**Written evidence submitted by Institute of Health Visiting (WBR0019)**

## 1. About the Institute of Health Visiting

The Institute of Health Visiting (iHV) was established with the support of the Cabinet Office and Department of Health in 2012. We are a charity, self-funding through our membership scheme, professional development/training programmes and successful partnership work. Our aim is to strengthen the quality and consistency of health visiting services for the benefit of all children, families and communities, and to reduce health inequalities.

## 2. Our evidence

In our evidence, we wish to assist the Committee to review evidence of how health visiting services, in particular, have been fragmented and reduced for our youngest children and families prior to the COVID-19 pandemic, and further adversely affected by COVID measures. Our evidence shows how these measures have exposed health visitors to occupational stress and demoralisation, placing them at risk of burnout. Furthermore, there is evidence to explain why this is the case and what needs to change to protect their mental health, support their resilience and to rebuild this professional workforce that is key to the wider the health and resilience of young children and families in their formative years.

## 3. Key points

Health visiting has been significantly weakened since 2015 by cuts to Public Health Grant funding, reduced staff numbers and rising caseloads. This has already imposed severe occupational stress upon the professional workforce.

The implementation of COVID-19 measures intensified and added to these stressors in ways that are particular to health visiting, for which we have specific independent research evidence.

There are structural issues affecting child and family public health services. Addressing the stress experienced by health visitors, protecting their mental health and building their resilience will require tackling to overcome the fragmentation of accountability and develop coherent strategy at national and local levels.

**Recommendations:**

i. Health visiting services must be **fully prepared for any future waves of COVID-19**. NHS England should revise the Community Prioritisation Plan (and Emergency, Preparedness, Resilience and Response (EPRR)) and develop clear messages on the importance of continuation of the service to ensure the needs of children are prioritised. This should include the removal of wording on the redeployment of health visitors.

ii. A clear **workforce plan** is needed to ensure that the service has sufficient surge capacity to manage the backlog of missed appointments, as well as demand for support due to the secondary impacts of the pandemic. Health visitors must be fully included in provisions of the NHS People Plan, with a recovery plan to rebuild the health visiting workforce. More detailed recommendations are contained in Health Visiting in England: A Vision for the Future.[1]

[1] https://ihv.org.uk/wp-content/uploads/2019/11/7.11.19-Health-Visiting-in-England-Vision-FINAL-VERSION.pdf

iii. A **cross-Government strategy is needed to reduce inequalities** and "level-up" our society. The Public Health Grant must be restored and strengthened to secure an effective health visiting service model, level of provision and professional workforce that works across the health and social care system and beyond, and provides a vital "safety-net" for babies and young children.

iv. **Strategic oversight for health visiting is needed at national and local levels** with clear lines of accountability for reducing inequalities at every level of the system, and actions to overcome the fragmentation and unwarranted variation currently affecting child and family public health as a whole in England.

v. The impact of working during the COVID-19 pandemic on **staff wellbeing** cannot be underestimated - a proactive plan is needed to ensure staff have the right support during the restoration of services and to create high-quality workplaces for all staff in the future.

## 4. Health visitors (HVs) and the health visiting service

Health visitors are Specialist Community Public Health Nurses registered with the Nursing and Midwifery Council (NMC). Health visitors are nurses or midwives who have undertaken additional public health training at graduate or masters level. Their training equips HVs to use their understanding of public health, the wider determinants of health and impact of health inequalities in their skilful work, recognising and responding to individual needs with the aim of improving health outcomes for every child and family.

> *"Health visitors are an essential part of the country's support structure for young children and their parents – especially those who are struggling to cope. But they can only do this if they have the time and capacity to develop good, trusting relationships with families. I am very concerned that the huge pressure on health visitor services is making it harder for them to do this, meaning some vulnerable children are in danger of falling through the gaps."*
>
> **Anne Longfield, Children's Commissioner for England**

Health visiting is the only service that proactively reaches out to all families with babies and children under the age of five to systematically assess health and developmental needs, and provide support proportionate to that need. The impact of the COVID-19 pandemic has been three-fold:

- **Rising levels of need:** Living through a pandemic has imposed pressures on families who have been largely confined to the home and may have been facing concerns for employment and family finances, the additional demands of providing 24-hour childcare and the physical and emotional impact of the virus itself on the health of family members.

- **Reduction in support available for families and mechanisms for identifying families who might need help:** The effects of "lockdown" have created an increased level of need at a time when access to usual support from either friends and family or local services have been removed, or reduced for families with known need and new cases of emerging need. All the usual ways to identify if a family is struggling are also far more limited now.

- **Redeployment of health visitors:** The status of health visitors as registered nurses makes them subject to calls upon them that would not be applied to the wider children's workforce: teachers, social workers, early years practitioners and so on may be challenged by the COVID-19 pandemic but, unlike health visitors, their services have not been reduced by redeployment as nurses to the NHS.

## 5. Health visiting and the NHS

Health visiting services are, in the main, provided by the NHS. However, since 2015 they are no longer commissioned by the NHS but by Local Authorities. Along with school health and sexual health services, health visiting is now being funded by the Public Health Grant, not the NHS. A small but increasing minority of health visiting services are commissioned from commercial companies, not-for-profits or are provided directly by Local Authorities. This commissioning context needs to be borne in mind in relation to the level of resource, working conditions and model of service provision that has become increasingly variable over the last five years, leading to rapidly rising levels of occupational stress amongst health visitors pre-COVID, to which the COVID pandemic has added in particular ways that we shall outline.

The structural position of health, between Local Authorities and the NHS, can result in the service being somewhat semi-detached from both. For example, on the one hand the urgent requirements of the COVID-19 outbreak saw health visiting fully embraced as belonging to the NHS, with substantial redeployments of health visiting staff. On the other hand, the recommendations of the NHS People Plan may not be resourced by the level of funding from Local Authority commissioned contracts. The breakup of Public Health England, which provides national professional leadership for health visiting, places health visiting in a more uncertain structural position, exacerbating the risks to which this essential workforce is exposed for the immediate future.

## 6. How resilient was the health visiting workforce under pre-COVID-19 conditions?

In November 2019, the Institute of Health Visiting (iHV) surveyed frontline health visitors working with families and communities. Our survey[2], the latest of six conducted annually from 2014, indicates the impact on the quality of the service available to families, and workforce capacity and morale from sustained reductions in funding through the Public Health Grant since 2015. It found:

- There is considerable unwarranted variation between Local Authorities in the quality of the health visiting service that health visitors are able to provide which may not be based on best practice or the family's level of need.

- As workforce numbers decrease year on year, the numbers of children in the caseloads that health visitors are accountable for increases. This translates to reduced time available for health visitors to support families and provide a vital "safety-net" to babies and young children.

- The health visiting service has become increasingly driven to demonstrate compliance to key process performance indicators, reducing their capacity to respond to identified needs, and utilise their skills to address key public health priorities and reduce inequalities. This has negatively impacted some parents' experiences of the service which they describe as a "tick box exercise" – we outline parents' view of the health visiting service in detail in "What do parents want from a health visiting service?"[3]

- 'Continuity of health visitor' is increasingly difficult to deliver in practice despite being highly valued by parents and strongly associated with improved outcomes; parents are more likely to

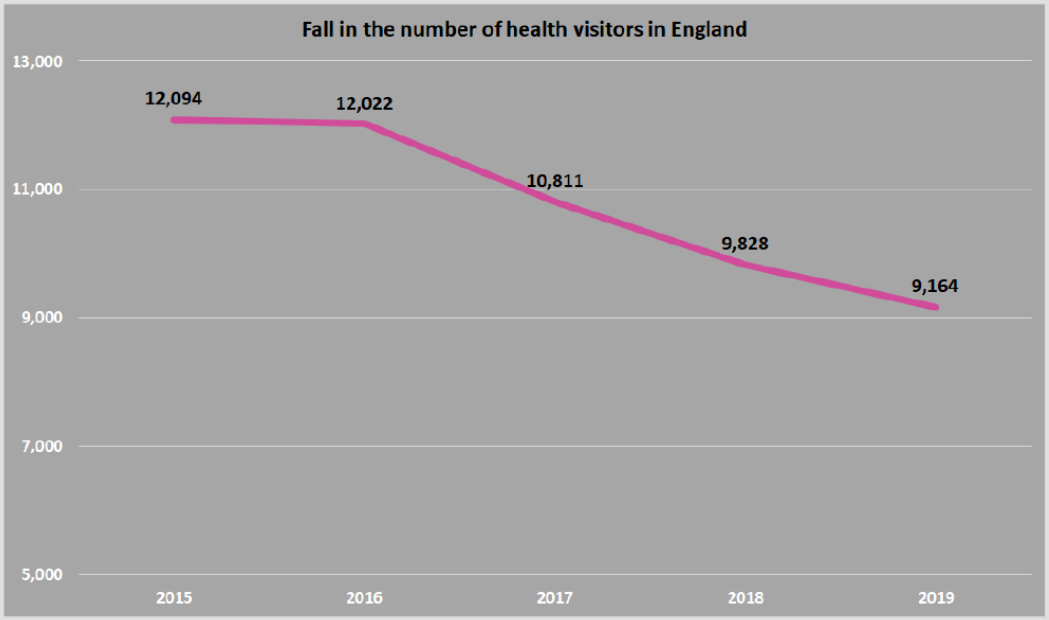
[2] https://ihv.org.uk/wp-content/uploads/2020/02/State-of-Health-Visiting-survey-FINAL-VERSION-18.2.20.pdf
[3] https://ihv.org.uk/wp-content/uploads/2020/01/HV-Vision-Channel-Mum-Study-FINAL-VERSION-24.1.20.pdf

disclose need and engage in interventions when they have established a trusted relationship with a named health visitor. Conversely, a reductionist model of service delivery which is structured around the delivery of tasks, rather than predicated on relationships and personalised care, is strongly linked with poor outcomes and increased risks[4] [5].

- Health visitors report high levels of work-related stress and distress from concerns about the risks to which "hidden" vulnerable children and families are exposed and how many are now left unsupported.

Key to delivering an effective, quality service is a well-trained professional workforce in sufficient numbers that is well motivated and supported to provide a personalised public health approach to families with young children. In our 'State of Health Visiting' survey in 2019, we describe the increase in health visitors' caseload size due to service cuts. This is due to the fall in the numbers of NHS employed health visitors in England since 2015, see Figure 2 below. (An increasing minority of health visitors are now employed by Local Authorities or independent providers, although this provides little reassurance as health visiting numbers are also falling outside the NHS).

**Figure 2. Fall in the numbers of NHS employed health visitors in England since 2015 and before COVID-19***




*Taken from the Hospital and Community Health Services (HCHS): Nursing and Health Visitor Staff by level in NHS Trusts and CCGs in England, March 2010 to March 2019, Headcount

Redeployment of health visitors during the pandemic drastically reduced the service further in many locations to support the NHS capacity to meet the COVID-19 response. We are concerned that an already depleted and overstretched workforce **was further reduced by this redeployment, with some areas seeing more than 50% of their workforce redeployed.** As a direct result, the remaining health visitors have been required to manage an increase in their caseload size which doubled in some areas, often with little handover to support continuity of care. Prior to the pandemic in 2019, 29% of health visitors we surveyed were already responsible for 500-1000+ children (iHV, 2020). The recommended maximum number of children per health visitor is 250.

[4] https://www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/MBRRACE-UK_Maternal_Report_2020_v10_FINAL.pdf
[5] https://seriouscasereviews.rip.org.uk/wp-content/uploads/TRIENNIAL_SCR_REPORT_2014_to_2017.pdf

**7. What has the impact of the COVID-19 been on resilience, levels of workforce stress and burnout in the health visiting service?**
**How does it manifest, how is it assessed, and what are its causes and contributing factors?**

From 19th March 2020, health visiting operated under NHS England's guidance for prioritisation of community services, risk reduction and plans to "release capacity to support the COVID-19 preparedness and response"[6]. Health visiting services were categorised as a "partial-stop" service and were drastically scaled back, leaving health visitors very concerned about the vulnerability of young families that they could no longer reach or support – see 'Babies in Lockdown'[7]; and, with considerable regional and local variation dependent on the interpretation and implementation of this national guidance. Health visitors were redeployed to support the NHS COVID-19 emergency, often in inappropriate ways. Where redeployment was highest (in some areas more than 50% of the workforce), this left health visitors with impossibly high caseloads, working in professional isolation.

On 3rd June 2020, earlier prioritisation was replaced by limited restoration of community health services for children and young people[8], a 'second phase' of NHS response which took some steps towards a fuller service and health visitors returning from redeployment.

In response to reduced COVID-19 demand on the NHS and concerns about rising inequalities, on 31st July 2020 the Government downgraded the NHS EPRR incident level from Level 4 (national) to Level 3 (regional) and published their plans for phase 3 of the pandemic response which advised to "fully restore services, with some prioritisation where indicated as capacity dictates"[9].

In early April 2020, the iHV surveyed[10] health visitors for a snapshot of their experiences of the impact of COVID-19 measures on their services, which also revealed the professional and personal impact of the emotional toll. It is no surprise that many respondents described feeling anxious and unsettled by the rapid pace of change, loss of control, sense of professional self-worth and the wider impact of COVID-19 on many aspects of their work:

> "The anxiety and stress and worry for our PIN [professional registration with Nursing & Midwifery Council], our livelihoods – being asked to practice outside of competence – and our [case-load of] families is raw and ongoing. I am absolutely shocked and dismayed at how the iHV, unions and the Government could allow this to happen. We were told in writing of our redeployment on the 27th March and deployed by the 30th. We had NO time to handover our caseloads of vulnerable families. There is so much more I want to write but I do not have the energy. I very much doubt I will be returning to Health visiting when this is over."

> "I am concerned that not only are we NOT helping in protecting our families from this pandemic virus but our voices as Health Visitors and PUBLIC HEALTH specialists are not being

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[6] NHS England and NHS Improvement (2020) COVID-19 Prioritisation within Community Health Services. 19th March 2020.
[7] https://babiesinlockdown.files.wordpress.com/2020/08/babies-in-lockdown-main-report-final-version.pdf
[8] https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/C0552-Restoration-of-Community-Health-Services-Guidance-CYP-version-3-June-2020-1.pdf
[9] NHS England and NHS Improvement (2020) Third phase of NHS response: https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/07/20200731-Phase-3-letter-final-1.pdf
[10] https://ihv.org.uk/wp-content/uploads/2020/04/Health-visiting-during-COVID19-An-iHV-report-FINAL-VERSION-8.4.20.pdf

listened to. This is, of course, causing some anxiety and poor morale amongst staff members."

"I'm sure we will find our feet in the new roles and prove useful in some way but currently there is a lot of ill feeling and talk of leaving the trust completely."

"It is all very sad… This is having a huge effect on staff morale in feeling supported and safe in our practice in the previous days and weeks in addition to the weeks ahead."

"I think this is something we have overlooked, staff safety and wellbeing. We are bending over backwards to ensure families are safe."

"I feel that health visiting is undervalued, which is very demoralising."

Preliminary findings of more systematic research by Professor Jane Barlow[11] are summarised as follows

- **Redeployment:**
- Health visitors had the highest rate of redeployment (compared to Midwives and Social Workers)
- 1/3 of redeployed practitioners reported inadequate preparation for the new role
- Redeployment to a range of settings - hospitals, district and community nursing, and adult services
- **Critical services were not delivered**

- **HVs' concerns regarding the secondary impact of COVID-19 on children and families/ unidentified and unmet need**

- **Cessation of universal visits meant that 'new' and 'increased' vulnerability not identified; not seen by anyone.**

- **Significant delivery of services virtually with**:
- no preparation/training;
- no evidence regarding its use with these families;
- many families not able to receive care that way;
- most wouldn't use it with vulnerable families going forward

- **Changes have had a significant impact on the mental wellbeing of the workforce**

(Barlow et al, 2020).

The most recent formal report by Conti and Dow,[12] University College London, provides the first key findings from new survey data collected between 19 June to 21 July 2020, specifically focused on health visitors. They report:

[11] Barlow J et al. The impact of COVID-19 on the ability of community-based practitioners to keep babies and young children safe [who is keeping the baby in mind?]. NIHR Department of Social Policy and Intervention, University of Oxford; 2020

[12] https://ihv.org.uk/wp-content/uploads/2020/07/Conti_Dow_The-impacts-of-COVID-19-on-Health-Visiting-in-the-UK-POSTED.pdf

> The increased workload and pressures have had significant negative impacts on staff wellbeing and mental health… Among those reporting higher levels of stress:
>
> - 50% are working longer hours;
> - 67% say that the stress is making them feel more worried, tense and anxious;
> - 26% say that are managing the stress in negative ways like drinking more alcohol or comfort eating, and another 26% report that their physical health is negatively affected;
> - and over half (55%) state that their sleep is affected.
>
> Higher stress is also affecting how health visitors feel about their work:
>
> - 55% of those with increased stress levels report feeling demotivated;
> - 28% struggle to concentrate; and
> - over a third (36%) told us that, if they could leave health visiting, they would.

And they conclude in their recommendations:

> The impact of working during the COVID-19 pandemic on staff wellbeing cannot be underestimated - a proactive plan is needed to ensure staff have the right support during the restoration of services and to create high-quality workplaces for all staff in the future. This requires leaders at all levels to support a workplace culture built on collaboration, inclusion and compassion. Professional competence and control require staff to have sufficient autonomy to lead a personalised health visiting service, rather than being overwhelmed by excessive chronic workload and overly bureaucratic processes.

### 8. What are the impacts of workforce burnout on service delivery, staff, patients and service users?

We have outlined above the impacts of burnout on staff and we have noted the drastic scaling back of a service already under pressure from staff reductions over the last five years.

The impact of COVID-19 on parents, families and their young children is evidenced in the report 'Babies in Lockdown'[13], and the Children's Commissioner[14] expresses specific concerns that:

> "All the usual ways to identify if a family is struggling have become far more limited under the COVID-19 lockdown. Guidance states that new birth visits from health visitors should now take place remotely, except for families who have been identified as vulnerable, while checks on older babies and toddlers do not have to take place at all."

The issue of NHS guidance on prioritisation of Community Services[15] drastically reduced the health visitor-led Healthy Child Programme[16]. Altogether, health, education and Local Authority services are the source of half of all referrals into Children's Social Care[17]. Without the services having regular contact with children and families, there is a real danger that children will fall through the gaps,

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[13] https://babiesinlockdown.files.wordpress.com/2020/08/babies-in-lockdown-main-report-final-version.pdf
[14] https://www.childrenscommissioner.gov.uk/wp-content/uploads/2020/05/cco-lockdown-babies.pdf
[15] https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/C0145-COVID-19-prioritisation-within-community-health-services-1-April-2020.pdf
[16] https://www.gov.uk/government/publications/healthy-child-programme-0-to-19-health-visitor-and-school-nurse-commissioning
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/167998/Health_Child_Programme.pdf
[17] Characteristics of Children in Need, 2019, Table C2

going without essential help and intervention from social workers, or early help from the wider health visiting and local early years support services for those below the statutory thresholds.

For babies, there is no substitute for health visitors proactively seeking out those who missed checks or haven't been seen; nor for identifying parents who are struggling with mental health or other issues that impact on their parenting capacity without support. The needs of these babies and very young children may therefore remain hidden for a considerable time or remain unknown and therefore unmet.

We know what parents' value and want from health visiting services, due to service user research in recent years and, most recently, a pre-COVID-19 survey[18] 'What do parents want from a health visiting service?' It is clear that without a recovery plan that rebuilds the health visiting service alongside a wider 'Whole-Society' commitment to early childhood health, wellbeing and development, health visitors will struggle to meet the needs of families at the most formative years with life-long effects.

The Children's Commissioner's first recommendation for 'Best Beginnings in the Early Years'[19] is that 'Government should create a new, cross-departmental strategy to support children's development in the early years.' At present, 'There is no overarching strategy that makes sure that support is in place when it is needed for every child, and that there is a clear, single point of access for families to get help. There are wide local variances meaning that a child in one area of the country could get a very different experience and offer of help than another. Likewise, the Institute for Public Policy Research calls for a 'Whole Society Approach'[20] that requires strengthening of health visiting and school nursing with a restored and enhanced Public Health Grant amongst other cross-sector measures.

The lack of coherent strategy, fragmentation and inequity of provision is, with like effect, reflected in workforce planning for health visiting, school nursing and wider children's workforce, giving rise to the concerns we raise in the following section (9).

**9. What long term projections for the future health visiting workforce are available, and how many more staff are required so that burnout and pressure on the frontline are reduced? To what extent are staff establishments in line with current and future resilience requirements?**

Since 2015, there has been no national workforce strategy for health visiting in England unlike in the other three devolved administrations. Rather, workforce is determined locally by each individual Local Authority through its commissioning function. It is not possible to predict long-term projections other than to note that the workforce has declined dramatically with the cuts to the Public Health Grant. The imminent demise of Public Health England compounds this uncertainty.

The COVID-19 pandemic has exposed how fragmented the service landscape is for our youngest children whose health, development and learning are not determined by specific agencies, settings or other categories but the way they combine and support their key relationships and experiences at home and beyond.

[18] https://ihv.org.uk/wp-content/uploads/2020/01/HV-Vision-Channel-Mum-Study-FINAL-VERSION-24.1.20.pdf
[19] https://www.childrenscommissioner.gov.uk/report/best-beginnings-in-the-early-years/
[20] https://www.ippr.org/research/publications/the-whole-society-approach

It is widely recognised[21] that reducing inequalities requires a whole-system, integrated approach as prevention and intervention cut across a range of stakeholders working with children and their families[22]. This is also affected by wider determinants of health like poverty, housing and government policy. Health visiting is part of a "system" – we maximise the impact of the service by working collaboratively with partners. Effective strategic leadership across the system is needed at all levels to ensure place-based co-ordination across those responsible for the wider determinants of health to enable integrated pathways to:

- Support all children and their families to reduce inequalities in key priority areas;
- Identify children at risk of poor outcomes;
- Provide a continuum of support for a continuum of need, to address multiple key priorities across Government departments.

The Children's Commissioner (2020)[23] has called on Government to make early childhood central to the 'COVID fightback' in 'Best Beginnings in the early years - A proposal for a new early years guarantee to give all children in England the best start in life'.

> Government should establish a national workforce strategy for the early years, based on robust workforce modelling, focusing on staffing across health, local government and early years settings. This should include a drive to sustainably increase the numbers of people working in the early years, including health visitors. p38.

The report on the Impact of COVID-19 from UCL[24] recommends:

- A clear workforce plan to ensure that the health visiting service has sufficient capacity to manage the backlog of missed appointments, as well as demand for support due to the secondary impacts of the pandemic.
- A proactive plan to ensure staff wellbeing during the restoration of services.

The iHV makes more detailed recommendations for the health visiting workforce in its 2019 report that sets out its Vision for health visiting in England, with additional requirements for post-COVID recovery. We recommend:

> Revised workforce modelling will be needed to establish workforce requirements to deliver the refreshed Healthy Child Programme currently being developed by PHE and all levels of the health visiting service offer. This should include current work demands, including essential and desirable work that is currently not completed, due to the depleted workforce arising from cuts ***and*** to recover from the backlog and build-up of unrecognised and unmet need during COVID restrictions. Due to the lack of capacity within the current workforce, a workforce plan will be needed to build capacity to implement the recommendations in full.

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[21] Black M, et. al. (2019) Learning across the UK: a review of public health systems and policy approaches to early child development since political devolution. Journal of Public Health. https://doi.org/10.1093/pubmed/ fdz012

[22] Public Health England (2019) PHE Strategy 2020-25. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/830105/PHE_Strategy__2020-25__Executive_Summary.pdf

[23] https://www.childrenscommissioner.gov.uk/report/best-beginnings-in-the-early-years/

[24] https://ihv.org.uk/wp-content/uploads/2020/07/Conti_Dow_The-impacts-of-COVID-19-on-Health-Visiting-in-the-UK-POSTED.pdf

**10. To what extent are there sufficient numbers of health visitors in training for service and resilience planning? On what basis are decisions made about the supply and demand for professionals in training?**

The transfer of commissioning away from the NHS to Local Authorities in 2015 has left a vacuum in national workforce planning and the commissioning of training from universities by Health Education England (HEE). HEE has funded health visitor education until now, although it is anticipated that this will be superseded by the use of the Apprenticeship Levy by individual employers. This does not equate to the equivalent level of funding for fees and salary provided by HEE but will transfer additional unfunded costs to employers or, indirectly, to commissioning Local Authorities. We consider this to be another risk to the recovery and sustainability of the health visiting workforce.

The IPPR Report makes specific recommendations for per capita resourcing of school nurses and enhanced mandated service provision by health visitors. We welcome these recommendations but would add that the health visiting workforce should also be remodelled on a per capita basis and take account of vulnerability[25] and deprivation. We provide more detailed recommendations in 'Health Visiting in England: A Vision for the Future' which is our evidence-based blueprint to rebuild health visiting services'[26].

**11. Will the measures announced in the NHS People Plan be enough to increase resilience, improve working life and productivity and reduce the risk of burnout now and into the future? What further measures will be needed?**

The NHS People Plan contains welcome principles and measures that will be supportive of all staff groups including health visitors, but only to the extent that health visitors are fully included. A significant minority of health visitors are not employed by the NHS, but by independent providers or by Local Authorities. Moreover, the funding to enable the provisions of the People Plan must be factored into commissioning plans for health visiting services within the Public Health Grant for so long as this continues. The breakup of PHE must also be used as an opportunity to ensure that professional leadership and funding of health visiting and school nursing which, between them lead the Healthy Child Programme, is assured. This must include workforce modelling, planning and resourcing in conjunction with Health Education England.

**12. Recommendations**

i. Health visiting services must be **fully prepared for any future waves of COVID-19**. NHS England should revise the Community Prioritisation Plan (and Emergency, Preparedness, Resilience and Response (EPRR)) and develop clear messages on the importance of continuation of the service to ensure the needs of children are prioritised. This should include the removal of wording on the redeployment of health visitors.

ii. A clear **workforce plan** is needed to ensure that the service has sufficient surge capacity to manage the backlog of missed appointments, as well as demand for support due to the secondary impacts of the pandemic. Health visitors must be fully included in provisions of the NHS People Plan with a recovery plan to rebuild the health visiting work force. More

[25] NOTE: The health visitor's role straddles the 3 levels of vulnerability recently defined by government: Clinical vulnerability; Higher risk and have statutory entitlement for care and support; Higher risk due to wider determinants of health / other factors leading to poor outcomes. Workforce modelling is needed to ensure sufficient funding for the HV workforce to address all 3 levels of need.

[26] https://ihv.org.uk/wp-content/uploads/2019/11/7.11.19-Health-Visiting-in-England-Vision-FINAL-VERSION.pdf

detailed recommendations are contained in Health Visiting in England: A Vision for the Future.[27]

iii. A **cross-Government strategy is needed to reduce inequalities** and "level-up" our society. The Public Health Grant must be restored and strengthened to secure an effective health visiting service model, level of provision and professional workforce that works across the health and social care system and beyond, and provides a vital "safety-net" for babies and young children.

iv. **Strategic oversight for health visiting is needed at national and local levels** with clear lines of accountability for reducing inequalities at every level of the system and actions to overcome the fragmentation and unwarranted variation currently affecting child and family public health as a whole in England.

v. The impact of working during the COVID-19 pandemic on **staff wellbeing** cannot be underestimated - a proactive plan is needed to ensure staff have the right support during the restoration of services and to create high-quality workplaces for all staff in the future.

***Sept 2020***

[27] https://ihv.org.uk/wp-content/uploads/2019/11/7.11.19-Health-Visiting-in-England-Vision-FINAL-VERSION.pdf