



# **Three years on from a move to local authority commissioning in England, what has changed?**

## **Results from a Survey of English Health Visitors**

**December 2018**

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## Three years on from a move to local authority commissioning in England, what has changed?

### Results from a survey of English Health Visitors, December 2018

For the last six years the Institute of Health Visiting has surveyed its members on the 'State of Health Visiting'. Here we report some of the findings from our 2018 survey of over 1200 health visitors and compare them to what health visitors told us in 2015 when their commissioning arrangements were moved from the NHS to Local Authority:

#### 1. Delivering and leading the Healthy Child Programme

The Healthy Child Programme (HCP) is a national programme of health prevention and health promotion. At its heart is a schedule of health and development reviews that should be provided to all families with children under five. This forms the basis for searching for and identifying health needs.

Our survey responses indicate that health visitors' capacity to deliver all of the five mandated health and development reviews of the HCP in England is reduced. These reviews are the minimum required by the HCP in England (there are more in the rest of the UK), yet they have been increasingly delegated to less qualified practitioners and / or not carried out.

We asked:

***'Thinking about the Healthy Child Programme/Universal Provision, are you or a team member able to deliver (all or most) of the following mandatory (in England) five assessments and the recommended 3-4 month assessment 'service offer' to all families on your caseload, either personally or by delegating to a team colleague?'***

% for 2018 are presented with 2015 in brackets.

- Antenatal visit = 51% (58%)
- New Birth visit = 96% (96%)
- 6 / 8 week = 91% (90%)
- 3 - 4 month visit = 16% (36%)
- 9 - 12 month review = 88% (93%)
- 2 ½ year review = 89% (80%)

##### 1.1 Who is undertaking these reviews?

New birth and 6 / 8 week reviews were reported as almost all being undertaken by qualified health visitors. However, 65% of 9-12 month reviews and 79% of 2-2 ½ year reviews are delegated to less well qualified staff. The qualitative comments of respondents indicate concern that this is now routine practice and therefore not true

delegation (based on a professional rationale), but rather has become a bureaucratic imperative.

## 1.2 What is the effect on delivery of the HCP?

Health visitors add that they cannot be confident of identifying perinatal mental health needs of mother and fathers due to very limited contact and assessment beyond 6-8 weeks for most families.

The survey results indicate that health visitors are increasingly focused on the most vulnerable children and families at the expense of the five reviews and that the Healthy Child Programme is being implemented in an increasingly 'targeted' manner, against its fundamental design principles. This leaves 'invisible' the growing numbers of vulnerable children who remain unknown to other services (Children's Commissioner, 2018)<sup>1</sup>.

*We have started to do the 6-8 week contact by phone, and only [provide] antenatal contacts to vulnerable families.*

The result is that HVs cannot be confident that they are identifying needs or providing early primary prevention. 60% state their ability to make a difference is hampered by '**Focusing only on those most at risk [that] dilutes universal service**'; rather, they are managing risk with children and families with known needs.

## 2. Intensity of need / risk / safeguarding

Health visiting is based on international evidence that the long-term return on investment in health outcomes is greatest when focused on early childhood preventative care based on 'proportionate universalism': that is, inclusive of **all** children and families, providing access to graded levels of additional support, early intervention or help, and where necessary, safeguarding and child protection.

We asked **about the vulnerable groups that health visitors work with.**

The responses indicate how successful health visitors are at engaging with children and families who are most vulnerable and often least confident to access support. 36% report working with children on a children protection plan all of the time or very often.

*I feel that safeguarding thresholds are so high now that where once a safeguarding referral would have been accepted by children's services it is now being bounced back to the referrer to arrange a CAF (Common Assessment Framework) but there is limited capacity to do this for all families and some families don't wish to engage in it anyway.*

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<sup>1</sup> Children's Commissioner (2018) *Vulnerability Report*. [www.childrenscommissioner.gov.uk/publication/childrens-commissioners-report-on-vulnerability/](http://www.childrenscommissioner.gov.uk/publication/childrens-commissioners-report-on-vulnerability/) [Accessed 21.11.2018]

*Frustration at the increasing threshold of what is deemed a safeguarding concern by Children's Services. Other multi-professionals having insufficient knowledge and training of safeguarding issues and making referrals to the HV to follow up their safeguarding concerns.*

Health visitors are now are 'walking a very tight rope' between being strongly driven to meet KPIs (the 5 mandated contacts) on the one hand and child protection social work-by-proxy on the other.

**43% are so stretched they fear there may be tragedy at some point.**

Health visitors are identifying and working with a very diverse range of **at-risk groups** and complex multifaceted problems that include both health and social issues. Almost as many health visitors are spending as much time supporting mothers and families with **perinatal mental health difficulties** as child protection issues.

Health visitors have concerns about **couple's relationships** in families and high levels of domestic violence, but only 10% can support couple relationships. However, they report lack of specific training and support, although they are well aware of the link of domestic violence to Adverse Childhood Experiences (ACEs), being one of the 'toxic trio', along with mental illness and drug or alcohol issues that are known to be damaging to child health and long-term outcomes.

### 3. Impact on families

45% of health visitors can only provide continuity of care to their most vulnerable families and it is hard to credibly offer an equitable service. 63% believe that focusing only on those most at **risk is diluting the universal service**, so that needs go unrecognised and the service is seen as only for people with problems, so it is stigmatising. One of health visiting's greatest strengths has always been that it is a non-stigmatising service.

### 4. Impact on health visitors

72% report that stress levels have gone up, with the main reasons being long hours and feeling worried about the safety of their vulnerable clients. 45% have experienced change of employer in the last year or expect to do so in the next year, adding to workplace uncertainty and stress, reflected in rising sickness-absence rates.

NHS Digital reports sickness-absence rates for health visitors rising year on year from 2015 from 4.9% to 5.44% in 2018 (the reverse of the trend for nurses, midwives and health visitors as a whole):

Year	%
2014/15	4.64
2015/16	4.90
2016/17	5.11
2017/18	5.44

## 5. Caseload size and organisation

Health visitors report increasing caseload size in England. 44% having caseloads of over 400 children (28% in 2015) and 28% report having between 500 and 1000+ children (12% in 2015).

The Institute recommends a maximum caseload of 250 children for the health visiting service to be able to have the impact it should.

A third have 'corporate caseloads', up from 29% in 2015, offering less continuity of care to families. What families most value is a trusted relationship with their health visitor.

Respondents were asked to divide the number of 0-5 age children by the number of Whole Time Equivalent health visitors. However, this year quality of data is less consistent and is likely to lead to underestimation of caseload size. In some cases, numbers refer to less than the whole 0-5 population: health visitors report 'discharging' children at age two or younger; increasingly selective / targeting on high risk cases; delegation of reviews / assessments to less qualified team members from 6-8 weeks. The effect is to diminish the universality of health visiting and hence the tacit contract with the public to be a non-stigmatising, equitable service for all until children go to school.

A new feature of responses this year is that numbers of children are sometimes combined in 0-19 populations, indicating that their services are more thinly spread and also, therefore, rendering caseload calculations less consistent.

### 5.1 Drop in health visitor workforce numbers – recruitment and retention and training of health visitors

76% report that WTE numbers of HVs have reduced since 2015. This is consistent with other data sources. Also, they report drastic reductions in student (trainee) numbers.

**Numbers of qualified health visitors employed by the NHS in England** (Source: NHS Digital, NHS figures only)

At start of health visitor implementation plan, January 2011:	<b>7906</b>
Lowest point July 2011:	<b>7546</b>
At the end of health visitor implementation plan: Oct 2015:	<b>10,309</b>
July 2017:	<b>8440</b>
July 2018	<b>7852</b>

## 6. Access to other services

Face to face meetings with GPs: 8% meet with GPs weekly or fortnightly; 27% monthly, 12.5% bimonthly; the remaining 40% who answered this question only occasionally, or as needed.

*We should be in the NHS working more closely with GPs. We are health not social services.*

Research indicates that one of the most valued aspects of the health visiting service for families is support to navigate and access support or services (the 'service journey'). Responses indicate that health visitors find services increasingly fragmented and difficult to engage on behalf of their clients.

## 7. Risks for the future

- Unidentified need, fueling increased demand for services;
- Fragmentation of services;
- Inconsistency in standards;
- England left behind rest of UK (for example, in Scotland increasing the numbers of health visitors by 500 (2015-2020) and capping caseload numbers);
- Loss of confidence in the profession by the public and other statutory services as the service is diluted and no-longer being 'for everyone' and with many health visiting services being delivered by other members of the team without professional health visitor training;
- Loss of confidence by the profession with practitioners leaving, feeling their role has become unsafe but without a supply of newly qualified practitioners due to changes in funding;
- Cynicism about government commitments to prevention, the health and welfare of children; and parity of mental and physical health services;
- Only health visitors routinely seek out vulnerable children across the **whole** population under age 5, but they are increasingly unable to do so. The Children's Commissioner (2018) has identified the growth in 'invisible' vulnerable children.

## 8. Conclusion

The decline in the numbers of health visitors in England since 2015 is spectacular and shocking due to its impact on the service that children and families are receiving and on the working lives of health visitors themselves.

Devolved administrations in the UK are strengthening health visiting through increased number of mandated visits, capping caseloads and increasing their health visiting workforce. Whilst, NHS England has determined "*a renewed focus on children's services, and prevention and inequality as they affect children*", as well as the prioritising of mental health. Health visiting is crucial to this ambition. However, it faces yet another round of cuts to the public health budgets in 2019/2020 in England and commissioners are currently trying to decide how to apply these!

Urgent action is needed - even to start to turn this around now would take at least 2 years, requiring reversal of public health cuts, renewing professional confidence in commitment to the universal preventative approach and stabilising reduction in training places.