Giving every child the best start in life
Backbench Business Debate, Tuesday 9th November 2021

Introduction:

This briefing has been developed by The Institute of Health visiting (iHV) in preparation for the backbench business debate on 'Giving every child the best start in life' in the House of Commons on Tuesday 9th November 2021. The iHV is an independent charity, professional body and centre of excellence for health visiting (HV), established to strengthen the quality and consistency of health visiting for the benefit of all children, families and communities.

The Government has committed to funding £500 million over the next three years to support families and transform the 'Start for Life' vision and family early help services. This investment will fund a network of Family Hubs, Start for Life services, perinatal mental health support, breastfeeding services and parenting programmes. It will also expand the Supporting Families programme.

The £500m funding announced for children is a welcome step in the right direction and will undoubtedly make a difference to families. It signals the Government's recognition of the importance of pregnancy and the earliest years within a cross departmental Start for Life Vision for babies, young children and families.

Ahead of the Spending Review, 700 leading children's sector organisations were united in their call for investment for 3,000 more health visitors over the next three years. These organisations, who understand how this sector works and know the considerable challenges that families are facing, recognise the importance of strengthening the health visiting service which provides a vital infrastructure of support for babies, young children and their families. Widespread concerns have been raised that, despite this significant weight of support, the settlement did not deliver the Government's pledge to 'rebuild health visiting'.[1]

3 key priorities for Health Visiting:

Funding – to properly resource the Start for Life Offer for all babies, young children and families to ensure the delivery of the full breadth of the Healthy Child Programme (HCP) of prevention and early intervention to all families, regardless of where they live. A ring-fenced grant would provide protection from political cycles of disinvestment.

Workforce – with the right capacity, capability, experience and skills to support families with the multitude of needs which can impact on outcomes for babies and young children. Recognition that many families often have multiple co-existing needs that require a workforce with the capability to work with the adult and child, and address physical and mental health, as well as social needs.

Quality – an infrastructure of support in the earliest years with the key ingredients to deliver improvements in child health outcomes and reduce inequalities. This requires a workforce with the skills to build relationships with families, identify need which is often hidden and not readily disclosed, broker families' engagement in support, and work therapeutically with them in the 'complex' and messy real world to find solutions and improve outcomes. The iHV is concerned that the Budget outcome metrics for Best Start all relate to 'education' and 'health' has been overlooked. History has shown us that 'you get what you measure' and, without effective levers to assure the quality of health

[1] Department of Health and Social Care (2021) The best start for life: a vision for the 1,001 critical days. https://www.gov.uk/government/publications/the-best-start-for-life-a-vision-for-the-1001-critical-days

visiting services, this will lead to further erosion of preventative public health and weaken the health visiting contribution to multiple health pathways.

Who are health visitors and what do they do?

1. Health visitors:
   - **Are registered with the Nursing and Midwifery Council as nurses, or midwives,** who have completed **additional Specialist Community Public Health Nursing training**.
   - Are a professional, regulated 'health' workforce – families and other members of the multi-disciplinary team can trust their level of skills, experience and expertise.
   - Are a unique, specialist 'health' workforce with the skills and experience to support **babies, children and adults** across numerous clinical pathways for **physical health, and mental health,** as well as **social needs, child development** and **safeguarding** concerns.
   - Reach out to families and build **relationships with** them, prevent problems happening in the first place, spot problems early and provide a vital **safety net for babies, young children** who are invisible to other services and can easily fall through the gaps between services.
   - Provide a vital **'case finding'** function, helping parents access interventions provided by Family Hubs. Without a mechanism to identify families with additional needs, all families are classified as having a 'universal level' of need in the 'system'.
   - Coordinate packages of care for multiple co-existing needs, which avoids fragmenting people into isolated 'problems' and families having to repeatedly 'tell their story'.

Health at the heart of health visiting:

2. Health visitors are a **safety-critical health workforce**, contributing to numerous child and adult physical and mental **health pathways.**
3. Health visitors' breadth of **clinical skills** needed for these specific **'health'** areas of work are critical to the delivery of safe and effective care:
   - **Preconception care**: including reducing smoking in pregnancy, support for alcohol and substance misuse, reducing genetic risk, support for healthy weight, and brokering engagement in antenatal care.
   - **Perinatal mental health**: including identifying and supporting directly/ or referring for specialist support, parents with perinatal anxiety, depression, post-traumatic stress disorder, eating disorders, intrusive thoughts, psychosis and those at risk of suicide.
   - **Postnatal care**[2]: identifying and managing **common and serious health problems** in women and their babies, sexual and reproductive health and contraception advice.
   - **Infant and child mental health**: helping parents and their infants form strong relationships.
   - **Infant feeding**: including breastfeeding support and recognition/ management of problems including faltering growth, reflux, intolerances and allergies.
   - **Managing childhood illnesses** and recognition of serious health problems – improving parental health literacy and nurse prescribing to reduce the burden on the NHS.
   - **Accident prevention** and support for families following an accident.
   - Improving **immunisation** uptake (adults and children); support for vaccine hesitancy.
   - Failsafe for **newborn screening** programme: supporting parents through diagnosis (Note: the HV workforce will need to have sufficient capacity to support the NHS plans for newborn genomic screening).
   - **Chronic conditions and disabilities:** Early recognition of these conditions can make a significant and life-changing difference to outcomes and prognosis. Health visitors also have a role in care coordination and providing support for parents.

[2] https://ihv.org.uk/news-and-views/news/ihv-welcomes-one-voice-letter-on-cuts-to-local-public-health-budgets/

The cost of not intervening early is enormous:

4. England is lagging behind other countries on many key child health outcomes: infant mortality reductions have stalled; breastfeeding and obesity rates are amongst the worst in Europe and health inequalities have widened across all indicators.[3]

5. Investing in an infrastructure of support for the First 1001 Days avoids costly late interventions. The cost of **"getting it wrong"** includes, but is not limited to, the following **costs to society**:

- **£16.13 billion per year** to address issues that might have been avoided through action in early childhood"[4].
- **Childhood obesity:** an estimated cost to the NHS of **£6 billion per annum**, this is forecast to rise to **£9.7 billion per year** by 2050[5].
- **Perinatal mental health:** 20% of women experience perinatal mental health[6] problems and around half are not accessing support[7]. Perinatal mental illness carries a total long-term cost to society of at least **£8.1 billion[8]** for each one-year cohort of births in the UK.
- **Domestic abuse**: Around 1 in 5 children will experience domestic abuse (DA) with an estimated cost of over £66 billion per year in England and Wales.[9] Due to its devastating impact, children are recognised as victims of DA in their own right.[10]
- **Child safeguarding:** The 2nd of November 2021 marked what would have been Victoria Climbie's 30th birthday. Victoria's preventable death was a key driver for a radical shift in safeguarding policy to protect children from harm. Yet on this anniversary in 2021, we have escalating rates of child protection, with almost 200 cases of serious harm or death of a child under the age of one in the last year, a 31% rise compared to the previous year[11], and babies under the age of one remain at the highest rate of homicide for any age group.[12]

Why is investment in health visiting urgently needed?

6. Increasing levels of need and vulnerability:

Preliminary data from the iHV (2021) Annual State of Health Visiting Survey (n=1,291) shows:

38% of health visitors are feeling so **stretched** that they are worried there may be a **tragedy i**n their area **43%** of HV's worry that they **cannot** do enough to **safeguard babies and children**
In the last year: • 81% of HV's have seen an increase in perinatal mental illness • 80% of HV's have seen an increase in domestic abuse • 80% of HV's have seen an increase in child behaviour problems • 72% of HV's have seen an increase in poverty affecting families • 71% of HV's have seen an increase in child safeguarding

[3] Royal College of Paediatrics and Child Health (2018) Child health in England in 2030: comparisons with other wealthy countries
[4] The Royal Foundation (2021) Big Change Starts Small. https://centreforearlychildhood.org/report/
[5] The Kings Fund (2021) Tackling obesity The role of the NHS in a whole-system approach. https://www.kingsfund.org.uk/sites/default/files/2021-07/Tackling%20obesity.pdf
[6] Public Health England (2021) Early years high impact area 2: Supporting maternal and family mental health https://www.gov.uk/government/publications/commissioning-of-public-health-services-for-children/early-years-highimpact-area-2-supporting-maternal-and-family-mental-health
[7] Best Beginnings, Home-Start UK, and the Parent-Infant Foundation (2020) Babies in Lockdown: listening to parents to build back better. https://parentinfantfoundation.org.uk/our-work/campaigning/babies-in-lockdown/#fullreport
[8] Bauer at al (2014) Centre for Mental Health and London School of Economics: The costs of perinatal mental health problems. https://www.centreformentalhealth.org.uk/sites/default/files/2018-09/costsofperinatal.pdf
[9] Rhys Oliver, Barnaby Alexander, Stephen Roe and Miriam Wlasny (2019) The economic and social costs of domestic abuse Research Report 107 Home Office https://www.gov.uk/government/publications/the-economic-and-social-costs-ofdomestic-abuse
[10]
[11] Department for Education, (2020-21) Serious incident notifications
[12] https://www.ncmd.info/wp-content/uploads/2021/05/NCMD-Child-Mortality-and-Social-Deprivation-report_2020210513.pdf

7. **Quality of service delivery: Unwarranted and unexplained variation in the delivery of the Healthy Child Programme between Local Authority (LA) areas:**

Recent Health Visitor Service delivery metrics (Office for Health Improvement and Disparities, Nov 2021) [13] lay bare the unacceptable and unwarranted variation in the quality of the health visiting service in England. Apart from the new birth visit – metrics for all the other mandated reviews are worse than the previous year and indicate that the health visiting service has not been fully restored:

Range between the worst and best performing LA's		
Type of mandated contact	**Lowest performing LA**	**Highest performing LA**
New Birth Visit by 14 days	**27.9%**	**99.9%**
6 week review by 8 weeks	**6.1%**	**99.6%**
12 month review by 12 months	**2.1%**	**99.1%**
2-2 ½ year review by 2 ½ years	**5%**	**99.4%**

8. **Quality of service delivery: Unwarranted variation in delivery of the Healthy Child Programme by a qualified health visitor: Preliminary data from the iHV (2021) Annual state of health visiting survey (n=1291)** show the percentage of mandated HCP contacts completed by a **qualified health visitor** as specified in the HCP.

Type of HCP contact	**Percentage of contacts completed by a qualified health visitor**
Antenatal	**19%**
New birth visit	**79%**
6 week review	**67%**
12 month review	**29%**
2- 2 ½ year review	**22%**

9. **Quality of service delivery: Risks of non-face-to-face contacts for identifying vulnerability, developmental delay and safeguarding concerns.**

Non-face-to-face methods for delivering the mandated assessments in the Healthy Child Programme are currently untested. The assessment of families using virtual platforms excludes families who are experiencing digital poverty and will disproportionately affect children who are 'clinically vulnerable'[14] because they cannot be clinically assessed via a digital platform for prolonged jaundice, weight or muscle tone assessment. In addition, emerging evidence from COVID-19 research has flagged that a virtual contact, **"significantly hindered [practitioner's] ability to safeguard vulnerable children due to its limitations in terms of actually seeing and assessing the children in person"** and pick up on risk factors like bruising or evidence of substance misuse or domestic abuse[15].

[13] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1029567/2020-21_Annual_-_Health_Visitor_Statistical_Commentary-2.pdf

[14] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/913974/Understanding_and_quantifying_vulnerability_in_childhood.pdf

[15] Barlow J, Bach-Mortensen A, Homonchuk O, Woodman J (2020a) The impact of the COVID-19 pandemic on services from pregnancy through age 5 years for families who are high risk of poor outcomes or who have complex social needs – Interim findings. Department of Social Policy and Intervention, University of Oxford, UCL Institute of Education on behalf of the NIHR Children and Families Policy Research

Preliminary data from the iHV (2021) survey indicate that virtual contacts have brought some welcome benefits. HVs have been quick to innovate and embed virtual methods, with 88.6% of HVs agreeing or strongly agreeing that they can be used effectively to provide families with **quick access to advice for straightforward concerns** between universal contacts

However, the findings from the iHV survey of frontline health visitors, after 20 months experience of using virtual methods more universally for HCP contacts, reported:

- 93.8% **disagree or strongly disagree** that video contacts are as effective as face-to-face contacts for **identifying needs/ enabling disclosure of risk factors** in vulnerable families
- 82.6% **disagree or strongly disagree** that there is enough evidence to **safely** roll out video-enabled contacts in health visiting.

More evidence is needed to inform when virtual contacts can be used safely and without negatively impacting on service quality. Despite lacking evidence of safety or effectiveness of virtual contacts, on 16th September 2021, Public Health England extended their interim guidance that virtual contacts would continue to be counted as a valid method of delivery of the health visiting mandated holistic assessment until the end of 2022.[16] The iHV has escalated concerns about the risk of harm that this decision poses to families to the OHID.

10. Workforce shortages:

- Health visiting in England faces the biggest workforce challenge in living memory with an estimated shortfall of 5,000 health visitors.[17]
- **Latest published data** on the health visiting workforce indicates:
  - 7,422 Full Time Equivalent (FTE) health visitors in England (6,289 recorded on NHS HV workforce data July 2021, published in October 2021)[18] and
  - 1,133 recorded on Independent Healthcare Provider workforce statistics - February 2021.[19]

  Overall, this represents a **loss of one third of all health visitors**, when compared to 2015 (11,266FTE).

- **Unmanageable caseloads:** Prior to the pandemic, in 80% of areas, HV caseloads were greater than 250 children per full-time equivalent (FTE) staff (the maximum caseload size recommended by modelling developed by the UK Public Health Association, [20] which immediately preceded and informed the 'Call to Action'[21]). In 22% of areas, caseloads were greater than 500 children; and in 10% of them, greater than 700 children[22].
- **Workforce forecasting:** Recently available data from the iHV (2021) Annual state of health visiting survey (n=1,291) shows that 35% of the HV workforce are age 55 -65 and are due to retire in the next 1-3 years. Urgent plans need to be put in place to mitigate the retirement of these experienced HVs, including plans to increase workforce capacity as well as plans to develop leadership capability to support succession planning. There is currently no national HV workforce plan for either of these workforce priorities.
- **Impact of HV workforce shortage on families/ Postcode lottery of support:** The cuts in services – which are still taking place in some areas - mean that many families no longer receive a good

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Unit (CPRU). https://www.ucl.ac.uk/children-policy-research/sites/children_policy_research/files/the_impact_of_the_covid-19_pandemic_on_services_from_pregnancy_through_age_5_years_interim_report_june_2020_0.pdf

[16] https://www.gov.uk/government/publications/childrens-public-health-0-to-5-years-national-reporting?utm_medium=email&utm_campaign=govuk-notifications&utm_source=11a89c36-3a94-4375-a2be-3dfd95593b00&utm_content=daily

[17] https://dl.orangedox.com/HVCosting

[18] https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics/july-2021

[19] https://digital.nhs.uk/data-and-information/publications/statistical/independent-healthcare-provider-workforce-statistics

[20] UK Public Health Association (2009) Health visiting matters: re-establishing health visiting.

[21] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/383426/27_childrens_public_health_services_from_pregnancy_to_age_5.pdf

[22] Conti, G; Dow, A. (2020b). "The impacts of COVID-19 on Health Visiting in England: FOI Evidence for the First Wave". Unpublished manuscript. Available at: https://dl.orangedox.com/HEALTHVISITINGFOINEW

service and there is a "postcode lottery" of support. Many families are not even receiving their mandated checks with a health visitor, let alone able to access additional, timely support.

- HVs are worried that they are only reaching the 'tip of the iceberg' of growing need[23], with widening inequalities. Babies pay the ultimate price for the failings in the systems designed to safeguard and protect them. Pre-Covid, the Children's Commissioner raised concerns about the number of invisible children, estimated to be more than a third of all vulnerable children[24] who are not known to services and therefore not getting any support.

- **Impact of workforce shortage on the success of Family Hubs:** Health visitors were central to the success of Surestart Children Centres. Similarly, the success of the Family Hub programme will be dependent on having a highly skilled health visiting workforce to welcome families who attend the Hubs and importantly, also to reach out to those who don't attend. There is a significant body of evidence that the families who need the most support are often the least likely to ask for help and the most likely to drop out of targeted interventions. It requires a highly skilled workforce to build trust, identify hidden and undisclosed need and broker engagement in support. Parents have also reported the difficulties that they face when the onus is on them to reach out and 'ask for help' when it's the hardest thing to do, some say that they may never reach out.

PQs for debate:

1. What proportion of health visitor mandated contacts have been provided face-to-face to families since March 2020?
2. What assessment has the Department made about whether there are sufficient Health Visitors in England to deliver the Healthy Child Programme in full and the refreshed Health Visiting Model.
3. What evidence has the Department used to support the decision to allow ongoing non face-to-face delivery of the mandated health visiting assessments until the end of 2022; Can assurance be provided that this is a safe decision and babies, young children and their families will not be harmed by missing out on face-to-face assessments?
4. How does the Department plan to ensure that there is no shortfall of qualified health visitors by the end of this 3-year Spending Review settlement period; and what discussions has the Department had with Health Education England and NHS England/ Improvements on those plans?

[23] Institute of Health Visiting (2020b) State of health visiting in England https://ihv.org.uk/wp-content/uploads/2020/12/State-of-Health-Visiting-survey-2020-FINAL-VERSION-18.12.20.pdf
[24] Children's Commissioner (2019) Childhood vulnerability in England. https://www.childrenscommissioner.gov.uk/report/childhood-vulnerability-in-england-2019/