Institute of Health Visiting
Excellence in Practice

Position Statement

Worrying cuts to health visiting services across England: Ticking the box but missing the point

19 June 2019

Worrying cuts to health visiting services across England - ticking the box but missing the point

Last weekend, the Observer published an article with the alarming title "Fears for new mothers as Suffolk slashes health visitor numbers". Suffolk County Council, alongside many other local authorities, is being forced to make difficult decisions about the health visiting services that they provide to families due to year on year cuts to the public health grant. A spokesperson from the council describes the cuts as "adjustments to the care and support we provide" with the rationale that the new service will "provide the very best care and support that our children and young people deserve".

Whilst this might sound an admirable aspiration, it will only be achieved if it is built on sound evidence and best practice. Investing in the earliest years saves money in the long run and, more importantly, ensures that every child is supported to achieve the best start in life. **We are concerned that, despite this evidence, health visiting services are being diluted and eroded due to a persistent gap between what the evidence tells us and we aspire to achieve, and what is currently funded and provided.**

The proposed changes mean that most families in Suffolk will no longer receive a universal health visiting service as set out in Public Health England's Commissioning Guidance – instead, health visitors will work predominantly with the most vulnerable families and will only see families for 2 of the 5 mandated reviews, and this may not be the same health visitor. This removes their essential opportunity to work in partnership with families to identify need upstream and offer support before it becomes problematic.

Extensive health visitor cuts are to be felt throughout Suffolk. Health visitors' caseloads are expected to rise to 3 times the level recommended by the Institute of Health Visiting, with each health visitor accountable for the care of around 750 children. There will be an increase in staff nurses, who have not completed any specialist public health training, and non-health professional staff, who will be expected to carry out some of the mandated visits previously carried out by health visitors. The Institute of Health Visiting has very serious concerns about the quality and effectiveness of the service that families will now receive. Health visiting is a role and service focused on promoting health, identifying hidden risk and needs, and offering families early support to reduce potential long-term negative health and social outcomes for their children. This is a skilled role backed by many years of training, where the practitioner carefully balances assessment and action to match the needs of the child without compromising ongoing engagement of the family on which the child relies. To the outsider, and clearly to some councils, it looks simple and something that can be picked up by any alternative grade of staff. However, in the absence of specific role preparation and experience, this will be at a cost to achieving children's outcomes.

Since 2015, local authorities were expected to secure continuous improvement in the health visiting service, with a level of flexibility to ensure that services were responsive to local needs. At the heart of the plan was improved access, experience and outcomes for all families. Yet, there has been a significant deterioration in the quality and quantity of health visiting provision in many areas of England, with considerable unwarranted variation in the level of service that families receive dependent on where they live, rather than their level of need. Even child health clinics have been closed in significant numbers.

Why do we need an effective health visiting service?

Prioritise first 1000 Days: The foundations for virtually every aspect of human development including physical, intellectual and emotional wellbeing are established in the first years of life. Inequalities start early and the effects are cumulative and can last a lifetime if not addressed. Health visitors are the only professional group who visit every family in England, providing a key role in prevention, early identification of need and early intervention – the evidence is clear, "turning off the tap is more effective than mopping the floor". Health visitors identify recognised and unrecognised health needs. From a human and economic perspective, unidentified need and late intervention are more costly in the long term.

Lead the Healthy Child Programme: Health visitors lead delivery of the Healthy Child Programme (HCP), which is a universal prevention, health promotion and early intervention programme available to all families. Health visiting is non-stigmatising and has high levels of acceptability to the public. Five of these universal reviews are 'mandated' in England. Policy in the rest of the UK requires a higher number of programmed reviews, indeed eleven in Scotland which aspires to be the best country in the world in which to grow up. That these are universally offered does not indicate that they are 'routine' or simple. Health visitors are trained to support the child within the context of their family and wider community, taking an ecological approach, incorporating knowledge of developmental science and the "helping process" to support parents to focus on the needs and priorities of their baby and family in pregnancy and the first years of life. Health visiting 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 profession. Health visitors have particular skills in their ability to see beyond the task; they understand the interplay of complex contextual issues that affect the health of individuals, families and groups and the community as a whole. There is evidence that health visitors are better at identifying family need and improving outcomes than practitioners without these skills.

Tackle key government priorities for children: The health visiting service should provide an important part of the solution to numerous current national priorities for children and families, including amongst others:

- 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);
- 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; improve immunisation uptake; supporting families at risk of or experiencing infant and perinatal mental health problems; reducing childhood obesity; 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) and Healthy Start benefits (DHSC).

What does a good health visiting service look like?

- **Led by health visitors in sufficient numbers; a highly skilled workforce** – It is important that we avoid a system that is "health visitor led" in name only. Public Health England states that "Whilst recognising the contribution of other partners, there will be some elements [of the HCP], which require clinical expertise and knowledge that can only be provided through services led and provided by the public health nursing workforce… with knowledge and skills that bring together individual, family and community interventions to improve health in populations by assessing and responding to local need".

  Health visiting is a form of specialist practice with standards of proficiency regulated by the Nursing and Midwifery Council. These standards are characterised by higher levels of discretion and judgement in decision making in clinical practice and leadership, achieved through further postgraduate education and training following initial registration as a nurse or midwife. Working in partnership with others is crucial to ensure the right support is offered to each individual family. Skill mix teams can support the health visiting offer – however, they should not be a substitution for health visitors and their crucial role in assessment and specialist intervention.

- **Personalised care/ continuity of practitioner** lead to improved identification of need and better outcomes and, most importantly, parents tell us that this is the type of service they want and value - to tell their story once and to be "met as a person", rather than on the receiving end of an impersonal "tick box" service. Continuity of practitioner throughout pregnancy and the first years of life enables practitioners and parents to form a trusting relationship that takes account of the dynamic changes that occur in each family during pregnancy and after the baby has been born. In Suffolk, health visitors will be required to carry out only 2 of the mandated 5 contacts leaving little chance to build the therapeutic relationship so essential for helping vulnerable families, especially those where there are mental health issues. The Institute's research has demonstrated that across the country 65% of families are already not seeing a trained health visitor formally after their child is eight weeks old due to similar decision making.

- **Realistic caseload size for needs assessment and effective intervention -** Health visitors are professionally accountable for the assessments of health and care for all families on their caseload. With the recent cuts, the health visitors in Suffolk now have caseloads of 750 children. In contrast, NHS services are clearly monitored against "Safer Staffing" levels, yet health services devolved to local government do not have this level of quality assurance or clinical governance. It goes without saying that however you do the maths, it is impossible for a single practitioner to be accountable for the assessment and care of 750 children. The Institute recommends a maximum caseload size of 250 children, and less in areas of high need.

  The Maternity Transformation Programme sets out clear expectations for continuity of practitioner and personalised care - yet this stops once the family is transferred to health visiting services, when in reality their parenting journey has barely begun. We would welcome a similar ambition for the health visiting service.

Sadly, the notable absence of robust policies for children in the Government's recent overdue response to the Health and Social Care Committee's Inquiry into the first 1000 days does little to engender hope that this erosion of health visiting services will be reversed before even more damage has been done. We join with our partners in a collective voice – **our children cannot wait any longer.**

We call on the government to take responsibility for the current state of health visiting services and to take the action required to make a difference.

We recommend:

1. A radical shift in government policy to provide **sustainable funding for prevention and early intervention services for children in England**. All government departments who accrue the benefits of an effective health visiting service 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**.

2. **Recognition of the advanced specialist nature of the health visitor's role** returning autonomy to work in partnership with families and others to meet the needs of all families in line with the requirements of the Healthy Child Programme and removing the current 'tick box' approach currently being imposed on them.

3. **Increased training budgets for student health visitors**. Whilst we welcome updates to the preparation of health visitors, we are very concerned that plans for the proposed apprenticeship-style programmes will apparently not continue the established mechanism for backfill to cover salaries during training. In common with other health professionals, health visitor students need to be supernumerary during their training, so this is essential, whether the programme is completed on a full or part-time basis. The iHV recommends that arrangements should be in place to complete training in a year otherwise there will be significant further workforce pressures.

4. **New national quality assurance requirements for commissioners of health visiting services** to be benchmarked against, with sufficient incentives and levers in place to end the current unwarranted variation in HV provision based on where you live, rather than level of need.

5. The planned **review of the Healthy Child Programme should include a review of the resources needed to secure national implementation in full** in all local authorities to ensure every infant, child and family has access to a high-quality health visiting service.

6. **The re-establishment of closer ties with other NHS services**, especially Midwifery and General Practice, to enhance the flow of information between these other essential universal services that support babies and their families.

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