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Education Committee

Health Visitors

Oral Evidence

Wednesday 22 June 2011

Nicola Amies, Director of Early Years, Bright Horizons Family Solutions and member of expert panel for Tickell review of EYFS, Liz Bailey, Head of Children's Services, Medway Community Healthcare, Maggie Fisher, Chair of Health Visitors Forum, Unite/Community Practitioners Health Visitors Association (CPHVA) and Regional Co-ordinator, Netmums, and Anne Page, Policy and Public Affairs Manager, Family and Parenting Institute

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Taken before the Education Committee

on Wednesday 22 June 2011

Members present:

Mr Graham Stuart (Chair)

Neil Carmichael	Damian Hinds
Nic Dakin	Ian Mearns
Bill Esterson	Tessa Munt
Pat Glass	Craig Whittaker

Examination of Witnesses

Witnesses: **Nicola Amies**, Director of Early Years, Bright Horizons Family Solutions and member of expert panel for Tickell review of EYFS, **Liz Bailey**, Head of Children's Services, Medway Community Healthcare, **Maggie Fisher**, Chair of Health Visitors Forum, Unite/Community Practitioners Health Visitors Association (CPHVA) and Regional Co-ordinator, Netmums, and **Anne Page**, Policy and Public Affairs Manager, Family and Parenting Institute, gave evidence.

Q1 Chair: Good morning, ladies. Thank you very much for joining us today to discuss health visitors and their role in school readiness—or indeed, in helping to stop school unreadiness. May I ask you about that subject to start us off? Why is school readiness, as a concept, so contentious among early years specialists, but less so among health professionals?

Anne Page: I think the educationalists who work in early years see themselves as providing education. They do not quite see themselves encompassing the same broad definition of child development as a health visitor or other people working in the health professions would, so there is something about how people see themselves as professionals. I would add that we have recently done work with parents, where we have interviewed a number of parents about what they expect from early years practitioners and early years centres. Those parents said that where they have issues about behaviour, they would like to be able to get information and advice from early years practitioners about behaviour management. When we discussed that with civil servants and practitioners, they were surprised, asking, "What's that got to do with education?" Yet parents saw no difference on the behaviour management continuum. A young child having a certain amount of concentration and being able to sit still for a few minutes, and a bit longer as the child gets older, is an integral part of their being able to learn. For educationalists, that was a separate field that other people dealt with. It is about how people see their professional remit to a certain extent. It may also be to do with training, but that is not my specialism.

Liz Bailey: From a health visiting perspective, health visiting is a universal service. Every single family will have a health visitor from the time the mother is pregnant through to when their child starts school. It is universal.

Q2 Chair: Is that in theory or in practice?

Liz Bailey: That is in theory. In practice, we are currently experiencing difficulties within our health visiting service around health visitor numbers, as you are probably aware. Hopefully, I will get a chance to talk about what we are doing about that, going forward for the next four years. The remit of the health visiting service is around enabling children and families to have the best start in life. That is to do with looking at child development, parenting skills and emotional, social and physical development. It is not only about preparing a child for school; it is about preparing that child for life and increasing their life chances. School is one big element of that, but it is about their whole life, including how they make friends. It is the whole remit. Health visitors come at it from a broad, universal angle. It is about preparing the child and the family for all that that child may face in its life. School is one huge element of that.

Q3 Chair: So, Maggie, the health visitor side has a broad, balanced view, as opposed to these early years specialists who obviously don't. Is that your view?

Maggie Fisher: Well, we come from looking at children in the context of the Bronfenbrenner framework or an ecological framework, looking at the child in the context of the family and the neighbourhood. It is an holistic assessment that health visitors do. Mental health and well-being is a preserve of childhood. It is very important, to give children a start in life, to ensure that things that can prevent them developing to their full potential are mitigated. The universal health visiting service is in a very good position to do that. The problem has been that the universal health service has virtually disappeared. It has become so targeted that it is not being effective any more. That is a huge difficulty that we have been facing.

Q4 Chair: Do health visitors intervene themselves? Are they mostly a signposter to other services, or do they deliver front-line differences and support? Often we seem to have a lot of assessment of children and lot of signposting—and then a great big failure to provide services that meet their needs. Do health visitors both assess and provide?

Maggie Fisher: Yes, we would make an assessment and also signpost. There is a difficulty, in that there is sometimes a lack of capacity in the community to meet the needs of children. The children's centres have been a fantastic resource that we can signpost to and which was welcomed by parents. There is great concern that the Sure Start children's centres funding is not ring-fenced any more. There has been a cut in that provision. There are some fantastic models where health visitors and children's centres have become well integrated. In Brighton and Hove, all the children's centre managersare health visitors and there is an early years professional whom they work alongside. They deliver very good outcomes. There are lots of different models of service delivery and of how health visitors can work well.

As I have said, the difficulty is that health visitors are often not seeing families as frequently as we used to 10 years ago, when the outcomes for children were much better. There is national evidence to show that children with speech and language delay are not being picked up. Evidence from the Royal College of Speech and Language Therapists shows that 40% of their referrals used to come from health visitors. Now that health visitors are not out there doing that work, only 15% of referrals come from health visitors. They also get a lot of inappropriate referrals from other settings, and the same thing happens with child and adolescent mental health services. Since the demise of the robust universal service, they have really noticed the effect that that has had.

Q5 Chair: You said that standards had fallen, or outcomes for young people had fallen. Can you evidence that?

Maggie Fisher: Yes; I quoted the speech and language therapist, and in Scotland the child and adolescent mental health services were the subject of an inquiry. The parliamentary Committee identified that at the crux of the question whether the statutory services were able to identify mental health problems in the very young was the way in which those services interacted with the group. The key role was traditionally fulfilled by the health visiting profession, which would uncover such problems in the course of a general un-stigmatised interaction with families with young children.

One difficulty is that we have had a huge influx of skill mix, and the health visiting service has been diluted to such an extent that it has ceased to be as effective as it was. Health visitors are managing huge case loads—in some areas, in excess of 500 or even 1,000 children—and they are managing skill mix teams, so they are unable to be out there doing the face-to-face work they need to do. In many areas, health visitors, if you are lucky, see a family twice at home, which may be a new birth visit and may be an eight-month developmental review, or it may not. Increasingly, we have other people doing that work, and the difficulties are not always being picked up.

Can I give you the example of the two-year developmental review? For this Committee, I was gathering evidence from across the country, and there all sorts of different types of delivery. In some areas it is targeted by the health visitor, and in others it is done by the community staff nurse or the community nursery nurse. In some areas it is done by home-to-home contact, and in others by coming into clinic. In some it is done as a group—as a birthday party—in others it is done by postal questionnaire, and elsewhere it is done over the telephone. That is meant to be a two-year check that is supposed to have universal coverage. I am not surprised that children are not being picked up, if that is how it is being delivered.

The Healthy Child Programme is a fantastic piece of policy and guidance. It is evidence-based and researched, and there are some fantastic tools in it to allow health visitors to do their jobs. When I asked health visitors at a recent conference how many of them had access to the validated tools, very few had, because it has not been commissioned and health visitors do not have access to the tools that equip them to do the job properly. So, there is a problem in the interpretation of the Healthy Child Programme and with the commissioning of it. I will be quiet now.

Q6 Chair: Thank you for that full answer. We will come on to many of those issues later. You said that outcomes for children had deteriorated over the last 10 years, which is a point I want to pick up on because there has been a vast investment in children's centres—expenditure has been increased. You gave an answer that I tried to follow as closely as I could, suggesting that there were issues about the way that health visiting is working, and so on, but you said that outcomes were worse for young people. What outcomes, and what evidence do you have that they are worse?

Maggie Fisher: Can I quote some national evidence from the ALSPAC study, which is the Avon Longitudinal Study of Parents and Children? We know that a lot of poor parents parent well, and a lot rich parents parent poorly, so you have the materially rich and the emotionally poor. The danger is, and what has happened with the targeted services is, that we actually miss children who have unmet needs that are not being clearly identified.

Q7 Chair: Okay; that is a technical point—I am not sure that "technical" is the right term—that we will explore. Specifically, you said that outcomes were worse. I wanted you to tell me what evidence you have, and not give a critique of the system and the way that it could be better. What evidence is there that, in 10 years, it has become worse?

Maggie Fisher: I have been gathering evidence for this Committee from across the country, and health visitors are sending me a lot of information confidentially, looking at school readiness. For instance, children are going into school who are still in nappies; they are not toilet-trained, are on a bottle, have dummies, have speech and language delay, and they have emotional, social and behaviour problems.

Q8 Chair: Is the basis for the assertion that it has got worse anecdotal, or is there any objective assessment, because that was true of some children 10 years ago? You said that it had got worse, and I was interested to see—I do not want to nail you on it.

Maggie Fisher: I think that the health intelligence is out there. It is probably not being collected. The other thing is that we know that children who have special needs are not being picked up. There has been an increase in children on the autistic spectrum and those with cerebral palsy being missed and not identified until late on. I have a lot of evidence to support that, but it is local health intelligence. It is not pulled together into a national body of evidence.

Q9 Craig Whittaker: Maggie, can I just take you back to your comments on outcomes? You mentioned the speech and language therapist, and, interestingly, I had a round table with him earlier in the week. One of the key points that came out was that 50% of our prison population have speech and language therapy issues. That hasn't happened in the past 10 years—unless we started putting kids in jail at 10—and it was obviously a problem before. Are you saying, therefore, that it has deteriorated even further and that, at some point in the future, we will have 75% or 80% of our prison population in that situation; or did we not get it right 10 years ago either?

Maggie Fisher: I think one thing that has happened is that we have become much more aware of picking up and identifying what the signs are. Much of the prison population includes young people or children with learning difficulties such as dyspraxia or dyslexia that have not been detected. We have got a lot better at even admitting that those complications exist, because, 10 or 15 years ago, there was a big sense of denial about some of those conditions, and head teachers have said to me that dyslexia does not exist. So there is a lot more acceptance and awareness of how children develop, and we now know that we could do more about that. There was a lot of denial and ignorance.

Q10 Chair: Nicola, can I bring you in?

Nicola Amies: Just coming back to school readiness, we find in the early years sector that there is no clear definition of what is meant by that term, and we search for that. For some people, it is that children are academically ready. For some, it is that children are socially, emotionally and academically ready for school. There is then a concern about when school starts. For some, it is when a child goes to reception at age 4. For others, it is when they go to year 1. That field of confusion will continue until we get a definite definition of what school readiness means. There was some research carried out in the United States in 2007 by the Franklin County Department of Job and Family Services in the state of Ohio. They carried out an assessment and review of school readiness and came to the conclusion that, until a definite definition of school readiness was established, it was very hard to work out how they were to measure that children were ready for school. We need to get that across.

To be ready for school, we feel that children need to able to cope with some of the big changes that will happen. We talk about survival skills. If a child has been in a nursery, for example, they are used to a ratio of one to eight, and they are going into a school setting with a ratio of one to 30, so there isn't a nurturing environment. They have to be able to cope with things such as being in a playground, which is a big change from where they have been before, coping with getting undressed and dressed fairly quickly for PE and coping with lunch boxes. That is quite a change for children, so it is important for us in the early years to prepare children for what we call survival skills.

It is about children being socially and emotionally ready to cope with school—it is a big change—as well as being academically ready. It is about children being able to approach learning with a positive disposition. They should have inquiring minds and be creative and problem-solvers. They need resilience, so that they can cope with anything that the world will throw at them. They should be prepared for school, but also for life. It is quite a big task for early years, working with parents and with our colleagues across the health sector as well.

I am aware that TACTYC—the professional association for early educators—is doing some research on school readiness. It is reviewing the literature that is out there at the moment. That will be published in September, but it has a very helpful definition that it is using at the moment. It views that readiness is when there is a balance between the child's individual development and the educational provision from which the child is able to benefit. It is looking at the individual child, what their needs are and how the educational setting will meet those needs. I know that we are talking about England, but I work in Scotland as well in my role, and it is interesting that in Scotland there is an option for parents to defer their child going into primary 1, which is the equivalent of year 1 here in England. I am not aware of that in England. Some children are not quite emotionally ready for school, so that is an option that parents can take, because they look very much at whether the child is holistically ready for school. There is that option in Scotland, but I am not aware of it here. It could be considered.

Q11 Chair: So you propose that that should be looked at as a right for parents?

Nicola Amies: That is an option that could be explored further as a benefit, if there are children who are clearly not ready, and that is to do with when they are born—summer-born children are at a slight disadvantage compared with other children.

Q12 Chair: I see nodding heads from Maggie and Liz. Can I ask *Hansard* to record that you are in agreement with that point? Anne, do you also agree?

Anne Page: Yes.

Maggie Fisher: Yes.

Liz Bailey: Yes.

Q13 Bill Esterson: I am interested in the last point because there is plenty of evidence that people generally, and children in particular, can learn only once their developmental needs are met and they are feeling secure and able to deal with other things, so I am glad you said that.

Partly from personal experience, but also from talking to children's centres and health visitors, I hear that a combination of good health visitor support with

parenting and what goes on with other professionals seems to be the best indicator of success. Certainly what schools tell me is that those children who are closest to what Nicola has defined as school-ready are those who have had help through both children's centres and health visitors. I am interested in your comments on that.

Liz Bailey: We actually have some local evidence about the work we have done with our children's centres. In Medway, we have had a children's centre programme running for the past four or five years—we have 19 children's centres in Medway. We have a huge remit for children's centres. Medway council and Medway Community Healthcare are coterminous in terms of geography—it is a unitary authority. We have a very long-standing and historically good relationship with the local authority, which has enabled a lot of really good partnership working to happen, particularly around the children's centre agenda.

Quite controversially, about four years ago we moved health visitors out of GP surgeries and into children's centres. It was controversial, as you can imagine, but it has had a massive impact on the children and families who attend those children's centres. Part of my remit is also children's therapy services, and we have put speech therapists into children's centres as well. We have very good health provision in those centres. The community midwives also work from them, so it is very much about families coming in the very beginning when they are pregnant and accessing a whole range of services that will support them.

The evidence I have on the impact of children's centres and all those professionals is from the Early Years Foundation Stage profile undertaken on children at the end of reception, which is a very holistic measure of how that child is doing. In 2005 in Medway, 34% of children achieved about 78 points or above and in 2010 that had gone up to 55%—that is a huge difference. There is a really direct correlation between what has been provided through those children's centres and how children have been really enabled to progress and obviously achieve more in that particular profiling exercise. For us in Medway that is a huge bonus, because it is a very deprived area and we have a huge amount of child protection and safeguarding issues. We are looking at really improving the life chances of those children in Medway.

Q14 Damian Hinds: May I come back to the definitions question? I think I was following what you were saying perfectly, Nicola, until you got on to the measure of balance between—I can't remember what you said. You had a good list and then it went a bit—

Nicola Amies: It is the balance between the child's individual development—looking at the child holistically—and the education provision from which the child is able to benefit.

Q15 Damian Hinds: What does that mean?

Nicola Amies: Looking at individual children's needs and how the educational provision will meet the needs of that child.

Q16 Damian Hinds: Okay, I am still not sure I follow that as a measure of school readiness.

Nicola Amies: That would not be a measure, it would be a definition.

Q17 Damian Hinds: Maybe we can talk about some of the earlier things. You rightly mentioned the difficulties with different definitions of which time stage you are talking about. Surely, between the Tickell report, the recent Frank Field report and other things, it is all there presumably. Frank Field talks about children being able to take their coats off and recognise their own names. Clare Tickell talks about children being toilet-trained, able to listen and getting on with other children. Some of those are very tick-boxish measures, I suppose. Others require a little more evaluation, but it should be quite straightforward. What has got in the way of having a straightforward common understanding of school readiness?

Nicola Amies: There isn't an agreed definition, an agreed measure, if you like.

Q18 Damian Hinds: Who should be in charge of having such a thing?

Nicola Amies: I would say that is a joint duty between health and education, with a view of experts in the field.

Maggie Fisher: Yes.

Q19 Damian Hinds: So why has there not been an urgency? This Committee has heard anecdotally about school readiness, that, at best, it has not improved over the past few years and, at worst, may have got worse. In the Millennium Cohort Study the gaps in school readiness between rich and poor children are at least as bad as they were 30 years ago. Given all that, why has there not been urgency to understand school readiness, and to establish a base point to move forward from? Any thoughts? It seems to matter a lot to people in early years, in education and health. What has been holding everyone back?

Maggie Fisher: I don't know exactly what has been holding everybody back, but lots of people seem to have very strong views and opinions on it. It is a bit of a pedagogical swear word—school readiness—and the argument is that schools should be ready for children, not children ready for schools.

Damian Hinds: I want to come on to that in a moment.

Maggie Fisher: I sit on the National Children's Bureau Early Childhood Forum steering group, which has put together a short definition, which I will share with you. It is about establishing rich foundations from birth for a life of learning, enjoyment and achievement. I think that is rather nice and sums it up succinctly.

Q20 Damian Hinds: Any other thoughts?

Liz Bailey: Going back to measurement at the reception stage, that measures how well a child has been achieving since being in school for one year. It seems to me that you need to bring that measurement back a year, so that you can assess a child's readiness for school around the same areas. It looks at the

emotional, social, physical, developmental and learning needs of a child. You need to do that pre-school. That would sit very much within the transition between health visiting and children entering school. I think there is a need to look at something like that, a measurement that says where they are at pre-school. Then, when you measure again after one year at school, you have a very good quantitative evaluation of how those children are doing at that point. At the moment, there aren't those kinds of measurement pre-school. We have developmental assessments that health visitors do, but, as Maggie said earlier, at the moment they are very patchy as to how often they are done, and they are often targeted at children in the greatest need. It is not universal. What we are doing in health visiting, the implementation of the new health visiting strategy and the increase in health visitors, is to enable families to have services and interventions right up to that point. There is an argument that health visiting is really around the age of nought to three. Then there is a gap between three and four or four and a half. We should actually still be continuing to see and assess and intervene with those children beyond three years. I hope that the work we are doing in taking forward health visiting, increasing the numbers and looking at a different model of delivery will enable that to happen.

Q21 Damian Hinds: I would like to come back to the services and interventions point in a moment. Before I do, there's the point people make that we should stop going on about children being ready for school, and should talk about school being ready for children. What is that all about?

Anne Page: From parents' point of view, we recently surveyed about 400 parents about early years particularly and what they expected. It was interesting that they did think that at age two onwards, which is when children are going into funded child care places—we are talking about ages two, three and four where the gap perhaps exists—parents have an expectation that the early years will help them get their children ready for school. Also, they told us that because they see their children becoming more independent at age three and four and they are in an early years setting, they feel that, as parents, they can be a bit more hands off and allow the child the independence. That suggests that parents see the job of services coming more into play as they begin to see their children grow up.

Q22 Damian Hinds: Gosh. The independent three-year-old—fascinating. Nicola, on this issue about schools being ready for children rather than children being ready for school, is that actually what is driving your definition of this balance, or is that just to keep everyone happy?

Nicola Amies: If that is going to be a definition of ready for school when they go into reception, it is important that, when we look at four-year-olds, we realise that they are not all the same. It is a challenge for a teacher with a class of 30 to be able to meet all those needs. Some four-year-olds are incredibly independent, very creative, use their initiative and problem solve. Others are very anxious, uncertain, nervous and need support with their academic skills. It must be a challenge—I have talked to teachers—to be confronted with a group of four-year-olds who are at varying stages. We need to look at how we can get that balance right, which is why looking at perhaps deferring might help and is one option. We should maybe also give more support to teachers in the classroom, although I know there are teaching assistants. That is the concern we have. Are schools ready? Are children ready? It is a question of getting the two married together and of what is right for the individual child to be successful in school and in life.

Q23 Damian Hinds: So we have talked a bit about what has happened over the past 10 years or so in terms of school readiness. It is probably fair to say that the data are not perfect—there are some studies and some anecdotal evidence, but we cannot be absolutely certain—but it sounds like quite possibly, at the very least, things have not improved markedly. That is the same decade in which we have had Sure Start. Why have things not improved markedly?

Liz Bailey: I think it is regional. Obviously, I can speak only on behalf of Medway. We have had some huge improvements in Medway, and a lot of that is down to the Sure Start children's centre agenda that we have been working on for the past four to five years. We have had some significant impacts on children's lives. It is not just the evidence that I presented earlier. In terms of outcomes, we have improved things like breast feeding rates and had a reduction in admissions to A and E for children under five, so we have got some definite outcomes that we have achieved through the children's centres.

Q24 Damian Hinds: Forgive me for interrupting. I am absolutely not disputing that; I am sure that there are positive outcomes. One of the points of Sure Start is to narrow the gap between children with wealthy, middle-class or engaged parents—whatever you want to call them—and the most disadvantaged children, specifically in terms of being ready for school because we know that, by the age of five, so much has already been set in stone. If we are to give those kids an equal chance, we must get them on an equal footing. It sounds like, although we cannot say for certain, that that has not happened. My question is: why has that not happened? What has not happened within Sure Start to give those kids the chance they deserve?

Maggie Fisher: Can I just cite the Flying Start programme, which is an example from Wales? It has had the same difficulties, but it has gone down a slightly different route. One of the things it has done is to invest in the health visiting service. Flying Start has had fantastic outcomes and I am happy to share the results with the Committee. The knock-on effect has been that, in other areas where health visitors have had big case loads and there is lots of deprivation, it has invested in an enhanced health visiting service. That has paid dividends.

I honestly believe that one of the difficulties is that there has been a huge investment in children's centres and the family nurse partnership at the expense of the universal health visiting service. We need both. I honestly believe that if we invest again in the

universal health visiting service, things will improve. There is huge evidence for the effectiveness of the health visiting service and I am happy to share those findings. We need to be working in partnership with colleagues in children's centres. The health visiting service and school nursing service are an important part of the team around the child, the team around the family and the team around the children's centre.

Q25 Damian Hinds: I know that you as individuals and as a panel cannot speak for Sure Start. I am asking you as impartial observers, analysts, experts, professionals and carers in the field to give your assessment of what has or has not happened and worked in Sure Start to improve the school-readiness of the most disadvantaged children in our society.

Nicola Amies: It is a mixed picture across the board. I have seen good results in Medway. Again, it is about whether Sure Start centres are truly reaching those hard-to-reach children and those vulnerable families who, for whatever reason, are not accessing Sure Start facilities. Some of that may be to do with stigma. I know that it has been raised as a possible concern that some people will not access Sure Start because there is a stigma around state support. It may be that there are other reasons, such as maternal depression, domestic violence or substance abuse. Those are barriers to such families accessing the support available from Sure Start, and that needs to be looked at far more closely.

Q26 Chair: Is it that the whole approach is wrong? I do not know whether it is the nature of politics, but the previous Government decided to roll out Sure Start centres, with every community having them—that was 3,500 centres. It was brutally centrally driven with the feeling that this is a good thing, so who would oppose it? Look at health visitors. Before the election, this Government said that they would increase the number by 4,200. Bang! It's going to happen.

Now, with the Education Bill, there is free nursery care for every disadvantaged two-year-old. Who could oppose that? It is very much like there is a fat controller pulling the big lever at the centre, rather than trusting the front line to use limited resources most effectively to meet local need. Do we need to stop coming up with headline measures that sound sympathetic and good and that go down well at the hustings? Should we not be increasing health visitors by this number? Should we be passing the resource down and saying, "Use it as you see best to build teams that best meet the needs, address these problems and deliver the outcomes we want," instead of someone in here announcing some big new measure?

Liz Bailey: To go back to Nicola's point on the culture and perception of Sure Start children's centres, in some areas there is a perception that they are there for those who need them the most, so some people would not necessarily access them. It depends on how you interpret that model and how you then deliver it locally. We have put midwives, health visitors and speech and language therapists in our children's centres. By the way, they are not called Sure Start children's centres, but just called children's centres, and the majority of them are located within school premises, so they are part of education as well.

The way we have taken it forward in Medway is a holistic partnership arrangement. Our access targets to children's centres are incredibly high, because everyone wants to come. There are pockets of hard-to-reach families, but the children's centres have an agenda to try to reach out and engage with those families. The same applies to health visitors to enable the families to come in and engage with some of those activities. I think that you are saying that there should be local interpretation of how you take forward the bigger strategies, and that is what we have done in Medway. It has paid off.

Q27 Chair: I suppose I am asking whether you should be measured on outcomes and given the resource, or whether these central initiatives change the system and are overall beneficial. Can those central initiatives be counter-productive in some cases? If things have got worse, despite all these initiatives and all this investment, it would suggest that there is something fundamentally wrong in policy making.

Maggie Fisher: I just wanted to share with you a piece of evidence from America by Shonkoff in "From Neurons to Neighbourhoods". He showed that it takes 10 hours of contact time to have one hour of intervention with hard-to-reach families. Fundamentally, that is where it has gone wrong. Health visitors were the people who were out there and having the contact with the families, and building up the relationships, getting them to the children's centres and signposting them to the services. If you are not out there, the hard-to-reach are not necessarily flocking to the doors of children's centres. It takes a huge amount of work to build up a trusting relationship—to get parents to access services. That is one of the issues.

Things like post-natal depression, domestic abuse and child protection occur across the whole social spectrum and across all social classes. It is not necessarily those who appear deprived; it can be other parents. We have an awful lot of middle-class parents who have huge areas of need, and they get very upset if they are prevented from accessing Sure Start children's centres. You want a rich mix of people who can support and learn from one another. It is not just the poor who need Sure Start children's centres.

As Liz has said, the delivery model of local services matters enormously. I have cited Brighton and Hove. Where health visitors are an integral part of children's centres, you don't have problems accessing your catchment population and the hard-to-reach, because your health visitors will get them through the doors.

Nicola Amies: I want to refer back to the research carried out in the States by Franklin county, Ohio. It is interesting because it refers to the Bush Administration's declaration that, by 2000, all children in America would start school ready to learn. When it looked at what was happening, it found that there was increased accountability in the public schools on results and there was national testing of children. However, when it looked at the research evidence in 2004 and 2003, it indicated that American

children entering kindergarten were less prepared for school than had been hoped, so that is an interesting piece for us to explore further.

Q28 Ian Mearns: I am really interested in this in terms of getting those youngsters who need the services most into the services that are available. How are we going to solve that particular conundrum?
I am a governor of a primary school in the centre of Gateshead. We talked earlier about youngsters not being school-ready. There are three and a half and four-year-olds coming into nursery who are not toilet trained, who cannot sit down and eat a meal at a table, who cannot dress themselves and who cannot functionally communicate, yet their parents could have had accessed a Sure Start children's centre but did not do so. We have talked about barriers such as drug and alcohol abuse—and sometimes just bone idleness. How are we going to get to the youngsters, sometimes saving them from their own parents' inability to engage with the services that are available?
Anne Page: I just wanted to comment on how these services are received by parents and families. There is no consistent system any more. It is so varied that people in the same extended family living in different geographic areas will have a completely different experience. The report that we did in 2007 found an example of a family of brothers and sisters who lived in two different London boroughs. They were travelling between boroughs to take best advantage of the services that each individual couple were accessing for their young children. They knew that somebody was getting a service over the border in the next borough that they were not getting in their own borough.
People need to know exactly what the system is. At the moment we have a very basic system based on antenatal care, pregnancy, birth and then post-natal care. The system then starts to get much more varied as children get older, so we need to have a clear pathway for parents and families of what they can expect. It is not even clear for families. They have a notion that the health service will provide in the early years, around birth and immediately after, and they have a notion that they will provide more as their children move into early years education.

Q29 Ian Mearns: Are you saying that parents in the middle of Gateshead will access the services available to them because there is a different menu of services available in, for example, south Tyneside? I do not think that that is the case.
Anne Page: No, I do not have an example. My example was from a London borough, which is just one example. I am not extrapolating that as a statistical example.
Liz Bailey: Just to clarify, there is a national programme—the Healthy Child Programme—that sets out the core services that every single family is supposed to receive, from pregnancy to the time the child starts school. It is laid out in the national strategy, and there are a number of key contacts that health visitors, their teams and other partners should deliver to every single family in the country. The variation comes with capacity issues in health visiting services. Parents should know what they ought to expect to receive, but in some areas they might not receive that, depending on the capacity of the service. Going back to your point, Graham, about why it should be a good thing that we are having 4,200 extra health visitors, it absolutely should be, because those extra people will enable us to deliver that programme to every single family. We are then providing what a universal service should be, and so there is something out there that is national.
Chair: Thank you for that. That leads neatly into Pat's question.

Q30 Pat Glass: Just moving on from what Ian said, I have explored with panels before whether we should be judging or holding to account early years providers—Sure Start children's centres, health visitors or whoever they are—on the basis of the GCSE outcomes in their area of children receiving free school meals. Liz, you smile, but the director of education is held responsible for this, although he has no direct control. If people were held responsible, would you not get in these hard-to-reach children? Would there not be more of an effort to get these children in and to deal with these families if there was proper accountability?
Liz Bailey: I think the issue is not about effort but about capacity, so from a health visitor's—

Q31 Pat Glass: We've got 4,200 new health visitors, so not a problem.
Liz Bailey: That's the plan.
Maggie Fisher: It takes a while.
Liz Bailey: Health visitors are accountable for their actions. They are autonomous practitioners.
Pat Glass: I am not just talking about health visitors—
Liz Bailey: Absolutely there are issues around accountability. I do not think that services look that far along or at the long-term outcomes. There is a gap to do with what those long-term outcomes should be. We have the Family Nurse Partnership Programme in Medway Health. All such studies in America tracked children for 20 years and looked at the long-term outcomes for them—around educational attainment, criminal activity and parenting skills—but in all the other universal services, I don't think that we look that far ahead. We look at short-term outcomes. I agree, yes, that we need to look that far ahead and to bring it back to what we are doing.

Q32 Pat Glass: What about you, Nicola?
Nicola Amies: I agree. We do not have that research or longitudinal study. I know that a lot of people refer back to the Head Start research and that longitudinal study of children in the United States, but we just do not have that. I find it interesting if we are looking at whether children are more or less ready for school than 10 years ago, yet we cannot get our arms around the data, which is very frustrating. What we hear is anecdotal evidence.
If there was more local control and accountability, knowing your local area and working with others in the sector might work. Interestingly, I heard a story

from a colleague who runs a children's centre in Hertfordshire. She is incredibly creative and she knows her local area well. By talking to colleagues in the field, she knows where the gaps are, such as the two-year-olds who might not be deemed vulnerable because of the criteria, so she knows that there is a need for those families to come to things. She is finding creative ways of bringing them in, and also of generating income to support that. That is a local example and more of it might help, but we need to know what the outcomes are—what it is we want for children and how we are going to go about measuring that.

Q33 Pat Glass: On something more tangible, let us come back to the issue of school readiness. I have spent 25 years in education, but we have been grappling with it for 25 years. I must confess that it almost felt like going back 20 years when, with virtually no experience of SEN, I took over a SEN department; I have found the same frustrations this morning. I walked into what seemed to be a secret garden, largely populated by women. We talked a great deal and there were lots of nice, warm words, but we never moved forward. It is not beyond the wit of man to do so. Should we be recommending that the Department for Education gets together a couple of educational psychologists, people from the health service, some teachers and head teachers, and comes up with what school readiness means? Accepting the context, and the issues of SEN and summer-born children, will we actually get something that says, "This is what school readiness means"?
Nicola Amies: I think that is very important, and we should involve people so that we can establish what school readiness means here in England and how we are going to achieve it.

Q34 Pat Glass: With all the health warnings, etc.
Nicola Amies: Yes.
Pat Glass: Okay, thanks. That is really helpful.

Q35 Chair: Sorry, for the record and for *Hansard*, did we have the support of all the other members of the panel, too?
Anne Page: Yes.
Liz Bailey: Yes.
Maggie Fisher: Yes.

Q36 Pat Glass: Moving on to assessment, which is one of my huge frustrations from working in this area for a long time, health visitors are going in and assessing children; educational psychologists are assessing children; teachers are assessing children—when will we stop assessing and actually intervene? If we had the 4,200 health visitors, would it allow us, at that early point, to be able to intervene properly with families? Would we be able to get small groups of children together and work with parents on toileting and getting their children off the bottle, the dummy, and all the rest of it? Would an increase in health visitors help that to happen?
Maggie Fisher: Absolutely.
Liz Bailey: Yes. We have the new health visitor implementation plan, and that strategy has been laid out through the Department of Health in a much more user-friendly way. It sets out exactly what the health visiting service should be delivering, which is no different from what it should have been delivering.

Q37 Pat Glass: So what does it say they should be delivering?
Liz Bailey: It says that there should be a universal package of care for every single family based on the Healthy Child Programme. For those families who are assessed with other needs, it is about delivering evidence-based interventions.
We are one of the early implementer sites, and we have signed up to work in partnership with NICE to help us develop our packages of care. We have some very good evidence-based interventions, which will be packaged up for health visitors to deliver with those families.
At the moment, because of the capacity issues, a lot of advice is given and there is an expectation that parents just get on and sort it out for themselves. Actually, though, going back to Maggie's point, some of those parents who you might think are articulate and able still need the support of the health visitor. If we have additional health visitors, we will be able to support those families.
The work that we are doing with NICE involves measuring outcomes, too. So if you offer an intervention for six or eight weeks, what is its outcome? What does that mean for that family and that population? Part of being an early implementer site is that we are able to start to do some of that testing and then, hopefully, it will be rolled out nationally from April next year.

Q38 Chair: Nicola, are you similarly positive about the 50% increase in health visitors?
Nicola Amies: We definitely need an increase in health visitors. I know they are looking at the private early years sector, but we would very much welcome health visitors coming into our settings. There is a lot of talk about health visitors working in children's centres. We find that if we identify that a child has a difficulty in their learning—an area of developmental delay—if the parent is not ready to acknowledge that, we cannot secure additional support for that child. If health visitors—familiar faces—came in and built up trust, it would be easier for us to talk with the parent and start to access those services. We could then get further specialist assessment and intervention for those children. We would very much welcome an increase.

Q39 Pat Glass: I want to be absolutely clear. This additional and big resource will not just be for more assessment; it will be for delivering the sleep programmes and all those kinds of things.
Chair: Maggie, do you want to come in on that?
Maggie Fisher: Going back to Nicola's point, years ago, all the health visitors liaised regularly with all the nurseries and playgroups and it worked incredibly well, but I feel as though we have gone backwards big time. If we have 4,200 health visitors, it only takes us back to where we were 10 years ago.

Yes, we can definitely deliver the outcomes. I have been given a background paper about the Healthy Child Programme and the education and training of health visitors, which I am happy to share with the Committee—it is only a short paper. But by working in partnership with children's centres staff and health visiting teams, we can absolutely deliver.

Chair: Thank you.

Q40 Ian Mearns: Quickly on that point, according to the Department of Health study, in Doncaster, the ratio of health visitors to children under 5 is 1:160. In Gateshead, my own authority, it is 1:243, and at the bottom of the pile, in Redbridge, it is 1:1,042. In Medway, it is 1:359. How many should it be?

Maggie Fisher: The CPHVA and professional guidance that we produce say 1:250 and less in areas of disadvantage. In fact, Sarah Cowley has worked out a scale. Family nurses working with vulnerable families have a maximum of 25. Health visitors may have 50, 75 or over100 vulnerable families. It is not safe and it is not reasonable. We need to be able to equip our health visitors with the education, the training and the resources that they need to be able to deliver the outcomes of the Healthy Child Programme. Certainly, the new service vision for the Department of Health will enable that. The health visitor implementation plan has been warmly welcomed by the profession. We are very optimistic for the first time in years that things can change. The Healthy Child Programme is a fantastic piece of policy and guidance, and if it is delivered properly it will deliver the outcomes for children. It is evidence-based and can make a big difference. The problem is that it is not being delivered, in how it is implemented and commissioned, as it should be at the moment.

Q41 Pat Glass: Can I ask for your opinion on issues of targeting? You were saying that the ratio of some professionals who work with vulnerable families is 1:25.

Maggie Fisher: Family nurse partners have a caseload of a maximum of 25 vulnerable families.

Q42 Pat Glass: Right. I disagree to some extent with what you said earlier, Maggie. You said that we are still getting children who we are not identifying with SEN. I think that we have got much better at that over the past 10 years, to the point where we are over-identifying some areas. However, I have concerns about the issue of targeting. Yes, we have some specialist people who work with 25 families, but in my experience there is a group of families who are very good at identifying and sharing information, and at getting assessment and getting things right where there are profound difficulties, but we are still not getting it right for the child who turns up at school and, as you said, is still not toilet-trained, does not know how to negotiate other than by using their fists and biting, does not know how to take instructions, and has less than 10 information-carrying words. Should we have steps around the levels of targeting?

Maggie Fisher: Yes, and I guess that that is what the Healthy Child Programme is doing. There is the universal service, the universal plus and the universal partnership plus, which is an intensive service. So yes, if we have a robust universal service. Parents are not going to share their concerns with you unless they trust you. It is easy to miss some things if you do not see a family regularly, so that you get a really good, holistic view of the child in the context of the family. Things like domestic abuse might be going on.

I'm sorry, but could you repeat your point?

Pat Glass: It was about whether we should have levels of intervention.

Maggie Fisher: Yes, we have levels of intervention within the Healthy Child Programme. Definitely.

Liz Bailey: I echo some of what Maggie was saying. Within the new health visiting strategy, that is how it is laid out. It is much more explicit now on the expectations of the service to deliver those types of levels. It is about how you then target your resources accordingly, looking at your case load numbers and the profile of the case loads. In Medway—I think this is reflected nationally—the number of child protection cases has increased by about 40% since baby Peter died, and that is purely because people have become much more vigilant about identifying it and about making referrals, and social care thresholds have changed. That has increased the workload of health visitors around the child protection safeguarding element. I agree that there is a gap of families who have needs but do not fall into the child protection bracket. Their needs may be mild or moderate, but the long-term effects of those issues, if they are not addressed, are significant. If we had the additional resources, we can really make a difference to families in that bracket.

Q43 Pat Glass: Nicola, you are on the receiving end of this to some extent. Do you see an improvement?

Nicola Amies: The proposal was that there was a two to two-and-a-half year-old assessment and that, at some point, we look at how that joins up with the two-year review on health. I would say that, if health and education can really work together on identifying those children earlier and making sure that support is there to enable them to be successful, it is very much welcome. We hear about the EYFSP results and the fact that 44% were not achieving a good level. We need to know what is happening to those 44%.

Anecdotally, we hear so many people saying again and again, "Children are coming in, not toilet trained." There is real concern about their speaking and listening skills. Where the ECAT programme is running, there is a noticeable difference in children's speaking and listening skills. I do not think that ECAT has been firmly embedded yet. I am sad to hear that some funding cuts are impacting on ECAT. I understand that the name will also be changed. I wish they would stop changing names. It is important that we do some work on how effective the ECAT programme has been in the Early Years.

Q44 Chair: This is Every Child a Talker.

Nicola Amies: My apologies. I should not use abbreviations, but I understand that there is clear evidence that Every Child a Talker is making an impact on improving children's speaking and listening skills. We need to look at that with the work that is

happening with the Healthy Child Programme, and the intervention.

Q45 Chair: You've got the Healthy Child Programme and the EYFS. Frank Field suggested that they should come together into his life chances indicators. Is he right? Do you have any thoughts on his recommendations on life chance indicators, Maggie?
Maggie Fisher: There was quite a lot of concern around using BMI, because that is not something that the National Child Development Measurement Programme would use because it has not been tested. It was not evaluated for use with children under five, so there was concern about that.

Q46 Chair: Sorry—this is the body mass index?
Maggie Fisher: Yes, the body mass index. It has not been proven that it is actually a suitable measure for children under five. Skin-fold is a better measure than height and weight. The Healthy Child Programme is a fantastic resource. It is an evidence-based programme that works. I am concerned about introducing another level of tools and assessments, when what we have already under the Healthy Child Programme is very good.

Q47 Chair: We are going back to my very first question. The health people are broadly happy with their assessment, and there is a lot of controversy among the educationalists. You then have Frank Field with an even broader spectrum. We need to bring everyone together to be happy. It is not enough that those involved in health are happy.
Nicola Amies: The Tickell review also mentions this. There is a proposal that there be a two to two and a half year-old summary of development in primaries—physical, social and emotional development—and, at some point, that health and education should join together so that it is an integrated piece of work. Everyone who is working with a child and family needs to be joined up in order to meet the needs of the child and the family.

Q48 Chair: I guess that part of the thinking with the life chances indicator is to make it clear to people what the meaning is. It is because of the cruel correlation between development at three or five, and where children end up at 16 or 20. Is that welcome? I guess that the name "life chances indicator" shows that it is not just that the child is not doing very well at the moment and will have a bad first year at school; but that in fact, it probably means they will not do very well at GCSE.
Nicola Amies: I know Frank Field suggests some possible assessment tools. Those need to be looked at very carefully before a blanket decision is made to use those assessment tools. Two of the assessment tools he suggested were Bracken and the BAS. In the early years field, people are very vocal about their views on that. More work needs to be done on what tools to use and the value of those tools. Those in early years will say that the best way of observing and assessing children is through naturalistic observations done over a period of time as a shared feature, rather than some of the standardised tests that do not always give an accurate picture.

Q49 Nic Dakin: Can I just follow that up? Pat asked earlier about school readiness and putting people in a room with experts and getting sorted out. Should they also pick up the point about the appropriate tests to use?
Nicola Amies: Yes, definitely. We need experts in the field who know a considerable amount about the benefits, the impacts and the negative sides of some of the tests that are out there.
Maggie Fisher: Yes. Some of the tools Frank Field has recommended are actually in the Healthy Child Programme and the two-year review, so there is some overlap, but there are some that we would be concerned about.

Q50 Nic Dakin: Can I pick up two other points that have just come out in the discussion? First, is the Tickell and Allen advice about having a two-and-a-half year single integrated review, which you mentioned, Nicola, desirable and achievable?
Liz Bailey: Yes.
Maggie Fisher: Yes, absolutely. It is the way to go. She talks about the personal child health record—the red book—and not enough use is made of it. We use it in health, but it needs to be a real tool that everybody uses; every time they see the child, they should write in it so that it is a record that the parent has. Any practitioner who works with the child will also have it, and they can record their observations and findings.

Q51 Nic Dakin: So it will happen; there's no barrier to it happening. Anne.
Anne Page: From what families tell us, they do want advice from health visitors. They want a coherent pathway and they want it to make sense. They want to know what is likely to happen and who is likely to be the trusted person. In terms of the red book, some disadvantaged families will find it difficult to organise themselves to use it in the way Maggie has just described—Maggie keeps nodding, so I am sure she agrees with me. Some families may need more than one approach if we are to work with them and show them how their book can be used. In terms of continuity for parents and families, if the red book is a parent health record, it will empower parents where they have the ability to take full advantage of that, but we must acknowledge that some parents and families will need help to do that.

Q52 Nic Dakin: How closely do health visitors and those working in early years settings, including at the start of the school, work together at the moment? Is that as it should be, or should it be different?
Liz Bailey: I think it is variable across the country. Again, I can only draw on the Medway perspective, but we have very good working relationships with our early years settings. As I said as regards our children's centres agenda, that has been firmly embedded in health, education and the local authority. I feel we have a very good model of how these things could work. That is not to say that what we do is perfect by

any means, and there is clearly work in progress to continue to reach some of those hard-to-reach families, but the partnership working goes on at ground level and strategically, so we have it throughout the range of levels in organisations. Everyone is signed up to that way of working, so you have created a whole culture that feeds up and down through organisations. That is one of the things that needs to happen. You can have professionals on the ground who might have good working relationships, but if, strategically, you do not have directors who are working together and are signed up to things like information-sharing agreements, partnership agreements and pooled budgets—we have those in Medway for some services around speech and language therapy, and that has worked very well—you will only tackle part of the problem. You have to drive that forward at a whole-system, organisational level.

Maggie Fisher: I would agree with Liz. It is a very mixed picture across the country, and different things are happening. A lot of it comes down to local leadership. Where there has been strong leadership of health visitors, and a belief and investment in that, things have worked well. Where there has not been that, they have not worked well and have gone backwards. I have evidence from across the country, which people have sent me, and the picture is very mixed.

Q53 Nic Dakin: A lot of anecdotal evidence is coming out, which is fine, but listening to this session generally, one of my frustrations is that you tend to refer to north American studies when you refer to evidence. Have we just not had research done in the UK that we can draw on? I do not know whether the evidence supports some of the things we have heard this morning or not. What we feel is happening is not necessarily what is happening. If we go back 10 years, things may be just the same. I am a bit frustrated that, when we point to studies, they tend to be north American examples, and anecdotes tend to be UK examples. Are there some UK studies that you can point us to?

Maggie Fisher: Yes, certainly. There is the "Discover" study that looked at what health visitors do and how health visiting is being implemented. I am happy to send evidence from that, because it gives a very good picture of the different types of health visiting services and also the evidence base for health visiting. I can send you that as well. There is a difficulty, because we often look across the pond to other countries for the international evidence. It does not necessarily always translate to a British culture and society. I would say look at Wales, because the Flying Start programme there is doing incredibly well. It has fantastic outcomes. It's in our country—well, it's not in our country; it's in the United Kingdom—and we could learn a lot from looking at that.

Chair: It is definitely in our country, for the record.

Q54 Nic Dakin: We have also had a richness of investigations—Tickell, Allen, Field—that are all pointing in the same direction, which I think you are saying you are broadly in support of.

Maggie Fisher: Yes, definitely. They all agree, and there is also the evidence from the Munro review as well. From what she said about social workers, there is a parallel process that you can apply to health visiting as well. Jane Barlow and Sarah Stewart-Brown have done an awful lot of research in this country around health visiting and parenting, and impacts and outcomes, so we do have a good evidence base in this country.

Anne Page: I would like to draw the Committee's attention to the existence of C4EO, the Centre for Excellence and Outcomes, which at least some of you are probably familiar with already. It has attempted in the last three years to build up a bank, which is available on its website, of promising interventions, some of which are robust when measured against particular measures, but some of them still have a bit of a way to go. They are attempting to encourage people to improve on the robustness of their evaluation of promising and good work going on around interventions with families in this country.

Q55 Chair: For the record, you are convinced of the critical importance of health visitors to the overall outcomes that we seek.

Anne Page: Based on our surveys of parents, yes.

Chair: Excellent.

Q56 Craig Whittaker: In 2004, we had just over 10,000 health visitors. In 2010, we were down to 8,000, which is a 20% reduction. We have covered the consequences of having fewer health visitors. Why the reduction? What has happened? Is it cuts? Is it people getting fed up with the service?

Liz Bailey: It is a range of things. There have been spending reviews and some cost-cutting exercises in the past, and health visiting has been one of the services affected by that. But I think a lot of issues have been around the profession. There has been a loss of motivation among staff to continue to work within the profession. The Victoria Climbié and Baby Peter cases have had a big impact on case loads and health visitors. Stress levels within health visiting have risen because of the number of child protection cases. It is a combination of individual perception of the profession and also financial issues.

Maggie Fisher: Things like "Health for All Children (Hall 4)" had a massive impact on the health visiting service. The way it was interpreted was that we did not need to have health visitors looking at healthy children, and we became more targeted, to the detriment of the service. There is also the north-south divide and the perception that people in the London and south-east region were relatively well off, whereas the poor north needed more resources.

Q57 Chair: When did that initiative start?

Maggie Fisher: In 2004, I think. The way it was interpreted, we did not actually need to have health visitors checking healthy children. We also had a huge influx of skill mix, and we are now skill mixed to the level that it is unsafe in some areas. We have health visitors managing huge case loads and skill-mixed teams.

I must also mention the deregulation of health visiting, when it was removed from the nursing register Correction: the title of of health visiting was removed from statute in 2001

Q58 Chair: When was that?
Maggie Fisher: That was in 2004 Correction Health for all Children was published in 2003 , and I think the closure of the dedicated register was 2004. If you want to demotivate a profession, deregulate it. There are many issues. See submitted evidence

Q59 Craig Whittaker: As a follow-on question, the Government are obviously looking at an increase to 4,200. If those fundamental issues are still there, surely they will not recruit 4,200 because there will not be the incentive to do the job.
Maggie Fisher: There are issues around pay and banding because of what has happened in health visiting. Some health visitors are on band 6 or band 7. Community midwives, who often used to come into health visiting, are band 7, but they will not go off and train for a year to become band 6. There are all sorts of issues. In terms of the service vision for health visiting, the Department of Health is looking at them, but there are many different reasons.
Health visiting is the second most stressed occupational group in the whole NHS if you look at the NHS staff survey. If we really want to attract health visitors back to health visiting, we must improve their working conditions, their value and status, and the way they are perceived. The health visiting implementation plan is starting to do that work, so this is a good time for people to come into the profession, but we've had a real winter for the past few years.

Q60 Tessa Munt: Can you explain the working conditions?
Maggie Fisher: I guess it probably depends where you work, but in areas where there are big case loads, few health visitors managing skill needs teams, and a lot of vulnerability and child protection, Victoria Climbié or Baby P could happen to any of us tomorrow when managing such levels of risk. That is one reason why many health visitors left the profession. The whole team where I worked left.

Q61 Tessa Munt: I would have expected child protection; I wondered whether there was anything outside the job.
Maggie Fisher: The stress—and I think it's probably the way you feel that you've been devalued, and that your skills are not appreciated when you're trying to work extremely hard and you're not making any progress. You know you're not doing the job properly that you were trained to do. That causes huge internal stress.

Q62 Tessa Munt: One very little question—sorry, Craig. What were you trained to do?
Maggie Fisher: I was trained to be a health visitor.

Q63 Tessa Munt: Sorry—what were you trained to do that you are not doing?
Maggie Fisher: To be able to work holistically with individuals, families and communities, and to go out and promote health and well-being, to prevent ill health, and to protect vulnerable children and adults. I didn't feel that I was able to do that adequately. We are duty bound under our own code of conduct to manage risk, and many of us felt that it was very difficult, given the capacity and resource issues, to manage risk. One example is not having the tools to do the job for the two-year review. So few of us have access to the validated tools that we need to be able to do the job properly. Those sorts of issues make you feel that what you do is not important, and has been devalued.
That is the past. Morale is low, but there is real hope for the future, and that things will change and we will get more help.

Q64 Craig Whittaker: Bearing in mind that you mentioned managing all these multi-tasking, multi-skill teams, do you have to be a qualified nurse to do the job?
Liz Bailey: At the moment, yes.

Q65 Craig Whittaker: We know that you do, but does that have to be?
Liz Bailey: Some areas are piloting direct entry to health visiting, so as long as you have a first degree in a relevant subject, you don't have to be a qualified nurse. That is one of the things about the new early implementer sites. We are looking at other ways of recruiting staff into the profession. Traditionally, it used to be that a midwife would come into health visiting, but we are now trying to broaden the opportunities for other people. For example, if you have a psychology degree or a degree in public health, that could potentially be a direct-entry route into a postgraduate degree in health visiting. Part of the whole push towards additional recruitment for health visiting is looking at alternative ways of recruiting into the service, because we cannot continue as we have been.
The other issue that I would like to add is that we have huge numbers of health visitors who are ready to retire. At the other end of the spectrum, organisations have to look at flexible retirement packages and how we are perhaps going to entice people back into practice once they have retired. So, we have got it at both ends—we have the issue of trying to increase the numbers of students coming in and training as health visitors, and we also have to combat the issue of the proportion who are about the retire.

Q66 Chair: Can you quantify that?
Liz Bailey: The proportion?
Chair: Yes. Do you have any figures to hand?
Maggie Fisher: It's about 50% who will retire in the next five years—it is huge.
Chair: It's 50% retiring in the next five years!
Maggie Fisher: It's massive.

Q67 Craig Whittaker: Does anyone have a different view to what has just been said regarding different types of recruiting?

Nicola Amies: Looking again at what the early years could do, there is concern around the early years work force and the qualifications that are out there at the moment. There was a time when there was the specialist early years qualification, the NNEB, and I know Clare Tickell has referred to that. There was a time when the NNEB qualification enabled people to work alongside colleagues in health. That qualification does not exist anymore. That depth of specialist training for early years does not exist as it did. If we go back 15 or 20 years, that was a very effective partnership, where you had qualified nursery nurses working alongside health and doing some of the support working—

Maggie Fisher: We still have qualified community nursery nurses, but there are so many different types of qualification now. As you say, those on the NNEB course had very good training; it was excellent. The other thing is that there is no career pathway for our community nursery nurses. Some of them are fantastic, excellent and skilled. When I asked them recently at a conference how many of them would like to train to be health visitors, 50% put their hands up, but there is no mechanism for them to be able to progress at the moment. We need to look at that.

Q68 Craig Whittaker: I was interested in what you said earlier on about what happened in Medway. The figures you cited went, I think, from 38%—for those hitting 78 points—up to 55%, which is really incredible. However, what about the other 45%? That is the thing that sticks in my craw, because that is almost 50% of our kids. My question to you is: is the universal health visiting service, as it currently stands, working and value for money?

Liz Bailey: As it currently stands, it is not working as it should be—absolutely. I believe that if we increase our capacity and deliver the model that is now set out in the new implementation plan, we can significantly improve those statistics. It is value for money at the moment, in the sense of the work that currently happens, because we are working with those with the greatest need. If you are looking at long-term outcomes, you could argue that with the family nurse partnership programme, for example, there are long-term outcomes about the benefits of preventing children going into care placements and a whole range of other social and economic benefits.

I think it goes back to the point that Pat made around the long-term outcomes for the universal population of children. We do not measure that at the moment. We do not track those children, and we are looking only at that top 30% of those in greatest need. My view is that if we are able to increase the capacity of health visiting through the next four years as predicted, and to deliver the new service as laid down in the new Department of Health plan, it is going to be one of the most valuable services within health, because there will be long-term benefits affecting those children as they move into adulthood.

Q69 Craig Whittaker: Can I ask you to clarify that? The 45% whom you are not getting to—

Liz Bailey: The figures that I quoted were for the numbers of children achieving 78 points. It went up to 55% last year.

Q70 Craig Whittaker: So how many of those not achieving that would you not be seeing?

Liz Bailey: They would be seeing those children.

Q71 Craig Whittaker: Okay. So they see all the children in the borough.

Liz Bailey: They see all those children. These are the children who have achieved that level. What the statistics say is that there is a correlation between some of that and the work that has happened in children's centres, pre-school. All those children are seen by health visitors at some point, but with the increase, we will obviously be able to improve those figures.

Q72 Craig Whittaker: Does this, then, go back to Pat's point earlier that we're very good at assessing, but we're not very good at getting to and doing?

Liz Bailey: Absolutely. I don't think health visitors are familiar with what the early years foundation stage profile measurements are. As a health visitor, you hand over your case to the school nursing service at the age of four and that's that, so in a way, a health visitor is not familiar with what happens from that point. Let's say that they were, that they knew this particular assessment was made of children, and they were aware of the impact they were having. That brings me back to the point about doing the pre-school assessment; so absolutely, there's a lot of work to be done around that particular point.

Q73 Neil Carmichael: How do you think the impact of more health visitors can be measured?

Maggie Fisher: Liz made the point about having these measures—measuring children when they get to the baseline and health visitors being aware of the measurements that will be used. That would be one good way. School readiness is one obvious way of doing it, but also relevant are the longer-term outcomes. We haven't really mentioned post-natal depression, but we did a survey on Netmums and 50% of mums admitted to feeling low or depressed in the first year of their child's life. We know the devastating consequences that can have on a child's development. Lynne Murray has this month published a study that shows that maternal post-natal depression has devastating consequences up to the age of 16. Also, we know about unpublished evidence from the London School of Economics about the cost-effectiveness of supporting mothers with post-natal depression just using health visitors. It was a cost-benefit analysis. The cost was £879 per birth, with a saving of over £620 million if you just looked at the effects on maternal mental health, before you even considered the effects on the child. There are an awful lot of measures that we can look at and use to measure the effectiveness of the health visiting service and outcomes for children, and mental health and well-being has to be one of them.

Liz Bailey: As part of the work we are going to do as part of the early implementer site, we have to develop

a suite of performance indicators and outcome measurements over the next year, so that we can demonstrate the impact of all the additional investment in health visiting. That's part of being an early implementer and working with the Department of Health to develop that.

There are several ways. There are going to be activity levels that we can measure in terms of how far we're actually delivering the Healthy Child Programme, based on just activity. I mentioned earlier the work we're doing with NICE in relation to the evidence-based packages of care. There'll be a pre-imposed outcome measurement of that to demonstrate what has happened and the impact within that. Then there'll be some public health key performance indicators that we'll be measuring, and there'll be some long-term outcomes. There'll be a whole suite of performance indicators that will develop over the next year.

Clearly, we can't just take all the health visitors, say "Thank you very much" and not demonstrate their impact, because it's a huge investment financially for our commissioners. It also means shifting money around from other services to invest in health visiting. Obviously from their perspective, there is a need to give some assurance that it is value for money and is meeting some very key outcomes.

Q74 Neil Carmichael: Do you think that the Government's targets for increasing the numbers of health visitors are realistic, especially in relation to available trainees and the likely flow of applications?

Maggie Fisher: The Department has just announced 1,400 training places for health visitors this year, and 10 return to practice courses are being run. Certainly, NHS London has been looking at some fast tracking of health visitors, which has been very encouraging. It is an optimistic target, but I think that with a lot of hard work and by selling the service and profession, we can do it. However, it is a bit like an oil tanker in the middle of the ocean; it takes a long while for it to turn and for things to start changing. The Department is certainly very committed to making it happen, as is our professional organisation—the CPHVA. I hope that it is achievable. The question is what happens with strategic health authorities, how much funding there is, and how they are being carried through. Again, we know that some areas are very committed to it and are doing it, but in other areas, they are not, so there might be a difficulty there.

Liz Bailey: As part of the whole implementation plan, every single provider service has had to put forward their trajectories for the next four years to show how they will meet their targets, so we have an end target of how many we need to meet per SHA and per provider organisation. Built into that is a four-year work force plan of how we will increase our numbers, and around that is how that will actually happen. It will be through increased numbers of students, which we are working on within our SHA; we have increased the numbers of places, and we have looked at different models of training students within our services. There will also be the return to practice courses that will be coming through. We can put all of that in, and there is a huge national campaign starting in July on return to practice, which is coming out of the Department of Health. It will target health visitors who are currently not working. We will then have local and regional recruitment drives to entice people back in, so there are a whole range of measures that we have put in place to try to meet our targets.

Because it is such a huge investment from commissioners, we, as providers, have to work incredibly hard to fulfil the investment promise that has been made to us from our commissioners. For example, we normally train four students, but for us, this year, we are training 10. We have hugely increased the numbers of students that we are training with a view to employing those 10 students the following year, when they have qualified. So, there are mechanisms in place.

Q75 Ian Mearns: It would be interesting to pursue something that was said earlier about a health visitor seeing the family and taking the child through till they are four or five, depending on the stage of development, and then handing them over to the school nurse service. It seems that an awful lot of what you have said today seems to be arguing for a massive increase in the capacity of the school nurse service, as well as health visitors.

Maggie Fisher: Absolutely.

Liz Bailey: I would absolutely agree with you. It is another service that has been seen as a Cinderella service, in a way, and again, there is a lack of recognition of the role of the school nurse with some of those children. The school-entry age changing means that health visitors have handed over case loads for children aged four. School nurses are very thin on the ground, and you will find one school nurse being responsible for 12 or 13 schools. You are talking about thousands of pupils, and the impact that one professional can have is minimal. The next stage of health visiting development is looking, from a public health point of view, at what the impact of school nursing is on the whole agenda, because they are the missing link in some of this. I don't know whether you would agree from an education perspective, Nicola.

Nicola Amies: I haven't got much experience with school nurses, but now you have said that, I can see that there would be a need. I was not fully aware in my role that there is a handover at four, so if colleagues are saying that there is a shortage of school nurses, there is clearly a need to look at that support and what is going to be most effective.

Q76 Chair: Anne, do parents notice the scarcity of school nurses?

Anne Page: It is not something we have a great deal of evidence for. We have more general evidence showing that parents expect early years school to play a role in promoting their child's well-being and welfare.

Chair: Before we come back to your pursuit, Neil, I shall go to Nic.

Q77 Nic Dakin: Given the investment in health visitors, would not one mechanism be to say that health visitors should remain with the child through

the first year of school as part of that payback on that resource investment?

Liz Bailey: I absolutely agree that that would be one way of looking at it. As part of the early implementer sites and the work we are doing with the Department of Health, that is going to be one of the topics of discussion that we will be looking at over the next year. It is not just a case of handing over; there has to be a transition period. If there are clearly children with a huge amount of need and no resources, we need to look at where we meet in the middle around that. Certainly, that will be some of the work that we will be doing over the next year.

Q78 Neil Carmichael: Earlier you talked about the importance of integration, which is absolutely right. Given that the Government are talking about having local authorities as commissioners for health services, how do you think that will unfold and impact matters? Could you answer that question, which is probably more for Maggie and Liz?

Liz Bailey: The commissioning of health visiting sits quite firmly within a local authority in the sense of all the things we have talked about today. It is not just about clear links; there's an absolute correlation between the work of early years and health visiting. If it doesn't sit with a local authority, it could sit with GP commissioning, for example. It would become very medicalised and sit outside of the remit of our partners in the local authority, which I believe is exactly where it should be commissioned from.

Q79 Neil Carmichael: The local authority?

Liz Bailey: Yes.

Maggie Fisher: I think there are pros and cons. One of the concerns is that we must not lose our links with general practice. I keep harking on about Brighton and Hove, but what they've done is this: all their health visitors are employed by health, but are sort of TUPEd over to the local authority. That seems to work quite well. We need to make sure that we work in an integrated way with local authority children's centres, but that we retain our links with general practice. What's happening in many areas is that health visitors are being pulled out of the GP practice and we are losing those vital links with primary care. In some areas, they are not even in children's centres; they are actually in a third area that is maybe on the outskirts of a town. That isn't very sensible either.

We do need to keep our links with health and our colleagues—GPs. One of the difficulties is that GPs are not signed up to this agenda around Sure Start children's centres generally. They don't see it as being part of their remit. Health visitors act as a bridge between local authority children's centres and GP practices. We need to make sure that we keep those channels of communication open because parents do see their GPs. I think they have 30 contacts in the first five years. We need to be sharing that information because it is vital, but you can only do that if you are seeing your GP colleagues regularly.

Q80 Neil Carmichael: That's exactly right. I completely agree with that. What I want to know from all of you is how you think the integration between a local authority with its commissioning role and public health role, which is obviously pivotal, plus the commissioning in the NHS—we have just talked about that—and, of course, schools will work?

Nicola Amies: I've heard a lot of talk about how health visitors are working with Sure Start children's centres. Again, if we could agree the name, it would help. We mustn't lose sight of the fact that a lot of children are cared for and educated in the private and voluntary sector who don't get enough access to health visitor support. There are numbers of children who come in and we identify that they've got learning difficulties or additional needs. There may be family needs. If we can't access them, they are children who will fall through the system. When we are looking at commissioning, we need to look at the full picture. Where are the children and how can health visitors access them?

Q81 Neil Carmichael: It's a question of having a holistic approach to this. It's not just a package dealing with health; it's not just a package dealing with learning disabilities at school; and it's not just a package dealing with a family difficulty. It could be a combination of any one of those and a whole range of other things. If we are talking about a health visitor, that person is going to be pivotal in picking up those issues. How does he or she make the link with the other organisations, and how can we formalise that so it becomes more than just, "We want a good link," so that we have a structure that delivers the outcomes?

Maggie Fisher: One of the difficulties is that not all children access children's centres. Nearly 40% do not, and there are a lot of children, such as refugees, asylum seekers and those from Traveller families, who are transient. We often find out about them because they pitch up at a GP practice for immunisations, health problems or whatever. I am not sure I know exactly what the answer is to your question, but I am sure there must be a way of doing it.

Often what happens locally depends on relationships. It comes down to the health visitor having good relationships with the GP practice and all of the people we need to work with, which health visitors are traditionally very good at doing. The difficulty is because the capacity is so small that a lot of those partnerships have fallen by the wayside a bit, because they have so many people to work with.

I will give you an example. Where I worked we were GP attached, and one children's centre might have to work with five different GP practices. It depends on how the services are organised locally, so it is quite hard to generalise about how it should work.

Q82 Neil Carmichael: Absolutely, but if you are going down the community provision route, the ideal situation would be where there are plenty of formal linkages between all of the structures. We want to avoid a bad situation in which people have to be responded to in an acute hospital, or whatever. That is obviously wrong for the person involved and unhelpful to all of the associated people, isn't it? Our task has to be to stop things getting worse. Where is the best place for that in relation to services at the local level?

Liz Bailey: There are two things there. Maggie talked about professional relationships at the local level, and from the 20 early implementer sites the message was loud and clear that there is an issue with the relationship between GP, health visitor and children's centre and a gap in information sharing. So there is something on that local one-to-one level.

I think we need to look to the children's trust set-up and to how children's trusts work on taking this whole implementation plan forward. All the key partners sit around strategically in the children's trust structure. That is where we have developed things such as information sharing agreements, which are absolutely crucial to this going forward. So you have all the representatives of all the organisations sitting around the table, plus you have the links with the safeguarding board, so that safety element is there bringing in those assurances on safeguarding.

There are two levels. You have your strategic level at which you need to get partners signed up to this way of delivering early years services, whether the services are health or education, and you have the local implementation with partners. There is a two tier approach.

Q83 Neil Carmichael: It is gathering information, isn't it? It is joining up the dots. Let's say that the health visitor is the person who is capable of doing that. That means that he or she will have to visit schools quite a lot. A startling fact that came out of one of the Committee's previous inquiries is that 12% of children go home to care for somebody in whatever circumstances. That is an incredible fact, isn't it? Imagine the circumstances in a family situation. We need to link that kind of situation up, don't we? How do you think that that could be achieved, Nicola?

Nicola Amies: Sorry, can you repeat the question?

Neil Carmichael: I am just drawing attention to the fact that 12% of children apparently—

Chair: Support for young carers.

Nicola Amies: Children should not be in that position, but sadly I see that it does happen.

Neil Carmichael: It does happen. 12% of children are in that situation.

Nicola Amies: It is a startling figure. If there was that community working, those children would be identified and support for those families would be there, so we would not hear those shocking statistics.

Maggie Fisher: You need home visiting for that. One other difficulty is that services for young carers in the community are being cut. It is an absolute travesty that that is happening. The most vulnerable are having services taken away from them. We need home visiting, and there needs to be support so that you can identify them. There needs to be the capacity in the community to support them, and that is often lacking.

Q84 Neil Carmichael: So where do you go? One out of every six children actually lives in a house with nobody at work or whatever. Ian was touching on that subject earlier. There is another area on which you need more information. In a situation like that, you might actually be unable to spot it straightaway because nobody is bothering to do anything because of bone idleness or what Ian was talking about, and there are other circumstances as well. How do we tease out those problems?

Liz Bailey: Health visitors do make a holistic family assessment when they first meet them. That is ongoing and they build upon it. That looks not only at health needs, but also at all the needs of the family. It will look at housing, employment—the whole range. They are best placed, because they make that holistic need assessment. It is not that they can actually address all of that, because, from that point onwards, the expectation is that they would then liaise with the appropriate people around those identified needs. There are clearly a huge number of families living in poverty and in really unreasonable circumstances that affect the ability of the children.

Q85 Neil Carmichael: I have one last question, because I know that I have asked a lot. I have teased out the various issues where you have problems, but what about the pathways to solutions and outcomes? The health visitor is aware of all the issues, and he or she has gathered the evidence. Who is really going to be responsible for ensuring that those pathways are clear, efficient and effective?

Liz Bailey: I think it is a collective organisational responsibility, because the pathways will clearly be into health, other health providers, education, early years and some will be into the voluntary sector. Again, I come back to the children's trust structure, because you are in a position to look at all those elements. I currently chair one of our sub-groups—the family and parenting partnership board—which sits under the children's trust board. We have 30 members that represent all organisations, and, on the partnership board that I sit on, we look at things such as the multi-professional, multi-agency issues that affect families and parents, which mean things like pathways and information-sharing agreements. We have a quite clear route for looking at that, reporting back through our children's trust board, so we have to give assurance, and there is accountability through that mechanism.

Q86 Chair: Liz, you supported the idea of the local authority championing and commissioning public health. Does the entire panel support that? Do you think that the local authority having that role, as well as the educational one, is going to help create better co-ordination?

Nicola Amies: I'd say certainly in ensuring that all the stakeholders are included, so that the private and voluntary sectors are at the table as well, because they are part of that joined-up picture of support that is available.

Anne Page: Yes, I agree with Nicola; parents and families are stakeholders in this, so they should be there somewhere.

Q87 Chair: As a democratically representative organisation, one would hope that the local authority might be more inclined to listen to and work with parents than perhaps unelected health bodies previously.

Anne Page: There has been a lot of work done around various ways of consulting user groups, and that could

be drawn together so that people can learn from best practice.

Maggie Fisher: I'm ambivalent about it. I can see strengths and weaknesses on both sides. It's where we were years ago; we were with the local authority and it feels like it's come round full circle again. I have some concerns about that, because we need to retain very strong links with health as well, so if there is a way of doing that, then, yes.

Chair: So it is not without risks. One final single quick question from Tessa.

Q88 Tessa Munt: A very quick one. I was only going to place on record my concerns and ask you about those who live in rural areas who find it very difficult to access services and about those families where both parents are working, and therefore they skip right out of the system because everyone thinks they're fine. Often they are working for reasons of not being able to keep afloat unless they do. That might be a "south" problem, which is why people do not come into the system.

Maggie Fisher: There is a huge issue there around when we deliver services, and particularly working with fathers. We need to deliver services when parents are available, and that is not nine to five, Monday to Friday.

Tessa Munt: Child minders are the other case.

Chair: Thank you all very much. It has been a long but, from the Committee's point of view, very productive session. I really appreciate you coming in to give evidence to us today.

Evidence to support the oral evidence given by Maggie Fisher to the Education Select Committee Wednesday 22 June 2011 regarding the inquiry into Health Visiting

QUESTION 4. EVIDENCE

Speech and Language Development Royal College of Speech and Language Therapies *DCSF (2008) The Bercow Report—Better communication: Improving services for children and young people with speech, language and communication needs. DCSF*

The Royal College of Speech and Language Therapists carried out a review in 2009 which showed traditionally about half—40 or 50%—of referrals to speech therapists in the pre-school period used to come from health visitors this has now changed since "Health for all Children 4", and it found that the figure is now about 15%. Further, in relation to children's speech and language development, crucial for later learning and settling at school, the same committee heard evidence: "that "one real problem" was that health visitors were no longer doing much in the way of universal services and were instead focusing from the outset on additional services and on the children who have complex and intense needs http://scotparliament.com/s3/committees/hs/reports-09/her09–07.htm

EVIDENCE FROM CAMHS

The Scottish Parliamentary Committee identified that the crux of the question whether the statutory services were able to identify mental health problems in the very young was the way in which those services interacted with the group. The key role was traditionally fulfilled by the health visiting profession, which would uncover such problems in the course of a general un-stigmatised interaction with families with young children.

The Scottish Parliament. Inquiry into child and adolescent mental health and wellbeing: Health and Sport Committee seventh report, (2009) (Session 3). Edinburgh: Scottish Parliament http://scottishparliament.cc/s3/committees/hs/reports-09/her09–07.htm

QUESTION 5. EVIDENCE

Health and Sport Committee Report. Scottish Parliament Paper 309. Inquiry into child and adolescent mental health and well-being. 7th Report, 2009 (Session 3) HC/S3/09/R7 http://scotparliament.com/s3/committees/hs/reports-09/her09–07.htm

Skill Mix and the effects skill mix has had on the universal health visiting service.

Fisher M. Skill Mix in health visiting and community nursing teams: principles into practice. London: Unite/CPHVA, 2009.

Unite/CPHVA's annual survey of 829 health visiting members in England (2008) Adams C & Craig I." A service at crisis point". Community Practitioner, 2008; 81: 12, 34–35 attached revealed: 29% of health visitors were responsible for more than 500 children and 35% said the level of skill-mix did not allow for safe and effective practice 47% said they were not involved in decisions regarding the mix of staff.

An unpublished CPHVA survey data from 2010 suggests that 45% of health visitors now have responsibility for more that 400 children and 26% for more than 600 children. Lord Laming advised in 2009 that the optimum caseload should not exceed 400 children. The Lord Laming. Safeguarding children in England: A progress report. HC 330. London: The Stationery Office, 2009.

The CPHVA regard this as the absolute maximum, recommending an average of 250 children per health visitor, and fewer in areas of high need. Unite/CPHVA. What size caseload should a health visitor have? Professional briefing, London: CPHVA. 2009 attached and available to download here:

http://www.unitetheunion.com/sectors/health_sector/professional_groups__assoc/cphva/professional_resources/professional_briefings.aspx

Question 6. Evidence

Please see attached presentation by Sarah Stewart-Brown using the evidence from the Avon Longitudinal Study of Parents and Children showing that there is an association between parenting and poverty but it is small. Many poor parents parent well and many rich parents parent poorly. Mental health was found to be the most influential factor in parenting; reducing financial difficulties did not influence parenting score.

Please see evidence in questions 41 and 42 re the inherent dangers in targeting.

Questions 7 and 8. Evidence

I was unable to recall at the time the evidence that is currently being gathered and the **objective assessment and outcomes for children** up the age of five years. I am including here the work form ChiMat (Child and Maternal Health Observatory) and the PREview Literature Review on the Factors which predict health and wellbeing outcomes for children from the Mother and Infant Research Unit at York see this link http://www.chimat.org.uk/preview and I have attached the pdf document outlining some of the issues they have identified from the (admittedly limited) data in the Millennium Cohort Study datasets. One of the difficulties is that such long term follow up studies tend to have a disproportionately high attrition rate among the more chaotic and troubled families, so these groups and their outcomes may be under represented.

The Healthy Child Programme (HCP) Pregnancy and the first five years of life here http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_118525.pdf is based on the evidence on what works and what the evidence suggests may improve outcomes for children with medium- and high-risk factors, Additional impact measures, such as immunisation rates, programme coverage, smoking in pregnancy, father's engagement, feedback from parents and the Early Years Foundation Stage at the age of five, are also useful measures of HCP outcomes.

This is a very useful report from the Centre for Social Justice Report "Making sense of early intervention: A framework for professionals" July 2011 downloadable from here http://www.centreforsocialjustice.org.uk/client/downloads/20110707_early_years_report_web_v3.pdf

C4EO, *Grasping the Nettle: early intervention for children, families and communities*, London, 2010 downloadable from here http://www.c4eo.org.uk/themes/earlyintervention/files/early_intervention_grasping_the_nettle_full_report.pdf

Question 9. Evidence

I was unable to evidence my comment on the day that there had been an **increase in children with special educational needs.** Evidence from the DfE that shows there has been a considerable increase in recent years in the number of pupils with SEN without statements (A new SEN Code of Practice in 2002–03 the new Code of Practice replaced the previous five stages of SEN with a new system of three classifications: School Action; School Action Plus; and statement led to a drop in the proportion of pupils with SEN without statements, but this has been rising steadily since then). From 10% of all pupils in 1995 to 18.2% or 1.5 million pupils in 2010. (DfE SEN SFRs (1995) to (2010) and DfES (2004).)

In the recent DfE SEN consultation paper evidence from DfE SEN SFRs (2005) and (2010) shows that the numbers of pupils with behavioural, emotional and social difficulties has increased by 23% between 2005 and 2010, to 158,000 pupils; the number of pupils with speech, language and communication needs has increased by 58%, to 113,000 pupils; and the number of children with autistic spectrum disorder has increased by 61%, to 56,000 pupils

Question 19. Evidence

I am attaching the **schools readiness** statement I referred to in my evidence from the NCB Early Childhood Forum.

Question 24. Evidence

Please see here http://dera.ioe.ac.uk/569/1/100715interimevaluationen.pdf also attached for an interim evaluation of **Flying Start** in Wales.

Children's Centre Outcomes. The Audit Commission Report Giving Children a Healthy Start Feb 2010 reported

> "Between 1998–99 and 2010–11 we estimate that £10.9 billion (including £7.2 billion for Sure Start, which had dedicated funding for health improvements in the early phase of roll-out) will have been

invested in programmes aimed in whole, or in part, at improving the health of the under-fives, but this has not produced widespread improvements in health outcomes. Some health indicators have indeed worsened—for example, obesity and dental health—and the health inequalities gap between rich and poor has barely changed.

Our research found that local authorities (LAs) and primary care trusts (PCTs) were aware of the key health issues affecting the under-fives in their areas, but this was not always reflected in strategic plans, and was rarely given priority in local area agreements (LAAs).” Page 4.

“Children from minority groups have poorer health outcomes and their parents are less likely to access mainstream health services due to lack of awareness or cultural preferences. Local bodies need to tailor and target their service provision appropriately, for these groups. But few LAs and PCTs in our research had a rigorous approach to identifying the take-up of existing services and addressing any gaps.” Page 4.

This repost made the following recommendations for Government:

— Continue to develop and actively promote age-specific cross departmental children’s health policy for the under-fives, thereby reducing inconsistency, and duplication between departments, and better informing local service planning and delivery;

— Undertake a review of the funding and workforce implications before continuing to roll out **the Family Nurse Partnership programme**; and

— Monitor and review the impact of the current economic downturn and potential financial impact on the provision of children’s services.

The repost made these recommendations to Local authorities and primary care trusts:

— Ensure that their Children and Young People’s and Operational plans contain appropriate and challenging targets for improving the health of the under-fives that are jointly set and consistent with each other;

— Be clear about where accountability for commissioning and delivering services lies; continually assess the quality of services and progress on health outcomes being achieved in the light of financial pressures to ensure that they are maintained;

— Have a clear understanding of the resources being allocated to under-fives and the impact on health outcomes;

— Use targeted evidence-based interventions to improve the health of the under-fives, particularly those in vulnerable groups, evaluating their impact and ceasing to invest in those that show a poor return;

— Rigorously assess the take-up of services and improve engagement with parents and service users to raise awareness of, and increase access to them;

— Ensure that professionals deliver information for new parents about their child’s health so it is phased to help understanding. It should be timely, relevant, accessible and culturally sensitive where appropriate; and

— Use the good practice available in this report and elsewhere such as Oneplace and *Facilitating Integrated Practice Between Children’s Services and Health*.

Available to download from http://www.audit-commission.gov.uk/sitecollectiondocuments/auditcommissionreports/nationalstudies/20100203givingchildrenahealthystart.pdf

The Family Nurse Partnership (FNP) was also reviewed by the Audit Commission in this report the FNP is targeted at a very specific population group—first time parents under 20—and therefore reaches only a small percentage of the potentially vulnerable groups this equates to less than 1% of the population. The report noted that the following and that the FNP has also contributed to the decline in the numbers of health visitors.

“The number of health visitors in England has declined steadily since 2004 (Figure 6) (Ref. 23). It is perceived as an unattractive career option with little chance of progression and a top band NHS salary of Grade seven—low compared with nursing roles in the acute sector. The ageing nature of the workforce has also led to high levels of retirement among staff, who have not been replaced. Some health visitors have also been used to staff the Family Nurse Partnership (FNP) programme (discussed in Chapter 5) which has required intensive targeting of resources.” Page 24 http://www.audit-commission.gov.uk/sitecollectiondocuments/auditcommissionreports/nationalstudies/20100203givingchildrenahealthystart.pdf

I think this report will answer many of the questions I was unable to answer on the day.

Please also see attached presentation in March 2011 on “**Predicting child health and development outcomes from maternal factors we can measure in pregnancy” by Dr Cathy Chittleborough** Research Associate, University of Bristol. This presentation evaluated the effectiveness of the FNP in the UK and concluded Programs aimed at teenage mothers as a high risk group are unlikely to improve child development outcomes at the population level.

Other factors such as maternal education, financial difficulties, smoking and depression should be considered in recruiting women to preventive programs. Maternal age <20 years identifies only 9% of the cases of poor

development at five years, whereas 74% of these cases would be identified among mothers with one or more of the six predictors.

I have also attached a paper I prepared with a colleague in 2009 entitled "Delivering Integrated Health Services through Children's Centres" attached which clearly shows that health visitors can play a key leadership role in children's centres to ensure efficient joint working between health and children's services.

Evidence on the effectiveness of health visiting

Acherson, D. (1998) Independent Inquiry into Inequalities in Health Report. TSO London.

Appleton J & Cowley S (eds.) The search for health needs: Research for health visiting practice Basingstoke, Macmillan. 2000.

Barlow J, Schrader McMillan A, Kirkpatrick S et al. Health-led parenting interventions in pregnancy and the early years. DCSF Research report, DCSF-RW070. London: DCSF 2008.

Barlow J, Kirkpatrick S, Stewart-Brown S, & Davis H 2005, "Hard-to-reach or out-of-reach? Reasons why women refuse to take part in early intervention", *Children and Society*, vol. 19, pp. 199–210.

Brandon, M. Beldrson, P. Warren, C. Howe, D. Gardner, R. Dodsworth, J. Black, J. (2008) *Analysing child deaths and serious injury through child abuse and neglect: what can we learn? A biennial analysis of serious case reviews* 2003–05. DCSF Research Report DCSF-RRO23 London.

Branson, C. Badger, B. and Dobbs, F. (2003). Patient satisfaction with skill mix in primary care: a review of the literature. *Primary Health Care Research & Development*, 4, pp 329–339. doi:10.1191/1463423603pc162o.

Centre for Social Justice (2008) *Breakthrough Britain The Next Generation* A policy report from the Early Years Commission Chaired by Dr Samantha Callan September 2008. The Centre for Social Justice.

Cowley S, Bidmead C. Controversial questions (part three): Is there randomised controlled trial evidence for health visiting? Community Practitioner, 2009; 82: 8: 24–28.

Cowley S & Frost M. The principles of health visiting: Opening the door to public health. London: CPHVA/ UKSC, 2006.

Elkan R, Kendrick D, Hewitt M et al. The effectiveness of domiciliary health visiting: a systematic review of international studies and a selective review of the British literature. Health Technology Assessment, 2000; 4: 13, i-v & 1–339.

Gimson, S. (2007) *Health Visitors- an endangered species.* Family and Parenting Institute.

Jack S, DiCenso A, & Lohfeld L 2005, "A theory of maternal enagagement with public health nurses and family visitors", *Journal of Advanced Nursing*, vol. 49, no. 2, pp. 182–190.

Kirkpatrick, S., Barlow, J., Stewart-Brown, S., & Davis, H. 2007, "Working in Partnership: User Perceptions of Intensive Home Visiting", *Child Abuse Review*, vol. 16, pp. 32–46.

Karoly LA, Kilburn MR, Cannon JS, Early childhood interventions. Proven results, future promises. Santa Monica Ca: Rand Corporation, 2005. http://www.rand.org/pubs/monographs/MG341/

MacMillan HL, Wathen, CN, Barlow J, et al Interventions to prevent child maltreatment and associated impairment. *The Lancet*, 2009; 373: 9659, 250–266.

Marmot Review on health inequities 2010 "Fair Society healthy lives" downloadable free from here http://www.marmotreview.org/AssetLibrary/pdfs/Reports/FairSocietyHealthyLives.pdf

Robinson J. An evaluation of health visiting. London: Council for the Education and Training of Health Visitors, 1982.

Russell, S. (2007) Families Need Health Visitors. Jan 2007 http://www.netmums.com/h/n/SUPPORT/HOME/ ALL/547//

Social Justice Policy Group (2006) *Breakdown Britain: Interim report on the state of the nation* London: Centre for Social Justice.

Social Justice Policy Group (2007) *Breakthrough Britain: Ending the costs of social breakdown* London: Centre for Social Justice.

Unite/CPHVA (2008) *The Distinctive Contribution of Health Visiting to Public Health and Well being: A Guide for Commissioners*. Downloadable from here http://www.marmotreview.org/AssetLibrary/resources/ external%20reports%20from%20consultation/CPHVA,%20unite%20- %20the%20distinctive%20contribution%20of%20health%20visiting.pdf

Unite/CPHVA (2007) *Community Practitioners' and Health Visitors' Association response to Facing the Future-A review of the role of health visitors October 2007.* Unite/CPHVA.

QUESTION 27.

In From Neurons to Neighbourhood: The Science of Early Childhood Development (2000, Shonkoff, J and Phillips, D.) book there is a section on intervention and an American study signposted families from the court system at risk/of or charged with harming/neglecting their children. They noted that for every 1 hr of intervention 10 hrs were needed for engagement. I have attached an executive summary for you. See attached Shonkoff Lecture July 2011.

QUESTIONS 38 AND 39. EVIDENCE

The Health Visitor Implementation Plan and the increase in the numbers of health visitors. Please see attached paper giving the background to this entitled Education Select Committee Background—22 June 2011 and the diagram HV service needs and response attached.

Getting it right for children and families. Maximising the contribution of the health visiting team "Ambition, Action, Achievement" DH/CPHVA 2009

http://www.unitetheunion.org/pdf/dhCPHVAHealthVisitAction10–09.pdf and attached.

QUESTION 40. EVIDENCE

Caseloads

Unite/CPHVA. What size caseload should a health visitor have? Professional Briefing, London: CPHVA. 2009.

http://www.unitetheunion.org/pdf/What%20size%20caseload%20should%20a%20health%20visitor%20have%202009.pdf already submitted under question 5.

The Lord Laming. Safeguarding children in England: A progress report. HCb330. London: The Stationery Office, 2009 https://www.education.gov.uk/publications/eOrderingDownload/HC-330.pdf

QUESTION 41 AND 42. EVIDENCE

The four levels of service the health visitors provide are:

1. **Your Community:** health visitors will help to develop a range of services in the community, and make sure families know about them.
2. **Universal:** A service to all families with health visitors offering help and interventions as part of the healthy child programme.
3. **Universal Plus:** A rapid response from the health visiting team when families need specific expert help.
4. **Universal Partnership plus:** Working with other organisations and professionals to deal with complex issues over time, and make sure that the right services, groups and networks are available to families locally.

Please see attached paper giving the background to this entitled Education Select Committee Background—22 June 2011 and the diagram health visitng service needs and response.

The evidence shows that targeting can only work effectively from within a robust universal service. Most serious child abuse is essentially unpredictable—even if the "whole picture" had been known, it would not have been possible to anticipate serious abuse for many of the children in the Biennial Serious Case Reviews. This emphasises the risk of providing a very selective service to families who are deemed to be "vulnerable" (Rose, Rose, G (1993) *The Strategy of Preventative Medicine.* Oxford University Press, Oxford.). A robust universal service is essential for safeguarding and public protection (see the population paradox below for further exploration of this).

Rose (1993) and Barlow and Stewart Brown's (2003) (Why a Universal Population-approach to the Prevention of Child Abuse is Essential. *Child Abuse Review,* 12, 279–281) research shows that the bulk of problems in society arise in the many who are not necessarily high risk rather than the few who are high risk. The reason for this is that there are a very large number who are not at especially high risk.

To give an example of the population paradox and the consequences of targeting can be seen by the prevalence of childhood behaviour disorder at ten years of age in different social classes. Behaviour problems are more common in social classes 1V and V than they are in social classes 1 and 11 The differences between classes are most marked for conduct disorder. Although behaviour problems are more common in social classes 1V and V most of the children with this problem are in social class 111M (Woodruffe et al 1993 in Stewart-Brown 1998 Stewart-Brown S (1998) *Public health implications of childhood behaviour problems and parenting programmes* in *Parenting, Schooling and Children's Behaviour* Hudson B, Buchanan A (Eds.) Ashgate Publishing Ltd, Aldershott Hants). The explanation for this paradox is that there are more children in social class 111M than in classes 1V and V where the numbers are relatively small. Children with conduct disorder are more likely to have educational difficulties, with approximately two-thirds estimated to need

intervention (Earls F (1994). *Oppositional defiant and conduct disorders* in Rutter M, Taylor E, and Hersov L (Eds). Child and Adolescent Psychiatry: Modern Approaches, Blackwell Science, Oxford).

Child abuse, domestic abuse and depression are common problems that health visitors deal with regularly. To detect and prevent child maltreatment a population level approach is essential (Barlow and Stewart Brown, 2003). For this to be effective practitioners need time to develop trusting relationship with families and conduct holistic assessments which are a process and not a one-off assessment completed in a single visit. Despite this repeated thesis in the literature and research, it is a factor not always understood and appreciated by commissioners and managers of services. The focus often appears to be on the tasks to be performed, rather than appreciating the skill level required to conduct holistic family needs health assessments.

The danger with targeting services at those of high risk is that there is a danger of leaving untouched vast swathes of those with health and social problems. Rose (1993), states that no screening instrument can be sufficiently precise to accurately identify those most likely to suffer problems.

> "… the burden of ill health comes more from the many who are exposed to a low inconspicuous risk than from the few who face an obvious problem."

School of Social and Community Medicine University of Bristol

> "… a large number of people exposed to a small risk may generate many more cases than a small number exposed to a high risk."

Geoffrey Rose *The strategy of preventive medicine*. (1992)

This can make delegation of duties in skill mix teams more complex as it is often difficult to make accurate assessments unless you have developed good relationships with families. This requires time a commodity often in short supply in many health visiting teams today, as the research paper attached by Cowley *et al* (2007) (Cowley S, Caan, W. Dowling, H. Weir, H. (2007) What do health visitors do? A national survey of activities and service. Public Health. Journal of the Royal Institute of Public Health. doi:10.1016/j.puhe.2007.03.016) indicates. Similar findings were also reported by Adams and Craig (2007 and 2008). (Adams, C, Craig, I (2007) Health Visitor Cuts Affecting Vulnerable Families. *Community Practitioner,* 80, (5): 14, 16–7, (Adams, C, Craig, I (2008) A Service at Crisis Point. *Community Practitioner,* 81, (12), *34–5)*

Regarding increases in children with special needs see evidence quoted on question 9.

Question 45. Evidence

Fields life chance indicators BMI in the under fives

Unite/CPHVA school nurses have concerns over Frank Fields recommendations to measure physical development at three years of age when he mentions height to calculate BMI. As far as we are aware there is no basis for BMI measurements in children, as the research hasn't been carried out (ie taking a representative cohort of say 5,000 children to establish what is the normal range) We only have research about their heights and weights. The evidence may prove that BMI is a wholly unsuitable tool to use with children, and that only skin fold measurements are reliable. The problems arising with the National Child Measurement Programme which measures children at aged five in school are that parents receive letters home stating that the child is overweight, when that is plainly not the case.

Question 49. Evidence

Frank Field's Life Chance Indicators recommended measurements at three years of age

Some of these life chance indicators are already suggested in the two year health and development review, before another set of measures is introduced there needs to be widespread discussion on the matter.

This is a very useful report from the Centre for Social Justice Report "Making sense of early intervention: A framework for professionals" July 2011 downloadable from here http://www.centreforsocialjustice.org.uk/client/downloads/20110707_early_years_report_web_v3.pdf

Question 53. Evidence

What health visitors do

Cowley S, Caan, W, Dowling S & Weir, H. What do health visitors do? A national survey of activities and service organisation. Public Health, 2007; 121: 869–879.

Cowley S & Rudgley D. Health visiting matters: Re-establishing health visiting. London: UK Public Health Association (UKPHA), 2009 http://www.ukpha.org.uk/special-interest-groups/child-public-health-/background-to-health-visiting-matters.aspx

Cowley S, Dowling S, Caan W. Too little for early interventions? Examining the policy-practice gap in English health visiting services and organisation. Primary Health Care Research and Development, 2009; 10: 130–142.

Cowley S. Health-as-process: A health visiting perspective. Journal of Advanced Nursing, 1995; 22: 3, 433–441.

Clark J, Buttigieg M, Bodycombe JM, et al. Recognising the potential: The review of health visiting and school nursing in Wales. Report to Welsh Assembly. Swansea; University of Wales Swansea, School of Health Science, 2000.

Cowley S & Appleton J. The search for health needs. In: The search for health needs: Research for health visiting practice. (eds. Appleton J & Cowley S) pages 5–24, Basingstoke: Macmillan, 2000.

Please see attached presentation from question 6 by Sarah Stewart-Brown using the evidence from the Avon Longitudinal Study of Parents and Children on parenting, health and the health service.

The Universal Health Visiting Service Unite/CPHVA 2009

http://www.unitetheunion.org/pdf/UniversalHealthVisitingService.pdf

Unite/CPHVA (2008) *The Distinctive Contribution of Health Visiting to Public Health and Well being: A Guide for Commissioners*. Downloadable from here http://www.marmotreview.org/AssetLibrary/resources/external%20reports%20from%20consultation/CPHVA,%20unite%20-%20the%20distinctive%20contribution%20of%20health%20visiting.pdf

Question 54. Evidence

Richness of investigation and reviews

Barlow, J, Kirkpatrick, S, Stewart-Brown, S and Davis, H (2005) Hard-to-Reach or Out-of-Reach? Reasons Why Women Refuse to Take Part in Early Intervention. *Children and Society*, 19, 199–210.

C4EO, *Grasping the Nettle: early intervention for children, families and communities*, London, 2010 downloadable free from here http://www.c4eo.org.uk/themes/earlyintervention/files/early_intervention_grasping_the_nettle_full_report.pdf

Elkan R, Kendrick D, Hewitt M et al. The effectiveness of domiciliary health visiting: a systematic review of international studies and a selective review of the British literature. Health Technology Assessment, 2000; 4: 13, i-v & 1–339.

The Healthy Child Programme Pregnancy and the first five years of life here http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_118525.pdf is based on the evidence on what works and what the evidence suggests may improve outcomes for children with medium- and high-risk factors, Additional impact measures, such as immunisation rates, programme coverage, smoking in pregnancy, father's engagement, feedback from parents and the Early Years Foundation Stage at the age of five, are also useful measures of HCP outcomes.

The Munro Review reflects parallel process happening in health visiting to that of social work. The systems are driving the work of the HVs not the HVs driving the work see both reports here:

Munro E, *The Munro Review of Child Protection Part One: A systems analysis*, London: The Stationery Office, 2011 downloadable free from here http://media.education.gov.uk/assets/files/pdf/m/munro%20review%20of%20child%20protection%20part%20one.pdf

Munro E, *The Munro Review of Child Protection Final Report: A Child Centred System. May 2011 downloadable free from here https://www.education.gov.uk/publications/standard/AllPublications/Page1/CM%208062*

The Marmot Review "Fair Society Healthy Lives" (2010) http://www.marmotreview.org/AssetLibrary/pdfs/Reports/FairSocietyHealthyLives.pdf

The Universal Health Visiting Service Unite/CPHVA 2009 attached

http://www.unitetheunion.org/pdf/UniversalHealthVisitingService.pdf

Question 56. Evidence

Decrease in the numbers of health visitor's evidence

Adams and Craig (2007 and 2008). (Adams, C, Craig, I (2007) Health Visitor Cuts Affecting Vulnerable Families. *Community Practitioner,* 80, (5): 14, 16–7, (Adams, C, Craig, I (2008) A Service at Crisis Point. *Community Practitioner,* 81, (12), *34–5).*

Please see attached workforce graph showing the decline in the numbers of health visitors since 1988 then annually from 1997–2010.

Research from the Family and Parenting Institute Health Visitors—an endangered species in 2007 see here and attached http://www.familyandparenting.org/Resources/FPI/Documents/Health%20Visitors%20-%20An%20Endangered%20Species.pdf and a follow up progress report on Heath Visitors in 2009 see here also attached http://www.familyandparenting.org/Resources/FPI/Documents/HealthVisitors_a_progress_report.pdf also documented the continuing decimation of the Healthy Visiting Service.

In 2008 Sally Russell from Netmums in a report entitled "Left Fending for Ourselves" surveyed over 6,000 mothers on their experience of the health visiting service and highlighted the devastating effects that a reduced health visiting service was having and the effects of skill mix and concern over extension of the Family Nurse Partnerships pilots will exacerbate these problem significantly. Rather than being a solution, it will continue to suck out staff from a service trying to help 99% of the population and already on its knees. It is ironic and very sad that the much heralded solution to postnatal problems experienced by the most vulnerable, could lead to the demise of the profession. See here http://www.netmums.com/files/FendingforOurselves_withappendix.pdf for the full report and also attached.

Question 57. Evidence

The effects Skill Mix has had

Adams and Craig (2007 and 2008). (Adams, C, Craig, I (2007) Health Visitor Cuts Affecting Vulnerable Families. *Community Practitioner,* 80, (5): 14, 16–7, (Adams, C, Craig, I (2008) A Service at Crisis Point. *Community Practitioner,* 81, (12), *34–5).*

Branson, C. Badger, B. and Dobbs, F. (2003). Patient satisfaction with skill mix in primary care: a review of the literature. *Primary Health Care Research & Development,* 4, pp 329–339. doi:10.1191/1463423603pc162oa.

The FPI research and the Evidence from the Netmums Survey in the evidence provided in question 56 document the effects skill mix has had.

Evidence for effects of skill mix and targeting in provided in the book "Skill Mix in Health Visiting and Community Nursing Teams Principles into Practice" By M Fisher (2009m Unite/CPHVA).

For evidence on the effects **the removal of the title health visiting from statute** please see evidence provided in question 58.

Question 58. Evidence

Regulatory issues and statute evidence regarding the legal status of the health visitor title and the profession.

For evidence on the effects **removal of the title health visiting from statute** has had and the concerns over public safety please see these two professional briefings entitled Public Safety and Statutory Regulation of Health Visitors available here http://www.unitetheunion.org/pdf/Public%20Safety%20and%20Statutory%20Regulations%20of%20HVs%20-%20Professional%20Briefing.pdf and the Regulatory Issues and the Future Legal Status of the Health Visitor Title and the Profession available here http://www.unitetheunion.org/PDF/RegulatoryIssuesHV.pdf these briefings were both written and provided as evidence to the NMC. This matter may seem peripheral to the remit of your enquiry into early years services, but Unite/CPHVA and its members believe it is crucial in understanding how to return the health visiting workforce to full strength. Importantly, we also have grave concerns over the public safety and regulatory issues.

Health visiting was removed from stature in 2001 and the health visiting register closed In 2004 this implied that the health visiting service was no longer valued and the qualification was no longer legitimate or required, as shown by the steep decline in the workforce. Please see attached workforce graph showing the decline in the numbers of health visitors since 1988 then annually from 19972010 and the effects on numbers when health visiting was taken out of statute and the register closed. There were 16.5% fewer health visitors employed in 2009 than five years earlier, which has led to a significant fall in the safety of services and difficulties recruiting. This has been exacerbated by a reduction in educational places and the number of newly qualified health visitors, which has been attributed to the way the NMC treat health visiting as a post-registration nursing qualification. Employers, service users and practitioners are confused by the lack of clarity surrounding the qualification and its title.

See also the attached Health Visitor Regulation Briefing.

Health visiting as distinct from Nursing

Newland, R. (2009) *Exploring the Role of the Health Visitor and Registered Nurse in the Health Visitor Team and the Health Visiting Service:* Professional Briefing Unitie/CPHVA downloadable here http://www.unitetheunion.org/pdf/HealthVisitorRole.pdf

Newland, R. (2009) *The New Birth Visit: Professional Briefing* Unite/CPHVA downloadable from here http://www.unitetheunion.org/pdf/TheNewBirthVisitNov08.pdf

Raymond B. Health visitors are nurses, but health visiting is not nursing. British Journal of Community Nursing, 2001; 6: 269–270

Unite/CPHVA (2008) *The Distinctive Contribution of Health Visiting to Public Health and Well being: A Guide for Commissioners*. Downloadable from here http://www.marmotreview.org/AssetLibrary/resources/external%20reports%20from%20consultation/CPHVA,%20unite%20-%20the%20distinctive%20contribution%20of%20health%20visiting.pdf

The Universal Health Visiting Service Unite/CPHVA 2009

http://www.unitetheunion.org/pdf/UniversalHealthVisitingService.pdf

QUESTION 59. EVIDENCE

See the attached crisis in health visiting facts and figures and here http://www.unitetheunion.org/pdf/The%20Crisis%20in%20Health%20Visiting%202009–05.pdf

QUESTION 60.

Working condition's evidence

Adams C & Craig I. (2008) A service at crisis point. Community Practitioner, 2008; 81: 12, 34–35 attached.

QUESTION 61. EVIDENCE

Stress besides child protection in the role

Adams C & Craig I. (2008) A service at crisis point. Community Practitioner, 2008; 81: 12, 34–35 see attached.

QUESTION 65.

Direct Entry into health visiting referred to by Liz Bailey

This paper may be of interest by Cowley S, Bidmead C. Controversial questions (part two): Should there be a direct entry route to health visitor education? Community Practitioner, 2009; 82: 7, 24–28 attached and the attached Health Visitors' Education Briefing.

QUESTION 66.

Workforce issues numbers due to retire latest figures

The crisis in health visiting (Facts and figures)

http://www.unitetheunion.org/pdf/The%20Crisis%20in%20Health%20Visiting%202009–05.pdf

QUESTION 67.

Community Nursery Nurse Qualifications

A recent survey by Unite/CPHVA on the qualification the community nursery nurses had revealed a list of 30 different qualifications. As there is not central collection point for numbers of nursery nurses, because they are not registered, there is no one who collects this data although I believe the CWDC may be doing some work on this.

QUESTION 73.

Measuring impact of Health visiting evidence

Please see evidence from questions 7 and 8.

Evidence on the use **of health visitors in post natal depression** referred to by the London School of Economics "Assessing the Economic Payoff of Low-level Interventions in Reducing Postnatal Depression" (2011) Annette Bauer, Martin Knapp, David McDaid is attached.

New evidence from Lynne Murray et al published in June 2011 on "Maternal Postnatal Depression and the Development of Depression in Offspring Up to 16 Years of Age" (2011) Lynne Murray, Ph.D., Adriane Arteche, Ph.D., Pasco Fearon, Ph.D., D.Clin.Psy., Sarah Halligan, D.Phil., Ian Goodyer, M.D., Peter Cooper, D.Phil., D.Clin.Psych attached . This study clearly demonstrates the cost and effects of not identifying and treating post natal depression and the far reaching consequences this has.

Please see evidence from **question 6** re the effects the reduced numbers of health visitors has had on the numbers of speech and language referrals and referrals to Child Adolescent Mental Health Services.

Please see attached presentation in March 2011 on "Predicting child health and development outcomes from maternal factors we can measure in pregnancy" by Dr Cathy Chittleborough Research Associate, University of Bristol. There is a statistically significant correlation between the shortage of health visitors and increased Infant Mortality Rates. Submitted as part of evidence to question 24.

QUESTION 74.

Training and commissioning evidence

The Government have commissioned a task force to look at these issues as it is impeding the prospect of success of the Health Visitor Implementation Plan see here (http://www.nursingtimes.net/nursing-practice/clinical-specialisms/district-and-community-nursing/government-announces-new-health-visitor-taskforce/5032883.article). I'm not sure what figures the DH have nationally but they are having regular reports being done on this issue so I would suggest the committee ask for this information to be published to back up the reports from the service.

QUESTION 75.

Increase in School Nurse Service

School nurses with the Specialist Community Public Health Nurse qualification (SCPHN) are now registered on the first and the third part of the Nursing and Midwifery Council (NMC) register. Numbers of SCPHN s and school staff nurses have been increasing slowly from a very low base, and there are now about 1,104 WTE (1,467 headcount) staff employed in England with a few hundred more in Wales, Scotland and Northern Ireland. The Welsh Assembly Government is the only one which has made efforts towards an ultimate goal of one full time qualified school nurse per secondary school. Caseloads throughout most of the UK are enormous and most practitioners do not have the time to do the job to their ability.

The School Nurse's Forum at Unite/CPHVA are currently working on a position statement which will be published soon.

QUESTION 78.

Integration of health visitors into the Local Authority

Please see attached paper on Delivering Integrated Health Services through Children's Centres.

QUESTION 79.

GP evidence of contact with the under fives.

GPs Sarah Stewart Brown research form ALSAC Study Poor parenting at eight months increased GP visits over next five years and vice versa.

A survey by Netmums in May 2009 of 1,262 mum's views of support for parents showed there was increased [pressure on GPs when parents had limited access or support to a health visitor. 51% of those without support had visited a GP as their first port of on a child/parent matter this drops to 29% for those who have access to a health visitor. (See attached paper on Netmums views on support for parents).

QUESTION 81.

Early Intervention Outcomes

Action for Children Research Effective Relationships with Vulnerable Parents to Improve Outcomes for Children and Young People: Final Study Report K Crowther and G Cowen August 2011 downloadable free from here http://www.actionforchildren.org.uk/media/1109148/effective_relationships_with_vulnerable_parents_to_improve_outcomes_for_children_and_young_people.pdf

Action for Children: A Skills Framework for developing effective relationships with vulnerable parents to improve outcomes for children and young people 2011 downloadable from here http://www.actionforchildren.org.uk/media/1109012/action_for_children_skills_framework.pdf

C4EO, *Grasping the Nettle: early intervention for children, families and communities*, London, 2010 downloadable free from here http://www.c4eo.org.uk/themes/earlyintervention/files/early_intervention_grasping_the_nettle_full_report.pdf

Centre for Social Justice Report downloadable free from here "Making sense of early intervention: A framework for professionals" July 2011 http://www.centreforsocialjustice.org.uk/client/downloads/20110707_early_years_report_web_v3.pdf

Deacon S, *Joining the dots: A better start for Scotland's children*, Edinburgh: The Scottish Government, 2011 downloadable free from here http://www.scotland.gov.uk/Resource/Doc/343337/0114216.pdf

Demos Report on Parenting: The Home Front. "it is time to be honest about what good parenting involves" 2011 downloadable free from here http://www.demos.co.uk/files/Home_Front_-_web.pdf?1295005094.

St.John T, Leon L, McCulloch A. Lifetime impacts. Childhood and adolescent mental health: understanding the lifetime impacts. London: Mental Health Foundation, 2005.

Sarah Cowley1, Sandra Dowling1 and Woody Caan (2009) Too little for early interventions? Examining the policy-practice gap in English health visiting services and organization

Primary Health Care Research & Development 2009; 10: 130–142 attached.

Marc Suhrcke, and Carmen de Paz Nieves (2011) The impact of health and health behaviours on educational outcomes in high-income countries: a review of the evidence The World Health Organization attached.

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