Introduction

This briefing is written for Unite the union Regional Officers, representatives and members. It attempts to provide a background and identify future risks and concerns related to health visitor members in England.

History

Health visitors have been in the UK since 1862 when they started to work in Salford, Greater Manchester. The Community Practitioners’ & Health Visitors’ Association was formed in 1896 and has since then represented the majority of health visitors, and then later school nurses and community nursery nurses. 2016 marks the Association’s 120th birthday.

What’s a health visitor?

Health visitors are registered nurses or midwives who are passionate about promoting healthy lifestyles and preventing illness. They work with families to give pre-school-age children the best possible start in life.

Health visitors are required to complete additional education and gain a qualification in specialist community public health nursing (at degree or masters level). This additional training enables them to assess the health needs of individuals, families and the wider community, with a view to early intervention. The role is primarily focused on working with children from birth to five years old and their families. There are also specialist health visitors who focus on at-risk or deprived groups such as perinatal mental health, breastfeeding, domestic abuse or the homeless.

Health visiting is based around four principles:

• Search for health needs
• Stimulation of an awareness of health needs
• Influence policies affecting health
• Facilitate health enhancing activities

Health Education England provides more information on their website, ‘Health Careers’

Background to the health visitor implementation plan

Unite/CPHVA started to campaign in the 2000s when it realised that health visiting was facing a significant crisis. Although no policy of the last Labour government had suggested that the number of health visitors should be reduced, the number continued to decline owing to local health planning.

We highlighted the fact that between 2000 and 2011, the number of health visitors in England reduced by 21% (10,046 to 7,941). This was at a time when the number of under five year olds had increased by 12% (2.98 million to 3.33 million). The effect that this had on average caseload sizes was to increase them by 30% (297 to 419 children under-5 per health visitor).

Each of the then 3 main political parties said something about health visiting in their election manifestos going into the 2010 general election. The Conservative Party appeared to be the most committed to affect change in this area. Indeed, they were the first to pick up our proposed figure of 4,200 more health visitors in a paper written by The Conservative Research Department ‘Helping new families: Support in the early years through universal health visiting’.

In their 2010 general election party
manifesto they mentioned health visitors twice: ‘We will support and improve Sure Start, and introduce a new universal health visiting service.’... and ‘Families need the best possible advice and support while their children are young. We will provide 4,200 more Sure Start health visitors – giving all parents a guaranteed level of support before and after birth until their child starts school. This will be paid for out of the Department of Health budget and by refocusing Sure Start’s peripatetic outreach services.’

This was then carried over to the coalition agreement which pledged: ‘We will refocus funding from Sure Start peripatetic outreach services, and from the Department of Health budget, to pay for 4,200 extra Sure Start health visitors.’

The ‘Health visitor implementation plan: A call to action’ was launched on the 8th February 2011 setting out the ‘challenging commitment to an extra 4,200 health visitors by 2015’. This identified that there would be an increase from the (original) May 2010 ‘baseline’ figure of 8,092 health visitors up to a final total of 12,348 by March 2015.

Progress on numbers of health visitors

By March 2015, the number of health visitors stood at 12,077; and although the target had been missed by 271, the increase in health visitor numbers from May 2010 to March 2015 was 49%.

Owing to this result, there is a risk that people may feel that health visitors had their investment at a time when other parts of the NHS and wider health sector faced considerable cuts between 2010-15. This would be true if it wasn’t for two significant issues:

- The cuts that happened between 2000 and 2011 meant that the work force growth between 2000 and 2015 was only 20%. This compared with a growth in all nursing, midwifery and health visiting professions (combined) of 22%
- The rapid increase in birth rate and therefore the number of under-5s in England which increased by 15% (2001-2014).
As of September 2015 there were 11,895 FTE health visitors in England. As the following chart shows, the HV plan was never reached and the target is unlikely to be reached in the future.

The transfer of commissioning of health visiting services to local authorities

On the 1st October 2015, the commissioning of health visiting was transferred to local authorities. This followed the earlier transfer of school nurses in April 2013. One of the arguments for this transfer was that as the local authority were now responsible for public health, commissioning the 0-19 services would enable closer working and integration.

There are however a range of risks that may come to light over the next months and years:

- **The cuts to public health:** At the point of transfer, the budgets for health visiting services were also transferred across to the local authority. However, at the same time, George Osborne has implemented large spending cuts to public health. This included £200 million cuts announced ‘in-year’ in 2015-16, a further £77 million cut in 2016-17 and £84 million cut in 2017-18. The funding transferred with health visiting services was not ‘ring fenced’.

- **Cuts to ‘early intervention’ funding:** At the beginning of March 2016, Action for Children, the National Children’s Bureau and The Children’s Society produced a report, ‘Losing in the long run’ which highlighted that between 2000 and 2020, the amount spent by the government on early intervention would be cut by 71%. The report included a helpful interactive map where you could look at the changes in funding from 2010 and the forecast for 2020. So for example, the 2010-11 early intervention allocation (excluding 2-year-old offer) in Birmingham was £90.5 million. By 2019-20 it is currently predicted to be allocated £25.1 million; a cut of 72%.
• **The local authority ‘expertise’ in putting services out to tender:** Local authorities have long experience of putting services out to tender. In health visiting, this isn’t a new proposition as starting with ‘Commissioning a patient led NHS’ (CaPLNHS), services were already being put out to tender with a range of providers winning these bids. The winning bidders ranged from local NHS services, third sector organisations, local authorities and private companies such as Virgin Care. It is to be expected that the pace of these tenders will increase. This in itself is a concern but this will also be combined with these new tenders having less money identified to deliver these services; there are a number of case studies below. In addition there is a risk of fragmentation if different parts of the service are placed with different providers and of course the risk of services moving out of the NHS.

• **Guidance versus instruction:** There is very little instruction set out from the Department of Health. In terms of health visiting there are 5 visits/contacts which are ‘mandated’. This was set up as part of a ‘sunset clause’ which runs from October 2015 to March 2017. It is planned that it will be reviewed in October 2016 by Public Health England. Whether each area takes mandation seriously is an important question and feedback from some parts of the country would suggest that they don’t, especially when it comes to carrying out antenatal contact.
Under the terms of the Health and Social Care Act 2012, upper-tier local authorities are now responsible for improving the health of their local population. Local authorities are key commissioners and hold an array of statutory duties for children, including:

- establishing arrangements to reduce child poverty
- promoting the interests of children in the development of health and wellbeing strategies (joining up commissioning plans for clinical and public health services with social care and education to address identified local health and wellbeing needs)
- leading partners and the public to ensure children are safeguarded and their welfare promoted
- driving the high educational achievement of all children
- leading, promoting and creating opportunities for co-operation with partners to improve the wellbeing of young people.

The core public health offer for all children includes:

- child health surveillance (including infant physical examination) and development reviews
- child health protection, immunisation and screening
- information, advice and support for children, young people and families
- early intervention and targeted support for families with additional needs
- health promotion and prevention by the multi-disciplinary team
- defined support in early years and education settings for children with additional and complex health needs
- additional or targeted public health nursing support as identified in the Joint Strategic Needs Assessment, for example support for looked after children, young carers, or children of military families.

**The education of new health visitors**: Under the implementation plan, universities had record numbers of student health visitors on their courses. In fact to try and meet the target some universities across England commenced two intakes per year (normally health visiting courses start in the September, running to the following August). We are already picking up on concerns related to the courses for 2016-17. We have written to Health Education England to highlight these concerns which come under a number of categories:

- Universities are being told to hold back from recruiting their 2016/17 intake.
- Universities are being told that the local healthcare provider organisations can’t afford to provide placements for students.
- Local LETBs (Health Education England Local Education and Training Boards) are reducing the number of their commissioned places.
- Local healthcare provider organisations are making clear that they won’t be able to recruit the students once qualified.

Health Education England have responded to our letter but the reply does not put our minds at rest.

**The government plan to remove bursaries for undergraduate health training and replace with a loan**: It is not clear as yet what impact this decision may have on post registration education. However, our members are concerned that it will have negative implications. We will be raising these concerns in our response to the government’s consultation.
• **Current capacity in health visiting teams**: In August we reported on a survey that the HV Organising Professional Committee carried out, with 751 responses from health visitors across England. It found out that:

  • Although we’ve seen record increases in the number of health visitors, only 43% thought that the number of health visitors in their organisation had gone up. 26% said they had stayed the same and 28% said they had gone down.
  
  • 89% reported that their workload had involved taking more responsibility for children and families over the past year.
  
  • When asked about stress, 85% reported that ‘demand of the job’ was causing them stress at work.
  
  • When asked whether health visitors thought a situation like Baby P\(^1\) could happen in their organisation, 12% reported they didn’t know, 3% very unlikely, 8% somewhat unlikely, 30% neither likely nor unlikely, 37% somewhat likely and 10% very likely.
  
  • Only 25% health visitors agreed that with current staffing levels the five mandated contacts could always be delivered.
  
  • When asked whether health visitors were confident that the service they worked for could help children and families with a number of issues, we got a range of answers (see chart\(^14\) below).

![Chart showing the percentage of health visitors confident in their service to accommodate various concerns](chart.png)
**Children Centres (aka Sure Start Centres):** Although not directly linked to health visiting in many areas, it is important to consider associated services. One of these is Children’s Centres (CC). Under the coalition and now under the Conservative government the number of CC’s have reduced dramatically. The situation in the run up to last year’s election was, according to the Labour Party\textsuperscript{15}: 786 had already been closed with a projection that by 2019, a further 1,055 would be closed. The Conservative Party reported these figures were ‘desperate stuff from Labour’\textsuperscript{16}. The true picture from reading press reports and speaking to members is that the argument is that CCs aren’t always closed but that they are reorganised so a centre that may have opened Monday – Saturday, 9-5 now either just opens for a few sessions per week or the services have been reorganised to be delivered from another venue.

**Initial next steps**

If Regional Officers, representatives or members are made aware of proposed cuts to health visiting services it is recommended that you complete the following initial steps:

- If you are a Unite member, contact your local representative.
- If you are a local representative, contact the Regional Officer to make them aware of any proposals.
- Provide details of any proposed cuts to Dave Munday, Professional Officer via dave.munday@unitetheunion.org. Dave will be able to highlight these concerns nationally with bodies such as Public Health England and with politicians. If required, information can be shared and kept anonymous.
- We will be able to assist with local campaigns supporting via your Regional Officer.

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<tr>
<th></th>
<th>Health visitors</th>
<th>All organisations</th>
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<tbody>
<tr>
<td>Staff recommendation of the organisation as a place to work or receive treatment</td>
<td>3.74</td>
<td>3.76</td>
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<td>Staff satisfaction with the quality of work and care they are able to deliver</td>
<td>3.78</td>
<td>3.89</td>
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<tr>
<td>% of staff agreeing that their role makes a difference to patient/service users</td>
<td>91%</td>
<td>88%</td>
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<td>Staff motivation at work</td>
<td>4.11</td>
<td>3.93</td>
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<td>Quality of non-mandatory training, learning or development</td>
<td>4.16</td>
<td>4.01</td>
</tr>
<tr>
<td>Staff satisfaction with resourcing and support</td>
<td>3.23</td>
<td>3.36</td>
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<tr>
<td>% of staff working extra hours</td>
<td>87%</td>
<td>73%</td>
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<tr>
<td>% of staff suffering work related stress in the last 12 months</td>
<td>36%</td>
<td>36%</td>
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<td>% of staff feeling pressure in the last 3 months to attend work when feeling unwell</td>
<td>63%</td>
<td>56%</td>
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<tr>
<td>Effective use of patient/service user feedback</td>
<td>3.54</td>
<td>3.71</td>
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<tr>
<td>Overall engagement score</td>
<td>3.9</td>
<td>3.82</td>
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**NHS staff survey results for health visitors:**

The 2015 NHS staff survey can be used to look at the responses provided by health visitors. The following chart highlights results to a section of the questions asked, compared with the average for all NHS staff (Those figures that aren’t percentages range from 1-5 with 5 being the most positive answer).
Appendix: Case studies

**Harrow:** In December 2015, Harrow released a copy of their planned budget for 2018/19 which proposed a 100% cut to the health visiting budget. A council spokesperson said:

“…no decision around health visiting will be made before 2018. He added that due to uncertainty around central government funding to local authorities the council was unable to guarantee that it would be able to continue funding health visiting in the long term.

Any decision around health visiting would be subject to a review and “extensive consultation with the public” he said.

He added: “In a broader context, this year’s cut to the public health grant was just the latest of many attacks on our funding for crucial local services. From 2014 to 2018, Harrow Council has had £83m of cuts imposed on it already.”

We responded publicly but also contacted officials at Public Health England to ask that they urgently intervene. By the following day, Harrow had backtracked on their proposal. A Community Practitioner blog on the subject provides more background.

**Barnsley (South West Yorkshire Partnership NHSFT):** The local authority put the public health service for 0-19 year olds out to tender (around September 2015). They put a ceiling of £4.8 million for any bids. The problem was that the current service cost £5.87 million to provide; so a proposed cut of over £1 million or 18%. A question was put to Alistair Burt (MP and Minister of State for Community & Social Care) at an All Party Parliamentary Group he was speaking at in October 2015. He was celebrating the work done by his government on increasing the numbers of health visitors.

The question asked whether he shared our concerns that the cuts to public health and local authorities would unravel the work done to get 4,200 more health visitors. His reply was unsurprisingly reminiscent of the replies received when similar concerns were raised before 2010, that it was up to local determination about what service works best for families. This of course is a lie as the decisions are being made to ensure balanced budgets are delivered. A blog for Community Practitioner provides more background on this situation.

The original invitation to tender did not receive any bids so the local Foundation Trust, South West Yorkshire Partnership, was asked to continue to provide the service. The trust felt unable to provide this service safely and so has given notice to cease provision. The Barnsley Chronicle reported the situation and our Regional Officer and rep have replied highlighting the concerns around being able to provide a safe service with insufficient funding. Community Practitioner has reported on this story.

**Sheffield (Sheffield Children's NHSFT):** We have been informed that Sheffield is required to make £1.3 million savings in their 0-19 service over the next three years. They’re currently looking at what this will mean but we understand one proposal is to merge the health visiting and school nursing service. Again this was done by some organisations during CapLANHS and normally meant that they would try to cover vacancies by making teams larger to hide the fact that there were less staff overall.

**Waltham Forest (North East London NHSFT):** Reps have reported that £1 million has been cut from the Health Visiting budget leading to a reduction from 30 to 16 band 7 posts; a significant number of these are team leaders, practice teachers, and 4 family nurse partnership nurses.

**Southwark and Lewisham (Guys and St Thomas NHSFT):** Members have reported that managers have met with health visitors and school nurses and announced between 40-60 jobs lost in health visiting and 4 band 6 posts for school nurses. It has also been reported that recruitment for empty posts has been frozen and retention contracts for current students cancelled. Community Practitioner has reported on this story.
**Harrogate and District NHSFT:** HDFT is currently bidding to provide the 0-19 service for North Yorkshire (excluding the City of York). Members have reported that ‘it’s looking grim’. In Scarborough the plans are looking as though they will end up with 2 whole time equivalent health visitors less than they had before the health visitor implementation plan was started in 2011. If Harrogate do win the contract then it will run for 4 years and each year the budget will be reduced, amounting to £0.5 million over the 4 years. The contract will be awarded in June.

**Brighton and Hove:** The Healthy Child Programme is going out to tender with £1 million budget cut over 3 years. The local provider has responded to the initial cut of £200,000 by replacing health visitors with community nursery nurses. The Family Nurse Partnership programme has also been decommissioned.

**Links:**

- Public Health England has produced a number of commissioning guides for 2016/17 which have greater detail about the responsibilities of local authorities. They are:
  1. Background information on commissioning and service model
  2. Model specification for 0-19 Health Child Programme: HV and SN services
  3. Measuring performance and outcome
  4. Reference guide to evidence and outcome

- Unite/CPHVA has produced a guide on commissioning which includes a number of principles that are ‘essential’.