Cyflwynwyd yr ymateb hwn i ymgynghoriad y Pwyllgor Plant, Pobl Ifanc ac Addysg ar Flaenoriaethau'r Chweched Senedd

This response was submitted to the Children, Young People and Education Committee consultation on Sixth Senedd Priorities

CYPE SP 106

Ymateb gan: Y Sefydliad Ymwelwyr Iechyd

Response from: Institute of Health Visiting

Beth yn eich barn chi yw'r prif flaenoriaethau neu'r materion y dylai'r Pwyllgor eu hystyried yn ystod y Chweched Senedd? Os oes modd, nodwch eich barn o ran sut y gallai'r Pwyllgor fynd i'r afael â hyn.

What do you consider to be the main priorities or issues that the Committee should consider during the Sixth Senedd? Where possible, please set out your view about how the Committee could address them.

Thema 1: Addysg oedran ysgol | Theme 1: School-age education

We confine our comments to pre-school age children as indicative of our sphere of professional competence and experience.

Thema 2: Addysg bellach ac addysg uwch | Theme 2: Further and higher education

We confine our comments to pre-school age children as indicative of our sphere of professional competence and experience.

Thema 3: Iechyd a lles, gan gynnwys gofal cymdeithasol (i'r graddau y maent yn ymwneud â phlant a phobl ifanc) | Theme 3: Health and well-being, including social care (as they relate to children and young people)

By Children and Young People (CYP) we include babies / infants and young children from conception, through birth infancy and early childhood to school entry. The First 1000 days (from conception to age 2). By health and well-being including social care we include those services and other environmental factors that have an effect on the

health, development, learning and wellbeing of CYP from before birth, through the course of childhood that set a life-long trajectory.

In order to focus priorities likely to have impact on Wales' Future Generations we conducted a small purposive enquiry of senior practitioners in the health visiting profession. We recognise that health visiting is part of a wider network and system of provision that needs to work together interdependently.

We asked our respondents about the First 1000 days of life. These are often overlooked in policy for CYP through the lens of 'Education' because (1) infants do not attend school; (2) they are not able to speak directly for themselves when they are pre-verbal and are therefore systematically excluded from otherwise creditable strategies to consult CYP themselves and hear what they have to say (3) the First 1000 days are more significant for learning, development, health and social outcomes than any other life-stage; (4) the First 1000 days are the most vulnerable across the life-course with the highest rate of homicide being in the first year of life, and setting inequalities that are hard to overcome; and (5) investment in the earliest years has the highest 'rate of return' economically (James Heckman) and for health outcomes (Sir Michael Marmot).

We asked our respondents:

1. What three priorities would you identify for the first 1000 days of Welsh children's lives to become a healthier future generation?

1.1 A holistic 360° vision for child health and wellbeing for all children but especially for the first 1000 days. In complex societies services become specialised, separating their focus, but health, wellbeing and development in early childhood are experienced and influenced in an integrated way. A priority for government, its agencies, services and front-line practitioners is to be able to provide a supportive, holistic environment in which they can flourish. This is difficult when children's needs are viewed through administrative or institutional lenses such as home vs school; health vs social care; development vs learning or school readiness.

An ecological approach to early childhood should be a priority across government depts that should accept the challenge to orientate and coordinate their policy

through the lens of the experience of childhood. In this respect we commend the consultation's engagement with CYP but urge the perspective of the youngest children to be given equal priority.

Health visiting as a profession and a mode of practice is firmly rooted in this ecological approach.

They lead and deliver the Healthy Child Wales (HCW) programme and it should be a priority that it be implemented in ways that are not confined to trajectories of health that lead to medically defined diagnostic outcomes. These are important but the HCW programme needs to address the continuum of the interaction between infants' early experience of care and neurodevelopment, and later outcomes for all domains of development, including physical and mental health, psychosocial and employment function. These infants will become the parents of the future – it is how transgenerational risk is transmitted – a cycle to be broken with the right approach. The ecological approach supports healthy relationships between infants and their carers. Within the family and the wider network of community relations and resources that include services. This is why the health and wellbeing of parents and other siblings are also the focus for health visiting in the context of the home and community: a 360 perspective.

1.2 Resilience and a strengths-based approach:

A healthy future requires a healthy start that provides the resilience to thrive even when health and other challenges are experienced. Resilience is not a property of the strong individual but of a network of relationships. Health visitors in Wales have been in the vanguard of this approach, exemplified by the development and use of the Family Resilience Assessment Instrument and Tool (FRAIT) created by health visitors for health visitors to use in their daily practice. However, this approach is not limited to one tool or technique. It requires the HV to prioritise the perspective of the unborn, pre or barely verbal infant with expert understanding of future outcomes emanating from the interaction between infant neurodevelopment and the environment of care. In the dyadic, biopsychosocial context, the environment of care is constructed by parental caregiving capacity and own history of being parented, safe and trusted support networks, financial and housing status, health and other factors. HVs apply this biopsychosocial approach in collaboration with parents to assess, create personalised care, and ultimately to support, promote and/ or protect infant outcomes across the lifespan.

Resilience is a function of a wider network of relationships beyond the immediate family. It is therefore a priority that families are connected to this network and, when they experience difficulties, to be supported to navigate their journey to the support

that they may need. This is a core capability of health visitors. They start a caring and compassionate journey with parents, building trusting relationships in order to provide holistic support, guidance and advice to help parents care for their developing child, ensuring that they are safe and healthy and identifying when this may not be the case.

In order to maximise their leadership potential at community level health visitors need to be free to engage with community networks from living room to boardroom to build on strengths reflective of particular contexts including inner city, post-industrial town, rural and coastal communities.

1.3 **Reducing exposure to risk / Adverse Childhood Experiences (ACEs)**

Wales has been at the forefront of making use of the insights of research into the prevalence and impact of Adverse Childhood Experiences . Health visitors welcome this as they have a proactive reach into every family when the impact of ACEs on parents in their earlier life often becomes evident as they make the transition to parenthood. Health visitors can adopt trauma informed approaches to working with families when they have the time and opportunity to win trust and explore family health needs with fathers and mothers. These needs can become evident in perinatal mental distress or other behaviours including problematic use of alcohol and other substances or domestic conflict or violence. These in turn can become ACE's for the young child at the most formative life stage that is the first 1000 days.

We encourage the Welsh policy makers to continue to support this work recognising that ACEs are not confined to pre-determined high-risk groups but are widespread throughout the population. This insight provides a powerful opportunity for prevention through the universal, non-stigmatising service provided by health visitors when they are supported and equipped through up-to-date training, supervision and appropriately weighted caseloads.

2. What three things do health visitors provide for babies, children and families in the first 1000 days to support better health and life chances for future generations?

2.1 Providing and facilitating trusting relationships

Recent research indicates that what parents most value about health visitors is that they get to know and be known by their health visitor and can rely on them for

sound evidence-based knowledge and support tailored to them and their circumstances. Moreover, the science of early childhood also supports the primary importance of the quality of relationship between the developing infant and their parent(s). Thus, evidence supports the power of heath visiting to support healthy foundations for later development across a range of outcomes. A good example is early language and communication which is a key predictor of later educational, social and emotional outcomes.

Crucial to providing and facilitating trusting relationships is sufficient time to engage with each family at key points in their parenting journey and to respond proportionately to emerging needs in a timely manner. This requires caseloads reflective of the level of need in the particular community and the organisation of services to provide ready access and continuity of practitioner, avoiding the experience of fragmented depersonalised care.

2.2 Searching for and assessing needs

Health visitors search for health needs and raise awareness of the child's and parental needs and factors that may impact on the child reaching their full potential. Part of this is identifying safeguarding concerns, parental capacity to care, identifying when a parent and child may require additional support and access to other services that may help.

2.3 Providing and mobilising support

Health visitors provide interventional support based on the child and parents' individual needs. This can be short or long-term depending on parental capacity, their child's health and psychological needs and whether a child has emerging or additional needs or complicating factors such as parental capacity, or issues such as family conflict or material deprivation. Health visitors have the capability to develop and lead pathways to care both for individual families, vulnerable or minoritised groups and across communities. The iHV has identified 15 'high impact areas' in its vision for health visiting for England that was informed by best practice in all four UK nations.

3. What three things would enable health visiting services to have the greatest impact on the health and wellbeing of future generations in Wales?

3.1 Universal health visiting services must be weighted according to contemporary public health needs during the first 1000 days and early years and characteristics of the communities served (inner-urban, rural, coastal etc)
The power of health visiting lies in its universal reach in contrast to most other services for families with young children that are either targeted or reactive. However, health needs are not evenly distributed but reflect wider inequalities. It is important to address inequalities in by ensuring that care of the child and family becomes needs-led and not a 'post-code lottery' which, for example, can disadvantage families with high level needs who do not fall into Flying Start areas. All health visitors need to have caseloads weighted to enable them to provide a proportionate responsive level of personalised care.

3.2 A highly skilled workforce that has access to evidence-based interventions and training.

The science of early childhood and research evidence for effective interventions is growing rapidly. As Specialist Community Public Health Nurses (SCPHN) health visitors are highly educated and able to assimilate and appraise new knowledge and practices, providing leadership for enhanced care and services. Specialist health visitors advance care for families with additional needs and support their health visiting colleagues and wider teams. Flying Start in Wales and Family Nurse Partnership in England provide examples of how a sustained programme of training, support and supervision underpins service quality, effectiveness and staff satisfaction. The iHV supports such as examples for all health visitors. The NMC will be publishing new standards for SCPHN that provide an ambitious vision for health visitors to exercise their expertise clinical skills as autonomous practitioners with leadership at community and system level. Realising this ambition will require continuing investment in the whole health visiting workforce to maintain and enhance their capabilities within an enabling environment.

3.3 Organisation and leadership of health visiting services that are reflective of relationship focussed care

Research supports a symmetry between the quality of care experienced by families and the organisation and leadership of health visiting services

There are a number of ways in which this can be articulated (e.g., compassionate leadership, restorative practice, trauma informed, sanctuary approach) but in each

case it is important that the organisation practices what it preaches and models what it expects of its front-line staff. This should include a high-trust high-support culture that sets high ambitions to 'make a difference' to the families and communities we serve.

The performance of services should be monitored, and improvement driven by relevant, proportionate and engaging data that motivates practitioners, service leads and policy makers towards collaborative learning and improvement. A concerted effort is required to capture data which reflect the issues that most concern parents and/ or are acutely relevant to infant wellbeing, and so engage HVs at every face-to face contact during 1st 1000 days. Data collected are largely categorical/ quantitative and do not capture labour intensive HV activities that respond to early needs - these manifest qualitatively (e.g., parental difficulty in soothing infant; low parental sensitivity to infant; housing needs that impact health and safety; asylum seeker mothers with trauma; child protection). Sadly, the iHV finds that practitioners frequently report the experience of 'ticking the box, but missing the point'. We are engaging in research to investigate more appropriate approaches to analytics and commend efforts to move beyond onerous and demotivating methods.

We support meaningful career pathways for expert health visiting practitioners in 1st 1000 days with proven specialist training/ skills leading across care pathways or for vulnerable groups such as looked after children or minoritised groups in order to champion service improvement at system level.

Thema 4: Plant a phobl Ifanc | Theme 4: Children and young people