Institute of Health Visiting
Excellence in Practice

State of Health Visiting, UK survey report

A vital safety net under pressure

9th iHV Annual Health Visiting Survey: data year ending November 2022

When families are supported, babies thrive and all of society thrives[1]

Publication date: 18 January 2023

Contents

The Institute of Health Visiting is a Centre of Excellence:

- Supporting the development of universally high-quality health visiting practice;
- so that health visitors can effectively respond to the health needs of all children, families, and communities;
- enabling them to achieve their optimum level of health, thereby reducing health inequalities.

Acknowledgements

We would like to thank everyone who took the time to complete our survey this year – we surpassed our target with 1,323 responses. This report presents key messages from our survey findings and valuable 'frontline practitioner intelligence' from health visitors working directly with families across all four nations of the United Kingdom.

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Publication date: 18 January 2023

Foreword by Alison Morton

Executive Director Institute of Health Visiting

"When families are supported, babies thrive and all of society thrives."

Our 9th annual survey findings provide a significant weight of evidence on the changing needs of families with babies and young children, and the state of health visiting in the UK.

Health visitors have been described as the '**backbone of the early years… a safety net for all families**'[2] . All families have a health visitor – through their universal reach, health visitors have a privileged and unique view into the lives of babies, young children and their parents/ carers across the UK. Health visitors' experiences presented in this report provide an important 'early warning signal' of the most pressing threats and challenges to the health and wellbeing of our youngest citizens who are often hidden behind front doors and invisible to other services.

Babies can't speak, but they do have a voice if only we will pause, and observe, and listen. Our survey findings tell their story through the experiences of health visitors who see babies and their vulnerability first hand. They amplify a message of widening health inequalities and escalating levels of population need, including parental stress and mental health problems that pose serious risks to children's future health, development and wellbeing. What happens in the earliest years of life matters as lifelong health inequalities take root in early childhood - it is therefore vitally important that, amongst so many other pressing policy priorities, we do not overlook their needs.

The findings also paint a deteriorating picture of a health visiting workforce under immense pressure as practitioners struggle to meet the scale of rising need. Families are facing the brunt of these challenges with a widening postcode lottery of health visiting support across the UK. As is sadly often the case, this affects the most vulnerable people who may struggle to access services and depend on them the most. The responsive, 'real-time' data presented in this report are a gift to policymakers as they will take many months, if not years, before their longer-term impacts on health and wellbeing are visible in any national dataset.

We publish at a time of ongoing uncertainty that will make matters worse if unheeded, with families facing the most serious cost-of-living crisis in decades[3] with ever-increasing health inequalities[4]. The whole of the health and care system is also struggling to rebuild in the wake of the pandemic. As health visitors often work alone, or in small teams in families' homes, their work is often hidden and it's easy to overlook how important it is. The NHS backlogs regularly hit the headlines, but they are only one part of the legacy left by the pandemic on the healthcare system; less high-profile backlogs of care and unmet need in health visiting services have been overlooked within a 'baby blind spot'[5] in national policy which will leave equally serious challenges for both mental and physical health for babies, children and families across the UK, now and in years to come.

Few disagree that every child deserves the best start in life, but at the moment too many children are missing out. To realise this ambition for all children, regardless of where they live in the UK, all agencies need to work together across the health and care system, and at every level of government, with the political will and investment needed to turn the 'best start in life' policy into reality. **It is not too late to change direction and pursue reforms, but the situation is serious.** We hope that this report, with its rich frontline practitioner intelligence and hard data on the pandemic's ongoing legacy, provide a 'tipping point' for action.

When families are supported, babies thrive and all of society thrives.

Alison Morton
iHV Executive Director

Executive Summary

Key messages from the State of Health Visiting, UK survey report (January 2023)
The largest UK survey of health visiting

1,323 responses

from practitioners working in health visiting between 26 September and 2 November 2022.

We received responses from health visitors in all four UK nations and every local authority region in England.

Rising needs and widening inequalities:

Health visitors reported that more families experienced stress, mental health problems, poverty and adversity over the past 12 months, posing serious risks to children's future health, development and wellbeing.

91% of health visitors reported an increase in **poverty** affecting families

91% of health visitors reported an increase in **families needing food banks**

83% of health visitors reported an increase in **perinatal mental illness**

75% of health visitors reported an increase in **domestic abuse**

47% of health visitors reported an increase in **families skipping meals as a result of the cost of living crisis**

56% of health visitors reported an increase in **homelessness and asylum seekers**

Health visitors have witnessed first-hand the impacts on children's safety, health and development:
A child's early years are crucial for their life chances as lifelong health and development inequalities take root in early childhood.

84% of health visitors reported an increase in children with **speech, language, and communication delay**

76% of health visitors reported an increase in **child behaviour problems**

65% of health visitors reported an increase in children with **autism (or signs of autism)**

48% of health visitors reported an increase in **child development problems**

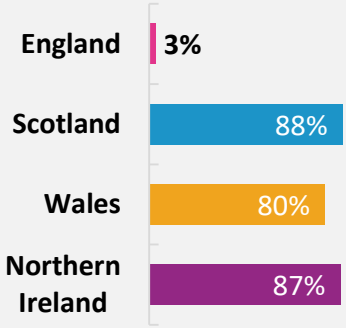
46% of health visitors reported an increase in children with **infant/ child mental health problems**

60% of health visitors reported further **increases in child safeguarding** over the last 12 months (building on increases reported last year).
Health visitors in England also raised serious concerns that **national data mask increases in child safeguarding**, as:

- Children living with significant risk and vulnerability are **not detected** as services are cut
- Social workers' caseloads are capped to a maximum - growing numbers of children living with significant risk and vulnerability now **fall below higher thresholds**.

A health visiting service struggling to meet the scale of rising need:

The level of health visiting support that a family received in 2022 varied between areas and across the UK nations. Babies, children, and families faced a 'postcode lottery' and many did not get the support they needed.



Only 3% of health visitors in England provide all families with **continuity of health visitor**.
This contrasts with:
88% in Scotland
80% in Wales
87% in Northern Ireland

Only 7%

of health visitors in the UK felt confident that all families would be able to **access the support they needed when a problem was identified**

The biggest barriers to making a difference were:

85% of health visitors reported there are **not enough health visitors**

86% of health visitors reported there is **not enough capacity in other services to pick up onward referrals**

64% of health visitors reported that prioritising the most vulnerable/ safeguarding, leaves **little or no time for prevention/ early intervention work**

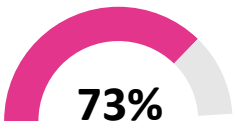
35% of health visitors recognised that the **service was inaccessible** for some families, and this created a barrier

Impacts on the UK health visiting workforce:

Many health visitors experienced work-related stress and burnout, with reduced job satisfaction.

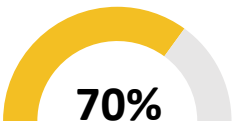
78%

of health visitors in the UK stated that their **stress levels had increased in the last 12 months**



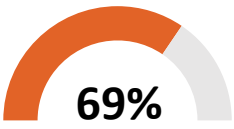
73%

of health visitors in the UK stated there are **not enough filled student health visitor places** to maintain their health visiting workforce supply needs



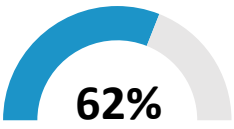
70%

of health visitors in the UK reported feeling **'worried, tense and anxious'**



69%

are working longer hours



62%

are feeling demotivated

A workforce crisis in England

Due to workforce shortages in England, many babies and young children missed out on vital health reviews and were not seen by a qualified health visitor:

1 in 5 children in England are missing out on vital health and development reviews

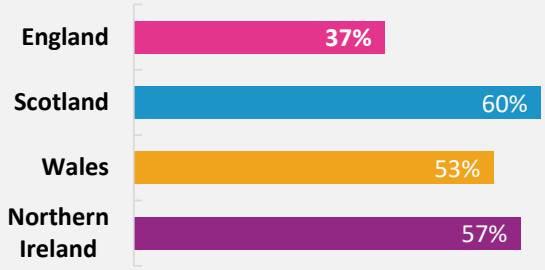
1 in 4 children in England are missing the 2-2½ year review

Only 13%
of health visitors in England are able to deliver the **antenatal contact to all families**

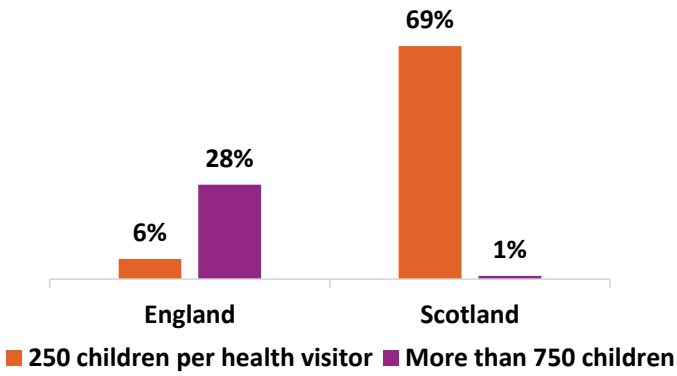
Only 54%
of health visitors in England are able to deliver the **6-8 week postnatal review to all families**

Only 15%
of health visitors in England are able to deliver the **9–12 month review to all families**

Only 12%
of health visitors in England are able to deliver the **2–2½ year review to all families**



Only 37% of health visitors in England feel confident that they are providing a 'good' or 'outstanding service' that can adequately safeguard children.
This contrasts with:
60% in Scotland
53% in Wales
57% in Northern Ireland

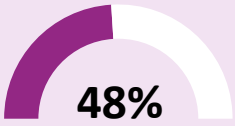


In England:

- **only 6%** of health visitors work with the recommended average ratio of **250 children per health visitor**
- **28%** have **more than 750 children**

This contrasts with Scotland:

- **69%** have **less than 250 children**
- **only 1%** report **750 or more**



of health visitors in England **intend to leave the profession in the next 5 years**

There is an estimated **shortfall of 5,000 health visitors in England** (↓ of **almost 40% of the workforce** since 2015).

There is currently no national workforce plan to fill these forecasted gaps or retain experienced staff.

It is not too late to change direction and pursue reforms, but the situation is serious.

Our main policy recommendations:

1. **Prioritise the first 1001 days of life** - a shared cross-government ambition and strategy for the first 1001 days is needed to improve health outcomes and reduce inequalities for babies, young children and families. This needs to be prioritised by the Treasury and seen as the smartest of all investments in our nation's future, rather than as a cost.
2. **A shift towards prevention and early intervention** is needed to support all people to lead healthy and fulfilling lives by addressing the key public health priorities that pose the greatest threats to our nation's health, thereby preventing debilitating and costly ill health in later life.
3. **Equity of access to support** is needed for all babies, children and families across the UK and an end to the current postcode lottery.
4. **System's thinking** – the benefits of an effective health visiting service accrue to numerous government departments and across a person's lifetime. Complex system's principles need to be applied across all aspects of health and care delivery, including workforce planning, funding and the development of measures that capture health visitor's input and impact across the system.
5. **Integrated clinical care pathways with significant 'front-loaded' investment in prevention and early intervention** are needed across health visiting, school nursing, midwifery, social care, General Practice, and early years, to ensure:
    - All babies, children and families are supported to reduce inequalities in key priority areas
    - All children at risk of poor outcomes are identified early
    - A continuum of support for a continuum of need is provided to achieve shared goals for key public health priorities for babies, children and families.
6. **Strengthening the health visiting service** requires a clear plan focused on the following three areas:
    - **Funding** - All areas need sufficient funding to deliver the full national specification for the health visiting service and preventative public health programme for children
    - **Workforce** - A demand-driven, well-resourced national workforce strategy is needed to increase the number of health visitors to address current and forecasted losses, and improve retention, job satisfaction and career progression for experienced staff
    - **Quality** - National government must do more to:
        - » support local authorities with resources to provide health visiting services at a level that delivers everything that government and NICE guidance expects of them, and that families need
        - » hold local authorities to account when services are not meeting national guidelines
        - » support the ongoing research, development and sharing of evidence-driven models of best practice based on proportionate universalism.

1.0 Overview of the iHV annual survey

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

Every year, the iHV conducts an annual survey to gain insights into the changing needs of families with babies and young children, and the state of health visiting in the UK. Our 9th annual survey was completed by 1,323 practitioners from across the UK between 26 September and 2 November 2022.

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

- families' stress, mental health problems, poverty and adversity
- child safety, health, wellbeing and development
- health visiting workforce and service delivery issues
- practitioners' support and development needs.

Sampling:
For a survey of this type, the response rate was extremely high which strengthens the reliability of the findings (sample size calculation: 95% confidence level; 2.5% margin of error).

Data analysis:
Numerical and text data were collected using a variety of open and closed questions and Likert rating scales. 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 provides us with 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:
We received responses from health visitors working in all four UK nations and every local authority region in England, with improved reach in the UK nations compared to previous years: most respondents (74%) were from England; 19.5% were from Scotland; and 3.25% were from Northern Ireland, which compare well with the population distribution across the UK. Proportionately, Wales achieved our lowest response rate at 2.5% (see Table 1). Most findings are presented as UK aggregate data. Where country-specific data are presented, we have indicated where these are 'England only'. Like all surveys, when interpreting the findings, it is important to remember that 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 between UK nations where the sample sizes are smaller.

Table 1: Percentage of survey respondents by UK nation compared to UK population

Nation	Percentage of survey respondents	Percentage of the UK population[6]
England	74%	84.3%
Scotland	19.5%	8.2%
Wales	2.5%	4.7%
Northern Ireland	3.25%	2.8%

Context:
Our survey was completed just over 2½ years after the start of the COVID-19 pandemic. At the start of the pandemic, we were told that it would be the 'great leveller', that we were all in the 'same boat' – sadly, health visitors are seeing first-hand that this is not the case. While the 'official line' is that the pandemic is over, in terms of health visiting practice, managing the aftermath of what has been left in its wake has barely begun. Over the last few years, our society has become more unequal, and the pandemic has exacerbated this by impacting those who were already disadvantaged the most. Alongside this, people are struggling with a cost-of-living crisis, families are worried about how they will heat their homes and feed their children, and inequalities are widening[7].

Health visiting has been described as the ***'backbone of early years services'*** and a ***'safety net' around all families'*** in a recent report, 'Early Moments Matter' by WHO UNICEF UK. However, despite this high-profile endorsement of the profession, our survey findings paint a picture of a workforce under immense pressure following years of disinvestment in some parts of the UK. As a result, families face a postcode lottery of support that is based on where they live, leaving many families without the vital support that they need during the crucial earliest years of a child's life.

Over the last year, numerous reports have highlighted the importance of 'giving voice' to those who often have no voice or are not being heard[8]. In 2022, like all previous years, babies remain the most vulnerable group in our society and although they cannot speak, they do have a voice that must be heard.

Sadly, some voices have been permanently silenced during the pandemic and we are left with the echo of their voices on the pages of numerous national reviews and inquiries[9] [10] that risk gathering dust amongst the libraries of previous reports, which carry similar messages over many years. As health visitors, we take our professional responsibility as part of the NMC Code[11] to advocate on their behalf seriously. At the Institute, it remains our mission to shine a light on the realities facing babies, children, and families in the UK today, in order to drive the change that is needed to give 'every child the best start in life'. Their voices and key messages are presented through the frontline practitioner intelligence set out in this report.

2.0 Survey findings

2.1 Rising needs and widening inequalities - families

The evidence is clear that a child's environment and experiences in the earliest days, weeks and months of life are critical to how their lives turn out and the kind of society we create[12].

Over the past year, health visitors across the UK have seen escalating levels of population need, widening health inequalities with an increase in vulnerability and safeguarding risks. Table 2 presents the increase in need and vulnerability reported by health visitors across a range of indicators.

Table 2: Percentage of health visitors reporting increased need across a range of indicators affecting families

Poverty affecting families	**91%**
Use of food banks	**91%**
Perinatal mental illness	**83%**
Domestic abuse	**75%**
Homelessness and asylum seekers	**56%**
Families skipping meals as a result of the cost-of-living crisis	**47%**
Substance misuse and/ or alcohol misuse	**39%**

2.1.1. Poverty:

The cost-of-living crisis is a growing worry for health visitors who are seeing daily the struggles that families are facing with soaring energy, food and housing costs. In this year's survey, a shocking **91%** of health visitors reported an **increase in poverty affecting babies, young children and families**. This is significantly higher than the proportion of practitioners making the same observation in Autumn 2021 (72%)[13]. It is also very concerning that 91% of health visitors are reporting **an increase in families needing food banks** - an increase of 19% in just one year.

In a recent interview, Professor Sir Michael Marmot stated 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."***[14]

Numerous recent reports have highlighted the myriad ways in which experiences of poverty impact on health and wellbeing[15] [16]. Cold and damp homes, due to fuel poverty, can worsen respiratory conditions, cardiovascular diseases, poor mental health, hypothermia and problems with childhood development – sadly, preventable deaths of children linked to poverty have been reported in 2022.

Poverty also affects food choices. The recent 'Broken Plate, 2022 report' by the Food Foundation[17] calculated that healthy nutritious food is nearly three times more expensive than obesogenic unhealthy products; one in five households would have to spend almost half their disposable income on food to achieve the government-recommended healthy diet. Babies and young children have very little agency over the content of their diets – this requires urgent attention as obesity in children is soaring[18] and will impact their quality of life now and in the future. Excess weight costs the UK approximately £74 billion[19] every year; the gap in life expectancy between the richest and poorest members of our society is widening and places a huge burden on our healthcare system and the wider economy.

Of the 4.2 million children in poverty in the UK, 1.3 million are babies and children under the age of five. The total number of children in poverty is predicted to rise to 5.2 million by 2023/24 – more than an additional one million children[20].

2.1.2 Families' stress and risk factors:

Health visitors reported increases in a range of factors that raise families' stress and pose risks to the health and wellbeing of babies and young children, including perinatal mental illness, domestic abuse and substance misuse (see Table 2). These findings support a growing body of research in this field – they are also presented in the recent 'Casting long shadows'[21] publication by the First 1001 Days Movement and the Institute of Health Visiting which reported that more babies and young children were exposed to stresses and adversity at home, and access to positive activities had declined.

To prevent Adverse Childhood Experiences (ACEs) in children[22], it is imperative that parents' needs, and the ways that they impact on parenting capacity, are mitigated with effective support and treatment. There is strong evidence that parents living with high levels of ongoing stress, mental health difficulties and attachment insecurity in their own childhood are more likely to find it more challenging to engage sensitively and positively with their child. Other risk factors include parental drug and alcohol use, young parents, looked after children, child maltreatment and homelessness.

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

What health visitors said about poverty and other risk factors:

> *Families have been severely impacted by austerity, universal credit, COVID and the on-going lack of good quality social housing. These social issues have had such a harmful impact upon parental mental health, child and infant physical and mental health, attachment, development and overall life chances and outcomes.*

> *The years of austerity and now the cost-of-living crisis for families has widened health inequalities and made our job more necessary, but also harder.*

2.2 Rising needs and widening inequalities – child safety, health and development:

Survey respondents were asked to provide information from their first-hand experiences of how children's health and development needs had changed over the last 12 months. The data paint a picture of rising levels of need and increased concerns for a range of conditions (see Table 3).

Table 3: Percentage of health visitors reporting increased need across a range of child safety, health and wellbeing indicators

Speech, language and communication delay	**84%**
Child behaviour problems	**76%**
Autism	**65%**
Child safeguarding	**60%**
Children subject to child protection plans	**52%**
Children subject to child in need plans	**51%**
Sleep problems	**50%**
Child development concerns	**48%**
Breastfeeding problems	**48%**
Infant/child mental health problems	**46%**
ADHD	**40%**
Childhood overweight/ obesity	**36%**
Growth concerns such as faltering growth	**33%**

2.2.1: Safeguarding:

Safeguarding is a thread that runs through all levels of health visiting, contributing to multi-agency networks to protect children (and in some instances their parents) from abuse and exploitation, and to safeguard their health and wellbeing. The Health Visiting Benefits Realisation review[23] concluded that the universal health visiting service was important to both safeguarding and child protection "because it safeguards all children".

Health visitors who responded to our survey told us that they are **deeply concerned about the rising numbers of child safeguarding cases and children living with risks of significant harm**.

In last year's survey, 71% of health visitors reported an increase in child safeguarding in 2021 compared to 2020. This year, **60% of health visitors reported a further increase in child safeguarding over the last 12 months**.

What health visitors said about child safeguarding:

> *The level of safeguarding is becoming **intolerable for health visitors** to cope with, we need more support.*

> ***Lack of early help service and inability to retain social workers has a big impact on our health visiting practice** and the families we support - increase in child protection, lack of continuity of social worker and less time for health visitors to focus on preventative work…. is a massive concern with the higher levels of need emerging.*

> *I have had no increase in child protection or child in need cases as the **thresholds are set so high**, however there is a massive increase in concerns and referrals to children's social care are **downgraded to early help which feels very worrying**.*

> *I left the health visiting service this year after 6 years… I was supporting and monitoring families who were very much at risk and in need of social care support, but who did not meet their thresholds. **I no longer felt like a public health nurse, but felt like a social worker**.*

National data on child safeguarding provide false reassurance:

In 2021, the number of children on Children in Need plans and Child Protection plans in England fell slightly compared with 2020[24]. Given the plethora of research that reports an increase in need and vulnerability for babies, children and families in the wake of the pandemic, and the pressures on universal services to meet the scale of need, this apparent reduction may be due to:

- Health visitors in England reported concerns that **child protection or child safeguarding cases are not being detected** due to practitioners' reduced contact with families and cuts to the number of health visitors – babies and young children who are distressed or at risk of significant harm are particularly vulnerable as they are largely invisible to other services without a robust health visiting service to identify them.

And

- **Social workers' caseloads are capped to a maximum number of children which masks rising levels of need.** Health visitors are reporting that the thresholds for children's social care are now much higher. Rather than falling levels of need, children living with significant vulnerability and risk now fall below this higher threshold, whereas in previous years they would have been supported by children's social care.

Babies are our most vulnerable citizens:

In line with previous years, the **rate of homicide remains higher for babies under one than any other age group**[25]. National data on serious incidents recorded for 2021-22 also reported that 39% of serious incidents of abuse, neglect and unexplained child deaths referred disproportionately to babies aged under one-year-old[26]. It is important to note that these figures only include notified serious incidents. Less is known about abuse that does not reach the threshold for being 'serious' or is invisible to services, and thereby leaves babies and young children without the support that they need which is known to be harmful[27] and has a cumulative impact on health and wellbeing.

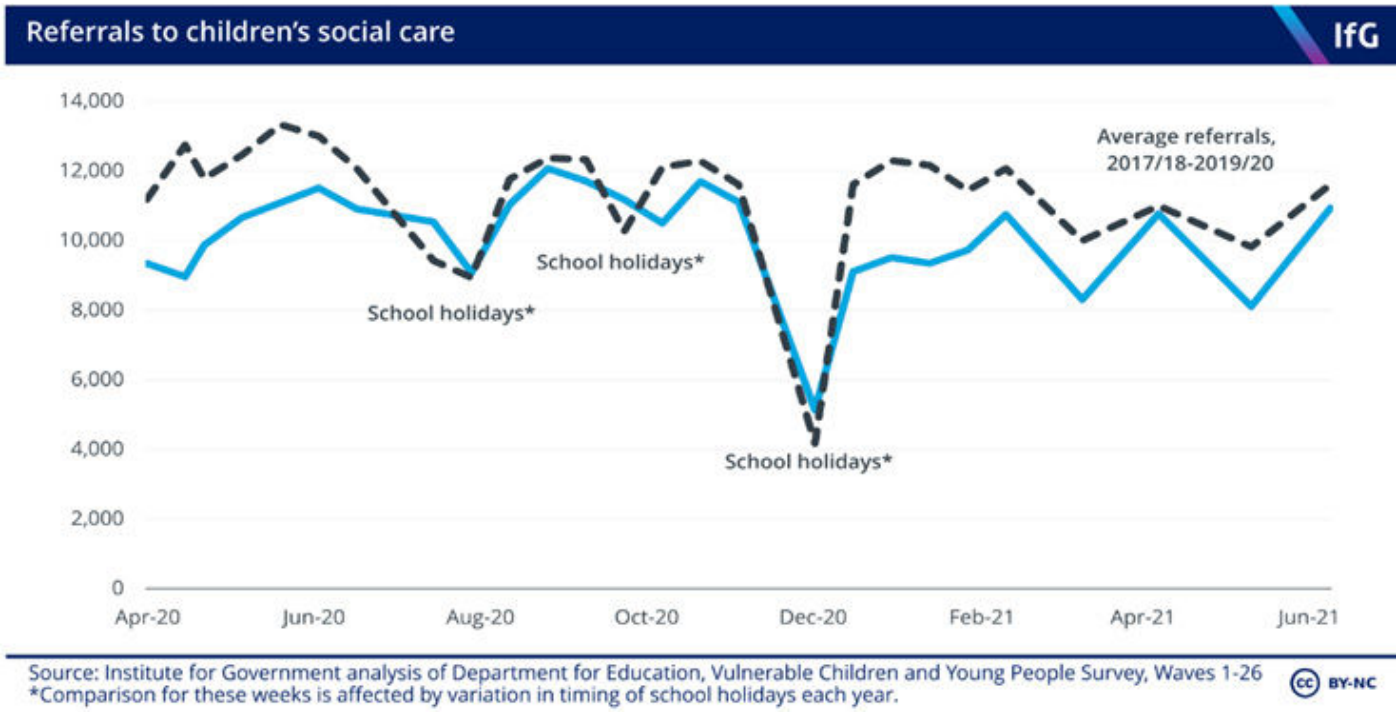
Even before the pandemic, the growing number of 'invisible vulnerable children' was recognised as a serious national concern - **2.3 million children in England are growing up with vulnerable family circumstances**, however, **more than a third are not known to local services**[28] and less than a fifth are being supported by children's social care.

The recent Child Safeguarding Practice Review Panel (2022)[29] highlighted the importance of information sharing between agencies:

'Practitioners need to be given the space and time to do quality work with the child [baby] and to critically reflect on the child's [baby's] experiences, including ***putting together the jigsaw of information*** *they hold about them and the network around them'.*

The graph[30] below (see Figure 1) highlights the important role that schools, and other adults, play in the identification of child maltreatment, with the number of safeguarding referrals increasing in term time and falling drastically in school holidays. This begs the question, ***"what about babies? Who is looking out for them and collecting the pieces of the jigsaw of information about them?"*** It is therefore imperative that we have a robust universal health visiting service that reaches all families as a safety-net mechanism to identify babies in distress whose parents/ carers may not have the agency to advocate on their behalf.

Figure 1: Referrals to children's social care 2020-2021: Institute for Government (2022)



2.2.2: Child health and development:

It is clear that the impact of the pandemic is not over for our babies and youngest children, and for many it has barely begun as hidden needs and developmental delay are only just starting to come to light. Recent research findings have shown that that babies born in the pandemic have fallen behind with their development and social skills[31 32], and this has disproportionately affected children from the poorest backgrounds the most.

What health visitors said about child health and development:

> *I am seeing children at 17 months not walking due to gross motor delay as a consequence of lack of space in inadequate housing; speech and social development impacted by lack of play and stimulation secondary to the harmful impact of poverty, deprivation and poor housing.*

> *We are seeing a huge rise in mental health problems with parents which is impacting on children. We are also seeing a huge rise in communication and social skills issues with children.*

> *Nightmare levels of poverty and domestic violence, along with a decrease in speech and language skills and children 'ready for school'.*

> *Massive increase in child development concerns - mainly communication and social skills, as we have come out of the pandemic, but also parents concerned about autism. Often conditions are not being picked up early as families are not accessing baby clinics… and we are not seeing children between 6 weeks and 1 year.*

Frontline practitioner intelligence from our survey, reinforces the most recent published national data on child development outcomes at 2-2½ years in England which show a worsening trend across all child development indicators when compared to 2019 data (see Table 4). While most children are developing as expected, a significant and growing minority are not, with fewer children at or above the expected level of development at 2-2½ years.

Table 4: Child development outcomes at 2-2½ years, Office for Health Improvement and Disparities

Child development outcomes at 2 to 2½ years	Percentage of children in England who received a 2-2½-year-old review who were at or above the expected level of development	
	Annual data 2021/22 – published November 2022	Annual data 2018/19 Published November 2019
Communication skills	86.2% (↓3.8%)	90.0%
Gross motor skills	93.1% (↓0.4 %)	93.5%
Fine motor skills	92.9% (↓1.1%)	94.0%
Problem-solving skills	92.4% (↓1.9%)	94.3%
Personal social skills	90.8% (↓2.1%)	92.9%
All five areas of development	80.9% (↓3.2%)	84.1%

This growing number of children with developmental delay needs addressing with the same level of attention that is being given to the NHS elective surgery backlogs - the findings equate to **an additional 13,060 children with delay in all five domains of child development** per annual birth cohort.

We also need to be concerned that **more than 1 in 4 children** (28.5%) in England **did not receive** their 2-2½ year developmental review in 2021/22 (reported in the next section), and their needs are currently unknown. In addition, there are concerns about data quality as some children who did receive the review had it completed over the phone which is much less accurate at identifying need than a face-to-face contact.

As a result, there will be a large group of children with developmental problems, or early signs of complex conditions, that **have been missed**. Services are now reporting that children with a range of issues like cerebral palsy, childhood deafness, vision problems, speech and language delay, and autistic spectrum disorders are being recognised much later[33].

Because child development skills are closely associated with children's educational attainment, future success and wellbeing, ignoring this issue risks undermining the life chances of so many children. Failing to act now will condemn them to starting school already so far behind their peers, thereby further widening the existing attainment gap and perpetuating a preventable cycle of intergenerational transmission of disadvantage.

2.3 A health visiting service struggling to meet the scale of rising need

The health visiting service's capacity to deliver the universal health visiting programme, and meet the scale of rising needs, varies considerably across UK nations and between local authority areas in England.

2.3.1 The universal health visiting service:

Each UK nation has slightly different policies, service models and schedule of universal contacts for their child health programmes starting in pregnancy and extending to support transition to school. The universal health visiting contacts are intended to provide a 'gateway' into the service and reach all families. During these contacts, health visitors work with families to:

- gain a shared understanding of families' needs and protective factors which change during this dynamic period of early parenthood;
- provide tailored support and anticipatory public health information;
- and identify babies, young children and families with additional needs, or at risk of poor outcomes, who would benefit from targeted support and early intervention to improve health and reduce inequalities.

The extent to which this is achieved varies across the UK. In particular, families in England are facing the brunt of years of underfunding and almost 40% cuts to the health visitor workforce, with a "**postcode lottery**" of support.

Our survey findings clearly show that **England is now an outlier** in terms of health visiting practice, with a considerably lower percentage of all universal health visiting contacts being completed by a **qualified health visitor** when compared with the other UK nations (see Table 5).

Table 5: Percentage of practitioners who reported that all universal reviews were completed by a qualified health visitor

Universal reviews	Percentage of health visitors in:			
	England	Scotland	Wales*	Northern Ireland*
Antenatal	13%	38%	0%	37%
New Birth Visit	76%	98%	87%	93%
6-8 week postnatal contact	54%	98%	73%	93%
3-4 months	4%	78%	13%	90%
6 months	2%	37%	60%	23%
9-12 month review	15%	79%	20%	80%
2-2½ year review	12%	76%	47%	83%
3+ year	1%	59%	33%	60%
*Caution: Due to smaller survey samples from Wales and Northern Ireland, comparisons between other UK nations may not be representative and require further testing				

Antenatal contact:
In line with the recent findings published in the Scottish Universal Health Visiting Pathway evaluation[34], our survey found that, despite the Scottish Government's investment in health visiting, the universal antenatal contact was not being offered to all families in Scotland. Across the UK, health visitors reported that the antenatal contact was not being prioritised and was frequently missed due to other workload pressures taking precedence. Further work is needed to explore the reasons for these decisions and raise awareness of the importance of the health visitors' antenatal contact, with investment to support its universal delivery. There is good evidence that the antenatal contact plays a crucial role in the development of a trusting relationship with families prior to the birth, improves the accuracy of the holistic health assessment of families' need and vulnerability[35 36 37,] thereby supporting early intervention and improving outcomes, and positively impacts parents' use of the service in the long term[38].

National health visiting metrics for England:
The annual health visiting performance metric data published by the Office for Health Improvement and Disparities (OHID)[39] present a very worrying picture. Whilst there have been small increases in the uptake of universal health visitor reviews in the England aggregate data, these mask **significant variation between the highest and lowest performing local authorities** (for example, uptake of the 6-8 week review ranges between 5.6% to 99.8% - see Table 6) and a shift in some areas to 'count' non face-to-face mandated contacts despite concerns being raised about the safety and effectiveness of this method of service delivery[40].

Table 6: Annual health visitor service delivery metrics, England

Annual health visitor service delivery performance metrics 2021/22 data (Mandated contacts: OHID, November 2022)				England 2020/2021 data
Type of contact	**Lowest performing local authority**	**Highest performing local authority**	**England 2021/22**	
New birth visit by 14 days	9.5%	99%	↓82.6%	88.0%
6-week review by 8 weeks	5.6%	99.8%	↑81.5%	80.2%
12-month review by 15 months	22.2%	99.1%	↑81.9%	76.1%
2-2½ year review by 2½	6.9%	98.8%	↑74%	71.5%
NOTE: reported data include both face-to-face and non face-to-face mandated health visiting contacts which make it difficult to provide commentary, or between area comparisons, on service quality or effectiveness.				

Postnatal reviews: It is concerning to see that in some areas there appears to be a trend towards later delivery of the health visitor new birth contact in England, with a reduction in the proportion achieved by 14 days following the birth – this is occurring despite a growing body of evidence that the first month of life represents the most vulnerable period for a baby[41]. The death rate of infants aged between 0 and 27 days inclusive (2.5 deaths per 1,000 live births) **remains at over twice that of the death rate for infants aged between 28 and 364 days** (1.2 deaths per 1,000 live births)[42].

The postnatal period also represents a period of heightened vulnerability and risk for woman or birthing parents. The recent MBBRACE report[43] highlights that mental ill-health and heart disease are now on an equal footing as the leading causes of perinatal maternal deaths in the UK. 32% of these women died during the period from the birth up to 6-weeks after pregnancy; 54% died between 6-weeks up to 12-months after pregnancy, with maternal suicide remaining the leading cause of direct deaths in this period.

Whilst we welcome the increased attention that is being given to improving the safety of maternity care following the Ockenden Review[44], **the fact that the majority of deaths occur after women are discharged from maternity services cannot be ignored and warrants much greater attention** and a similar level of investment in health visiting services. Investing in the health visiting profession will increase health visitors' capacity to identify risk factors and 'red flags' and support families in the critical postnatal period which will, in turn, save lives.

What health visitors said about their ability to deliver universal contacts to families:

A minority of respondents were positive about the level of service and support that they were able to offer families – the majority of these health visitors worked in Scotland, Wales and Northern Ireland:

> *I think the care to families in Scotland is excellent.*

> *The service is outstanding however given the vacancy level this is a difficult position to maintain.*

Health visitors across the UK highlighted that the increased emphasis on achieving high coverage of the universal contacts and the use of process performance metrics risked 'ticking the box but missing the point', with **statutory and mandatory functions prioritised to the detriment of early intervention and prevention services**. This remains an unresolved issue that has been highlighted in previous iHV surveys[45].

> *The Universal pathway ensures all children are seen repeatedly which is good. However, if caseload number is not manageable, then this results in identifying need that you then have no capacity to help with. If you take time (and families with trauma or lack of trust in services need a lot of patience and persistence if you are going to be able to help), then other assessments fall behind. But good work is defined as keeping up to date with assessments, meaning those most in need of support are missing out. We measure the wrong things.*
>
> Health visitor in Scotland

A few respondents in Scotland highlighted some limitations of the extended schedule of universal home visiting for all families, calling for:

> *a more tailored service with less 'routine' core visits and more specific care to those who need it.*

Universal 'drop-in' clinics: Many health visitors across the UK called for the reintroduction of drop-in health visitor clinics where these had been closed in some areas. This would make it easier for parents to access support between universal contacts, particularly families with the greatest needs who often struggle to access services the most:

> *In the deprived area I work in, a drop-in health visitor clinic would be beneficial to encourage parents to engage if they feel vulnerable in the home.*

2.3.2 Additional targeted health visiting – a 'postcode lottery' of support

We asked health visitors: **"If a need is identified, are families able to access the support that they need?"** UK data are presented as the responses were very similar across all four nations (see Table 7).

Table 7: Families' ability to access the support they need

If a need is identified, are families able to access the support that they need?	Percentage of respondents
Yes – all or most of the time	7%
Some of the time	83%
Hardly ever	9%
No	1%

Throughout the UK, health visitors have worked tirelessly during the last 12 months to ensure that families get the support that they need. However, **only 7% of health visitors were confident that families could always access the right support when they needed it** - our survey respondents highlighted a range of underlying causes (see Table 8).

86% of health visitors reported that there is not enough capacity in other services to pick up onward referrals and this impacts on their own workloads with unmanageable levels of unmet need. Our survey findings reflect the wider health and social care crisis across the whole of the UK with services struggling to manage increased demand and a growing backlog of unmet need[46 47].

Table 8: Key underlying causes for families being left without support

Key drivers for families being left without support	England	Scotland	Wales	Northern Ireland
Health visiting service lacks capacity to offer a package of support	70%	42%	60%	37%
Other Key Performance Indicators (KPI) are prioritised over identified need	56%	10%	13%	24%
Not enough capacity in other services to pick up onward referrals	85%	90%	80%	80%
Services inaccessible for families	31%	45%	33%	47%

Health visitors said that families were being left without support and there was an expectation that health visitors would plug the gaps left by other overstretched services:

> *The local authority lacks capacity - Children's Social Care and Early Help Workers have strict thresholds to reduce the need on their service.*

> *Huge increase in demands on HV service due to shortfalls in other areas in past couple of years.*

> *Children's social care in our area is in a dire state… Reports are not available on time and meetings are cancelled at short notice or without communication. This wastes precious HV time and is a risk to families. Other support services do not have capacity to support our families and work is not done… totally not in the interests of children and families.*

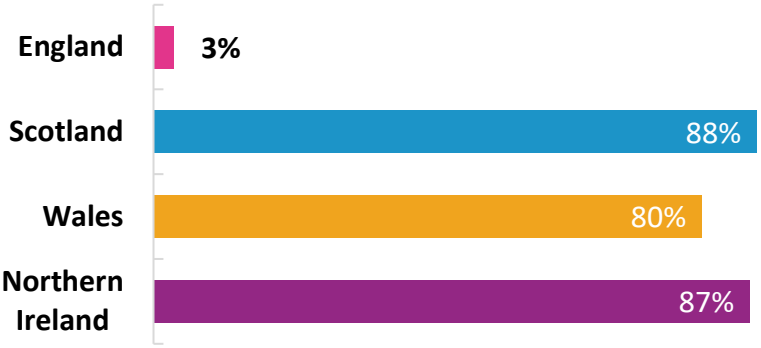
> *All other services discharge back to health visiting – including Community Psychiatric Nursing referrals for [parents with severe mental illness] who cannot travel to appointments which are always clinic based.*

Health visitors expressed concerns that, in some areas, services were moving further away from the underpinning evidence and mechanisms of change to improve health outcomes:

> *I don't think the leadership in health visiting really understand what early intervention work is aiming to achieve, or if they do they have lost sight of this….The focus is so much more 'medical model, monitoring, checking, ticking, policing, processes' and too much training for 'tick box purposes' rather than for meaningful changes in practice.*

> *Health visitors have little agency in their work…. and what we are trying to achieve is lost in process. I used to feel proud of what I do, and I don't anymore, I feel embarrassed. What is the point of identifying health needs when the system has nothing to support this?*

2.3.3 Continuity of health visitor:



Only 3% of health visitors in England provide all families with continuity of health visitor. This contrasts with:

- **88%** of health visitors in Scotland are able to provide continuity of health visitor to all families
- **80%** in Wales
- **87%** in Northern Ireland

Many health visitors in England were concerned about this shift away from 'relationship-based' practice that has repeatedly been shown to be an integral mechanism for delivering the safety-critical work of the health visitor which protects babies and young children from harm[48 49 50] and improves outcomes. Health visitors in England reported that the fragmented 'task-oriented' approach to universal service delivery, in some areas, was failing families:

> *We are drowning, we see universal families once for one hour. We are missing maternal mental health issues, domestic abuse, delayed development etc. We are failing a generation.*

> *Lack of continuity and opportunities to build relationships with families results in less job satisfaction. Also having to constantly offer a minimum service means you never feel like you have 'done a good job' and feel you are failing the families that need help. Constantly feeling like you could potentially end up as part of a serious case review for missing something or make a mistake due to lack of time.*

2.3.4 Child safeguarding:

We asked practitioners to self-rate the quality of their service in terms of how confident they felt about its ability to safeguard children:

- **43%** of practitioners rated their service as stretched and **'requiring improvement'**
- And **14%** rated their service as **'inadequate'** and feel so stretched that there **may be a tragedy** in their area at some point.

Only 37% of health visitors in **England** felt confident that they are providing **a 'good' or 'outstanding service'** that can adequately safeguard children. This contrasts with:

- **60%** in Scotland
- **53%** in Wales
- **57%** in Northern Ireland

2.3.5 Biggest reported barriers to 'making a difference' within the health visiting service

A resounding **85%** of health visitors in the UK stated that the biggest barrier to making a difference to babies, children and families was the fact that there are **'not enough health visitors'** (see Table 9). Other barriers to 'making a difference' were also linked to the reductions in health visitors, including staff sickness, as well as time-consuming IT systems and administration, resulting in less time available to support families.

Table 9: Reported barriers to making a difference

Not enough health visitors	85%
Too much time spent on administration reduces direct contact with families	68%
Prioritising the most vulnerable/ safeguarding leaves little or no time for prevention/ early intervention work	64%
Lack of capacity to support families with needs identified at the universal contacts	63%
Lack of time to deliver community-based initiatives	62%
Impact of wider determinants, for example, housing, poverty, employment, crime, environment	57%
Sickness absence within workforce	57%
People don't fully understand who health visitors are and what they do	48%
Lack of continuity of carer impacts on relationship building	44%
Insufficient administration support	41%
Families who are "hard to engage" or "seldom reached" with the health visiting service	39%
Not enough skill mix staff	34%
Lack of professional autonomy to plan personalised care	24%
Time needed to supervise, line manage and train skill mix workforce	23%
No barriers	1.8%

2.4 Impacts on the health visiting workforce

2.4.1 Workforce wellbeing

The increased pressures of working during the COVID-19 pandemic, alongside worsening workforce shortages and rising levels of need, have had a significant impact on health visitors' wellbeing[51 52].

78% of health visitors in the UK stated that they had experienced increased levels of work-related stress in the last 12 months.

70% of health visitors reported feeling worried, tense and anxious. Health visitors also reported low mood, feeling demotivated, and were worried about the impact of stress on their physical health (see Table 10). This requires urgent action to prevent more health visitors leaving the profession.

Table 10: Impacts of work-related stress on health visitor wellbeing

70% feel worried, tense and anxious	69% are working longer hours	48% are not sleeping well
62% are feeling demotivated	55% are worried about the impact of stress on their physical health	34% are managing stress by comfort eating
53% are worried about how stress from work is impacting on their own role as a parent and partner	50% are experiencing low mood because of work stress	33% are struggling to concentrate at work
20% are accessing services: mental health/ counselling/GP for support of their emotional wellbeing as a direct result of stress at work		

60% of our survey respondents also stated they are very concerned about the cost-of-living crisis:

- 76% of health visitors in the UK report that they are 'worse off' financially due to cost-of-living crisis
- 69% of health visitors in the UK report that they will manage this by cutting down on heating and 53% will cut down on other essentials.

Voices from practice highlighted the following concerns about their wellbeing:

> *I retired earlier than I intended because of the impact of work-related stress, a lot of my colleagues are not in my position and have to soldier on.*

> *The workload has increased - greater severity of problems in families… Staffing has decreased due to retirement, sickness, people moving out of health visiting to reduce stress. Burnout from 2 years of working at full capacity in isolation with little recognition from management.*

> *I am taking a career break after being a HV for 10 years, the pressures have increased. Expectations from the trust, public and other professionals is unrealistic.*

> *Currently work 7 days per week to meet safeguarding needs / report writing.*

> *The lack of hope for a better future, particularly for vulnerable children and families in a massively broken wider system, is a deeply depressing daily occurrence and the impact this has on staff is underestimated.*

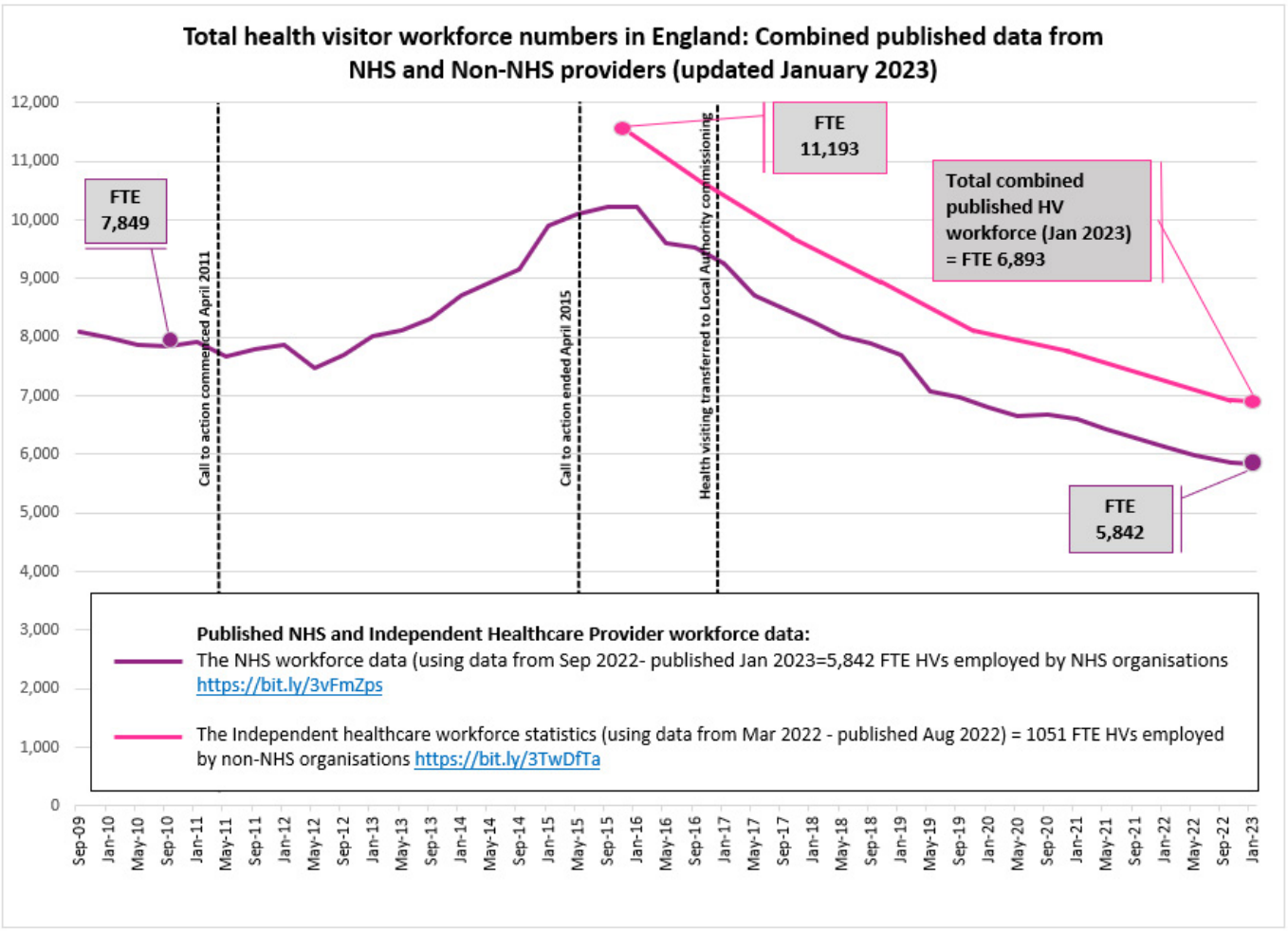
2.4.2 Workforce shortages (in England)

86% of health visitors working in England who responded to our survey reported that, in the last 12 months, the number of health visitors had decreased where they worked; in contrast, only 2% reported an increase. Greater demand for support, alongside month-on-month reductions to the numbers of health visitors, have negatively impacted on staff wellbeing and absence – this creates a vicious cycle that drives further workforce losses if unaddressed, making workforce planning all the more urgent.

Workforce shortages were the single biggest challenge facing the NHS and the wider health and care system well before COVID-19[53]. Further workforce losses have continued unabated during the pandemic, and England now **faces the biggest health visitor workforce crisis in living memory**.

An economic report published in June 2021, estimated a shortfall of 5,000 health visitors[54] in England. Since this calculation, the profession has sustained a further reduction of 912 full time equivalent (FTE) health visitors across both NHS and non-NHS providers (see Figure 2) representing a **loss of almost 40% of health visitors in England since 2015**[55 56].

Figure 2: Health visiting workforce numbers in England (NHS and Independent healthcare providers)



Factors contributing to the decline in health visitors in England:

- Insufficient funding in the Public Health Grant to deliver the Health Visiting model for England. The biggest costs are staff costs, and this leads to prioritisation or scaling back of the delivery model which must be managed within the budget. Even with more recent uplifts in cash terms, the **public health grant in 2021/22 was 24%, or £1 billion, lower in real terms** compared to 2015/16[57].
- A reduction in student health visitor training places since 2015. Health visitors across the UK reported concerns about insufficient health visitor training places (see Table 11).
- High rates of staff attrition.

Table 11: Student health visitor training places

Question	UK	England	Scotland	Wales	Northern Ireland
In your area, are there enough filled student health visitor places to maintain your health visiting workforce supply needs?	No 73%	No 79%	No 59%	No 80%	No 44%

2.4.3 Workforce forecasting

Effective workforce planning ensures appropriate levels of staff are available to meet supply and demand projections to deliver safe, high-quality care. Creating an effective workforce requires an evidence-based workforce plan, including succession planning, to ensure sufficient workforce capacity[58].
Our survey findings highlight that the current workforce crisis in health visiting will get worse if not addressed:

- **17%** of health visitors in the UK are aged between 55-59, and approaching retirement age, compared to only 2% of health visitors in their twenties.
- **48%** of health visitors in England stated that they **plan to leave health visiting in the next 5 years** (see Table 12 for all UK nations' data).

Table 12: Health visitors' intentions to leave the profession across the UK

	England	Scotland	Wales	Northern Ireland
I plan to remain in health visiting	25%	32%	25%	33%
I plan to remain in health visiting with career promotion in the profession	23%	17%	30%	44%
I intend to leave health visiting in the next 1-3 years	34%	28%	25%	20%
I intend to leave health visiting in the next 3-5 years	14%	21%	10%	3%

Whilst there are known limitations in reported 'intention to leave' responses, even if the actual forecasted losses were only half the reported percentages disclosed in our survey, this still represents a serious workforce issue that requires urgent attention to mitigate its consequences.

The reasons for leaving, or remaining in, the health visiting profession are predictable[59] and supported by research[60]. The findings from our survey reinforce this evidence which shows that those joining health visiting often have a psychological motivation for the professional role – they stay in the job because they believe that they can make a difference to children and families' outcomes; and professional autonomy, particularly in the complexity of health visitors' work, enhances job satisfaction. In contrast, health visitors leave the profession when these are lacking and also due to poor career progression opportunities, work-related stress and retirement.

Recent national data[61] on 1,032 health visitors who left the profession in 2021 and 2022 reported that the main reasons for leaving the profession were:

- Retirement: 281 health visitors
- Voluntary resignation - work-life balance: 138 health visitors
- Voluntary resignation - reason not recorded: 63 health visitors
- 'Unknown' was recorded for 297 health visitors- this formed the largest listed category.

The Government's commitment to prioritise the recovery of health visiting[62] will require several approaches to improve workforce capacity and support the recruitment, retention, and career progression for health visitors. It is therefore vital that we hold onto the health visitors we have in post currently and start to create opportunities for health visitors to return to practice. Bringing trained health visitors back into the profession by understanding and addressing the reasons why they have left will also be an important first step to improving health visiting workforce numbers for the future.

It is reassuring to see that a quarter of health visitors in England want to stay in the profession and a further 23% aspire to progress through career development and promotion within health visiting. Research[63] has shown that light touch retention initiatives, such as giving nurses enough flexibility at work and looking after their training and professional development, helped the NHS retain almost 1,700 more nurses and midwives. Some retention initiatives include:

- Advanced clinical practice
- Leadership development
- Continuous Professional Development
- A compassionate and inclusive culture
- Improved professional autonomy
- Valuing of health visitors as highly-skilled Specialist Community Public Health Nurses
- Rebuilding workforce wellbeing.

2.4.4 Manageable workloads

We asked health visitors to calculate the average number of children per full time equivalent (FTE) health visitor in their total 0-5 population to provide a comparison between areas (see Table 13. Note: comparisons were not possible for Wales and Northern Ireland due to small sample sizes; adjustments for deprivation are also needed when interpreting the findings).

Only 6% of health visitors in England reported they have the recommended average ratio of 250[64] children aged 0-5, or less, per FTE health visitor; **compared to 69% of health visitors in Scotland**.

Table 13: Ratio of children 0-5 per full time equivalent health visitor

Ratio of children 0-5 per full time equivalent health visitor	England	Scotland
250 and under	6%	69%
251-500	36%	28%
501-750	30%	1%
751-1000	17%	0%
More than 1000	11%	1%
This information is not known to me	26%	9%

Due to corporate working arrangements, it is a concern that over a quarter of health visitors in England do not know the actual number of children that they are accountable for. Health visitors lead the delivery of the Healthy Child Programme and are accountable for all children 0-5 years on their caseload, including those that have episodes of care and tasks delegated to the health visiting skill mix team.

Some health visitors reported that soaring ratios of children 0-5 per health visitor are masked by only counting families requiring targeted support, or with complex needs, on the health visitor's caseload – in some areas all health visiting universal assessment contacts are being managed by practitioners who are not health visitors after only one 'snapshot' assessment by a health visitor.

> *Our caseloads consist of a list of vulnerable children. Health visitors only work with vulnerable children in our areas and the Band 5 nurses and skill mix team complete the universal contacts. The health visitor will always do the first visit, either the antenatal or new birth visit and then if assessed as universal – will be allocated to a community health nurse. Allocation takes place every week and we are under pressure by management to 'step down' families on our caseload so we can take new allocations and so it goes on…*
>
> Health visitor in England

2.4.5 Wellbeing Support

Health visitors reported that they received support for their wellbeing from a range of places:

- 72% get support from family and friends
- 54% get support from colleagues sharing an office
- 41% get support from child protection supervision
- 36% get support from their manager

What health visitors said about sources of support:

> *I used to feel well supported with informal support from colleagues in the office, but am now hot desking at various venues and some working from home. So I am now working in a solitary way which often feels lonely and difficult when managing stressful families.*

> *I feel that our team lead and manager actually have a negative effect on myself. They do not give you support when you ask for it. I have lost faith in the NHS and I have worked for them since I was 21.*

2.4.6 Clinical supervision

Access to workplace supervision can improve patient care, reduce work-related stress and improve staff wellbeing. We asked health visitors if they were able to make time to attend scheduled clinical supervision sessions and whether they considered it to be of good quality (see Table 14).

Only 30% of health visitors reported that they are always able to access good quality clinical supervision. The figures are low considering the extreme pressures of the job. Health visitors reported that when supervision was not prioritised, this was due to high workloads – in some areas, supervision had been cut or was not readily available.

Table 14: Health visitors' access to clinical supervision

Yes, all the time, and the support I have is good quality	30%
Yes, some of the time, and the support I have is good quality	28%
No, hardly ever but when I do have supervision, the support is good quality	9%
Yes, all the time but the support I have is not good quality	7%
Yes, some of the time, but the support I have is not good quality	7%
No, hardly ever but when I do have supervision, the support is not good quality	4%
No, never	8%

Comments from practice:

> *I would like access to clinical supervision, but this isn't available in my locality.*

> *Restorative supervision was cut from the service support offer in the last year.*

> *The current model used for safeguarding supervision is no longer of any value in regard to dealing with the complex families… [it] is too informal and has now combined with restorative supervision in which no families are actually discussed, this creates more anxiety in regard to the next serious case review.*

3.0 Practitioners' reflections

3.1. Professional pride

Despite extreme workforce pressures, many health visitors took the opportunity to say that they loved being a health visitor and were proud to be part of the profession:

> *Would promote this as an excellent career choice.*

> *I have been a Health Visitor for 31 years and still feel passionate about it.*

> *Since discovering health visiting as a student nurse in 1982, I knew this was the job I wanted to do. I have been lucky that health visiting has been my career. The best job in the world and I would encourage this as a career for others.*

Our 2021 state of health visiting report highlighted how health visitors felt that their role was poorly understood. Many health visitors wanted better recognition of health visitors' skills, experience and vital contribution to child and family outcomes as Specialist Community Public Health Nurses. These comments were repeated in this year's survey findings:

> *To raise the profile of health visiting - That there is a greater awareness in the general population of the essential role of the HV.*

> *Better understanding of prevention and respect of our knowledge/ skills from the local authority commissioners and government.*

To start to address this, the iHV has produced infographics on '***Who are health visitors and what do they do?'***[65] for all UK nations. A series of short films[66] were also launched in December 2022 to promote health visiting.

The film ***'Health visiting in your community***' captures the voices and stories of parents with a wide variety of different needs – they speak powerfully about the difference that the health visitors' care and support made to their family when they needed it most. The film also captures health visitors' passion and sense of pride in the profession that makes such a difference to families.

The film has been widely shared and received high profile endorsements from:

- Chief Nursing Officer for England
- Chief Nurse for NHS Health Education England
- Chief Nursing Officer for Scotland
- Chief Nursing Officer for Wales
- Deputy Chief Nurse & Head of WHO Collaborating Centre for Public health nursing, Office for Health Improvements and Disparities (OHID) England
- Chairman of the LGA Community Wellbeing Board
- UK Committee for UNICEF (UNICEF UK)

The link to the film can be shared on local health visiting websites and is available to view here.

Alongside our main film, the iHV has also produced a shorter film '*Voices from practice*'. In this 2½ minute film, some of the health visitor 'stars' from our main film share a bit more about why they chose to become a health visitor and what the role means to them. Watch here.

3.2 Health visitors' priorities for the future

Health visitors were asked if there was one thing that they could change about the future of health visiting, what would it be? Their top responses included:

- More health visitors (substantially, the most frequent response)
- More funding
- Return of 'drop-in' clinics
- Return to face-to-face contacts
- Smaller caseloads
- More continuity of carer
- Higher pay scale
- Raise the profile of health visiting.
- Improvements in IT and documentation so there is more clinical time available to spend with families

Here are some specific comments from all 4 nations:

England

"Return of drop-in clinics"

"Capacity to allow for early intervention and support children and families in interim whilst awaiting further assessment"

"Increase public perception of a health visitor"

"Redesign the documentation platforms so that it is easier and quicker to keep up with record keeping"

"We need more health visitors"

"Be able to offer more continuity - seeing the same families from antenatal through to starting school"

"Increase SCPHN student places to build up workforce to ensure adequate staffing levels"

"Go back to face-to-face and not virtual contacts"

Scotland

"Promote it as a profession and adequately fund it"

"A commitment to training more HVs so caseloads could be managed. I would like to see a return to the full pathway in Scotland but only when the staff resource allows it"

"Stop using HV as 1st Level buffer for lack of Social Worker /Child Safeguarding role"

"Reduce the documentation. It would free up so much time for patients and stop HVs from working excessive unpaid hours"

"A drop-in health visitor clinic would be beneficial"

"Reduction in hours spent record keeping with inadequate IT systems. Increased HV numbers. Management with a background in Health Visiting"

Wales

"Greater appreciation from Government and the public of the fantastic job they do. Plus, more staff please!"

"Those who select for training: a more diverse range of people from different ages, backgrounds, and genders… and make sure they know what the job entails so that when trained they stay in the profession"

"The role of the Health Visitor is promoted and that families and the community understand our role".

Northern Ireland

"Lower caseloads and continuity of care to aid relationship building"

"Smaller caseloads and with vacant caseloads being filled and not added to your already large caseload"

"Better recognition of our role and how good continuity of HV staff hugely benefits families accessing our service. Higher band of pay given our responsibilities"

"More appreciation for the work we do"

4.0 Conclusion

Our survey findings paint a bleak picture of a health visiting workforce under significant pressure. Health visitors across the UK have reported soaring rates of increased need for babies, young children, and families, exacerbated by the ongoing impacts of the pandemic and cost-of-living crisis. At the same time, many health visitors are reporting that there are insufficient health visitors to meet the scale of rising need.

This is being felt most acutely in England, as health visitors are battling to deliver a service following a reduction in the number of health visitors of almost 40% since 2015. Consequently, many families are not receiving the support that they need, and this is being intensified by a lack of capacity in other health and social care services who are also experiencing extreme pressures.

It is not too late to change direction and pursue reforms, but the situation is serious. There is now unequivocal evidence that the current rate of health visitor workforce attrition, and insufficient training places to plug the forecasted gaps, is not sustainable and will jeopardise the delivery of all UK Governments' child health programmes. In England, the Government categorised health visiting as one of six priority services in its Start for Life Vision[67] for the first 1001 days. However, this commitment is at risk without investment and a plan to rebuild the health visitor workforce.

Without wanting to scaremonger, it only requires simple maths to calculate that the health visiting profession in England will cease to exist in 15 years if the current rate of workforce loss is not addressed. This cannot be ignored any longer as the inevitable knock-on impacts are already being felt across the health and care system[68], the costs of late intervention are soaring[69], and the recent Inquiry into the murders of Arthur Labinjo-Hughes and Star Hobson recognised:

"*The issue of **capacity in health visiting** services is a **national concern** and merits further attention*"[70].

WHO UNICEF-UK[71] has described health visiting as the '**backbone of the early years… a safety-net for all families**' – and a large coalition of more than 200 organisations working with children has called for urgent reinvestment in health visiting[72].

There is some good news - the value of the health visiting profession has been recognised in Scotland and its government has invested £40 million to recruit and train an additional 500 FTE health visitors to deliver the Universal Health Visiting Pathway (UHVP) which offers 11 universal contacts to families[73].

A longitudinal study of the UHVP[74] in Scotland reported positive outcomes, with:

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

In Wales, the Government has expanded the Flying Start model and introduced the Healthy Child Programme Wales Quality Assurance Framework[75], and Northern Ireland is currently updating their Healthy Child Healthy Future programme[76].

Health visiting in England is facing the brunt of disinvestment right now with no plan from the current government to address the workforce crisis. In autumn 2022, health visitors welcomed the opposition government's pledge to rebuild health visiting, with a Labour Party manifesto commitment to train 5,000 more health visitors[77].

Improving child health requires a '**whole system integrated approach**' as prevention and intervention cut across a range of professional groups. No one organisation provides the complete solution. It is also now widely recognised that the benefits of an effective health visiting service accrue to numerous parts of the health and care system, although they often take many years to materialise in hard data[78] and extend well beyond the early years, laying the foundations for future health and wellbeing across the lifecourse.

'Prevention is better than cure'[79] , but investment so far has failed to match the rhetoric. Investment in prevention and early intervention makes sound economic sense, with well documented and robust returns on investment felt across society. Short-sighted policy decisions to cut prevention and early intervention in the earliest years of life cost more in the long run, with the cost of late intervention to society currently soaring at an estimated £23 billion a year[80].

When families are supported, babies thrive and the whole of society thrives.

It is not too late to change direction and pursue reforms, but the situation is serious.

5.0 Policy recommendations

1. **Prioritise the first 1001 days of life** - a shared cross-government ambition and strategy for the first 1001 days is needed to improve health outcomes and reduce inequalities for babies, young children and families. This needs to be prioritised by the Treasury and seen as the smartest of all investments in our nation's future, rather than as a cost.
2. **A shift towards prevention and early intervention** is needed to support all people to lead healthy and fulfilling lives by addressing the key public health priorities that pose the greatest threats to our nation's health, thereby preventing debilitating and costly ill health in later life.
3. **Equity of access to support** is needed for all babies, children and families across the UK and an end to the current postcode lottery.
4. **System's thinking** – the benefits of an effective health visiting service accrue to numerous government departments and across a person's lifetime. Complex system's principles need to be applied across all aspects of health and care delivery, including workforce planning, funding and the development of measures that capture health visitor's input and impact across the system.
5. **Integrated clinical care pathways with significant 'front-loaded' investment in prevention and early intervention** are needed across health visiting, school nursing, midwifery, social care, General Practice, and early years, to ensure:
    - All babies, children and families are supported to reduce inequalities in key priority areas
    - All children at risk of poor outcomes are identified early
    - A continuum of support for a continuum of need is provided to achieve shared goals for key public health priorities for babies, children and families.
6. **Strengthening the health visiting service** requires a clear plan focused on the following three areas:
    - **Funding** - All areas need sufficient funding to deliver the full national specification for the health visiting service and preventative public health programme for children
    - **Workforce** - A demand-driven, well-resourced national workforce strategy is needed to increase the number of health visitors to address current and forecasted losses, and improve retention, job satisfaction and career progression for experienced staff
    - **Quality** - National government must do more to:
        - » support local authorities with resources to provide health visiting services at a level that delivers everything that government and NICE guidance expects of them, and that families need
        - » hold local authorities to account when services are not meeting national guidelines
        - » support the ongoing research, development and sharing of evidence-driven models of best practice based on proportionate universalism.

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