Children's COMMISSIONER

Best Beginnings: Technical report 2

Findings from 2 – 2 ½ year review and health visitor statutory information request

July 2020

Contents

Executive summary

Age two is an important time in a child's development when delays can be identified and additional support most effective. As part of the universal pregnancy to age five Healthy Child Programme (HCP), every local authority in England is required to conduct a health review at age 2-2 ½ for all children. National data is patchy on the number of children that do not receive the review, with no information on the additional vulnerabilities these children may have. In addition, there is no data on factors that might determine how effective the review is at identifying issues and providing additional support. These include whether the 2-2 ½ year review is: conducted face to face with families, integrated with an early year progress check, undertaken by a health visitor, as well as what type of additional support is provided for those identified as having a developmental delay or in need of additional support.

There is also no national data on the number of health practitioners delivering the 0-5 HCP, whether this has changed since the responsibility of the HCP was transferred to LAs, what proportion are health visitors, and how large their caseloads are.

In order to fill these important data gaps, the Children's Commissioner's Office requested data from every local authority Director of Public Health (DPH) in England to provide a national picture on the characteristics of the children that do and do not receive a 2-2 ½ year review, and how children are supported when additional needs are identified, as well as on health visitors delivering the HCP.

Information was received from 148 of the 152 local authorities – a response rate of 97%.

How many children did not receive their 2-2 ½ year review?

- In 2018/19, one in five children (20%) on average did not receive their 2-2 ½ year review in 2018/19.
- In 31% of local authorities (LAs), a quarter of children eligible for a 2-2 ½ year review did not their review. In 3% of LAs, more than half of eligible children did not receive a review (including one LA where 65% of eligible children did not receive a review).
- The reasons given by LAs for children not receiving a review included: parental choice, transient populations, and hard to reach families.

How many of these children had additional vulnerabilities?

Of reporting LAs:

- 13% could identify how many children eligible for the two year old entitlement had not received their 2-2 ½ year review.
- 30% could identify how many 'Children in Need' had not received their 2-2 ½ year review.
- 12% could identify how many children with special educational needs or disability (SEND) support had not received their 2-2 ½ year review.
- Where LAs were unable to do this, their reasons included: Records being paper based; an inability to identify individual vulnerabilities at a population level; providers not collecting the information; data being held in different data systems; an inability to link the data with no common child level identifier; restrictions in use as well as specific issues of definition and recording.

Who completes the 2-2½ review?

- On average a third of the reviews in 2018/19 were conducted by health visitors (33%) and two thirds by other professionals. However there was substantial variation in this across LAs.

How many reviews are integrated with early year progress checks?

- On average 8% of 2-2 ½ year reviews per LA were integrated with an early years progress check in 2018/19.
- In nearly half of reporting LAs (47%), no integrated reviews took place.
- Only 5% of LAs had integrated review for more than half of their children receiving a 2-2½ review.

How many children had an additional need or developmental delay identified at their 2-2½ review?

- Just under three quarters (73%) of reporting LAs were able to give the number of children who were identified at their 2-2½ year review in 2018/19 as having an additional need or developmental delay.
- Among these LAs, on average 17% of children who received their 2-2½ year review were identified as a having an additional need or developmental delay. But this varied across LAs from 3% to 59%.
- Where LAs were unable to provide information on this, their reasons included: Paper based records; an inability to extract data on additional need or developmental delay at a population level and issues of definitions and criteria
- On average 82% of children identified at the 2-2 ½ year review were identified by the ASQ, 18% by another criteria.

Were children who had an additional need referred to or in receipt of additional support?

- Just over half of reporting LAs (54%) could give the number of children referred or in receipt of additional support.
- Among these LAs, an average of 76% of children identified as part of the review as having an additional need or developmental delay were referred or received additional support. A large proportion (43%) reported that all of the children identified were referred to or received additional support.[1]
- A minority of LAs could give the numbers of children on broken down by the type support, including: child development support, services for parents, universal family services, children's social care and early help.

What was the number of practitioners delivering the 0-5 HCP and what were their caseloads in 2018/19?

- On average 74 practitioners per LA were delivering the HCP in 2018/19, consisting of an average of 56 health visitors[2] and 19 other practitioners[3], a ratio of 74% to 26%. Ten percent of

[1] It should be noted that some councils highlighted that a discrepancy between the number of children and the number of referrals, due to multiple referrals for some children with complex needs.
[2] Holding a Specialist Community Public Health Nursing (SCPHN) qualification
[3] Members of the health visiting team who were not qualified health visitors (non-SCPHN). This included band 5 staff nurses, community health workers, nursery nurses.

reporting LAs only had health visitors delivering the 0-5 HCP, while 1% of LAs had only other practitioners delivering.

- The average caseload for a practitioner delivering the HCP in 2018/19 was 368 children, with the highest being 833 children and the lowest 37 children.
- 7% of reporting LAs had an average caseload under 200 children, with 30% having a caseload of over 400 children and 7% with a caseload of over 600 children in 2018/19.

Has the number of practitioners delivering HCP changed since 2016/17?

59% of all reporting LAs stated that they had seen a decrease in the number of practitioners since 2016/17, while 29% stated that the number had stayed the same and 12% stated that it had increased. Analysis shows:

- Average caseloads were higher in areas where practitioner numbers had decreased, compared to areas that had stayed the same or had increased since 2016/17.
- The average number of practitioners was lower in LAs that reported a decrease in the number of practitioners since 2016/17, than in LAs that report an increase or no change in the numbers delivering the 0-5 HCP.
- The average number of health visitors delivering the 0-5 HCP was lower in LAs that reported a decrease in 0-5 HCP practitioners since 2016/17.

Introduction

Age two is an important time for children. It is when they begin to get a real understanding about the environment around them, bond with other children and develop their fine and motor skills. Yet it is also a time when problems with both language development and behaviour can start to be identified, and where interventions can be most effective, making a real difference to their future. Evidence suggests that the provision of universal access to healthcare at around the age of two has the greatest potential to promote health and wellbeing and reduce health inequalities in later life.[4] There is further evidence to suggest that it is an effective health visiting programme that can have a substantial impact on early child outcomes.[5]

The pregnancy to age five Healthy Child Programme (HCP) is England's universal early intervention and prevention public health programme providing families with screenings, immunisations, health and development reviews, supplemented by advice around health, wellbeing and parenting.[6] It is an evidenced-based[7] programme which aims to offer all families in England the support and services needed to ensure children achieve their health and wellbeing potential. The responsibility for delivering the HCP lies with health professionals led by health visitors but also including integrated services that bring together Sure Start children's centre staff, GPs, midwives, community nurses and others.[8]

As part of the HCP programme in England, local areas must conduct a health review at age 2-2 ½ for all children within their local authority. The 2-2 ½ year review is a health focused review incorporating an assessment of child development, including social and emotional wellbeing as well as healthy eating, managing behaviour, oral health, vaccinations and keeping their child safe. The review is the last universal check of a child's development until the end of Reception, when a child is five. It is therefore an important mechanism for identifying families in need of additional support and children who have signs of developmental delays to help prepare them for school.

As critical as the 2–2½ year review is, over 1 in 5 (22%) children did not receive their 2-2½ year review in 2018/19.[9] No national data is collected on the characteristics of the children that receive the review, and – more importantly – the children who do not receive the review. Are these children from deprived families? Have they been identified as having special needs or disabilities? Are they known to the social care system? There are no national figures on these important questions.

[4] Marmot M, Friel S, Bell R, and Houweling TA (2008) Closing the gap in a generation: health equity through action on the social determinants of health, 372: 1661-1669. Available at: http://nccdh.ca/resources/entry/closing-the-gap-in-a-generation-health-equity-through-action-on-the-social; Roberts, H (2012) What works in reducing inequalities in child health? 2nd Ed. Chicago: The Policy Press; The Marmot Review: Fair Society, Healthy Lives. Strategic Review of Health Inequalities in England post-2010. Available at: http://www.instituteofhealthequity.org/resources-reports/fair-society-healthy-lives-the-marmot-review

[5] The Wave Trust (2013) Conception to Age 2 – The Age of Opportunity (https://www.1001criticaldays.co.uk/sites/default/files/conception-to-age-2-full-report_0.pdf); The 1001 Critical Days (2013). The Importance of the Conception to Age Two Period: A Cross-Party Manifesto (https://www.1001criticaldays.co.uk/sites/default/files/1001%20days_Nov15%20%2800000002%29.pdf)

[6] Shribman, S., & Billingham, K. (2009). Healthy Child Programme: Pregnancy and the first five years of life. Department of Health.

[7] Hall, D. M., & Elliman, D. (2006). Health for all children: revised fourth edition. Oxford University Press; Early Intervention Foundation (2018) What works to enhance the effectiveness of the healthy child programme: an evidence update

[8] Health visitors are qualified and registered nurses or midwives who have obtained additional training and qualifications as specialist community public health nurses (SCPHN - HV). Department of Health (2009) Healthy Child Programme: Pregnancy and the First 5 Years of Life. Available at: https://www.gov.uk/government/publications/healthy-child-programme-pregnancy-and-the-first-5-years-of-life

[9] Using quarter 1 to 4 data, an annual percentage was calculated from: Public Health England. Health Visitor Service Delivery Metrics 2017/18 Annual Data. Statistical Commentary (July 2019 'Quarter 4' release). Available at: https://www.gov.uk/government/statistics/health-visitor-service-delivery-metrics-2018-to-2019

Of those that do receive a check, around one in ten (9%)[10] did not have their review completed using the Ages and Stages Questionnaire (ASQ) – a population measure of child development outcomes.[11] Data that *is* collected on children's development scores is acknowledged to have data quality and validation issues.[12] The result is a patchy national picture on children's development at this age. This hinders the ability to identify and address developmental needs early on. Critically, data is not collected nationally on what support is offered to children that are identified as part of the 2-2 ½ year review as having an additional need or developmental delay. What type of support is offered? How are families and children are referred to additional support? What support is taken up? What happens as a result of this support?

In 2015 the responsibility for commissioning children's public health for children aged 0 to five moved from the NHS to Local Authority's Departments of Public Health. Prior to this the NHS collected data on the number of health visitors.[13] Since then, there has been no national data collection on the number of professionals – health visitors or other professionals – delivering the HCP. In written evidence to the First 1000 Days enquiry, the Institute of Health Visitors (IHV) stated that the number of health visitors employed has fallen by over 20% since service commissioning transferred from NHS England to Local Government in October 2015. This has taken the numbers down below what the IHV would consider to be safe levels of coverage.[14]

In addition there has been evidence that the decrease in the number of health visitors has increased caseloads. The 2018 IHV annual survey of 1,200 health visitors reported that caseloads have increased: 15% of caseloads were between 600 and 1,000, up from 7% in 2015. Furthermore, 72% of health visitors reported that their stress levels have increased as a result.[15] IHV has recommended that caseload size should not exceed 250 children per full-time-equivalent health visitor, or a maximum ratio of 1:100 in more deprived areas.[16]

Routine statistics on 2-2 ½ year reviews do not capture who conducts the review. The 2018 IHV annual survey reported that 77% of 2-2 ½ year reviews were delegated to non-health visitors who have lower levels of training and clinical expertise.[17]

Age two is also a time when many children start early education and care, and is when the most disadvantaged two-year olds are entitled to 15 hours of free provision per week. It is also a time when there is a requirement for parents using provision to be provided with a written summary of their

[10] Calculated from the same data as above.

[11] According to PHE, ASQ-3 is not a screening tool, but provide an objective measure of development and allows comparisons to be made helping to identify children who are not developing as expected and supporting decisions on closer monitoring of progress or targeting of services. Dimensions of development which are tested include communication, gross motor, fine motor, problem solving and social / emotional skills. Public Health England. Child development outcomes at 2 - 2½ years 2017/18 Annual Data Statistical Commentary (October 2018 release). Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/750448/2017_2018_Annual_Child_Development_Statistical_Commentary.pdf

[12] Public Health England. Child development outcomes at 2 - 2½ years 2017/18 Annual Data Statistical Commentary (October 2018 release). Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/750448/2017_2018_Annual_Child_Development_Statistical_Commentary.pdf

[13] https://www.england.nhs.uk/statistics/statistical-work-areas/health-visitors/indicative-health-visitor-collection-ihvc/ . While the NHS does collect data on NHS employed health visitors (available here: https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics/june-2018) this does not include health professionals who are not employed by the NHS to deliver the HCP.

[14] First 1000 days of life inquiry. Written evidence from the Institute of Health Visiting (October 2018) Available at: http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/health-and-social-care-committee/first-1000-days-of-life/written/88862.html

[15] Institute for Health Visiting (2018) Annual Report https://ihv.org.uk/wp-content/uploads/2018/12/26.11.18-Annual-Report-2018-FINAL-VERSION.pdf

[16] First 1000 days of life inquiry. Written evidence from the Institute of Health Visiting (October 2018).

[17] Institute for Health Visiting (2018) Annual Report

children's progress in the Early Years Foundation Stage prime areas of learning.[18] It is expected that these reviews are integrated with the HCP 2-2 ½ year review as it offers an opportunity for a holistic assessment of a child's development and their transition to early education.[19] The National Children's Bureau states that "integrating the existing health and education reviews at age two will help to identify problems and offer effective early intervention for those children who need more support, at an age where interventions can be more effective than they would be for an older child."[20] A lack of integration could mean that parents receive only partial information about their child's development and development needs are not identified. However, there is no national data available on the number of reviews that are integrated.

[18] The Early Years Foundation Stage (EYFS) is the statutory framework setting the standards for all early years providers for learning, development and care for children from birth to age five. The prime areas of learning are: Personal, Social and Emotional Development, Communication and Language and Physical Development.

[19] The purpose of the Integrated Review to: Identify the child's progress, strengths and needs in order to promote positive outcomes in health and wellbeing, learning and behaviour; facilitate appropriate intervention and support for children and their families, especially those for whom progress is less than expected; and generate information which can be used to plan services and contribute to the reduction of inequalities in children's outcomes.

[20] NCB (2015) The Integrated Review - Bringing together health and early education reviews at age two to two-and-a-half. Available at: https://www.ncb.org.uk/sites/default/files/uploads/staff/NCB%20Integrated%20Review%20Supporting%20Materials%20for%20Practitioners%20March%202015.pdf

Methodology

On 19 August 2019 the Children's Commissioner's Office wrote to all 152 Local Authority (LA) Directors of Public Health (DPHs) in England to request data on the Healthy Child Programme's 2 – 2 ½ year review. This section sets out the development, data collection, analysis and limitations of the request.

Development and piloting

The data request items were developed in consultation with relevant experts and professionals including Public Health England, the Institute of Health Visiting and the Local Government Association. Following this a draft set of questions and a supporting information pack were piloted with a number of LA public health commissioners as well as providers. Feedback from this pilot was used to refine the set of questions and the information pack.

Data requested

The final data request asked about:

- The number of children eligible for a 2-2 ½ year review in 2018/19[21] in the local authority;
- The number of eligible children that did and did not receive their 2 – 2 ½ year review in 2018/19;
- The number of eligible children whom the LA could identify as:
  - Eligible for the free entitlement to early education at two years old
  - A "Child in Need"
  - Having SEND support;
- The number of children whose 2-2½ year review was completed by a health visitor or a member of the Healthy Child Programme team;
- The number of children whose 2-2½ review was face to face with a member of the Healthy Child Programme team, or as a face-to-face integrated review (combining the Healthy Child Programme 2-2½ year review and Early Years 2 year Progress check);
- The number of children identified as part of the review as having an additional need or developmental delay, whether this was identified by the ASQ responses or by another criteria, whether they were referred/received additional support, and if so what that support was;
- Whether the LA had made or was planning to make changes to provision of the 2-2½ year review in 2019-20;
- The number of health visitors and other practitioners delivering the 0-5 Healthy Child Programme, whether this number had changed since 2016/17, and the estimated average caseload.

Mainstage data collection, sample and response rates

The data request ran from 19 August 2019 to 13 September 2019, with some LAs providing data after the deadline. We received responses from 148 of the 152 LAs, a response rate of 97%. Two pairs of local authorities, Cornwall and Isle of Scilly and Hackney and the City of London, gave combined responses. Therefore the number of data points – i.e. the sample size – for the analysis in this report is 146.

Data checks

After cleaning the data, a number of analyses were carried out to quality assure the data. This including clarifying with a number of LAs issues such, e.g. numbers of children receiving the check being higher than the number who were eligible, or the combined number of children reviewed by either a health

[21] reporting year from 1st April 2018 to 31st March 2019

visitor or another practitioner being higher than the total number of children having the review. Reasons for these discrepancies included the churn of the eligible population as well as different reporting systems or providers of data.

The number of children eligible for the 2-2½ year review and the number of children that received the check in 2018/19 were checked against official statistics published by Public Health England (PHE). [22] According to the PHE statistics the proportion of eligible children receiving their review was 78% for 2018/19. From the data request this figure was 79% when using the same calculation of dividing all the children in the data who received the review by all of the children in the data who were eligible for it. It was 80% when averaging the proportion of eligible children receiving the review in each LA. The similarity in the percentages gives a degree of validity to the numbers reported.

Limitations

This statutory data request was subject to a high degree of quality assurance in its design, testing, collection, analysis and reporting. However, a number of limitations should be noted:

- **Consistency in reporting**. While internal development and piloting with experts, directors of public health and practitioners took place to ensure questions were clear and consistency understood. There may be a degree of inconsistency in how data was reported by local authorities in the main data collection.
- **Data validation**. While the data received was rigorously checked and quality assured for discrepancies and outliers, data has been provided from local authorities themselves and as a result has not been independently verified. In addition, the source of much of the data was the information systems of the providers of the HCP, which was not readily available to local authorities who commission the service – limiting their ability to quality assure the data.
- **Different reporting period**. For one response the data is for 2019/20 pro rata based on Q1 data, as the local authority was not able to give past records for any of their data. Rather than exclude them from the analysis altogether, it was agreed to include the data once checks on the number of children receiving the 2-2½ year review with official statistics for 2018/19 was undertaken.

[22] Using quarter 1 to 4 data, an annual percentage was calculated from: Public Health England. Health Visitor Service Delivery Metrics 2017/18 Annual Data. Statistical Commentary (July 2019 'Quarter 4' release). Available at: https://www.gov.uk/government/statistics/health-visitor-service-delivery-metrics-2018-to-2019

Healthy Child Programme 2-2 ½ year review findings

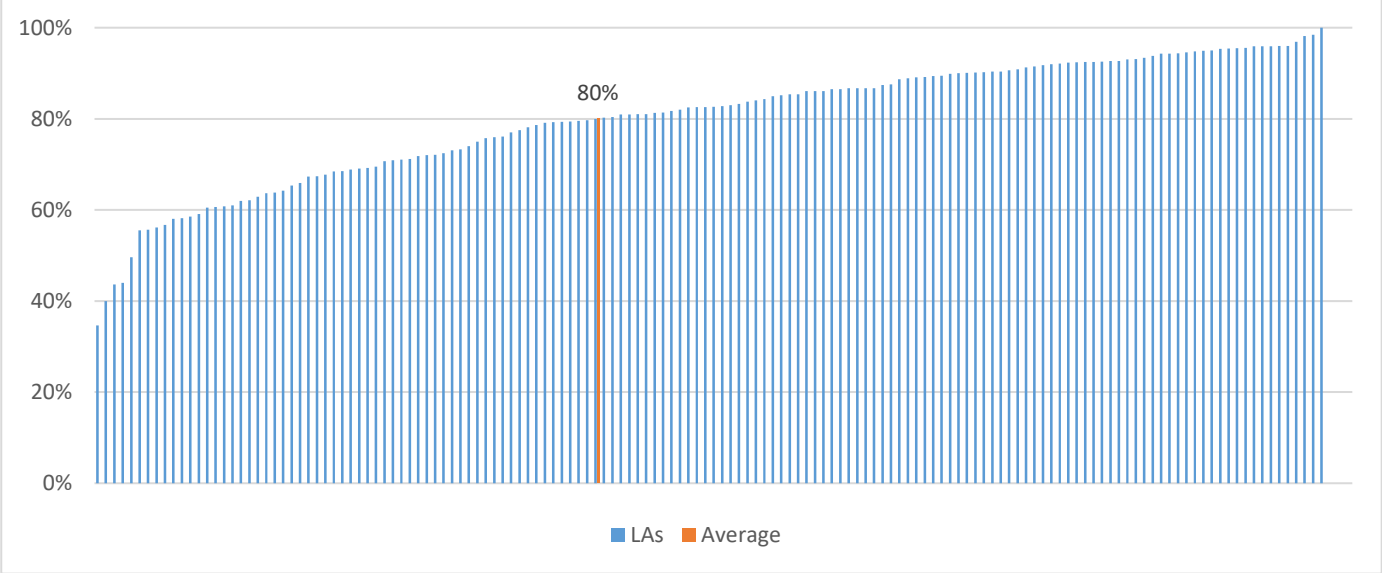
This section sets out findings from the data request on the 2-2 ½ year review itself. The findings are based on 11 questions about the children receiving the review as well as information about the review itself and subsequent support.

How many children received their 2-2 ½ year review?

Local authorities were asked to provide the number of children that were eligible for a 2-2 ½ year review as well as the number of eligible children that did and did not receive their 2 – 2 ½ year review in 2018/19.[23]

Figure 1 shows the percentage of eligible children who received their 2-2 ½ year review in 2018/19[24]. It shows a large amount of variation (ranging from 35% to 100%) across LAs, with an LA average of 80% of eligible children receiving their review.[25] Using nationally published statistics, the proportion of eligible children receiving their review was calculated at 78% for 2018/19.[26]

Figure 1. Percentage of eligible children receiving 2-2 ½ year review in reporting local authorities



Note: N = 146 (100% of returns)[27]

Figure 2 shows the reverse of Figure 1 by presenting the percentage of eligible children who did *not* receive their 2 – 2 ½ year review in 2018/19. On average one in five (20%) children did not receive their 2 – 2 ½ year review.[28] Again there is substantial variation across LAs: from 0% of eligible children not receiving a review in one LA, to 65% in another LA.

[23] reporting year from 1st April 2018 to 31st March 2019

[24] In 6% of reporting LAs there was a difference between the number of children that were 'eligible' and children that did nor did not receive a review. This was because in some instanced children that were not eligible during the specified period may still have received a face-to-face check during that period if this was completed late - hence a higher figure. In other cases children will have moved into the area, having had their review in another area and not be counted on the LA clinical system, but still be within the eligibility numbers – hence a lower figure.

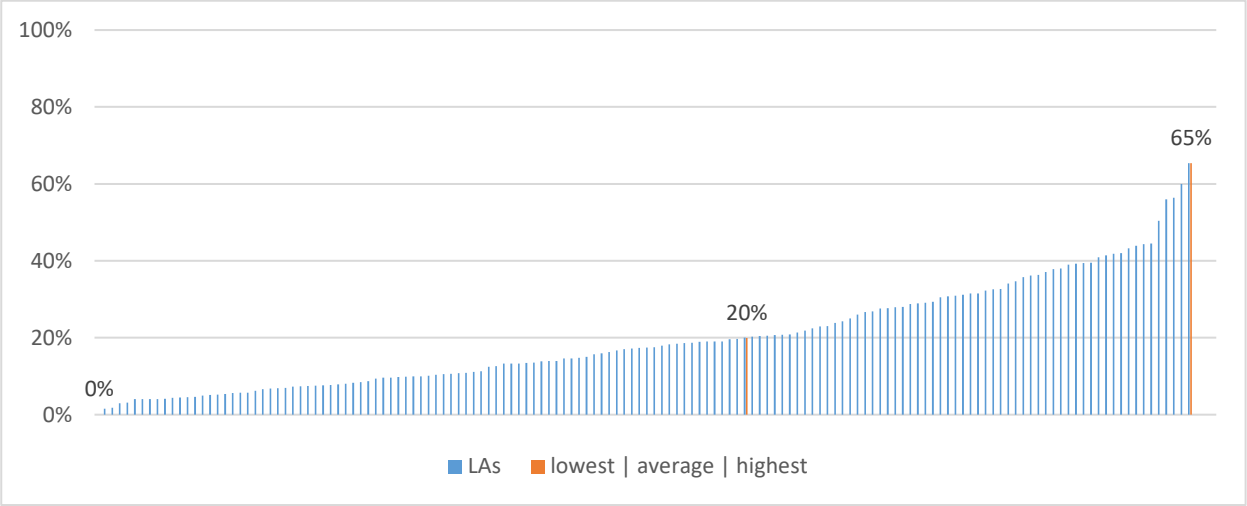
[25] The average figure is an average per LA, i.e. an average of each LA's percentage of those receiving the 2-2 ½ year review. When dividing the number of eligible children across all LAs by the number that received a 2-2 ½ year review, the average was 79%.

[26] Using quarter 1 to 4 data, an annual percentage was calculated from: Public Health England. Health Visitor Service Delivery Metrics 2017/18 Annual Data. Statistical Commentary (July 2019 'Quarter 4' release). Available at: https://www.gov.uk/government/statistics/health-visitor-service-delivery-metrics-2018-to-2019

[27] As noted in the methodology section. 148 LAs responded to the data request by two gave joint responses, leaving 146 data points for analysis.

[28] When dividing the number of eligible children across all LAs by the number that did not received a 2-2 ½ year review, the average was 21%.

Figure 2. Percentage of eligible children not receiving 2-2 ½ year review in reporting local authorities



Note: N = 146 (100% of returns)

This variation is also seen in national data. In 2018/19 Quarter 4 (the latest available data), 22% of eligible children did not receive their review. This ranged from 2% in one LA to 77% in another.[29]

From the data request analysed here, in 31% of LAs a quarter of children eligible for a 2-2 ½ year review did not receive it in 2018/19. In 3% of LA, more than half of eligible children did not receive a review.

Table 1. Number of LAs where significant proportions of children did not receive their 2-2 ½ review

	Percentage	Number
More than a quarter of children	31%	45
More than half of children	3%	5

Some local authorities gave additional contextual information for why children did not receive their 2-2 ½ year review. This included:

- **Parental choice**. LAs noted that this was more likely for parents who had returned to work or parents who felt they were already aware of their child's development. This was particularly the case for parents with their second or subsequent children.
- **Transient populations**. One LA stated that 17% of their 2-2 ½ year 2018/19 cohort moved into the local authority under the age of 2 ½. Another calculated a rough churn rate of 30%, which included both in- and outside-borough movement. LAs noted that often public health departments were not notified and struggled to know whether a child had received their review in their original area of residence.
- **Hard to reach populations**. One LA highlighted that families who have previously been identified as having additional needs were often those who could not be contacted for a review. In these instances HCP teams worked in partnership with the early years practitioners and in some instances notified statutory services.

This raised the question as to whether local authorities knew if the children not receiving the review had additional vulnerabilities.

[29] Using quarter 4 data from: Public Health England. Health Visitor Service Delivery Metrics 2017/18 Annual Data. Statistical Commentary (July 2019 'Quarter 4' release). Available at: https://www.gov.uk/government/statistics/health-visitor-service-delivery-metrics-2018-to-2019

How many of these children had additional vulnerabilities?

In an effort to understand whether the children who did and did not receive the 2 – 2 ½ year review in 2018/19 had additional vulnerabilities, the data request asked for the number of eligible children whom the LA could identify as:

- *Eligible for two years old free entitlement to early education*[30] – as an indication of children who were from disadvantaged families;
- *'Children in Need'*[31] – a children on the LA's 'Child in Need' register;
- *Having Special Educational Needs (SEN) support*[32] – as an indication of children who had additional needs which the local authority had obligations to provide for.

Many LAs responded by stating they had data on the overall number of children in their area with these additional vulnerabilities based on early entitlement, SEND and CIN census returns to the Department for Education. However, many LAs reported that they could not link these at a child level to identify whether children with these vulnerabilities had received a 2-2 ½ year review.

As Table 2 shows, only 20% of councils that responded could identify children who received the two year old entitlement and had a 2-2 ½ year review in 2018/19 and only 13% could identify those who had not received the review. Almost half (47%) of council's who responded could state how many identified 'Children in Need' had their 2-2 ½ year review, with 30% of LAs able to identify Children in Need who had not had their review. A quarter (25%) of LAs that responded could give the number of children identified as needing SEN support who had a review and 12% of those that did not have the review.

Table 2. Identification of children with additional vulnerabilities by whether they had their 2-2 ½ year review in 2018/19

	Eligible for 2 year old free education and had 2-2 ½ year review	Eligible for 2 year old free education and did not have 2-2 ½ year review	Child in Need' and had 2-2 ½ year review	Child in Need' and did not have a 2-2 ½ year review	Child with SEN support and had 2-2 ½ year review	Child with SEN support and did not have a 2-2 ½ year review
n. of LAs that could identify these categories	29	19	69	44	37	18
% of LAs	20%	13%	47%	30%	25%	12%

[30] As defined by the Department for Education https://www.gov.uk/help-with-childcare-costs/free-childcare-2-year-olds

[31] Defined by the Department for Education as "when a child is referred to children's social care, an assessment is carried out to identify if the child is in need of services, which local authorities have an obligation to provide under section 17 of the Children Act 1989." Latest statistics on the number of CIN is available at: https://www.gov.uk/government/statistics/characteristics-of-children-in-need-2017-to-2018

[32] Defined by the Department for Education as children who have an identified special educational needs as defined by SEN support or having an Education, Health and Care Plan. Definitions and the most recent national statistics can be found here: https://www.gov.uk/government/statistics/special-educational-needs-in-england-january-2019

While limited data was obtained on the additional vulnerabilities these children had, councils provided a large amount of written information explaining the inability to submit this data. Reasons included:

- **Records being paper based**. Electronic child level data were therefore unavailable. This was mentioned by five LAs – some of which were now moving to electronic reporting.
- **Inability to identify individual vulnerabilities at a population level**. Many noted that this information was held on individual child clinical records, often in free text. This made counting the number of children with these vulnerabilities impossible without a manual audit of all individual child records. Some LAs noted changes to the delivery, including the commissioning of new providers, making retrospective data unavailable. Others noted the delivery of the service – with LAs combining or implementing new models – meant they had limited capacity to undertake audits.
- **Providers did not collect the information**. Several LAs noted this with one council stating they did not have an approach to the collection of this information as it was not statutory.
- **Data being held in different data systems**. Many councils noted that they were only provided with aggregated data from their providers who were usually an NHS Trust. Information sharing agreements were not in place meaning that LAs could not access child-level data. For example:
  - One noted that obtaining the data *"requires cross referencing individual children's data held in 4 different databases across 3 different organisations. It may be possible but further work is required with our information governance team to ensure we remain GDPR compliant and that this is adequately covered by our information sharing agreements."*
  - Another LA said that it would require Early Years Education (2 Year Offer), Inclusion Support (SEND) and Children's Trust (Children in Need) teams to share lists of individual children in those groups of the specified age cohort with the Health Visiting Service in order for them to check whether or not they received their 2- 2 1/2 year review. This was not currently within their Information Sharing Agreements.
- **Inability to link the data with no common child level identifier**. For example, data on the number of funded two year olds has no patient identifiers to match it to HCP data. One LA reported that: "*NHS numbers were provided but the LA data had insufficient records with no NHS number so it was impossible to identify the children*"

Many mentioned they were currently working on an information sharing agreement between the LA and the provider to make the data available. LAs that had been able to give data stated this had been done by matching lists of children eligible for 2-2 ½ year review against CIN, SEND, funded two year old databases. But some noted that as there is no common identifier between systems, their matching was subject to errors.

There also were a number of specific issues collecting data on the specific categories.

Two year old entitlement to free early education

For LAs that could not identify children eligible for the two year old entitlement to free early education, a common reason included:

- **Restrictions on use**. Child-level information on who is eligible for the two year old offer is supplied to LAs by the Department for Work and Pensions (DWP). This information was not subsequently available to LAs having strict guidelines on how and who can be shared with and is only kept within the short timescales specified by the DWP.

A number of LAs had been able to provide data with one having matched details[33] of children who received the 2 year old offer provided by the Early Years Funding Manager to details for the children due to have a 2-2½ year review.

Case Study
An LA that was not able to provide data stated they were working closely with Children's Centres who have this information at the joint group two year development reviews and actively follow up families not taking up the offer and will in the future share this information with health visitors; enabling them to add this to their records to discuss when in contact with these parents.

Children in Need

For LAs that could not identify children who were 'Children in Need', reasons included:

- **Issues of definition**. As the health visitor data system did not record the number of children by social care (local authority) definition of a 'Child in Need'. Some LAs that were able to give information on the number of children who were Universal Plus, Universal Partnership Plus and Level 4 Social Care cases but noted this did not necessarily align with the CIN definition. One LA stated that CIN status was not captured but safeguarding information on a case by case basis was captured.
- **Issues of recording**. Many councils stated that this was not recorded by the provider. One noted that CIN is only recorded 'live' and therefore they did not have any data on the number of children identified as CIN retrospectively.

LAs that had been able to provide data on the number of 'Children in Need' receiving or not receiving the 2 – 2 ½ year review had done so by matching NHS numbers held by the HCP team with the LA's CIN database.

Children with SEND support

For LAs that could not identify children who had been identified as needing SEN support, reasons included:

- **Providers did not collect this information**. Although some collected the number of children that had an Education Health and Care Plan, most did not have information on children with SEN support.
- **Low numbers**. LAs noted that the number of children at age two with SEND was very low.[34]. One LA explained that children with complex needs are not routinely offered a 2 1/2 review because any identified development delay will be being addressed as part of their care package.
- **Data compilation issues**. One council noted figures could not be added across terms as there will be children who were in receipt of SEN support across terms.
- **Issues of definition**. As with CIN, some LAs requested a clear definition of SEN support. For some LAs there were in some cases confusion about the categorisation. For example, one

[33] These were matched on the first name, family name, DOB and post code.
[34] As shown in Department for Education national SEN statistics. Available at: https://www.gov.uk/government/statistics/special-educational-needs-in-england-january-2019 additional tables B.

authority stated that the categories of Universal, Universal Plus and Universal Partnership Plus could be used as a proxy for SEND.

Case Study
One LA noted their high level of child protection work with significant levels of deprivation, domestic abuse, mental health needs, drug and alcohol issues and a higher than national average infant death rate in addition to high numbers of families with English as an additional language. Their commissioned model brings together health visiting, children's centres and early education advisors under one management team with one child health record. This has allowed the development of a much more integrated universal and universal plus offer to preschool children and their families.

Recommendations

A number of councils noted that as a result of the information gathering undertaken for the data request, they would review their data collection, information systems and reporting. A number of local and national recommendations are therefore set out below.

Local recommendations include ensuring data systems used to collect information on the 2-2 ½ year review are electronic and do not rely on free text responses to collect data on specific characteristics to allow for collection of child-level data on children's vulnerabilities across the local authority.

Councils noted that writing requirements into contract specifications for the provider to establish a robust electronic record system to enable the recording of child vulnerabilities including take up of the two year old free entitlement, SEN support, and CIN, would enable this to be taken forward.

National recommendations include:

- Using the NHS number as a unique identifier for children in addition to setting out the parameters and definitions of vulnerable characteristics which would read across to both local authority (particularly children's services and early years) and health (community nursing) for matching data.[35] This would need to be jointly led by the Department for Education, Department of Health and Social Care, and PHE.
- Allowing for child-level information supplied by DWP on who is eligible for the two year old offer to be made available for LAs to use to support identification of children with need.
- Setting up a cross-governmental working group to set out guidance and Information Governance expertise supporting LAs to ensure adequate data sharing agreements to track and understand children's vulnerabilities.

[35] For example, how children who were classified as 'Children in Need' would be counted. This could be children who were CIN on the day of their review or during the six months they were eligible for the review, or at any time in the reporting year, or their current status – as this can change at any time. With children identified as 'having SEND Support'. This could be children who had SEN support at the time of their review, at any time in the reporting year or their current status.

Who completes the 2-2½ review?

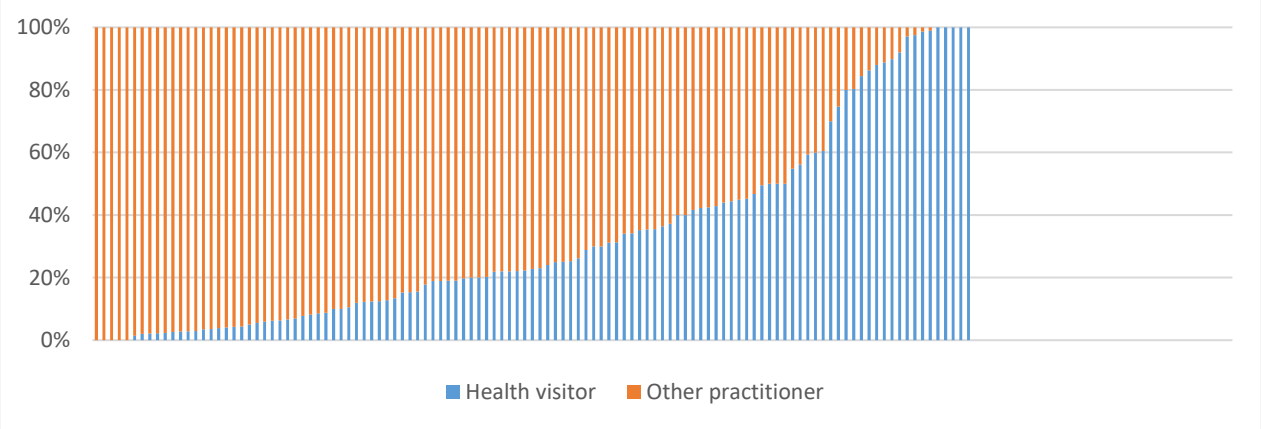
As set out in *Healthy Child Programme: Pregnancy and the First 5 Years of Life*[36], responsibility for delivering the HCP in the first years of life lies with health professionals led by health visitors but delivered through integrated services that bring together Sure Start children's centre staff, GPs, midwives, community nurses and others.

Currently there is no national data on who carries out the 2-2½ year review with parents. The data request therefore asked how many children who received their 2-2½ review in 2018/19 had it completed by either:

- Health visitor who holds a Specialist Community Public Health Nursing (SCPHN) qualification[37]; or
- Member of the Healthy Child Programme team who was not a qualified health visitor (non-SCPHN). This included band 5 staff nurses, community health workers, nursery nurses.

On average a third of the reviews were conducted by health visitors and two thirds by other professionals. Figure 3 shows how the ratio between health visitors and other practitioners varied across LAs.[38] Table 3 shows that only a small proportion of LAs were conducting reviews using only health visitors (3%) or only other professionals (3%).

Figure 3. Ratio of practitioners completing the 2-2 ½ year review



Note: N = 115 (79% of all LAs responding)

Table 3 - LAs where all reviews were conducted by either health visitor or another practitioner

	Health visitors	Other practitioners
% of all responding LAs	3%	3%
Number of LAs	5	5

Information from LAs demonstrated the number of different models that HCP teams had with regards to the review. Some councils stated that most universal 2-2 ½ year reviews were completed by non-SCPHN staff such as community nursery nurses or early years workers[39], and families with more complex needs who had Universal Plus (UP) or Universal Partnership Plus (UPP) reviews were completed by qualified health visitors.

[36] Department of Health (2009) Healthy Child Programme: Pregnancy and the First 5 Years of Life. Available at: https://www.gov.uk/government/publications/healthy-child-programme-pregnancy-and-the-first-5-years-of-life

[37] This also includes student health visitors studying for this qualification

[38] This used figures given on the number of reviews conducted by health visitors and by other practitioners in 2018/19. In many cases these two figures added together were the same as the number of children that had a review in 2018/19. However, in some this was not due to children having moved into the area having already had their review (but the LA not knowing by whom).

[39] Where one LA noted the training programme for these other staff groups to conduct the review as part of an effort to develop a sustainable staffing service model.

How many 2-2½ reviews are face-to-face with a child?

A key part of the HCP, including the 2-2½ reviews is to assess a child's development while building a good relationship between the parent and health practitioner. To do this, it is important that the 2-2½ year reviews takes place face-to-face with a parent.[40]

The data request found that on average 99% of reviews had been conducted face-to-face.[41] As shown in Table 4, 12% of LAs reported having less than 100% of their reviews conducted face to face and 2% of LAs having less than 90% of their reviews conducted face to face, with one LA reporting 41% of all 2-2½ year reviews conducted in 2018/19 being face-to-face.

Table 4 – Percentage of LAs reporting face-to-face visitors of less than 100%

	Percentage of LAs	Number of LAs
Less than 100%	12%	18
less than 90%	2%	3

One LA noted that they had to reduce the number of face-to-face reviews due to health visiting capacity and were targeting these based on the level of need as a temporary risk management solution. Another stated that assessments were now offered within an ASQ clinic rather than ad-hoc appointments either in a home or clinical setting with targeted home visits continue only offered for families that are Universal Partnership Plus.

[40] Department of Health (2009) Healthy Child Programme: Pregnancy and the First 5 Years of Life. Available at: https://www.gov.uk/government/publications/healthy-child-programme-pregnancy-and-the-first-5-years-of-life

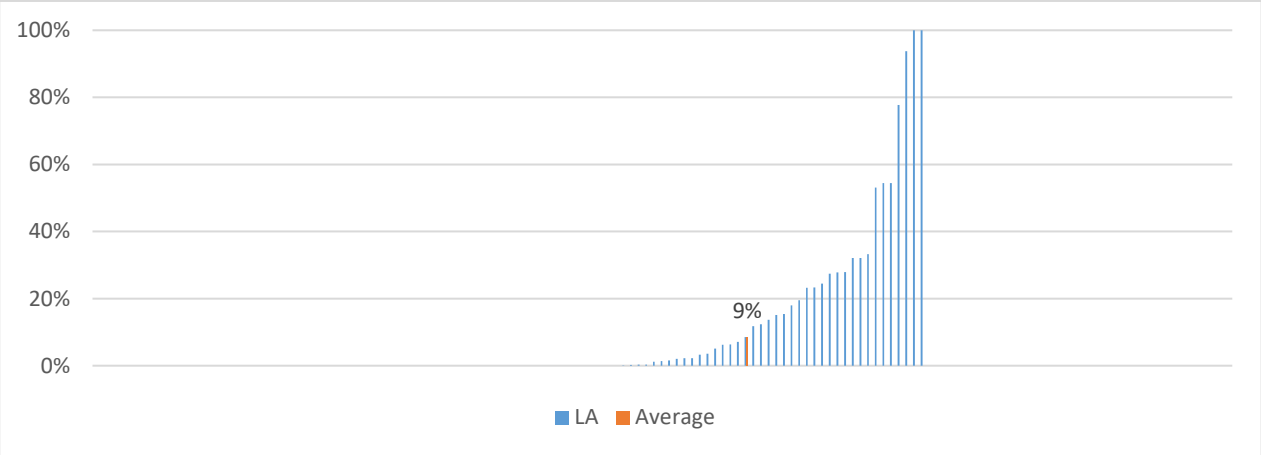
[41] 98% of all LAs responding (n.143)

How many 2-2½ reviews are 'integrated' with early years?

Since September 2015 health visiting services and early years providers have been expected to bring together health and early education reviews for young children at the age of two to two-and-a-half. The data request asked LAs how many 2-2½ year reviews in 2018/19 were an integrated review combined with an Early Years 2 year Progress check with an early years practitioner and a parent/carer.

Figure 4 shows that on 9% of children were receiving a 2-2½ year review as an integrated face-to-face early years progress check with an early years practitioner and a parent/carer in 2018/19.[42]

Figure 4. Proportion of children receiving an integrated review as part of their 2-2½ review



Note: N = 109 (75% of reporting LAs)

Table 5 shows that in nearly half (47%) of all reporting LAs no integrated 2-2½ review – early years progress check took place. Meanwhile, 5% of LAs reported having more than half of their 2-2½ year reviews integrated in 2018/19.

Table 5 – Percentage of LAs conducting integrated reviews

	%	*n.*
LAs with no integrated reviews	*47%*	*69*
LAs where more than half were integrated	*5%*	*23*

The reasons given by LAs for not carrying out integrated reviews centred around the fact that they were not resourced to do them. LAs stated that a lack of capacity, both in settings and within their 0-19 HCP service, meant they were not able to do joint face to face assessments for all children. They also noted that reductions in public health grant have prevented increases in funding for public health nursing and difficulties in recruitment has added pressure to conducting integrated reviews.

It should also be highlighted that several LAs expressed caution about integrated reviews due to:

- **A lack of good data systems**. One LA had previously trialled integrated reviews but said that they had not been successful logistically due to health visitor and Early years setting information sharing not being robust enough to enable joint working.

[42] A quarter (25%) of LAs did not provide data on the number of integrated reviews. Reasons given for not supplying the data included limitations in the information management system or a means to capture the variety of formats for an integrated review (e.g. discussion between HV and EY practitioner, but not necessarily face-face and with the parent). In addition to system changes including: changes in HCP providers, a switch from paper to electronic records and a restructure of the local authority's early help service.

- **Delays with administration**. One council had piloted the 'Together at 2' reviews with early years settings but stated that although the joint reviews have benefits, the practicalities of administering them can cause delays.

In response to the question regarding changes they had or were making to the HCP service in this current reporting year (2019/20), the majority mentioned further embedding the integrated approach with colleagues in early years settings.

This included:

- **Information sharing and integrated pathways**. Some gave families their ASQ paperwork to share with the Early Years providers or receiving information from the early years provider for the early years 2 year progress check which the health visitor reviews when completing the 2-2½ year review ASQ assessment. Some were sharing information with settings following the review (via the red book)[43], or piloting the combination of education and health reviews with the view to involving practitioners and parents in the room together in subsequent years and developing pathways where consent is sought for all children who attend Early Years settings to have their ASQ results shared.[44]
- **Co-location**. One LA Health Visiting team was co-located with children's centres and worked closely with the early years service working to undertake joint contacts where there is a need and had developed strong links with local nurseries.
- **Named health visitors**. In one local authority all maintained or private and independent nurseries have a named health visitor to promote liaison.
- **Multi-agency**. This centred on multi-agency pathways and staff training to ensure consistency

Case Study

With the re-procurement of their HCP and in light of reductions in the Public Health Grant, one LA worked with local partners to redesign the service, utilising the wider skill mix available to deliver the most comprehensive model possible. One of the key elements in the redesign was the change in the timing of the review for children at 2-2½ years, to 3-3¼ years. The planned outcomes for this change are for: increased numbers of children to have a fully integrated review - to assess most effectively a child's development and readiness to learn in preparation for school; increased opportunities to provide co-ordinated support and interventions to ensure the best outcomes for children and families; reduced duplication and clearer and more consistent information, guidance and support for parents and carers. An evaluation of the impact of delivering integrated reviews at 3-3 ½ years, on the development of children as assessed at the Early Years Foundation Stage (EYFS), and on improving broader outcomes and reducing inequalities was being commissioned.

Case Study

As part of the health visiting service contract specifications and the provider's tender commitments the provider was required to thoroughly review the 2-2½ year integrated review pathway in order to improve its impact. The provider undertook a detailed scoping exercise – including visits to sites where they already have high quality integrated reviews. Following this scoping, the provider worked with local early years education partners to co-produce a new model for quality integrated 2-2½ year review to strengthen integrated reviews with early years education settings and parents. The model was currently being piloted, with a plan to roll-out across all localities by end 2019. With future plans to extend this to childminders, which could be more challenging to achieve.

[43] As this LA noted that many settings in their area undertake their review out of the timescales for the 2 – 2 ½ year review.

[44] In this LA If a review has not been completed then the setting supports the parent to complete and return to the health visitor for assessment. A face to face contact is also offered if required at this time as part of integrated review.

How many children have an additional need or developmental delay identified at their 2-2½ review?

A key cornerstone of the Healthy Child Programme is to ensure early identification of additional needs or developmental delays.[45] Therefore, the data request asked local authorities to report on the number of children being identified as part of the review as having an additional need or developmental delay.[46]

Just under three quarters (73%) of reporting LAs were able to give the number of children who were identified at their 2-2½ year review in 2018/19 as having an additional need or developmental delay.

Some of the LAs who were unable to provide this information gave similar gave the following reasons:

- **Paper based records**. Electronic information on a child's additional need or developmental delays were therefore unavailable. This was mentioned by six LAs – some of whom were now moving to electronic reporting.
- **Inability to extract data on additional need or developmental delay at a population level**. Many noted that this information was held on individual child clinical records, often in free text. This made knowing what type and how many children had additional need or developmental delay very difficult without a manual audit of all individual child records. Some LAs noted changes to the delivery, including changes of providers or new information systems making retrospective data unavailable, or the delivery of the service (with LAs combining or implementing new models) also meant they had limited capacity to undertake audits.
  One LA stated that they used to send the completed information to Child Health Information Services in the past, but when there was a change in provider they lost this facility to input a breakdown of development need, and therefore had to record assessments in clinical notes.
- **Definitions and criteria**. Some LAs noted that the assessment tool, the ASQ, having five domains with a gradation of scoring led to uncertainty as to whether a poor score on one domain would be counted as a developmental delay.

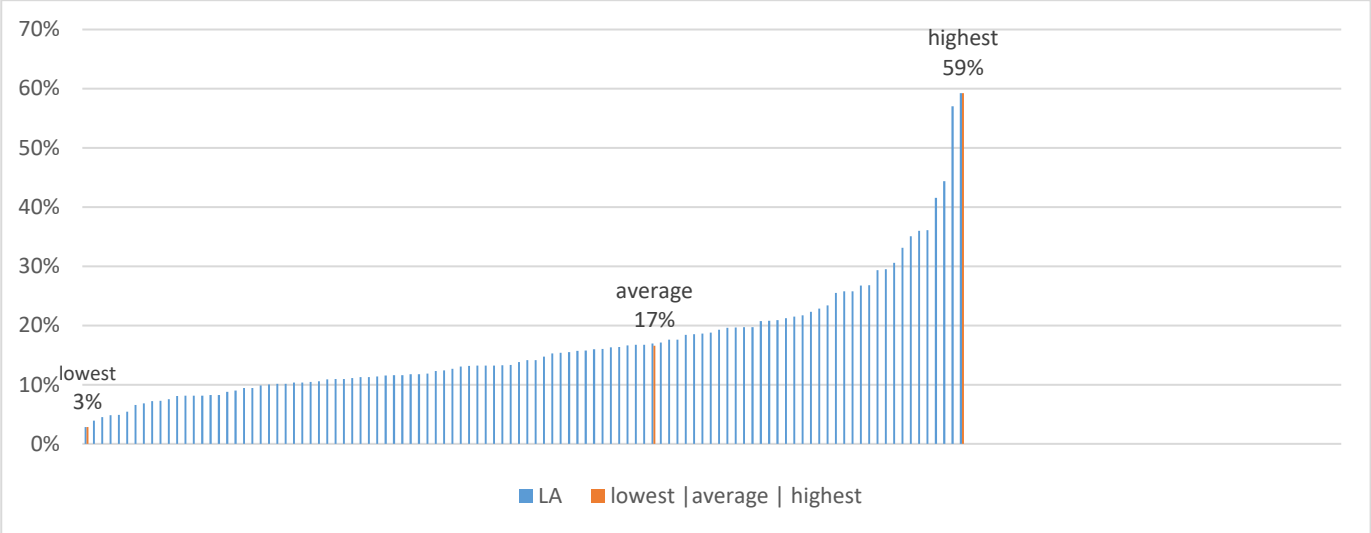
As noted for data on children's additional vulnerabilities, LAs recognised the need for better information systems to enable analysis of children's needs by cohort and geography and inform service planning and delivery.

From LAs that were able to give the number of children identified, on average 17% of children that received their 2-2½ year review were identified as a having an additional need or developmental delay (Figure 5). Yet there was a large amount of variation across LAs, from 3% of children who received a review to 59% of children.

[45] Department of Health (2009) Healthy Child Programme: Pregnancy and the First 5 Years of Life. Available at: https://www.gov.uk/government/publications/healthy-child-programme-pregnancy-and-the-first-5-years-of-life

[46] From the pilot it was found that there were many definitions of what additional need or development delay entailed. Therefore a finite definition was not given and instead a list of examples were provided. This included: Child development support (i.e. speech and language, community paediatrician, audiology, orthoptist, paediatric continence service, physiotherapy and other support for developmental concern); Services for parents (i.e. adult mental health, adult weight management, sexual health services, smoking cessation, substance misuse and other targeted services for parents); Universal family services (i.e. parenting course, family learning, healthy eating/ physical activity programmes and other universal services); Children's social care and referrals to local authority early help. LAs could also provide other categories themselves.

Figure 5. Proportion of children who had a 2 – 2 ½ year review who were identified as part of the review as having an additional need or developmental delay



Note: N = 106 (73% of reporting LAs)

How were the additional needs or developmental delays identified?

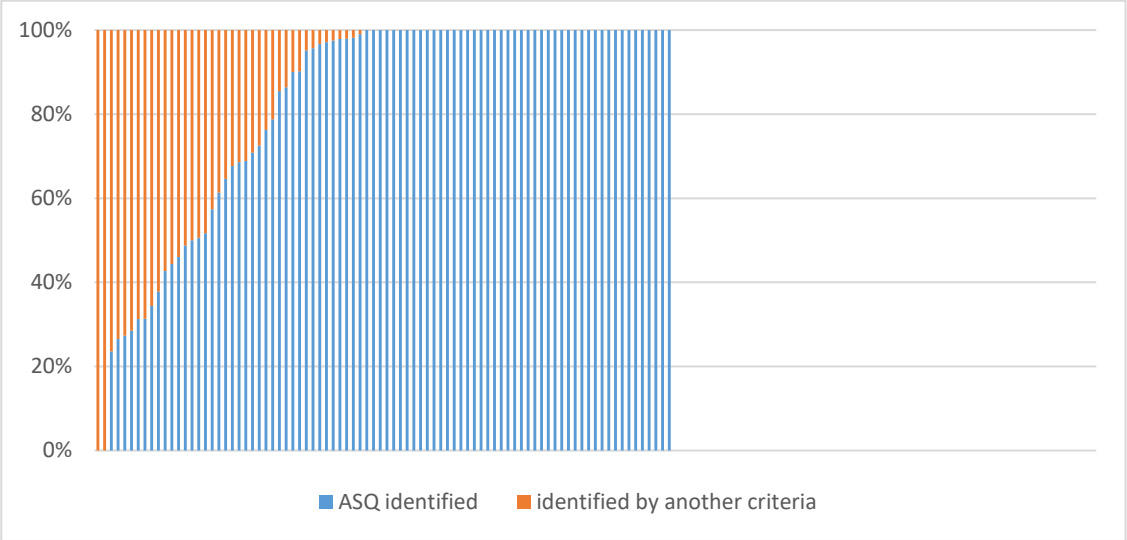
Information was requested on how many children were identified as having an additional need or developmental delay as part of the review by: the Ages and Stages Questionnaire (ASQ) responses and criteria; or by Universal Plus, Universal Partnership Plus, or Troubled Families criteria for example.

LAs did state that the ASQ is a screening tool that supports clinical assessment and may not always be appropriate when reviewing children with complex heath needs or development delays. They noted the importance of professional concern and that need is not only identified by the ASQ but by the contact itself where, especially for children in receipt of Universal Plus and Partnership Plus level of care, health visitors are often aware of developmental delay or additional needs prior to the 2-2 ½ year review. Yet many LAs also noted that the ASQ is a good confirmatory tool. LAs also noted that a referral could be made from ASQ result *alongside* another criteria such as a complete Family Health Needs Assessment, a professional judgement, and parental concern. Another noted the restrictions within the ASQ licence which did not facilitate efficiency and utilisation of email and other electronic communication methodologies with parents and professionals.

Of LAs that provided data for the number of children identified by both ASQ and another criteria[47]; on average 82% of children identified at the 2-2 ½ year review were identified by the ASQ, 18% by another criteria. Figure 6 shows the ratio across all reporting LAs, highlighting a degree of variation. In over half of reporting LAs, all identification of children with additional need was via the ASQ.

[47] 59% (n. 86 reporting LAs) gave figures for both, with 72% (n.105) giving figures for 'ASQ' and 62% (90) giving figures for 'another criteria'.

Figure 6. Ratio of how additional needs or developmental delays were identified



Note: N = 86 (59% of reporting LAs)

How many children were referred to or in receipt of additional support?

The data request asked local authorities to report on the number of children identified as part of the review as having an additional need or developmental delay who were referred or received additional support.

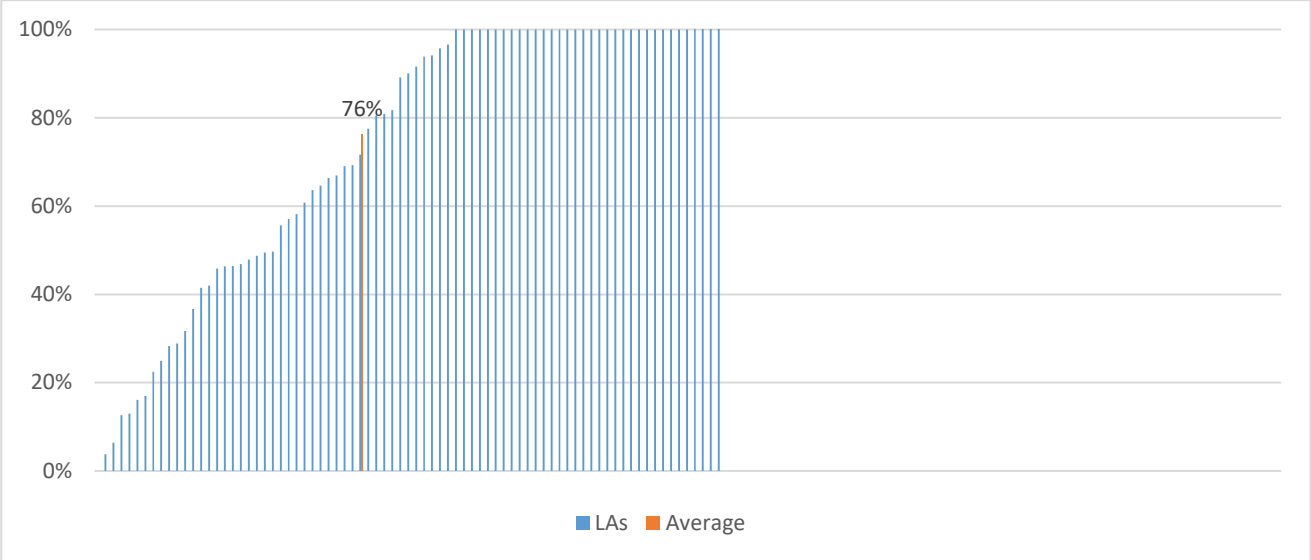
Just over half of reporting LAs (54%) could give the number of children referred or receiving additional support. Reasons for not providing the data included:

- **Poor data systems**. Similar issues as highlighted previously in this report including data being held on paper based records or the inability to extract data at a population level. Worryingly LAs also stated the limited transfer of data between LAs meant that data on the children needing a review and any needs identified could be lost – this was a larger issue for places with significant transient populations.
- **Children already receiving support or self-referring**. LAs noted that some children were not referred on to support or specialist services because they were either: already identified by a specialist service and receiving support already, or was receiving in house support and did not meet the threshold for specialist support.[48] Another noted that children's centre and early years staff refer to additional support services and parents may be signposted (and therefore self-refer) to a wide range of services; and as a result their data systems did not fully capture all onward referrals.

In LAs that did provide data, an average of 76% of children identified as part of the review as having an additional need or developmental delay were referred or received additional support (Figure 7). A signification proportion (43%) reported that all (100%) of the children identified were referred to or received additional support.[49]

[48] For example, where a child has not met the threshold for ASQ-3: communication they are referred into early year's team for additional support.
[49] It should be noted that some councils highlighted that there was a discrepancy between the number of children and the number of referrals due to multiple referrals for children with complex needs which could have created some over reporting.

Figure 7. Proportion of children referred or received additional support who had an additional need or developmental delay identified as part of the 2-2½ year review



Note: N = 79 (54% of reporting LAs)

Case study

One local authority had completed audits of child records at 2 ½ , 3 and 3 ½ years for children who did not meet expected levels of development across the five ASQ domains at their 2-2 ½ year review, to understand if the children were receiving the multiagency support they needed and if the help was supporting their development. The audits gave a high level of assurance against both these. Their ambition has been to facilitate the sharing of this data between the NHS provider and the LA so that records can be matched and triangulated to ensure that all children with any identified need can be identified and their progress tracked. However, this has proved highly problematic with no agreement on the lawful basis for sharing and different approaches concerning consent.

Good practice

- A number of councils were already – or as a consequence of the data request – reviewing their information systems to collect and report on the numbers and types of additional needs or development delays and subsequent support or referrals.
- Some councils had implemented a system where all children who score below the threshold for age appropriate development using the ASQ tool require a follow-up with the HCP team. Others had introduced targeted pathways to aid this.

What additional support did children receive?

The data request asked LAs to provide data on the number of children receiving by type of additional support. Support was categorised as:

- Child development support (e.g. speech and language, community paediatrician, audiology, orthoptist, paediatric continence service, physiotherapy and other support for developmental concern)
- Services for parents (e.g. adult mental health, adult weight management, sexual health services, smoking cessation, substance misuse and other targeted services for parents)
- Universal family services (e.g. parenting course, family learning, healthy eating/ physical activity programmes and other universal services)
- Children's social care and referrals to local authority early help
- Other (to be specified)[50]

As shown in Table 6, 42% of LAS could give the numbers of children referred or receiving child development support, 26% for services for parents, 28% for universal services, 36% for children's social care and early help. The Table also shows the average proportions of children referred to or receiving support, for each type of support.

Table 6. Proportion of reporting LAs and proportion of children referred to or receiving by type of support

	Child Development support	Services for parent	Universal family services	Children's social care & early help	Other
% of all reporting LAs	42%	26%	28%	36%	29%
% of av. number of children referred/receiving support by type of support	73%	24%	50%	32%	12%

Reasons for not being able to report this information included:

- **Limited data on referrals for additional family support, particularly services for parents**. LAs reported that they were unable to identify services for parents due to the different health information systems for children and adults and the inability to link them. Some councils noted all children identified as having an additional need or developmental delay were identified by Universal Plus or Universal Partnership Plus pathways. However, some noted that children on these pathways would not necessarily have an additional need or development delay. In addition as some children move in and out of this pathway, some LAs could not identify if they went on as part of the 2-2 1/2 year review.
- **Lack of data on children referred or supported by children's social care.** LAs had provided the number of children referred to children's social care or early help by cross referencing NHS numbers of those children who had a 2-2 ½ year review against those children known to Children's Social Care and early help. They noted this would give an indication of numbers but it may not be a very reliable result as the child may have been in contact with children's services and 'early help' before the review at age 2-2 ½. This was compounded by the fact that NHS numbers are not routinely collected on the early help assessment forms.

[50] LAs noted additional support included primarily: community nurse and Children's and Family Centres, which in some instance were also part of the council's Early Help model. In addition to portage, drop-in Speech and Language, and dietetics.

A number of LAs were focusing on speech and language:

- In one LA health visitors were working closely with a speech and language therapist to set up some language groups in the community where children were triaged and supported by health visitors and those who require a higher level of need are be referred to a Speech and Language Therapists.
- In another LA, the Healthy Child Team were being trained to better identify and respond to communication, speech and language needs.

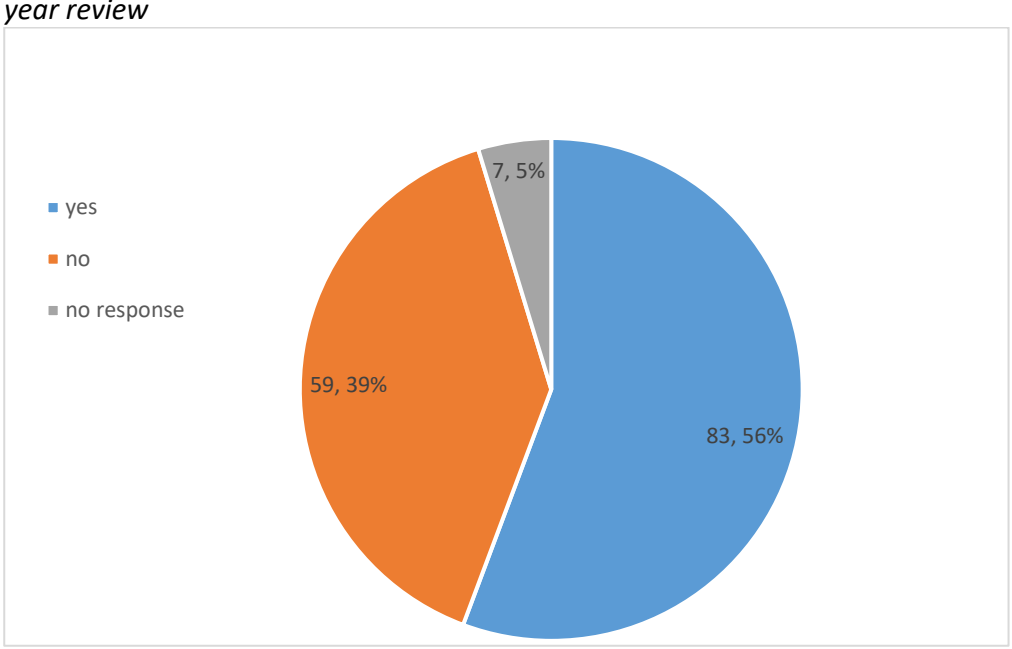
One council noted additional support for high risk families which includes four antenatal visits and bespoke follow-ups.

What changes to the 2 – 2 ½ year review have been made or planned in 2019/20?

Given that the request asked for data for the 2018/19 reporting year, it also whether LAs were planning or had made changed for 2019/20, such as changes to staff provision, venue, method or timing of the 2 – 2 ½ year review.

All reporting LAs gave a response, as shown in Figure 8, with the majority (56%) stating they were making changes.

Figure 8. Number of LAs who were planning or have already made any changes to provision of the 2-2.5 year review



Note: N = 146 (100% of reporting LAs)

LAs were also given the opportunity to state what these changes entailed. Responses included:

Increasing take up. A number of LAs gave specific examples of how they would do this:

- Changing the way they follow up children if the parent does not respond to the initial letter offering an appointment. These children are followed up one month later and sent a specific appointment date / time at a venue close to their home. This had improved the uptake. They had also increased the skill mix to allow them to increase the number of available appointments and are using additional community sites in more accessible locations. The appointment times have also been extended at the beginning and end of the day to make it easier for working parents.
- Introducing a digital options or telephone appointments line for booking and appointment systems to facilitate uptake.

Many LAs were **implementing an integrated two year review** pathway and offer with early years provision:

- One noted this was very much across the LA with "a group of practitioners from Health, Early Help and the PVI are working together to ensure the review is as integrated as it can practically be."
- One LA had partnered with the Local Authority Inclusion Team and had developed a pathway for the 2 year integrated review.

- Another was setting up data sharing with early years providers and early years SEND coordinators, piloting an integrated review including the ASQ being emailed to parents in advance of review in response to parental feedback.
- Introduction of a monthly Saturday ASQ clinic and the offer of an ASQ appointment in an Early Years setting for those children accessing 2 year funded nursery provision.
- Modifying the format of the session to include group discussion with opportunities for children and parents to meet, play and be observed by staff alongside 1-1 parent-practitioner discussion and review time.
- One LA noted efforts to implement an integrated review at 2 for a targeted cohort of children in response to their SEND inspection.
- One was developing a single data view of children across the early years with the intention of enabling much better tracking of activity and outcomes within their Early Years Pathway.
- One LA was reviewing and strengthening of integrated delivery of 2-2.5 year review, working with Children's Centre partners to promote and deliver an integrated review
- One was working with the education division of the council to develop integrated reviews and had increased number of Early Years settings as part of the delivery of integrated reviews.

Complementing the 2-2 ½ year review with additional reviews. A number of LAs were enhancing their HCP by implementing additional reviews, namely at age 3-3 ½. One LA stated that this will go to parents alongside school place applications to help identify any school readiness issues that arise post 2-2 ½ year review.

Increasing home visits. One LA stated that the 2-2 ½ year review "has been historically offered as clinic appointment, but Health Visitor teams are now moving to offer as home visit where there is sufficient capacity"

Case Study: Group 2-2 ½ year review

One LA noted they offer the 2-2 ½ year review as a group of six parents and children based in Family Centres with a team member also from their service carried out by an Associate Public Health Practitioners (APHP i.e. Band 4, previously known as a nursery nurse) who will report back to their health visitor any children requiring follow up. All families are asked to attend this review unless specifically requested not to (i.e. child with very complex needs) and they will still be offered a 1 to 1 for support by APHP or health visitor depending on need. Other UP/UPP families are always invited as it has proved very successful to observe their child in a group setting as part of (not instead of) the follow up and monitoring with these families. The LA believed this introduces families to the merits of family centres if they have not already engaged or registered with them and assists in joint working to encourage all eligible children for 2 year funding to take up the offer.

Health visitors delivering the 0-5 Healthy Child Programme findings

This section details findings on health visitors and other practitioners delivering the 0-5 Healthy Child Programme (HCP), not just the 2-2 ½ year review, as these practitioners deliver the entire programme across 0-5[51]. It details the number of health visitors and other practitioners delivering the entire 0-5 Healthy Child Programme (HCP), whether this number had changed since 2016/17 and the estimated average caseload.

What was the number of practitioners delivering the HCP in 2018/19?

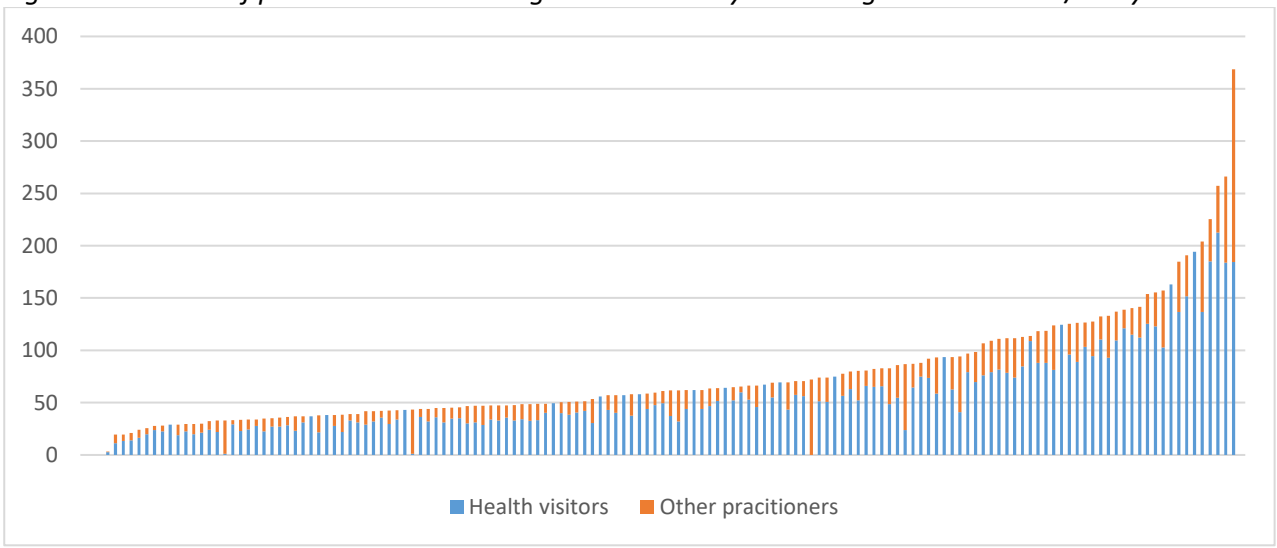
The data request asked LAs for the full time equivalent number of practitioners who delivered the 0-5 Healthy Child Programme and had a caseload in 2018/19,[52] broken down by:

- Health visitors, holding a Specialist Community Public Health Nursing (SCPHN) qualification; and
- Members of the health visiting team who were not qualified health visitors (non-SCPHN). This included band 5 staff nurses, community health workers, nursery nurses.

Several LAs had to estimate these numbers as they had a different model, such as a 0-19 HCP integrated workforce model or what was termed a corporate model.[53]

Figure 9 shows the absolute number of full time equivalent practitioners broken down by health visitors and other, non-SCPHN practitioners delivering the HCP in 2018/19 by reporting LA. Not surprisingly given the large variation in the size of the 0-5 population in local authorities, there is large variation in the number of practitioners from just 3 in one LA to 369 in another. The average number across LAs was 74 practitioners (56 health visitors and 19 other practitioner).

Figure 9. Number of practitioners delivering the 0-5 Healthy Child Programme in 2018/19 by LA



Note: N = 144 (99% of reporting LAs)

[51] Several LAs had to estimate these numbers for delivering 0-5 HCP as they had a 0-19 HCP integrated workforce model.
[52] Stated as the 2018/19 reporting year from 1st April 2018 to 31st March 2019.
[53] Where 0-5s are assigned to individual Health Visitors (SCPHN) by Universal, Universal Plus or Universal Partnership caseloads as required.

To get a better representation of the ratio between health visitors and other practitioners, Figure 10 shows the proportion of health visitors to other practitioners delivering the 0-5 HCP in 2018/19 by reporting LA. The average ratio was 74% health visitors and 26% other practitioners. Ten percent of reporting LAs only had health visitors delivering the 0-5 HCP and 1% had only other non-SCPHN practitioners delivering.

Figure 10. Proportion of practitioners delivering the 0-5 Healthy Child Programme in 2018/19 by reporting LA

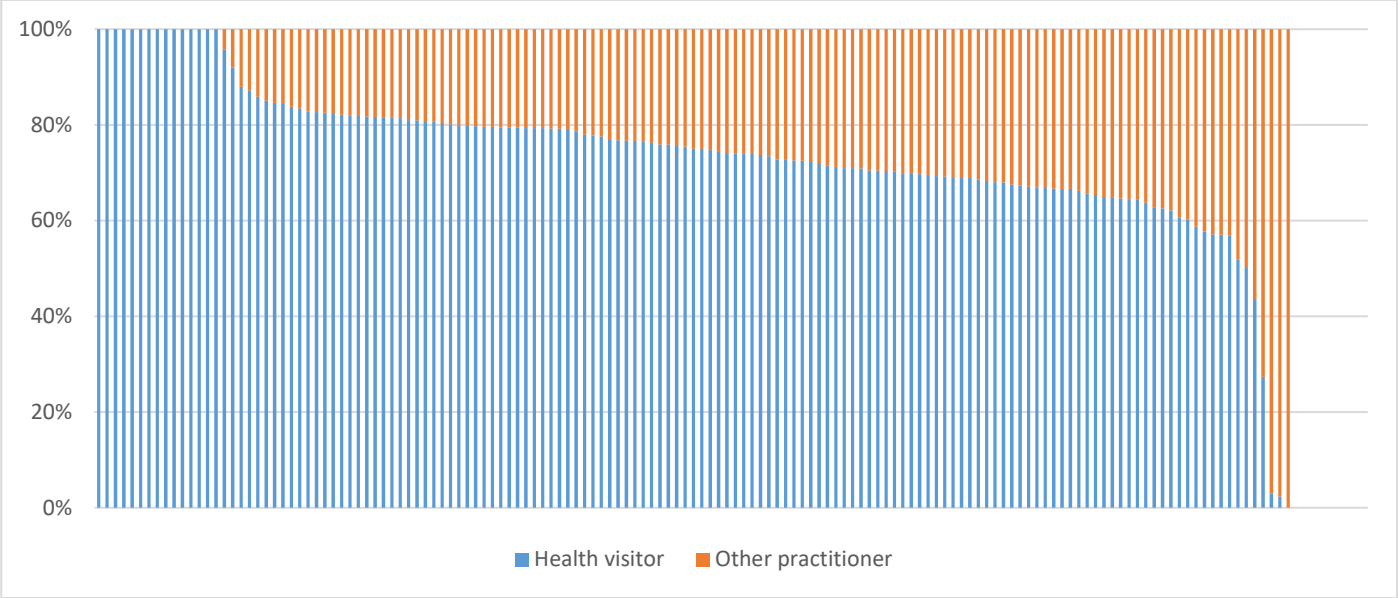
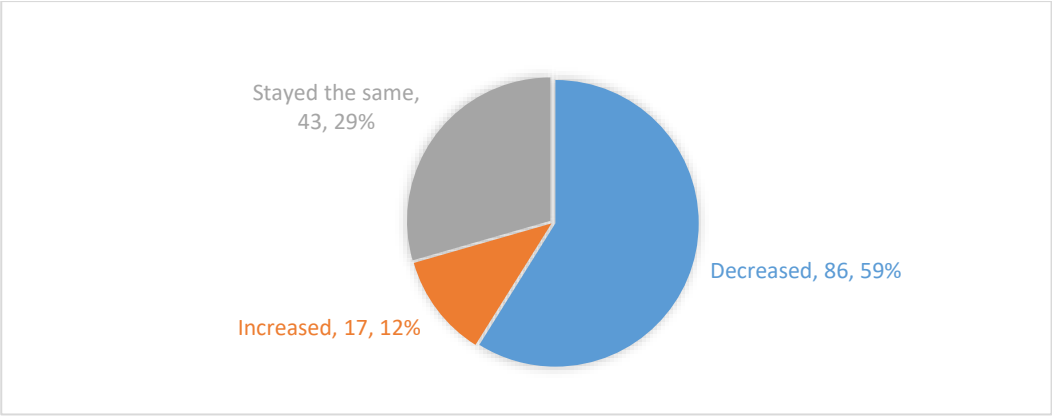


Figure 1 – n.143 (98% of reporting LAs)

Has the number of practitioners delivering HCP changed since 2016/17?

The data request asked local authorities whether the number of practitioners delivering the 0-5 Healthy Child Programme has changed since 2016/17 – the first full reporting year after the transfer to local authorities in October 2015. Figure 11 shows that 59% of all reporting LAs stated they had seen a decrease in the number of practitioners since 2016/17, while 29% stated that the number had stayed the same and 12% of LAs stated that it had increased.[54]

Figure 11. Proportion and number of LAs that have seen changes in the number of practitioners since 2016/17



Note: N = 146 (100% of reporting LAs)

[54] Some LAs noted the increase is attributable to population increases.

Why have there been changes?

LAs noted the decline in staffing due to budgetary pressures with some stating this as a direct result of centrally driven cuts to the Public Health Grant (PHG). One LA stated that budgetary pressures had reduced health visiting staff by approximately a third. Another noted that it was not sustainable to reduce the number of health visitors and a further cut in public health expenditure could potentially see the health visiting service reducing the number of contacts.

Some LAs had increased the skill mix of their workforce to accommodate the reduction in the PHG with others highlighting the reduction in the grant alongside issues of recruitment and retention, adding pressure to the delivery of the HCP.

Case Study
One LAs noted the decrease in numbers of Health Visitors since 2016-17 being directly linked to the national cuts in the PH Grant and the need to reduce the 0-19 HCP Service contract value. They stated their local commitment is for Health Visitors to lead on the delivery of the 0-5 HCP, but not necessarily to provide all elements of the programme. “Our 0-5 HV Service staff work closely with partners in Midwifery, Children’s Centres, Early Years settings and Social Care to provide a co-ordinated, supportive and appropriately skill-mixed 0-5 HCP Service. Whilst every child aged 0-5 will be allocated a named Health Visitor who has an overarching health responsibility for that child, they do not personally provide all of the universal HCP to that child and their family”.

LAs noted the staffing challenges associated with the decrease in the number of health visitors and other practitioners including issues with recruitment (also seen nationally), retention (with retirement and long-term sickness mentioned) and the need for investment in training in order to support safe and sustainable delivery of the Healthy Child Programme's mandated contacts. Some LAs were increasing the skills mix of their HCP teams including registered nurses and midwives to address the recruitment challenge of decreased numbers of staff with SCPHN qualifications. Others were being forced to take on agency staff.

However, some LAs were still positive, with one stating “although there has been a substantial reduction in the 0-19 workforce, there is a greater focus on delivering a multi-agency offer. We have positive partnerships with both MAST and the early years' service and a joint 2 year integrated review has recently been developed”. Another noted they were “working in a more diverse and relationally capable way across previously separate service and commissioning boundaries” within their Healthy Family Team with other practitioners such healthy family support workers, and community engagement workers.

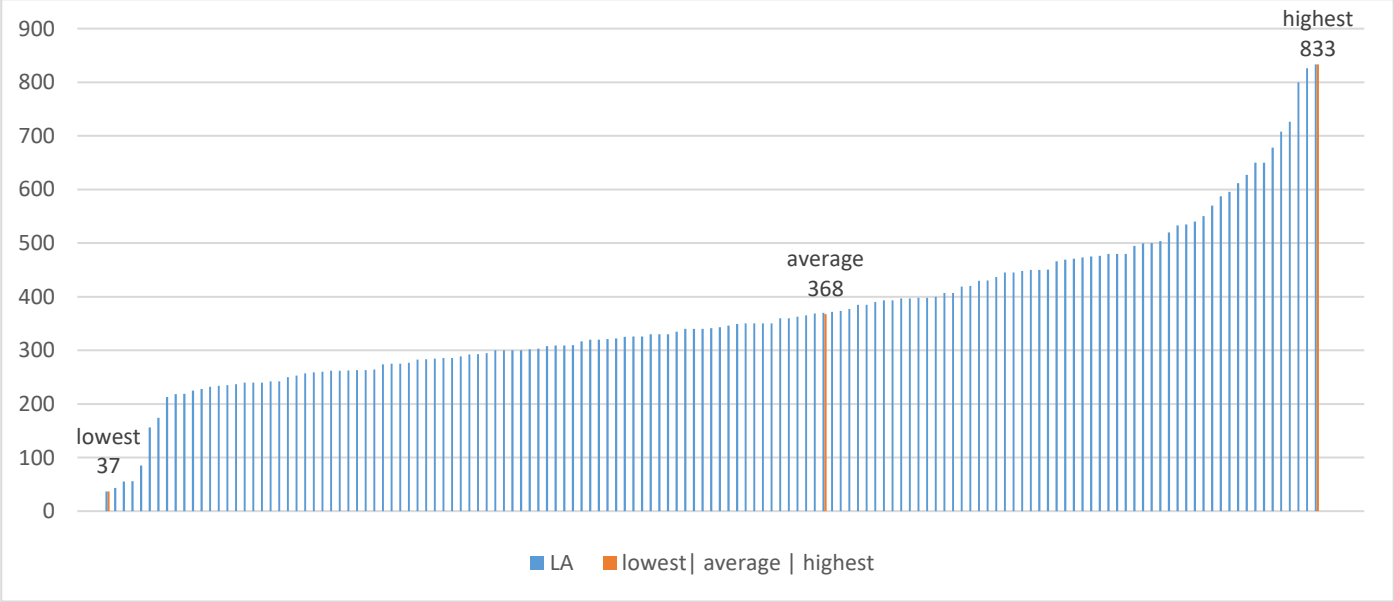
What was the estimated average caseload for each professional delivering HCP in 2018/19?

The data request asked for the estimated average caseload for each professional delivering the 0-5 Healthy Child Programme (HCP) in 2018/19.[55] These figures should be treated with some caution as they are estimates and LAs said that there was the potential for significant caseload variation depending on:

- **skill and qualifications** within their HCP practitioner
- **time of year**; and
- **need** and model. LAs noted the different caseloads for in universal, UP and UPP or areas of higher need or safeguarding. One noted their new model with Family Centres and pathways to include the Family Centre Workers (FCW) meaning that counting a HV caseload was no longer accurate. In addition they reported UP and UPP caseloads rather than children 0-5 as these pathways have a different number of contacts.

Figure 12 shows substantial variation in caseloads across reporting LAs. The average caseload for a practitioner delivering the HCP in 2018/19 was 368 children, with the highest being 833 children and the lowest 37 children.

Figure 12. Estimated average caseload per professional delivering 0-5 HCP in 2018/19 by LA



Note: N = 141 (97% of reporting LAs)

Table 7 shows that just 16% of LAs providing data had an average caseload under 250 children. Therefore 84% reporting LAs had caseload of over 250, above what the Institute for Health Visiting recommends for safe ratios.[56] Furthermore, 30% of LAs reported having a caseload of over 400 children, and 7% of LAs reported a caseload of over 600 children.

[55] For LAs that did not currently capture the average number the request suggested estimating this number by dividing the number of 0-5 children supported by the HCP by the full time equivalent number of practitioners delivering the HCP with a caseload.

[56] First 1000 days of life inquiry. Written evidence from the Institute of Health Visiting (October 2018) Available at: http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/health-and-social-care-committee/first-1000-days-of-life/written/88862.html

Table 7. Proportion and number of LAs with a certain average caseload in 2018/19

	%	n.
caseload under 200	7%	10
caseload over 400	30%	45
caseload over 600	7%	10
n.141 (97% of reporting LAs)		

Analysis was undertaken to look at the relationship between LAs reporting a change in the number of practitioners delivering the 0-5 HCP since 2016/17 and average caseloads per practitioner in 2018/19. Figure 13 shows that average caseloads were higher, on average, than in areas where practitioner numbers had stayed the same or had increased.

Figure 13. Average caseload per practitioner delivering 0-5 HCP by LAs that report at change in number of practitioners since 2016/17

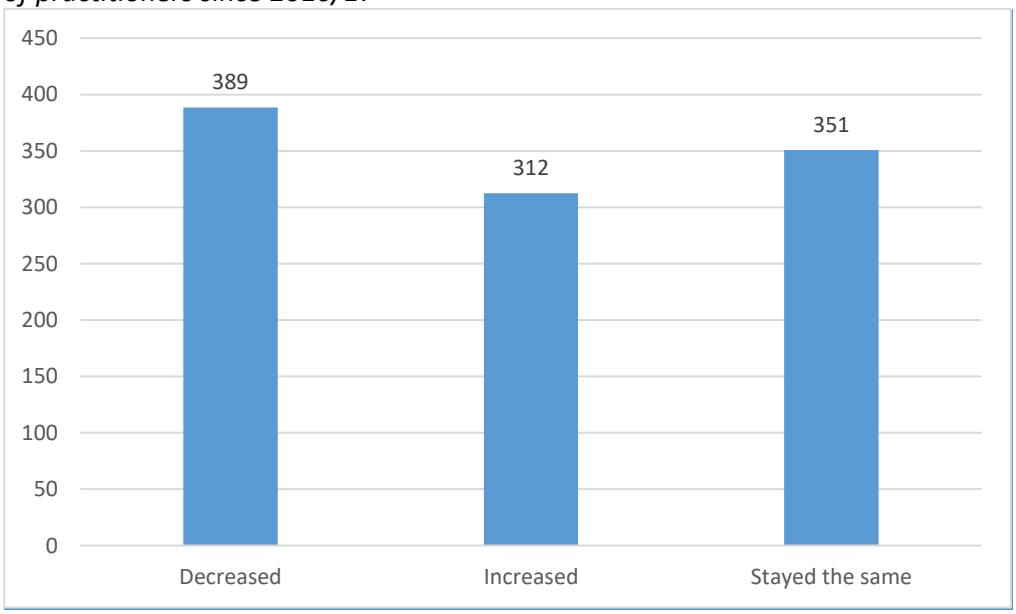


Figure 14 shows the relationship between the change in the number of practitioners delivering the 0-5 HCP since 2016/17 and the average number of practitioners in 2018/19. It shows that the average number of practitioners is lower on average in LAs that report a decrease in the number of practitioners since 2016/17 than in LAs that report an increase or no change in the numbers delivering the 0-5 HCP.

Figure 14. Average number of practitioners delivering 0-5 HCP by change in number of practitioners since 2016/17

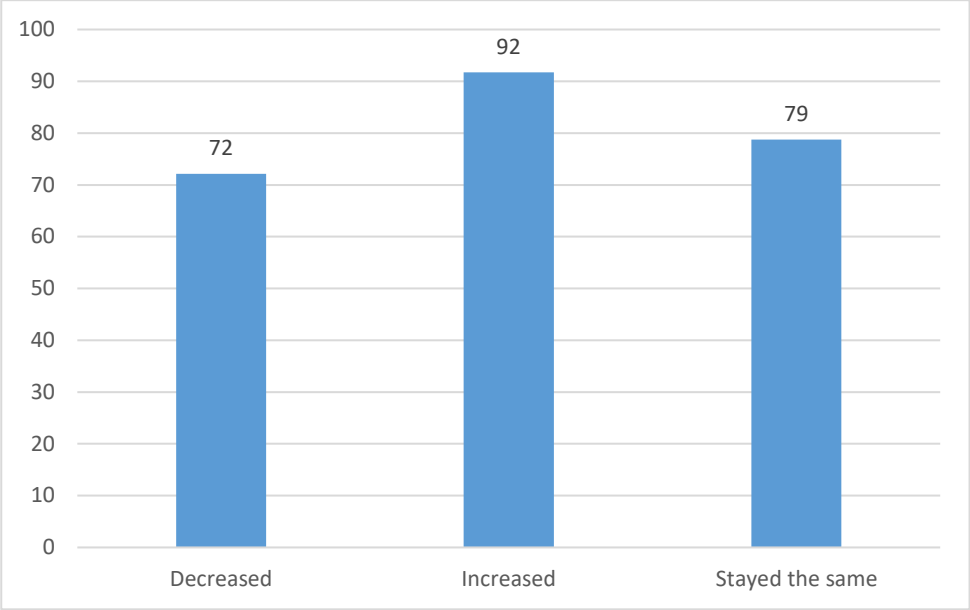
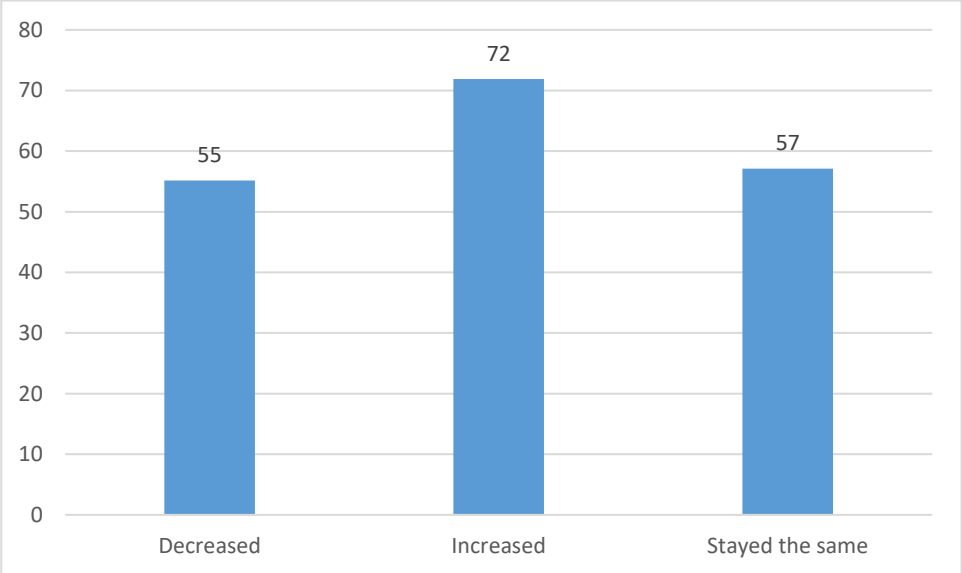


Figure 15 looks at only the number of health visitors in 2018/19 delivering the 0-5 HCP. As with Figure 14, it shows a lower average number of health visitors currently delivering the 0-5 HCP in LAs that reported a decrease in 0-5 HCP practitioners since 2016/17.

Figure 15. Average number of health visitors delivering 0-5 HCP by LAs reporting change in practitioners since 2016/17



Conclusion

Given the importance of the 2-2 ½ year check in supporting a child's health and wellbeing including identifying developmental issues as well as providing and referring onto additional support, we sent a statutory data request to all local authority Directors of Public Health in England. Responses were received from almost all local authorities (148 of the 152) allowing for a comprehensive national picture to be presented in this report. This in itself demonstrates that it has been possible to collect much more detailed information on both the 2-2 ½ year review and the practitioners who deliver the 0-5 HCP that is currently published in national statistics.

We found that one in five (20%) children did not receive their 2-2 ½ year review in 2018/19. While this was partly due to parental choice, capacity was also stated as a major factor. This is a national concern as it means a fifth of children are not receiving a check on their cognitive and social and emotional development, vaccinations, diet, nutrition and oral health. As this is a universal review, it means that these children are effectively becoming invisible to public health professionals, and any potential difficulties could be missed.

Of particular concern was that the majority of LAs were unable to identify whether children not receiving their review had additional vulnerabilities. Just over one in ten local authorities were able to identify the number of children either eligible for the two year old entitlement to free early education or identified as needing SEN support who had not received their 2-2 ½ year review. Only 30% of LAs were able to identify how many 'Children in Need' had not received their 2-2 ½ year review. Local areas need to know whether the children who are missing out on a 2-2 ½ year review are also the same children who do not take up their two year old entitlement to free early education, or have an additional vulnerability having been identified as a 'Child in Need' or a child with SEND.

Many of the issues centred on poor data recording. It should be mandatory for councils and providers of the HCP to record these additional vulnerabilities for children that receive and do not receive the 2-2 ½ year review, to enable better targeting and support. National initiatives to improve HCP data systems along with the facilitation of best practice are critical, so that data is collected and easily retrievable.

Another major factor was limited data sharing agreements between health and children's social care. Expert guidance and best practice should be provided nationally on information governance and data sharing to allow local areas – particularly between NHS Trusts and local authorities – to share data. This would need inter-departmental work between PHE, the Department of Health, DWP and DfE, especially on issues such as a common definitions and child identifier, as well as more specific issues such as the ability to use DWP data on the number of children eligible for the two year old entitlement to free early education.

On average only a third of the reviews in 2018/19 were conducted by health visitors (33%) and two thirds by other professionals without the same level of health qualifications. While some LAs were ensuring families with more complex needs who were on Universal Plus (UP) or Universal Partnership Plus (UPP) had a review completed by a qualified health visitors, this was by no means the approach taken by all LAs.

Only a small minority (on average 9%) of the reviews were integrated with early year progress checks in 2018/19 as mandated – and no integrated reviews took place in nearly half (47%) of all LAs. Many of the LAs stated this was due to capacity issues. Integrated reviews are seen as critical to ensuring integrated multi-agency working between public health and early education to ensure a holistic

assessment and identification of need to prepare children for school. While there were instances of good practice surrounding information sharing, integrated pathways, co-location and multi-agency working, most LAs were clear that much more needed to be done on to increase the number of integrated reviews that take place.

Over a quarter (27%) of LAs were unable to give the number of children who were identified at their 2-2½ year review in 2018/19 as having an additional need or developmental delay. This inability to identify these children is a major concern at a time in a child's life when identification of developmental delays can be most effective. Again, a lack of recording and poor information systems were major issues.

Among the LAs who were able to provide this information, on average 17% of children who received their 2-2½ year review were identified as a having an additional need or developmental delay. Of the children identified, an average of 76% were referred or received additional support. However, only a minority of LAs could state what type of additional support this was and how many children were referred to it or receiving it. While the identification of need is important, it is the support that is received as a result of identification that can make a substantial difference to a child's life. LAs need to ensure this information is collected by providers. They also need to improve their HCP data systems to be able to follow and track the additional support children receive to ensure children receive the help they need. Going further, LAs should look to mandate information on the outcomes of the additional support is collected.

The average estimated caseload for practitioners delivering the 0-5 HCP in 2018/19 was 368 children. The largest average caseload in an LA was 833 children and the smallest was 37 children. The majority (84%) of LAs had an average caseload above 250; over what the Institute for Health Visitors recommends. Furthermore, 30% of LAs reported average caseloads of over 400 children and 7% reported a caseload of over 600 children. This is a cause for concern because it may diminish the capacity of those undertaking the review to provide the full support to families and identify additional needs and development delays. Many LAs mentioned reductions in the Public Health Grant as a major factor, coupled with issues of recruitment and retention.

The data request found that 59% of all reporting LAs had seen a decrease in the number of practitioners since 2016/17, with 29% of LAs stating the number had stayed the same and 12% stating it had increased. Average caseloads were higher in areas where practitioner numbers had decreased. The average number of practitioners overall as well as health visitors within the HCP team delivering the 0-5 HCP were also lower in councils that had seen a decrease in practitioner numbers since 2016/17.

In sum, we have been able to collect much more detailed information on the 2-2 ½ year review and those delivering the 0-5 HCP than is currently published nationally. This has highlighted some major concerns including the additional vulnerabilities children that do not receive the review have and the identification of children's developmental needs and the provision of additional support. This data should inform the planning, commissioning, delivery, monitoring and evaluation of the 2-2 ½ year review, the 0-5 HCP more generally early years services, locally and nationally.

Children's COMMISSIONER

Children's Commissioner for England
Sanctuary Buildings
20 Great Smith Street
London
SW1P 3BT

Tel: 020 7783 8330
Email: info.request@childrenscommissioner.gov.uk
Visit: www.childrenscommissioner.gov.uk
Twitter: @ChildrensComm