

Health visiting in primary care in England:

a crisis waiting to happen?

When did you last see a health visitor? When did you last communicate with a health visitor? These seem apt questions given the evidence from a recent survey of health visitors by the Institute of Health Visiting (iHV); (Working with GPs Survey, unpublished, London, 2016. For further information contact Dr C Adams, Director, iHV). The evidence shows great variability in contact between health visitors (HVs) and GPs in England: of 1179 respondents, 23% of HVs saw a GP at least once a week; 33% 1–2 times a month, and 33% less frequently or hardly ever. In this editorial we review the recent history of health visiting and how, in particular in England, we have arrived at the current situation where HVs, once considered essential members of the wider (non-practice employed) primary health care team (PHCT),¹ are now so detached that at a recent meeting (ICCHNR Symposium, University of Kent, September, 2016), a GP could say that they, HVs, are 'out there somewhere' but where seemed to be a mystery to him and possibly others.

WHERE ARE THE HEALTH VISITORS?

Health visiting began in the era of Victorian philanthropy, gradually being formalised, as a public health profession and service, during the twentieth century. It moved into the NHS in 1974, along with district nursing, community midwifery and public health, which had formerly been delivered through local government. HVs began to be attached to general practice at this time, and by 2000 this was the most common form of service organisation. The iHV survey found that in 2016 these arrangements now apply to fewer than half of the HV respondents, with only 28% based in a health centre with GPs and 13% in a GP practice.¹ The rest are indeed 'out there somewhere' based in children's centres, other local authority premises, health centres (where there are no GPs) or even 'mobile workers' on the end of a tablet or mobile phone. The move away from GP attachment began during a period of retrenchment for HVs, as the workforce shrank by around 20% between 2004 and 2010, despite a rapidly increasing birth rate² and growth in evidence³ about the importance of the early years to future health. While there is no agreement on reasons for this decline three potential explanations are offered. First, regulatory changes led to the qualification and title of 'health visitor' being removed from statute in 2004, which some suggest indicated

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a lack of support for the role.⁴ Second, survey evidence⁵ implicated the then current guide to child health surveillance,⁶ known as 'Hall 4' (Health for All Children), which reduced the number of required health promotion contacts by a HV from seven to one, proposing the rest should be optional depending on need and professional judgement. Third, it was suggested that due to lack of evidence of the impact of the role, hard-pressed commissioners redirected funding into other services.⁷

In response to the early years' evidence and the increase in the birth rate, in 2011 the government released a 'Call to Action' and a four-year Implementation Plan to promote and develop the profession and halt the rapid decline in the health visiting workforce in England.⁸ By the time the Implementation Plan ended in March 2015, an additional 3985 HVs had been recruited (just short of the goal of 4200), amounting to an increase of 49% in the workforce in England with the total number of HVs in England then being at the high point of 12 077 full time equivalents (FTE),⁹ including around 1000 employed in non-NHS organisations.

CURRENT FUNDING FOR HEALTH VISITORS

One key goal of the Implementation Plan was to transform the service, while aligning it with the new NHS architecture following the Health and Social Care Act 2012. This involved shifting responsibility for commissioning of health visiting services to local government in England, along with other public health provision, from October 2015. The following month, the annual spending review announced an in-year reduction of 6.2% in the public health budget for 2015–2016 followed by further annual cost savings of 3.9% each year until 2020. NHS funding for the existing health visiting workforce was transferred to local councils on a 'lift and shift' basis in October 2015, but as this was not ring-fenced, the service was included in the cost-saving measures, leading to a

reduction of at least 988 FTE HVs,¹⁰ with only 9311 FTE HVs remaining in NHS posts in August 2016. HVs employed outside the NHS are no longer included in routine workforce data, making direct comparisons difficult. Many commissioners, that is, local authorities, have announced reviews or are putting services out to tender. In 2015–2016, 13% of local authorities have reported cuts in health visiting and in 2016–2017, 56% of local authorities are planning reduced investment in health visiting.¹¹ Disinvestment by over 50% of local authorities to take effect from April 2017, seems set to rapidly wipe out any gains made in the HV Implementation Plan.¹²

What does this relocation of commissioning of HVs and new reduction in numbers mean for primary care? In the 2008 WHO report¹³ that re-launched primary care as the focus for healthcare reform, people-centred primary care was identified as the vehicle to achieve service delivery reforms with the PHCT providing the coordination of continuous, comprehensive, person-centred care to a defined population networking to other services as necessary. These goals are reiterated in UK documents^{14,15} with working together in networks across organisation boundaries, and sharing electronic records emphasised:

'Primary care will have at its heart active collaboration between healthcare professionals and the people they care for. ... Community nurses and health visitors will work much more closely with general practices and will share electronic records'¹⁴

Among respondents to the iHV survey the frequency of open text responses concerning the need for shared electronic records demonstrates the value that HVs see would be gained from such shared records. However, reductions in the numbers of HVs, which may be anticipated over the next few years, will make this closer working with or without shared records more difficult to achieve.

HEALTH VISITORS AND PRIMARY CARE

What then do HVs contribute to primary care? They are qualified nurses or midwives who have undertaken an additional one year programme either at BSc or MSc level to gain registration with the Nursing and Midwifery Council as Specialist Community Public Health Nurses (Health Visitor). They are the only nurses who have as their main focus prevention and have unique access to families through home visiting enabling them to identify health needs early. As part of the transfer arrangements to local authorities, Public Health England put in place a detailed specification for the health visiting service, including a simplified service model.¹⁶ This '4-5-6' model describes the way HVs operate at four different levels: to build community capacity, to offer a universal preventive service to all new and expectant parents and their infants, to provide additional support and early intervention (called 'universal plus') where indicated, and to provide continuing support to the families who need more intensive provision, often in conjunction with other services (called 'universal partnership plus') all underpinned by action on safeguarding as necessary. There are five health reviews specified between pregnancy and school age, which were mandated through a statutory instrument that is due to expire in March 2017. This mandate is currently under review.

Finally, six 'high impact' areas of health visiting work were specified, of key public health interest and where there is good evidence enabling outcomes to be audited and measured. These are: transition to parenthood, perinatal mental health, breastfeeding, healthy weight and activity, reducing hospital attendance and accidents, and the two-year review to include transfer to school and readiness to learn. There is increasingly strong evidence about the impact of the 'first 1001 days of life,' from conception to aged two years,¹⁷ and the impact this period has on future health and wellbeing. Furthermore, there is evidence about which interventions can help improve young children's current and future health¹⁸ and about HVs' part in delivering these interventions through a proportionately universal service.¹⁹ The wider research evidence for the longer-term benefits to health and wellbeing as well as the cost savings to primary care and the NHS across all the high impact areas, suggests that HV practice is, and should be, of significant concern to primary care.¹⁶ Perhaps the areas in which HVs can help in achieving the General Practice Forward View¹⁵ is in enabling practices and federations of practices to connect with their local

communities, helping to integrate primary and social care and working on public health initiatives with primary care colleagues. There is now greater scope to achieve this through the new models of care, and lessons learned from the vanguard sites, that are being rolled out as part of the Five Year Forward View.²⁰

Effective primary care is based on trusting relationships between practitioners and patients and between the practitioners providing that care. With falling numbers of HVs maintaining and building those relationships this becomes more difficult. Prevention activities in primary care are also being weakened just when there is an overwhelming imperative to focus on prevention and self-care. Primary care needs to take action to avert this crisis!

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