the UHVP is being delivered by all Health Boards and is largely equitable across all socioeconomic groups.
- Additional reviews identified new concerns for children without previous concerns flagged (without the UHVP, these children with additional needs would have been missed).
- Parents reported a positive and trusting relationship with their health visitor. As a result, families were better able to ask for and accept the support on offer.
- 89% of parents stated that they knew a great deal, or a fair amount, about the impact on children of parents' smoking, drinking alcohol, or using drugs.
- The service reached those that needed it most - parents living in the most deprived areas of Scotland were most likely to report having received a great deal or a fair amount of information from their health visitor.
- Health visitors were described as "approachable, non-judgmental, professional".

Investment in supportive models of care, like the UHVP model, are key to taking forward the recommended changes in Working Together. It is widely recognised that the benefits of an effective health visiting service accrue to numerous parts of the health, education and social care system. Prevention is better, cheaper and kinder than cure - investment in health visiting in England to deliver a service based on 'proportionate universalism', drawing on learning from the Scottish UHVP

[25] Institute of Health Visiting (2023) State of Health Visiting, UK survey report: A vital safety net under pressure https://bit.ly/3DqvCrH
[26] OHID (2022) Health visitor service delivery metrics experimental statistics: quarterly data for 2021 to 2022 https://www.gov.uk/government/statistics/health-visitor-service-delivery-metrics-experimental-statistics-quarterly-data-for-2021-to-2022#full-publication-update-history
[27] Doi, L., et.al., (2021) Evaluation of the Universal Health Visiting Pathway in Scotland Phase 1 Main Report – Primary Research with Health Visitors and Parents and Case Note Review. https://www.gov.scot/binaries/content/documents/govscot/publications/research-and-analysis/2021/12/evaluation-universal-health-visiting-pathway-scotland-phase-1-main-report-primary-research-health-visitors-parents-case-note-review/documents/evaluation-universal-health-visiting-pathway-scotland-phase-1-report-primary-research-health-visitors-parents-case-note-review/evaluation-universal-health-visiting-pathway-scotland-phase-1-report-primary-research-health-visitors-parents-case-note-review/govscot%3Adocument/evaluation-universal-health-visiting-pathway-scotland-phase-1-report-primary-research-health-visitors-parents-case-note-review.pdf

model, will alleviate pressure on children's social care in the long-run. This also makes sound economic sense as late intervention is currently soaring at an estimated £23 billion a year[28].

## Conclusion:

In this response we have set out the key challenges that the extension of the role of lead practitioner will pose to the health visiting profession. We recognise that a new approach is needed to address the soaring numbers of children categorised as 'Child in Need', or subject to a 'Child Protection Plan', and associated costs of late intervention. In our view, a radical shift 'upstream' is needed. When adequately resourced, health visitors have a significant role to play in taking the pressure off children's social care by preventing, identifying and working with families to address problems before they reach crisis point. We have also highlighted some instances where the role of health visitors could be extended, with the right investment and workforce capacity. We recommend that early implementer or pilot sites are funded to test some of the assumptions made in the proposed model before national roll-out.

[28] MacAlister J (2022) The Independent Review of Children's Social Care: Final report. https://www.gov.uk/government/publications/independent-review-of-childrens-social-care-final-report

## Appendix: Additional information on the role of the health visitor

Health visitors work to improve 'child safeguarding' using the broadest definition of this term:

- Protecting children from abuse and maltreatment.
- Preventing harm to children's health or development.
- Ensuring children grow up with the provision of safe and effective care.
- Taking action to enable all children and young people to have the best outcomes.

Through their universal work, health visitors are ideally placed to identify early risks and protective factors, and understand the multifactorial context of relationships, families, and communities. It is therefore crucially important that health visitors have sufficient time and capacity to enable them to identify and support the holistic needs of the whole family, and work in a preventative way to reduce health inequalities and improve health outcomes for babies and children across a continuum of need.

Early intervention relies on the early identification of babies and young children at risk of poor outcomes. Without an acceptable universal, proactive and systematic mechanism of identifying vulnerable babies and young children, who are often invisible to other services, all early intervention strategies will struggle to reach and engage their target audience, leaving them without the support that they need to reach their full potential.

Safeguarding is a thread that runs through all levels of health visiting, contributing to multi-agency networks to protect children (and in some instances their parents) from abuse and exploitation, and to safeguard their health and wellbeing. The Health Visiting Benefits Realisation review[29] concluded that the universal health visiting service was important to both safeguarding and child protection *"because it safeguards all children".*

A growing body of research[30] [31]has identified the following key elements of a successful health visiting service:

i. **Trusting relationships** - Health visitors have a high level of acceptability with families as they are part of the 'health workforce' – trained to work with babies, young children, families and communities; for physical and mental health issues, child development, social needs and safeguarding in its broadest context. This reduces the stigma of asking for help (everyone has a health visitor), compared to children's social care. Through continuity of carer, they build trusted relationships with families. This improves the identification of needs and leads to better uptake of health promoting messages.

ii. **Universal service** – health visiting provides a proactive and systematic way of reaching all families during pregnancy and with babies and young children (no other service provides this). This is important as many families, especially the most vulnerable, may not be aware of the extent of their own, or their child's needs, or the services that could help them. Health visitors provide a vital safety net for babies, young children and families who can

[29] Public Health England (2017) The health visiting benefits realisation review. https://bit.ly/3vRqPvQ

[30] Cowley, S., Malone, M., Whittaker, K.,Donetto, S., Grigulis, A., Maben, J., (2018) What makes health visiting successful—or not? 2. The service journey. Journal of Health Visiting, 6 (8). pp. 404-412. https://doi.org/10.12968/johv.2018.6.8.404

[31] Doi, L., et.al., (2021) Evaluation of the Universal Health Visiting Pathway in Scotland Phase 1 Main Report – Primary Research with Health Visitors and Parents and Case Note Review. https://www.gov.scot/binaries/content/documents/govscot/publications/research-and-analysis/2021/12/evaluation-universal-health-visiting-pathway-scotland-phase-1-main-report-primary-research-health-visitors-parents-case-note-review/documents/evaluation-universal-health-visiting-pathway-scotland-phase-1-report-primary-research-health-visitors-parents-case-note-review/evaluation-universal-health-visiting-pathway-scotland-phase-1-report-primary-research-health-visitors-parents-case-note-review/govscot%3Adocument/evaluation-universal-health-visiting-pathway-scotland-phase-1-report-primary-research-health-visitors-parents-case-note-review.pdf

easily fall through the gaps between services – this can happen when parents disengage in interventions, or when a time-limited intervention ends.

iii. **Responsive to changing needs over time** – Early parenthood is a period of dynamic change – and needs will often vary considerably between pregnancy and a child starting school. There is currently no reliable measure, with sufficient predictive value, to categorise families as 'universal' for the period between 0-5 years following a single snapshot assessment (for example, during pregnancy or following the birth). There are a multitude of reasons why families might 'fall on hard times' or need additional support to give their child the 'best start in life'. In order to safeguard our babies and young children, it is therefore vital that we have robust universal services with regular 'touchpoints' with families from pregnancy to starting school, as well as easy access to additional support when it is needed during this time.

iv. **Recognition that making health changes is difficult** - Families need practitioners who can help them build resilience. Support needs to take account of the families' individual context. This requires a workforce with the knowledge, skills, resilience and supervision to work in partnership with families and provide effective support. Sufficient workforce capacity is needed to meet the level of need, with continuous practice development, supervision and professional reflection embedded to prevent 'burnout'.

The Independent Review of Children's Social Care[32] published in May 2022 proposed the introduction of a 'Family Help' model to replace 'targeted early help' and 'child in need' work. The new model would be delivered by 'Family Help' teams, to give children and families the support they need (P.61), and there are current examples of this approach which have been evaluated. Workforce investment will be key to the success of these models to ensure that there are adequate numbers of health visitors (and other professionals), trained to strengthen the offer to vulnerable families. The impact of shame and stigma experienced by families cannot be underestimated. A system that provides trust, continuity, and positive interventions is needed to support families and enable children to develop in an optimal, loving and stable environment. Health visitors, as specialists in public health nursing, can support this work but there should not be an automatic default to designate health visitors as the lead professional.

The review[33] into Star Hobson's death highlighted that the high turnover of social workers and large volume of work affected the quality of support offered to her family. As a result, assessments were too superficial, lacked rigorous follow-up to test assumptions, and did not address the repeated concerns from family members. The review stated that:

*"Practitioners need to be given the space and time to do quality work with the child [baby] and to critically reflect on the child's [baby's] experiences, including putting together the jigsaw of information they hold about them and the network around them".*It also recognised that, *"The issue of capacity in health visiting services is a national concern and merits further attention".*

Due to a number of factors, health visiting services have struggled to meet the increased levels of need within the population. These issues pre-date the pandemic but have been exacerbated by it and the ongoing cost-of-living crisis. The Institute of Health Visiting has submitted evidence to the COVID-19 enquiry to support wider system learning and national emergency preparedness. The impact of the COVID-19 pandemic on health visiting was twofold[34]:

[32] MacAlister J (2022) The Independent Review of Children's Social Care: Final report. https://www.gov.uk/government/publications/independent-review-of-childrens-social-care-final-report

[33] The Child Safeguarding Review Panel (2022) Child Protection in England https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1078488/ALH_SH_National_Review_26-5-22.pdf

[34] Institute of Health Visiting (2020). State of health visiting in England. https://bit.ly/3BZYvcD

i. **Increased risk and need** – Alongside the universal support that health visitors routinely provide to all families, more families with babies and young children required additional health visiting support as they were tipped into vulnerability due to the secondary impacts of the pandemic and rising levels of poverty. Health visitors reported increases in cases of domestic violence and abuse, mental health problems and safeguarding concerns. Evidence from research[35], national reviews[36] [37] and the Government's own child development data[38] collected at the health visiting 2-2½ year review show that a significant and growing minority of babies born in the pandemic have fallen behind with their development, with widening inequalities.

And

ii. **A reduction in the capacity of the service to support families** due to:

- The initial categorisation of the health visiting service as a "partial stop" service in the NHS Community Prioritisation Plan.
- The redeployment of up to 63%[39] of health visitors in some areas away from supporting families.
- Requiring access to PPE to visit families.
- A need to rapidly introduce virtual contacts for many families but initially often without the IT systems in place, or evidence on how to implement this safely.
- Ever falling workforce numbers.

The increased pressures of working during the COVID-19 pandemic, alongside worsening workforce shortages and rising levels of need, have had a significant impact on health visitors' wellbeing[40],[41]. The erosion of the public health role could further exacerbate this and negatively impact upon future retention and recruitment to the profession.

The 'voice' of frontline practitioners attending the iHV roundtable was that the recommendation that health visitors should take on the lead role for Child in Need cases may tip the balance and further break what is perceived to be an already broken system. Conversely, if the key considerations referenced in the main body of our response are addressed, then there are opportunities to strengthen the role of health visitors to improve prevention, earlier identification of need, and more intensive support to vulnerable babies and young children categorised as 'Child in Need'.

[35] iCAN (2021) Speaking up for the Covid generation. https://speechandlanguage.org.uk/media/3753/speaking-up-for-the-covid-generation-i-can-report.pdf
[36] Ofsted (2022) Research and analysis. Education recovery in early years providers: spring 2022. https://www.gov.uk/government/publications/education-recovery-in-early-years-providers-spring-2022/education-recovery-in-early-years-providers-spring-2022
[37] Hogg, S. & Mayes. G. (2022) Casting Long Shadows: The ongoing impact of the COVID-19 pandemic on babies, their families and the services that support them. First 1001 Days Movement and Institute of Health Visiting. https://bit.ly/3QrHFdV
[38] Office for Health Improvement and Disparities (2023) Official Statistics Child development outcomes at 2 to 2 and a half years. https://www.gov.uk/government/statistics/child-development-outcomes-at-2-to-2-and-a-half-years-annual-data-2021-to-2022
[39] Conti, G., Dow, A., (2021) Using FOI data to assess the state of Health Visiting Services in England before and during COVID-19 https://discovery.ucl.ac.uk/id/eprint/10132710/1/Conti_Dow_COVID-19_Health_Visiting_FOI1_POSTING_Aug.2021.pdf
[40] Conti G & Dow A (2020) The impacts of COVID-19 on Health Visiting in England. First Results. https://bit.ly/3r7tekJ
[41] Hogg, S. & Mayes. G. (2022). Casting Long Shadows: The ongoing impact of the COVID-19 pandemic on babies, their families and the services that support them. First 1001 Days Movement and Institute of Health Visiting. https://bit.ly/3iiacGw

**For further information about health visiting, please see:**

- iHV film: 'Health visiting in your community'

- iHV infographic: 'Who are health visitors and what do they do?'

- The 3 components of the Healthy Child Programme are:
  - The Healthy Child Programme Schedules of Interventions Guide
  - The Health visiting and school nursing service delivery model
  - The Healthy Child Programme: health visitor and school nurse commissioning guidance