Institute of Health Visiting
Excellence in Practice

State of Health Visiting, UK survey report

Millions supported as others miss out

10th iHV Annual Health Visiting Survey: data year ending November 2023

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The Institute of Health Visiting (iHV) is an independent charity, professional body and Centre of Excellence - established to strengthen the quality and consistency of health visiting practice, so that health visitors can effectively respond to the health needs of all babies, children, families and communities enabling them to achieve their optimum level of health, thereby reducing health inequalities.

Who are health visitors?

The role of the health visitor was described by UNICEF UK in 2022[1] as *'the backbone of early years services across the UK… the 'safety net' around all families'*. All families in the UK with babies and young children from pregnancy until aged 5 years have a health visitor. Health visitors are the only profession that systematically and proactively reaches out to every family, providing support for all families and a safety-net for the most vulnerable. Health visitors work with individuals and communities, focused on 'health creation' and supporting better outcomes during pregnancy, early childhood and adulthood; across physical health and mental health (for babies, children and adults), child development, social needs and safeguarding.

Health visitors are highly skilled professionals who have a background in nursing or midwifery with further training, now at Masters level, to become health visitors, registered as Specialist Community Public Health Nurses. When sufficiently resourced, they can prevent, identify and work with families to treat problems before they reach crisis point, thereby alleviating pressure on other parts of the health, education and social care system. The profession is regulated by the Nursing and Midwifery Council to set standards and protect the public.

Acknowledgements:

We would like to thank everyone who took the time to complete our survey. We had a phenomenal 1,186 responses which capture valuable health visiting 'frontline intelligence' from across the UK.

Report prepared by iHV team: Alison Morton, Georgina Mayes, Jay Desai and Julie Cooper.

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Foreword by Alison Morton

CEO, Institute of Health Visiting

"We know there is work to be done to reverse the devastating cuts to the profession over the last 8 years... health visitors have made it clear that they are ready to rise to the challenge"

Health visitors are in a privileged position, they see firsthand the struggles that families with babies and young children are facing, often hidden behind front-doors and invisible to other services. Our 10th annual "State of Health Visiting" survey findings provide valuable "frontline practitioner intelligence" on the most pressing public health priorities and challenges faced by babies, young children and their families across the country.

In this year's survey, health visitors raise the alarm that child health and development in our nation continues to deteriorate, health inequalities are widening, more children are living with risk and vulnerability, and parents are turning to A&E departments for support for early childhood problems that would previously have been managed by a health visitor. Increasing poverty was the cause of greatest concern to health visitors who witness its impacts on child health, wellbeing and safety on a daily basis.

The good news is that health visitors saw millions of families last year, reaching significantly more babies and young children than any other health service or early years agency. However, too many families are still missing out on this vital support as health visitor workforce numbers continue to fall; England has lost more than 40% of its health visitors since 2015 and families face a postcode lottery of support. These cuts are a false economy and have knock-on consequences for other services.

Our survey findings highlight the incredible potential and desire within the profession to turn this situation around. But we cannot ignore the fact that the workforce is under significant pressure with unacceptable levels of work-related stress, as health visitors manage enormous caseloads, and escalating levels of need and vulnerability.

It is not too late to turn this situation around. We need more health visitors. And, to return to building services that place the needs of babies, children and families at the centre - rather than the soul-destroying pursuit of "tick box" measures that miss the important things that really matter to families and improve outcomes.

We are delighted that all the main political parties have pledged to increase the number of health visitors. We know there is work to be done to reverse the devastating cuts to the profession over the last 8 years. Investing in health visiting makes sound economic sense. When adequately resourced, health visitors can work with families to prevent, identify and treat problems before they reach crisis point. This needs a clear national plan – the health and wellbeing of our nations' babies and young children is too important to leave to chance.

Health visitors across the UK have made it clear that they are ready to rise to the challenge, to ensure that every baby truly does have the very best life from the start.

Alison Morton
CEO, Institute of Health Visiting

Executive Summary

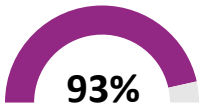
Key messages from the State of Health Visiting survey report (January 2024)
The largest UK survey of health visiting

1,186 responses from practitioners working in health visiting between 2 October and 6 November 2023.

We received responses from health visitors in all four UK nations and regions in England. Due to smaller sample sizes in Scotland, Wales and Northern Ireland, most findings relate to health visiting in England.

Health visitors raise alarm as more parents struggle with the impacts of poverty.

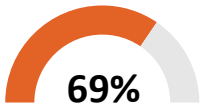
It's deeply shocking that 93% of health visitors reported an increase in the number of families affected by poverty in the last 12 months. Of health visitors surveyed:



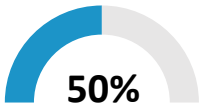
93% reported an increase in poverty affecting families

89% reported an increase in the use of food banks

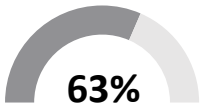
78% reported an increase in perinatal mental illness



69% reported an increase in domestic abuse



50% reported an increase in families skipping meals as a result of the cost-of-living crisis



63% reported an increase in homelessness and asylum seekers

Only 3% of the health visitors surveyed reported that families had not been impacted by the cost-of-living crisis. Some reported that poverty was so widespread that it had become the norm.

The state of child health is deteriorating and inequalities are widening:

Health visitors are concerned about rising levels of poverty and parental struggle as there is strong evidence of their direct impacts on child health, development and safety. Of health visitors surveyed:

82% reported an increase in children with speech, language and communication delay

75% reported an increase in child behaviour problems

70% reported an increase in children with autism (or signs of autism)

49% reported an increase in child development problems

Practitioners warn that more children are living with risk and vulnerability, but the extent of the problem is masked as:

81% reported an increase in children with safeguarding concerns that now fall below the threshold for children's social care

- More children are now falling below the increasing thresholds for children's social care which is saturated with need.
- Babies and young children living with risk and vulnerability are less likely to be detected as health visitors have reduced contact with families. Services are focused on "firefighting" rather than prevention, identification and early intervention.

Millions supported but many miss out in health visiting's postcode lottery

There is wide variation in the level of health visiting support that families receive based on where they live, rather than their level of need.

Health visiting, promoting health and "searching for health needs":

Health visitor universal mandated contacts provide an important opportunity to:

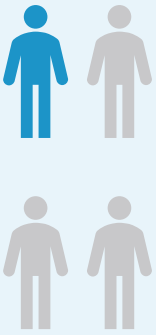
- promote child health and development
- ensure that families at risk are identified at the earliest opportunity
- improve babies' and children's health outcomes

Health visiting services reach more families with babies and young children than any other service.

Health visiting is the only service that systematically and proactively reaches all children (from pregnancy to age 5).

Office for Health Improvement and Disparities' data (published in November 2023) highlight that:

- **More than 1.96 million children** received mandated universal health visiting reviews in England in the last year.
- **Yet many miss out.** 434,553 eligible children missed out on these vital reviews.
- The 2-2 ½ year review had the lowest uptake, with more than 1 in 4 children (26.4%) missing this review.



A health visiting workforce crisis in England

There is currently an estimated shortage of 5,000 health visitors in England (↓ of more than 40% of the workforce since 2015).

- 84% of practitioners surveyed said that the number of health visitors in their teams had ↓ over the last 12-months.
- Only 5% had reported an ↑ in health visitors.

Not enough health visitors to meet the scale of rising need

Due to workforce shortages, many families with babies and young children miss out on the extra support that they need:

Only 45% of health visitors were "confident" or "very confident" that their service was able to meet the needs of **vulnerable babies and children** when a need is identified.

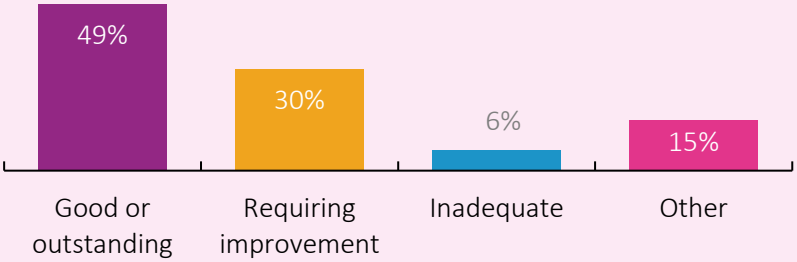
79% said that the health visiting service lacked capacity to offer a package of support to all children with identified needs.

80% said that other services lacked capacity to pick up onward referrals, with higher thresholds for children's social care and long waiting lists.

45% said that other Key Performance Indicators were prioritised over identified need:

- Statutory responsibilities for Child Protection and Child in Need cases were prioritised at the expense of preventative public health and early intervention.
- Mandated universal contacts to identify need were prioritised over health visitors' targeted or specialist support for families with identified needs.

Service quality - health visitors rated their service as:



15% chose to answer this question with "other", citing variation in the delivery of the national Health Visiting Model across England, with no benchmarks for best practice, or levers to address poor service delivery models.

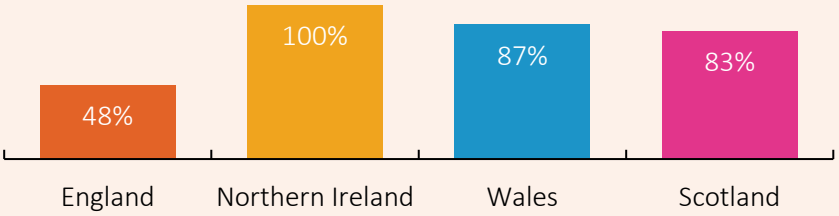
Relationships matter

Trusting relationships, nurtured through continuity of health visitor, are key to building parental confidence, identifying babies and young children living with risks and unmet needs, and improving the success of health visiting interventions.

Less than half of health visitors **in England (48%)** are able to provide families with **continuity of health visitor** "all or most of the time".

Compared to:

- **100%** in Northern Ireland
- **87%** in Wales
- **83%** in Scotland.



Health visiting workforce – recruitment, retention and wellbeing:

71% of health visitors said that their work-related stress had increased in the last 12-months

52% are working longer hours

68% of health visitors said there are not enough student health visitor places to maintain their workforce supply needs

74% of health visitors felt able to offer a robust training placement to student health visitors

41% of health visitors are intending to leave the profession in the next five years

The main reasons are:

- Lack of career progression opportunities
- Work-related stress/ poor health
- Role drift away from preventative public health to ↑ child protection

Our main policy recommendations:

Our survey findings present a clear imperative to act. We're calling for the following key changes:

1. **A cross-government commitment that prioritises and invests in the first 1001 days is needed.** Spending needs to be seen as a capital investment in our nation's future, rather than as a cost. To ensure that babies' health, wellbeing and safety is prioritised, it is imperative that we have a Children and Families Minister to represent our youngest citizens in the heart of government.

2. **A much greater focus on prevention and early intervention** is needed to support all people to lead healthy and fulfilling lives.

3. **The important 'health' contribution of health visitors needs to be maximised.** A long-term vision and a cross-departmental plan with funding for health visiting is needed to maximise its vital contribution across the health, education and social care system in the earliest years of life.
"Put 'health' back at the heart of health visiting and end the role drift away from preventative public health".

4. **A national plan to strengthen health visiting in England, focused on three areas:**

    i. **Funding** - All areas need sufficient funding to deliver the full specification for the national health visiting model and Healthy Child Programme Schedule of Interventions. Long-term investment will help services to plan and build world-class services, ending the uncertainty of short funding cycles.

    ii. **Workforce** - The national long-term workforce plan to retain, train and reform the health visiting workforce needs to be delivered in full, with 5,000 more health visitors to meet the scale of families' needs and replace workforce losses since 2015.

    iii. **Quality** - National government must do more to end the current postcode lottery of health visiting support to ensure that:

    - All areas provide health visiting services in line with national policy, and that families need, holding failing areas to account when services are not meeting national guidelines.
    - System blockers are removed and best practice is enabled. For example, by enabling better data collection (measuring what matters), information sharing and analytical capability, to improve joined-up care for families and provide intelligence on the quality of health visiting services across England.
    - Health visiting research, workforce development and the sharing of evidence-driven models of best practice are supported.

5. **Close the temporary COVID-19 amendment to "count" non-face-to-face health visiting mandated contacts in the national health visitor service delivery metrics for England.** This is an important quality and safety marker for health visiting services and a safeguard for our youngest citizens.

1.0 Overview of the iHV annual survey

Every year, the Institute of Health Visiting conducts an annual "State of Health Visiting" survey. The survey findings provide valuable insights into the changing needs of families with babies and young children, alongside key issues for health visiting practitioners and services across the UK.

Health visitors see firsthand the realities of family life across the UK which is often hidden behind front doors and invisible to other services. The health visiting service is unique in that it reaches more families with babies than any other service[2], supporting millions of families every year. The frontline practitioner intelligence captured in the findings in this report is a valuable gift to policymakers. It provides an early warning signal of the most urgent public health priorities and factors that are impacting the health and wellbeing of our youngest citizens and the health visiting services that support them.

Objectives:
To provide an up-to-date understanding of health visitors' experiences of:

- families' needs – including the impacts of adversity
- the state of child health, development and safety
- health visiting workforce and service delivery
- practitioners' support and development needs.

Sampling:
This year's survey was completed by 1,186 practitioners from across the UK between 2 October and 6 November 2023. For a survey of this type, the response rate was high which strengthens the reliability of the findings (England sample size calculation: 95% confidence level with a 3.0 % margin of error).

Data collection and analysis:
Quantitative and qualitative data were collected. Qualitative data analysis was inductive and based on the principles of thematic analysis to draw out key themes which are supported by direct quotes from practitioners to reflect the reality of their experiences. We reached data sufficiency early in the data collection process whereby the headline statistics and themes varied very little as further responses were added to the sample – this supports a high level of confidence that the findings are reliable, providing a significant weight of evidence on the changing needs of families with babies and young children, and the current state of health visiting.

UK reach:
Our survey was completed by health visitors working in all four UK nations and regions in England: most respondents (90%) were from England; 5% from Wales; 4% from Scotland; and 1% from Northern Ireland. Due to lower responses in the devolved UK nations, this report presents findings from England although some UK comparisons are included. Like all surveys, the results are based on a sample of the population, not the entire population. Consequently, results are subject to margins of error and readers should exercise caution with comparisons where there are wide variations in health visiting provision between local authority areas.

Context:
Our annual survey is now in its tenth year. During the last ten years, we have seen the needs of babies, children and families increase. Children in the UK now have some of the worst health outcomes compared to other similar nations and health inequalities have widened[3,4]. This situation pre-dates the COVID-19 pandemic but has been exacerbated by it and the subsequent cost-of-living crisis[5]. The health visiting service has been impacted by these rising levels of need, with more families needing health visiting support for a range of issues covered in this report.

Over the same time period, we have seen health visiting numbers in England plummet following their peak in October 2015 at the end of the national "Health Visitor Implementation Plan 2011-2015: a call to action"[6]. England now has the lowest number of health visitors since records began, with 40% fewer health visitors now compared to 2015; and numbers continue to fall every month[7,8]. The reduction in the number of health visitors in England is due to a combination of factors including significant reductions in the Public Health Grant that funds the service, workforce shortages, and locally driven cuts to health visiting service delivery models.

There is wide variation in the level of health visiting support provided to families in England - ***whilst millions are supported, many miss out.***

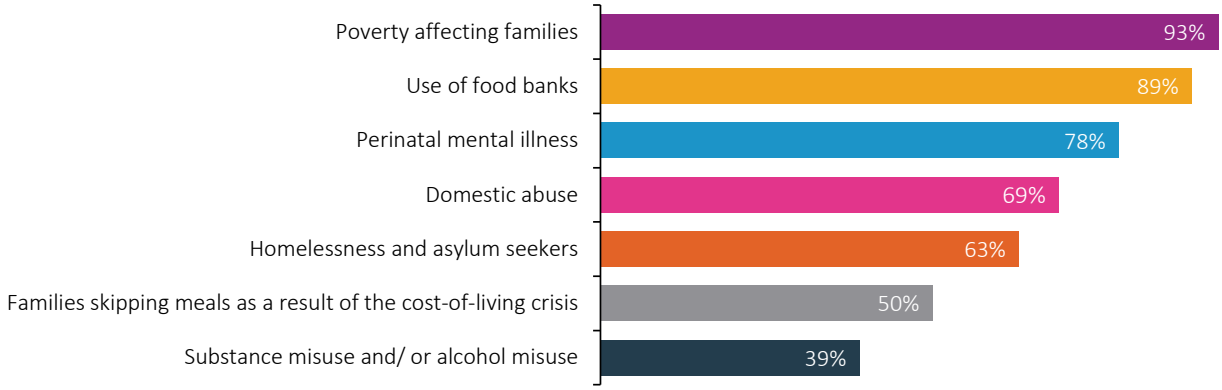
2.0 Survey findings - current issues for babies, children and families:

2.1 Increasing parental struggle

In our survey, record numbers of health visitors reported increases in the number of families experiencing a range of issues that are linked to poor health and increased vulnerability in the last 12 months. These include increases in the number of families affected by poverty, perinatal mental illness, domestic abuse and homelessness (presented in Figure 1).

Increasing poverty affecting families was the greatest concern for health visitors. It's deeply shocking that 93% of health visitors reported that they had seen an increase in the numbers of families with babies and young children affected by poverty in the last 12 months.

Figure 1: Percentage of frontline health visitors reporting increased need across a range of indicators affecting families



88% of health visitors reported that the increase in the cost of living had directly impacted on babies, children and families' health in the last 12 months (See Figure 2).

Figure 2: Impact of the rising cost-of-living on babies, children and families' health. Percentage of practitioners surveyed who reported that health had:

Families were impacted by the rising cost of living in a number of ways (presented in Table 1).

Table 1 : Percentage of health visitors who reported that families were impacted by the rising cost of living in the following ways:

Rising cost of food	97%
Increased family stress due to financial worries	92%
Increased heating costs	91%
Rising cost of suitable housing	89%
Rising cost of fuel (petrol or diesel)	71%
Rising cost of transport	62%
I do not think babies, children and family's health has been negatively impacted by the rising cost of living	3%

Lack of affordable, high quality and secure housing is linked to poor child health and development[9]. 89% of health visitors surveyed had witnessed the impacts of rising costs of suitable housing which was affecting so many families, not just the poorest:

> *Housing stock seems to be worsening both in quality and availability. Cannot believe the number of families being shifted from one Travelodge to the next.*

> *Those families who are not entitled to benefits are also struggling. Mortgage rates have risen for homeowners. Parents are considering going back to work sooner than they want to.*

Only 3% of health visitors reported that babies, children and families' health had not been impacted by the rising cost of living. Some of these practitioners worked in very deprived areas and reported that poverty was so widespread that it was the norm:

> *My area is very deprived and most of these problems are evident most of the time. I haven't personally noticed an increase.*

Health visitors provided rich qualitative data on the realities of poverty that they had witnessed firsthand. These included comments that some parents were diluting infant formula milk to make it last longer because they couldn't afford to buy more. Some parents were struggling to access healthcare and had missed their child's appointments (for immunisations or development reviews), or delayed seeking medical treatment because they couldn't afford travel costs. And many had seen the direct impacts of poverty on health due to cold, damp and mouldy homes and poor diet:

> *Families can no longer afford the basics. Homes will be cold this winter, as they were last year. Parents are not putting the heating on. This leads to damp and mould, so a corresponding increase in respiratory problems. Exacerbated by a poor diet as food is so expensive.*

> *Dealing with these issues takes up the majority of my working day. Missed health appointments due to no money/fuel. No money for formula milk. No heating. Increased maternal mental health concerns.*

> *[I have seen] watering down of formula milk.*

> *I have seen families unable to access early medical support because of the cost of transport and parking. Children are becoming more unwell before being taken to GP/hospital.*

What health visitors are seeing in practice aligns with the findings from a recent global report by Unicef, "Child poverty in the midst of wealth" (2023)[10], which reported that:

- Child poverty in the United Kingdom (UK) had increased by 20% over a seven-year period (2014-2021).
- Child income poverty rates in the UK were the highest among the world's richest countries.
- The UK ranked 37th out of the 39 nations in the European Union (EU) and the Organisation for Economic Co-operation and Development (OECD) based on income poverty rate for children and their success in reducing child poverty in a time of prosperity.

2.2 Impact on child health, development and safety

Health visitors were concerned about rising levels of poverty and parental struggle as there is strong evidence of its direct impacts on child health, development and safety.

Sir Michael Marmot described these impacts, stating that,

"Stress associated with poverty will damage children's brains, it will damage child development. The impact on health inequalities will be seen, not just in this generation, but in the children in the next generation, because children's growth and development will be damaged by their parents' struggle." (Marmot, 2022)[11]

This is particularly relevant for babies and young children. There is global evidence that the earliest years of life are a period of uniquely rapid growth, when babies' brains and their understanding of the world are shaped[12], and the foundations for lifelong health and wellbeing are laid[13]. Where people are born, live and grow, whether they are rich or poor, and the support that they receive from their families, communities and the services around them, can all make a big difference to an individual's life chances. There is also strong evidence that exposure to certain environmental risks during critical periods of development and growth (preconception, pregnancy and the earliest years) can have significant consequences on an individual's short- and long-term health. These can increase the risk of disease in later life and have cumulative impacts which can pass from one generation to the next in the absence of effective action to address them[14,15,16].

2.2.1 Child health and development

Survey respondents were asked how children's health and development had changed over the last 12 months. The data paint a picture of rising levels of need and increased prevalence of a range of child health and development concerns (see Table 2).

Table 2: Percentage of health visitors reporting increased child health and development concerns

Speech, language, and communication delay	82%
Child behaviour problems	75%
Autism	70%
Child development concerns	49%
ADHD	49%
Breastfeeding problems	46%
Infant/child mental health problems	45%
Childhood overweight/ obesity	40%
Parental worry about managing childhood illnesses	30%

Practitioners' concerns are captured in the following responses to our survey:

> *[There are] more children with significant difficulties around their development.*

> *Definite increase in children with social communication difficulties observed.*

> *Development issues in all areas - not school ready - lots more parents contacting about development and behaviour concerns.*

Worryingly, the situation is getting worse and showing no signs of recovery post-pandemic. Frontline practitioner intelligence from our survey reinforces the findings from research[17,18], national reviews[19,20] and the Government's own child development data[21] which show that a significant and growing minority of babies born in the pandemic have fallen behind with their development, with widening inequalities (see Table 3).

Table 3: Percentage of children achieving the expected level across all five areas of development for two-year-olds in 2022/23 compared to 2020/21 (Source - Office for Health Improvement and Disparities – Published 7 November 2023)

Area of development	Percentage of children at or above expected level of development: 2022/23	Percentage of children at or above expected level of development: 2020/21
Communication skills	↓ 85.6%	86.5%
Gross motor skills	↓ 92.8%	93.4%
Fine motor skills	↓ 92.6%	93.2%
Problem solving skills	↓ 91.8%	92.7%
Personal-social skills	↓ 90.3%	91.1%
All five areas of development	↓ 79.2%	81.1%

The most recent published national data[22] on child development outcomes at 2-2½ years in England show that more than a fifth of children (20.8%) were not "at or above the expected level of development" in five areas of development in 2022/23 - which is a rise on the previous year (19.9%). The proportion of children at the expected level of development has fallen in all of the five measured areas of child development (see Table 3).

Health visitors in our survey highlighted many contributory factors to childhood developmental delay including a surge in families struggling with poverty, mental health issues and isolation:

> *Speech, language and communication issues, fine motor issues [have increased] - parents are not recognising that their child isn't doing what is expected at their age as they haven't been interacting with other children/families of similar ages.*

> *All families are struggling. Many are unable to afford preschool which is impacting on speech and language development, resilience and social skills. Those who need the services most are least able to access them. Children's centres used to fill the gap, but no longer do.*

> *The increasing cost of living is impacting on children and families in their daily lives… including our working families. Increasing levels of mental health problems in parents which is impacting on the children within the household.*

Practitioners also raised concerns that late identification of developmental delay or childhood vulnerability factors were due to cuts in health visiting services:

> *We are also not identifying health needs - we are becoming invisible to families. In [local authority area] we see all new birth visits at home but that could be the last time we see a child.*

> *Large increase in parents seeking diagnosis for SEND… lack of drop-in clinics mean children are not being regularly seen - parents don't make appointments.*

2.2.2 Child safety/ protection

Health visitors reported an increase in the number of children living with adversity and factors that would classify them as vulnerable, according to the government's definition[23], over the last 12 months (see Table 4).

Table 4: Percentage of health visitors reporting increased numbers of babies and young children with child safeguarding/ child protection concerns

Children with safeguarding concerns below the threshold for Child Protection/Child in Need plans	81%
Children subject to child in need plans	60%
Children subject to child protection plans	58%

These findings from our survey appear to contradict the Government's published national data which are showing a small decline in the number of children classified as "Children in Need"[24], listed below:

- Referrals to children's social care have fallen by 1.5% or 9,800 since 2022
- Number of children on a child protection plan have fallen by 0.3% since 2022
- Number of Children in Need have fallen by 0.3% since 2022.

This contradiction begs the question, "Should we be reassured by the decline in the number of 'Children in Need' reported in the national data, or worried?"

Whilst published data is showing a downward trend, health visitors' frontline practitioner intelligence suggests that we should be very concerned that national data paint a very misleading picture of the actual scale of children living with risk and vulnerability in England. Most health visitors in our survey (81%) reported an increase in children with safeguarding concerns that now fall below the threshold for Child Protection or Child in Need plans, over the past 12 months – this is a 20% increase on practitioners' observations in 2022[25]. Practitioners were concerned that:

- More children are now falling below the increasing thresholds for children's social care which is saturated with need.
- Health visitors now have reduced contact with families with babies and young children as services are subject to ongoing cuts – this reduces their opportunities to prevent, identify and work with families to safeguard children before the situation reaches crisis point.

Babies are our most vulnerable citizens

Babies under the age of one are our most vulnerable citizens; they are at the highest risk of homicide[26] and serious incidents[27], and also have the highest rate of A&E attendance compared to any other age group. 81% of health visitors in our survey felt "somewhat" or "very confident" in identifying babies at risk of harm. However, this is predicated on them having contact with families (see Figure 3).

Figure 3: Health visitors' confidence in identifying babies at risk under the age of one

Health visiting is the only service that systematically and proactively reaches all children (from pregnancy to age 5). The Department for Education's recently published "Children of the 2020s" cohort survey findings[28] reported that health visitors reach more families with babies and young children than any other agency – and by a very large margin. By the time their child was nine months old:

- 97% of families had seen a health visitor
- 88% had seen a midwife
- 87% had seen a GP
- Only 15% had used services offered by a Family Hub or Children's centre
- Only 2% had seen a Family Support worker or Early Help worker

Health visiting services are widely accepted by families who welcome practitioners into their homes – they are non-stigmatising as every family has a health visitor, avoiding the stigma associated with children's social care and other targeted support services. Through their universal work, health visitors are ideally placed to identify early risks and protective factors, with an understanding of the context and local community in which families live and the multiple factors that can impact on child and family 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 (including Family Hubs) will struggle to reach and engage the families who need this support the most.

3.0 Survey findings - current issues for health visiting services:

3.1 Health visiting universal contacts promote health and "search for health needs"

The period between pregnancy and the age of 2½ years is a dynamic period of change for a baby/ young child and their family. The purpose of mandated universal health visiting contacts is to provide a series of key touchpoints with families with babies and young children as part of the national "Healthy Child Programme (HCP)"[29]. The HCP is the national prevention and early intervention public health framework in England. It aims to keep children "*healthy and well from preconception to adulthood*". The health visitor mandated universal contacts provide an important opportunity to:

- promote child health and development
- ensure that families at risk are identified at the earliest opportunity
- improve babies and children's health outcomes.

Based on the latest annual Health Visitor Performance Metrics data published by the Office for Health Improvement and Disparities in November 2023[30]:

- **More than 1.96 million children** received mandated universal health visiting reviews in England in the last year. Health visiting services reach more families with babies and young children than any other service[31].
- However, there is wide and unwarranted variation in the provision of these reviews between the lowest and highest performing local authority areas in England (see Table 5).
- 434,553 children missed out on these vital reviews (inclusive of New Birth Visits, 6-week reviews, 12-month and 2-2½ year reviews) during the year.
- Only 152,238 pregnant women received the antenatal contact, out of around 530,000 who would have been eligible for this review – although no national denominator is provided.
- The 2-2½ year review had the lowest uptake, with more than 1 in 4 children (26.4%) missing this review. This review is important as it provides a measure of child development and an opportunity to identify children with unrecognised special education needs, disability, or vulnerability to support targeted early intervention before they start school.

Table 5: Annual HV performance metrics: mandated contacts 2022/23[32] (includes non-face-to-face contacts)

	England average	**Lowest** performing LA	**Highest** performing LA
New Birth Visit by 14 days	79.9%	13.3%	99%
6-week review by 8 weeks	79.6%	4.9%	98.5%
12-month review by 15 months	82.6%	22.9%	99%
2-2 ½ year review	73.6%	5.3%	98%

This variation in health visiting provision across England is ongoing and is due to what has been described by the government as "local decision making". From our experience, these decisions are largely based on a lack of funding or workforce capacity to deliver these contacts, rather than the best interests of the child/ family.

The key public health priorities for babies, children and families do not vary significantly between local authority areas to justify such large deviations from the national health visiting model for England and Schedule of Interventions in the national Healthy Child Programme[33]. We highlighted our concerns regarding the number of children who were missing

out on their developmental reviews in our last survey report published in January 2023. The situation is likely to create knock-on consequences across the health, education and social care system if not addressed. We now have a situation where half of all children are not ready to start school[34].

In contrast, following the Scottish Government's investment in their health visiting services, the Universal Health Visiting Programme (UHVP)[35] evaluation reported an increase in the number of babies and young children with previously undiagnosed needs identified. These children were then able to access early intervention.

3.2 Health visiting capacity to meet the scale of rising need – targeted and specialist support

The health visiting service provides so much more than five mandated universal reviews[36]. When health visitors identify babies, children or families with additional health, development or safeguarding needs, they will work with families to determine the most appropriate course of action, including providing additional targeted and specialist support directly, or in partnership with other local services.

In our survey, only 45% of health visitors were "confident" or "very confident" that their service was able to meet the needs of vulnerable babies and children when a need was identified.

Health visitors suggested a number of reasons why services were unable to meet identified needs:

- 79% of health visitors said that the health visiting service lacked capacity to offer a package of support to all children with identified needs.

> *The most vulnerable will be completely prioritised however there is no capacity to provide early intervention and therefore higher risk of escalation. Feels like damage control for the most vulnerable.*

> *We need lower caseloads so this meaningful work can be provided more consistently to all children and families. What other nurses carry such enormous caseloads?*

- 45% of health visitors said other Key Performance Indicators (KPI) were prioritised over identified need:
  - » Child protection and child in need cases were frequently prioritised at the expense of health visitors' preventative and early intervention work.
  - » Health visiting mandated universal reviews that are "counted" in health visiting metrics were prioritised over targeted and specialist support for identified needs (ironically, for a service that aims to improve outcomes through early intervention, these additional targeted health visiting contacts are not counted in national health visiting service delivery metrics). These prioritisation decisions were driven by a desire to demonstrate compliance to external auditors, including commissioners.
  - » Some respondents stated that their service was not commissioned to provide the additional targeted support that was needed.

> *HVs are increasingly being used to support children's social care issues… preventative and supportive work is not a KPI/ funded, and therefore low priority - not done effectively.*

> *We are only able to complete targeted work and safeguarding - I believe what we are managing to do is exceptional, however this is at the expense of the universal service and early intervention.*

> *We cannot revisit [families with identified needs] as we're only allowed to do work that has a KPI. We have good client feedback but unable to help people in the way we used to. We are there to make the KPIs look good.*

- 80% of health visitors said other services lacked capacity to pick up onward referrals (including higher thresholds for children's social care, and long waiting lists for community paediatricians and children's therapy services).

> *Social care referrals are barely ever picked up due to social care capacity and thresholds being so so high - [health visitors] are left 'holding' a lot of vulnerability.*

> *Long delays/waiting lists in referral intervention, leaves families with limited support, at a time when they are struggling to cope. HV caseload is audited and KPIs, and safeguarding work is prioritised over targeted supportive preventative work.*

By providing more intensive health visiting support, Scotland has seen wider system benefits including better identification of children with unmet needs/ special education needs and disabilities (SEND)[37] and a reduction in A&E attendance rates[38]. In contrast, England has seen A&E attendance rates for children aged 0-4 years increase by 42% in the last ten years and much of this increase is for conditions that did not require hospital treatment and could be managed in the community by health visitors (see iHV report: Understanding the rise in 0-4-year-old Emergency Department attendances and changing health visiting practice (2023))[39].

3.3 Health visiting workforce

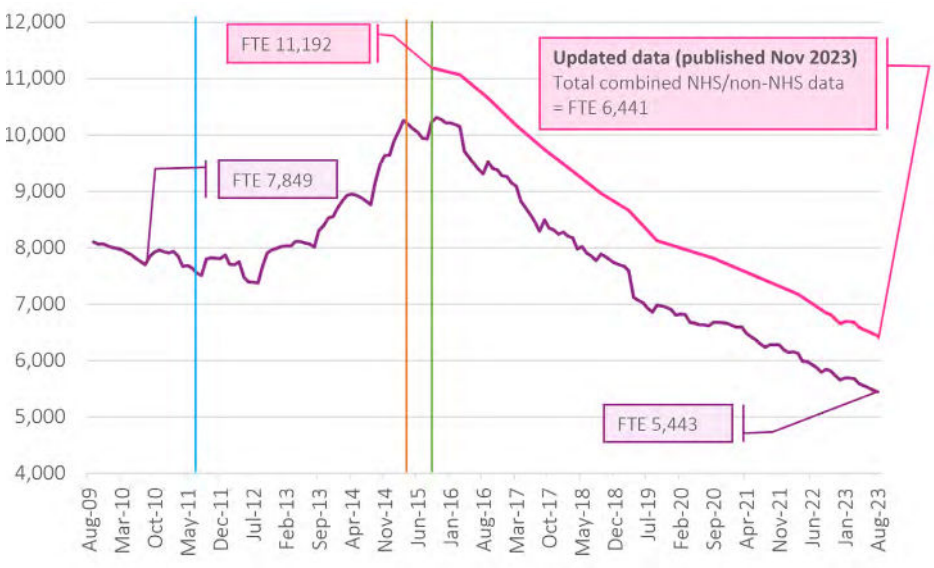
3.3.1 Health visitor numbers continue to fall

Health visitor numbers in England continue to fall and have been cut by more than 40% since 2015 [based on published workforce data on health visitors employed in NHS and non-NHS settings[40,41] - see Figure 4]. Over the same time period, the Public Health Grant that funds the service has been cut by £1 billion in real terms[42]. As a result, there is an estimated workforce shortage of about 5,000 health visitors[43] in England. And this has led to an inevitable reduction in the level of support that health visiting services are able to offer to families.

Despite the Government's Start for Life Vision's stipulation that health visitors were one of six essential services in the early years required to deliver "rapid and visible support" for families[44,45], since the Vision was announced in March 2021 there has been a further loss of 1,257[46,47] full time equivalent (FTE) health visitors in England – and numbers continue to fall every month.

It is encouraging to see that the main political parties have recently committed to increase the number of health visitors in England[48,49].

Figure 4: Total health visitor workforce numbers in England: Combined published data from NHS and Non-NHS providers (updated November 2023)



Published NHS and Independent Healthcare Provider workforce data:

- The NHS workforce data (using data from Aug 2023 - published Nov 2023) = 5,443 FTE HVs employed by NHS organisations https://bit.ly/3RmpGrD
- Total combined workforce - including Independent healthcare workforce statistics (using data from Sep 2022 - published Feb 2023) = 6,441 FTE HVs employed by NHS/non-NHS organisations https://bit.ly/3N8WFxY
- Apr 2011 - Call to action commenced
- Apr 2015 - Call to action ended
- Oct 2015 - Health visiting transferred to Local Authority commissioning

84% of survey respondents said that the number of health visitors had decreased where they worked over the past 12 months. Only 5% reported an increase (See Figure 5).

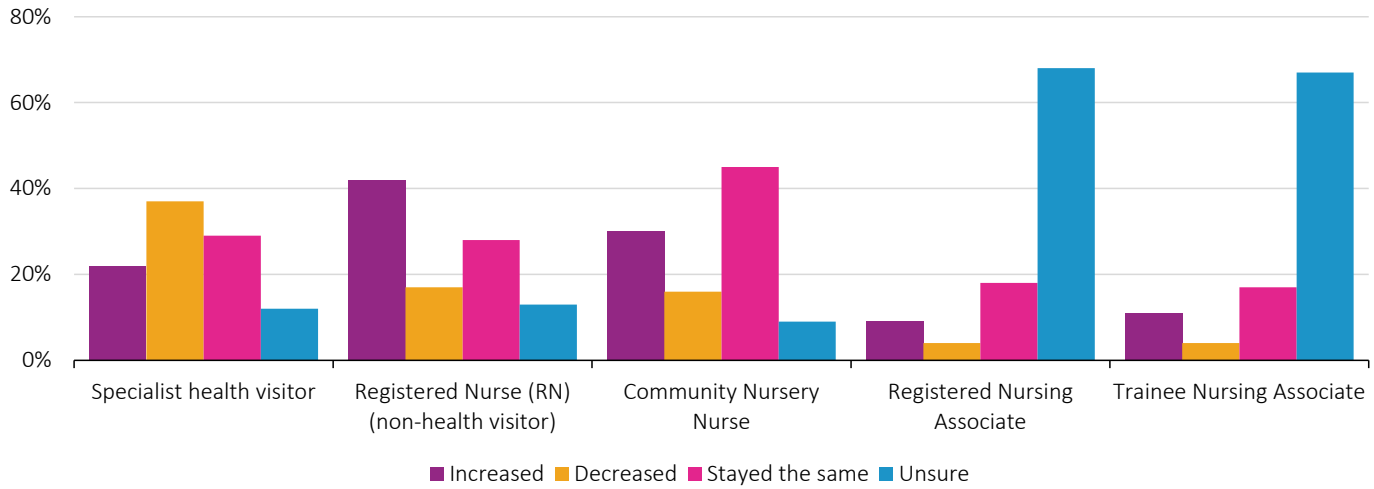
Figure 5: In the last year, has the number of FTE health visitors in your provider organisation:

3.3.2 Skill mix

Skill mix teams have been commonplace in health visiting in England for many years[50], and skill mix practitioners are valued members of health visiting teams. Teams comprise a range of practitioners who complement health visitors and support their work to create good health through a universal service that addresses the needs of individuals, families and communities[51]. Research examining the impacts of skill mix in health visiting remains sparse, although there is transferable learning from wider nursing research which highlights the risk associated with substituting registered practitioners with other roles, with concerns about the impacts on outcomes[52].

In our survey, 42% of respondents reported an increase in Registered Nurses (non-SCPHN roles) employed in health visiting over the last 12 months. It is a concern that 37% of respondents also reported a decrease in specialist health visitor posts during this time. 30% of respondents reported that the number of Community Nursery Nurses posts have also increased, with 45% reporting that the numbers have not changed (see Figure 6). There is limited use of the Nursing Associate role in health visiting, although this is an area that requires further investigation as part of a career pipeline review for health visiting[53].

Figure 6: Changes to skill mix team



Robust processes of delegation and supervision are needed to safely manage workloads in health visiting skill mix teams. Health visitors retain responsibility for activities delegated to non-health visitor team members and are accountable for each decision to delegate[54]. In our survey:

- 81% of health visitors reported that they “mostly” or “always” only delegate to skill mix team members when they had completed an assessment of need to support a plan of care and to a practitioner with the right skills to meet the identified needs.

- 19% of health visitors said that they "only sometimes" or "hardly ever" complete their own assessment before they delegate to a member of the skill mix team. The most common reason for this was that health visitors lacked capacity/ time to do this, or workload "redistribution" was a routine part of their service design (for example, all universal health visitor assessments at one year or 2-2½ years were routinely delegated to the skill mix team in some areas without any professional oversight from a health visitor).

> *This used to be the case, all referrals were discussed at a weekly skill mix meeting and allocated accordingly. Now skill mix staff are trying to cover …. and don't have time for anything else.*

> *All one - and two-year checks are done by skill mix team - I don't see them at all. This is a worry as health visitors are accountable for the families when something goes wrong or is missed.*

> *Community Nursery Nurses (CNN) do all universal transfer in contacts and all developmental reviews... but they don't know what they don't know - our recent Staff nurse was in this category and we are still picking up the pieces.*

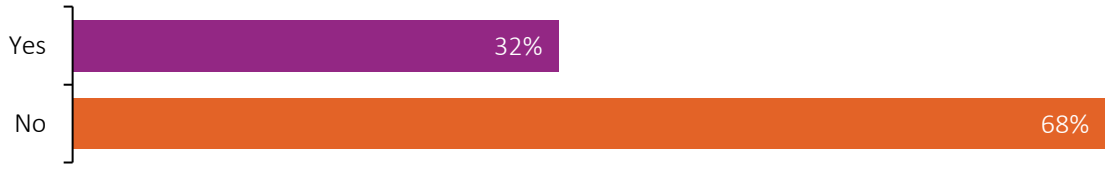
3.3.3 Workforce supply needs

The first NHS Long Term Workforce Plan[55] was published in June 2023. The Plan sets out the Government's long-term commitment to increase health visitor workforce numbers in England. The Plan states:

"The health visiting workforce is fundamental to improving the health and wellbeing of families from pregnancy to starting school by promoting health, preventing ill health and reducing inequalities. And by providing support in the community, they help alleviate pressures on hospital".

In our survey, 68% of health visitors raised concerns that there are currently not enough student health visitor places to maintain health visiting workforce supply needs in their area of work (See Figure 7). It was encouraging to see that, despite the workforce challenges, 74% of health visitors felt able to offer a robust training placement to student health visitors.

Figure 7: Are there enough filled student health visitor places to maintain health visiting workforce supply needs?



3.4 Health visiting caseloads – continuity and relationship-based care

There is good evidence that trusting relationships, nurtured through continuity of health visitor, are key to building parental confidence, identifying babies and young children living with risks and unmet needs, and improving the success of health visiting interventions[56,57].

3.4.1 Caseload configurations:

The way that health visiting services in England are organised has changed in recent years, with lots of variation between local authorities (see Table 6). Some areas have moved away from individual health visitor caseloads to corporate caseloads, where a group of health visitors share the responsibility and accountability for a locality-based caseload of children aged 0-5 years. Others have introduced selective caseloads that only count families on their "targeted" or "specialist" health visitor caseloads, rather than all children aged 0-5 years in their local population. This makes direct comparisons of caseload sizes between areas more challenging.

Recent research[58] identified a lack of consensus on the best methods to organise health visiting caseloads and measure health visitor workload. This is recognised as an area that requires further research.

Table 6: Percentage of health visitor responses to the question, "The health visiting service as a whole is responsible for the total caseload of all children 0-5 years in your local population. How does your service manage 0-5 population caseloads?"

	England	Scotland	Wales	Northern Ireland
Each health visitor has their own **individual caseload** comprising a proportion of **all children** aged 0-5 years in our locality (universally and across all levels of need)"	29%	100%	90%	100%
Each health visitor has an **individual caseload (selective)**: the caseload count only includes the number of children aged 0-5 years that they are actively working with (for example, for targeted or specialist work and/or allocated universal assessment contacts when they are due).	42%	0%	6%	0%
Our service uses **corporate caseloads**: a group of health visitors share the responsibility and accountability for a locality-based caseload of children 0-5 years (universally and across all levels of need)	29%	0%	4%	0%

Individual vs. corporate caseloads:
In England, 71% of health visitors had an individual caseload (29% had individual caseloads comprising a proportion of all children aged 0-5 years; and 42% had individual selective caseloads), whilst 29% worked within a "corporate caseload". In contrast, all health visitors in Scotland and Northern Ireland had an individual caseload of families with children 0-5 years – and only 4% of practitioners in Wales had adopted a "corporate caseload" model for health visiting.

Health visitors described the benefits of an individual caseload to support relationship-based/ personalised care as well as the identification of needs/ vulnerability:

> *Having an individual caseload, allows for a therapeutic relationship to develop.*

Some practitioners in England reported that, despite being named as the caseload holder, they had limited contact with families due to large caseloads and widespread use of skill mix team members to manage the workload. In effect, they were a caseload holder in name only:

> *All families see a health visitor for their new birth visit and are then seen in clinic settings by the skill mix team unless they are targeted [as vulnerable and require targeted supported].*

Health visitors described how corporate caseloads eroded their ability to build relationships with families which has been recognised as a central mechanism for successful health visiting[59]:

> *The corporate [caseload] approach does not allow for any continuity for families. This affects the therapeutic relationship and prevents holistic management of the child. It can result in "missing" elements of neglect, for example, since there is a broad picture built over time when identifying problems.*

> *We are corporate [caseload] due to not having enough staff to have individual caseloads. There are too many families with concerns per HV due to a lack of staff. I don't know my clients personally anymore.*

> *No continuity of care. This makes it difficult to build a rapport with families especially where there are mental health concerns and no capacity to follow up myself or to manage my own diary.*

Selective vs. whole 0-5 population caseloads:
In order to manage workloads, 42% of survey respondents reported that their health visiting service had moved away from "whole 0-5 population" caseloads. A variety of versions of selective caseloads had been introduced in some areas, including:

- Health visitor caseloads restricted to younger children – older children were not "counted". The most common cut-off ages were 10 months and 2 years – at this point children were "discharged" from the health visitor caseload.
- Caseloads that included older aged children – for example, 0-7 years and 0-19 years.
- Universal health visiting and targeted/specialist health visiting were commissioned separately and delivered by different teams:
  - Some practitioners reported that this model was complex to deliver in practice for families whose needs changed over time, as they moved above and below the threshold for these different teams.
  - Health visitors also reported concerns that targeted support was often only provided when families reached crisis point, with limited opportunities for health visitors to provide prevention and early intervention support outside the mandated universal reviews and below the threshold for targeted/ specialist team support.

> *Insufficient capacity to support low level need, but the need is still very much present. E.g. an extra visit to review mental health as you feel it may decline, now we just leave it with mums to call us if it does decline. Safeguarding is always prioritised.*

Safety-net for all children through "whole population" health visitor caseloads:
Regardless of whether a child is "counted" or not, it has always been the case that health visitors were accountable for **all** children aged 0-5 within the local population – families did not need to be referred into the service, everyone had a health visitor. This universal "safety-net" is particularly important to build a picture of families' changing needs over time and the accumulation of vulnerability factors before they reach crisis point. For example, health visitors would have received information on frequent A&E attendances, families' disengagement with early intervention, and been aware of social and family factors that can impact on child outcomes. The review into the murders of Star Hobson and Arthur Labinjo-Hughes flagged the particular importance of "putting together the jigsaw of information" for child protection, stating:

"Practitioners need to be given the space and time to do quality work with the [baby]/child and to critically reflect on the child's experiences, including putting together the jigsaw of information they hold about them and the network around them. Otherwise, there is a risk that the [baby]/child will become invisible."
(Child Safeguarding Practice Review Panel, 2022)[60]

The universal role of health visitors is particularly important for safeguarding babies and young children who are often not known to any other agency unless their parents reach out. The Independent Review of Children's Social Care[61]and the Start for Life Vision[62] both highlighted the need to improve information sharing between agencies to improve child safeguarding and coordination of care. This will depend on health visiting services having the capacity, and workforce with the right skills, to collect and interpret data from multiple sources and plan the most appropriate course of action with the family.

3.4.2 Continuity of health visitor

- Less than half of health visitors in England (48%) reported that they provided families with continuity of health visitor "all or most of the time" – compared to 100% in Northern Ireland, 87% in Wales and 83% in Scotland.
- 40% of health visitors in England stated that they could only offer continuity of health visitor to vulnerable families or those on child protection or child in need plans.

Research into parents' views of health visiting[63] and the Government's own Start for Life review[64] identified that continuity of carer is important to families. Parents want to "be known" and to avoid having to repeatedly "tell their story" to a multitude of different practitioners. Continuity of health visitor is also a key component of what makes health visiting successful, identified in research[65] and as a core element of the Institute of Health Visiting's evidence-based Vision[66] for health visiting.

3.4.3 Caseload sizes/ ratio of health visitors for the 0-5 population:

Due to variations in the configuration of health visitors' caseloads, it is impossible to compare health visitor caseload sizes, or the ratio of health visitors for the 0-5 population, between local authority areas in England. This information could not be deducted from our survey findings, or from national datasets as the data are not collected.

The practice of only counting the number of children that health visitors are actively working with and configuring caseloads based on "known need" is a cause for concern, as it:

- masks health visitor workforce shortages and actual levels of population need – thereby weakening the case for investment in health visiting to deliver the Healthy Child Programme as intended to all children.
- removes health visitors' proactive universal reach and ability to "search for health needs" across the whole population which is a core principle of health visiting[67].

In our view, the universal scope of health visiting, reaching all families with children from pregnancy to age 5 in the population, needs to be protected. There is also widespread support for health visiting across agencies working to improve child health and reduce inequalities[68]. Health visiting provides a vital backbone for early years services and a safety-net for the most vulnerable babies and young children who may not be known to other services unless their parents reach out[69].

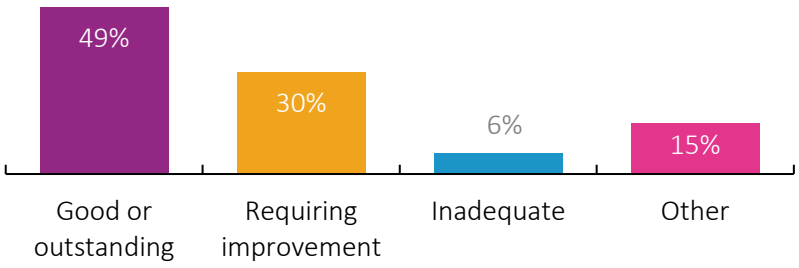
3.5 Service quality

In this section, we report the findings from our survey questions on the quality of health visiting services.

3.5.1. Delivery of the national health visiting model as intended.

Health visitors were asked to rate the quality of their local health visiting service based on its ability to deliver the national health visiting model as set out in the Office for Health Improvement and Disparities guidance[70] and Healthy Child Programme Schedule of Interventions[71] (Figure 8):

Figure 8: Health visitors' rating of the quality of their local health visiting service.



15% chose to answer this question with "other", citing variation in the delivery of the national Health Visiting Model across England, with no benchmarks for best practice, or levers to address poor service delivery models.

Survey respondents provided information to support their rating. Themes included:

- **Key performance indicators mask service quality issues and do not measure what matters:**

> *KPIs are classed as 'achieved' if the appointment has been offered within the time frame - not whether children are actually seen. The model itself is inadequate in a city where over a 3rd of children live in poverty.*

> *The quality [of health visiting] is determined by the local authority who commission the service with very limited understanding of the complexity of the role and dictated by unrealistic KPIs, not clinical need.*

> *We meet KPIs … but the complexity of the work on each HVs caseload is not captured.*

> *I am concerned we are missing children. We are ticking the box and missing the point and the babies keep coming - so become more and more stretched as staff leave and recruitment is so difficult.*

- **Not enough health visitors to meet the scale of need:**

> *This is not about the health visitors' work, it's about the amount of health visitors. We simply do not have enough.*

> *The staff are brilliant and go above and beyond but due to vacancies, trying to achieve the KPIs, we are unable to offer the extra support that is required.*

> *We have not got enough health visitors and do not seem to be able to recruit and retain staff. We are 25% short of HVs across the Trust. The service we can offer is being cut back and then cut back further.*

- **Unable to provide core elements of health visiting: continuity of care/ drop-in baby and child health clinics/ public health early intervention**

> *We are commissioned by the local council who decides what we can and cannot offer to our families. We no longer offer groups or drop-in clinics.*

> *We can't see the families on our own caseload as much, a lot of our visits get delegated… which is not a quality service as families do not build relationships with their own health visitor.*

> *The lack of capacity to offer quality support to vulnerable families, children with SEND is limited and we are forever skimming the surface doing as much as we can but knowing it's not enough, worrying we have missed something.*

> *The workforce has lost so much autonomy and ability to be responsive to need. Safeguarding has taken over from prevention.*

- **Use of staff who are not trained health visitors (SCPHN) or nurses**

> *Our skill mix staff are amazing, but the skills that HVs have are specialist skills for a reason - we are searching for health needs at every contact and assess families in a different way.*

> *Universal services managed by lower staff bands/ assistants who may not have a health qualification or one relating to children.*

> *Skill mix includes non-clinical staff who miss things a health visitor would see.*

In a subsequent question, we asked health visitors what the biggest barriers were to "making a difference". Nearly all health visitors (88%) reported that the biggest barrier was not having enough health visitors. Other reasons included:

- People don't fully understand who health visitors are and what they do.
- Prioritising the most vulnerable leaves little or no time for prevention and early intervention work.
- Lack of capacity to support families with needs identified.
- Too much time spent on administration reduces direct contact with families.
- Impact of wider determinants on health (e.g. poverty, housing, environment).

3.5.2 Face-to-face contacts

At the start of the COVID-19 pandemic, non-face-to-face health visiting contacts were rapidly introduced as "better than nothing" in line with government guidance[72] at the time. The application, suitability, effectiveness and acceptability of non-face to face contacts for health visiting interventions was unknown and untested and will depend on the purpose of the intervention. For example, giving quick straightforward advice over the telephone is very different to completing a holistic assessment of a baby/ young child's health, wellbeing, development and safety at a mandated universal health review appointment – this relies on babies and young children being seen in person.

On 24 March 2022, a ministerial directive was issued by Maria Caulfield MP, Parliamentary Under Secretary of State, to end this temporary workaround. The Minister confirmed that, ***"The collection of health visitor service metrics … will reflect the national service model, which confirms that mandated reviews should be conducted face to face."***[73]

Whilst it has taken some time for services to return to face-to-face delivery of the mandated health visiting review contacts, it is reassuring that our survey findings have confirmed that the majority of practitioners now deliver the universal reviews face-to-face "all or most of the time".

- Only 0.1% of practitioners reported routine delivery of the New Birth Visit using non-face-to-face methods.
- 2% routinely delivered the 6-8 week review using non-face-to-face methods.
- 3.7% routinely delivered the 12-month review using non-face-to-face methods[i]
- 3.3% routinely delivered the 2-2½ year review using non-face-to-face methods
- 17.3% routinely delivered the antenatal contact using non-face-to-face methods.

[i] (More than 4 out of 5 practitioners surveyed reported that their service offered all of the one year and 2-2½ year reviews using face-to-face methods. A small proportion had adopted a blended approach for these reviews, using non-face-to-face methods occasionally – on average, for one out of every five contacts or less).

Institute of Health Visiting position on the use of non-face-to-face methods for health visiting mandated contacts:

The iHV recognises that non-face-to-face methods bring some benefits for certain aspects of health visiting service delivery. However, there is unequivocal evidence that they increase the risk of harm to babies and young children if used for health visitors' mandated assessment contacts.

There is strong evidence from research[74], frontline practitioner intelligence[75,76] and findings reported in the Child Safeguarding Practice Annual Review (2020) which highlight the increased risks posed to babies and children from virtual contacts [virtual contacts were linked to almost half of the child deaths and serious incidents investigated during the first year of the pandemic[77]].

It is impossible to deliver the full specification for the mandated health visitor review contacts, as set out in the Healthy Child Programme Schedule of Interventions[78], using non-face-to-face methods.

When health visitors' mandated contacts are completed using non-face-to-face methods, the assessment is based solely on what the health visitor is told, rather than also including what these highly skilled practitioners can observe using their clinical assessment skills.

Babies and young children need to be physically seen at these mandated universal contacts as the national service specification[79] requires health visitors to:

- Measure and plot growth, including weight and head circumference.
- Review health, wellbeing and development of the infant. Parental self-report is known to be an unreliable method to identify the signs of clinical conditions and disability, or safeguarding concerns (these may be unknown by the parent or hidden).
- Identify infants requiring targeted or specialist interventions for infant mental health. This requires observation of parent-infant interaction which is not possible using non-face-to-face methods.
- Review the mother's mental wellbeing and that of any partner. This is more challenging on a telephone call which typically only involves one person (usually the mother).
- Identify safeguarding concerns – there is clear evidence that non-face-to-face methods have significant limitations in terms of accurately identifying vulnerability and risk.

We are calling on the Office for Health Improvement and Disparities to close the temporary COVID-19 amendment to "count" non-face-to-face health visiting mandated contacts in the national health visitor service delivery metrics. This is an important quality and safety marker for health visiting services and a safeguard for our youngest citizens.

3.6 Workforce retention, wellbeing and development

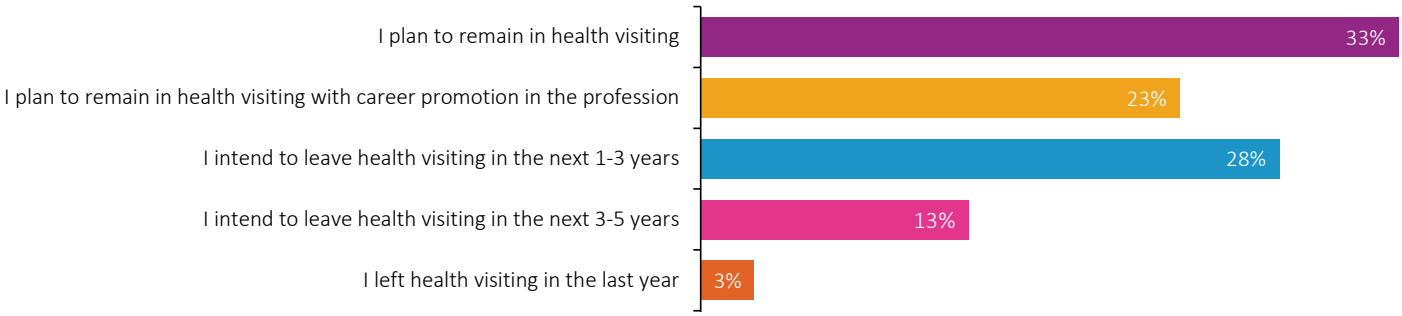
3.6.1. Health visitor retention and intention to leave

We asked health visitors about their future career intentions (see Figure 9). 56% of health visitors plan to remain in health visiting; this includes 23% who are planning for a career promotion within the profession (this is higher than last year's findings when only 48% of health visitors were planning to stay in the profession).

It is a concern that 41% of health visitors reported that they are planning to leave the profession in the next 5 years. The main reasons for this were:

- Lack of career progression opportunities in health visiting
- Work-related stress/ poor health
- Role drift away from the public health role of health visitors to child protection/ taking on more responsibilities that would previously have been provided by children's social care
- Planned retirement

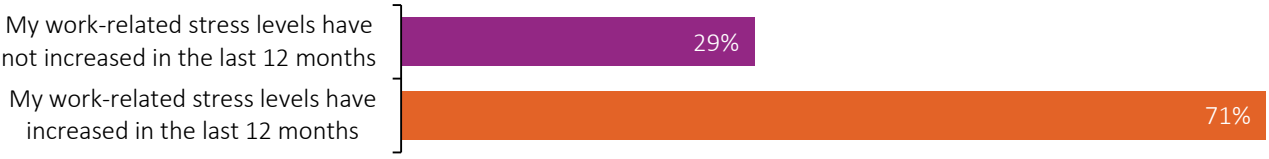
Figure 9: Health visitors' future career intentions



3.6.2 Workforce wellbeing and work-related stress

71% of health visitors reported that their work-related stress levels had increased in the last 12 months (See Figure 10). This is slightly less than last years findings (78%) but still unacceptably high.

Figure 10: Work-related stress levels



Practitioners who reported an increase in work-related stress described its impacts on themselves as individuals:

- 52% were working longer hours
- 49% were feeling worried, tense and anxious
- 43% were feeling demotivated
- 39% were worried about the impacts of stress on their physical health
- 32% were experiencing low mood

Over half (53%) of practitioners reported that they had received good quality supervision over the last year. However, the rate of work-related stress in health visiting remains stubbornly high and warrants much greater attention to address the root causes to improve staff wellbeing and retention of this valuable workforce.

4.0 Practitioners' reflections

4.1 Professional Pride

Despite the extreme work pressures that health visitors face, 654 practitioners filled in the free text box in our survey which invited them to leave comments if they felt proud to be a health visitor and to tell us why. There were too many quotes to share all of them. We are grateful to everyone who shared their passion with us which provides hope for the future of our profession. The following quotes represent the views of a multitude of health visitors from across the UK:

> *I am proud to be able to support parents to meet their children's needs at the most vulnerable time of their lives. I get job satisfaction knowing the positive preventative work I deliver will have an impact on a child's outcomes. I feel honoured to work with families at the most challenging times of their lives and feel proud to advocate for them and their children.*

> *I am confident I have had a positive impact overall in my 30 years practice. Occasionally I am approached by ex-clients with lovely feedback, even many years later. As a teen parent living on the breadline myself, I couldn't have a better reward.*

> *Health Visiting is one of the most rewarding and fulfilling roles in nursing. It is challenging, dynamic and works with clients on a person level as well as supporting whole community initiatives. We are able to see our interventions have generational impact and break cycles of inequality and inequity. We have a unique skill set that is transferrable in any sector. It is a role that I love and will always do so.*

> *I have been a HV for 30 years and, despite challenges, the HV's I lead are the most amazing group of staff who provide outstanding care and support to our families. The cuts have enabled innovative thinking, given us a push to look at what and how we are delivering services and have changed some things for the better. The specialist knowledge collectively as a group enables progressive thinking and developments for the improved outcomes for families and children.*

> *I am a Community Nursery Nurse and get great satisfaction in supporting families.*

Other practitioners sadly stated that they were no longer proud to be health visitors – this reflected the wide variation in health visiting service quality across England which is a key theme in this year's survey:

> *I'm not. I used to be, but now I am ashamed of the service that we provide.*

> *I know I have been an excellent health visitor and received lots of compliments from families. I loved in particular working with hard-to-reach families. I ran the Refuge, homeless and travellers' sites and had amazing results. But when [new service provider] took over, our service deteriorated so badly I had no choice but to leave the job I loved. All autonomy was removed by staff with no experience and no health/ health visiting qualifications. Health visitors left in droves. Due to difficulties re-staffing they brought in more unqualified staff!? I fear for the future of health visiting in [name of area redacted].*

4.2 Hope for the future

At the end of our survey, we asked practitioners from all UK nations to tell us about the things that needed to change for health visiting now, and in the future, with responses presented in the following themes:

1. **More health visitors (including more funding to support increased substantive posts)**

> *We desperately need more health visitors… to support all families in such troubling times.*

> *More of us! The impact we could make is being diluted through a lack of funding.*

> *Things are so bad we need more staff. It's dangerous in practice. Until this changes nothing else really matters.*

> *To have more health visitors to help retain the ones currently in practice.*

2. **Focus on preventative public health (strengths-based/ "health creation)**

> *To have capacity to do the job that health visiting is fundamentally, to be a public health nurse not a child protection nurse.*

> *Sufficient practitioners to be able to return to named health visitors supporting a family from the antenatal period until their child goes to school.*

> *More time to complete health promotion and early intervention… Work always feels very responsive to crisis.*

> *More public health and community development instead of ticking boxes.*

> *More preventative care rather than firefighting all the time.*

3. **Build health visiting services around the needs of families: relationship-based, provide accessible support in communities (including reinstating health visitor drop-in clinics, increased home visiting, closer alignment with GPs)**

> *Give power back to families and provide open access drop-in clinics (in partnership with family hubs and other community resources) so that face-to-face human contact is nurtured. Human beings need social contact.*

> *To have the time to really listen to families - it is one of the most valuable tools we have but we don't always have the capacity to do this.*

> *Better continuity for the families… putting children at the heart of decision making.*

> *More universal visits - bring back drop-in clinics - our managers undervalue them but staff and families massively value them.*

> *Go back to GP alignment. The corporate caseload has made HVs less autonomous, not using their initiative, or showing flexibility.*

4. **Reduce variation in delivery of health visiting services across the UK:**

> *Services across UK need to have some standard areas which are equal. All areas have such different services and support offers - I understand they should reflect the demographics of each area, but our young parents programme was decommissioned and that is something that should be available everywhere, for example.*

> *Put health visiting back with local healthcare trusts and not in other organisations as they lack the long term invested interest in the health of the local population.*

> *End the postcode lottery. To become centralised under the NHS, not commissioned, so the same service is provided across the country for consistency.*

5. Measure what matters

Realistic and supportive commissioning to enable better fidelity to the early identification, support and prevention model of the Healthy Child Programme.

Stop such heavy KPI indicators and look at the impact of individual, tailored care with families and children.

Halt the decline. More proactive visiting and less bean counting.

Bring back the power of early intervention. The research evidence is there, but it's not embedded in our practice anymore as we are all just surviving, meeting KPIs.

6. More staff development

Retain health visitors. Have a clear career progression for experienced health visitors and train new health visitors to maintain the service.

We need more specialist roles and opportunities to progress which is very much lacking currently.

Have more of a career ladder for us. Support our development... with the best professionals offering us the very latest information and updates in research.

A career pathway for Community Nursery Nurses to become Public Health Nurses.

To have a career progression for band 4s.

7. Better recognition and valuing of the vital role of the health visitor

We need for the government to be reminded of how valuable the service is and why it is important.

We are not good at showcasing the positive work we do. And local authorities don't use our skills it feels like they would rather re-invent the wheel.

Health visiting in general needs a rebrand. Other health professionals do not recognise the name health visitor as specialist public health nurses and do not realise we have to do additional training and a degree to be one. Local Authority also do not see the amount of work we put into preventing families from becoming more vulnerable or that we are one of the first to sound the alarm when there are significant concerns.

8. A profession ready to rise to the challenge

Involve us in how the service develops - we are passionate, knowledgeable and tenacious - give us a problem and we will find a way to resolve it that ensures the service is visible, professional and impactful.

Health visitors desperately want to both lead and deliver the service, they have such potential to improve outcomes. Reform is desperately needed.

Investment into health visiting is an investment into the wellbeing of our future generations.

5.0 Conclusion and summary of recommendations

Our survey findings present a clear imperative to act. With deteriorating child health and development, soaring costs of late intervention and widening inequalities, doing nothing is not an option. The good news is that change is possible. If we get the early years right, we can avoid so much harm later in life. The costs are small compared to the spiralling costs of NHS treatment, child maltreatment and cumulative costs across the life course.

We recommend the following actions:

1. **A cross-government commitment that prioritises and invests in the first 1001 days is needed.** Spending needs to be seen as a capital investment in our nation's future, rather than as a cost. To ensure that babies' health, wellbeing and safety is prioritised, it is imperative that we have a Children and Families Minister to represent our youngest citizens in the heart of government.

2. **A much greater focus on prevention and early intervention** is needed to support all people to lead healthy and fulfilling lives. This requires coordinated action across government departments to address the wider determinants of health, as well as efforts to tackle the major conditions that take root in early childhood and are largely preventable. Preventing, identifying and treating problems before they reach crisis point is not only cheaper, it's also much kinder than cure.

3. **The important 'health' contribution of health visitors needs to be maximised.** The benefits of a well-resourced health visiting service accrue across the health system (to the NHS, GPs, urgent care, as well as public health). Health visitors also support the goals of other government departments - reaching all families with babies and young children to reduce child maltreatment, improve child development and support families living with multiple disadvantages. A long-term vision and a cross-departmental plan with funding for health visiting is needed to maximise its vital contribution in the earliest years of life.
"Put 'health' back at the heart of health visiting and end the role drift away from preventative public health."

4. **A national plan to strengthen health visiting in England, focused on three areas:**
    i. **Funding** - All areas need sufficient funding to deliver the full specification for the national health visiting model and Healthy Child Programme Schedule of Interventions. Long-term investment will help services to plan and build world class services, ending the uncertainty of short funding cycles.
    ii. **Workforce** - The national long-term workforce plan to retain, train and reform the health visiting workforce needs to be delivered in full, with 5,000 more health visitors to meet the scale of families' needs and replace workforce losses since 2015.
    iii. **Quality** - National government must do more to end the current postcode lottery of health visiting support to ensure that:
        - All areas provide health visiting services in line with national policy, and that families need, holding failing areas to account when services are not meeting national guidelines.
        - System blockers are removed and best practice is enabled. For example, by enabling better data collection (measuring what matters), information sharing and analytical capability to improve joined-up care for families and provide intelligence on the quality of health visiting services across England.
        - Health visiting research, workforce development and the sharing of evidence-driven models of best practice are supported.

5. **Close the temporary COVID-19 amendment to "count" non-face-to-face health visiting mandated contacts in the national health visitor service delivery metrics for England.** This is an important quality and safety marker for health visiting services and a safeguard for our youngest citizens.

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Appendix
Additional 2023 survey questions

Each year in our annual survey, we ask additional topical questions on key areas of enquiry for the health, safety and development of babies and children, as well as health visiting practice and professional development needs. This practitioner intelligence informs our work at the iHV and helps us focus our efforts on the areas where we think we can make the biggest difference. This year, we publish our survey findings on the following topics:

Appendix 1: Reducing unintended injuries and harm: unsafe baby products

The iHV has been working with ITV news, the Child Accident Prevention Trust and the Lullaby Trust to raise awareness of the dangers posed to babies and young children by unsafe baby products that are easily purchased in the UK. Unsafe products include those that are marketed for babies but increase the risk of sudden infant death syndrome (SIDS), suffocation, choking, strangulation and harm due to a range of hazards including small parts, cords, accessible button batteries and increased risk of overheating. In our survey, we asked health visitors for their views and concerns about these products:

- Most health visitors (88%) said they had come across parents using unsafe baby products.
- Nearly all health visitors (97%) said they were concerned about the availability of these products in the UK.
- 93% of health visitors had advised parents not to use certain unsafe products – although many found this challenging as these products are readily available to purchase in the UK and public awareness of the dangers is low.

Following the airing of the ITV News story on this issue, a number of manufacturers have withdrawn the products featured in the programme, with others pledging to review the risks. Read the full iHV news story which contains links to resources for practitioners and families on this topic here.

Appendix 2: Timing of health visitors' new birth visit

Current national policy: All UK nations have similar schedules for the timing of the health visitor New Birth Visit (NBV), stipulating that it should be completed between 10-14 days after the birth In England, Wales and Northern Ireland[80,81,82], and 11-14 days in Scotland[83]. It is noteworthy that none of the UK nations have changed the timings of the New Birth Visit following the publication of the revised NICE guidance on Postnatal Care (NG 194) in 2021[84]. The updated NICE guidance suggests that providers consider offering a later NBV, up to 14 days after discharge from midwifery services.

Applying NICE guidance in practice – updated Postnatal Care guidance: NICE states that guidelines are not a substitute for professional knowledge and clinical judgement. It is well documented that guidance can be limited in their usefulness and applicability due to a number of different factors including: the availability of high-quality research evidence, the quality of the methodology used in the development of the guideline, bias of the review, the generalisability of research findings and the uniqueness of individuals that are receiving healthcare, leading to potentially misleading and untrustworthy results[85,86].

The strength of NICE guidance is based on the level of evidence used. NICE states:

"Our recommendations are based on:

- *the trade-off between the benefits and harms of an intervention*
- *the quality of the underpinning evidence.*

Some recommendations are made with more certainty than others. We word our recommendations to reflect this. Where there is clear and strong evidence of benefit, we will use the word 'offer'. Where the benefit is less certain we use the word 'consider'."[87]

It is significant that the updated NICE Postnatal Care guidance uses the word "consider" for its recommendation on the later timing of health visitors' New Birth Visit. NICE acknowledges that the guidance is based on no evidence and relied solely on the views of the limited review panel hosted by the Royal College of Obstetricians and Gynaecologists[88]. The guidance stated that services should:

"Consider arranging the first postnatal health visitor home visit to take place between 7 and 14 days after transfer of care from midwifery care so that the timing of postnatal contacts is evenly spread out".

National health visiting metrics:

The most recent OHID data on Health Visitor Service Delivery metrics highlight a reduction in the percentage of New Birth Visits completed by 14 days in recent years (See Table 7).

Table 7: Comparison of the New Birth Visit completed from 2020/21 to 2022/23[89,90]

New birth visits within 14 days 2022/23	New birth visits with 14 days 2020/21
↓ 79.9%	88%

iHV Survey findings: We asked health visitors for their views on the timing of the New Birth Visit: The majority of health visitors surveyed (86%) were against delaying the timing of the NBV to 14 days after discharge from midwifery services:

- 25% felt that the NBV should remain at 10-14 days
- 56% of health visitors wanted the timing "window" extended to around 7-17 days to provide more flexibility and to support continuity of care/ transition between midwifery and health visiting care
- 5% felt the NBV should be offered even earlier in the postnatal period – for example 5-9 days to support earlier intervention for difficulties.
- Only 14% of health visitors agreed with the NICE Postnatal Guidance that the new birth visit should be offered much later in the postnatal period (up to 28 days – or with a gap of 14 days after discharge from midwifery care).

Health visitors provided their reasons for not choosing to delay the timing of the NBV in line with the revised NICE guidance:

- Health visitors were clear that health visiting has an entirely different scope, public health orientation to practice and specification to midwifery services, spanning from preconception to five years, i.e. health visiting is not a continuation of midwifery services or driven by a medical model.
- To ensure seamless transition between midwifery and health visiting services. This avoids families falling in the gaps between services during a potential gap of up to 14 days between the handover from midwifery to health visiting services.
- To enable health visitors to build relationships with families during the dynamic period of change in the first weeks after a baby is born. Working with families during this time builds a foundation for future health visiting between 0-5 years.
- To enable earlier identification and support for any issues including breastfeeding problems, perinatal mental illness and early parenting concerns in the early postnatal period.

Our survey respondents agreed that greater flexibility around the time of visiting was needed. Extending the time limit, for example from 7-17 days, would enable continuity of health visitor more easily which respondents felt was important for quality of care and the identification of need/ vulnerability.

The following quotes from our survey findings make the case for not delaying the NBV until 14 days after discharge from midwifery services:

> *This is a public health contact, different to midwifery contact.*

> *So that problems are identified early and relationship with HV has begun, so parents know who to contact for support.*

> *Breastfeeding issues cannot always be identified and fathers are not usually seen.*

> *[Current timing] ideal as midwife support in place till this time, an assessment can be made and follow up support targeted in the first month.*

Health visitors also called for greater professional autonomy to work with families to determine the most appropriate timing of the NBV based on their needs:

> *[7-17days] allows for parent & HV flexibility. We work with our parents & sometimes it is not suitable for them to be seen 10-14 days, so can be seen after this time scale. But continuity of HV is important, so we encourage HVs if not suitable within 10-14 days to make an appointment suiting parents, regardless of number of days.*

> *Flexibility is needed - Earlier support for infant feeding and longer time period to allow for NICU.*

Some survey respondents raised concerns about the current reality of reduced postnatal midwifery support for families that is the norm in many areas, or late discharge from midwifery care, and the implications that these have on families and considerations for NBV timing:

> *Midwifery is also over stretched, and some families have little or no professional contact.*

> *Families are sometimes not reviewed by midwives, therefore this timing [7 to 17 days] is important to resolve emerging feeding or other parental issues.*

> *Midwives should be completing more [postnatal support]. In fact, the day 5 Newborn bloodspot test and weight review are completed by Midwifery Care Assistants, and not Midwives. Very often when we go out at day 10-14, babies have only been seen once.*

At the iHV, we are concerned that the implementation of the revised NICE Postnatal Care guidance to delay health visitors' New Birth Visit and create a gap between midwifery and health visiting services of up to 14 days will increase risks for babies, postnatal women[ii] and families during the early postnatal period for the following reasons:

- **The earliest weeks of a child's life are a period of heightened vulnerability and risk**. The death rate of neonates aged between 0 and 27 days inclusive remains at over twice that of the death rate for infants aged between 28 and 364 days[91].
- **The first month of a child's life is also a period of heightened risk for postnatal women[92,93] and anxiety for parents**, particularly first-time parents who are learning to manage baby-care and common childhood illnesses for the first time. Babies under one month have the highest rate of A&E attendance compared to any other age group, with rates increasing by 42% in the last ten years. Most of these increased presentations are for relatively minor conditions that did not need hospital treatment and could be managed by health visitors in the community[94].

[ii] While we refer to women in this report, we recognise that some transgender men, gender-diverse people, and people who are intersex may be affected by some of the same issues. We also recognise that people who are trans, gender-diverse or intersex have specific needs, experiences and health issues that need addressing. The use of the term "women" in this report is not intended to exclude other groups or overlook the challenges they face.

- **The period between birth and 28 days is a dynamic period of change and new risks and vulnerability can arise during this time.** An assessment of need completed in the antenatal period, or immediately after the birth has limited predictive value of a family's level of need a few weeks later – breastfeeding problems, perinatal mental illness and undiagnosed childhood conditions can manifest during this time and other risks like domestic abuse can all increase during this period.

- **Vulnerable babies and families risk falling in the gap between services during the transition between midwifery and health visiting care.** Introducing a two-week period between midwifery and health visiting care creates a gap in service lines of accountability; neither service will be clearly accountable for the care once the midwife discharges the family from their care. Who will identify changing needs experienced by families during this 2-week gap period? A short period of overlap, when both health visiting and midwifery services are working with a family, provides a safety net for all families and supports smooth transition between midwifery and health visiting services, reducing the risk that vulnerable families will fall in the "gap" between services.

The iHV submitted a written response to the NICE consultation on Postnatal Care (NG 194) in 2020 - with some excerpts below:

We would agree with the rationale for introducing a greater degree of flexibility to personalise support based on individual need, although this should be driven by the needs of the family, rather than the organisation. The expectation should remain that, for most families, the New Birth Visit should be delivered ideally within 10-14 days of the birth. The proposed blanket recommendation to delay the start of the health visitor's postnatal support for women and their infants removes this level of personalisation, rather than enhances it.

The role of the health visitor (HV) is very different to the role of the midwife, and the proposed recommendation would in effect delay the start of the HV postnatal "offer". The early postnatal period represents a time of considerable adjustment for many parents and the HV service provides crucial support with transition to parenthood, early identification of risk factors and, most importantly the establishment of the HV/ parent relationship through continuity of carer. There is much to be gained by having the HV involved in this early postnatal period. Delaying the start of the HV postnatal support "offer" has the potential for unintended consequences in terms of eliciting health needs and negative impact on the development of a trusting relationship. There is significant evidence that women will disclose needs more readily in the context of an established relationship. The relationships established during this period lay the foundation for this important quality and safety component of future care which lasts until the child is 5. It is so much more than an "end" of midwifery care. Having the HV as part of their early journey, through the ups and downs of early parenthood, lays the foundation of this relationship.

Governance and accountability: There should be no gaps in the postnatal journey where no service is accountable for care. Conversely, having a period of overlap, when both the HV and MW services are working with a family, provides additional support and reduces the risk of families falling in the "gap" between services – who will be picking up changes during the 7-14 day gap period between the end of midwifery care and the start of HV support? For some families, with pre-existing needs, the HV may have been working with them on these issues throughout pregnancy. This revised guidance will in effect delay the re-commencement of this work postnatally.

In response to the Committee's concern about the lack of support between 2 weeks and 6 weeks: The recommendation to address this would be better achieved by increasing the emphasis on the HV role beyond the "mandated" contacts (the mandated contacts are only a small part of what a health visitor does in the postnatal period). The HV should tailor support to individual need – PHE (now the Office for Health Improvement and Disparities) describes this as "universal in reach, proportionate in response", by offering additional postnatal contacts in response to those that need them. For example, for a breastfeeding or perinatal mental health problem identified at the first HV postnatal contact or previously identified need.

Support for families with clinical or safeguarding vulnerability: The Committee's caveat that, *"If, however, there were concerns about the woman or the baby, this would have either already been identified from the antenatal visit or would be passed on from the midwifery team to the health visitor team"* is not supported by the evidence. The evidence is clear that needs change over time and, in particular, between the pre- and post-birth circumstances of families. The HV holistic assessment is a "process assessment over time", rather than a single snapshot, which takes account of changes in families' circumstances. The accuracy of these assessments is dependent on the establishment of a trusting relationship between the parent and the HV. Engaging with families early in their parenting journey enables this relationship to develop which will then continue into the first years of a child's life – this is central to the effectiveness of the HV service (It is so much more than the delivery of a series of "tasks").

Key performance indicators (KPI): We agree that the current KPI of achieving the New Birth Visit within 14 days is too restrictive for some families – the expectation should remain that, for most families, the NBV should be delivered ideally within 10-14 days of the birth. However, we would suggest increasing the eligibility period to 7-21 days to allow providers to "report by exception", in order to accommodate the baby's or parents' needs or circumstances.

Institute of Health Visiting
A Registered Charity Number 1149745
c/o Royal Society for Public Health, John Snow House, 59 Mansell Street, London E1 8AN
Telephone: +44 (0) 207 265 7352 | Email: events@ihv.org.uk
www.ihv.org.uk