Position Statement

Health Visiting and the NHS in the next 10 years

August 2018
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Recommendations

That health visiting is included in the 10-year plan with reinvestment to:

1. Build on the Marmot principle of proportionate universalism to tackle inequalities and shift the curve of demand on services;
2. Support the key leadership role of health visitors to lead the delivery of the Healthy Child Programme (HCP) with partner agencies – with strengthened joint governance mandated within a national quality framework for systems-based practice for child and family public health;
3. Provides a health visiting (HV) service sufficiently well-staffed, trained and supported to deliver a form of provision through which all children’s and families’ health needs and resilience can be reviewed and facilitated at key developmental phases/transition;
4. Resources health visitors to take a specific lead for infant and perinatal mental health; oral health, promoting good nutrition; improving the home learning environment and with it speech, language and communication skills of pre-school children; and for addressing child safety for the first 1001 days;
5. Ensure that health visitors take a lead for supporting the health needs of the most marginalised and vulnerable children whether as a result fundamentally of poverty, social exclusion, chronic health, special needs or other cause.

The Institute of Health Visiting (iHV)

The Institute of Health Visiting was established in 2012 to strengthen the quality and consistency of health visitor services. Since then, the Institute has achieved a great deal for the profession - creating a raft of best practice guidance, developing and delivering award winning training in a variety of key public health areas and, most recently, completing a recommended national curriculum for the profession. The Institute also works in partnership with a range of government, professional and third sector partners.

The Institute targets its activity to where there are gaps in provision, in areas of greatest public health need, or where the quality is challenged, i.e. where it can have the greatest impact by disseminating and implementing the latest evidence-based approaches. We believe that the areas where health visitors can have the most significant universal
impact are in promoting mental wellbeing of parents and infants (e.g., by reducing perinatal mental illness, strengthening parental relationships and interactions with children, identifying and supporting where there is domestic abuse and substance abuse), promoting the home early learning environment and the development of speech and language, advising on healthy nutrition, and by advising on child safety to reduce accidents. Furthermore, health visitors work in such a way as to support the resilience of all families, especially when affected by adverse economic and social circumstances including minority and marginalised groups and vulnerable and special needs children.

Over the past few years health visitors have told us that fewer families are receiving the services they need, due to falling staff numbers and an employer focus on Key Performance Indicators (KPIs) - rather than health outcomes – furthermore, they have suffered a loss of professional autonomy. This is against a backdrop of rising poverty and health need. They expect that even more children will enter school without the ability to speak and communicate clearly, with increased mental health concerns, with rising obesity, and will experience the need to use more expensive secondary care services as well as GPs. We are already seeing the burden this creates for other services down the line.

Health visitors, through their universal non-stigmatising service, were once the eyes and ears of the community, skilled at holistic assessment to identify risk and variation from the developmental norm early. However, due to the restructuring of services and the cuts to their numbers since they moved under local authority commissioning (at a time of cuts to the local authority public health budget), this function is now severely challenged.

**Health Visiting in 2018**

We welcome the initiation by Sir Simon Stevens, Chief Executive of NHS England, of a new 10-year plan for the NHS to be published later in the year. In particular, we welcome inclusion of priorities that were not part of the Five Year Forward View, notably:

“*a renewed focus on children’s services, and prevention and inequality as they affect children*”. as well as the prioritising of mental health.

This aligns fully with the intended work undertaken by health visitors at the heart of child and family public health services and as leaders in delivery of the Healthy Child Programme for families and children from before birth to 5 years of age.

The watch words for health and social care looking forward from 2018 are transformation, sustainability and integration. From 2011-2015, health visiting in England underwent a transformation programme of expansion and renewal through the ‘Call to Action: the Health Visitor Implementation Plan’ (DoH, 2011). A decline in the workforce was reversed with an increase of almost 50% health visitors in four years, and refreshing the service model summed up as a 4-5-6 model of delivery. Unfortunately,
the transfer of commissioning of the service to Local Authorities has seen these gains diminished and even reversed in some areas, with drastic workforce attrition (over 20% in 2.5 years amongst NHS employers (NHS Digital)) and weakening of the service model. This is largely explicable in terms of the cuts in local authority funding in general and specifically in the public health grant. It is also linked to fragmentation of services for families and children between local government, the NHS and other arms of public services. In other words, transformation has not been accompanied by sustainability and integration. Health visiting has become practically invisible in the NHS landscape because its concern is children and their families, whereas the overwhelming concern of the NHS and wider health and social care system, reflected in sustainability and transformation partnerships (STPs), is older-adult health and managing demand on the NHS to cope with the pressures, and on social care to cope with reduced budgets.

There needs to be an equivalent sense of collective urgency to focus on the health and wellbeing of children and families as a critical public health issue. That there are urgent issues is widely recognised. Recently, the Parliamentary Committee on Science and Technology has reported on the evidence of the impact of Adverse Childhood Experiences (ACE-s) on short and long-term health outcomes and the Health and Social Care Committee has launched its enquiry into the First 1001 Days from conception to age 2. Andrea Leadsom MP, Leader of the House of Commons, has been asked by the Prime Minister to chair a cross-Government working group set up to review how to improve the support available to families in the period around childbirth to the age of two – the first 1001 days.

There is a gap between knowledge of what affects child and family health and how services are commissioned and organised to implement this knowledge. What is required is that services are organised around the holistic needs of children and families in the circumstances where they live (that is an ecological approach), not the organisations themselves. Health visiting is a crucial service as well as a vital social connector between every family with a pre-school child and services and other community assets and resources.

Unfortunately, we currently have a fragmented system of service delivery for children, some more robust than others. Furthermore, there has been a race to the bottom in only providing the minimum (mandated) universal service of 5 health visitor led contacts from pregnancy to 2.5 years in most areas of the country, Blackpool being one exception with 8 universal contacts. Despite the Healthy Child Programme and national commissioning advice, local authorities have flexibility regarding how they commission their children’s public health service and are doing so in a large variety of ways, frequently substituting cheaper workers for health visitors. By contrast the Scottish Government has Getting it Right for Every Child (GIRFEC) supported by a legal framework. Wales has the Future Generations Act. In both countries, children and families are front and centre of policy from government to the local level, and health visiting has an assured place in supporting the health and resilience of families at their most formative times with health visitors themselves delivering all core universal contacts. A “renewed focus on children’s services, and prevention and inequality as they
affect children” in England is therefore timely and needs to be of sufficient weight to prevent children’s public health slipping down the agenda again.

We also welcome the renewed focus on mental health and inequalities more generally. These both apply to children from before birth onwards, directly and indirectly. Poor child health indicators such as low breast-feeding rates, obesity and dental decay reflect what Sir Michael Marmot calls the social gradient. Perinatal mental health difficulties have an impact on infant mental health, and hence contribute to a multiplicity of adverse outcomes including poor school readiness. The Healthy Child Programme (HCP) is strengthened by being led by health visitors who operate in the home and the community at the level of service delivery, and across professional, agency and provider boundaries at the level of service organisation. However, as stated above, this is increasingly challenged leading to more fragmented services for children that are subject to frequent changes due to re-tendering and procurement exercises.

Health visitors are presently located in a commissioning environment that militates against the kind of continuity of care and carer and other markers of quality that make for a successful service (Cowley et al, 2018a). But we recognise that the commissioning landscape is far from static and that emerging forms of integrated care systems and joint commissioning are finding ways of linking transformation, integration and sustainability, presently lacking for preventative child and family services. We offer our proposals in support of the 10-Year Plan for the NHS as an opportunity to stabilise, improve and integrate health visiting as a crucial contributor and enabler of “a renewed focus on children’s services, and prevention and inequality as they affect children”.

**Proposals for health visiting and the NHS in the next 10 years**

We propose that CCGs and LAs within the emerging forms of integrated localised joint commissioning should be required to have a joint investment and delivery plan for children and families, inequalities, prevention and mental health that:

1. Builds on the Marmot principle of proportionate universalism to tackle inequalities and shift the curve of demand on services;
2. Supports the key leadership role of health visitors to lead the delivery the Healthy Child Programme (HCP) with partner agencies – with strengthened joint governance mandated within a national quality framework for systems-based practice for child and family public health;
3. Provides a health visiting (HV) service sufficiently well-staffed, trained and supported to deliver a form of provision through which all children’s and families’ health needs and resilience can be reviewed and facilitated at key developmental phases / transitions;
4. Resources health visitors to take a specific lead for infant and perinatal mental health; oral health, promoting good nutrition; improving the home learning environment and with it speech, language and communication skills of pre-school children; and for addressing child safety for the first 1001 days;
5. Ensures that health visitors take a lead for supporting the health needs of the most marginalised and vulnerable children whether as a result fundamentally of poverty, social exclusion, chronic health, special needs or other cause.
We recommend a similar investment plan for the school-age population with SCPHN – School Nurses to lead the HCP and have an identified lead role supporting children and young people’s (CYP) mental health and wellbeing.

Investment is requirement for the whole service. Points 4 and 5 should have **specific funding** but be conditional on there being robust evidence of points 1 – 3 being in place. We would recommend that these specialists are also small caseload holders to make the role feasible.

**To explain further:**

1. **Build on the Marmot principle of proportionate universalism to tackle inequalities and shift the curve on demand on services:**

Preventative work is now seen as key to tackling a pressing raft of public health challenges in order to contain the long-term costs of failure to intervene ‘early’ and the demographic shift that accumulates a burden of ill-health on individuals, communities and the country’s economic performance. This is underlined by the ‘Five-year forward view’ (NHSE, 2014) according to which ‘the future health of millions of children, the sustainability of the NHS, and the economic prosperity of Britain all now depend on a radical upgrade in prevention and public health’. Marmot (2010) has demonstrated the health gains at population level to be achieved through improving health and reducing inequalities in the earliest years of life; and Heckman has depicted graphically the return on investment and the costs of failure (see Figure 1). Moreover WAVE (2013) has demonstrated that ‘early years’ interventions are a rare opportunity to spend money in a way that delivers social and economic benefits at the same time’ (p.101).

![Figure 1: The Heckman Equation](https://www.heckmanequation.org)

The ‘prevention paradox’, as outlined initially by Geoffrey Rose (2008), explains that the greatest impact will be achieved by addressing needs across the population as a whole in order to improve health. This is as well as by reducing the severity and number of cases with the greatest needs that make the greatest demands on public services over the long term.
This requires ‘proportionate universalism’ in the foundation years for which health visiting is a core component.

The evidence base drawn from epidemiology, and reviews of early intervention, underlines the strength of argument in favour of preventative approaches (Field, 2010; Allen, 2011). In particular, evidence suggests that the quality of early childhood experiences and relationships with primary care givers are of central importance (WAVE, 2013; Tickell, 2011). Also, key to promoting the quality of these relationships are the knowledge, skills and attitudes of the workforce engaging with children and families in whatever setting. Nutbrown (2012) underlines that it is the quality of the early years workforce and the settings that they create for children accessing care and/or education in the early years that promote better outcomes. Likewise, ‘Why Health Visiting?’ (Cowley et al, 2015, 2018b) underlines the critical importance of the quality of health visitor – client relationships to effective outcomes of health visitors promoting the health and social and emotional development of young children in the home by working with parents in the first 1001 days.

National standards based on expert peer review and evidence are now available for health visitors to deliver public health outcomes specified as six high impact areas (iHv, 2015).

There is consensus that early years services should adopt evidence-based practice and programmes. It needs to be remembered that this applies not only to specific interventions such as manualised parenting programmes, but also the overall shape of the service offered. According to the Harvard Center on the Developing Child, ‘Decades of brain science and developmental research suggest a three-tiered approach to ensure the health and well-being of young children’ to which, in the Health Visitor Implementation Plan (Department of Health, 2011), the community level of service delivery is added to strengthen community capacity. These four levels (community, universal, universal plus, and universal partnership plus) are based on sound epidemiological analysis of health inequalities and ‘proportionate universalism’ (Marmot, 2010).

The Healthy Child Programme, the evidence for which has recently been reviewed (PHE, 2015; EIF, 2018), includes five child health and development reviews mandated by the commissioning of 0-5 services by local authorities. Unfortunately, even this minimal service is not able to be delivered universally by health visitors due to under resourcing.

The six high impact areas for public health outcomes in the early years are those for which there is evidence of sensitivity to health visiting interventions and for which the health visiting workforce is well equipped to deliver.

The four levels of service delivery, five mandated reviews and six high impact areas combine to form the 4-5-6 service model of health visiting.

The WAVE Trust (2015) states that ‘1001-days’ strategies should be based on primary preventive principles that, applied universally, with particular emphasis on fostering mental/emotional wellbeing and secure attachment, and preventing child maltreatment.

The term ‘universal services’ has come to be understood in somewhat different ways within local authorities and the NHS and health visiting. This is more than a semantic difference
and is of importance because, while Local Authorities have a legal duty to promote the health and wellbeing of their populations, statutory provision of Children’s Services focuses on secondary preventative programmes and duties to safeguard and protect children at risk of significant harm. Shifting the curve of health need at population level requires an inclusive, universal reach which is embodied in the health visiting mode of practice and the HCP. This is summed up by Cowley et al, (2018b) as follows:

Universal health visiting takes a particular format. It moves beyond ‘availability’ in the sense of being there if wanted into actually delivering a specified service to all families, which enables primary prevention and health promotion. It provides a ‘safety net’ that is accessible without stigma and, while the service is universal, it is not uniform. The mandated provision is a base from which to vary the service according to the assessed health needs of families. By using this core service ‘offer’ to tailor information specific to each family’s individual needs, health visitors can draw on particularist principles (Carey and Crammond, 2017), provide differentiated help at the level of each family, acknowledging health, cultural and social situations to achieve a service that is proportionate to need (Carey et al, 2015). This enables health visitors to work towards reducing the social gradient of health inequalities by delivering services based on ‘proportionate universalism’, which is argued to be the key to reducing health inequalities (Marmot, 2010).

Based on this understanding, we advocate that the NHS can support effective work against inequalities in child health by underwriting this mode of practice within a commissioning environment that rebalances the terms of integration with children’s social services, early years provision and the range of child health services commissioned and provided by the NHS.

2. Support the key leadership role of health visitors to lead the delivery the Healthy Child Programme (HCP) with partner agencies – with strengthened joint governance mandated within a national quality framework for systems-based practice for child and family public health;

The Healthy Child Programme (HCP)
Across the UK, parents are offered a series of regular planned universal health visitor reviews of the health and development of each child in dialogue with their parents and family, often in the home. In England, this is the spine of the HCP (Department of Health, 2009) and led by health visitors. Families can expect different patterns of service delivery depending on where they live in the UK: in Wales there are 9 reviews; Northern Ireland, 7, with a planned increase to 9; in Scotland there are 11, all carried out by qualified health visitors. Both Scotland and Wales specify which reviews are to be carried out by a qualified health visitor, rather than a team member, which helps to ensure the quality of their programmes. The minimum in England is five key child development reviews:
• antenatal health visit;
• new baby review;
• 6 to 8-week assessment;
• one-year assessment;
• the 2 to 2½ year review.

These, together with health promotion, parenting support, screening and immunisation programmes (PHE, 2015) comprise the HCP led by health visitors for the 0-5 population. The Department of Health (2015) states:

It is also important to note the aggregated public health benefits of the range of family assessments and delivery of public health messages at key points during the first five years of a child’s life when they can make the greatest difference. The assessments undertaken by health visitors go beyond these specific activities … [T]he ‘return’ on such activity is that issues are tackled before they become more serious, impacting on families and/or impinging on costlier services. (Para 2.11).

It also states:

It is recommended that professional health visitors with specialist public health knowledge and clinical skills are used to deliver the 0 to 5’s HCP. (para. 2.3)

One key achievement of the Call to Action: the Health Visitor Implementation Plan, 2011-2015 was the beginning of a relatively consistent service nationwide, whilst allowing for local variation tailored to need. This was achieved by clear specifications, guided by evidence and focused around a single (‘4-5-6’) model of service organisation, with quality control from the centre. The 4-5-6 model was both an extremely helpful descriptor and open to criticism in two main aspects: its scope and only partial mandation.

In term of scope, the ‘community’ level of the model is rarely included in service specifications, despite its importance. Specifying only five health reviews is inadequate: Scotland, N. Ireland and Wales have the more evidence-based number of between eight and 11 reviews. Each of the six high impact areas is important, but other important aspects are omitted, such as oral health and smoking, whilst some encompass too broad an area to be helpful.

Only the five health reviews, rather than the whole service model, have been mandated and the regulation does not specify which professional must carry them out. Regulation holds health visitors accountable for delegation of reviews, although in practice they often have little choice or control over who undertakes many of these reviews. This stands in contrast to specifications in the other UK countries, which recognise the need for the particular skills of a qualified health visitor to carry out all health reviews. We comment further about skill-mix and the substitution of staff below (Section 3.3).

The HCP is a sound, evidence-based delivery vehicle for improving child health at individual and population levels. However, fragmentation of services for families and children between local government, the NHS and other arms of the public services since the implementation of the Health and Social Care Act (2012) and, in particular, the transfer of commissioning of health visiting in 2015 has weakened the governance that supports the HCP, which depends
on a number of strands being effectively coordinated. The Maternity Transformation Programme, General Practice Forward View and STPs have little to say about health visiting and preventative child health, but all are critical to the continued vitality of a child health strategy that works against the persistent challenges of health inequalities and the unequaled return on investment in the health of the earliest years of childhood.

At the operational level, health visiting has rebased its service model from GP attachment to being population/community based, better aligned with local authority Children’s Centre services often at the expense of links to the wider health system. According to the National Children’s Bureau (2012):

Collaboration of health visiting services with Children’s Centres would enable them to shift the curve of disadvantage and poor attainment by concentrating ‘specifically on pregnancy to three year olds, with an emphasis on language development for very young children and paths to employment for mothers and fathers [without which] [the risk is that without the light touch support and community capacity building that centres are particularly good at, more and more families will fall into the tail end of the curve, creating huge and costly problems for families and communities in the future.

(NCB, 2012: 8).

Recent reviews of children’s centre services (NCB, 2012) advocate greater emphasis on outreach. Integration of health visiting with early years services offers new opportunities. Health visiting is more than an ‘outreach’ service from Children’s Centres or other health or educational facilities: it reaches across boundaries determined by services and settings to engage with children and families where they live. Home visiting is a core element of health visiting alongside needs assessment and a positive orientation to health. Home visiting is associated with improvements in parenting and cognitive development, reduction in child behavioural problems and accidental injury, and improved detection and management of postnatal depression according to a recent review of evidence (PHE, 2015). Health visitors retain responsibility for children on their caseloads beyond age three - until they start school, after which the health component of their care transfers to school nurses.

A randomised controlled trial (RCT) in North Carolina demonstrated the preventive impact of universal home visiting by nurses similar to UK health visitors, specifically reducing the amount of emergency medical care through early assessment, identifying individual family needs, intervening briefly or connecting the family with targeted community resources (Dodge et al, 2013). PHE’s review of the evidence for the HCP in England also identified a number of ‘cross-cutting issues’ including: the identification of families with additional needs; matching needs and services; reaching the ‘hard-to-reach’; working with families, and family readiness to change; practitioner motivation and readiness to change; adopting evidence-based approaches with fidelity; and developing others within the workforce development. These characterise the core practices and service orientation of health visitors for which they are very well equipped to lead provided that they are adequately trained, supported staffed to do so (see point 3, below).
We propose that the NHS should act with others to strengthen the governance of the HCP across all partners through joint commissioning within a national quality framework for systems-based practice for child and family public health to realise the benefits of closer working with both NHS child health services and primary care and local authority services such as children’s centres. In such a context, health visitors are well equipped to fulfil more realistically their long-recognised mandate to both deliver in practice and to lead the HCP at system level.

3. Provide a health visiting (HV) service sufficiently well-staffed, trained and supported to deliver a form of provision through which all children’s and families’ health needs and resilience can be reviewed and facilitated at key developmental phases / transitions;

3.1 Staffing and workforce
A second key achievement of the Implementation Plan was development and recording of a ‘Health Visitor Minimum Data Set’ by NHS Digital. This was discontinued in October 2015, since when only the number of health visitors employed by NHS organisations and those returning workforce data through the Electronic Staff Record (ESR) have been published, which increasingly gives a very partial picture. The lack of accurate figures makes workforce planning extremely difficult, which is discussed further below. Despite its deficiencies, the NHS Digital dataset shows that the number of health visitors employed has fallen by over 20% since service commissioning transferred from NHS England to Local Government in Oct 2015 until April 2018, taking the numbers down below what we would consider to be safe levels of coverage.

The national workforce figures offer one illustration of how deeply the public health funding cuts have affected health visiting (see Figure 2). The vast majority of our interactions with members are about concerns around service cuts and re-tendering exercises. These contacts mirror the experience of health visitors and service managers, who spend huge amounts of time in competing for contracts.
The number of health visitors employed outwith the NHS is not routinely published. The lack of accurate figures makes workforce planning extremely difficult.

In October 2015, sufficient funding was transferred on a ‘lift and shift’ basis to Local Government to cover a flat ‘minimum floor’ of one full time equivalent (FTE) health visitor to 300 pre-school children. The Advisory Commission on Resource Allocation (ACRA) was engaged to advise about how to deal best with higher need and vulnerable first-time mothers. They recommended children in low income households receive a weight per head of four times higher than children not in low income households (Department of Health 2015).

We recommend that caseload size should not exceed 250 children per FTE health visitor or a maximum ratio of 1:100 in more deprived areas. We also recommend that there is not an over emphasis on employing newer, less experienced health visitors to save money, as experience really counts in health visiting practice. There needs to be an equal emphasis on preceptorship, reflective practice, supervision and continued learning for all health visitors.

3.2 Education and training

There are pressing immediate risks to the sustainability of health visiting education due to the combination of the impact of disinvestment by local authority commissioners in the
workforce, marginalization from the NHS, and the imminent cessation of HEE funding of programmes and salary replacement costs for students.

The prospective Apprenticeship funding model is still under development and is poorly understood in the sector. A pre-apprenticeship recruitment pipeline is not well established. Apprentices are paid at Band 4 which is a disincentive to recruitment of nurses and midwives employed at a minimum of Band 5.

Currently, maintenance of the nursing or midwifery entry point is a required underpinning for health visiting practice. However, we believe a new entry gate should be considered that selects those parts of nursing and midwifery needed but has a longer period focused on public health and health visiting. This could be at Masters level for existing graduates with the right academic background, e.g. psychology, life sciences. We have at least one university willing to test this, and it is a model which was to some extent available pre the graduate nursing courses introduced in the 90s, when it was possible to integrate a 3-year graduate programme in life, social or biological sciences alongside an 18-month nurse training to graduate first with a BA or BSc and then as a nurse, and finally as a health visitor or district nurse. Many of our nurse leaders of today undertook such programmes.

It should be noted that since 2004, the title Health Visitor has been no-longer legally protected in England. This leaves the public without assurance of the level of training and accountability of practitioners providing a ‘health visiting’ service, when trust is critical to effective relationship formation and receptivity to support and advice in the home and elsewhere.

3.3 Skill-mix and staff substitution

There is evidence that parents are happy to receive a full range of health visiting services from a range of staff, providing the service is well co-ordinated with teams working collaboratively. They wish to ‘know’ and develop a good relationship with a staff member and feel their health visitor knows them, in order to ensure the service they receive is tailored to their specific needs. (Donetto et al, 2013)

Although positive user experiences are valuable, there is a lack of UK evidence about the impact on health outcomes from using staff who are not qualified as health visitors to carry out functions, such as health reviews, where a particular, complex skillset is known to be needed. One trial from the Family Nurse Partnership provided evidence that using paraprofessionals, whose background and training levels were similar to those of UK-based Community Nursery Nurses, showed significantly poorer outcomes from the programme (Olds et al, 2002).

Health visitors are trained to develop a relationship with families whilst carrying out a full assessment of health needs, drawing on their broad public health knowledge and primary care ability to provide brief interventions, plan future provision, matching needs and
supporting access to more intensive input or alternative community resources. Community staff nurses, children’s centres workers and community nursery nurses are all highly valued team members, but they do not have this specialist preparation and should not be used as substitute health visitors rather to supplement them by delivering health visitor determined interventions in the home.

The weight of evidence on what makes a successful health visiting service is based on studies of qualified health visitors rather than skill-mix teams (Cowley et al, 2013) and it is on this basis that the Health Visitor Implementation Plan investment was undertaken and which informs the current enhancement of the service in Wales and Scotland. The evidence also suggests improved outcomes when there is matching of need with services and / or other community resources and assets. This requires sustained relationships with assessment of need at key transitions and developmental phases.

3.4 Staff support and supervision

The capacity to attend and be responsive to the needs of young children and their carers requires health visitors to maintain personal and professional resilience - to remain courageous and compassionate as well as proficient when working with families experiencing vulnerability and mental distress. The support and supervision of health visitors, including a restorative function, is key to the quality of professional relationships, judgement and decision making. We are told this has been generally lacking since the transfer to local authority commissioning.

4. Resource health visitors to take a specific lead for infant and perinatal mental health; oral health, promoting good nutrition; improving the home learning environment and with it speech, language and communication skills of pre-school children; and for addressing child safety for the first 1001 days;

5. Ensure health visitors taking a lead for supporting the health needs of the most marginalised and vulnerable children whether as a result fundamentally of poverty, social exclusion, chronic health, special needs or other cause.

Perinatal and infant mental health are inextricably linked. Commissioning Guidance (PHE, 2016) states health visitors: identify and support those who need additional support and targeted interventions (for example, parents who need support with parenting and women suffering from perinatal mental health issues including postnatal depression in accordance with NICE guidance) and promote secure attachment, positive parental and infant mental health and parenting skills using evidence-based approaches.

The initial antenatal visit in the HCP provides a relational basis for assessing perinatal mental health for mothers and fathers and supports parents to ‘mentalise’ their unborn child, laying the ground for parental bonding.

Commissioning guidance includes the expectation that health visitors assess mental health at the New Birth Review, at 6-8 weeks and at 3-4 months making use of evidence-based
tools and the skills that support a trusting relationship that is key to sharing concerns at a vulnerable time of life. This highlights the importance to the planning and commissioning of health visitor services that the five mandated elements form a minimum baseline, potentially leading on to a fuller health visiting service provision where required.

Updated NICE (2014) guidelines highlight key contributions of the health visitor in the recognition of mental health problems in pregnancy and the postnatal period and referral, assessment and care planning in response to a suspected mental health problem in pregnancy and the postnatal period, and providing interventions as appropriate. The guidelines underline the importance of providing “culturally relevant information on mental health problems to the woman and, if she agrees, her partner, family or carer”.

Health Education England (2016) has recommended that every health visiting service should include at least one Specialist Health Visitor (PIMH). Specialist Health Visitors in Perinatal & Infant Mental Health (PIMH) are health visitors with post-qualifying training and experience that equips them to fulfil specialist clinical, consultative, training and strategic roles on behalf of health visiting services within the fields of Perinatal and Infant Mental Health. They have a crucial role within multi-disciplinary pathways delivering effective mental health care to mothers, fathers and their infants during the perinatal period and usually up to the baby’s second birthday or beyond. They provide specialist training and consultation to the wider health visiting and early years workforce, where they are highly valued. With properly funded, protected time for this work Specialists have been successful in establishing and developing services and integrated working, thereby improving outcomes for families. However, there are still few Specialist Health Visitors (PIMH) posts in health visiting teams across England.

We recommend health visitors take a specific lead for infant and perinatal mental health as a starting point, but there are other high impact health issues for which health visitors are well equipped to make a substantial difference to child health, prevention and inequalities. The further appointment of an overarching health visitor consultant with the responsibility of researching and quality assuring local services would also be beneficial. We also recommend that this approach should be considered for School Nurses and child health, particularly in light of the government’s aim to increase capacity for mental health support in and around school communities.

However, we argue that the contribution of focused health visitor input is predicated on points 1-3 in our proposal, embracing the evidence for universal, primary prevention with proportionate levels of response and support.

To this end, we encourage the development of commissioning arrangements for a joint investment and delivery plan for children and families, inequalities, prevention. The release of additional monies should be based on quality indicators reflecting all five elements of this proposal within an overarching strategy to link integration, sustainability and transformation in the life-chances and outcomes for children and families.

**Conclusion**
There is a logic to health visiting being commissioned by local authorities, along with other public health services, that re-establishes historic roots in local communities and public health. However, realisation of the potential benefits requires that health visiting also be firmly integrated with the NHS as part of the wider nursing family. Health visitors are registered specialist community public health nurses and constitute a distinct profession grounded in their service orientation and core practices that provide a personalised child and family public health approach to prevention and health inequalities that affect children and future generations. Planning for the next ten years of the NHS affords the opportunity to establish a national quality framework for systems-based practice for child and family public health to realise the benefits of integration of health visiting with both the NHS and local authority services and the wider landscape of provision. In this context, the powerful principle of proportionate universalism, upon which health visiting is predicated, can be realised at system level to prevent ill-health, enhance health outcomes for children and families, working to level the social gradient of health inequalities, and to reduce demand on secondary and tertiary level services with the social and economic return on investment that this brings.

The faltering health visiting workforce will need to be stabilised and strengthened. However, with the right education and training, staffing levels and support, the profession is well equipped both to deliver and lead the full scope of the Healthy Child Programme. There are many opportunities to make good recent fragmentation and to establish fuller integration with both the NHS and local authority services and systems. Dedicated leadership by health visitors will realise the benefits of this in respect of specific child and public health issues such as perinatal and infant mental health, as well as specific groups and settings.

**Success factors**

As an aid to charting what is required for such a programme of change and development we propose the following as success factors alongside linking the impact of that success to the National Outcomes Frameworks:

- Marmot principles based in proportionate universalism adopted systemically and culturally across commissioners and service providers.
- National quality framework for systems-based practice for child and family public health that links with wider agendas including Maternity Transformation Plans, STPs, General Practice Forward View, Best Start in Life.
- Healthy Child Programme is underpinned by shared governance mandated by local commissioners working to national quality framework.
- An indicative clinical governance framework is developed to provide assurances that information and interventions offered to the public are evidence-based and appropriate for intended beneficiaries, balancing criteria of fidelity to evidence with acceptability.
- System performance is evaluated at system level to assure full scope of HCP, i.e. HCP is not only measured by KPIs tied to 5 mandated reviews.
- Mandated 5 reviews are increased to 9 and seen as a minimum floor, not an aspiration.
o Resources are matched to need by building on current modelling in Scotland and Wales and recent work in England for the HV implementation plan.

o The workforce is stabilised and strengthened by taking remedial action consequent upon an urgent impact assessment of the introduction of the Apprenticeship funding route for entrants to the profession.

o Work towards caseload size not exceeding 250 children per FTE health visitor or a maximum ratio of 1:100 in more deprived areas.

o Try to maintain a balance of experienced health visitors and newer health visitors

o There needs to be an equal emphasis on preceptorship, reflective practice, supervision and continued learning for all health visitors.

o An additional ‘dual qualification’ route to registration as a nurse and health visitor is developed and trialled as an attractive career route for graduates wishing to have an impact on the life-chances of future generations.

o Research is commissioned to identify the merits of optimal skill-mix and appropriate education, training and support for health visiting teams.

o Specific clinical leadership roles are developed, resourced and evaluated to support service development and good practice at service level, beginning with perinatal and infant mental health.

References


