# Briefing Paper

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## The Role of the Health Visitor

- The health visitor is an experienced public health professional who, following qualifications in nursing and/or midwifery, has successfully completed further education and training, often at Masters Level to enter the profession. S/he is regulated by the Nursing and Midwifery Council (NMC) and must abide by its Code of Conduct.
- The health visitor 'brand' is valued, trusted and respected by mothers/fathers and families.
- The service provided by the health visitor is available to all, irrespective of their situation.
- This means that access to a health visitor does not carry stigma. People from all walks of life will have a health visitor during pregnancy and /or early parenthood.
- Health visitors work in partnership with mothers/fathers and families to help them to understand the value of, access and use health and other services.
- The focus of the health visitor's work with children and families is to promote and protect health and well being and prevent ill health.
- The health visitor role is entrenched in public health with a key focus on tackling inequalities, social exclusion and promoting the health of children, families and communities through early intervention and enduring preventive work.
- The health visitor often works in situations which are complex and lack clarity, and she/he is skilled in holistic assessment which enables her/him to identify hidden as well as visible needs.
- Health visitors draw on a social model of health that focuses on promoting resilience and building on an individual child's, parent's or family's strengths.
  **(CPHVA http://www.unitetheunion.com/pdf/contributionHV.pdf)**
- Specifically, Health Visitors are recognised as the professional lead for the Healthy Child Programme (HCP) and for safeguarding vulnerable children.

## The National Problem

The role of the health visitor has been severely compromised nationally by a shortage of staff. Since 1998 there has been a drop of 12.95% in WTE health visitors whilst; the population has grown by 4.65%, the number of live births has increased by 8.51%

There has been a drop of 15.4% in the number of WTE health visitors between 2004 and 2009, but this is the average. The CPHVA have uncovered areas which have reduced numbers much more dramatically than this, with some areas cutting numbers by 50% and above (Unite the Union 2008, 2009). In August 2008 40% of health visitors had responsibility for over 500 children and 20% of over 1000 children (Adams & Craig, 2008). Figures from the 2010 annual survey, as yet unpublished, show the situation has worsened considerably.

- CPHVA/Unite believes on average health visitors should be responsible for 250 children and no more than a maximum of 400 children in areas of very low vulnerability. The number should be around 100 in areas of high vulnerability, such as in inner London.
- The 2008 NHS staff survey (Care Quality Commission 2009) showed that health visitors (of all the staff groups in primary care trust results) were:
  - o 80% working unpaid over time (2nd worse group KF9),
  - o Reported the highest level of work pressure felt by staff (KF6);
  - o And only 45% of health visitors felt satisfied with the quality of work and patient care they were able to deliver (KF1).

  - o least likely to recommend their trust as a place to work (KF34);
  - o had the lowest levels of job satisfaction (See appendix p.9 (KF32);
  - o reported the second worse communication between senior managers and staff (KF29);
  - o had 41% of staff suffering from work related stress in the last twelve months (2nd worse result, KF19);

Given these findings from 2008 and 2009 it is difficult to see how the NHS London strategy, of making 30 funded places available in a return to work campaign, targeting health visitors who have left the profession, will be successful

- The Netmums.com survey 'Left fending for ourselves' (Russell 2009) found that:
  - 46% of mums only saw their health visitor once or twice in the 8 weeks following birth;
  - After 8 weeks, 49% of mums were not invited in to see their health visitor nor visited at home by a health visitor in the first year following their initial visit;
  - 59% of parents wanted to see more of their health visitor;
  - 70% said they wanted to see one health visitor, who knew their family, rather than being seen by different individuals from a team;
  - Only 5% of mothers would prefer to see a 'parent support worker' or children's centre staff (and that was only for some issues);

## The Problem in London

Due to high levels of vulnerability and a highly mobile and diverse population in the London region the national shortage of health visitors is magnified leaving health visitors struggling to cover basic work such as visits to mothers who have recently given birth. The DH workforce census of whole time equivalent health visitors for Sept 2009 shows a worsening picture.

Lambeth was ranked worst primary care trust in England by the Family and Parenting Institute in 2009. Here there were only 33 WTE health visitors each with a caseload of 894 under-fives; in 2009, there were 30.

In Waltham Forest where there had been a 40% cut in health visiting numbers are plummeting from 43.6 WTE in 2000 to 26.1 in 2008. A recruitment drive failed as health visitors chose to work in other locations. School nursing was also cut in this area and numbers are down from 10.4 WTE in 2007 to 6.8 in 2008.

Hounslow have seen health visiting numbers drop from to 18 WTE in 2007 down from 37 WTE. There was a further fall in 2008 with a record low of 15 WTE, with new birth visits taking up to four months instead of the recommended ten to 14 days with an impact on breast feeding figures. Recruitment has improved here, with 21.68 health visitors currently in post, but a local authority scrutiny panel reports that the ratio of children to health visitors averages 1: 983, with health visitors in one team carrying responsibility for the equivalent of 1457 children each (London Borough of Hounslow 2010).

In Barking and Dagenham they failed to train the nine student health visitors promised and numbers fell from 33 WTE in 2007 to 20.5 in 2008 against a rising birth rate leaving health visitors struggling with caseloads of 763 plus. The future for parents and children in this PCT is looking dire as numbers in 2009 (DH) have fallen to an all time low of 11 WTE HVs.

Haringey PCT had only 34 WTE in 2007 but in 2009 the numbers fell again to 32 WTE health visitors, where there should be 45-60. In spite of evidence from America (Olds et al 2002) that visiting by paraprofessionals was not as effective as visiting by specially trained nurses yet in Richmond non-health visiting staff are conducting birth assessments and in Barnet nursery nurses running group health visits for one year-olds.

(Source: Family and Parenting Institute 2009. See appendix (p.10) for caseload numbers)

In Enfield caseloads are getting bigger and 'demoralised' health visitors are leaving, some to work in neighbouring Haringey where the PCT are carrying out a recruitment drive to attract more health visitors since the 'Baby Peter' inquiry, leaving only 36 WTE in 2009. They are offering higher salaries on a Band 7. Health visitors are generally paid at a Band 6 level.

In Enfield according to a local CPHVA representative the two student health visitors have left their training due to lack of support. For figures for London from the Family and Parenting Institute please see appendix p.8. They show significant variation and clear pressures in some parts of London. There is an expectation that every PCT will publish HV caseloads in the Autumn (Ioannou 2010). It is clear from these figures that some PCTs have been able to improve the situation with health visiting numbers but others fail to do so with the situation seeming to worsen.



Health Visiting in London

The latest figures for 2009 that have been published by the Department of Health (See appendix p.11) show again that some PCTs have been successful in increasing their establishment of WTE health visitors whilst others have failed spectacularly. Newham, Sutton and Merton, Lewisham and Redbridge have all made significant increases whilst Barking and Dagenham, Wandsworth and City and Hackney have all seen a sharp fall in health visitor WTE numbers.

## The Risks to Families and Children from Low Health Visitor Input

- The present deficits within the health visiting work force put the universal application of the Healthy Child Programme at risk.
- 10% of children are now considered to suffer with diagnosable mental health issues, but many might have been prevented by early intervention in the preschool years. There is clear research evidence that the first two years of a child's life is very significant to the child's future mental wellbeing but most families now receive minimal contacts with a health visitor during that period as part of the universal service (Cowley & Adams, 2009).
- University of Sheffield research showed that new mothers developing postnatal depression would be helped if health visitors are trained to spot signs and offer psychological help. A recent Unite/CPHVA survey revealed that of the 829 health visitors interviewed, a third reported that they were not confident that their NHS trust's service allowed cases of postnatal depression to recognised. This research provides clear evidence for reinstating a properly resourced and trained health visiting workforce to address this debilitating illness. Untreated postnatal depression can have severe implications, not only for the mother but for her whole family. University of Sheffield researchers looked at 4,000 women. At the six or eight-week check, 600 women - 15% - were found to have signs of postnatal depression. This equates to some 100,000 women a year suffering from postnatal depression across the UK.
- Unite/CPHVA 14th annual survey (August 2008) found that 25.4% of the 829 health visitors interviewed said that the chance of a local child death similar to that of Victoria Climbie was either 'somewhat' or 'very' likely.
- Nationally, there has been a fall in pre-school referrals to speech and language therapy from health visitors from around 50% of all referrals received to 15%. (Royal College of Speech and Language Therapists 2009) It is a cause of concern, in that children's 'readiness to learn' on school entry is closely linked with their ability to communicate. In due course, this affects their adult health, so health inequalities and life chances.
- Witnesses for the Commons Health Select Committee report into Health Inequalities from 2008 found that " the 'early years' — and services provided to children and their families within this period — as potentially very important in tackling health inequalities." (p.87) "Health inequalities are addressed only if concerns are identified sufficiently early to prevent the infant from entering an adverse life trajectory, with established physiological and behavioural patterns, which might have been changed in the first months and years of life."(P.89)
- Some of the key factors in later health inequalities are issues that fall squarely within the role of health visiting: "Crucial factors include maternal smoking during and after pregnancy as well as alcohol and drug use; maternal diet during pregnancy; maternal obesity during pregnancy; infant and child nutrition; smoking in the family home; postnatal depression; and parenting skills. Breastfeeding was repeatedly emphasised by our witnesses — including the Secretary of State — as a top priority for reducing health inequalities, yet breastfeeding, in common with other lifestyle factors, follows a social gradient: only 67% of women in routine and manual occupations initiate breastfeeding compared with 89% of women in managerial and professional occupations. The differences are even more pronounced in terms of the duration of breastfeeding — only 32 per cent of women in the routine and manual socioeconomic group breastfeeding beyond six weeks, compared with 65 per cent in managerial and professional groups."(P.87)
- The health visiting workforce is vital to improving the health of children (Ioannou 2010)

## The Solution

- Commissioners for children's services need to make available a budget that will allow the employment of health visitors to the levels recommended by the CPHVA and Lord Laming i.e. 250 under fives per HV for low vulnerability and 100 under fives for high vulnerability areas.
- Training budgets must be made available so that adequate numbers of HVs can be trained in the future. NHS London have promised 100 places for the training from September. Although this is a start it is clearly inadequate to cover present staffing problems.
- Budgets need to be made available in order to train Specialist Practice Teachers in the field so that student health visitors can be placed with experienced and well-trained specialist health visiting staff.
- More Band 7 posts need to be commissioned across London in order to implement the Healthy Child Programme.
- Services need to be commissioned to allow leeway in the budget for the unforeseen circumstances of the work e.g in one borough (Brent) health visitors are commissioned to carry out a 45 minute new birth visit to parents. Whilst this may be adequate for some parents, others may need a visit of 1.5hrs if there are problems.
- The health visiting service needs to be commissioned in such a way as to allow health visitors to use their professional judgement as to how many visits a family might need in order to establish a working relationship with the service. In one London borough at least (Waltham Forest) they are not allowed to make more than the one home visit at the birth of a new baby. More vulnerable families would need a greater number of visits. This is an expectation from the DH who call this approach 'progressive universalism'.
- Health visiting work is complex in nature and is at the coal face of community work. Health visitors will encounter newly arrived families in their communities long before they show on any census data e.g. Roma families in London are over-represented in serious case reviews and health visitors may spend many hours helping these families with little to show in terms of commissioning outcomes. There is often a great deal of safeguarding work done with these families to prevent them meeting the child protection plan threshold and therefore are not apparent on vulnerability statistics.
- Health visitors need to be able to spend time to engage families, particularly where there are problems. The soon to be launched report (Tuesday 22nd June) Principles for Engaging with Families, applies as much to the work of health visitors as to the other professionals mentioned (See Appendix p.8).



Health Visiting in London

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# Appendix

## Principles for engaging with families

1. Successful and sustained engagement with families is maintained when practitioners work alongside families in a valued working relationship
2. Successful and sustained engagement with families involves practitioners and parents being willing to listen to and learn from each other
3. Successful and sustained engagement with families happens when practitioners respect what families know and already do
4. Successful and sustained engagement with families needs practitioners to find ways to actively engage those who do not traditionally access services
5. Successful and sustained engagement with families happens when parents are decision-makers in organisations and services
6. Successful and sustained engagement with families happens when families' views, opinions and expectations of services are raised and their confidence increases as service users
7. Successful and sustained engagement with families happens where there is support for the whole family
8. Successful and sustained engagement with families is through universal services but with opportunities for more intensive support where most needed
9. Successful and sustained engagement with families requires effective support and supervision for staff, encouraging evaluation and self-reflection
10. Successful and sustained engagement with families requires an understanding and honest sharing of issues around safeguarding

(Page 3. NQIN 2010)

**NB. These principles are not new to health visitors but their ability to work in this way is severely compromised given the high caseload numbers. This leads to loss of job satisfaction and recruitment and retention problems.**





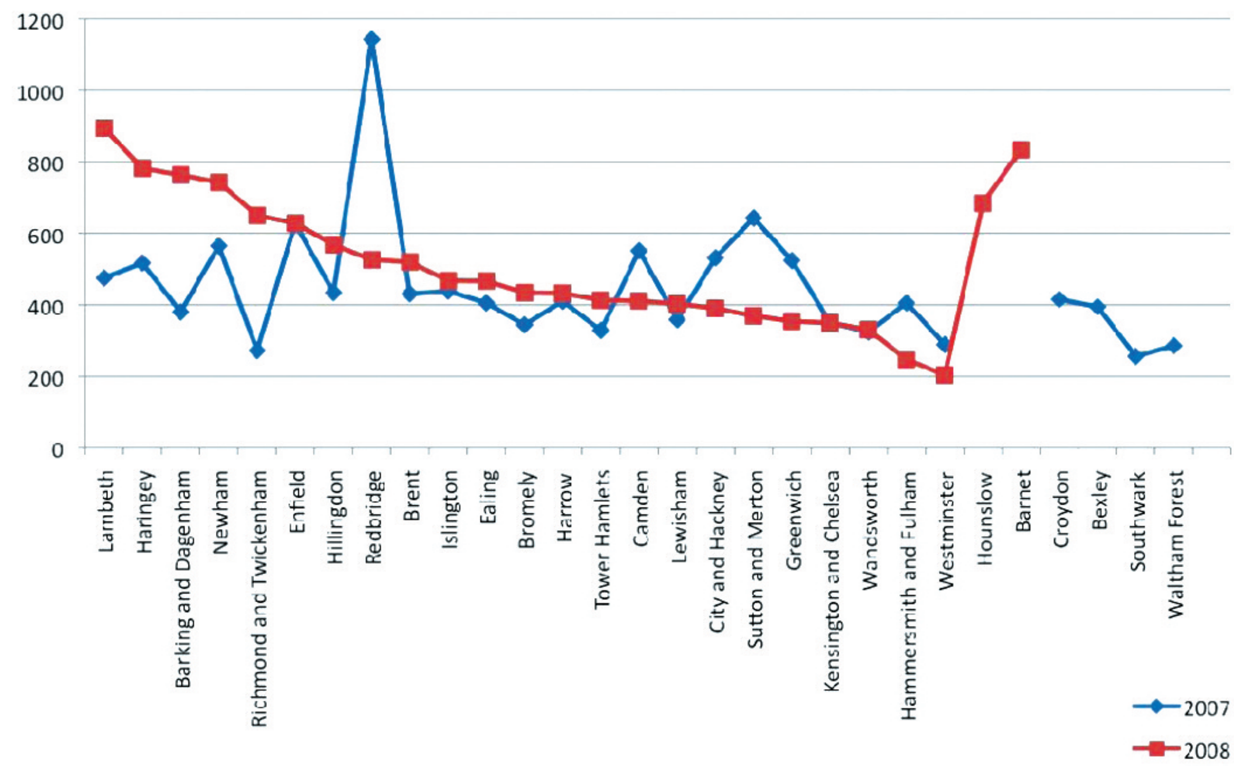
| PCT | Ratio of Children under 5 to HVs 2008 (FPI) | HV Job Satisfaction Mean Scores KF34 (CQC) 2008 |
|---|---|---|
| | | |
| Lambeth | 894.25 | --- |
| Barnet | 833.65 | --- |
| Haringey | 781.90 | --- |
| Barking and Dagenham | 763.13 | --- |
| Newham | 742.84 | 3.39 |
| Hounslow | 684.56 | 3.30 |
| Richmond and Twickenham | 650.02 | 2.99 |
| Enfield | 628.73 | 3.67 |
| Hillingdon | 568.08 | 3.52 |
| Redbridge | 525.86 | 3.53 |
| Brent | 519.75 | ---- |
| Islington | 467.48 | ---- |
| Ealing | 466.72 | 2.89 |
| Bromley | 433.94 | 3.61 |
| Harrow | 432.73 | 3.14 |
| Tower Hamlets | 413.27 | 3.07 |
| Camden | 411.13 | ----- |
| Lewisham | 403.12 | 2.91 |
| City and Hackney | 390.13 | 3.32 |
| Sutton and Merton | 369.38 | 3.73 |
| Greenwich | 354.19 | 3.03 |
| Kensington and Chelsea | 349.61 | ----- |
| Wandsworth | 330.58 | 3.80 |
| Hammersmith and Fulham | 247.55 | 3.21 |
| Westminster | 203.60 | 3.78 |
| Croydon | ---- | 3.34 |
| Southwark | ---- | 3.43 |
| Bexley | ---- | 3.58 |

**Ratio of Health Visitors to Under 5s and Job Satisfaction levels (2008)**

Nationally Health Visitors have the lowest levels of job satisfaction and are least likely to recommend their Trust as a place to work. (CQC 2008)

(Health visitors job satisfaction was measured on a five point scale of 1 = very dissatisfied to 5 = very satisfied. ---- indicates no figures available to report)

**London Ratios of Children under five to health visitors. (based on Family and Parenting Institute Figures 2007, 2008)**








**Numbers of WTE Health Visitors 2007-2009**