

Helping new families

Support in the early years through universal health visiting

Executive summary

Rationale for the policy

It is widely accepted that the first steps in a child's development are crucial to the child's life chances. There is also strong evidence to suggest that the provision of health visitors is a highly effective way of helping parents to do the best for their children in the early stages of development.

But there is a serious shortage of health visitors today. The average time parents spend with a trained health visitor in the first year is only four hours and six minutes. This lack of early years' child care support is not acceptable.

The Government are planning to address this problem by continuing to run down the number of health visitors whilst spending £200 million a year on creating a new cadre of Sure Start outreach workers. These new outreach workers will lack the professional training of health visitors (and are therefore less likely – according to the survey evidence – to command the confidence of parents).

Summary of proposals

Our vision is for a universal health visiting service, responsive to the needs of individual families. We propose to increase the number of health visitors by 4,200 (a 56 per cent increase on expected numbers in 2010), and to increase health visitor training concomitantly.

By the end of the first Parliament, an incoming Conservative government will ensure:

1. a minimum guarantee of two visits in the home to all mothers during the later weeks of pregnancy until birth to advise on pregnancy nutrition, health, and preparation for child raising;
2. a minimum guarantee of six hours of health visitor support in the home for all families over the first two weeks of a child's life;
3. a minimum guarantee of visits every two weeks in the home for all families for the next six months of a child's life;
4. a minimum guarantee of monthly visits, either in the home or in the health visitor's base, for all children between six months and one year to support mothers in the critical transition to solid feeding, establishing good sleep patterns and coping as a family with a growing child;
5. a minimum guarantee of at least two visits every year for every child between the ages of one and five, either in the home or in the health visitor's base, for immunisation advice, hearing and vision tests, and developmental and growth checks; and
6. the establishment of a £10 million per year Child Health Inequalities Fund to boost support for families in the most deprived areas.

Paying for the policy

The cost of the policy is £200 million per year. This will be funded by:

- using £150 million of the £200 million per year, with which the Government are intending to pay for a new cadre of ‘outreach’ workers from Children’s Centres, to hire, instead, 4,200 additional professional health visitors;
- using £40 million of the remaining £50 million a year to fund additional training for health visitors; and
- using the remaining £10 million a year to pay for our Child Health Inequalities Fund.

This level of support will be available to all families. Health visitors and parents can agree how support is best delivered to meet a family’s individual needs in those critical early years.

Our proposals in detail

The crucial significance of early steps in development

The importance of early childhood development and the impact of early intervention and prevention in determining future health, social well-being and educational achievement is widely recognised. There is increasing and compelling evidence that demonstrates the importance of early attachment and experience on the infant's neurological development.¹ There is evidence that development in the first years of life is 'strongly associated' with educational outcomes in later life and that 'significant differences in life chances are apparent even before children enter the education system'.² Similarly, it is clear that conditions in early life have long-term effects on adult health: childhood is the key stage for development of the resources that underpin adult social position and adult health, including physical and emotional health, social identities and health behaviours.³ As one commentator puts it, 'second chances are often second best in terms of laying the foundations for decent life chances'.⁴

The case for health visitors

In the not so distant past, women worked for a relatively short period before starting a family and most did not consider returning to work until their youngest child was at school. By contrast, the highest proportion of births are now amongst women aged 30 to 35, many of whom live away from their own parents or other family members and are dislocated from their immediate community. Leaving work and having a baby is a much greater physical and emotional adjustment for women than two or three decades ago. It is little wonder that more than half of all mothers are left feeling lonely and isolated.⁵

A trusted brand

As the main workforce interacting with parents at such a critical time, health visitors are vital to early support for parents. 76 per cent of parents want support and advice on child health and development specifically from a trained health visitor with up-to-date health care knowledge. When compared with other options this is a massive endorsement: only 58 per cent would look to other family members, 33 per cent to a qualified nurse and 16 per cent to a childcare worker.⁶ Even more strikingly, 83 per cent of parents of under-fives want support in the home, compared with 39 per cent in a GP's surgery and 41 per cent in a children's hospital. Health visitors are overwhelmingly welcomed by parents. And this public endorsement cuts across the social spectrum. The success of the Family Nurse Partnership programme, currently being piloted across ten areas in England, reinforces this point: the majority of vulnerable mothers involved in this more intensive form of health visiting are highly engaged with the programme and early evaluation results suggest very positive, and sometimes dramatic, effects.⁷

International evidence of successful outcomes

There is considerable international evidence that universal and regular health visiting can improve outcomes for children.

Professor David Olds's model of intensive home visiting for vulnerable families has produced dramatic results in the United States. The programme has led to improvements in women's prenatal health, reductions in children's injuries, fewer subsequent pregnancies, greater intervals between births, increases

¹ DH, 'The government response to *Facing the Future: A review of the role of health visitors*', October 2007.

² http://www.cabinetoffice.gov.uk/upload/assets/www.cabinetoffice.gov.uk/strategy/lifechances_socialmobility.pdf

³ http://www.nice.org.uk/niceMedia/pdf/childhood_disadvantage_health.pdf

⁴ Ibid.

⁵ Tesco and Mother and Baby Magazine survey reported in the Daily Mail, 'The first year of motherhood 'is the loneliest in a woman's life', survey shows', 18 October 2007.

⁶ YouGov survey on behalf of Family and Parenting Institute 'Parents of Under 5s', 12 March 2007. The sample size totalled 5,422 respondents who were asked to tick all that applied for this question.

⁷ Beverley Hughes MP, 'Expanding the Family Nurse Partnership Programme', 7 January 2008.

in fathers' involvement, increases in employment, reductions in welfare and food stamps, improvement in school readiness, 80 per cent reduction in child maltreatment among poor married teens, and a 66 per cent reduction in emergency room visits for children between one and two years old. Researchers returning to children in the first trial when they reached fifteen years old found a 48 per cent reduction in child abuse and neglect, a 59 per cent reduction in arrests and a 90 per cent cut in numbers receiving supervision orders.⁸ The programme is said to have had 50 per cent better outcomes when trained nurses, rather than para-professionals, were used to deliver the programme.⁹

In Scandinavia, where frequent health visiting is the norm, child mortality rates are much lower than in most of the rest of the world.¹⁰ Ironically, the Maternal and Child Health service in Denmark – which gives each health visitor a caseload of only 150 children – arose out of legislation in 1971 designed to reflect 'the influence of the English health visiting system'¹¹.

Current service characteristics

Workforce demographic

A health visitor is a qualified and registered nurse or midwife who has undertaken further (post registration) training in order to be able to work as a member of the primary healthcare team. The purpose of the health visitor is the promotion of health and the prevention of illness amongst all age groups,¹² but a focus of the health visitor has always been work with mothers and babies.

There are an estimated 9,000 full-time health visitors in England¹³, employed at a Primary Care Trust (PCT) level and historically based in GP surgeries (though, with the introduction of Sure Start Local Programmes and their expansion into Children's Centres, many health visitors now work from Children's Centres¹⁴). They are employed on pay band 6 to 7 with an annual salary ranging from £23,458 to £37,326 – giving a total cost of service estimated at £274 million.¹⁵

According to a recent YouGov survey, the typical health visitor is female and has considerable experience in the role.¹⁶ The average age is 49, with 54 per cent over 50, 29 per cent over 55 and eleven per cent still working aged over 60. Only three per cent are under 35 years old. 39 per cent have been practising for over twenty years, with a further 30 per cent for more than ten years. 37 per cent work on a full-time permanent contract of 37.5 or more contracted hours per week and 58 per cent are employed on a part-time basis, with varying hours. Entry is with a nursing or midwifery qualification followed by a one year course in community health (at a typical cost of £30,000 per head). Half of all health visitors have a BA or a Masters degree.

Problems with the current system

Despite substantial new spending committed to improving the welfare of children (a total of £4.8 billion from 1997 to 2008 on the Sure Start project alone), reports from bodies such as the Family and Parenting

⁸ <http://www.guardian.co.uk/theissues/article/0,,2080632,00.html>

⁹ DH, 'Facing the Future: A review of the role of health visitors', June 2007.

¹⁰ The child mortality rate, based on the number of children dying before the age of five per 1,000 live births averaged over a four-year period, was below five in only six countries – Sweden at 3.25, followed by Iceland (3.75) Norway (4.00) Denmark (4.25) Japan (4.50) and Finland (4.75). The Independent, 1 April 2007.

¹¹ Kamerrman and Khan (1993) 'Home visiting in Europe: The Future of Children' Home Visiting, Volume 3, No. 3, Winter.

¹² <http://www.nhscareers.nhs.uk/details/Default.aspx?Id=807>

¹³ Family and Parenting Institute, 'Health visitors – an endangered species', April 2007.

¹⁴ There are currently 1,500 Sure Start Children's Centres offering a one-stop shop of integrated services to all children under five and their families. The Government target is for 3,500 to be set up nationwide by 2010 ensuring that there is one available for every community. DH, 'The government response to *Facing the Future: A review of the role of health visitors*', October 2007.

¹⁵ <http://www.nhscareers.nhs.uk/details/Default.aspx?Id=766>

¹⁶ Davis, D. 'Survey shows ongoing crisis in health visiting', *Community Practitioner* Volume 80, Number 11, pp.50-53, November 2007.

Institute report and the Community Practitioners' and Health Visitors' Association, indicate severe problems:

1. **Declining human resources.** Total numbers of health visitors are falling sharply with a ten per cent decline over the last three years and training levels well below replacement rates (800 health visitors left the profession in 2006 while only 329 were trained in 2006/07, in spite of 798 applicants). A lack of adequate funding from PCTs is cited as being responsible for the growing deficit in health visitor numbers, coupled with the breakdown of a structured career pathway and an overall lack of government commitment to the health visiting profession.¹⁷

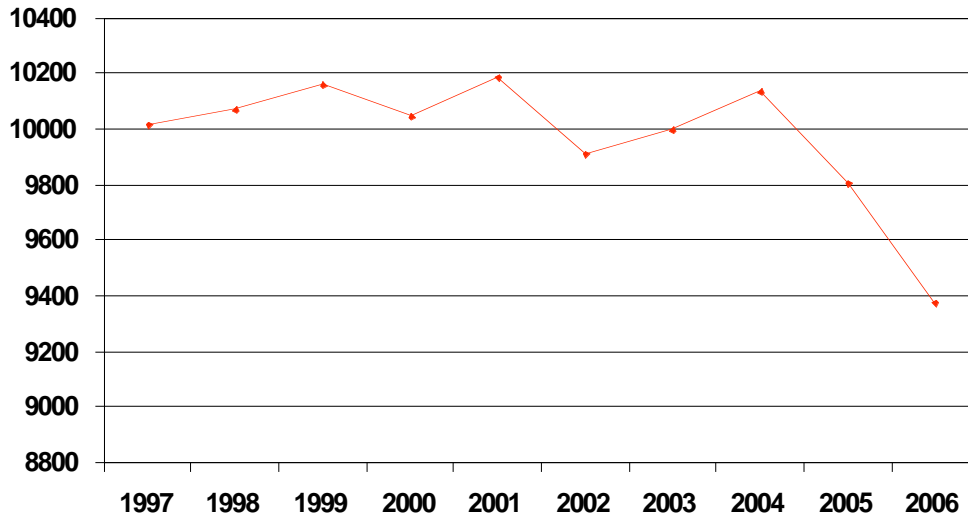


Figure 1: Health visiting workforce 1997-2006

Source: Prof. Cowley, 'The contribution of the NHS to reducing health inequalities', submission to the Health Select Committee's inquiry into health inequalities, November 2007.

As a result of the ageing of the workforce, almost 30 per cent of the health visitors will be eligible for retirement in the next five years. Their skills will soon be lost if they are not used in the next five years to train a future generation of health visitors.

¹⁷ Prof. Cowley cites four 'speculative' reasons underpinning this lack of legitimacy within the health visiting service: 1. the tension between the DH and the DCSF – the latter of which has lead responsibility for key Public Service Agreement targets but is mostly concerned with education and children over the age of three; 2. the removal of health visiting from statute in 2001 and closure of their register in 2004 – which sent a signal that the Government does not support health visitors, instead favouring substitution of nurses into their usual field of work; 3. the fact that parenting support is not seen as an NHS priority; and 4. neither the evidence indicating the need for support in the early years, nor the evidence for supporting early interventions, is well collated.

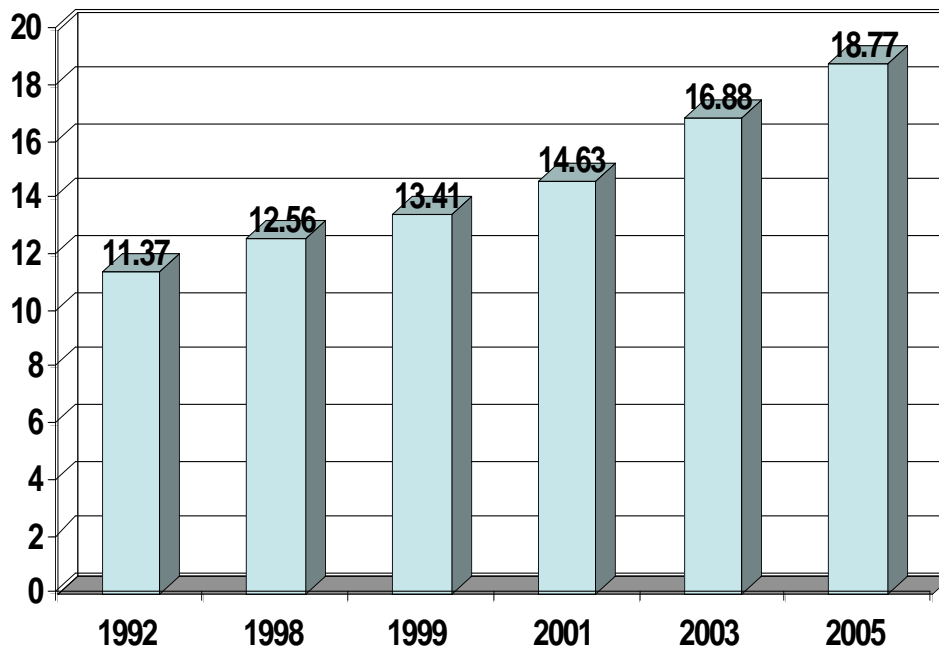


Figure 2: Percentage of health visitors over 55 years (retirement age)

Source: Prof. Cowley, excerpt from unpublished paper 'Regeneration: A starting point for planning next steps'.

In response to demands from parenting organisations such as Netmums and The Family and Parenting Institute – both of whom have campaigned actively for an increase in health visiting numbers – the Government cite headcount numbers, rather than the full-time equivalent, thereby disguising the extent of the problem.¹⁸ The Government also draw attention to the increase in the number of nurses working in the community over recent years, thereby wrongly implying that – for parents with young children – this somehow compensates for the drop in health visitor numbers.¹⁹

In reality, declining health visitor numbers and declining numbers of health visitor hours mean that staff can no longer guarantee safe practice and that the preventative remit of the health visitor is inhibited. One report indicates that a 40 per cent drop in health visitor numbers in Waltham Forest, north-east London, has led to cases of rickets, degenerative neurological conditions, poor diet, and babies' immunisations being missed as well as post-natal depression not being picked up quickly enough.²⁰

2. **Increasing caseloads.** As a result of the deficit in health visitor numbers, 29 per cent of health visitors report that caseloads are so large that they are losing track of vulnerable families.²¹ With birth rates in the UK at their highest levels since 1980, this problem is likely to become worse in coming years. We estimate that, on current trends, health visitors will have to cover a third more children under five by 2012. The Community Practitioners' and Health Visitors' Association calculate that an additional 4,000 full-time health visitors will be needed to allow effective dissemination of the Family Nurse

¹⁸ Prof. Cowley, 'The contribution of the NHS to reducing health inequalities', submission to the Health Select Committee's inquiry into health inequalities, November 2007.

¹⁹ "This needs to be seen in the context of unprecedented investment in the NHS and services for children in the last ten years. NHS spending trebled between 1996/7 and 2007/8 and there are 79,000 more nurses in the NHS than in 1997." DH, 'The government response to *Facing the Future – A review of the role of health visitors*, October 2007.

²⁰ <http://news.bbc.co.uk/1/hi/england/london/7234320.stm>

²¹ Survey of Health Visitors by Amicus, 2007.

Partnership pilot for all 120,000 families who may require that model of intensive support, if a decision is taken to nationalise the pilot.²²

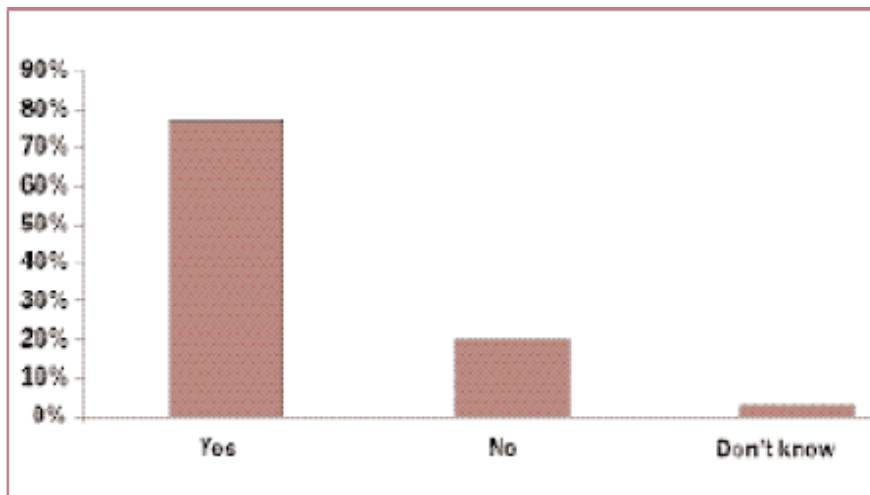


Figure 3: Has your workload involved responsibility for more children/families over the past year?

Source: Davis, D. 'Survey shows ongoing crisis in health visiting', *Community Practitioner* Volume 80, Number 11, pp.50-53, November 2007.

3. **Low workforce morale.** No doubt due to lack of Government commitment, declining numbers and increasing caseloads, health visitors are experiencing an all-time low in terms of morale, with high stress levels and 63 per cent feeling 'very' or 'somewhat' pessimistic about the health visiting profession in the next five years.

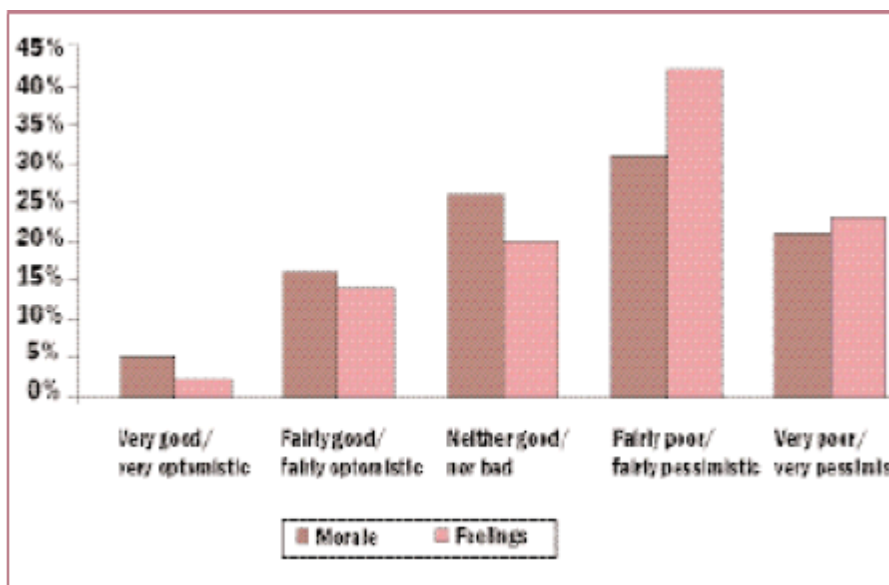


Figure 4: Current morale within the health visiting profession and optimism for the future

Source: Davis, D. 'Survey shows ongoing crisis in health visiting', *Community Practitioner* Volume 80, Number 11, pp.50-53, November 2007.

²² Community Practitioners' and Health Visitors' Association response to 'Facing the Future – A review of the role of health visitors', October 2007.

4. **Lack of health visitors in deprived areas.** It is generally believed by the professionals that the maximum caseload for optimal contacts from birth to five years is no more than 300. But the average ‘child under five’ caseload is, at present, 362. And, within this average, health visitor numbers vary greatly from PCT to PCT, with the ratio of health visitors to children under five in their area ranging nationally from a best case of 1:160 to a worst case of 1:1,142. Training also varies widely across PCTs. South Central Strategic Health Authority is reported to be training only 40 students in 2008 across an area that covers four million people.²³

Ten PCTs with most health visitors per head of children under five

	Primary Care Trust	WTE health visitors	Under-fives (approx)	Proportion to children under five
1	Doncaster PCT	102.64	16,500	160.76
2	Sunderland Teaching PCT	61.1	11,608	189.98
3	Hull Teaching PCT	68.92	13,780	199.94
4	Blackpool PCT	36.8	7,673	208.51
5	North Lancashire PCT	63.35	13,772	217.4
6	South Tyneside PCT	34.9	7,661	219.51
7	Knowsley PCT	40.98	9,000	219.62
8	Manchester PCT	95.59	21,458	224.48
9	Calderdale PCT	53.12	11,941	224.79
10	Middlesbrough PCT	44.61	10,095	226.29

Ten PCTs with fewest health visitors per head of children under five

	Primary Care Trust	WTE health visitors	Under-fives (approx)	Proportion to children under five
131	City and Hackney PCT	33.33	17,714	531.47
132	Camden PCT	25.04	13,801	551.16
133	Newham PCT	44.21	24,981	565.05
134	North Tees PCT	18.48	10,500	568.18
135	Surrey PCT	112.16	64,000	570.61
136	Coventry Teaching PCT	31.78	18,992	597.61
137	Enfield PCT	34.38	21,587	627.89
138	Sutton and Merton PCT	38	24,434	643
139	Warwickshire PCT	39.2	28,233	720.23
140	Redbridge PCT	16.63	19,000	1,142.51

Figure 5: Wide variations in the number of health visitors in different PCTs

Source: Family and Parenting Institute, ‘Health visitors – an endangered species’, April 2007.

²³ Community Practitioners’ and Health Visitors’ Association response to ‘Facing the Future – A review of the role of health visitors’, October 2007.

The quartiles with the lowest health visitor caseloads, include PCTs with 23 of the 43 most deprived populations²⁴, and deprivation does not seem to have played any part in PCT decision-making on health visitor numbers. As the graph below shows, there is no correlation between an area's Index of Multiple Deprivation ranking and its Family and Parenting Institute survey score:

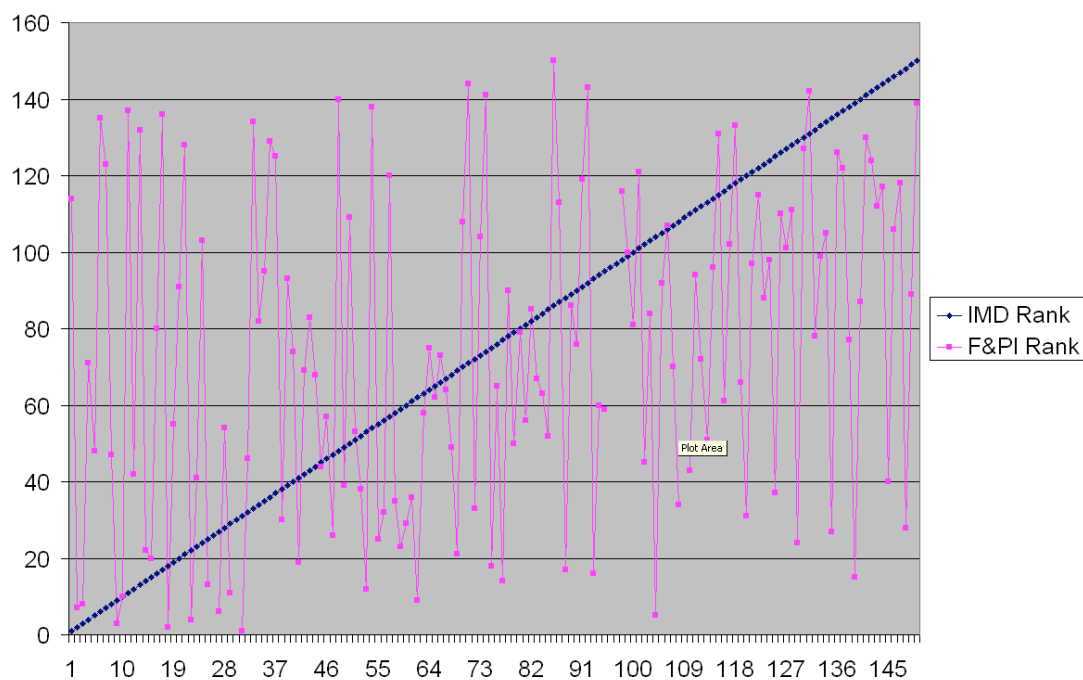


Figure 6: Health visiting caseload size against IMD score²⁵

Source: Prof. Cowley, 'The contribution of the NHS to reducing health inequalities', submission to the Health Select Committee's inquiry into health inequalities, November 2007.

5. **Lack of continuity of service provision.** The average time parents say they spend with a health visitor in the first year is four hours and six minutes.²⁶ Despite the view of professionals that regular visits can both help the health visitor to identify vulnerable children and parents with postnatal depression, and to build a personal relationship with the family, 42 per cent of parents say that they spend less than two hours with health visitors in the first year of their child's life.
6. **Lack of clarity about the role.** Practitioners report a lack of consistency in the services offered to parents and a lack of clarity about the role itself. They observe that more needs to be done to ensure the role is 'hands on' rather than managerial and is not 'squeezed by and subject to the decisions of individual PCT managers'²⁷. There is also confusion about who should be providing the supportive community care: health visitors in some PCTs have been replaced with Community Nursery Nurses, with lower entry qualifications (e.g. NVQ level 3) and on lower pay scales (£16,405 to £19,730).
7. **A retreat from universal health visiting.** The Government's review of the role of health visitors outlined their vision for a 'progressive universal' model of child health promotion. In practice, however, the Government's 'progressive universalism' seems all too likely to mean a further retreat from

²⁴ Family and Parenting Institute (Gimson, S. 'Health Visitors' speech to the APGPF, 15 May 2007).

²⁵ IMD refers to the Index of Multiple Deprivation; F&PI Rank refers to the Family and Parenting Institute survey.

²⁶ Prof. Cowley, 'A Funding Model for Health Visiting: Baseline Requirements', *Community Practitioner*, 2007 80(11) pp.18-24.

²⁷ Family and Parenting Institute, 'Health visitors – an endangered species', April 2007.

universal provision of meaningful health visiting. These fears were expressed by the Community Practitioners' and Health Visitors' Association in their response to the Government's review.²⁸

Importantly, parents are overwhelmingly against the idea of targeting – eight out of ten parents agree that all new parents could benefit from a good health visitor who visits enough times to build up a relationship. 83 per cent of parents believe that they cannot get help from other sources and do not agree that only those who are really struggling need much help from their health visitor.²⁹

Furthermore, research suggests that hard-to-reach families themselves are less likely to accept support from health visitors if the health visiting service is seen as targeted on them rather than as universal, because targeted support is seen as stigmatising.³⁰ Anecdotal evidence suggests that teenage mothers in particular are likely to see targeted health visitors as being there to police them, check up on them and point out mistakes.³¹

Moreover, it is not clear that targeting is always effective given the difficulty of identifying vulnerable families³²: only 61 per cent of health visitors currently feel that their caseload allows them to identify all cases of postnatal depression – a real issue, since postnatal depression is experienced by some ten to fifteen per cent of mothers³³.

8. **Inadequacy of Sure Start outreach.** There are currently considerable variations in the way Sure Start 'outreach' works on the ground. There is no single model or clear structure for how to reach vulnerable families. The National Evaluation of Sure Start (NESS) report specifically examining 'Outreach and Home Visiting Services in Sure Start Local Programmes' identifies seven distinct models employed in Sure Start: the Whole System model, the Generic Team model, the Holistic Multi-Team model, the Community Development model, the Focused Intervention model, the Health Team model, and the Voluntary Sector model. Furthermore, NESS found considerable variation in the specified role of the outreach worker and training received.

Our proposals

Instead of inventing a large new cadre of Sure Start 'outreach' workers – the Government plan – we want to underpin the role of health visitor as a critical element in the provision of family and child health throughout England, and we want this to be a preventative service responsive to the needs of all parents. We support the efforts made to ensure provisions of support for the most disadvantaged families before and after the birth of their children to improve medical and social outcomes, but believe that the best way of doing this is to ensure that health visiting is a universal provision for all families, with capacity for a flexible service based on need. With the growth of super-surgeries and the demise of the community GP surgery and its weekly well baby clinic, we believe that health visitors should become the fulcrum of support for new mothers in the community. The special attention we pay to the most vulnerable families must be an addition to, not a substitute for, providing all families with a guaranteed and adequate level of help during the first steps in a child's development.

²⁸ Community Practitioners' and Health Visitors' Association response to 'Facing the Future – A review of the role of health visitors', October 2007.

²⁹ Family and Parenting Institute, 'Health visitors – an endangered species', April 2007.

³⁰ Evidence from the Millennium Cohort Study indicates poorer families are less likely to receive a visit from health visitors than those families with higher incomes, due to a 'fear' of statutory services and concerns about the negative consequences of engaging (i.e. children may be taken away from them if they are seen to be unable to cope). HM Treasury, DfES, 'Aiming high for children: supporting families', March 2007.

³¹ Family and Parenting Institute, 'Health visitors – an endangered species', April 2007.

³² The present Government's Sure Start programme is also failing to identify vulnerable families effectively – see next point on the 'Structure of Sure Start'.

³³ Royal College of Midwives, 'Response to Chief Nursing Officer's review of the nursing, midwifery and health visiting contribution to children at risk', January 2004.

With over half of mothers returning to work by the time their child reaches six months old, it is vital that mothers and health visitors are able to work together to develop a plan that takes into account the working commitments of both parents.

Therefore, by the end of the first Parliament, an incoming Conservative government will ensure:

1. a minimum guarantee of two visits in the home from their twentieth week of pregnancy until birth to advise parents on pregnancy nutrition, health, and preparation for child raising. These visits are supplementary to midwife coverage and will allow for better preparation for parenthood as well as enabling the health visitor to build up a relationship with the family from an early stage³⁴;
2. a minimum guarantee of six hours of health visitor support in the home for all families over the first two weeks of a child's life. It will be for the parents and the health visitors to agree on the best way in which this six-hour entitlement can best be used, given the particular circumstances and needs of the family;
3. a minimum guarantee of an hour every two weeks for all families for the next six months of a child's life. This will include group activities where necessary, such as well baby clinics and breast-feeding support;
4. a minimum guarantee of monthly visits, either in the home or in the health visitor's base, for all children between six months and one year to support parents in the critical transition to solid feeding, establishing good sleep patterns and coping as a family with a growing child. It will become increasingly important to ensure good maternal health as mothers return to work;
5. a minimum guarantee of at least two visits every year for every child under the age of five, either in the home or in the health visitor's base, to perform immunisations, hearing and vision tests, and developmental and growth checks. The health visitor will be able to advise on child nutrition and health as needed and prepare the child for the transition from home to school; and
6. establishment of a £10 million per year Child Health Inequalities Fund to boost support for families in the most deprived areas.

This model will allow for a minimum guarantee of 23 hours of contact time between health visitors and children immediately before and during their first year of life – the level recommended by professionals within the health visiting service. This level of support will be available to all families. Health visitors and parents can agree how support is best delivered to meet a family's individual needs in those critical early years. This will be true universal coverage.

How will we build a financial structure that can deliver our goals?

Providing this level of service today would mean recruiting 2,700 more health visitors than current levels. By 2010, under the present Government's seeming neglect, another 1,500 are estimated to have left the profession giving us a shortfall of 4,200 health visitors from optimum levels.

³⁴ Evidence from D-SCOVOR data – 'Determining future directions for health visiting: a Scoping Census Of Health Visitor Registrants' – analysed with associated Index of Multiple Deprivation scores, indicates that where an antenatal visit was offered by the health visiting service, significantly more postnatal visits were also scheduled. See Prof. Cowley, 'The contribution of the NHS to reducing health inequalities', submission to the Health Select Committee's inquiry into health inequalities, November 2007.

An incoming Conservative government would immediately act to reverse this decline by:

- funding a substantial increase in training places to recruit the maximum needed over a five year period, estimated to cost a maximum of £40 million per annum³⁵;
- providing ring fenced funds for salary and benefits for 4,200 additional health visitors at a total additional cost of £150 million per annum over 2007 levels; and
- providing £10 million to set up a Child Health Inequalities Fund to boost support for families in the most disadvantaged areas.

The total cost of our proposals is £200 million per annum. This will be funded by reallocating the money which the Government currently intend to provide to employ additional ‘outreach’ workers at Sure Start Children’s Centres – estimated to total £201 million per year by 2010.

By using the money currently intended for ‘outreach’ workers to fund instead the provision of universal access to a highly professional health visitor programme, we will strengthen the Sure Start programme. There is compelling evidence that Sure Start Centres with a higher proportion of health-related staff (i.e. health visitors and midwives), focusing on the provision of early years’ support, experience higher levels of maternal acceptance.³⁶ We therefore agree with the Government’s own National Evaluation of Sure Start that ‘health visitors are particularly important in facilitating initial access to Sure Start services’³⁷ and we believe that by enabling professional health visitors, rather than less qualified individuals, to act as Sure Start ‘outreach’ workers, Sure Start will be better placed to identify and engage with isolated families who may not voluntarily come to a Children’s Centre.

³⁵ We have assumed that although we will be able to halve the exit rate from the profession, the age of the workforce will still mean an on-going decline in the numbers of existing health visitors. This, together with a small increase in the overall number of births and children under five, means that the actual shortfall from 2010-2015 is estimated to be 6,000.

³⁶ http://www.surestart.gov.uk/_doc/P0002439.pdf

³⁷ http://www.surestart.gov.uk/_doc/P0001077.pdf