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Review of the Healthy Child Wales Programme

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Review of the Healthy Child Wales Programme

Authors: Heledd Bebb, Nia Bryer, Myfanwy Davies and Tanwen Grover, OB3 Research

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For further information please contact:

Health Research Branch

Social Research and Information Division

Knowledge and Analytical Services

Welsh Government

Cathays Park

Cardiff

CF10 3NQ

Email: Research.HealthAndSocialServices@gov.wales

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Glossary

Adverse Childhood Experiences (ACEs)

Experiences or traumatic events, particularly in early childhood that can significantly affect the health and well-being of people.

Additional Learning Needs (ALN)

A person has additional learning needs if they have a learning difficulty or disability (whether the learning difficulty or disability arises from a medical condition or otherwise) which calls for additional learning provision.

Autistic Spectrum Disorder (ASD)

A developmental disorder or neurodiversity seen in children who may present persistent challenges in reciprocal social communication and social interaction or restricted, repetitive patterns of behaviour, interests or activities.

Baby Friendly Initiative (BFI)

An accreditation programme and standards to improve maternity and hospital practices to encourage and support breastfeeding.

BadgerNet

An online portal and app for electronic maternity notes, with information generated from a hospital based maternity system using details entered by midwives or other health professionals.

Body Mass Index (BMI)

A way of measuring whether someone is a healthy weight for their height.

Children and Young Persons Integrated System (CYPrIS)

The national digital IT system used in Wales for managing child health records.

Child Health Information Services (CHIS)

The NHS commissioned service in England responsible for maintaining a secure and comprehensive clinical care record for children aged 0-19.

Child Health System Programme - Pre School (CHSP-PS)

A dataset which supports the delivery of the child health programme in Scotland by facilitating the automated call and recall of children for the agreed schedule of child health reviews for pre-school children.

Connecting Care

A digital programme which aims to integrate information across community, mental health and social care services in Wales.

Cover of vaccination evaluated rapidly (COVER) **programme**

A childhood immunisation data collecting programme.

Coronavirus disease 2019 (COVID-19)

An infectious disease caused by the SARS-CoV-2 virus.

Digital Health and Care Wales (DHCW)

A Special Health Authority delivering digital health services in Wales.

Female Genital Mutilation

A procedure where the female genitals are deliberately cut, injured or changed without a medical reason to do so.

Flying Start

Flying Start is part of Welsh Government's early years programme for families with children under four years of age living in disadvantaged areas of Wales.

Family Resilience Assessment Instrument and Tool (FRAIT)

A standardised tool used by health visitors to assist in decision making and planning further interventions.

Getting it right for every child (GIRFEC) **Framework**

Scotland's national commitment to provide all children, young people, and their families with the right support at the right time so they reach their full potential. The framework is used by services across Scotland to improve and uphold the well-being of children and families.

National Community Child Health Database (NCCHD)

The dataset which brings together data from local Child Health System databases held by NHS Trusts in Wales and used to administer child immunisation and health surveillance programmes.

Newborn and Infant Physical Examination Cymru (NIPEC)

This is a universal and systematic examination of the newborn baby aimed at identifying and referring all children born with congenital abnormalities of the eyes, heart, hips and (in males) testes.

Primary Access Regional Information System (PaRIS)

An electronic health record for community health and care providers which aims to be a one record, one client, one system cradle-to-grave system

Sudden Infant Death Syndrome (SIDS)

The sudden and unexplained death of an apparently healthy baby aged up to 12 months old.

Schedule of Growing Skills (SOGS)

A standardised developmental assessment tool for children from birth to 5 years. It is designed for use by health professionals to identify areas of strength and potential delay.

Welsh Community Care Information System (WCCIS)

A national IT programme aimed at enabling the safe sharing of information between community health and social care to deliver improved services and support for people in Wales.

WellComm

A speech and language toolkit for use at early years and primary settings aimed at identifying speech and language barriers early.

Welsh Index of Multiple Deprivation (WIMD)

The Welsh Government's official measure of relative deprivation for small areas in Wales. It uses specific indicators to rank all areas in Wales from most to least deprived and is updated every 4-5 years.

1. Introduction and background

OB3 Research was commissioned by the Welsh Government to undertake review of the Healthy Child Wales Programme (HCWP).

1.1. Aims and objectives of the research

The review assessed the perceived impact of the HCWP and examined whether its current delivery is fit for purpose and supports the programme's objectives. The objectives of the study were to:

- review the original goals and objectives of the HCWP
- compare the HCWP with similar child health programmes in other countries
- explore the perceived impact of the HCWP using data and feedback from key stakeholders
- review the content and timing of each contact point and establish if any amendments are required
- assess any changes that might affect the programme's relevance, such as new policy guidelines
- explore access to, and use of, digital technology and resources within the HCWP
- explore the feasibility of implementing Prosiect Pengwin's speech, language and communication screening and intervention tools
- provide an overall summary of the programme's strengths and weaknesses.

1.2. Overview of the Healthy Child Wales Programme

The Healthy Child Wales Programme (HCWP) is the national framework that sets out the universal offer of child health contacts, screening, surveillance and health promotion for all children and families in Wales. It was launched in 2016 and covers the period from the transition from maternity services through infancy, early childhood and into the early school years, establishing a minimum schedule of planned contacts delivered primarily by health visiting and school nursing services.

The HCWP specifies nine contacts with health professionals at set points in time for children in Wales aged between 10 to 14 days and 3.5 years. Most of these contacts are provided by health visiting teams in Wales, except for the 6-week contact which is General Practitioner (GP) or primary care led. Health boards are expected to offer these contacts to all children in Wales, with enhanced and intensive services being offered based on need.

Through this structured schedule, HCWP seeks to ensure that every child has equitable access to preventative health care, developmental review and early support, regardless of where they live or their family circumstances. Its core objectives include:

- delivering key public health messages from conception to school age
- supporting bonding and secure attachment between infants and caregivers
- early identification of developmental, physical, or social concerns so that support can be provided promptly
- ensuring high and equitable uptake of routine immunisations and screening
- supporting successful transitions into education and onward services.

HCWP is designed to operate on the principle of progressive universalism. All families are entitled to the same core programme of contacts, but the model allows for additional, enhanced, or intensive support to be provided where need is identified. Where additional needs are identified, HCWP is intended to facilitate timely referral into targeted health services, early years provision, parenting support, or specialist interventions.

The programme provides a consistent structure through which multiple national policies and initiatives are delivered, including safeguarding activity, health promotion, and early intervention strategies. By offering predictable and universal points of contact, HCWP is intended to support multi-agency working and continuity of care across services such as maternity, childcare, education, and social services. As a result, HCWP is a key component of the preventative infrastructure intended to improve long-term outcomes for children and families and to reduce inequalities over the life course.

The programme draws on established evidence [footnote 1] that early, sustained, and proportionately targeted interventions improve long-term outcomes for children and reduce demand on specialist services later in life.

A formative evaluation of the HCWP was undertaken in 2018 to examine the early implementation of the programme across Wales. It found that while the HCWP brought welcomed consistency to practice and benefits such as stronger health-promotion focus and better developmental referrals, there were variations in delivery between health boards and a need for improved digital support and further refinement of tools and processes.

1.2.1. Prosiect Pengwin

Prosiect Pengwin is a recent initiative focusing on speech, language and communication development. Developed by Cardiff Metropolitan University on behalf of Welsh Government, it aims to co-design tools and resources to support health, education and childcare practitioners in identifying and supporting children with emerging speech, language and communication needs. Prosiect Pengwin has been developed to align with the HCWP contact schedule.

[1] The Overview of the HCWP references several foundational research reports including The Black Report (1980) which showed links between early disadvantage and lifelong poorer health , the Acheson Report (1998) which reinforced the importance of early intervention to reduce health disparities and the Marmot Review (2010) which argues that proportionate universalism and early action are essential to reduce inequalities and improve life chances.

1.3. Structure of this report

The remaining sections of this report are structured as follows:

- Chapter 2 sets out the methodology for undertaking the research
- Chapter 3 sets out the policy context
- Chapters 4 to 7 present the findings of the fieldwork and international comparison analysis relating to the delivery of HCWP
- Chapter 8 provides feedback received on Prosiect Pengwin
- Chapter 9 outlines the HCWP's performance to date
- Chapter 10 provides evidence of perceived outcomes and impacts
- Chapter 11 provides findings from focus groups with parents
- Chapter 12 sets out our conclusions and
- Chapter 13 presents our recommendations.

2. Methodology

2.1. Approach

The work programme for this review was conducted across 5 stages from August 2025 onwards. The fieldwork stages were undertaken during November and December 2025, with analysis and report drafting during January 2026.

2.1.1. Stage 1 - Inception

The first stage comprised an inception meeting with the Welsh Government to agree the work programme and secure access to relevant documentation. During this stage, a series of scoping interviews were also undertaken with 14 contributors from the Welsh Government, Digital Health and Care Wales (DHCW), Public Health Wales (PHW), Institute of Health Visiting and Prosiect Pengwin.

A meeting of the Strategic Health Visiting Leaders Advisory Forum Wales was also attended to inform members of the review and request their support.

The purpose of these interviews was to build a robust understanding of the key issues relating to the review, identify any additional research or data to inform the research, and agree the themes and questions to be addressed during fieldwork.

2.1.2. Stage 2 - Desk review

The second stage of the research involved desk review and analysis. This included:

- a review of key Welsh Government policy documents and Ministerial announcements relating to health visiting and child health
- an international comparative review of early years child health programmes which considered models in England, Scotland, Northern Ireland, Norway, Finland, Denmark, Sweden and New Zealand
- an analysis of published quarterly and annual HCWP data covering the period between October 2016 and December 2024 and analysing additional Welsh Index of Multiple Deprivation (WIMD) data tables produced by DHCW for the review.

2.1.3. Stage 3 - Preparation of research instruments

The third stage of the research involved the development of research instruments. This included developing an online survey using SNAP XMP software. The survey was designed for distribution to health visitors across Wales. The survey was piloted with strategic health visiting leads at one health board, with minor changes made to the survey questions as a result, before its wider distribution.

This stage also involved developing discussion guides for interviewing strategic stakeholders, health visitor leads at each health board, health visiting staff and other professionals involved with the HCWP and for facilitating focus group sessions with parents and primary caregivers (hereon referred to as ‘parents’). These research instruments were

shared with the Welsh Government for comment and approval. Privacy Notices and Information Sheets were also developed and agreed.

Arrangements for the recruitment of participants for the 4 focus groups with parents were also made during this stage, with a sampling framework to ensure geographic spread across Wales and a mix of contributors in terms of ethnicity, age, socioeconomic status and gender. The screener for the focus group also identified whether a parent was in a Flying Start area and whether they had faced any barriers in accessing their health visiting service locally.

2.1.4. Stage 4 - Fieldwork with stakeholders, health visiting staff and parents

The fourth stage involved fieldwork with strategic stakeholders, health visitor leads, health visiting staff and other professionals involved with the HCWP, and parents. This included:

- survey distribution to health visiting staff. A survey link and associated email invite was distributed to the health visiting leads at each of the 7 health boards. A further 2 reminder emails with embedded links to the survey were also drafted and distributed. A total of 292 health visiting staff responded to the survey, which is estimated to be a 35% response rate [footnote 2]

- interviews, small group discussions, focus groups and workshop discussions with a total of 134 professionals involved with the HCWP between early October and the end of December 2025. The approach taken was flexible to enable the research team to respond to the opportunities made available within each health board structure

- parent focus groups. Four virtual focus groups were held in November with a total of 32 parents recruited (8 for each focus group). 31 attended in total. An independent recruitment company was used to recruit and screen suitable contributors. All parents who participated in interviews or focus group discussions were given a £40 shopping voucher for their time and contribution.

2.1.5. Stage 5 - Analysis

The final stage of the work programme involved analysing survey and qualitative fieldwork data. The survey data was analysed by health board, role and profession. Percentages are rounded to the nearest whole number and, as a result, may not always sum to 100%. Qualitative survey data were coded and analysed thematically. Detailed write-ups of interviews and focus group discussions were prepared using a reporting template. Write ups were analysed thematically, utilising the Framework Method (Gale et al, 2013), [footnote 3] allowing for the systematic identification of themes and comparisons across different types of contributors.

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[2] The number of FTE health visitors in Wales as at March 2025 according to NHS workforce statistics published by Stats Wales is 820.5.

[3] Gale, N.K., Heath, G., Cameron, E. et al. Using the framework method for the analysis of qualitative data in multi-disciplinary health research. BMC Med Res Method Vol 13, 117 (2013). https://doi.org/10.1186/1471-2288-13-117

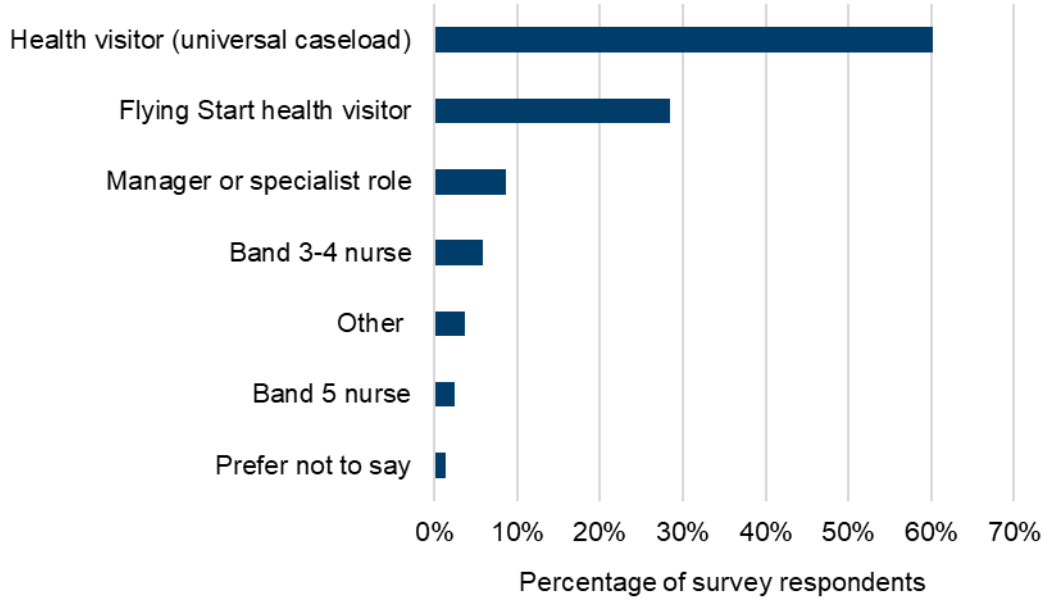
2.2. Profile of those who contributed to the research

In this section we set out the profile of survey respondents, fieldwork contributors and focus group participants who contributed to the research.

2.2.1. Profile of survey respondents

The majority (60%) of those who responded to the health visiting staff survey were health visitors with a universal caseload, while a further minority (29%) worked as Flying Start health visitors. Very few (under 10% in each case) were in other roles, such as managerial or specialist roles.

Figure 2.1: Percentage of survey respondents working in each type of role

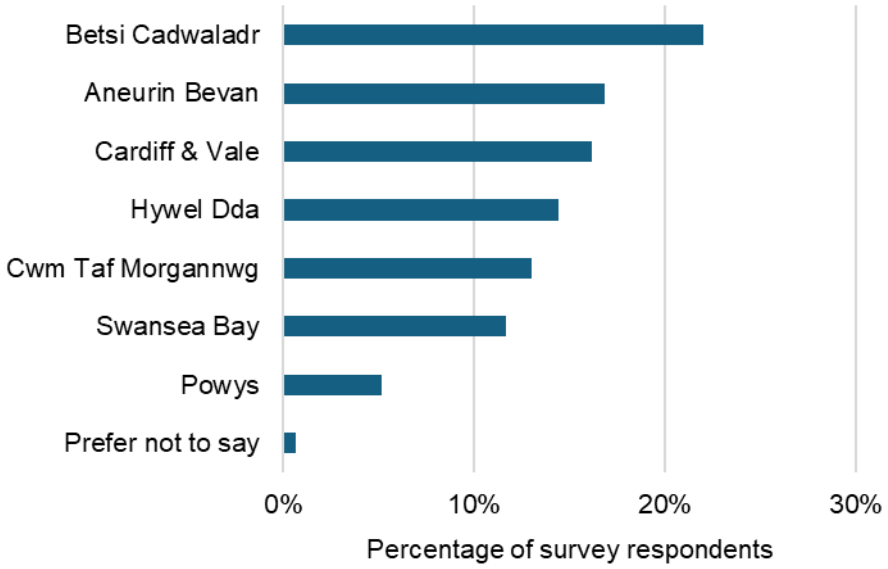


Description of figure: A bar chart showing that the majority of survey respondents worked as universal caseload health visitors, while a further minority worked as Flying Start health visitors.

Source: OB3 Research health visiting staff survey, November to December 2025, n=291.

The largest percentage of survey responses (22%) were received from those working in Betsi Cadwaladr University Health Board (UHB). Fewer were received from those working in the smallest health board, Powys Teaching Health Board (THB) (5%). Survey responses were divided fairly equally across the remaining five health boards.

Figure 2.2: Percentage of survey respondents who worked in each health board

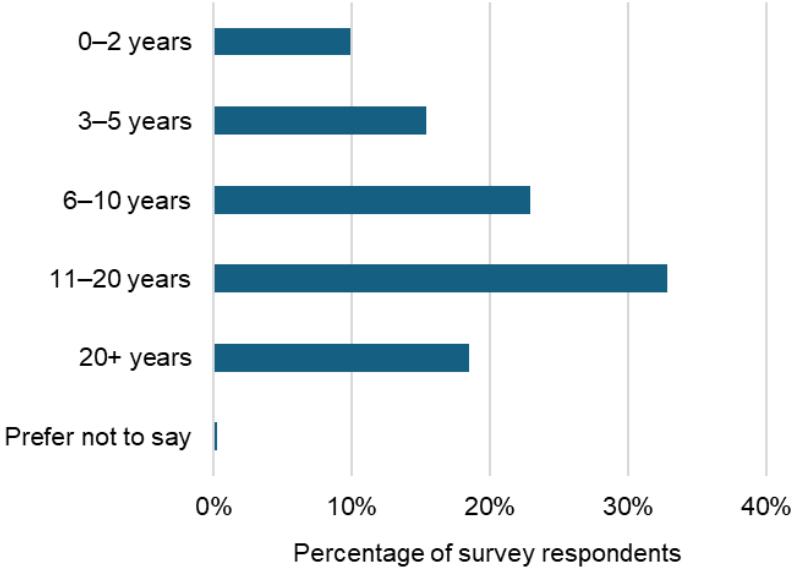


Description of figure: A bar chart showing that survey responses were divided fairly equally between respondents from each health board, with a slightly higher proportion from Betsi Cadwaladr UHB and a slightly lower proportion from Powys THB.

Source: OB3 Research health visiting staff survey, November to December 2025, n=291.

Survey respondents had generally worked in health visiting for many years. Around half had worked in health visiting either for 11 to 20 years (33%) or over 20 years (18%), while around a quarter (23%) had worked in health visiting for 6 to 10 years. Few had worked in health visiting for 3 to 5 years (15%) or up to 2 years (10%).

Figure 2.3: Percentage of survey respondents who had worked in health visiting for each period of time



Description of figure: A bar chart showing that survey responses were received from those who had worked in health visiting for different levels of time, with around half having worked in health visiting for over 11 years and few for under 2 years.

Source: OB3 Research health visiting staff survey, November to December 2025, n=292.

2.2.2. Profile of fieldwork interviewees

The fieldwork stage included feedback from a total of 135 individuals including:

- 32 strategic health visiting leads and operational managers
- 72 health visitor staff (including a range of universal, mixed case load and Flying Start health visitors and band 4 and 5 community nursery nurses[4])
- 21 other professionals including those responsible for child health data (4), Flying Start coordinators and staff (4), GPs and paediatricians (5) and speech and language therapists (7). A number of those interviewed also provided input on specific specialisms including looked after children, neurodiversity or breastfeeding
- 10 additional strategic and national stakeholders including Welsh Government policy leads for children's health, maternity services, early years, Flying Start and school nursing, PHW and representatives from the Royal College of Paediatrics and Child Health (RCPCH), the Royal College of General Practitioners (RCGP) and the Royal College of Speech and Language Therapists (RCSLT).

2.2.3. Profile of focus group participants

A total of 31 parents contributed across the 4 online focus group discussions. Their profile was as follows:

- 28 were female and 3 were male
- 11 were between 26 to 35 years old, 18 were 36 to 45 years old and 2 were 46 to 55 years old
- 27 described themselves from a White (British, Welsh or Irish) background and 4 as other ethnic backgrounds (including Black Caribbean, Mixed white and Asian, Pakistani and Mixed background)
- 4 described themselves as Welsh speakers (but wished to contribute in English)
- participants from across Wales' health board regions contributed including 9 from Aneurin Bevan UHB, 7 from Cardiff and Vale UHB, 4 from Cwm Taf Morgannwg UHB, 4 from Swansea Bay UHB, 3 from Betsi Cadwaladr UHB, 3 from Hywel Dda UHB and 1 from Powys THB region
- 9 lived in a Flying Start area, 19 did not live in a Flying Start area and 3 did not know
- all had at least 1 child under the age of 5.
    - 8 had a child aged between 0 to 12 months
    - 7 had a child between 12 to 24 months of age
    - 16 had a child aged between 3 to 4 years of age

[4] Bands are used to classify staff by skill, responsibility and qualification level within the NHS pay system. Band 4 typically refers to community nursery nurses or assistant practitioners. Band 5 often refer to newly qualified staff nurses. Band 6 is the standard, qualified Health Visitor role.

    - 8 had a child between 4 to 5 years of age
    - 8 also had children over the age of 6.
- participants were asked to choose the occupational group of the chief income earner within their household. The responses were as follows:
    - 6 were in senior management/director level/chief executive officer roles
    - 6 were in middle management roles
    - 2 were in supervisor or lower management roles
    - 7 were in office, clerical or administration roles
    - 2 were professionals (doctor, lawyer, architect etc.)
    - 5 were business owners or self-employed
    - 2 were crafts/tradesperson/skilled workers
    - 1 was a manual/unskilled worker.

2.3. Methodological considerations

This review drew on a wide range of documentary, quantitative and qualitative sources. At the outset, a substantial volume of background material was provided, including policy documents dating back to the early 2000s and a range of research and evaluation reports. To ensure relevance and proportionality, the analysis focused primarily on documents published within the last decade that directly related to the objectives of this review and the current operation of the HCWP. Earlier documents were used selectively to provide contextual understanding where appropriate.

Quantitative analysis was undertaken using HCWP data published on Welsh Government's StatsWales website. The analysis was undertaken using now archived data published on Welsh Government's StatsWales website Healthy Child Wales Programme. In addition, following discussions with DHCW, supplementary data relating to the WIMD were provided and analysed to support exploration of inequalities in programme coverage and outcomes.

The international comparison component of the review examined how a selected group of countries organise universal child health surveillance and early years contact schedules. Countries were selected following discussion during scoping interviews with stakeholders, based on their relevance to the Welsh context. The analysis is descriptive and draws on publicly available programme documentation and published literature.

An online survey of health visitors was distributed via health visiting leads in each health board. To support consistent dissemination, draft text was provided for an initial invitation and two reminder emails. The pattern of responses, including increased 'spikes' following each reminder and representation from all 7 health boards, suggests the survey was distributed widely and in a timely manner, although reliance on local distribution routes means absolute coverage cannot be confirmed.

During the scoping phase, stakeholders consistently highlighted the high workloads and time pressures facing health visiting staff across Wales. Participation was therefore contingent on providing flexibility in engagement methods and timing. Interviews were offered outside standard working hours where needed, including early mornings, and parent focus groups were held in the evenings to maximise participation.

At Welsh Government's request, this review did not gather detailed feedback on specific assessment tools used by health visitors, as a separate review of these tools was being undertaken concurrently by PHW. As such, no specific questions about HCWP assessment tools were included in the survey or discussion guides, although some issues relating to specific tools were raised from time to time. This avoided duplication but limited the scope of findings in relation to tool use.

The qualitative fieldwork followed a purposive, snowball approach. Strategic and operational health visiting leads supported access to frontline staff across Wales. As such, the engagement methods used varied by region and included individual interviews, small group discussions and larger online workshops, using both verbal discussion and chat-based feedback via Microsoft Teams. Additional perspectives were sought from professionals outside health visiting via representative organisations, with invitations distributed more widely through established forums such as the National Strategic Clinical Network for Child Health and relevant Royal Colleges. In this report, references to "stakeholders" are used to describe participants drawn from a range of roles and organisational settings relevant to the HCWP, rather than implying representation from every individual stakeholder group.

Finally, the review was asked to explore awareness and perceptions of Prosiect Pengwin. However, awareness among frontline health visiting staff was limited, with greater familiarity observed among operational managers and strategic roles. As a result, feedback on this initiative is partial and should be interpreted with some caution.

3. Policy review

This chapter provides an overview of the Welsh Government's main children's health policies and strategies which relate to and intersect with the HCWP. It also provides detailed background information for the Flying Start programme and its inter-relationship with HCWP.

3.1. Welsh Government children's health policies and strategies

3.1.1. A Vision for Health Visiting in Wales (2012)

The Vision for Health Visiting in Wales sets out an expectation that all families are supported through an All-Wales Healthy Child Programme (later HCWP) where health visitors deliver screening, immunisations, health and developmental reviews, and parenting support, using a consistent assessment framework. Health visiting is underpinned by 4 core principles: identifying health needs, raising awareness, influencing wider determinants of health, and promoting health and wellbeing. The vision highlights the need to tackle health inequalities amid increasingly complex family circumstances and challenges such as rural delivery, rising demand, declining health visitor numbers and growing caseloads. Early intervention is positioned as central to improving outcomes, particularly for families with multiple risk factors, with a strong emphasis on infant mental health and secure attachment. The vision also promotes greater integration across midwifery, primary care, health visiting and school nursing alongside outcomes-focused, evidence-based practice and makes the economic case for early years investment as both socially and financially beneficial.

3.1.2. Maternity Services Strategy for Wales (2019 to 2024)

The Maternity Services Strategy for Wales sets out a vision for safe, high-quality, woman- and family-centred care across the perinatal period, positioning maternity services as the foundation for children's long-term health and well-being. The strategy explicitly recognises maternity care as a key partner to early years programmes, including the HCWP, during the first 1,000 days of life. A central commitment is to continuity of care from the antenatal period through to postnatal support, with smooth transition into health visiting and universal child health services. The strategy places strong emphasis on reducing health inequalities with prioritised, targeted support for vulnerable women and families, including mental health and safeguarding concerns.

3.1.3. School Nursing Framework for Wales (2017)

The School Nursing Framework for Wales outlines a vision for a universal school nursing service that builds on the HCWP, ensuring continuity of care as children transition from health visiting into the school years. It reinforces HCWP's emphasis on a consistent, universal health offer across Wales and highlights the importance of smooth handover between services. The framework also promotes standardised delivery and integration with wider public health services to support equitable access and coordinated prevention.

3.1.4. Children and Young People's Continuing Care guidance (2020)

The Children and Young People's Continuing Care Guidance sets out the national framework for identifying and supporting children with complex, long-term health needs. While focused on specialist provision, it intersects with the HCWP as universal contacts provide key opportunities for early identification and referral into continuing care pathways. The guidance emphasises timely, coordinated referral between universal and specialist services to avoid gaps in support.

3.2. Other related policies and programmes

The HCWP sits within a complex and interrelated policy landscape concerned with prevention, early intervention, child development, safeguarding and equity. Many Welsh Government strategies and programmes explicitly identify universal health visiting and school nursing contacts as delivery mechanisms, while others create expectations that shape how HCWP is implemented. This section reviews the main Welsh Government policies and programmes that intersect with HCWP, how they relate to its objectives and delivery model, and highlights implications for HCWP implementation.

3.2.1. Overarching strategies and systems-level frameworks

The HCWP is underpinned by a set of cross-government and health-system frameworks that establish the strategic, statutory and accountability context within which it operates. These frameworks do not prescribe HCWP delivery in detail, but set clear expectations regarding prevention, integration, equity, long-term impact and system performance.

The Well-being of Future Generations (Wales) Act provides the statutory framework within which Welsh Government policies, including HCWP, must operate. The Act requires public bodies to work towards 7 well-being goals and to adopt 5 ways of working: long-term thinking, prevention, integration, collaboration and involvement. HCWP's design represents a preventative approach and its reliance on partnership working reflects the Act's integration and collaboration duties.

Within its Programme for Government well-being statement, the Welsh Government commits to strengthening early years provision and scaling programmes such as the HCWP and Flying Start through funding and phased expansion. The Programme for Government frames HCWP as part of a wider ambition to support families early and reduce inequalities.

A Healthier Wales sets out a long-term vision for transforming health and social care in Wales, with a strong emphasis on prevention, early intervention, integration and care delivered closer to home. The plan highlights the importance of community-based services and integrated pathways across maternity, early years and wider children's services. HCWP, with its universal contact schedule, focus on early detection of need and reliance on partnership working across health, local government and early years services reflects the principles of A Healthier Wales.

The NHS Wales Planning Framework sets expectations for how local health boards plan, deliver and monitor services over a 3-year cycle. It emphasises prevention, community-

based services and delivery of national programmes, and explicitly expects health boards to implement national programmes such as HCWP consistently. The framework creates a direct accountability mechanism for HCWP by requiring local boards to include performance and coverage of national programmes within their integrated medium-term plans.

3.2.2. Public health prevention and health promotion

Several national strategies explicitly identify HCWP as a delivery mechanism for prevention and early intervention.

The First 1,000 Days Programme, led by PHW, provides an evidence-based framework focused on improving outcomes from pre-conception through pregnancy and the first two years of life. The programme aligns closely with the HCWP, as it provides the universal delivery mechanism through which many First 1,000 Days principles are operationalised in practice. HCWP contacts offer structured opportunities for health visitors to support early attachment, infant feeding, parental mental health, and early child development, translating the First 1,000 Days evidence base into consistent, population-level action.

The Breastfeeding Action Plan for Wales outlines a national framework to increase breastfeeding initiation and continuation, recognising its significant health benefits. It identifies the HCWP as the universal mechanism through which consistent breastfeeding advice, support and monitoring can be delivered to all families. The plan highlights persistent inequalities in breastfeeding rates and emphasises the need for coordinated support across maternity and health visiting services, particularly in the early postnatal period. HCWP is also central to the plan's focus on data collection and accountability, as breastfeeding outcomes are monitored through routine universal contacts.

The National Immunisation Framework for Wales provides a strategic foundation for immunisation policy in Wales by prioritising equitable, accessible and data-driven vaccination services, reinforcing the importance of routine childhood immunisations as part of public health delivery. Under this framework, changes to the routine childhood vaccination schedule effective 1 July 2025, including revised timing of key vaccines and the introduction of a new 18-month vaccination appointment, have implications for HCWP delivery, as they influence the timing and integration of immunisation-related contacts within the programme.

The Healthy Weight: Healthy Wales strategy explicitly cites the HCWP as a delivery channel for a range of preventative and early intervention measures The strategy calls for strengthening interventions by health visitors, midwives and school nurses (Making Every Contact Count), and the use of HCWP contacts for early obesity prevention and family behaviour change.

PHW's Child Measurement Programme measures the height and weight of children in reception class and complements HCWP surveillance, with coordinated approaches to improve follow-up and referral.

PHW national screening programmes including newborn and pre-school screens intersect with HCWP screening responsibilities. The HCWP schedule is the intended platform to

ensure screening uptake and accurate recording, and to follow up missed screens or abnormal results through health visiting pathways.

Designed to Smile is the national oral health programme for young children and works alongside health visiting and early years services. Healthy Start is a nutrition-support scheme for low-income pregnant women and families with young children. Its role in improving early nutrition and maternal health aligns closely with HCWP's preventive remit, with HCWP contacts providing opportunities to identify eligibility and support benefit uptake.

The Parenting. Give it time parenting support materials and campaigns are designed to be linked with health visiting contacts. HCWP contacts are therefore used as a routine opportunity to signpost parents to parenting resources and local programmes, strengthening early parenting interventions and uptake.

3.2.3. Early years, children and families

Several policies affect the contexts in which HCWP contacts are delivered and the services to which families may be referred.

The Children's and Young People's Plan sets out Welsh Government's strategic vision for improving outcomes across the early years, childhood and adolescence. Universal health contacts are identified as a central plank of early years support, with the plan reaffirming the commitment to health visitor support for all families with children under seven. The plan articulates an ambition to move towards a single, more coherent system of early childhood education and care, alongside expanded access to childcare and parenting support.

The Flying Start programme was established in 2006 and continues to be a cornerstone of early years provision providing targeted support for families with children aged under 4 in Wales living in relatively disadvantaged areas. It focuses on childhood development and aims to give every child in Wales the best possible start in life by investing in early intervention. It offers a package of childcare, enhanced health visiting, parenting support and speech, language and communication interventions. Whereas HCWP provides a schedule of universal contacts, Flying Start adds enhanced visits at specific points, including 24+ weeks gestation, the postnatal period up to 6 weeks, between 9 and 12 months and at 18 to 24 months, to provide additional opportunities for monitoring development, supporting parental well-being and identifying needs at an early stage.

The 2024 process evaluation of the phased expansion of Flying Start examined implementation, achievements and challenges during the first two phases of its expansion. The evaluation identified effective preparation and strong partnership working as key enablers of successful rollout, particularly where health boards, local authorities and childcare providers worked collaboratively. The evaluation also highlighted ongoing challenges that have direct relevance for HCWP, including workforce and provider capacity, variation in implementation across local authorities, and limitations in data sharing between agencies. The evaluation emphasised the importance of multi-agency integration, adequate preparation time and robust data systems to ensure that universal and targeted services operate as a coherent offer rather than in parallel.

The Talk With Me: Speech, Language and Communication Delivery Plan sets out a national approach to improving children's speech, language and communication skills, with a focus on the identification and prevention of difficulties. The plan explicitly positions health visiting and early years contacts as key points for promotion, observation and early support. The HCWP provides the structured universal platform through which Talk With Me is implemented, particularly via developmental surveillance, parental guidance and timely referral to specialist services.

4. Programme rationale, scope and delivery structure

4.1. Introduction

This chapter examines the design and purpose of the HCWP. It sets HCWP within the international landscape of universal child health surveillance programmes, comparing its structure and approach with similar systems elsewhere. It then explores how stakeholders understand and value the programme's core aims, and their views on its design and the extent to which it remains fit-for-purpose. Finally, it synthesises views on how HCWP could be strengthened to meet contemporary challenges while preserving its universal foundation. The chapter also considers governance and workforce capacity issues.

4.2. International comparison

The HCWP operates within a wider international landscape of universal child health surveillance and early years public health provision. Many high-income countries have adopted nationally defined schedules of contacts delivered by specialist community public health nurses or equivalent professionals, combining promotion of child health and development with efforts to reduce inequalities.

Comparable systems include the Healthy Child Programme in England, the Universal Health Viewing Pathway in Scotland, Healthy Child, Healthy Future in Northern Ireland, Nordic child health clinic systems [footnote 5] and New Zealand's Well Child Tamariki Ora programme. Across these countries, there is shared emphasis on universal, non-stigmatising access combined with proportionate support for families with higher levels of need.

Programmes typically offer a core schedule of contacts centred on growth monitoring, developmental surveillance, immunisation and parental support, with additional contacts or intensified input where risks are identified. Within this context, HCWP provides a framework that standardises core contact points from birth to school age and seeks to ensure that all children have equitable access to developmental surveillance and early intervention opportunities, regardless of where they live.

In common with systems in the Nordic countries and New Zealand, HCWP sits within a wider early years' policy environment that seeks to integrate health visiting with maternity services, primary care, early education, safeguarding and targeted family support. HCWP's alignment with proportionate universalism, and its use as a platform to identify and refer families to enhanced services including Flying Start and other local programmes, mirrors international efforts to use universal child health programmes as gateways into more intensive or specialist provision.

[5] This includes child health programmes in Denmark, Norway, Sweden and Finland.

4.3. Review findings

4.3.1. Programme purpose and rationale

Stakeholders expressed strong support for HCWP's role in standardising child health provision across Wales. The programme was valued as providing a national, universal framework that ensures every child receives the same core contacts regardless of where they live or their family circumstances.

Before HCWP, provision varied widely between areas, a situation described by one strategic health visiting lead as the "wild west". Health visitors noted that this variation disadvantaged mobile and vulnerable families, creating inequity across Wales. Welsh Government stakeholders emphasised that HCWP functions as a "once for Wales" structure, replacing earlier variation and ensuring children receive the same surveillance opportunities wherever they live. Other professionals saw HCWP as reducing fragmentation and ensuring gaps between services were covered, rather than "leaving it to chance". The structured schedule was viewed as a non-stigmatising mechanism that provides opportunities to identify families whose needs are not otherwise visible, including those who do not engage with targeted programmes such as Flying Start.

Interviewed stakeholders consistently understood HCWP to be a developmental surveillance rather than a population screening programme. Welsh Government officials and strategic leads stressed that health visitors use professional judgement at evidence-based contact points to distinguish normal variation from genuine concern, avoiding over-medicalisation of children. HCWP was also recognised by interviewed contributors as a key vehicle for wider public health aims including delivering health messages, supporting attachment, promoting breastfeeding, supporting speech and language development, injury prevention and immunisation uptake. It was also described as providing a gateway into more intensive or specialist support when needed.

4.3.2. Programme scope

Senior clinical and policy leads emphasised that child development "has not changed", and the evidence underlying chosen contact points, especially at 6, 15 and 27 months, remains sound. The universal schedule was valued as providing structured opportunities to identify need early and ensure families do not fall through gaps in provision. Other professionals largely accepted the idea of a structured schedule and saw HCWP as a necessary foundation, providing a useful backbone for prevention and early identification. Outside health visiting however, many professionals understood HCWP only in broad terms and remained unclear which elements are mandatory, what is covered at each contact, and how far the programme extends into school age.

Health visitors felt that HCWP captures only a fraction of their actual work.

> "I wouldn't even say a quarter - it doesn't cover hardly anything of what we do."

Health visitors discussed how the programme focuses on scheduled contacts whilst missing intensive postnatal support, safeguarding work, mental health interventions and crisis

responses. They felt that the current HCWP guidance does not adequately address contemporary challenges according to frontline health visitors, and several areas need updating including:

- perinatal mental health screening and support pathways: perinatal mental health dominates current caseloads but receives minimal attention in the framework. Maternal and paternal well-being are not systematically recorded or monitored. Many health visitors advocated specifically for including the father's mental health and involvement in this aspect of support too
- physical activity, nutrition and obesity prevention: physical activity and obesity prevention are barely mentioned within the current HCWP: one health visitor noted physical activity appears once as a tick-box, yet childhood obesity was described as "the biggest threat" facing Welsh children
- additional learning needs (ALN) are rising sharply: some health visitors believed that HCWP did not always identify these needs early enough as it only provides limited developmental screening, with tools like Schedule of Growing Skills (SOGS) used inconsistently. They also called for clearer referral routes
- domestic abuse, substance misuse and wider social determinants were described as not being sufficiently front and centre in the programme. Health visitors felt that issues such as female genital mutilation, while important, were likely over-emphasised because they had been a particular policy focus some years ago. They suggested that this level of emphasis is no longer warranted and risks diverting attention from broader social issues that affect many more families.

Health visitors were keen to embed these contemporary issues that families were increasingly having to navigate and recognised that training for health visitors in these areas was needed, alongside resources that families could use between contacts. Primary care clinicians and speech and language therapists also called for a clearer line of sight between HCWP and other national frameworks (notably immunisation and healthy weight work), and suggested that consideration be given to how HCWP can better address growing risks such as parental mental health (including fathers), rising prevalence of neurodevelopmental need and childhood obesity, and the effects of modern sedentary lifestyles on physical development.

Health visitors consistently described HCWP as increasingly rigid, limiting their ability to use professional judgement to adapt contact timing to child development and family circumstances. Many felt the programme had become compliance-driven and overly prescriptive, with one noting that HCWP should be "a guide [but] let us use our judgement". Health visitors emphasised that they are trained to make clinical assessments, know their families, and can identify when contacts should be brought forward or safely spaced out. Strategic leads echoed this, arguing that fixed schedules have eroded professional autonomy and constrained responsiveness to need.

Speech and language therapists also questioned the reliance on fixed, age-based contacts, noting a shift in professional practice towards a more stage-based developmental assessment. They highlighted the risk of age-specific milestones being misleading,

particularly given parental expectations shaped by social media, and described this as an ongoing design tension, despite services and data systems being organised around age points.

Several contributors argued that any reform of the programme should prioritise smarter alignment of existing programmes rather than simply seeking additional resources.

> "We need to explore smarter ways of working - not just by asking for more money, but by rethinking how existing programmes and resources can be better aligned."

In practice, this was described as protecting universal HCWP contacts as a consistent backbone, while allowing greater flexibility to trigger enhanced input where need is identified. This approach reflected a strong view by contributors that scarce resources should be targeted where they can do most harm-reduction, rather than being diluted across an expanding universal offer. As one GP noted, services must be able to "adapt to specific needs…investment here in the very early stages is absolutely key."

Contributors were keen to see clearer alignment between HCWP, the National Immunisation Framework and early years integration activity, so that contacts, data collection and referral pathways reinforced rather than fragmented other programmes. They also highlighted the need for stronger and more consistent measurement, such as routine capture of weight and BMI data across the transition to school, to enable prevention priorities like obesity to be monitored and addressed. Co-production with adjacent services (including Flying Start, speech and language therapists, community paediatrics and education) was seen as essential to avoid unintended gaps, particularly where HCWP contacts act as access points to other provision.

Strategic leads also emphasised the importance of formally recognising and universally delivering the antenatal contact, alongside additional visits, to make the full scope and value of health visiting visible. Beyond the profession, understanding of HCWP was often superficial, with uncertainty about which elements are mandatory, what is covered at each contact, and how far the programme extends into school age. Finally, speech and language therapists and paediatricians argued that HCWP should more explicitly emphasise early parent-infant responsiveness and communication, beginning in pregnancy and early visits. They emphasised the importance of embedding messages around talking to babies, responsive interaction, breastfeeding and responsive feeding as core elements of the programme rationale and early contacts.

4.3.3. Delivery structures

Interviews with health visitor leads, frontline health visitors and national stakeholders found that there is marked variation in how the HCWP is structured and delivered in practice.

Across Wales, responsibility for HCWP typically sits with senior nurse or service-lead posts for children and young people or health visiting, supported by area or county-level leads and team leaders. Most health boards described a tiered structure in which band 7 leaders and practice educators oversee teams of band 6 health visitor case-holders, with band 5 nurses

and band 3-4 nursery nurses or assistant practitioners contributing within agreed delegation frameworks.

National stakeholders broadly endorsed this structure but emphasised that governance and lines of accountability are opaque, with no clear national service specification equivalent to maternity standards in place. Frontline health visitors recognised this tiered model but reported that delegation boundaries are often unclear and vary by locality, especially around which HCWP contacts can safely be given to band 5 or nursery nurses.

Every area reported increased reliance on skill mix [footnote 6] to maintain HCWP delivery in the context of high caseloads, sickness, vacancies and an ageing workforce, but the balance between health visitor-led contacts and delegated activity differs markedly. Some boards emphasised that band 6-7 health visitors remain primary case-holders while nursery nurses are being pulled back from routine HCWP reviews into targeted interventions, whereas others use nursery nurses and community staff nurses more extensively for 2 to 3 year developmental contacts and lower-risk families. National stakeholders tended to frame this rising reliance on skill mix as necessary evolution rather than fully planned redesign, noting that caseload pressure, vacancies and Flying Start geography drive very different local patterns of delegation.

4.3.3.1. Integration with Flying Start and local models

The relationship between HCWP and Flying Start is a major source of local variation in scope and delivery. Some regions have moved towards integrated or blended caseloads in which individual health visitors hold a mix of Flying Start and universal families. One area delivers additional antenatal and 20-month contacts to improve equity. Others retain clearer structural separation and report sharper contrasts between small, intensive Flying Start caseloads and very large generic caseloads of up to around 250 children per health visitor.

4.3.4. Governance

Several stakeholders were unclear on who “owns” the HCWP and reported that, over time, accountability and strategic direction had weakened. Because HCWP is not a screening programme, it does not sit neatly under PHW, and governance arrangements between Welsh Government, PHW, and health boards were described as complex and opaque. Strategic leads within health boards highlighted the need for accountability to be more transparent, with clearly defined responsibilities at national and health board levels, for expectations of health boards to be explicit and consistently communicated, and for stronger mechanisms to feed through insights from frontline practice and data into national policy and programme decision-making.

The evaluation found that national governance arrangements for HCWP are currently limited and fragmented. There is no dedicated programme steering group or equivalent forum to provide oversight, to coordinate strategic decision-making or monitor implementation across health boards. Health visitors and other stakeholders consistently

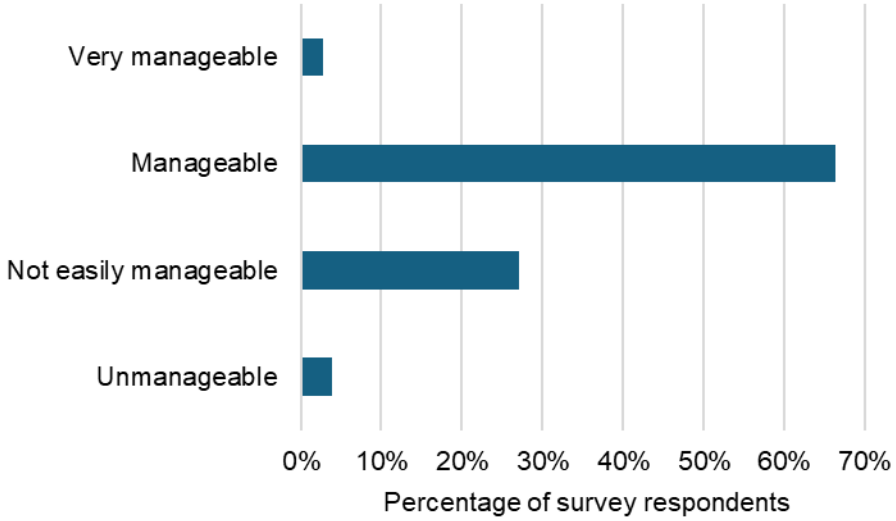
[6] *Skill mix* describes how different roles, qualifications and competencies within the health visiting team (for example, registered health visitors, nursery nurses and support staff) are combined and used to deliver care and maximise workforce capacity.

highlighted the practical impact of this ambiguity, reporting unclear lines of responsibility when implementing guidance, managing local adaptations, or responding to emerging challenges, particularly around workforce pressures and multi-agency pathways. Stakeholders expressed a strong preference for a defined governance structure at national and health board levels, with named leads, clear roles, and alignment with wider early years and population health strategies.

4.3.5. Workforce capacity

The majority (66%) of survey respondents described their current workload as manageable, though a further minority (27%) described it as not easily manageable. Very few described their workload as either unmanageable (4%) or very manageable (3%).

Figure 4.1: Percentage of survey respondents who described their current workloads as manageable or unmanageable

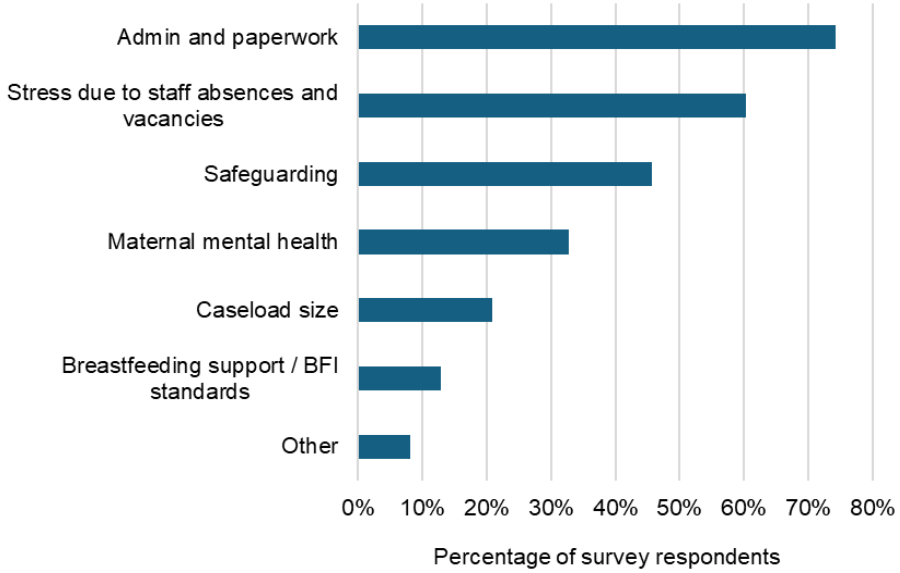


Description of figure: A bar chart showing that the majority of survey respondents describe their current workload as manageable, with a minority describing it as not easily manageable.

Source: OB3 Research health visiting staff survey, November to December 2025, n=288.

The main pressures reported by survey respondents were admin and paperwork (74%), stress due to staff absences and vacancies (60%) and safeguarding (46%). A minority also reported pressures relating to maternal mental health (33%) and caseload size (21%), with a few also citing pressures relating to breastfeeding support / Baby Friendly Initiative (BFI) standards (13%). Very few (8%) noted other pressures, including an increase in high-need cases (including ALN and vulnerable families) and pressures relating to travel distances and time.

Figure 4.2: Percentage of survey respondents reporting different types of pressures on their workload

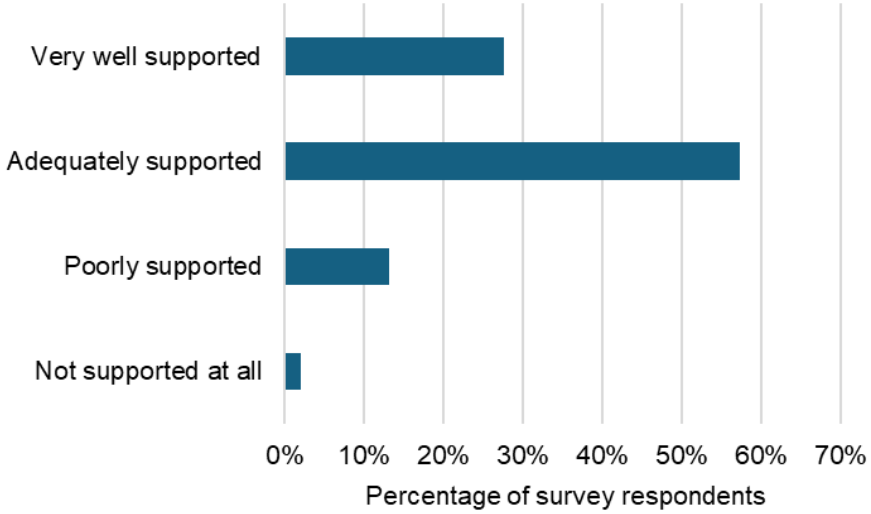


Description of figure: A bar chart showing that the most common pressures on the workload of survey respondents were admin and paperwork, and stress due to staff absences and vacancies.

Source: OB3 Research health visiting staff survey, November to December 2025, n=287.

A minority (28%) of survey respondents reported that they felt very well supported in their role, while around half (57%) felt adequately supported. Few (13%) felt poorly supported and very few (2%) felt they weren't supported at all. Those with Flying Start caseloads were also more likely than average to report feeling very well supported, while those with mixed caseloads were more likely than average to report feeling poorly supported.

Figure 4.3: Percentage of survey respondents who reported feeling supported in their role



Description of figure: A bar chart showing that many survey respondents reported feeling either very well supported or adequately supported in their role, with few feeling poorly supported.

Source: OB3 Research health visiting staff survey, November to December 2025, n=290.

Interviews with health visitors across Wales identified workforce capacity as a major constraint on the sustainable delivery of HCWP. Health visitors consistently described the programme as ambitious but delivered amid persistent staffing shortages and limited capacity, with growing pressure affecting quality, continuity and staff well-being.

> “If anybody leaves, the rest of the team have to absorb that caseload…and I do think in this authority there is a high risk of burnout.”

Health visitors described caseloads as unmanageable in many areas, with rural practitioners highlighting additional pressure from travel time and professional isolation. Contributors gave examples of routine HCWP contacts being displaced by urgent postnatal visits or safeguarding activity, requiring constant reprioritisation. Health visitors emphasised the unpredictable nature of their work, noting they “never know what they’ll walk into”.

Health visitors and Welsh Government stakeholders reported widespread staff shortages and high sickness absence. Vacancies were typically managed by redistributing caseloads, further increasing pressure and reducing resilience. Welsh Government stakeholders acknowledged that health visitors are already prioritising families with the highest levels of need but noted that this occurs within an under-resourced system, where recruitment challenges, including difficulties recruiting Welsh-speaking health visitors, limit what can realistically be delivered. Health visitors framed recruitment and retention as a strategic risk to HCWP delivery, pointing to an ageing workforce, fragile training pipelines and reduced university training capacity. While “grow your own” approaches were used and viewed positively, many questioned whether current training volumes are sufficient to replace anticipated retirements.

In response to these pressures, health visiting practitioners and strategic leads described skill mix as an increasingly central feature of HCWP delivery. Community nursery nurses and band 4 and 5 staff were consistently seen as providing valuable support for developmental activity, clinic-based contacts and targeted interventions. However, contributors were clear that skill mix cannot replace qualified health visitors for complex work. Several health visitors and leads stressed that post-pandemic increases in family complexity have widened the gap between what skill-mix staff can safely undertake and the demands placed on qualified health visitors.

There was strong support across health visitors for developing a sustainable bank workforce to cover leave and vacancies. Where bank health visitors were available, this was described as invaluable in maintaining continuity and protecting permanent staff from workload escalation. Contributors also highlighted the importance of administrative support, noting that recruitment freezes have shifted clerical tasks onto clinical staff, further reducing capacity for direct family contact.

The cumulative impact of these pressures was described by health visitors as having a substantial effect on morale. Contributors spoke about the emotional toll of safeguarding and mental health work, particularly where they felt they were the only professionals maintaining contact with vulnerable families. Several expressed concern that health visiting is perceived as an “easy service to blame” when wider system pressures lead to gaps in provision.

> “We’ve got very wide shoulders and we’re the easy ones for people to point to.”

Perspectives from GPs and national stakeholders reinforced these findings. GPs emphasised the scale of the health visiting role and the erosion of continuity over time, noting that reduced staffing and loss of co-location have weakened informal communication and trust. National stakeholders acknowledged that health visiting has not consistently received the strategic attention and investment afforded to other parts of the nursing workforce, despite its central role in early intervention and prevention.

> “We ask them to do an awful lot in what amounts to maybe a 20-minute, half-hour contact.”

5. Programme delivery - contacts

5.1. Introduction

This chapter covers the 9 core, universal contacts of the HCWP. It provides an overview of the core contact schedule, the content and purpose of each contact and a comparison with example contact schedules from other countries. It also summarises the detailed feedback provided in relation to each core contact. Issues relating to enhanced contacts and additional Flying Start contacts are discussed in chapter 7.

5.2. Overview of HCWP core contact schedule

While local delivery models do vary, the HCWP sets minimum expectations for the content and intent of each of the nine universal contacts.

- Birth contact (10 to 14 days) - the first routine health visitor contact is typically a home visit and provides the first substantive opportunity for health visiting staff to assess maternal emotional well-being, review infant feeding and weight-gain and support bonding and attachment.
- 6-week physical examination - a routine review offered to all infants which includes a physical examination of key areas such as the eyes, heart, hips and, in boys, the testes, consistent with UK screening recommendations, delivered by or through primary care professionals.
- 8-, 12- and 16- weeks - a cluster of health visitor contacts to review growth and developmental progress, reinforce public health messages and encourage vaccine uptake.
- 6 months contact - a home visit offered where the health visitor will assess growth, feeding and weaning practices, discuss baby safety and development and undertake a family resilience assessment.
- 15-month contact - the focus is on assessment of growth and development, with a particular emphasis on speech and language development.
- 27-month contact - positioned to support preparation for ‘school readiness,’ including toilet training. Key public health messages are reinforced and any referral pathways activated if developmental delay or other needs are identified.
- 3.5-year contact - a home visit offered as the final pre-school universal contact. It includes a growth and development assessment and discussion of the transition to education. Health visitors are expected to identify children who will require a formal handover to the school nursing service.

5.3. International comparison

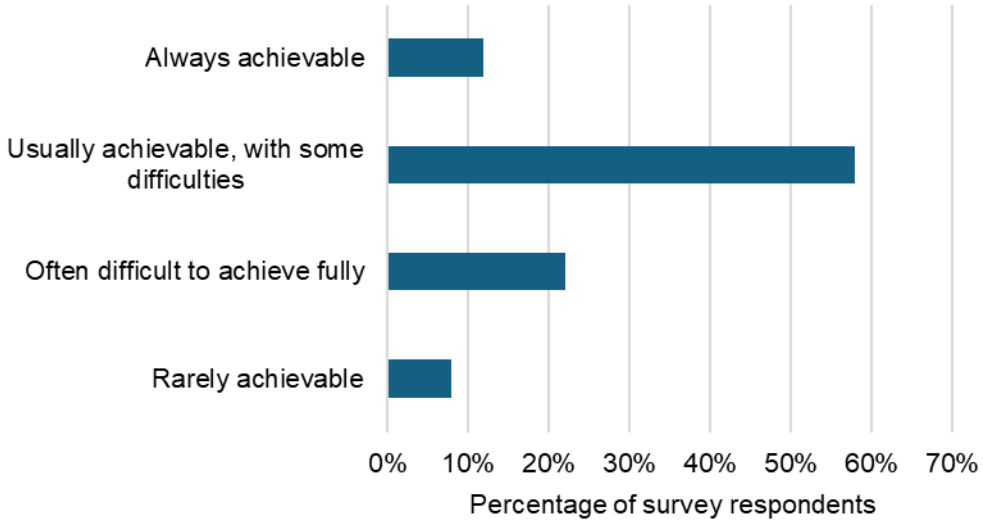
Evidence from other countries shows that a range of approaches are taken.

- England offers 5 mandated (universal) health visiting contacts to all families - antenatal, new baby review at 10 to 14 days, 6 to 8 weeks review, 1-year review, and 2 to 2.5 years review. School entry checks are also undertaken and there is increased review frequency put in place to support children at risk.
- Scotland provides 11 core contacts from antenatal to 4.5 years with additional input and reviews based on assessed risk.
- Northern Ireland delivers 6 core contacts - antenatal, new birth visit, 6 to 8 weeks, 3 to 4 months, 9 to 12 months, 2 to 2.5-year and a 3 to 4 year pre-school review, with extra services when assessed as needed.
- The Nordic models are notable for statutory or near-statutory universal preventive services and strong multidisciplinary teams.
    - Finland operates 9 scheduled contacts that focus on clinical assessment and family welfare through municipal health centres with extended examinations at 3 key ages, commonly 4 months, 18 months and 4 years.
    - Sweden concentrates 12 visits in the first 2 years via child health centres that often integrate GP and community paediatric input.
    - Denmark delivers 12 contact points with up to 5 nurse visits during the first year and 7 GP checks cover ages 0 to 5 including vaccination. Additional checks are determined locally within a national legislative framework.
    - Norway provides 14 contact points from 7 days to 4 years with handover at 5 years. Follow-up and home visits occur per assessed risk.
- New Zealand offers 13 contact points from birth to 4 years with additional visits to support indigenous minorities, extended families from high deprivation areas, and adults with mental health needs.

5.4. Review findings

Around half (58%) of survey respondents report that delivering the scheduled contacts is usually achievable, with some difficulties, while a further few (12%) find it always achievable. A minority (22%) find it often difficult to achieve fully, though very few (8%) find it rarely achievable.

Figure 5.1: Percentage of survey respondents who found delivering all the scheduled contacts achievable

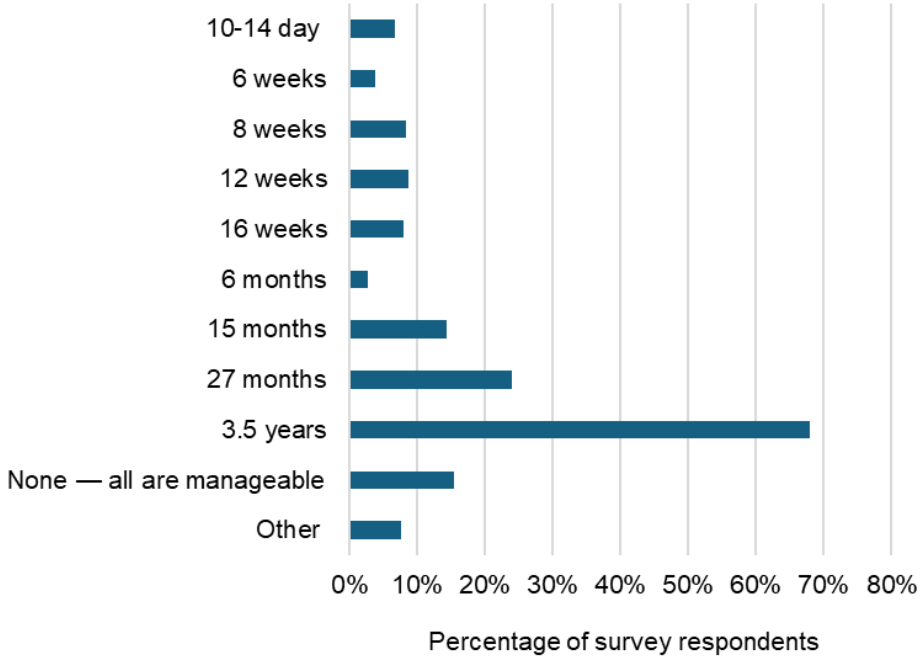


Description of figure: A bar chart showing that many survey respondents find it either always achievement or usually achievable, with some difficulties, to deliver the schedule of contacts.

Source: OB3 Research health visiting staff survey, November 2025 to December 2025, n=286.

Survey respondents reported that contact points become progressively more difficult to deliver, with a minority reporting it difficult to deliver contacts at 15 months (14%) and 27 months (24%). The majority of respondents (68%) find the final 3.5-year contact point to be one of the most difficult to deliver. However, a few (15%) noted that they find all the contact points manageable to deliver.

Figure 5.2: Percentage of survey respondents who found each contact point most difficult to deliver on time



Description of figure: A bar chart showing that survey respondents find it progressively more difficult to deliver each contact point on time, with a substantial peak in difficulty at the 3.5-year contact point.

Source: OB3 Research health visiting staff survey, November 2025 to December 2025, n=284.

Health visitors and other professional contributors consistently identified HCWP contacts in the early months of life as the most valuable point of engagement. Health visitors emphasised the importance of early home visiting for identifying need, supporting safeguarding and infant feeding, and establishing trusting relationships with families. Early contacts were also seen as important for setting expectations about how families can access support over time, increasing the likelihood that families will seek help proactively rather than disengage from scheduled contacts. However, health visitors and wider stakeholders also noted that parents are often overwhelmed during this period. As a result, contributors thought it important that key messages across multiple contacts or through follow-up and community-based support be conveyed, rather than concentrating large volumes of information into a single early visit.

Health visitors viewed the recent shift back towards increased home visiting since the COVID-19 pandemic positively, reporting that it strengthens rapport and improves understanding of family circumstances. They acknowledged that contacts are not always delivered in a strictly prescriptive way. Many described adapting the timing, content and format of contacts to reflect family needs and circumstances, while remaining within the overall programme framework. This flexibility was widely described by health visitors as necessary, whilst they recognised that standardisation supported equity and accountability,

they also felt that overly rigid delivery was less effective if it did not align with how families engage with services.

> “It’s quite prescriptive and that’s not how I work.”

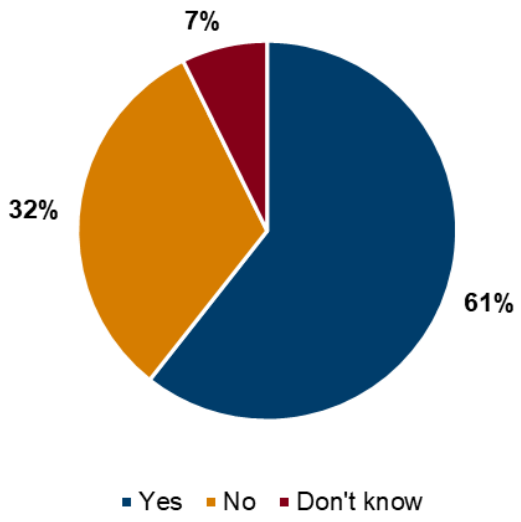
> “We are following it, but we’re following it in a way that works for our families.”

Later contacts were generally described by health visitors as more challenging to deliver and, in some cases, they perceived them to be of reduced value, particularly where engagement had declined or where children were already well supported through childcare or education settings. Despite this, health visitors emphasised the importance of maintaining a visible service offer and ensuring appropriate handover or closure, noting concerns that extended gaps between contacts increase the risk that emerging issues may go unidentified.

> “Families often say to me that it’s a long time since they last saw a health visitor.”

The majority of survey respondents (61%) felt that all contact points are needed, while a minority (32%) did not and very few (7%) didn’t know. Those with Flying Start caseloads were also more likely than average to report that all contacts points are needed.

Figure 5.3: Percentage of survey respondents who felt that all the contact points are needed



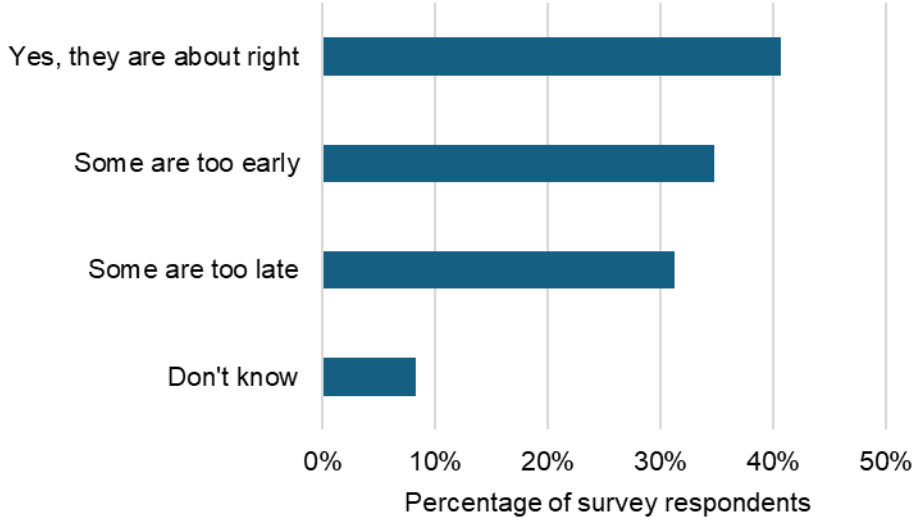
Description of figure: A pie chart showing that the majority of survey respondents felt that all contact points are need.

Source: OB3 Research health visiting staff survey, November 2025 to December 2025, n=287.

Survey respondents expressed mixed views about how appropriate they find the timing of universal contacts. While the largest proportion (41%) reported that the timings are about right, a minority (35%) felt that some are too early, and a minority felt that some are too late (31%). Those working in Betsi Cadwaladr UHB and Powys THB more frequently reported finding the timing about right, while those in Cwm Taf Morgannwg UHB and Swansea Bay

UHB were less likely. Those with Flying Start caseloads also more frequently reported finding the timing about right, while those with generic caseloads more frequently reported the timing of some contacts as too early.

Figure 5.4: Percentage of survey respondents who felt that the timing of universal contacts is appropriate



Description of figure: A bar chart showing that survey respondent views are equally divided between those who felt the timing of the universal contacts is appropriate and those who felt some are too early and/or too late.

Source: OB3 Research health visiting staff survey, November to December 2025, n=288.

Sections 6.4.1 to 6.4.8 below summarise the main points raised during the fieldwork in relation to the 9 specified contact points.

5.4.1. 10- to 14-day contact

The 10 to 14-day contact, or birth visit, was consistently regarded as a critical component of the HCWP for establishing early relationships, assessing infant feeding, supporting parental adjustment, and identifying safeguarding concerns. However, health visitors highlighted duplication with ongoing midwifery visits, which often continue up to 28 days post-birth, sometimes occurring on the same day.

> “Midwives are still visiting at that point, so we’re often doubling up on the same information.”

Many practitioners supported extending the window for this contact to up to 21 days to allow clearer role differentiation and more focused support, accounting for operational realities such as weekend births, maternal hospital stays, and workforce pressures. Conversely, some health visitors felt that for first-time or vulnerable parents, the contact may already be too late, particularly in the absence of antenatal engagement:

> “Getting that relationship from the very beginning really helps across the long term - families are more likely to contact you if they need support.”

5.4.2. 6-week contact

The 6-week review with a GP was valued for monitoring maternal well-being, infant growth, feeding, and adjustment. Health visitors emphasised that this timing allows assessment of postnatal mood and early feeding, with flexibility applied for first-time parents or higher-need families.

> "The 6-week visit is well-timed and important for picking up postnatal mood issues."

> "that's often when mums start to open up about how they're really feeling."

Concerns from health visitors included the proximity to the 8-week contact and GP appointments, creating clustered interactions:

> "6 and 8 weeks are very close together…that's 4 appointments in 2 weeks with a young baby - it's a lot for families."

Some health visitors and GPs noted that combined 6- and 8-week contacts were often recorded as a single event which resulted in under-reporting and underestimating professional input. GPs outlined a typical structure in which mother and baby are both seen, often within a combined 30-minute appointment (approximately 15 minutes each), covering the Newborn Infant Physical Examination Cymru (NIPEC) examination and the mother's physical and mental health alongside feeding and early adjustment.

Health visitors generally viewed the 6–8 week review as primarily a GP responsibility for growth/measurement and argued for redesigned, purposeful contact at this interface, rather than attendance at immunisation clinics simply to meet HCWP contact counts. Face-to-face delivery was strongly preferred, particularly for infant assessment, with informal multidisciplinary communication emphasised as critical to safeguard emerging issues.

Interviewed GPs were not familiar with any recent training or Continuous Professional Development (CPD) specific to this NIPEC review and felt previous training had not fully equipped them for the programme's developmental aims.

5.4.3. 8-, 12- and 16- week contacts

These contacts were frequently discussed collectively rather than as discrete interventions. Health visitors reported that the 8-week contact sits too close to the 6-week visit and should be optional, targeted, or delivered in a clinic. The 12-week contact was often described as repetitive, offering limited additional benefit, and could be replaced by a later review or drop-in clinics. The 16-week contact, associated with weaning advice, was seen as timely but sometimes duplicating other services, especially in areas where nursery nurses or community teams already provide weaning clinics or group sessions. Across all 3 contacts, repeated advice on feeding, growth, and infant care was considered inefficient and potentially counterproductive.

> "All the baby contacts are too much - one meaningful contact would be better."

Workload pressures sometimes resulted in fewer home visits being undertaken than health visitors would ideally wish, with some areas increasingly using remote contacts for low-risk families. Clinic contacts were seen as useful for weighing and reassurance, although some reported that frequent weighing could lead to unnecessary parental anxiety and additional follow-up work where normal variations are over-interpreted. Clinic contacts were deemed less suitable for sensitive discussions on emotional well-being, domestic abuse, or family dynamics:

> "Clinic contacts aren't always meaningful and aren't the right place to talk about emotional issues."

5.4.4. 6-month contact

The 6-month contact was widely recognised by health visitors and other interviewed stakeholders as important for health promotion and weaning advice. However, there was consistent concern that its current timing limits its effectiveness and contributes to inefficiencies within the wider schedule of contacts as it often generates the need for a follow-up visit. Survey findings reinforced this view, with 39% of respondents who commented on contact timing raising issues in relation to the 6-month review. Health visitors consistently reported that at 6 months many infants have not yet reached key gross motor milestones, such as independent sitting or weight bearing:

> "6 months is too early to assess development - very few babies show differences then."

Many reported that by 6 months families have often already begun weaning their child. As a result, the 6-month visit was seen as either too late to influence early feeding practices or too early to address common challenges that emerge once weaning is established. Public health stakeholders similarly suggested that a later contact could better support families and reduce early introduction of solids associated with increased obesity risk.

> "By 6 months most families have already started weaning."

Concerns were raised about the long interval to the 15-month contact, leaving children without structured support during rapid developmental change. Health visitors supported moving the 6-month contact to 7 to 9 months, aligning with observable milestones and reducing the need for repeat visits: The contrast with Flying Start provision was highlighted, as intermediate contacts in those areas were thought to bridge developmental gaps effectively.

5.4.5. 15-month contact

The 15-month contact was of most concern in terms of timing, with 60% of survey respondents raising issues in relation to it. It was seen as too early to support meaningful developmental assessment, too close to the 12-month immunisation, and too far from the 27-month contact:

> "15 months is slightly too early - I end up going back again at 18 months anyway."

A dominant theme across health visitor interviews was the long gap between the 6- and 15-month contacts. This period was described as one of rapid developmental change and considerable transition for families, including increasing mobility, emerging communication, changes in sleep and feeding, and parental return to work. The absence of a routine universal contact during this time was viewed as a missed opportunity to observe development and provide timely guidance. Many health visitors reported compensating through informal or additional visits around 9 to 12 months where concerns had been noted, though these sit outside the formal schedule and add to workload pressures.

> “The gap between 6 and 15 months is huge - so much development happens in that time.”

The 15-month contact attracted strong views about the appropriateness of its timing. Health visitors and other stakeholders highlighted that key developmental domains assessed at this age, particularly speech, language, social communication and walking, show wide normal variation. As a result, concerns frequently fall below referral thresholds or cannot be progressed with partner services, increasing parental anxiety without improving outcomes.

Many survey respondents and interviewees supported moving the 15-month contact to 18 months. At this age, developmental patterns are clearer, assessment tools are more valid, and alignment with referral criteria for speech and language therapy and neurodevelopmental services is improved:

> “At 18 months you can be much clearer about walking, speech and behaviour.”

There was also concern about the length of time between the 15- and 27-month contacts, which was described by health visitors and stakeholders as another period of rapid developmental change. This was seen as increasing the risk that emerging additional needs, particularly in relation to communication, behaviour and neurodiversity, may be identified later than was optimal.

5.4.6. 27-month contact

Twenty per cent of survey respondents who provided additional comments on contact timing (30 of 152) raised concerns about this contact, most commonly in relation to the long gap between the 15- and 27-month reviews. The 27-month review was widely regarded by health visitors as an important opportunity to identify emerging developmental needs, especially in relation to speech, language and neurodevelopment. Health visitors emphasised that developmental concerns often become clearer by this age:

> “Concerns are much clearer by twenty-seven months, especially speech and language.”

However, many felt that the long gap from 15 months reduces impact, with children potentially missing timely intervention. Health visitors described this as a period of rapid developmental change, during which emerging needs or regression may occur without routine professional oversight. Health visitors reported that families also perceived this gap

as problematic, often commenting that they had not seen a health visitor for a long time, with some families described as “falling off the radar”.

Some speech and language therapists were explicit about the developmental limitations of the gap between 15 and 27 months. They described this period as critical for language development and in one health board they highlighted the introduction of a locally commissioned 18-month Talk with Me contact as a timely and effective response. This was viewed as improving confidence in identifying children requiring support.

Across the evidence, there was support among health visitors and stakeholders for adjusting the timing of the 27-month contact. Suggested approaches included moving the review to 24 months, adopting a flexible window between 2 and 2.5 years, or introducing an additional interim contact between 15 and 27 months for families with greater need. Finally, health visitors noted that while the 27-month contact is often delegated to band 4 or 5 staff, its clinical value depends on sufficient time, skill and continuity to explore developmental concerns and support families effectively.

5.4.7. 3.5-year contact

Across survey responses and qualitative interviews with health visitors and stakeholders, there was strong consensus that the 3.5-year contact is one of the least effective contacts. Over half of survey respondents to the relevant open-ended question (47 of 91) stated that the contact was not needed.

Health visitors widely reported that by 3.5 years most children are already attending nursery or school and are under regular observation by early years or education professionals. The contact was also seen by health visitors as duplicating other routine interactions. In many areas, children attend clinic appointments for immunisations around 3 years, and those in early years settings are routinely monitored through established education and referral pathways. As a result, the 3.5-year visit was viewed as adding limited value for families without known vulnerabilities, with parents sometimes questioning its purpose. One health visitor noted that parents often ask, “Why are you here now?”

A further concern was that the 3.5-year contact occurred too late to meaningfully influence ‘school readiness’. Health visitors reported that issues such as speech and language development, behaviour, toileting and readiness for education often require earlier intervention to allow time for parental support and onward referral. In areas where children start school at 3, the contact may take place after school entry, reducing its relevance and creating uncertainty around responsibility for monitoring and transition between health visiting and school nursing services.

The contact was also consistently described as difficult to deliver. Health visitors highlighted that parents are often back in work and children attend nursery or school during standard working hours, resulting in high levels of non-attendance. Contacts are therefore frequently completed by telephone or missed altogether, requiring repeated attempts to arrange visits and representing an inefficient use of workforce capacity.

> “Parents are back at work and children are in nursery - it’s really hard to pin them down.”

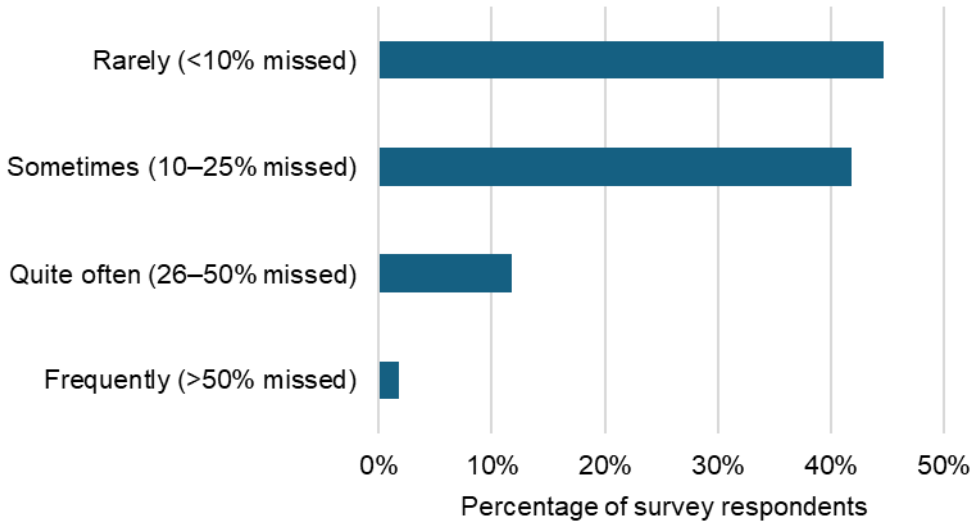
Reflecting these challenges, health visitors reported that the 3.5-year contact is increasingly delegated to band 4 or 5 staff in many areas. While seen as a pragmatic response to workload pressures, this was also interpreted by some as further evidence that the contact does not warrant a universal, face-to-face health visitor review.

Rather than retaining the current universal model, many health visitors supported a more targeted and flexible approach. Suggestions included limiting the contact to children not attending early years settings, those who had missed previous reviews or immunisations, or families with known vulnerabilities. Alternative models, such as clinic-based reviews, initial telephone or letter contact with face-to-face follow-up as required, and clearer handover arrangements to school nursing services, were widely supported. Improved alignment with local school entry patterns and clearer transition processes were also seen as essential to maintaining continuity of support.

5.4.8. Reasons for missing contacts

Many survey respondents reported that families either rarely (45%) or only sometimes (42%) miss or decline HCWP contacts. Few reported that families either miss or decline appointments quite often (12%) or frequently (2%).

Figure 5.5: Percentage of survey respondents who reported that families miss or decline HCWP contacts in their area



Description of figure: A bar chart showing that many survey respondents reported that families rarely or only sometimes miss or decline HCWP contacts.

Source: OB3 Research health visiting staff survey, November to December 2025, n=289.

Survey respondents reported that families rarely or sometimes miss or decline HCWP contacts, with relatively few reporting frequent non-attendance. Patterns varied by health

board and caseload type, though overall findings suggest that missed contacts are not driven by widespread disengagement from health visiting services.

Health visiting survey respondents identified practical constraints as the primary reasons for missed contacts. Parents' work commitments and general unavailability were the most commonly cited factors, particularly for later contacts once parents return to work and children attend nursery or school. This was most evident for the 3.5-year contact, which respondents reported families are less willing or able to prioritise in the absence of developmental concerns.

> "It's not that families don't value it - life is just busy."

Forgetting appointments was also frequently reported by health visiting staff, typically linked to appointments being scheduled far in advance and competing family commitments. Respondents emphasised that this rarely reflects intentional non-engagement, noting that families are usually willing to rebook, suggesting opportunities to improve reminder systems and appointment design.

> "Parents often say they'd like a text reminder on the day."

Perceived lack of need was more commonly associated with families with older children, previous parenting experience, or children already supported through education or childcare settings. Health visitors reported that some parents do not clearly understand the purpose or value of later reviews, particularly where contact intervals are long.

A smaller proportion of respondents identified non-engagement, including repeated non-attendance or difficulty maintaining contact. Interview evidence indicates that this more frequently affects families experiencing mental health difficulties, safeguarding concerns, language or cultural barriers, or highly transient circumstances.

Interviewed health visitors described missed contacts as an ongoing operational challenge, particularly during periods of workforce pressure. Later contacts, especially the 3.5-year review, were most vulnerable to being dropped for lower-risk families.

> "If there are no concerns and the child is in school, parents don't always see the point."

Health visitors reported that managing non-attendance is resource intensive, with traditional follow-up methods such as letters seen as largely ineffective. Services are increasingly using text messaging and follow-up calls, alongside risk stratification, to prioritise active follow-up for higher-need families while offering more flexible alternatives for those assessed as lower risk.

5.4.9. Innovative approaches

The evidence gathered through interviews with health visitors highlighted a range of innovative approaches being used locally to improve engagement, and efficiency.

A key theme is the use of skill mix and role redesign. Universal and practical contacts, such as weaning, toileting, and breastfeeding support, are increasingly delivered by band 5 staff

and community nursery nurses, allowing health visitors to concentrate on safeguarding, complex need, and enhanced or intensive support. This approach was viewed as beneficial for workload management and for ensuring professional expertise is used where it adds most value.

> “Using band-5 staff and nursery nurses for universal contacts frees health visitors to focus on safeguarding.”

Delivering the 16-week weaning contact earlier was seen by some health visitors as timelier and more relevant, as it reaches families before many begin weaning and supports behaviour change rather than retrospective advice.

> “The weaning groups have been really popular.”

> “The QR code makes it easier for parents to sign up.”

Group-based approaches featured prominently, including antenatal workshops, peer-focused groups (such as those for young mothers), and postnatal mental health support groups developed in response to gaps in specialist provision. Local weaning and toileting groups, supported by simple booking tools such as QR codes, were also described as improving accessibility and uptake. These were viewed as effective for increasing engagement, normalising support, and making efficient use of staff time, while recognising that they cannot fully replace one-to-one contacts where sensitive or complex information needs to be gathered.

> “Workshops and groups give practical, timely support and really increase engagement.”

Health visitors also described flexible and opportunistic delivery models. These included splitting content across multiple visits, adding short follow-ups after birth, using clinic-based “check-ins” for very low-risk children, and offering early-morning, late-afternoon, or weekend appointments to accommodate working families. In some areas, Saturday “catch-up clinics” were used to address backlogs in routine contacts, particularly at 15 and 27 months.

> “Saturday catch-up clinics have really helped us get back on track.”

Closer integration with other services was another important enabler of effective practice. Where health visitors were co-located with social workers or maintained strong informal links with local services, safeguarding conversations improved as a result and also reduced duplication. Joint visits with parent support workers or nursery nurses were also described as improving engagement and smoothing transitions between services. Finally, simple communication tools, particularly text messaging, were highlighted as an effective way to keep universal contacts on track.

6. Programme delivery - integration

6.1. Introduction

This chapter examines the delivery and impact of enhanced or additional contacts through Flying Start, transitions between services, and multi-agency working. It explores the effectiveness of communication and handover processes between midwifery, health visiting, and school nursing teams, as well as the role of wider partner agencies, including enhanced Flying Start provision, in supporting families. Evidence is presented to highlight both strengths and challenges within these aspects of the HCWP, with attention to practical, structural, and workforce-related factors that influence outcomes for children and families.

6.2. Overview of HCWP enhanced or additional contacts

In addition to the 9 core universal contacts specified in HCWP (from 10 to 14 days to 3.5 years), there are enhanced or additional contacts that fall outside this baseline offer, either through programme variation or for families with additional needs.

The antenatal contact is an early engagement opportunity offered by the health visiting service during pregnancy, particularly for families with identified vulnerabilities or additional needs. Although not routinely captured in national HCWP reporting data, health visitor-led antenatal contacts occur in some local settings.

Following notification of a new birth, families may receive an initial birth contact from the health visiting service. The timing and format of the birth contact may vary according to family need and local arrangements, and it may be delivered face to face or remotely. It is distinct from the universal 10 to 14-day contact, which represents the first full HCWP review.

In designated Flying Start areas, the core HCWP contacts are supplemented by additional health visiting contacts, including visits in late pregnancy (around 24+ weeks gestation), earlier postnatal visits (at 3, 4 and 5 weeks), and extra contacts in the first 2 years (such as at 10 months and 21 months). These enhanced contacts are offered specifically to families in Flying Start areas to provide more frequent support and monitoring in areas of relative disadvantage.

HCWP also encompasses contacts that are coordinated with other services, such as immunisation clinics and community child health clinics, and may involve health visitors, GPs, community nursery nurses, or other practitioners depending on the nature of the contact and local delivery arrangements.

In 2024, Welsh Government published a new HCWP for school-aged children that extends the universal programme of structured health contacts into compulsory school age (5 to 16 years) and formalises the transition from health visiting to school nursing services. Under this model, the school entry health review at age 5 is delivered by the school nursing service, marking the point at which responsibility for universal child health contacts transfers from health visitors to school nurses.

6.3. International comparison

In England and Northern Ireland, health visitors and school nurses form the core workforce, supported by GPs, allied health professionals, and children's centre staff. This broadly aligns with HCWP's use of health visitors as the primary point of contact. Similarly, Scotland designates health visitors as named persons for every child, reflecting a more formalised role for universal oversight. By contrast, in Denmark, scheduled health assessments are conducted primarily by GPs, with community nurses providing parallel home visits, creating coordination challenges between two overlapping systems. Sweden, Finland, and Norway deploy regional or municipal centres with multidisciplinary teams, including nurses, doctors, physiotherapists, psychologists, and speech and language therapists, offering higher integration and broader expertise than is typical within the HCWP.

New Zealand uses a more fragmented model, with different agencies delivering maternity, immunisation, oral health, and before-school checks. Unlike HCWP, which provides a coherent, centrally guided schedule, New Zealand relies on multiple contractors with limited integration, highlighting the risks of siloed services and weak transitions between stages of care.

A consistent feature across most countries is the emphasis on inter-professional collaboration and links with early years, education, and social care. Scotland's Getting It Right For Every Child (GIRFEC) framework and Finland/Norway's municipal health centres both mandate joint planning, shared referrals, and cross-sector working to ensure early prevention and intervention. Denmark and Sweden also rely on structured pathways and joint case conferences for complex cases. While HCWP encourages links between health, social care, and education, the level of formal integration and mandatory data-sharing observed in these Nordic countries is generally stronger, particularly in monitoring vulnerable families.

New Zealand, by contrast, illustrates the challenges of integration when multiple agencies operate independently. Fragmentation limits seamless transitions, highlighting the importance of formal coordination mechanisms, as found in HCWP and the Nordic models.

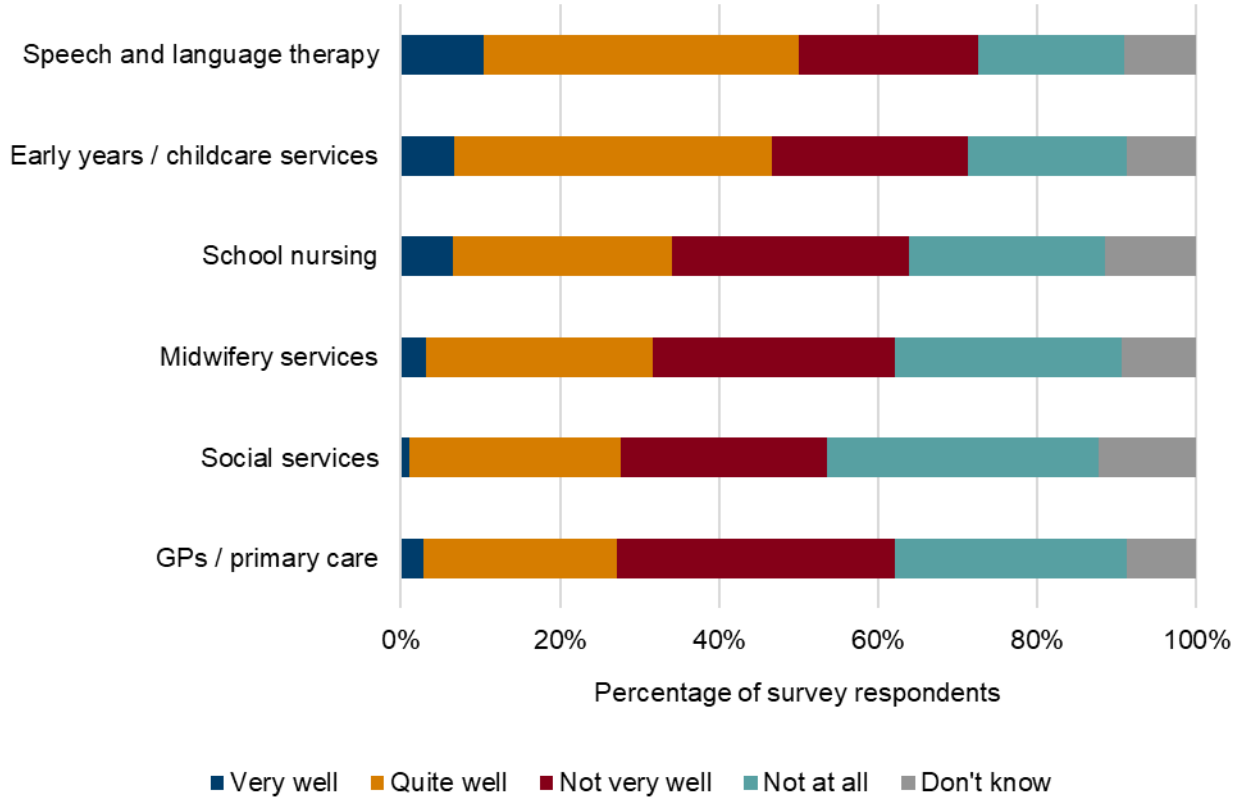
Scotland emphasises home-based delivery, reflecting a proactive approach to family engagement. Denmark, Sweden, and Finland combine clinic- and home-based services, often reserving multidisciplinary home visits for complex families. England and Northern Ireland use a mix of home and clinic delivery, with flexibility for targeted interventions. HCWP shares this hybrid approach, though the international evidence suggests that highly integrated home-based teams may better support early intervention and safeguarding.

6.4. Review findings

Survey respondents expressed more positive views about the links between the HCWP and some services compared to other services. However, no more than half of respondents felt that the HCWP linked very or quite well with any single service. Respondents were most positive about the links with speech and language therapy, with half reporting that the HCWP links very well (10%) or quite well (40%) with this service. They were least positive

about the link between HCWP and GPs / primary care, with the majority reporting the HCWP did not link very well (35%) or at all (29%) with this service.

Figure 6.1: Percentage of survey respondents who reported that the HCWP linked well with each other service



Description of figure: A stacked bar chart showing that survey respondents expressed very mixed views about how well HCWP links with other services. The chart shows they were most positive about the links with speech and language therapy and least positive about the links with GPs / primary care.

Source: OB3 Research health visiting staff survey, November to December 2025, n=288, 285, 288, 287, 286, 287 respectively for each service.

6.4.1. Antenatal contact

Across interviews, the antenatal contact was consistently described as one of the most valuable components of the HCWP, supporting early relationship-building and identifying vulnerabilities before they became entrenched. Health visitors highlighted that prior knowledge of families allows postnatal visits to be more focused and effective, building on existing understanding rather than starting from scratch. Pregnancy was described as a key transition period when families are often more receptive to advice and capable of reflecting on behaviour change.

Health visitors emphasised the antenatal contact as a preventative, relational intervention, not solely a mechanism for risk identification. Many observed that every pregnancy warrants contact, normalising early support and reducing reliance on crisis-driven interventions after

birth. Flying Start staff strongly supported a universal offer, viewing it as an important opportunity to engage families who might otherwise be less likely to seek help:

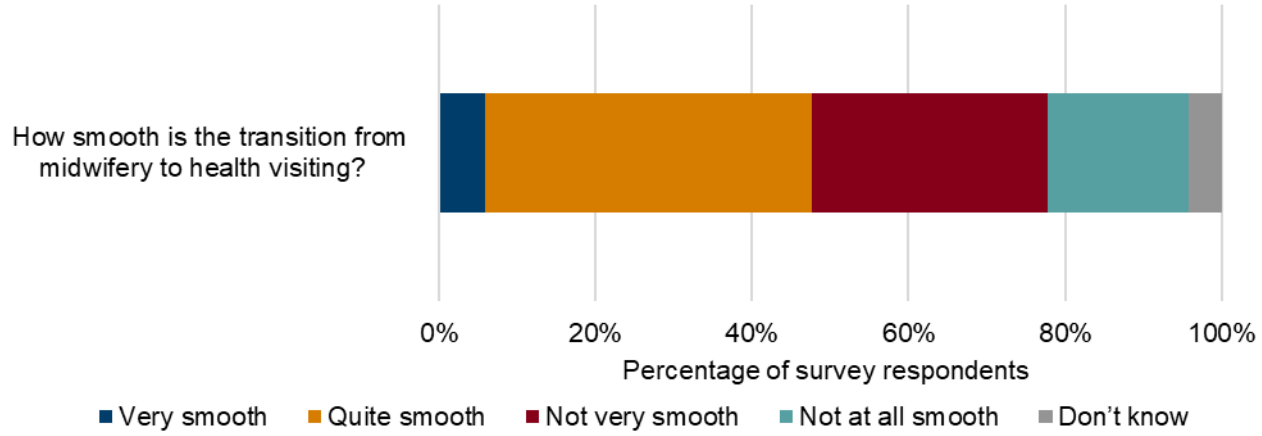
> "The antenatal contact - I think that would be a really useful universal contact as opposed to a targeted one."

Despite broad agreement on its value, antenatal contact was reported as inconsistently delivered with access often constrained by staffing pressures or eligibility criteria, with some areas limiting provision to targeted families. Reduced co-location and limited presence in GP surgeries were said to restrict informal information-sharing and routine antenatal work. While antenatal contact is widely valued, participants acknowledged that it is particularly vulnerable to displacement when workforce capacity is constrained, meaning its preventative potential is not realised consistently across Wales.

6.4.2. Midwifery to health visitor transition

Around half of survey respondents felt that the transition between midwifery and health visiting is either very smooth (6%) or quite smooth (42%) as shown in Figure 6.2 below.

Figure 6.2: Percentage of survey respondents who reported that the transition between midwifery and health visiting is smooth



Description of figure: A stacked bar chart showing that around half of respondents were broadly positive about the transition between midwifery and health visiting.

Source: OB3 Research health visiting staff survey, November to December 2025, n=289.

Feedback from the survey and interviews consistently highlighted that smooth transitions rely on strong professional relationships. Where health visitors and midwives had named links, established rapport, or worked in the same locality, transitions were described as proactive, with timely sharing of information and identification of vulnerabilities.

> "The midwife that I link to regularly updates me on her caseload and I update her on any older siblings… with any concerns."

Co-location was reported as particularly valuable for safeguarding and complex cases, reducing reliance on delayed documentation and facilitating informal discussions. Where

physical proximity was not possible, structured meetings - monthly or quarterly - helped maintain continuity and prevent missed contacts.

> “We have monthly midwifery liaison; this is extremely helpful and necessary.”

In one health board, both midwifery and health visiting sit within the same directorate, which was seen to facilitate collaboration and accountability. Structured processes, including Sharing Information in Pregnancy (SIP) notifications, ensured that health visitors were informed when a woman was booked with midwifery services and alerted to potential vulnerabilities. These formal mechanisms were reinforced by regular verbal handovers, typically every 6 weeks, which participants felt helped to identify and support families at higher risk.

In contrast, inconsistent handovers were a common concern, especially where transitions depended solely on birth notifications. Health visitors described starting postnatal care “on the back foot,” with absent or delayed SIP forms, discharge summaries, or antenatal booking information, increasing workload and emotional strain. Critical information, including perinatal mental health issues, traumatic births, safeguarding concerns, or neonatal complications, was sometimes only learned from parents.

> “Recently contacted an antenatal contact who had lost baby at 23 weeks…very upsetting incident for both parents and myself.”

> “Very rarely informed of pregnancy even if there has been safeguarding issues.”

The use of different, non-integrated IT systems, alongside limited or conditional access to maternity records was also raised by survey respondents as a structural barrier to safe and timely information sharing.

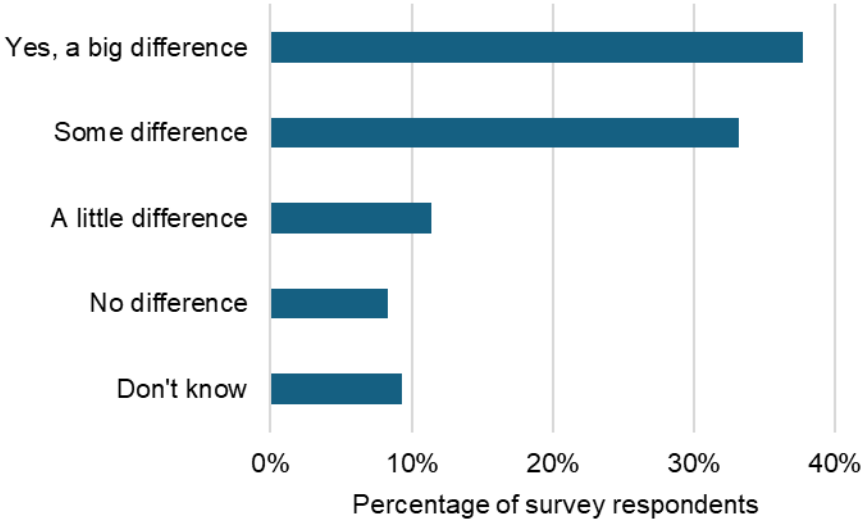
> “We are operating on completely different systems of the records.”

Several respondents described how overlapping visits and advice, for example around feeding, safe sleep, or weight monitoring, particularly around the 10 to 14-day period, can cause anxiety for parents and be inefficient for services. Health visitors noted that challenges also remain where families receive care across health board boundaries, particularly with neighbouring boards, where information sharing was described as less reliable.

6.4.3. Flying Start and enhanced contacts

Many survey respondents felt that the additional health visiting services provided through Flying Start make either a big difference (38%) or some difference (33%) for families. Few felt that they make only a little difference (11%) or no difference (8%).

Figure 6.3: Percentage of survey respondents who felt that the additional health visiting services through Flying Start make a difference to families

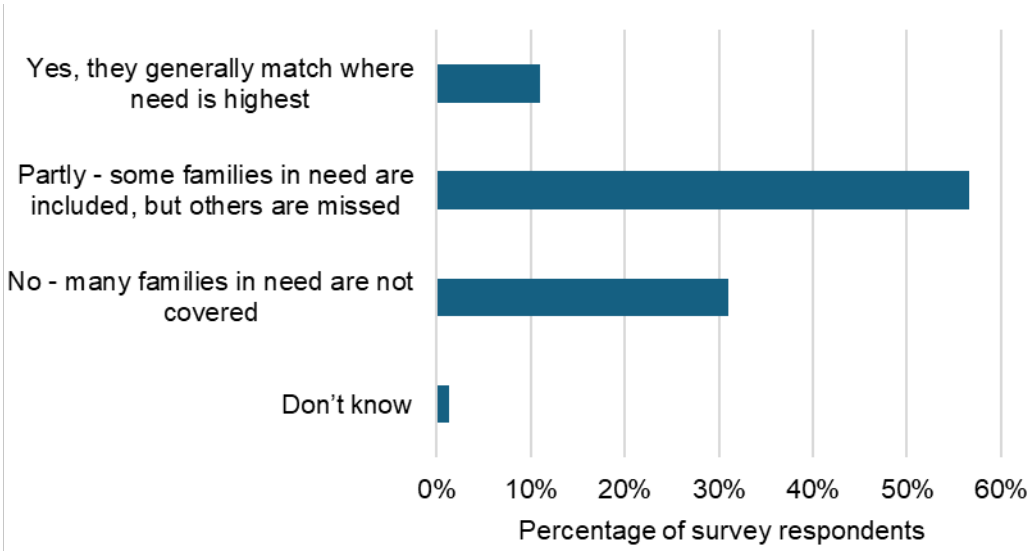


Description of figure: A bar chart showing that many survey respondents felt that the additional health visiting services provided through Flying Start make either a big difference or some difference to families.

Source: OB3 Research health visiting staff survey, November to December 2025, n=289.

Based on their experience, survey respondents did not generally feel that additional support provided through Flying Start fully targets the right families. Few (11%) felt that the support generally matches where need is highest, while around half (57%) felt that the support partly targets the right families (some families in need are included but others are missed) and a minority (31%) felt that many families in need are not covered. There was also a difference in views between those with generic caseloads and those with Flying Start caseloads. Those with Flying Start caseloads reported more frequently than those with generic caseloads that support was targeting the right families.

Figure 6.4: Percentage of survey respondents who felt that additional support provided through Flying Start is targeted at the right families



Description of figure: A bar chart showing that many survey respondents either feel that the additional support provided through Flying Start either doesn't target many families in need or targets some families in need but misses others.

Source: OB3 Research health visiting staff survey, November to December 2025, n=290.

When asked how decisions should be made about which families receive additional support (like that offered in Flying Start), survey respondents primarily expressed two main opinions:

- half (50%) felt that decisions should be based on both area (geography) based on deprivation indices and on individual family circumstances (need-based)
- a similar proportion (47%) felt that decisions should be based wholly on individual family circumstances (need-based)
- very few (2%) felt that decisions should be based on area (geography) alone, or other criteria (2%).

Health visitors consistently highlighted the benefits of Flying Start. Smaller caseloads and additional contacts allow health visitors to build stronger relationships, detect emerging needs sooner, and tailor support to families. Specific assessments, including the WellComm speech and language toolkit and the 9 to 12 and 21-month reviews, were credited with earlier identification of developmental or safeguarding concerns. Families in Flying Start areas were also thought to be able to access childcare, speech and language therapy, mental health support, and parenting programmes more quickly than in universal areas. Health visitors reported positive engagement, particularly with higher-need families.

> "Increased HV support and developmental reviews can identify delays or safeguarding concerns sooner."

> "Generally, I get excellent engagement with families as they build a relationship… and feel able to disclose sensitive information."

However, health visitors reported variation in delivery. Staff shortages, reduced parenting and speech and language therapy support, and expansion without proportional capacity were all said to have led some Flying Start areas to resemble universal practice, with childcare often being the primary visible benefit. Several survey respondents raised concerns about postcode-based eligibility, which excluded high-need families outside Flying Start areas and included some less deprived areas, creating inequities.

Flying Start was consistently described by health visitors as enabling closer integration and coordination across health visitors, nursery nurses, midwives, GPs, and community teams, with more frequent information sharing and joint working. In contrast, universal areas often relied on formal referrals rather than shared systems or regular contact. Health visitors noted that families frequently perceive these differences, which can create frustration and pressure to explain why services differ by postcode.

> “Parents are aware that friends or relatives nearby may receive additional contacts or support.”

Speech and language therapists emphasised the value of Flying Start for early identification of speech, language and communication needs, noting that health visitors’ trusted relationships are pivotal in triggering timely intervention.

Strategic leads and Welsh Government stakeholders also supported a move towards needs-led provision, maintaining HCWP’s universal contacts as the backbone of progressive universalism while enabling Flying Start-style additional support based on professional assessment, shared data, and team-around-the-family working. This was seen as better able to reach families with the greatest needs, including those least likely to attend routine contacts.

Vulnerable groups identified across interviews and survey feedback included asylum-seeking and refugee families, transient or mobile families, children outside mainstream schools, children looked after, and children experiencing trauma. Health visitors and speech and language therapists reported that frequent relocations, temporary accommodation, delayed GP registration, language barriers, and unfamiliarity with the UK system can disrupt continuity of care and scheduled contacts.

> “There’s pockets of families that are going to struggle more to engage… whereas if they were moved into [another area], it’s all there, up and running and well-established.”

6.4.4. Multi-agency referrals and integration with HCWP

During interviews, health visitors, paediatricians, speech and language therapists, GPs, and early years leaders widely described the HCWP as a central component of the early years system, linking with Flying Start, Families First, neurodiversity pathways, immunisation, oral health, and early years integration initiatives. While this integration was viewed as a strength, stakeholders cautioned that the proliferation of overlapping programmes has increased complexity, creating uncertainty around roles, responsibilities, and referral thresholds. Welsh Government stakeholders emphasised that any redesign of HCWP

contacts must be co-produced with adjacent services to avoid unintended consequences for programmes that rely on HCWP as an entry point.

Across professional groups, HCWP was perceived as effective at identifying need but less effective at sustaining multi-agency engagement once referrals are made. Referrals were frequently described by paediatricians as “static,” with limited feedback or dialogue while families wait for assessment or intervention. Paediatricians highlighted the risks of this approach during early childhood, when development can change rapidly.

> “A child on our list only means a child is on our list. It doesn’t mean that we’re doing anything with this family.”

Health visitors echoed these concerns, noting that referral systems often rely on personal relationships rather than consistent processes. Partnerships with speech and language therapists, community paediatrics, safeguarding officers, and GPs were considered strongest where teams were co-located or had shared governance structures, such as in parts of Merthyr Tydfil, and weakest where services were dispersed across organisations and digital systems. Several health visitors reflected on the loss of informal communication since moving away from being located at GP practices.

> “There is no handover now… we used to meet and chat about children.”

Health visitors also highlighted the need to complete multiple referral forms for different services, often repeating information, with little visibility of outcomes. Speech and language therapists highlighted receiving high volumes of poor-quality or inappropriate referrals, sometimes driven by professional anxiety rather than clinical need. The lack of information sharing was consistently raised as a fundamental barrier. GPs described having no access to health visiting records, calling the situation “very bad” and incompatible with modern care.

> “It’s absolutely bonkers… that we can’t do this.”

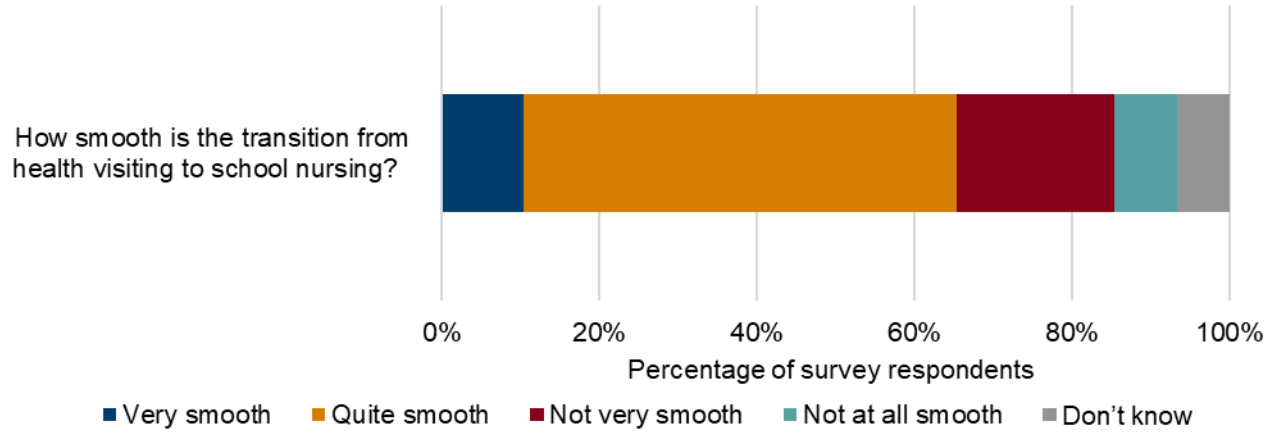
Although initiatives such as Connecting Care offer promise, participants across professional groups agreed that progress is limited by differing organisational accountabilities and legacy systems. Without shared records or agreed communication standards, collaboration remains fragile and inconsistent.

Despite these challenges, there was broad agreement on the way forward. Stakeholders from all sectors called for a shift from informal, personality-dependent collaboration to structured, standardised pathways supported by digital infrastructure and clear accountability. Proposed solutions included single digital referral systems, clearer parent-facing explanations of HCWP contacts, stronger alignment between health, education, and local authority processes, and greater use of community and third-sector provision to meet social and developmental needs without defaulting to medical referral. Without these changes, participants felt multi-agency working around HCWP was likely to remain inconsistent, leaving gaps that directly affect children and families.

6.4.5. Transition from health visiting to school nursing

Despite the fairly negative views on the links between the HCWP and school nursing outlined in Figure 6.1, the majority of survey respondents felt that the transition between health visiting and school nursing is either very smooth (10%) or quite smooth (55%). Those with a generic health visiting caseload were also more positive than those with Flying Start caseloads about the transition between health visiting and school nursing, though this difference was less pronounced.

Figure 6.5: Percentage of survey respondents who reported that the transition between health visiting and school nursing is smooth



Description of figure: A stacked bar chart showing that the majority of survey respondents were broadly positive about the transition between health visiting and school.

Source: OB3 Research health visiting staff survey, November to December 2025, n=287.

Survey respondents and interviewees consistently described the transition from health visiting to school nursing as pivotal but currently inconsistent across Wales. Health visitors emphasised that co-location or established working relationships with school nursing teams improved transitions, allowing faster resolution of issues and informal case discussions. Termly or seasonal handovers, particularly ahead of school intake, and face-to-face meetings for higher-need children were also reported as effective.

> "I always arrange a face-to-face handover with the school nurse in August for the children transferring to school."

When structured forms and processes, such as the Child Health Summary Sheet or School Handover Sheets, were in place and supported by shared administrative staff, information transfer was described as smoother.

> "Our admin works across the health visiting and school nursing team - this ensures a smooth transition."

However, survey respondents and interviewed health visitors reported several challenges where transitions were less effective. School nursing teams were thought to prioritise safeguarding cases and deprioritise children with ALN, ongoing health needs, or complex

family circumstances, creating a “cliff-edge” from intensive universal health visiting support to minimal school nursing engagement.

> “It feels like they have an intensive service from health visitors and then have nothing after the age of 5.”

Difficulties were also noted in identifying the correct school nurse, accessing up-to-date contact details, and confirming that handovers had been received or reviewed. Capacity pressures, including high caseloads and understaffing, were frequently cited as limiting school nurses’ ability to engage with handovers, adding administrative and emotional burdens on health visitors.

Timing of handovers was another recurring concern. Survey respondents and interviewed health visitors highlighted three main issues:

- a long gap between the last health visiting contact (typically the 3.5-year review) and school entry, leaving information outdated
- handover information requested at the end of a school year or the term before school start, which can sometimes be months after the last contact
- variation across health boards and between Flying Start and universal areas regarding when handover should occur, creating confusion for families and practitioners.

Formal handovers were generally perceived as effective for children with identified or complex needs, with written reports supplemented by verbal discussion, but transitions for children with lower levels of need were often minimal or invisible. Health visitors suggested that a brief follow-up at school entry could bridge gaps, particularly for issues like continence or emerging developmental concerns.

> “Problems such as delayed potty training or constipation can develop between the 3.5-year review and school entry, with no routine mechanism for identifying or addressing them.”

GPs reinforced these concerns, describing the erosion of the traditional school nursing role as a loss to the early years system. They emphasised that practical developmental issues, such as continence, are increasingly presenting to secondary care, whereas earlier intervention through integrated community support could prevent escalation.

> “If you don’t put incontinence advisors in early, it becomes a lifelong problem… we see children at 11 who are still soiling.”

7. Programme delivery - digital infrastructure, data and information

7.1. Introduction

This chapter outlines the data capture and reporting arrangements currently in place across the HCWP. It then presents findings from the literature review on the digital infrastructure and data arrangements used in other child health programmes. The chapter goes on to examine how HCWP contacts are recorded and reported, including levels of confidence in, and accountability for, these processes. Finally, it considers the value of HCWP data and reporting for health visitors, the challenges associated with data capture and reporting and summarises suggestions for improving and strengthening HCWP data quality and reporting.

7.2. Overview of HCWP data capturing and reporting

The HCWP is supported by a Quality Assurance Framework that sets out clinical governance, workforce, training and supervision requirements and the mechanisms for local monitoring and improvement. The programme relies on the National Community Child Health Database (NCCHD) and local child health systems to schedule contacts and capture standardised data.

HCWP data capturing and reporting requirements were set out at the outset of the programme in the data standards change notice. This stipulates that data should be recorded manually by health visitors using a standardised data collection form and entered into the child health system by child health clerical staff.

The programme's data capturing and reporting is supported by the child health system Children and Young Persons Integrated System (CYPrIS), managed by DHCW, which enables health boards to schedule health visiting contacts. The data entered within the child health system is retained within the NCCHD, also managed by DHCW. Data is extracted from the NCCHD on a quarterly and annual basis and shared with the Welsh Government, who monitor data quality and completeness. The data is then published as reports on StatsWales.

7.3. International comparison

Digital infrastructure is widely recognised as a critical enabler of effective child health surveillance, supporting continuity of care, developmental monitoring, and integration across services. Across the countries reviewed, systems vary considerably in maturity, reflecting differences in governance, professional roles, and historical development. A recurring theme is the distinction between systems designed primarily for statutory reporting versus those actively supporting clinical decision-making and multidisciplinary coordination. Where data are primarily used for accountability, as in parts of England, Northern Ireland, and New Zealand, their utility for frontline practitioners is limited, creating inefficiencies and requiring families to repeat information. Conversely, Finland's municipal model illustrates how shared organisational systems can facilitate joint assessments and integrated care, embedding digital records into routine practice rather than using them solely for reporting.

Within the UK, HCWP's current digital infrastructure appears similar to that in England and Scotland: structured national systems exist (e.g., CHIS in England; CHSP-PS in Scotland), capturing mandated health visiting contacts and outcomes, but real-time sharing across professionals remains inconsistent. Northern Ireland's new Healthy Child, Healthy Future programme faces comparable limitations, with population-level reporting more robust than integrated case management. Across these systems, operational fragmentation, different electronic platforms across health visiting, school nursing, primary care, and social services, echoes the challenges seen in Wales, where interoperability gaps reduce the potential for timely, multi-agency action.

In Nordic countries, digital infrastructure tends to be more embedded, though practical integration varies. Denmark's National Child Health Register and Norway's legally mandated electronic records enable comprehensive national monitoring, yet "firewalls" between service records constrain real-time collaboration. Sweden demonstrates similar patterns: strong local capture but limited cross-regional interoperability. These experiences highlight that high-quality national data alone does not ensure day-to-day integration operational connectivity, shared protocols, and professional engagement are equally important. By contrast, New Zealand's fragmented digital environment underscores the risks of multiple unlinked systems, with families and practitioners facing repeated data entry and delayed communication. For HCWP, these international lessons emphasise the need for digital solutions that support both reporting and practical coordination, enabling consistent, real-time information sharing across health visitors, school nurses, GPs, and allied services.

7.4. Review findings

7.4.1. How HCWP contacts are recorded

Interviews with health visitors indicated that HCWP data collection remains largely paper-based across most health boards. In some areas, health visitors use locally developed electronic versions of paper forms, although practice was described as inconsistent, including within the same health board. In most health boards, health visitors reported completing HCWP forms after each contact and sharing them with child health administrative teams for entry onto CYPrIS, via email, scanned documents or physical paperwork.

> "The preferred method is to e-mail, but we've still got some paper, and I just do mine in on paper."

In contrast, health visitors at one health board reported recording HCWP contacts directly into a local digital system (PaRIS), with child health administrators manually extracting and entering data into CYPrIS.

Responsibility for entering data onto CYPrIS varied across health boards. Health visitors reported that in some areas this is undertaken by administrative teams, while in others health visitors enter data themselves. In one area, the responsibility for entering data onto CYPrIS had shifted recently from administrative staff to heath visitors. In some cases, health visitors had read-only access to CYPrIS. Health visiting managers consistently described

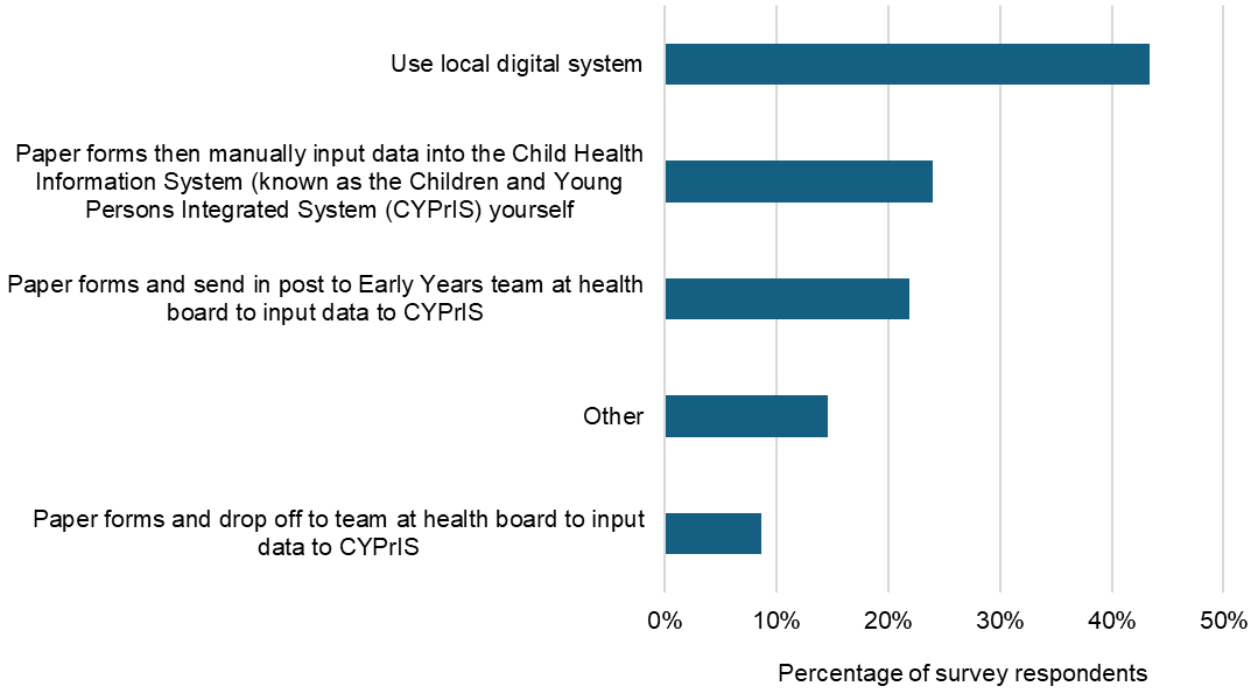
the need for manual checking, data cleaning and triangulation to ensure accuracy, including returning incomplete forms or issuing regular lists of missing data to health visitors.

Health visitors and leads also described the use of multiple parallel systems alongside CYPrIS, including the Welsh Community Care Information System (WCCIS), PaRIS and local tools such as the Integrated Birth Book. In some areas, separate paper files (for example, 'purple paper files') were still in use, although these had largely been phased out where WCCIS was adopted. Health visitors working in Flying Start areas also reported additional reporting requirements through Flying Start systems (referred to in one area as the Tribal reporting tool).

Contributors consistently highlighted that CYPrIS is not integrated with these systems, resulting in duplicate or triplicate data entry, often alongside recording information in the child's personal 'red book' to meet multiple reporting requirements.

The findings from the survey of health visitors, set out at Figure 7.1, reinforces this mixed and complex approach to recording HCWP contacts. Survey respondents mostly reported using a local digital system to record HCWP contacts (43% of respondents). A minority (24%) reported using paper forms then manually input data into CYPrIS, while a minority (22%) also reported using paper forms which they then send in the post to the early years team at the health board to input into CYPrIS. Very few (9%) reported completing paper forms which they then drop off at the health board to input into CYPrIS.

Figure 7.1: Percentage of survey respondents who reported different methods of recording HCWP contacts



Description of figure: A bar chart showing that survey respondents most commonly use a local digital system to record HCWP contacts, while the majority of other respondents'

complete paper forms which they either input themselves into CYPrIS or post or drop off with early years colleagues.

Source: OB3 Research health visiting staff survey, November to December 2025, n=288.

7.4.2. Confidence and accountability of data reported

Health visitor confidence in the accuracy of nationally reported HCWP data varied across health boards. Health visitors at a health board operating a fully digital system reported the highest confidence, noting that its system (PaRIS) requires authorised entries and transfers data directly into CYPrIS for national reporting. Health visitors at 2 health boards reported moderate confidence, which they attributed to recent improvements in local data reporting processes. In contrast, most other health boards expressed more limited confidence, particularly those relying on paper forms and manual data entry with minimal validation.

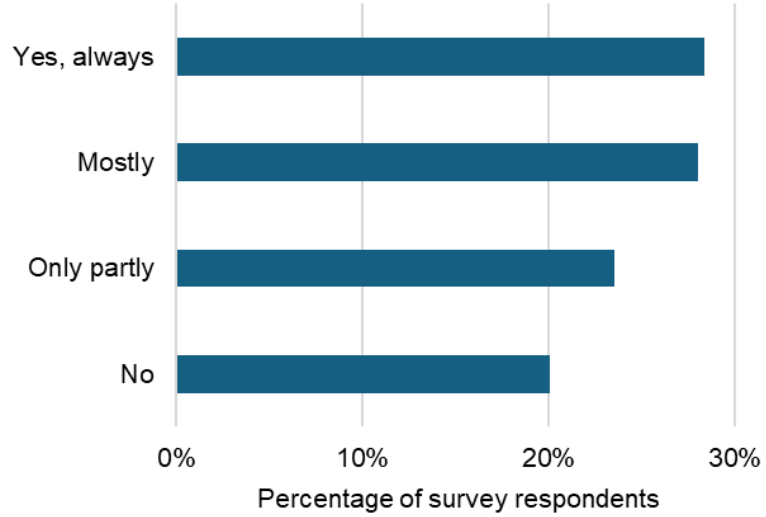
Contributors in these areas reported that national data often under-represents activity, for example: “It’s showing far less than what we are achieving”. In one health board, manual checks indicated completion rates close to 100%, substantially higher than those reflected in national data. Another health board described a recent shift to sharing forms with child health administrative teams by email in an attempt to address persistently low reported completion rates.

Despite these concerns, health visitors and leads described a strong shared sense of accountability for HCWP performance and a high level of professional commitment to meeting national expectations. Health visitors at one health board reported increased local scrutiny of HCWP delivery following a Welsh Government request to improve performance. Suggestions for strengthening accountability included clearer feedback on how Welsh Government and national bodies use reported data, and national reporting that better reflects local delivery contexts, such as rurality, staffing pressures and legitimate reasons for missed contacts.

Health visitors consistently reported that they were clear about HCWP requirements, particularly which core contacts must be completed and recorded, and described the schedule as embedded in everyday practice. However, contributors were less certain about expectations relating to targeted or additional support, noting that guidance on when to offer extra contacts, how these should be recorded, and how they contribute to performance reporting is less clear and open to local interpretation.

In contrast, there was less consensus amongst survey respondents about whether the data they record accurately reflects their activity with families, as shown at Figure 7.2. A fairly equal proportion of survey respondents felt that the data always reflect their activity (28%), mostly reflect their activity (28%), only partly reflect their activity (24%) or do not reflect their activity (20%).

Figure 7.2: Percentage of survey respondents who felt that the data they record accurately records their activity with families



Description of figure: A bar chart showing that survey respondents had very mixed views about the extent to which the data they record accurately reflects their activity with families, with similar proportions stating that it always, mostly, partly or does not do so.

Source: OB3 Research health visiting staff survey, November to December 2025, n=289.

Health visitors were asked to explain what was missed or under-reported as a result of using current reporting methods and highlighted the following gaps:

- enhanced and intensive contacts beyond the core HCWP schedule are largely invisible in the data. Health visitors reported that additional home visits, follow-ups and sustained support, particularly around feeding, sleep and parental mental health, are not routinely captured. Some described having weekly contact between the birth and 8-week visits with families with no mechanism to record this activity

  > “A lot of work is enhanced and intensive contacts outside of HCWP core contacts”

- current reporting focuses on the number of contacts rather than the effort and complexity involved. Health visitors emphasised that visit length and follow-up activity vary considerably by family need, with some complex visits lasting up to two hours and generating substantial referral and coordination work. Contributors felt that families requiring intensive support are not formally identified in reporting systems and that a ‘tick-box’ approach fails to reflect the holistic nature of their practice

  > “Even though the caseloads can be similar some families need more support, I feel that this isn't captured in the data”

- perinatal mental health and emotional well-being work is inadequately captured. Health visitors reported that there is no dedicated field to record mental health support provided, despite this being a time-intensive and central part of their role.

Contributors also noted gaps in how substance misuse and domestic abuse are recorded, with current forms capturing only whether these issues are asked about, rather than identified or addressed

> "There is nowhere to input maternal mental health support given"

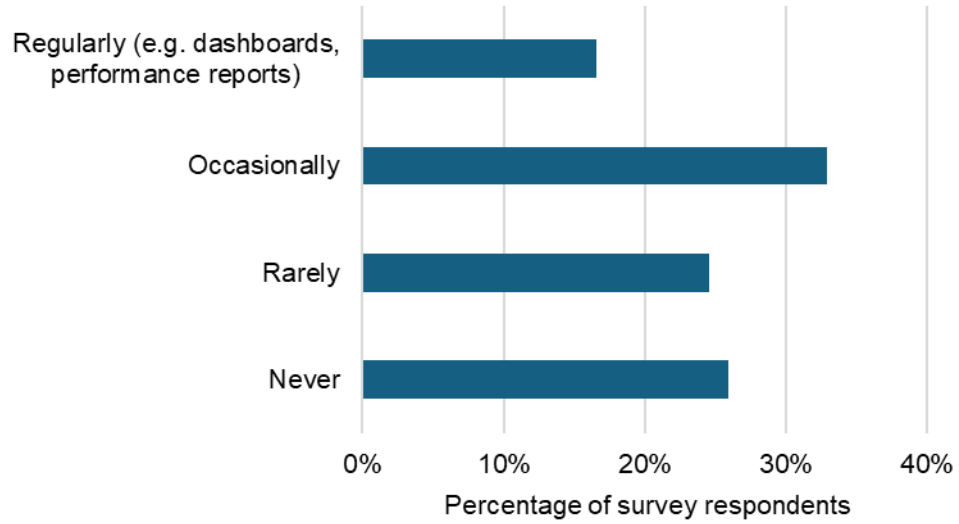
- safeguarding and multi-agency work is not reflected in reported data. Health visitors described substantial time spent on safeguarding visits, follow-up actions and multi-disciplinary work, including multi-disciplinary team (MDT) meetings, child protection conferences and liaison with social care, education, GPs and other partners. This activity was widely described as absent from current reporting

> "All safeguarding and MDT are not recorded"

7.4.3. The value of HCWP data and reporting to health visitors

Roughly half of survey respondents reported that they either never (26%) or rarely (25%) receive feedback or reports based on the HCWP data they capture. However, roughly half reported receiving feedback or reports either occasionally (33%) or regularly (17%).

Figure 7.3: Percentage of survey respondents who reported receiving feedback or reports based on the HCWP data they submit

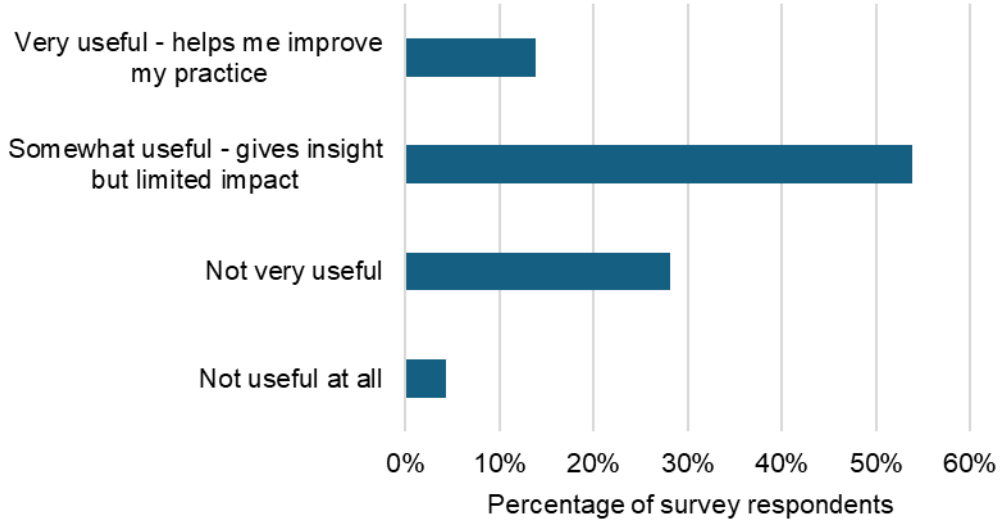


Description of figure: A bar chart showing that roughly half of survey respondents either never or rarely receive feedback or reports. Roughly half, however, do receive feedback or reports occasionally or regularly.

Source: OB3 Research health visiting staff survey, November to December 2025, n=289.

Amongst those who do receive at least some feedback or reports based on the data they submit, a few (14%) found this very useful and noted that it helped improve their practice, while around half (54% found it somewhat useful, noting that it gives them insight but has limited impact. A minority (28%) thought that the feedback or reports are not very useful, though very few (4%) consider them not useful at all.

Figure 7.4: Percentage of survey respondents who find the feedback or reports they receive useful



Description of figure: A bar chart showing that the majority consider the feedback or reports they receive at least somewhat useful but that a minority do not find them useful.

Source: OB3 Research health visiting staff survey, November to December 2025, n=210.

7.4.4. Challenges associated with data capturing and reporting

Six main challenges relating to data capturing and reporting were consistently raised by national stakeholders and health board staff, including health visitors. These related to:

- reliance on paper or ‘paper-light’ processes. Despite some local digital progress, most health boards remain dependent on paper or hybrid systems. Contributors reported that incomplete, lost or delayed forms contribute to under-reporting and inaccurate performance data, noting that paper processes offer no safeguards against incomplete submission
- non-integrated and fragmented digital systems. Across all health boards, contributors highlighted poor connectivity between data systems. Health visitors reported recording the same information across multiple platforms that do not communicate effectively, leading to duplication, inconsistency and reliance on manual data transfer
- delays in data entry and reporting. Health visitors and leads described HCWP data as frequently entered late due to workload pressures and system inefficiencies. In one area, industrial action contributed to delays, while elsewhere administrative teams prioritised other tasks such as immunisation data. As a result, CYPrIS dashboards were viewed as out of date, limiting their usefulness for planning and decision-making
- heavy administrative burden and duplication of effort. Contributors consistently reported that manual processes and repeated data entry increase workload and reduce capacity for direct family contact. Health visitors described spending a disproportionate amount of time on paperwork, with one noting that “the paperwork is

monotonous … you visit all morning and then spend all afternoon writing", and that even straightforward contacts can take up to an hour to record

- under-reporting of health visiting activity. Health visitors emphasised that nationally reported HCWP data does not reflect the intensity or breadth of their work. Safeguarding activity, referrals, community work and intensive support for complex families were frequently described as invisible, while strict time windows mean that slightly late contacts are not counted, distorting the picture of performance and workload

- lack of insight about difference made. Contributors noted that current reporting captures whether a contact occurred, but not what happened or what difference was made. There was strong support for more outcome-focused reporting, with additional fields to record key actions, issues identified and support provided during contacts.

7.4.5. Cross-border and cross-boundary working

Practitioners, particularly those serving border communities, reported that families who live in one health board area but register with a GP in another (including across the England-Wales border) can experience delays, duplication and uncertainty about responsibility for the first contact and subsequent reviews. Health visitors described instances where allocation was prolonged when a family's postcode and GP registration sat in different jurisdictions, alongside examples of missed or late contacts.

They also reported inconsistent midwifery handovers, with SIP forms arriving late or incomplete and occasions where health visitors met families before any handover information was received. Limited read-only access to BadgerNet/midwifery notes was highlighted as a practical barrier that can lead to repeated assessments or gaps in background information.

Local documentation practices were said to vary, for example in how birthmarks are recorded and whether a child's red book is routinely issued, contributing to uneven information flow. Regular verbal handovers can mitigate some issues; however, cross border registrations continue to disrupt continuity, and parents who move between areas echoed these concerns, describing unclear expectations and uncoordinated first visits resulting in difficulty reaching the appropriate contact.

7.4.6. Suggestions made to improve and strengthen HCWP data quality and reporting

Three main improvements were suggested by fieldwork contributors to improve the HCWP data quality and reporting:

- introduction of a single, Wales-wide digital health visiting system. Health board contributors, including health visitors, strongly supported a single system that would follow the child and link with maternity, GP, social care and education records. Contributors frequently referenced maternity's BadgerNet as a model, noting that a unified system could reduce duplication and error, support families who move

between areas, enable real-time data entry and generate automated alerts for service managers

- a move away from paper-based processes towards digital, point-of-care recording. Contributors emphasised the need to replace paper systems with digital referrals, pre-populated forms and mobile tools (such as tablets) to allow information to be recorded during visits. While acknowledging connectivity challenges in some areas, health visitors felt that digital entry aligned to clinical workflows would reduce paperwork, improve accuracy and streamline delivery

- a review of HCWP data items to improve relevance and usefulness. Contributors called for more meaningful national data, noting that some existing fields are unclear or of limited value. Examples included domestic abuse data capturing whether issues are discussed rather than identified. Health visitors also highlighted that not all collected data is published and questioned its value. There was strong support for capturing intensity of work, reasons for delays, additional provision, and outcomes achieved by families.

The health visitor survey reinforced these findings. Of 128 respondents, 23% reported not having access to CYPrIS and relying on administrative staff for data entry. Views were mixed on whether health visitors should have direct access, reflecting concerns about administrative burden:

> "I would like to be able to record my contacts directly rather than completing a form to send to someone else. This would decrease the risk of human error and the admin time per child, and free up Child Health staff to do other work."

> "Please allow admin to input, even more of HV time taken up with endless paperwork, ticking boxes."

Among survey respondents with views on system improvements, the most frequently raised issues were:

- poor integration with other systems, resulting in repeated data entry and difficulty accessing information held in WCCIS, PaRIS, GP and maternity systems
- data quality and timeliness issues, with out-of-date or inaccurate information limiting CYPrIS' usefulness as a live management tool
- high duplication and limited functionality, with respondents describing CYPrIS as adding to workload and functioning primarily as a one-way reporting tool rather than a clinical system
- usability and technical limitations, including slow performance, limited access during home visits and workflows not aligned to health visiting practice:

> "We need a better overall electronic system…to have better joined up care and better communication."

8. Prosiect Pengwin

8.1. Introduction

This chapter first provides an overview of the Prosiect Pengwin and levels of awareness amongst those who contributed to the review. It then explores the feasibility of implementing the project within the HCWP, and the enablers and constraints of doing so.

8.2. Overview

Prosiect Pengwin is a project led by a team of researchers at Cardiff Metropolitan University, who were commissioned by Welsh Government to develop a set of tools to monitor and support early speech, language, and communication development in children growing up in Wales. The Welsh Government commissioned this project as up to 50% of children with speech, language or communication needs are currently being missed within current screening practices.

In addition, Welsh Government's 2022 Review of Early Language Screening found that widely-used speech and language identification tools were not fit-for-purpose in Wales, including the WellComm tool and the SOGS. This review identified principles which need to be considered in the screening of early language skills of children in Wales. These principles were considered in the development of Prosiect Pengwin.

The Prosiect Pengwin tool has been designed to fit with the HCWP schedule and its surveillance approach (repeat contacts rather than a one-off assessment). The screening tools under development are designed to be used at the HCWP universal contacts at 15 months, 27 months and 3.5 years. The tool is designed to be used by the health visiting workforce and early years practitioners to identify speech, language and communication needs and to provide or signpost to support, as needed.

The tool is currently being co-produced with practitioners, including health visitors who sit on the steering group, and parents, with tools being tested and refined to ensure they are practical, inclusive and suitable for both English and Welsh-medium contexts. Pilots in both languages are currently underway, and a Welsh Government consultation on the next phase (primary school age) undertaken between February and April 2026 provided an opportunity for health visitor and wider team responses. Welsh Government estimates that the screening tools will be rolled out from 2027. To support the tool, the Welsh Government is also developing training for tool users and a range of interventions to support children identified with speech, language or communication needs.

8.3. Review findings

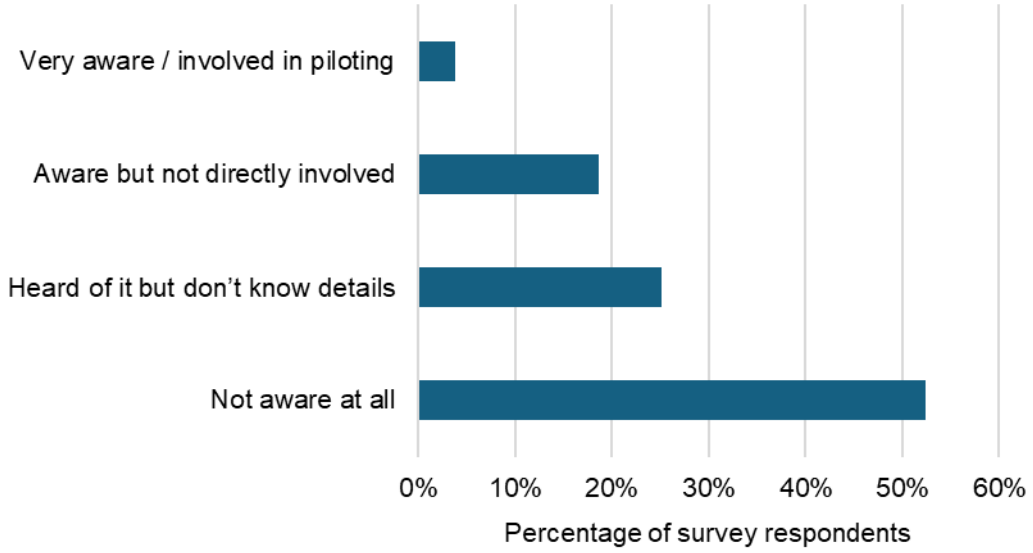
8.3.1. Awareness of Prosiect Pengwin

Awareness of Prosiect Pengwin during our fieldwork varied across stakeholder groups, particularly between those working at national level and those working in front-line health visiting teams. National stakeholders and a minority of health visiting leads involved in early discussions were relatively well informed about the project's aims, policy rationale and

intended alignment with HCWP. Health visiting leads described information as somewhat fragmented, with some noting that despite initial meetings, little had been communicated since. Speech and language therapists were aware of Prosiect Pengwin but often lacked detail about its content, expectations or timelines. Overall, awareness was highest among national stakeholders and lowest among frontline practitioners, with most staff reporting insufficient information to understand what the tool involves, how it will work in practice, or what will be expected of them.

As shown in Figure 8.1, just over half (52%) of health visiting staff who responded to the survey were not aware of Prosiect Pengwin at all. Less than half had either heard of it but didn't know the details (25%) or were aware but not directly involved (19%). Very few were very aware of Prosiect Pengwin or involved in the pilot.

Figure 8.1: Percentage of survey respondents who were aware or unaware of Prosiect Pengwin



Description of figure: A bar chart showing that just over half of survey respondents were not aware of Prosiect Pengwin while most of the remainder had varying levels of awareness.

Source: OB3 Research health visiting staff survey, November to December 2025, n=290.

8.3.2. Prosiect Pengwin objectives and potential added value

Amongst those with some level of awareness of Prosiect Pengwin, there was a shared understanding of its core aims and potential added value. The most widely recognised aim was to support earlier and more accurate identification of speech and language needs. National stakeholders emphasised that the tool is intended to help health visitors identify concerns at key developmental milestones, enabling timely support and reducing the risk of children entering education with unmet needs. Health visiting leads echoed this, noting that early identification is central to the health visiting role and that a structured tool could enhance professional judgement.

> “The ambition to have that [a bespoke Welsh-language surveillance tool] is absolutely right and proper and needed.”

A second perceived aim was to create a consistent approach to speech and language assessment across Wales. National stakeholders described Prosiect Pengwin as a way to reduce variation in practice, improve the quality of referrals and ensure that all children receive equitable assessment. Health visitors agreed that, in principle, a standardised tool could support more reliable decision-making.

National stakeholders also placed particular emphasis on the bilingual nature of the tool, describing it as a key strength and a necessary feature of any assessment used in Wales.

National stakeholders and health visitors also highlighted the limitations of existing tools noting that the speech and language elements of SOGS are widely viewed as unfit for purpose, whilst health visitors with Flying Start caseloads described WellComm as flawed. Prosiect Pengwin was seen as an opportunity to replace these tools with something more robust, developmentally appropriate and aligned with Welsh policy.

> “We currently in Flying Start do our WellComm speech and language [assessment]. I don't think it works brilliantly well, and I think it's very difficult to get a true assessment from a child. A lot of it is going with what parents say.”

A minority of health visitors felt that a well-designed tool could support clearer conversations with parents about developmental expectations and next steps. They valued the potential for Prosiect Pengwin to help families understand what is being assessed and why.

8.3.3. The role of health visitors

There were mixed views on whether Prosiect Pengwin sits appropriately within the remit of health visitors, and these views varied between stakeholder groups. Many national stakeholders felt the tool was a natural extension of existing health visitor responsibilities, emphasising that health visitors already undertake developmental surveillance and should therefore be well-placed to deliver structured speech and language assessments. Some health visitors echoed this, particularly those in Flying Start areas who already use tools such as WellComm and felt confident in their ability to incorporate another structured assessment with the right support. However, health visiting leads were more cautious, warning that while health visitors are highly skilled in terms of assessing child development, Prosiect Pengwin could be considered too specialist for the health visitor role.

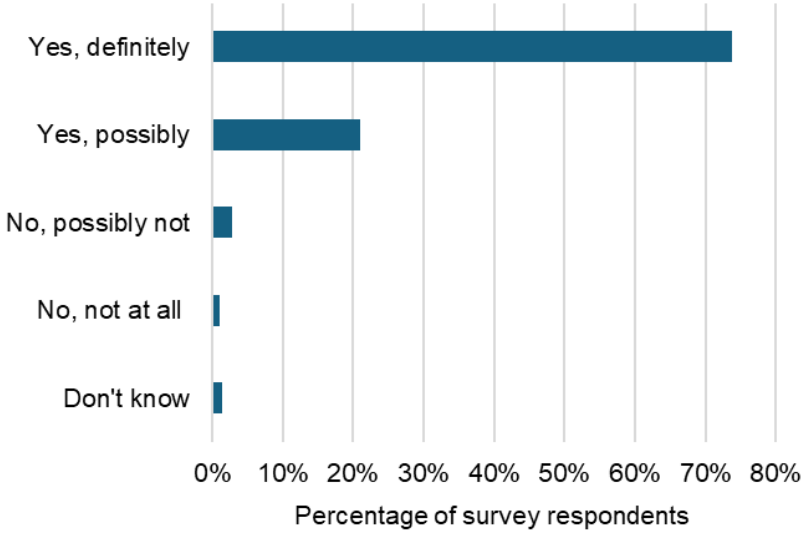
This concern was also expressed by speech and language therapists. They argued that several elements of the proposed tool require specialist clinical knowledge, noting that even band 5 speech and language therapists may struggle to assess some of the features Prosiect Pengwin asks health visitors to identify. They emphasised that health visitors are not trained to detect subtle or complex speech and language issues and warned that expecting them to do so could lead to inappropriate referrals or missed needs. They felt that Prosiect Pengwin could represent an overextension of the health visiting role unless intensive training is provided.

> “It’s been raised by our lead speech and language therapist that some of the expectations on the health visitors are not within a health visitor’s role…that health visitors would not be skilled enough to be able to complete the assessment because we’re not speech and language therapists.”

Overall, while some saw Prosiect Pengwin as broadly compatible with the health visitor role others felt it risks blurring professional boundaries and placing unrealistic expectations on health visitors.

However, responses to the health visitor survey showed broad consensus that health visitors should have some type of role in assessing speech and language needs. Many survey respondents (74%) felt that health visitors should have a role in identifying speech, language and communication needs, as shown in Figure 8.2. A further minority (21%) felt they should possibly have such a role, while very few (4%) felt they should not.

Figure 8.2: Percentage of survey respondents who felt that health visitors should have a role in identifying speech, language and communication needs



Description of figure: A bar chart showing that many survey respondents believed health visitors should have a role in identifying speech, language and communication needs.

Source: OB3 Research health visiting staff survey, November to December 2025, n=290.

8.3.4. Views on the feasibility of implementing Prosiect Pengwin

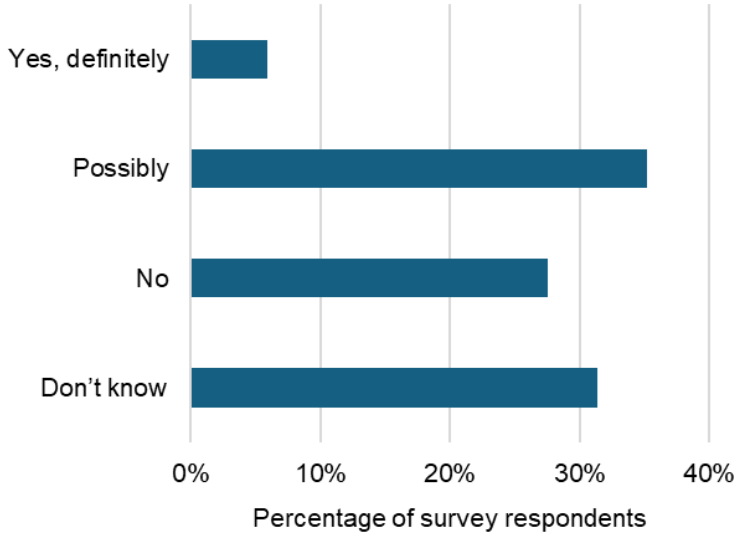
Across interviews with health visitors, substantial barriers were identified that would need to be addressed before Prosiect Pengwin could be implemented effectively.

Workforce capacity and existing workload pressures were the most frequently cited challenges. Health visitors and health visiting leads described high caseloads, lengthy appointments and competing priorities, and questioned the feasibility of introducing additional assessments without increased staffing or more effective use of skill mix. Contributors highlighted the need for additional health visitors, support workers or specialist roles, alongside protected time for assessment and follow-up. Health visiting leads

emphasised that any new requirements would need to be accompanied by additional resources to avoid further increasing pressure on the workforce.

Survey respondents expressed very mixed views as to whether they and their team would have capacity to implement Prosiect Pengwin or similar tools if rolled out nationally, as shown in Figure 8.3. Very few (6%) reported that they would have capacity, whereas the remainder of survey respondents were fairly divided between those who felt they would possibly have capacity (35%), would not have capacity (28%) or didn't know (31%).

Figure 8.3: Percentage of survey respondents who reported that they and their team have capacity to implement Prosiect Pengwin or similar tools if rolled out nationally



Description of figure: A bar chart showing that very few respondents reported that they would have the capacity to implement Prosiect Pengwin or similar tools, while the remainder were unsure or felt they wouldn't have the capacity.

Source: OB3 Research health visiting staff survey, November to December 2025, n=290.

Survey respondents who reported that they either would not or might not have capacity to implement Prosiect Pengwin, or were unsure, were asked what adjustments would be needed. In total, 169 respondents suggested potential changes. Half (50%) identified the need for staffing adjustments, including reduced caseloads, greater use of skill mix, increased recruitment, filling vacancies and addressing gaps caused by sickness absence.

A smaller proportion (17%) emphasised that health visiting contacts already involve extensive information-gathering, assessment and public health messaging. These respondents felt that introducing additional tools would be difficult alongside existing priorities without extending contact length, which they viewed as impractical and potentially inappropriate for families. As one respondent noted:

> "Each contact is already quite heavy on advice/information we are asked to give/collect… so thought would need to be put into how we can do this and still carry out the volume of contacts with reasonable appointment lengths."

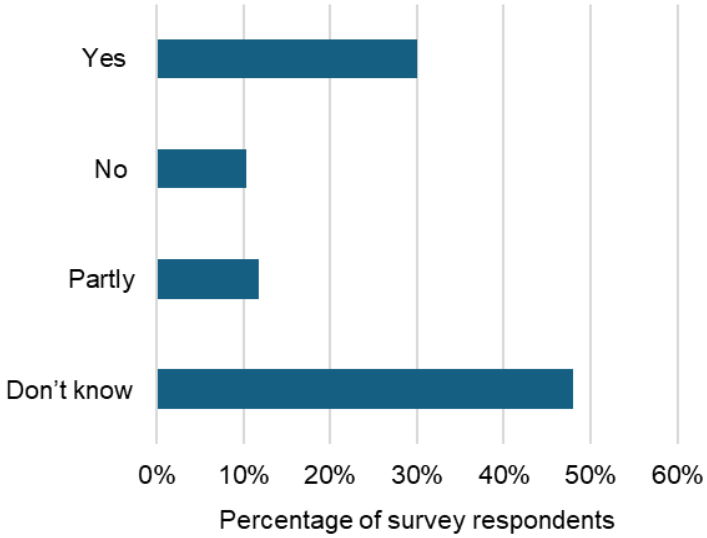
A minority of respondents highlighted other requirements, including training and resources relating to Prosiect Pengwin (11%), while fewer than one in ten suggested changes such as reduced paperwork or improved digital systems. Just over a quarter (28%) reported that they would need more detailed information about the Prosiect Pengwin tools before commenting on their capacity to implement them.

Wider stakeholders and health visiting leads reinforced the need for training, emphasising that this should be practical and supported by supervision and ongoing support, rather than limited to theoretical input. Stakeholders also raised concerns about speech and language therapy capacity and referral pathways, noting that some areas lack sufficient provision or do not include speech and language therapists within core HCWP teams. Contributors cautioned that identifying additional need without increasing intervention capacity could be counterproductive.

Views were mixed on the appropriateness of implementing Prosiect Pengwin at 15, 27 and 42 months. Many health visitors felt 15 months was too early for reliable speech and language assessment, while the 27-month contact was described as already heavily loaded. Those working with Flying Start caseloads noted that many children attend nursery by age two, potentially reducing the value of assessment at that stage. Health visiting leads emphasised the importance of aligning assessment points with child development and service capacity, reflecting wider concerns about the overall HCWP contact schedule.

Survey respondents were asked whether the proposed ages (15, 27 and 42 months) were feasible for adding the Prosiect Pengwin tools to their workload. As seen in Figure 8.4, just under half (48%) didn't know whether it was feasible. A further minority (30%) felt it would be feasible, while a few (10%) felt it wouldn't be feasible or only partly feasible (12%).

Figure 8.4: Percentage of survey respondents who reported that the proposed ages were feasible for adding the Prosiect Pengwin tools to your workload



Description of figure: A bar chart showing that just under half of survey respondents didn't know whether the proposed ages were feasible, while a minority felt it would be feasible.

Source: OB3 Research health visiting staff survey, November to December 2025, n=290.

Survey respondents who reported that the proposed ages would not be feasible, or only partly feasible, were asked to suggest alternatives. Some suggested introducing the tools between 18 and 24 months, rather than at either 15 or 27 months. These respondents felt this period was more developmentally meaningful for assessing language, noting that assessment at around 2 years allows greater opportunity for input and review as children develop through wider social interaction, including playgroup attendance.

A minority reported that implementation of the tools would not be feasible at any age, citing existing capacity and workforce pressures. A further group felt that 42 months was inappropriate, noting that this contact is not designed as a developmental review, that schools are better placed to identify speech and language needs at this stage, or that engagement with this later contact point is typically low.

Stakeholders also highlighted that existing weaknesses in recording and monitoring systems could limit effective implementation of Prosiect Pengwin. Contributors noted that data systems would need to be improved both to support accurate recording of Prosiect Pengwin assessments and to reduce the administrative burden on health visiting teams.

9. HCWP performance to date

9.1. Introduction

This chapter provides an overview on the performance of the programme against the 9 contact points offered for children aged between 10 days and 3.5 years since 2018. The data is sourced from the National Community Child Health Database (NCCHD), hosted by DHCW and published on the archived StatsWales. This chapter also considers annual and quarterly reports prepared by the Welsh Government where relevant.

A recent quality report on the HCWP identifies a number of quality issues with the performance data collected through the programme. These include:

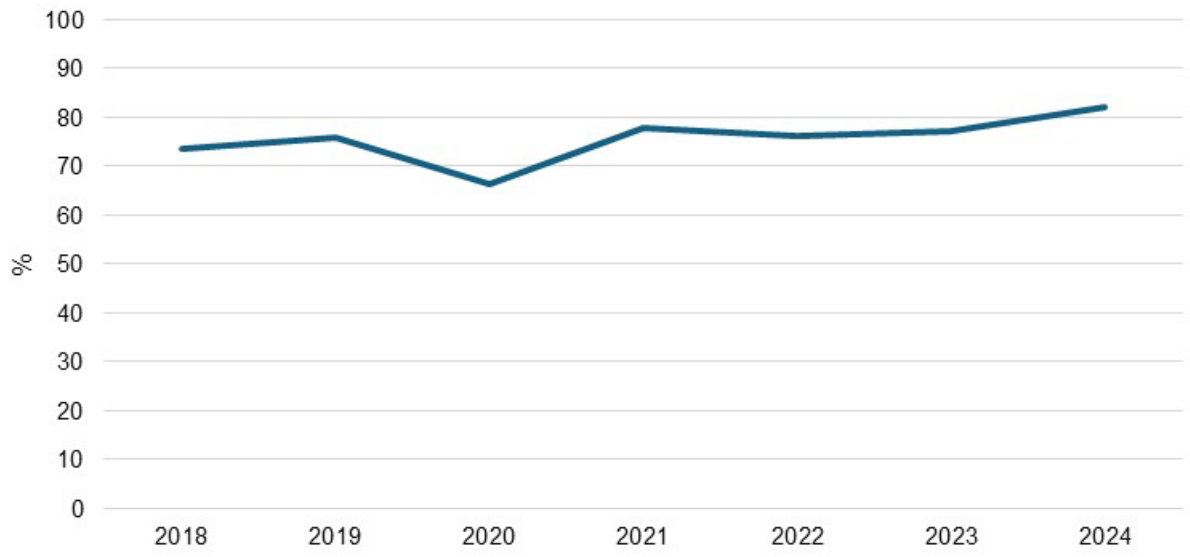
- the use of a paper-based system which limits the accuracy of the data collected. The system is reliant on health professionals completing the paper form correctly, submitting it to a child health administrator who then upload the data onto the child health system. Whilst the data collected is of sufficient quality it is likely to undercount the contacts taking place due to incorrect data being inputted on to the form, forms being submitted late or not at all, and manual imputation errors
- some GPs, who undertake the 6-week contact as this involves a physical examination, record the contact on their GP systems but not on the HCWP data collection form. These contacts are therefore not included in the NCCHD
- the number of 8-week contacts reported is lower than the number of contacts which occur in practice as these contacts often take place simultaneously to the 6-week GP contact, and are reported via a single, rather than separate, data collection form
- childhood vaccination appointment rates are greater than HCWP completed contacts, which suggests that there is an undercount of activity recorded in NCCHD, given that vaccination appointments are usually arranged at the same time and location as HCWP contacts.

In addition, the same report notes that the HCWP data collection form includes information on additional data items, such as female genital mutilation (FGM), the age at which breastfeeding ceased, the age at which solid foods were introduced, and the Schedule of Growing Skills (SOGS). However, it highlights that these data items are not currently recorded with sufficient accuracy or consistency to support publication.

9.2. Contact completion rates by contact age

The percentage of HCWP contacts completed has steadily increased for the most part since the start of the programme. The highest contact completion rate, at 82.2%, was recorded during the last reporting year in 2024, when 205,675 of 250,064 eligible children were contacted at the appropriate age as shown at Figure 9.1.

Figure 9.1: Annual HCWP contacts received within age ranges



Description of figure: the chart shows a steady increase for the most part in the percentage of HCWP contacts completed since the programme was established, with the highest proportion recorded in 2024.

Source: StatsWales

The drop in completed contacts experienced during 2020 and 2021 was due to the impact of the COVID-19 pandemic. During the early period of the pandemic, some health visitors were redeployed by health boards to work in hospitals and undertake different roles. Many contacts were also completed over the telephone or virtually so not all contacts were recorded accurately.

In response to Welsh Government guidance during the pandemic, health boards prioritised key contact points, notably the 10- to 14- day contact and the 6-week contact in the first instance, and the 6-month contact point was later added to these priorities. In May 2020, the Welsh Government issued guidance advising health boards to reinstate the additional contacts and health boards were expected to work towards providing a full range of contacts from summer 2020 onwards. In December 2020, health boards were advised by the Welsh Government to risk assess cessation or the reduction of health visiting services and prioritise the 10- to 14- day, 6-week and 6-month contacts. These impacted the achievement of various programme contacts during the pandemic, as discussed later in this chapter.

9.3. Contacts received within age ranges

Contact completion rates have varied widely across each contact point since the HCWP was established, as shown at Table 9.1. The highest contact rate (at 91.8% in 2024) has consistently been for the 10- to 14- day contact and this high rate was maintained during the pandemic period. The lowest contact points have been the 12- and 16-week contact points, at 75.5% and 75.2% respectively in 2024.

Overall, there has been a long-term upward trend in the percentage of eligible children receiving contacts within the expected age range. The contact at 3.5 years has historically been very low (e.g. 54.8% in 2018) although an improvement was observed during 2024, when 77.6% of these contacts were achieved.

Table 9.1: Proportion of contacts received within age ranges, 2018 to 2024 [footnote 7]

	2018	2019	2020	2021	2022	2023	2024
10 to 14 days	90.6%	93.5%	93.2%	94.0%	92.1%	93.4%	91.8%
6 weeks	81.2%	77.9%	78.0%	83.8%	82.2%	82.1%	82.5%
8 weeks	72.3%	78.6%	59.7%	75.0%	70.6%	73.5%	79.6%
12 weeks	65.1%	71.1%	51.1%	67.4%	63.8%	68.1%	75.5%
16 weeks	64.3%	71.1%	50.4%	67.7%	63.8%	67.1%	75.2%
6 months	79.4%	80.5%	79.7%	86.6%	85.3%	88.3%	88.5%
15 months	81.3%	81.7%	70.1%	81.1%	82.2%	84.7%	86.1%
27 months	75.5%	74.4%	63.5%	79.1%	79.9%	76.9%	83.8%
3.5 years	54.5%	55.7%	54.0%	66.6%	67.1%	62.2%	77.6%
All contacts	**73.6%**	**75.7%**	**66.4%**	**77.8%**	**76.2%**	**77.2%**	**82.2%**

Source: StatsWales

9.4. Contacts within programme age range

Whilst it is expected that children receive a HCWP contact at specific ages, in practice each contact point has a minimum and maximum age thresholds. The minimum and maximum thresholds for each of the 9 contact points are:

- contact at 10 to 14 days: 10 to 14 days
- physical examination at 6 weeks: 6 to 12 weeks
- contact at 8 weeks: 8 to 12 weeks
- contact at 12 weeks: 12 to 16 weeks
- contact at 16 weeks: 16 to 20 weeks
- contact at 6 months: 26 to 35 weeks
- contact at 15 months: 65 to 79 weeks
- contact at 27 months: 117 to 130 weeks

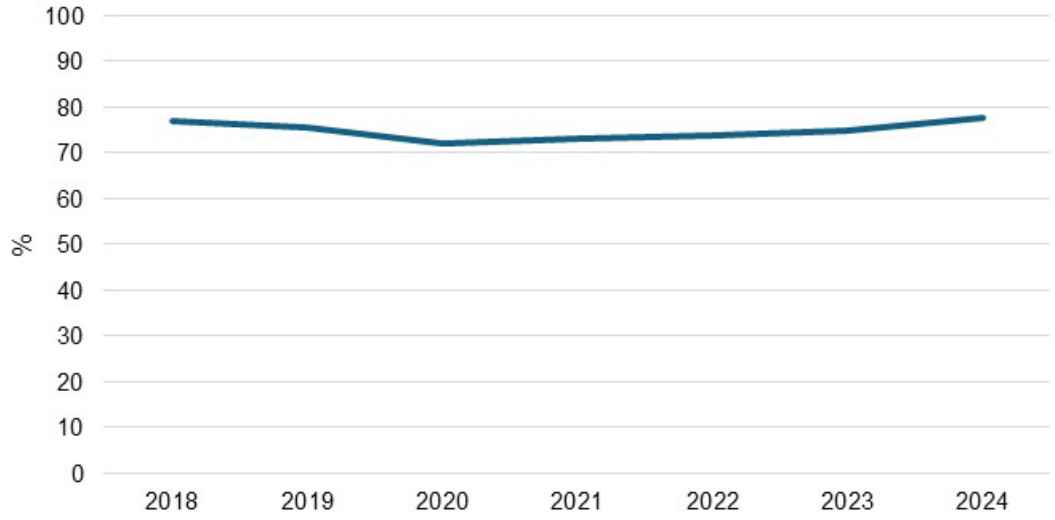
[7] There are known data quality issues with the 6-week GP appointment and 8-week immunisation appointment, and the data presented is an under-count of the actual activity taking place due to the paper-based data collection process not being fully implemented

- contact at 3.5 years: 185 to 208 weeks.

Figure 9.2 shows that most of the programme contacts took place within these specified age ranges. The proportion dropped during the pandemic period but have since increased. By 2024, 77.8% of all contacts received were within the expected age range for the programme.

Since the beginning of the HCWP, the 6-week contact point has had the highest whilst the 3.5 years contact has had the lowest rate of contact achieved within the expected age range, although the gap between these has narrowed over time. By 2024, 91.7% of the 6-week contacts and 57.0% of the 3.5-year contacts were achieved within the expected age range.

Figure 9.2: Annual HCWP contacts received within expected age ranges



Description of figure: This chart shows that most HCWP contacts occurred within the expected age ranges.

Source: StatsWales

9.5. Reason for no contact

All eligible children across Wales should be invited to all 9 HCWP contacts. Where no contact takes place, the reason is recorded on the child health system. Contacts may not be completed because they were not offered by health boards due to capacity issues, contacts were offered and not taken up, or contacts did occur, but the data collection form was not completed or added to the child health system.

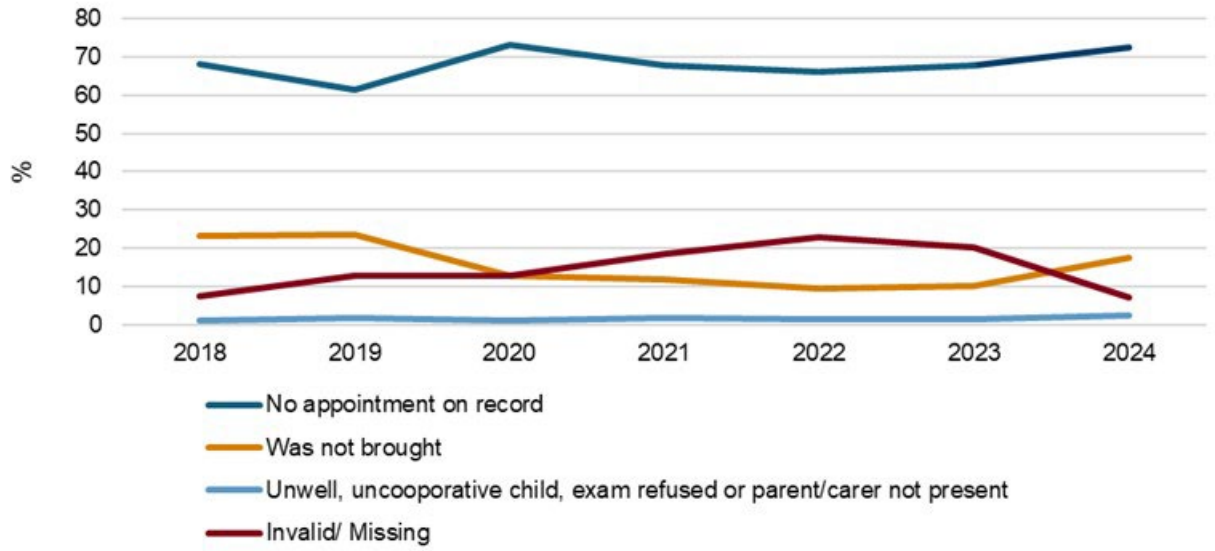
As shown at Figure 9.3, since 2018 and across all 9 contact types, the main reason for a non-contact was that there was no appointment on record. This was particularly high during 2020 reflecting the pandemic disruption and again during 2024, when 72.6% of incomplete contacts were due to no appointment on record.

Where an appointment was made, the main reason why the contact did not take place across all delivery years was because the child was not brought to the appointment. The

proportion has fluctuated over time, dropping during the 2020 to 2023 delivery period but increasing again to 17.6% of all incomplete contacts during 2024. As children get older, the likelihood of them being recorded as not brought to a contact increase, indicating a clear age-related pattern in attendance.

A small proportion of the incomplete contacts were due to missing or invalid data. Between 2018 and 2022 there was an increase in the proportion of missing or invalid data from 7.5% to 22.9% across the programme. By 2024 this had dropped to 7.3% suggesting an improvement in data recording and reporting processes. As with non-attendance, missing or invalid records are more common for older children.

Figure 9.3: Reason for no contact, all contacts combined 2018 to 2024



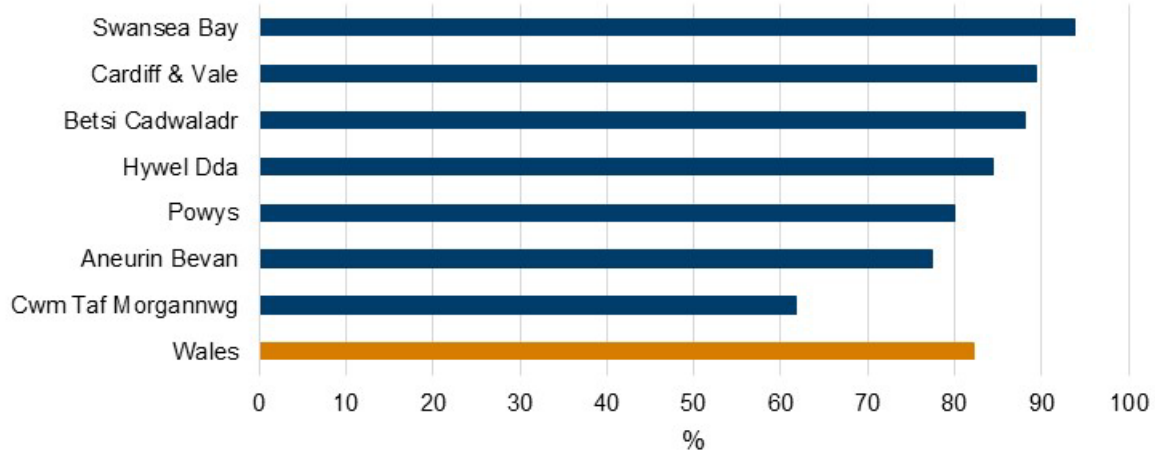
Description of figure: This chart shows that most of the contacts which did not take place were due to having no appointment on record.

Source StatsWales

9.6. Local health board analysis

The contact completion rates vary across health boards, as illustrated at Figure 9.4, which presents 2024 contact completion rates across all contact types by local health board. Swansea Bay UHB (at 93.8%) and Cardiff and the Vale UHB (at 89.3%) had the highest contact completion rates whilst Aneurin Bevan UHB (at 77.4%) and Cwm Taf Morgannwg UHB (at 61.7%) had the lowest contact completion rates during 2024.

Figure 9.4: Contact completion rate for eligible children by local health board, 2024



Description of figure: This chart shows the contact completion rate by health board during 2024, compared with the Welsh average.

Source: StatsWales

There has been an increase in contact completion rates across all but 2 local health boards between 2018 and 2024, with notable recent increases between 2023 and 2024 at Cardiff and Vale UHB, Aneurin Bevan UHB and Hywel Dda UHB. Cwm Taf Morgannwg UHB experienced a major drop in its contact completion rate in 2024 (from 84.2% in 2023 to 61.7% in 2024) whilst Powys THB experienced a smaller drop (from 85.4% in 2023 to 80.0% in 2024). The HCWP annual report for 2024 attributes the decline at Cwm Taf Morgannwg UHB to a period of industrial action during this year. Whilst all contacts were still being delivered the data was not collected in this region.

The variation in contact completion rates between health boards is evident at each of the 9 contact points but becomes increasingly pronounced as children age. Whilst early contacts at 10 to 14 days and the 6-week physical examination show relatively narrow variation across Wales, differences widen from the 9-week contact onwards. Several health boards such as Aneurin Bevan UHB and Hywel Dda UHB reported sharp drop-offs in coverage by the 12 to 16 weeks contact point whereas others such as Swansea Bay UHB maintained consistent high performance. By later contacts at 15 months, 27 months and 3.5 years, the coverage ranges from near-universal levels in some health boards such as Hywel Dda UHB and Swansea Bay UHB to barely half of eligible children in others.

9.7. Local authority analysis

An analysis of HCWP contact completion rates by local authority area over time shows that several areas demonstrate consistently high contact completion rates and stand out as strong performers over time. Completion rates across Anglesey, Gwynedd, Conwy, Wrexham and Powys have been maintained well above the Wales average, particularly in the post-pandemic period. As shown at Figure 9.5, by 2024, all these authorities, as well as

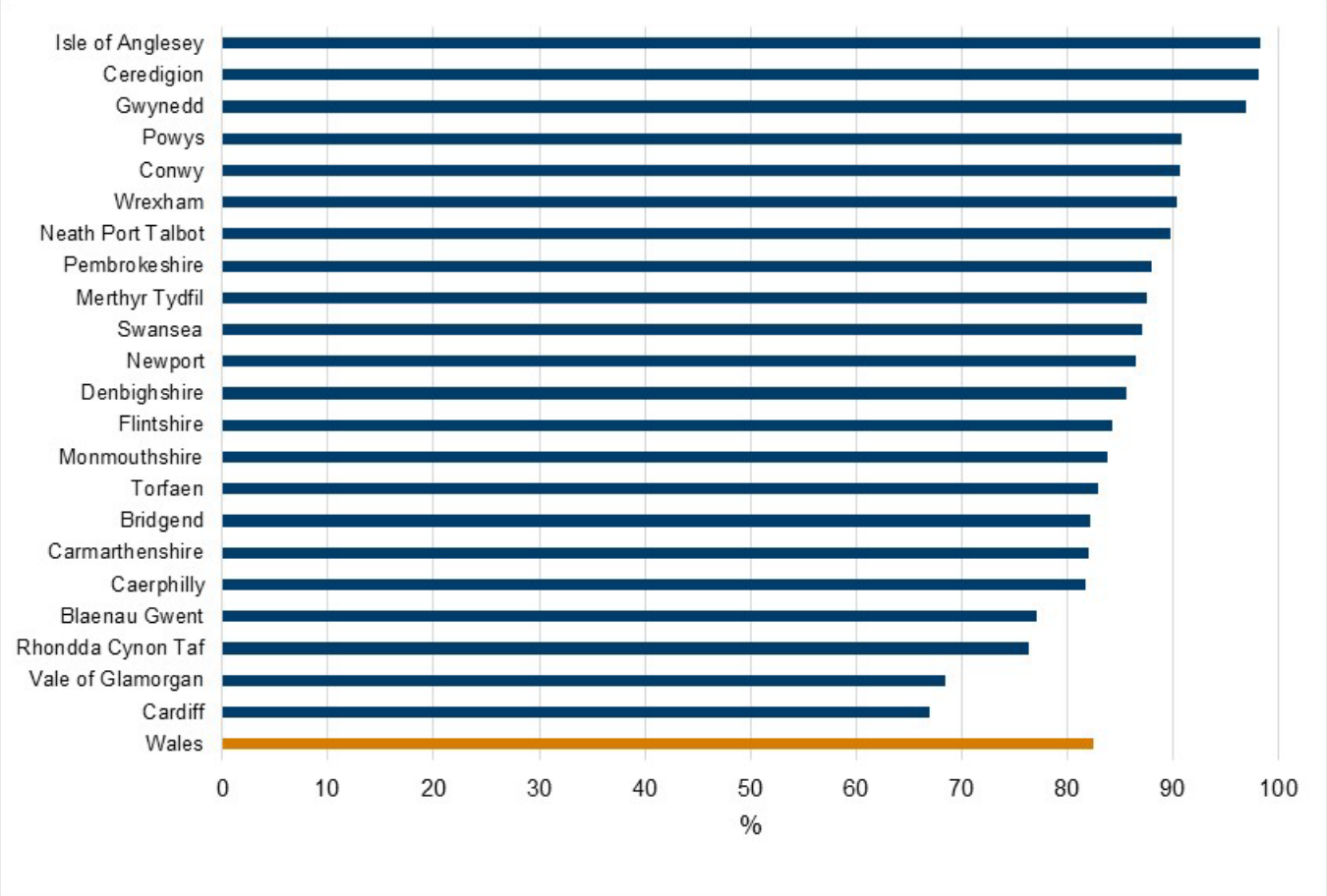
Ceredigion, recorded completion rates at or above 90%, with Anglesey, Ceredigion and Gwynedd approaching or exceeding 95%.

Improvement over time was also reported across several local authority areas, particularly following the disruption to service delivery in 2020 due to the pandemic. Caerphilly, Newport, Torfaen, Monmouthshire and Pembrokeshire demonstrated strong recovery from lower completion rates during the pandemic, with sizeable increases by 2024 that brought them close to or above the Wales average. The most pronounced change was observed in Ceredigion, where completion rates fell sharply between 2020 and 2022 (to a low of 44.2% in 2021) before rising to over 98% in 2024.

In contrast, completion rates across a smaller group of local authority areas were low or declining. Cardiff and the Vale of Glamorgan stand out in this respect, with both recording lower completion rates in 2024 than in earlier years and failing to follow the overall national recovery trend. Rhondda Cynon Taf also reported a recent decline in contact completion rates, falling from sustained rates above 85% in 2022 and 2023 to just over 76% in 2024. Blaenau Gwent remains below the Wales average despite some improvement over time.

These local authority patterns suggest ongoing challenges in sustaining HCWP contact delivery in some more urban or socioeconomically deprived local authority areas, whereas higher and more consistent completion rates tend to be seen in rural, less transient authorities, where sustained engagement with families may be easier to achieve.

Figure 9.5: Contact completion rates for eligible children by local authority area, 2024



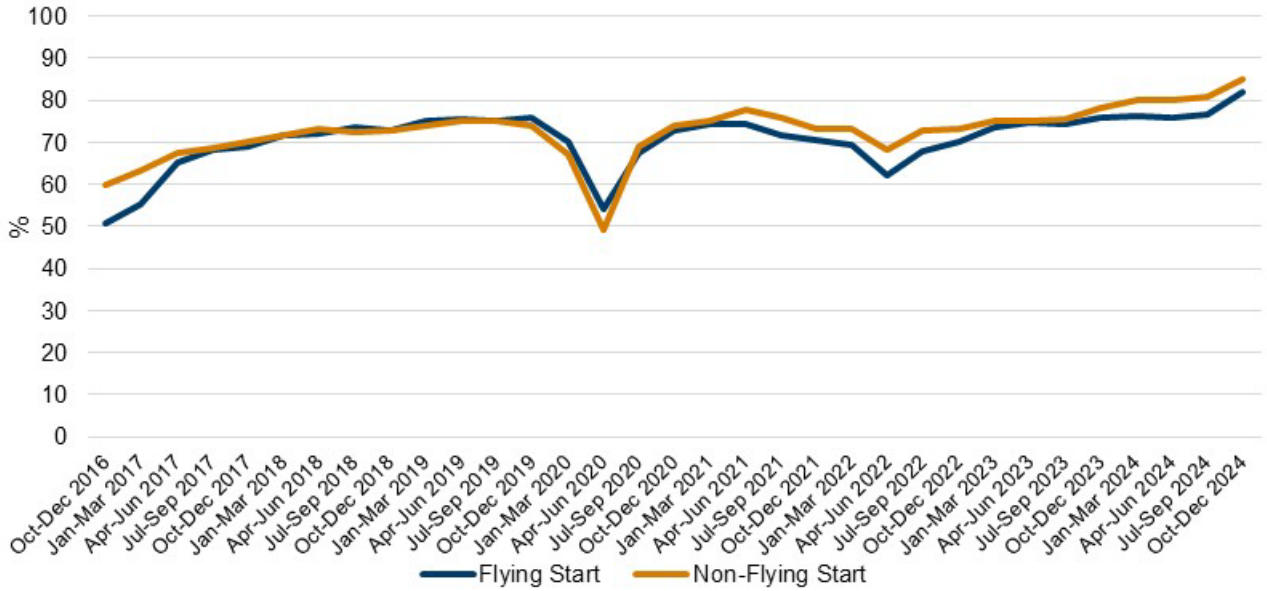
Description of figure: This graph shows contact completion rates by local authority area compared to the Wales average in 2024.

Source: StatsWales

9.8. Flying Start and non-Flying Start areas

During the first 6-months of delivery between October 2016 and March 2017, contact completion rates were lower for children in Flying Start areas compared to those in non-Flying Start areas. Since then and up to early 2021, there was very little difference between the completion rates across both areas. The gap has widened slightly over the course of 2021 and then again over the course of 2024. During the latest quarterly reporting period up to December 2024, 82.1% of eligible contacts in Flying Start areas were completed compared with 84.9% of contacts in non-Flying Start areas.

Figure 9.6: Contact completion rates for eligible children in Flying Start and non-Flying start areas, by quarter



Description of figure: This graph shows that quarterly contact completion rates in Flying Start and non-Flying start areas have broadly followed similar trajectories, albeit that rates in non-Flying Start areas have been higher in recent years.

Source: StatsWales

9.9. Analysis by Welsh Index of Multiple Deprivation

A request was made to DHCW for HCWP contact data during the 2024 calendar year by WIMD quintile. [footnote 8] It is worth noting that the data received are slightly different to

[8] The WIMD is the Welsh Government's official measure of multiple deprivation for small areas in Wales. The WIMD consists of 1,909 geographical areas covering the whole of Wales, which are known as Lower Super Output Areas (LSOAs). These areas have been ranked from the most to the least deprived LSOAs using 8 indicators such as income, employment, health, education and access to services. For this analysis we

published StatsWales data for 2024 in that the data contained a lower number of eligible children and a higher number of completed contacts than reported via StatsWales. [footnote 9] Despite this, the data are broadly similar, and Table 9.2 sets out the contact completion rates for each of the 9 contact points by WIMD quintile.

The table shows that engagement with the HCWP is consistently highest among families living in the least deprived areas, with take-up increasing incrementally across deprivation quintiles. However, it is worth highlighting that the take up of HCWP contacts in the most deprived areas (WIMD quintile 1) remains consistently high across all programme contact points and is closer to levels observed in less deprived quintiles than would typically be expected. Other than for the 6-week contact point, completion rates for eligible children in WIMD quintile 1 are higher than those in quintile 2.

The relatively strong engagement observed across quantile 1 is possibly a reflection of the enhanced programme support made available in Flying Start areas, given that they are geographically well aligned. This suggests that intensive targeted intervention in Flying Start areas could be effective in mitigating the expected socioeconomic gradient for completed contacts.

Table 9.2: Contact completion rates for eligible children by WIMD quintile, 2024

	1 Most deprived	2	3	4	5 Least deprived
10 to 14 days	91.5%	90.0%	93.4%	93.9%	94.2%
6 weeks	79.4%	82.9%	84.7%	84.8%	84.2%
8 weeks	78.5%	75.9%	78.9%	82.7%	85.9%
12 weeks	73.2%	71.9%	74.8%	78.5%	82.6%
16 weeks	72.7%	71.6%	75.2%	77.6%	82.2%
6 months	86.4%	85.4%	91.0%	91.5%	92.0%
15 months	84.9%	83.4%	88.4%	88.3%	90.4%
27 months	82.2%	81.4%	86.4%	87.4%	88.0%
3.5 years	81.4%	81.2%	82.3%	83.6%	84.4%

Source: DHCW

9.10. Immunisation uptake data

Childhood vaccination uptake is monitored and reported by PHW through the national Coverage of Vaccination Evaluated Rapidly (COVER) programme. This dataset provides a

consider the 5 quintiles within which the 1,909 LSOAs have been grouped. Quintile 1 contains the 20% most deprived LSOAs whilst Quintile 5 contains the 20% least deprived LSOAs.

[9] The DHCW 2024 data contained 248,546 eligible children and 207,066 completed contacts. StatsWales reported 250,064 eligible children and 205,675 completed contacts during 2024.

useful indicator of engagement between health services and children targeted through the HCWP and offers a comparable source of evidence alongside HCWP reporting.

This section examines the main findings from the annual COVER data on childhood vaccination uptake among children aged 1, 2 and 4 years, drawing on PHW Annual Reports covering the 10-year period from 2016 to 2025.

The key finding from Table 9.3 is that reported immunisation uptake is consistently higher than HCWP completed contact rates for children aged up to 4 years, despite vaccinations often being delivered during the same appointments as HCWP contacts. For example, the lowest recorded uptake of the 6-in-1 vaccine at age one between 2016 and 2025 was just over 94%, whereas HCWP completed contact rates for children under 1 year (shown in Table 9.1) were notably lower.

The other main observation to make is that annual childhood vaccinations take-up across Wales remained broadly stable from 2016 to the year ending March 2021, with only small year-to-year fluctuations. Coverage then fell by March 2023, followed by a modest recovery by March 2025, although levels generally remain below their pre-2021 highs. Coverage at 4 years remains notably lower than early-years uptake, dipping after the pandemic and only partially recovering by March 2025.

Table 9.3: Annual childhood vaccinations take-up in Wales [footnote 10,11]

Year ending March:	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
1 year (6 in 1)	96.6%	96.3%	95.9%	95.4%	95.8%	95.6%	95.2%	94.5%	94.2%	94.1%
1 year (MenB)	97.4%	94.4%	95.3%	95.1%	95.5%	95.4%	94.8%	93.8%	93.5%	93.8%
1 year (Rotovirus)	93.4%	94.1%	93.8%	93.6%	93.8%	93.8%	93.2%	91.7%	91.8%	92.0%
1 year (PCV)	n/a	n/a	95.9%	95.5%	95.9%	96.0%	96.6%	95.9%	96.0%	95.7%
2 years (MMR1)	95.3%	95.1%	94.7%	94.5%	94.5%	94.8%	94.2%	92.9%	92.9%	93.0%
2 years (PCV)	95.6%	95.4%	95.2%	94.8%	94.6%	94.8%	94.1%	92.4%	92.6%	92.7%
2 years (Hib/MenC)	94.7%	94.5%	94.5%	94.2%	93.8%	94.4%	93.7%	92.2%	92.3%	92.5%
Up to date in vaccination schedule at 4 years	85.3%	84.9%	84.9%	87.2%	88.0%	87.6%	87.0%	84.5%	84.3%	85.3%

Source: PHW Annual Reports

9.11. Breastfeeding data

Data for breastfeeding at birth and for babies turning 10 days, 6 weeks and 6 months is recorded via the NCCHD and refers to records where any breastfeeding was recorded. The mother's intention to breastfeed prior to birth has been recorded since 2016 via the Maternity Indicators dataset. Both data sources are provided to the Welsh Government by DHCW. These datasets provide useful contextual information for this review, although it is impossible to directly attribute any changes in breastfeeding rates to HCWP intervention alone despite health visitors taking an active role to promote and support breastfeeding amongst mothers.

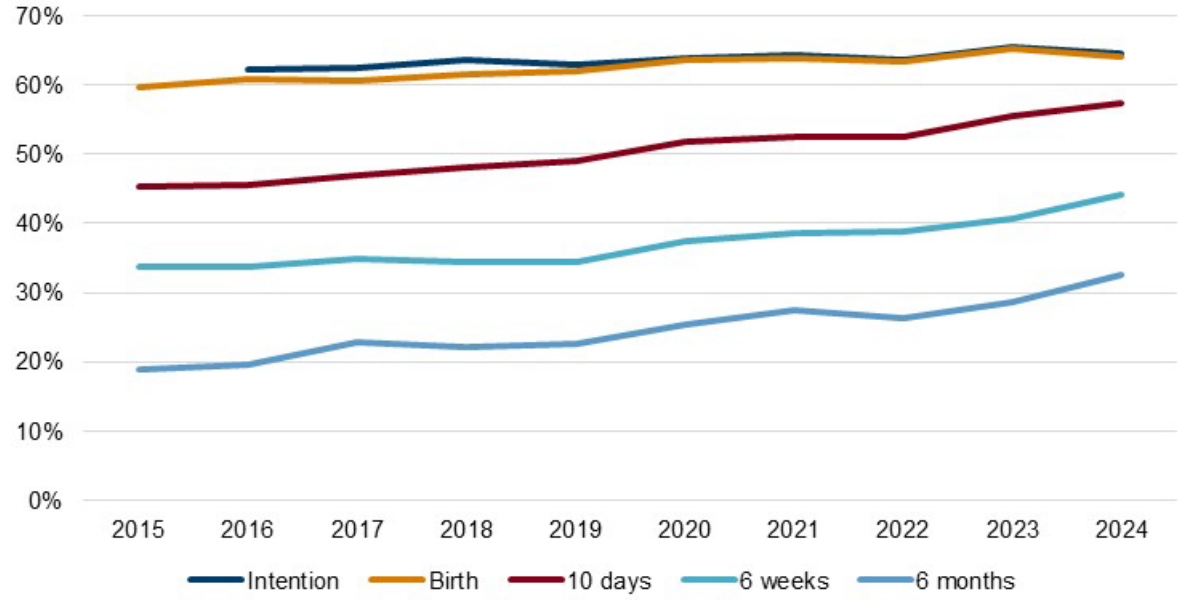
Figure 9.7 shows a clear and steady improvement in breastfeeding rates across Wales over the 10-year period since 2015, particularly from 2020 onwards. There has been a slight increase in the proportion of mothers intending to breastfeed and breastfeeding at birth over the 10-year period, with these two indicators closely mirroring each other over time, suggesting that most women who plan to breastfeed are able to start. A slight drop was reported across both indicators in 2024 with 64.0% of babies being breastfed at birth in that year.

Breastfeeding rates at 10 days and 6 weeks have risen more noticeably over the 10-year period since 2015, although there remains a consistent drop-off after birth. The most

[10] For 1-year olds, figures presented are for 3 doses of the 6 in 1 (Diptheria, Tetanus, Whooping cough/Pertussis, Polio, Haemophilus influenzae type b and Hepatitis B; 2 doses of Meningococcal B vaccine (MenB); 1 dose of Rotavirus; 1 dose of Pneumococcal Conjugate Vaccine (PCV) at 1 year of age. For two-year-olds, it is 1 dose of Measles, Mumps, and Rubella (MMR), 2nd dose of PCV and the Haemophilus influenzae type b and Meningococcal C vaccine (HibMenC) booster.
[11] MenC vaccine was given in 2016 and 2017

marked improvement is seen for breastfeeding rates at 6 months, where rates have increased from 19.0% in 2015 to 32.5% by 2024.

Figure 9.7: Proportion of babies breastfed at different ages, 2015 to 2024



Description of figure: This chart shows that the proportion of babies being breastfed at birth has broadly increased over the 10-year period since 2015, although there was a slight drop between 2023 and 2024.

Source: StatsWales. Intention to breastfeed data has only been captured since 2016, so earlier data is unavailable.

10. Outcomes and impacts

10.1. Introduction

This chapter first sets out the findings of the literature review about methods to monitor and report upon other child health programmes' outcomes and impacts. It then considers the findings of the review about how HCWP intended outcomes are measured and ways of improving this. Finally, it considers the evidence captured about the difference made by the programme and factors which restrict the intended programme outcomes.

10.2. International comparison

International evidence shows broad alignment with HCWP in positioning universal child health surveillance as a foundation for improving child health, development and well-being. However, comparison highlights that, like HCWP, many international systems struggle to translate extensive activity and process data into meaningful evidence of improved outcomes. Across countries, outcome frameworks are often weakly linked to frontline practice, with surveillance data used primarily for accountability and reporting rather than service improvement, mirroring concerns raised in Wales about recording burden without clear clinical or preventative value.

Compared with HCWP, England's system places greater emphasis on nationally standardised indicators for accountability and benchmarking but similarly shows limited evidence that these measures drive local quality improvement. Scotland's GIRFEC framework offers a more holistic, child-centred outcomes model than HCWP, integrating health, education and social domains, yet international reviews suggest it faces similar challenges in demonstrating causal links between health visiting activity and long-term outcomes. Nordic systems collect richer developmental and behavioural data than HCWP but outcome measurement remains largely descriptive, with limited evaluative use or impact on inequalities. New Zealand's Well Child Tamariki Ora programme is closer to recent Welsh policy aspirations, combining equity-focused indicators with an explicit quality improvement framework; however, it has also been criticised for over-reliance on process measures, prompting a shift towards outcomes reflecting children's lived experiences.

Comparison with other international examples suggests that HCWP's challenges are not exceptional but reflect wider structural issues in child health surveillance. The evidence indicates that systems most comparable with Wales are those that move beyond counting contacts towards holistic, child-centred outcomes, integrate data across services, and use outcome information for local improvement rather than solely national oversight. Across contexts, there is growing recognition that effective outcome frameworks must balance national consistency with local flexibility, enabling professional judgement while maintaining accountability.

10.3. Review findings

10.3.1. How HCWP intended outcomes are measured

National stakeholders expected HCWP to provide a universal early years' foundation to all families and children across Wales and emphasised the importance of the programme in providing equity of access. As such, they described the intended outcomes of the programme as:

- healthier children and families - including outcomes such as improved infant feeding, healthier growth patterns in early childhood, reduced risks of rapid weight gain or reduced risk of becoming overweight or obese, better oral health, improved diet, and better general physical well-being were identified
- improved early development and children being ready to learn and thrive - with outcomes relating to early development of speech, language and social skills identified, together with outcomes associated with being 'school ready' to be able to learn, communicate and engage at that point in time
- earlier identification of need - which was expected to reduce the need for additional prolonged or intensive interventions. Outcomes such as early identification of speech and language delays and feeding difficulties were highlighted, as well as timely referrals to specialist services to address these needs.

Given that the longer-term outcomes which HCWP aims to influence are difficult to measure directly, national stakeholders accepted the use of process measures (notably the completion of key contacts) as proxy indicators of an effective programme, provided such contacts were of good quality and provided appropriate support.

National stakeholders struggled to evidence how HCWP was achieving these intended outcomes given that the programme focuses on monitoring the number of contacts delivered rather than what happens during those contacts or the difference those contacts have upon children and families. It was commonly suggested that any outcome data, such as data covering feeding, growth, development and well-being, were incomplete and not used to assess the difference being made by HCWP. Whilst some health visitors used tools such as the Family Resilience Assessment Instrument Tool (FRAIT) which could generate outcome data, these were not being consistently used, and the data was not being reported onwards in any way.

> "We publish data on the number of contacts…and contacts missed. Is that useful? I don't think it is, particularly. I'm more interested in what happens in each contact… that's where the useful information is."

National stakeholders were also mindful that some of the national indicators which could be used to measure HCWP outcomes, such as levels of obesity, diet quality, oral health and difficulties at school entry, were not showing much sign of improvement over time. The lack of improvement across these types of indicators suggested to them that things are "not working well" at present although they acknowledged the difficulties of isolating HCWP's contribution from wider contextual factors.

10.3.2. How HCWP outcomes could be better measured

There was strong consensus amongst those interviewed that there is scope to improve how HCWP outcomes are measured, to better demonstrate its effectiveness. National stakeholders and health visitors alike suggested that measurement should move beyond simply recording scheduled contacts, to focus on what happens during each contact, including the quality of engagement, the type of needs and issues identified, the advice or intervention provided, and any follow-up actions taken.

National stakeholders, health visitors and health visiting leads also highlighted the importance of tracking progress and improvements made by children and families, sometimes referred to as the 'distance travelled', as well as capturing parent experiences of the service received. Health visitors suggested a need to better capture information about referrals made and how HCWP intervention helps alleviate the need for intensive support elsewhere. Health visitors noted that the programme delivers preventative and safeguarding work that is not reflected in current metrics, including support for families facing mental health challenges, domestic abuse, and developmental concerns.

There was also a shared view that the programme could align more closely with the First 1,000 Days Programme in Wales in the way it reports to better reflect the focus on reducing inequalities and addressing challenges such as obesity, poverty, and emotional well-being.

> "The programme doesn't reflect what we know about child development - we're behind other areas that focus on emotional well-being and the first 1,000 days."

10.3.3. Difference made

National stakeholders, health visitor leads and health visitors consistently felt that HCWP makes a meaningful difference to children and families, although found it difficult to evidence beyond anecdotal examples. Impact was thought to be strongest where programme contacts happen as intended but delivered flexibly and reduced where emphasis is on completing visits.

Contributors identified several ways in which HCWP supports children and families:

- a universal safety net and baseline level of support. HCWP was widely described as providing a guaranteed set of contacts at key stages in early childhood, ensuring that all children are seen and no family is entirely missed. Contributors felt this standardisation has strengthened safeguarding and reinforced the visibility and value of health visiting
- timely identification of need. Where delivered as intended, HCWP was seen to support the identification of safeguarding concerns, child development delays or parental mental health needs. Regular contact points and home visits allow health visitors to build an understanding of families over time and act on emerging concerns through timely referrals to support services which in turn help to prevent problems from escalating

> "If we weren't visiting or involved as a health visiting service, then those developments wouldn't be picked up as quickly."

- effective coordination and referral. Many health visitors described HCWP as an important coordinating and referral point which allows children and families to access additional services such as speech and language therapy, paediatrician intervention, parenting programmes, and mental health support. The universal nature of HCWP helps build trusting relationships with families, including those who might not otherwise engage with health services. Health visitors described these relationships as central to the programme's preventative work allowing them to identity mental health issues, domestic abuse and early social-emotional difficulties.

> "We're so privileged that we can go into those homes and get that full picture of what's happening with that family. And quite often we're the only professional that is having that routine contact with that family - the first one to identify the needs."

10.3.4. How HCWP guidance supports the difference made by health visitors

Survey respondents were asked how much difference the HCWP guidance makes to their ability to address 20 different health and well-being themes. As set out at Figure 10.1, the majority of respondents (60% or over in each case) reported that the HCWP guidance makes either 'a lot' or 'some' difference to their ability to address 18 out of the 20 health and well-being themes, with over half (55% and 57%) saying the same for the final 2 health and well-being themes.

Survey respondents reported that the HCWP guidance makes most difference to their ability to address themes such as ensuring early intervention for delayed development, sharing key public health promotion messages and reducing sudden infant death risk. For each of these themes, just under half of survey respondents reported that the guidance makes 'a lot' of difference (48%, 48%, and 47% respectively).

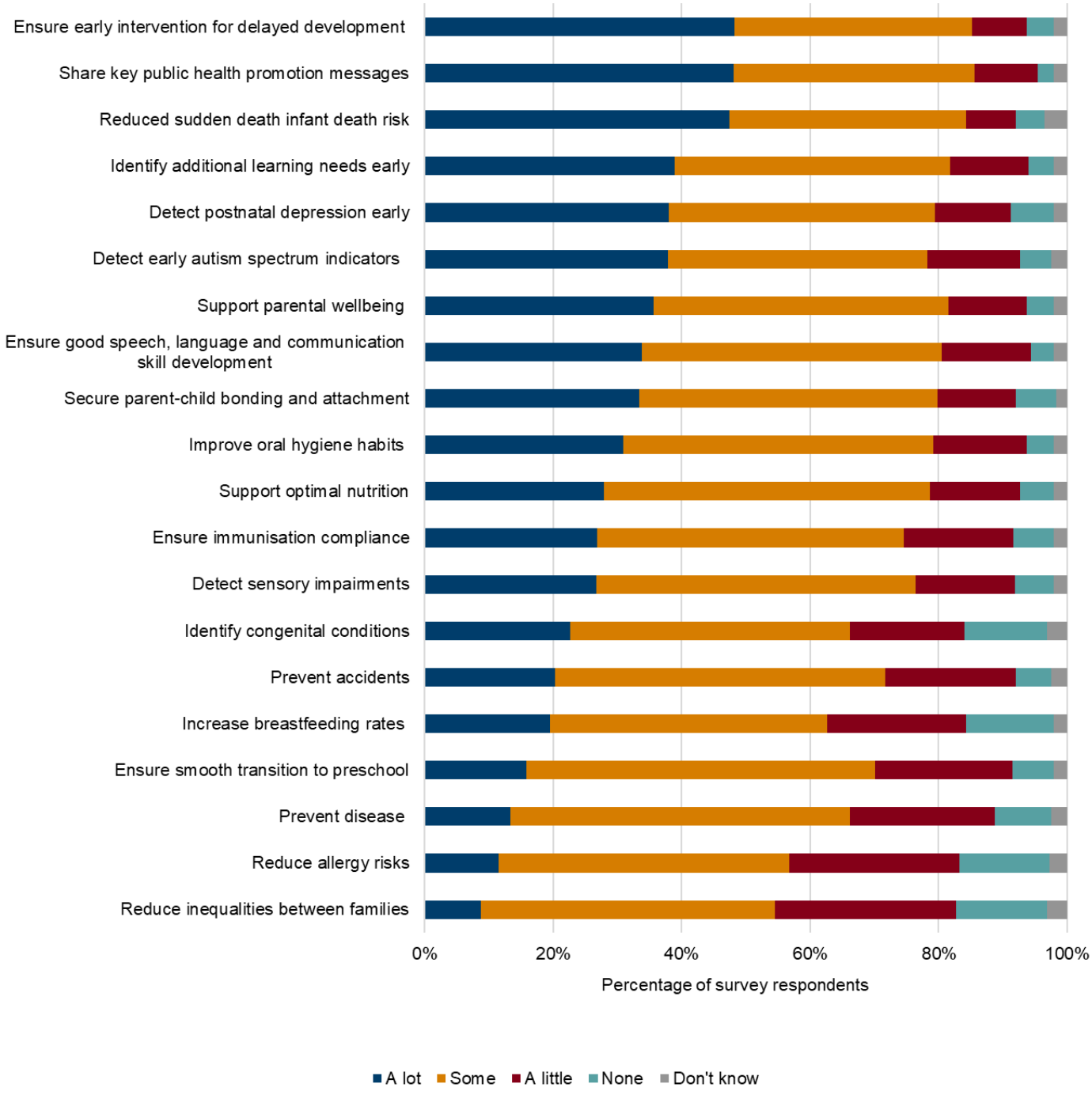
A minority of survey respondents also felt that the HCWP guidance makes 'a lot' of difference to their ability to address a further 13 themes. This ranged from 39% of respondents who felt that it supports them to identify additional learning needs early down to 20% of respondents who felt that it supports them to prevent accidents and to increase breastfeeding rates.

Survey respondents were least positive about how much difference the HCWP guidance makes to their ability to reduce allergy risks and reduce inequalities between families, with only a few reporting that it makes 'a lot' of difference but a little under half still reporting that it makes 'some' difference (45% and 46% respectively).

There were some differences in the overall percentages of those who thought the HCWP guidance makes either 'a lot' or 'some' difference based on the health board area in which they worked. The largest variation was seen regarding themes such as increasing breastfeeding rates and improving oral hygiene habits, whereas the lowest variation was seen across themes such as ensuring a smooth transition to pre-school and ensuring early intervention for delayed development.

There was also variation in the views of respondents based on the type of caseloads they hold. Those with Flying Start caseloads more frequently reported finding that the HCWP guidance makes either ‘a lot’ or ‘some’ difference to their ability to address each health and well-being theme and this was the case across all 20 themes.

Figure 10.1: Survey respondent views on how much difference the HCWP guidance makes to their ability to address each area of health and well-being



Description of figure: A stacked bar chart showing that the majority of respondents reported that the HCWP guidance makes either ‘a lot’ or ‘some’ difference to their ability to address 18 out of the 20 health and well-being themes.

Source: OB3 Research health visiting staff survey, November to December 2025, number of respondents between 284 and 297 for each row.

This positive difference becomes more evident when reflecting upon the reduction in programme services during the COVID-19 pandemic. Interviewed health visitors highlighted that when services were reduced, they missed speech and language issues, observed more delays in toilet training, saw increased parental health problems and a greater number of safeguarding concerns. When services resumed to normal after the pandemic, health visitors realised that early, regular contact helped to identify these issues.

> "We now have children that are going to school that maybe are not toilet trained - we're seeing the aftermath of [COVID] now. It's showcased how important the programme is and how that early intervention is really important."

10.3.5. Illustrative examples where HCWP has had a positive impact

Health visitors were asked to provide an example of where HCWP had a positive impact for a family they work with. The most common impacts cited related to:

- earlier identification and earlier intervention. HCWP was considered to provide health visitors with an approach to identify needs earlier than would have been the case otherwise leading to better outcomes for children because issues were being identified before nursery or school entry. Health visitors described being able to identify a wide range of concerns including speech, motor and social communication delays; autism spectrum disorder (ASD); visual and hearing problems; physical health concerns such as cataracts, constipation and overweight; feeding difficulties; and growth concerns. Examples included:
    - early identification of cataracts following detection of a squint
    - cerebral palsy identified through gross motor assessment at 15 months, leading to early physiotherapy
    - ASD concerns raised at the 15-month contact, enabling diagnosis and specialist placement before school

- identification and support for parental mental health during contact points, particularly during antenatal and early postnatal contacts. Health visitors observed that parents disclosed very serious concerns to them due to the trusted relationship established. They described being able to identify antenatal anxiety and depression as well as postnatal depression. Health visitors reported being able to support parents with these issues, as well as mental health issues stemming from bereavement, birth trauma and isolation. Examples included:
    - disclosure of thoughts of harming a baby prompting immediate safeguarding and mental health intervention
    - identification of domestic violence during 15-month and 3.5-year reviews that may otherwise have remained hidden

  Case study. One interviewed health visitor spoke about the effectiveness of using the FRAIT tool with parents during a home visit. The inclusion of fathers

through these standardised questions was thought to help reveal important and sometimes unexpected issues. “We didn’t really ask dads anything until FRAIT came along. And there’s a section in FRAIT for dads, and we’ve been very surprised at what dads will tell you if they’re present.” The health visitor reported that they had uncovered cases of trauma, abuse and hidden need that might otherwise have gone unnoticed. “I can think of several health visitors where they’ve discussed things like sexual abuse, which their partner didn’t even know. They cried when they started talking about themselves. They were overcome with emotion because they were suddenly asked something.”

- preventative public health work. Health visitors described HCWP as supporting preventative public health work by identifying issues early, often before parents recognise a concern. This included breastfeeding support, oral health, immunisation discussions, healthy eating, reducing screen time, safe sleep and injury prevention. Examples included:
    - families reconsidering immunisation discussions following ongoing discussion
    - sensitive conversations about childhood obesity leading to behavioural change
    - breastfeeding re-established after early difficulties

    Case study. One interviewed health visitor spoke about the positive impact their work around breastfeeding had: “I do a lot of breastfeeding support, so it’s really nice when you do some intensive support at the beginning, you know, the first few weeks and when you see a family through those early initial really hard weeks, then they come through to other side and they’re just so proud of themselves for sticking with it. All those extra support visits have really paid off.”

- advocating and supporting families to access services earlier. Health visitors frequently described their role as advocates and coordinators, including making referrals to health services such as paediatrics, speech and language therapy, physiotherapy, audiology and orthoptics, as well as linking families with community support and advice on housing and benefits. Health visitors also reported making an important contribution to the safeguarding of children, ensuring that cases are identified and escalated appropriately

    Case study. One health visitor recounted the importance of their role in safeguarding children at risk when recalling the case of one baby who had been removed from their home and placed into foster care, before eventually being placed into the care of a grandparent. “You see the benefits when you go into a safeguarding family. You get the satisfaction that you've actually helped [the baby] come out of that situation. I saw a little girl last week [at] 27 months, [who] had a really rough start. Mum was an alcoholic and drug user. I went back to do her SOGS at 27 months - flying is an understatement. I couldn't have stopped smiling. She was in the window telling me it's snowing. Her development was all age appropriate. It could have been a lot worse. So, it was a very positive HCWP contact.”

- trusting relationships. While many health visitors struggled to share a specific example, they nonetheless believed that the real impact of HCWP lies in the relationship built over time with parents. Health visitors commonly described the value of having a named health visitor who can develop a trusting relationship with families and who can often provide reassurances about their child's development. One example captured this well:

  > "A mum rang and said, 'I didn't know who to talk to but I'm feeling brave and I know you, so I rang."

10.3.6. Illustrative examples where HCWP has not worked well

Surveyed and interviewed health visitors were also asked to share an example of where HCWP had not worked well or failed to meet a family's need. Health visitors highlighted:

- limited access to timely onward support. Health visitors expressed frustration at being unable to secure timely and appropriate support for children with identified needs. Contributors cited referrals being declined due to age thresholds or changing criteria, long waiting lists, and referrals repeatedly returning from triage without action.

  "You highlight a problem, then tell them [the family] they have to wait years."

  Rural health visitors noted that transport barriers and limited outreach further restrict access. Examples included children with clear developmental delay unable to access early intervention until later contacts, speech and language referrals declined due to age, families becoming anxious after concerns were raised without follow-up support, and rural families outside Flying Start areas unable to access outreach services. Examples included:

  - a 15-month-old with evident developmental delay unable to access early intervention until 27 months
  - speech and language concerns identified but referrals declined due to age thresholds
  - families becoming anxious after concerns were raised but no support followed
  - a family in a rural area, who lived outside of a Flying Start area and were reliant on public transport, were unable to secure any outreach support services

- contact points too far apart which led to missed or delayed identification of issues. Health visitors repeatedly described children who appeared developmentally typical at one contact but then had regressed or stalled before the next scheduled contact point. Examples included speech and language delays and missed opportunities to support weaning, sitting, walking or play skills.

  Case study. One health visitor described how a child who was living in a safe refuge had major speech delay which had not been fully recognised at the 27-month contact. The issue only became clear closer to school age at the 3.5-year contact. The health visitor referred the case to a play worker and planned a

referral to a speech and language service, but the family moved on before the intervention could be fully delivered. This example illustrates the difficulties of providing the service in cases where families move between areas and are affected by domestic abuse and housing instability

- perceived loss of professional autonomy. Health visitors described the HCWP as being overly prescriptive and increasingly experienced as a “tick-box exercise”, reiterating concerns about rigid timeframes and an over-emphasis on form completion, with some expressing concern that less experienced staff may prioritise paperwork over family-centred practice.

11. Perceptions of parents

11.1. Introduction

This chapter explores parents' perceptions of the HCWP, drawing on focus group interviews. It first sets out findings about the support that makes a positive difference to families, including early home visits, timely clinical interventions and practitioner continuity. It then considers gaps in information and communication, examining how unclear scheduling, limited prior information and weak service transitions affect families' experiences. Finally, it considers the programme's varied impact and outcomes and presents parents' priorities for change to improve service delivery.

11.2. Review findings

11.2.1. Difference made

Parents valued early home visits after birth, especially when these included clear explanations, careful checks and sensitive questions about mental health. Home visiting was seen as practical and reassuring, particularly after caesarean sections, premature births or during the isolation of COVID-19 as not having to travel in the early postpartum period was described as a major advantage.

Timely clinical support made a strong impression, with parents describing how health visitors had successfully identified jaundice, hernias, heart murmurs and speech delays and arranged swift referrals to paediatrics, speech and language therapy, lactation support or mental health services. When this happened, families felt listened to and believed the service directly improved their child's health and their own well-being.

> “I had a little bit of trouble feeding him and I think within...I mean, it was a long time ago and also mad, you know, first baby, COVID times...but I’m pretty sure it was in two days I’d heard from the lactation specialist and an appointment booked to see her.”

> “[I] went last year when I was like not getting paid because I was on maternity. My health visitor got in touch with a food bank and bought, like, a Christmas package up for us. We had, like, 5 bags of food.”

Practitioner continuity and having direct contact details were identified as crucial aspects of good support. Where families saw the same health visitor over time and had a mobile number or reliable text contact, they described trust, flexible problem-solving and rapid responses when new issues emerged such as medication-related weight or feeding problems. Parents also valued health visitors who checked in proactively, followed up by phone or text. Parents provided examples of receiving tailored support in circumstances such as postnatal depression, premature birth or caring for an adopted child. Specialist support, such as from looked-after children health visitors, was particularly valued where it was available, though parents noted this was often time-limited.

11.2.2. Access, information and communication

Across all focus groups, parents reported having limited information about the health visiting service before first contact. Many noted that they did not receive a clear, written outline of what health visitors do, which visits to expect, or which issues were within scope. Several described "finding out as you go", relying on friends, conducting online searches or asking a midwife in order to understand the service. Parents who moved between areas, or across the England-Wales border, found that explanations varied and that expectations changed depending on where they lived.

Parents mentioned that communication around scheduling was often unclear. They struggled to remember or predict when developmental checks were due. Some described how they had only realised they had missed a 27-month or later review when contacted much later on, or when schools raised concerns such as speech delay. Several parents felt that information in the red book was dense and hard to navigate. They mentioned how they wanted a simple, age-linked schedule written in plain language, explaining checks and how to seek extra help.

Parents also described weak transitions between services. They mentioned that the handover from midwifery to health visiting sometimes felt abrupt, with little explanation of changing roles. One parent built a strong relationship with her midwife during pregnancy and felt anxious about losing that connection without understanding what the health visitor could offer. Support for the move from health visiting to school nursing was described as "invisible", often limited to a generic letter. Where these transitions were not clearly explained, parents were unsure who was responsible for monitoring development or whom to contact when concerns arose.

> “We just had a letter saying, if you’ve got any concerns, ring us. But like, I didn’t know where she should be developmentally...obviously then when she went to school, they were like, oh, we think she might be slightly delayed in her speech.”

> “My second I remember having the last visit with the health visitor when she was about four...and then she said, oh, you know, this will be the last visit with me. And then they go to the school nurse...so, the last two years I haven’t heard anything.”

Parents made suggestions for clearer, more consistent and more responsive services. They called for a simple, written or digital explanation of the service at the outset, a visible timetable of developmental checks and explicit information about who does what at each stage from pregnancy through to school entry. They also emphasised the importance of continuity and flexibility: seeing the same health visitor where possible, reliable follow-up for missed appointments, options for home or clinic contact, and appointment times that reflect working patterns and transport realities. Working parents in particular described how they found daytime, clinic-only appointments difficult to attend and requested evening or weekend options.

> “I work full time. I’m a teacher and yeah, a little bit reluctant from my school point of view to be able to let me go out to an appointment during the day. So

> potentially for me appointments of an evening or kind of early evening would be the best. Would have been better for me."
>
> "For us, face to face appts were all done on one set day a week in the clinic... There was no option for appts later in the day, on weekends, etc."

Several requested digital innovations, apps for tracking development, electronic red books, or text reminders for appointments, to complement face-to-face support.

11.2.3. Equity and variance

Parents' experiences of frequency and mode of contact were variable. Some families received regular home visits and flexible follow-up, while others had minimal or no contact, especially during COVID-19, or reported long gaps after the early months. A few felt stifled by repeated appointments around weight concerns, whereas others described a complete absence of support during the same period.

> "We felt very much smothered by it, and we felt very much accused...if it wasn't the health visitor contacting us, it was the hospital. So, we were basically having an appointment pretty much every day of the week."
>
> "It was during COVID and there was nothing. As a young mum, I was scared and I felt completely alone and no idea where to go to."

Parents reported wide variance and differences between localities and across borders. In some areas health visitors routinely visited homes and offered direct mobile numbers whilst in others, parents were expected to attend clinic-based weigh-ins, use a generic hotline or navigate fragmented systems, particularly when care spanned England and Wales. These variations affected ease of access.

The issue of continuity of personnel was raised by many parents as they described examples of how they saw multiple health visitors in a short period, with inconsistent advice on feeding, sleep, vaccinations or development.

> "…the different health visitors basically give us different advice for the same thing. So, we'll follow one set of advice, go to the clinic and then the other health visitor will say, "why are you doing that?" Like you shouldn't be doing that and then we start following her advice and then we saw the original health visitor and she was like, "you don't need to be doing that."
>
> "You could talk to one health visitor, and they tell you one set of guidelines...and then you go back a couple of days later and you see another health visitor...and they're telling you different information."

For parents, frequent staff changes undermined trust and made them reluctant to share sensitive concerns. As such they described an increased reliance on informal networks or internet searches for guidance. Where parents did see the same health visitor consistently, they described this as boosting their confidence and willingness to seek help.

11.2.4. When support falls short

Some parents had experienced interactions that they described as somewhat judgmental or overly checklist driven. A small group felt scrutinised or blamed, particularly highlighting issues around infant size, feeding choices, sleep arrangements or extended breastfeeding, and said this discouraged future contact with their health visitor. One parent described feeling "accused" during repeated weight-monitoring visits, while another felt uncomfortable after a health visitor criticised bedsharing.

> “He’s slept in the bed with us since day one and she was like, oh, I have to tell you not to do that. I have to advise you that we’re totally against that. And I was kind of like, it's very conflicting from what I’ve read online.”

Parents of children with additional or neurodivergent needs reported that their concerns were sometimes minimised or that they had to advocate forcefully for referrals or seek support outside the health visiting service.

> “I personally, I found health visitors quite dismissive...they were just not willing to help.”

One parent mentioned that they had to push for a speech therapy referral and perceived that less confident parents might not have persisted. Missed or delayed developmental checks were seen as a weakness. Parents who discovered problems later, for example, speech delay identified by schools rather than health visitors, questioned whether earlier, structured contact might have led to timelier support. Others worried that the system depended too heavily on confident parents who knew how to push for referrals, leaving quieter or less informed families at risk of unmet need.

11.2.5. Families who do not engage

A consistent picture emerged of the small cohort of families who disengage or never engage at all. This cohort includes highly mobile households (for example, refugees and asylum seekers as well as families who flee domestic abuse), families experiencing homelessness or frequent cross border moves, Gypsy, Roma and Traveller communities, and those living in rural poverty with limited transport and few nearby services.

Health visitors also linked nonengagement to

- practical barriers such as distance required to travel to centralised clinics, work patterns, language and cultural needs
- system factors such as late or incomplete handovers, long gaps between scheduled contacts, unclear responsibility across organisational boundaries, and postcode-based eligibility that can miss need, and
- relational issues including a mistrust of services, fear of multiple professionals entering the home, and limited continuity with a single, trusted practitioner. There was also a view that an increasing cohort of parents actively disengage – making a conscious and intentional decision not to use the service.

Parents' accounts reinforced this analysis, describing unclear information about the HCWP offer and schedule, challenges reaching the right person when only a generic line was available, and occasional experiences of interactions that felt checklist-driven or poorly timed, each of which reduced their willingness to engage.

Participants suggested strengthening cultural and language support and using targeted link worker or specialist health visitor roles (with protected capacity) to build trust in specific communities. Clearer, more consistent handovers and information sharing, particularly when families move across areas or borders, were also viewed as important to prevent breaks in contact and repeated assessments.

11.2.6. Impact and outcomes

Parents described varied experiences of how the HCWP affected their families. Impact depended heavily on the quality of individual relationships, the consistency of their contact with their health visitor and whether support matched family circumstances. Several parents valued early home visits for reassurance and practical guidance, particularly as first-time parents.

> "Certainly, first time round, that's...you know, priceless."

> "I wanted support. I wanted someone to come and tell me, oh, you're doing OK."

> "I had like 6 million questions!"

Clinical support provided through HCWP sometimes made a difference to child and family health, with timely detection and referral seen by parents as directly improving outcomes. Tailored support for complex circumstances also had a strong impact. Parents caring for adopted children, managing postnatal depression or dealing with financial hardship described health visitors who provided specialist knowledge, practical help and regular contact matched to their needs. Parents wanted interactions grounded in respect for diverse parenting practices and family circumstances, with health visiting staff who were confident to support additional needs and to signpost to wider services without stigma. They asked for health visitors who listen without judgment and who tailor advice to individual situations rather than following rigid checklists.

> "I remember always being checked in with [ensuring] that I wasn't being abused vulnerable and really appreciated that."

> "So, she contacted me when I was pregnant...I got a good relationship with her because I had full-on depression. She's been really, really supportive. So, the first visit, because I knew already who it was, it was nice that she then checked up on me every week."

> "Recently my little one had his 12-month vaccines...but due to me recently having depression she wanted to check on me which I thought was amazing."

Many parents felt the service's usefulness declined after early visits. While initial contact provided reassurance, later contact was often less frequent, less structured or felt

procedural rather than responsive to emerging needs. Some parents with prior parenting experience found visits less necessary but felt unable to decline them without potentially raising concerns.

12. Conclusions

12.1. Introduction

Our conclusions are set out below in relation to the 8 identified objectives of the HCWP review.

12.2. Review the original goals and objectives of the HCWP

The review has found that the original goals of the HCWP remain appropriate and widely supported. HCWP continues to provide a national, universal framework that establishes clear expectations for health visiting contacts from birth to 3.5 years. The consistency it provides is valued across policy, management and frontline delivery and is seen as central to ensuring equity of access for families across Wales.

The HCWP's original goals of universal early years support, early identification and intervention, and reducing inequalities remain valid and relevant, and are strongly endorsed by stakeholders. The programme is seen as a flagship framework that provides a safety net and consistent offer, with early contacts (10 to 14 days and 6 weeks) delivered well and valued.

However, the evidence demonstrates that there is a growing mismatch between the formal objectives of HCWP and the realities of health visiting practice. Health visitors consistently report that HCWP captures only a portion of their workload, with substantial time devoted to complex, unscheduled and often intensive work that sits outside the programme's formal structure. As a result, HCWP can feel overly task-focused and does not accurately reflect or capture the breadth and complexity of the health visiting role. The consequence is professionals feeling increasingly over-burdened and this is further driven by workforce capacity constraints, rising family complexity, and rigid compliance pressures.

Workforce capacity is the single biggest constraint identified in the review. Health visitors described increasing caseloads, administrative burden, and emotional strain, with risks to morale and sustainability. The programme's increasing rigidity was seen to erode professional judgement and reduce effectiveness. Without addressing workforce pressures, further expansion of HCWP expectations (including new tools or assessments) risks undermining quality and continuity.

There is also a risk that the programme's metrics and expectations do not accurately represent the services delivered or where pressures are most acute. Key preventative, safeguarding and mental health work, for example, is invisible in national data.

While HCWP remains the right framework, with sound, universal objectives, it requires modernisation to keep up with the pace of change and remain achievable in practice. Specifically, HCWP requires clearer articulation of how universal contacts sit alongside wider health visiting activity. Without this, there is a risk that national oversight focuses on completion of contacts rather than on whether families' needs are being effectively met,

limiting the programme's ability to drive meaningful improvement. Moving forward, the HCWP needs to integrate more flexibility into contact timing and content to allow professional judgement and a proportionate response. Its scope also needs to be refreshed to reflect contemporary priorities such as mental health, healthy weight, additional learning needs and domestic abuse and a greater focus on outcomes (what changes as a result of contacts) rather than the 'tick box' exercise of counting contacts.

12.3. Compare HCWP with similar programmes internationally

The international comparison shows that HCWP is broadly aligned with early years public health programmes in comparable countries. Like many international models, it combines universal provision with targeted responses to additional need, and is underpinned by a preventive, early-intervention ethos. At the same time, international examples illustrate that different policy choices are possible. Some countries place greater emphasis on statutory or near-statutory entitlement, clearer minimum standards for delivery, or more intensive contact in the earliest years of life. Others structure their core contacts around fewer, more developmentally focused reviews, supported by stronger multidisciplinary integration.

The significance of this finding is that HCWP is not a fixed or inevitable model. Wales has scope to adjust how the programme is delivered without undermining its core principles. International evidence suggests that changes to contact timing and integration with other services could strengthen HCWP's impact, but it also highlights that such changes require careful consideration of workforce capacity and system readiness. The implication is that any future reform of HCWP should be seen as a strategic policy choice, informed by evidence rather than constrained by the existing model.

HCWP is also not an outlier in facing some of the issues raised during this review such as the challenges of outcome attribution, accurate data collection and sharing of records across multi-disciplinary teams.

Where HCWP most differs is in the timing and number of contacts and the strength of integration with adjacent early years services (midwifery, early education, speech and language therapy, paediatrics). The Nordic countries provide Wales with some useful examples of how this could be strengthened in a community-based model in line with the ethos of A Healthier Wales. There is also some evidence from the international comparison that Wales is more heavily reliant on performance monitoring of contact completion, with weaker links between data and continuous, local improvement.

12.4. Explore perceptions of the impact of HCWP

It is important to highlight the challenge of attributing any observed impacts solely to HCWP, given that many valued aspects reflect established health visiting practice; as a result, the findings are better interpreted as indicating where HCWP has added value to existing health visiting practice rather than attributing impacts to the programme alone.

The evidence captured in this review shows that HCWP can have a meaningful and positive impact for families when it is delivered as intended. Feedback from parents demonstrate how they value early home visits, on-going relationship with a named health visitor, and

access to professional advice and reassurance. Health visitors describe the important role HCWP plays in enabling this early engagement, building trusting relationships and identifying concerns that might otherwise remain hidden.

Parents value HCWP when it works well but reported some confusion about later contacts, inconsistent communication and a variable experience of delivery depending on locality. Parents would benefit from having a better understanding of the programme and a more flexible offer, as these changes would result in greater engagement and fewer appointments being missed.

HCWP is mainly perceived as impactful for spotting needs early, protecting children, supporting parents' mental health and providing preventative health advice. Impact is at its strongest where contacts are delivered flexibly and tailored to need but weaker where delivery is compliance-driven.

The review finds that impact is inconsistent and highly dependent on local delivery and system capacity. Families' experiences vary between areas, with some reporting reduced contact or limited follow-up. A recurring theme across the evidence is the gap between identifying need and securing timely support. In many cases, HCWP contacts successfully identifies concerns, but onward access to assessment or intervention is often unavailable or delayed, reducing the practical benefit of early identification.

The evidence indicates that the HCWP does not consistently achieve its intended impact for some specific groups of children and families, particularly children with higher levels of need living outside Flying Start areas, families experiencing housing instability or high mobility, and children with additional or emerging needs such as those who are looked after or have potential neurodevelopmental or additional learning needs. For these groups, limited contacts and barriers to accessing timely support constrain the preventative value of the programme.

Children with higher needs but living in areas not covered by Flying Start were repeatedly highlighted as at risk of reduced impact. The evidence indicates that Flying Start enhances engagement and timely interventions, particularly in deprived communities, but postcode-based eligibility creates inequities. Looked after children, and those with potential neurodevelopmental or additional learning needs also often did not receive the additional support required or the identification of their needs did not align well with the HCWP schedule. Many stakeholders favoured a needs-led model that builds on HCWP universal contacts and allows additional support to be triggered through professional opinion and experience. This would help address inequities for high need families outside Flying Start areas while protecting the non-stigmatising nature of universal provision.

Health visitors identified mobility and housing instability as major barriers to continued engagement. Families moving frequently, between health boards, temporary accommodation or across borders, were reported to miss multiple contacts, fall between systems, and experience delays in referrals more frequently.

Parents (both mothers and fathers) also often lacked the follow-on support required for perinatal mental health needs or other issues identified by health visitors. Working parents

reported practical barriers to attending later contacts, especially the 27-month and 3.5-year reviews, leading to missed opportunities for early identification. Families with limited knowledge of child development or limited ability to advocate for themselves were also viewed as more frequently disengaged or overlooked without flexible, persistent outreach. Parents consistently asked for clearer communication about what HCWP offers and when contact points will occur.

The key implication is that HCWP's impact is constrained not by its ability to identify need, but by the wider system's capacity to respond. Identification without intervention increases the risk of parental anxiety and professional frustration without improving outcomes. Strengthening HCWP therefore requires closer alignment between the programme and the services to which it refers, rather than further emphasis on identification alone.

The review highlights that transitions (from maternity or to school nursing) are pivotal but inconsistently managed, with risks of "cliff edges" for children with emerging or lower-level needs. Integration is strongest where relationships and co-location exist but remains fragile elsewhere due to fragmented systems and unclear accountability. Improving clarity and delivery of these transitions would reduce duplication of effort, ensure information is transferred between services and improve family experience.

The outcomes achieved by the HCWP are not reflected in national data currently as the reporting is focused on whether contacts occurred, not what happened or changed as a result. Key activity around safeguarding, perinatal mental health, enhanced support and multi-agency work is all under-reported. The HCWP would benefit from some light-touch outcome and quality indicators (around actions taken, needs identified, referrals, follow-up and resolution), and enable local feedback loops so teams can see and use their data more effectively.

12.5. Review the content and timing of HCWP contact points

Analysis of programme data and stakeholder evidence indicates that HCWP is most effective in the early postnatal period. Completion rates are highest for the earliest contacts, and these visits are highly valued by both families and practitioners. In contrast, completion rates decline for later contacts.

The evidence consistently highlights the period between 15 and 27 months as a point of vulnerability. This is a phase of rapid developmental change, yet the long gap between contacts increases the risk that emerging speech, language, behavioural or social concerns are identified later than optimal. The universal 3.5-year contact is the most contested element of the programme, with widespread concerns about its deliverability, attendance and added value for families with no identified needs.

The implication is that the current contact schedule does not always align with developmental need or service realities. Maintaining the existing schedule without adjustment risks missing opportunities for earlier intervention while continuing to invest resources in contacts that add less value. Reviewing and recalibrating contact timing therefore represents one of the clearest opportunities to increase the effectiveness of HCWP without expanding the overall scale of the programme. Therefore, whilst the

universal logic remains robust the schedule needs rebalancing around the following contact periods:

- Antenatal and early postnatal: evidence suggests antenatal contacts, while part of the HCWP, are not consistently delivered; strengthening this engagement, reducing duplication with midwifery contacts at 10-14 days, and maintaining the 6-week contact with discretion and better alignment with other services could improve effectiveness.
- 8-, 12-, 16- weeks, 6 months: there is an opportunity to be more flexible and streamline the 8-, 12-, and 16- week visits and/or use a skill mix for lower-risk families, separate early feeding support from later developmental assessment and close the perceived long gap between 6 and 15 months with an additional, well-timed review.
- 15 and 27 months: the evidence suggests that there is appetite to replace the 15-month contact with a better-timed developmental checkpoint (around 18 months) and retain the 27-month review due to its high clinical value but allow greater timing flexibility or add an interim review to avoid missed early intervention windows.
- 3.5 years: This was widely viewed as low value and duplicative with nursery/school settings and would be better aligned with school entry via structured transitions to school nursing.

12.6. Assess changes affecting the relevance of HCWP

Current population and policy trends make HCWP more, not less, relevant. The rising prevalence of speech, language and communication needs, an increased recognition of perinatal and parental mental health issues, an increase in more serious safeguarding issues, and persistent inequalities in child health outcomes all reinforce the importance of a strong universal early years offer.

HCWP continues to align with Welsh policy priorities (prevention, early intervention, equity, ALN and mental health). However, additional policy expectations since its inception have expanded faster than its capacity to deliver. The evidence also indicates that the HCWP guidance has not been consistently updated to reflect these emerging challenges. Key priorities such as perinatal mental health, fathers' engagement, early language development, healthy weight and toilet training are addressed unevenly across areas and are not always clearly embedded within programme guidance or training. This in turn contributes to variation in practice and reduces the programme's ability to respond systematically to contemporary risks.

Without a clearer and more explicit alignment with current priorities, HCWP could become less effective over time, even as the need for early intervention increases. Refreshing programme guidance to reflect these challenges would strengthen its relevance and consistency but it must also be accompanied by consideration of workforce capacity and referral pathways.

12.7. Explore access to and use of digital technology and data

The review identifies major weaknesses in the data systems underpinning HCWP. Reliance on paper-based forms and manual data entry leads to under-recording, delays and inconsistencies. This in turn which undermines confidence in reported completion rates and limits the usefulness of data for performance management or service improvement purposes. The variation in recording practices across areas further complicates interpretation of national data.

The practical consequence is that both national and local decision-making are constrained by incomplete or unreliable information. Managers lack access to timely, accurate data to target improvement activity, and frontline staff receive limited feedback on how all the data they collect are used or how their service compares with others which reduces opportunities for learning and improvement.

Improving data quality and usability is therefore not only a technical issue but a fundamental requirement for effective governance and accountability within HCWP. The digital infrastructure is a critical constraint and is not fit for purpose. Paper and hybrid processes, variable practices, and non-integrated systems drive under-recording, delays and duplication of effort. CYPrIS is often seen as a reporting tool, not a clinical support system and cannot provide the type of data that local management and health visitors require.

There is a dire need for a single-entry, integrated Wales-wide digital platform which is aligned to clinical workflows and has built-in interoperability with midwifery, GP services, speech and language therapy and paediatric systems. The addition of clinically useful fields (around actions, needs and outcomes) would further provide frontline dashboards that could support local decision-making, not just national reporting.

12.8. Explore the feasibility of implementing Prosiect Pengwin tools

The review finds that Prosiect Pengwin aligns well with HCWP objectives and contact points and is viewed positively by many strategic and operational stakeholders. There is recognition that improved tools for identifying speech, language and communication needs could add value, particularly given current pressures in this area.

However, awareness among frontline staff is very limited, and there are unresolved questions about training requirements, workload implications for health visitors and the capacity of referral services. The views gathered on its feasibility also vary, particularly in relation to the ages at which the tools would be used (and this is further complicated if feedback about preferred changes to certain contact points are implemented).

Whilst Prosiect Pengwin has potential to enhance HCWP, this can only be achieved if implemented carefully. An initial pilot, followed by a gradual roll-out, is recommended to ensure benefits are realised without creating additional pressure on the workforce or on already stretched speech and language services.

12.9. Summarise strengths, weaknesses, and overall implications

Taken together, the evidence shows that HCWP has a strong foundation: it is universal, widely supported and effective at reaching and engaging families early. It builds trusted relationships with families and undertakes an important preventative public health role and has the capacity to identify and escalate concerns and needs.

Its limitations do not lie in its core concept, but rather in how it is working operationally within a constrained system. The variability in delivery, workforce pressures on health visitors and other key professionals surrounding them (midwifery, school nursing, speech and language), suboptimal contact timing, weak data infrastructure and inconsistent integration with wider services all limit its impact.

HCWP is a valuable programme which provides a useful platform to adapt for improvement. Making some targeted reforms which are focused on timing, data, governance and system integration could lead to meaningful improvements, and ultimately improved outcomes for the young children which the programme seeks to serve. Conversely, maintaining the programme in its current form without adjustment runs the risk of perpetuating uneven outcomes and missing opportunities for early intervention at a time when pressures on families and services are ever increasing.

If the contact schedule is adjusted to fit children's developmental needs, and designed with more flexibility, HCWP will be better positioned to achieve its aims. Strengthening workforce and partner capacity is also essential so that early identification can be followed by timely support.-With modern digital systems, including a single, integrated platform that captures clinically useful data, the programme could become a flagship example of Wales' commitment to supporting future generations.

13. Recommendations

We make the following recommendations as a result of our review of the Healthy Child Wales Programme (HCWP):

Recommendation 1

Welsh Government should reaffirm the HCWP as Wales's universal, progressive early years health visiting framework, while leading a programme of modernisation to reflect current workforce capacity, increasing family complexity and contemporary policy priorities. The universal nature of HCWP should be retained as the foundation of equitable access, but the programme should be refreshed so that it operates as a more flexible framework rather than a rigid schedule of contacts. This modernisation should explicitly recognise the breadth of health visiting practice, including unscheduled and complex work, and ensure that HCWP remains deliverable.

Recommendation 2

Welsh Government, working with health boards and professional stakeholders, should undertake a national refresh of the HCWP contact schedule. This refresh should aim to reduce duplication with other services, close developmental gaps and align contacts more closely with key stages of child development. It should include restoring and formally recognising antenatal health visiting contact, streamlining early infancy contacts where duplication with other services exists, introducing a more developmentally meaningful toddler review around 18 to 24 months, and reducing, replacing or redesigning the universal 3.5-year contact as a more targeted or transition-focused offer aligned to school entry. The outcome should be a refined national schedule with clearer intent for each contact, greater flexibility in timing windows and explicit guidance on when and how input should be intensified for families with higher levels of need.

Recommendation 3

Welsh Government and health boards should seek to ensure that enhanced input is driven more consistently by assessed family need rather than geography alone. This should include reviewing how eligibility for enhanced support is operationalised, reducing reliance on postcode-based criteria where possible, and supporting health visitors to exercise professional judgement in allocating additional input. Strengthening assessment-led provision in this way would reduce inequities between areas and ensure that families with similar levels of need receive comparable levels of support.

Recommendation 4

Health boards, supported by Welsh Government, should adopt a strategic national approach to sustain the health visiting workforce. This should:

- support recruitment, retention, and bank capacity, reducing reliance on goodwill
- minimise administrative burden to maximise clinical time

- promote skill-mix models where they enhance delivery, without replacing qualified health visitors in complex work
- ensure guidance explicitly protects professional autonomy and reinforces progressive universalism based on assessed need
- seek to adequately resource multi-agency pathways so that the needs identified through HCWP can be acted upon

Recommendation 5

Welsh Government should establish a clear national governance structure for HCWP including a programme steering group and named leads for specific areas that require attention such as data and workforce. Roles and responsibilities of Public Health Wales, health boards, and local authorities should be clarified, and expectations for reporting, and escalation of performance concerns clearly set out. Clear governance would reduce ambiguity, support consistent local decision-making, and ensure coherent implementation of policy changes. A short communications package should accompany implementation to ensure shared understanding among health boards and partner organisations and minimise operational confusion.

Recommendation 6

Welsh Government and DHCW, working with health boards, should transform HCWP data and digital infrastructure so that it supports practice as well as improved reporting. This should include developing a single, integrated, Wales-wide digital system for health visiting that aligns with clinical workflows and is interoperable with maternity, primary care, education and social care systems. The system should enable digital, point-of-care recording, reduce duplication and manual data entry, capture enhanced activity including safeguarding and mental health work, and support a shift towards outcome- and quality-focused data. Digital transformation should be phased, co-designed with users and supported by training to ensure adoption and sustainability.

Recommendation 7

Welsh Government should rebalance national HCWP performance monitoring so that contact completion remains important but is complemented by light-touch measures of outcomes achieved. Performance frameworks should move beyond counting contacts alone to include indicators that reflect the effectiveness of contacts and the contribution of HCWP to improved outcomes for children and families. Unnecessary data items that are not used in reporting or analysis, for example, data on female genital mutilation, age at cessation of breastfeeding, age solid foods were introduced, and completion of SOGS, which are not currently published due to poor data quality, should be discontinued to reduce administrative burden on health visitors. Consideration should also be given to using qualitative case studies to provide richer insight into how HCWP contributes to outcomes, helping to more accurately reflect and attribute programme impact.

Recommendation 8

Welsh Government, health boards and local authority partners should strengthen HCWP's role as a central early years' programme by improving integration, transitions and multi-agency pathways. This should include clearer and more consistent antenatal to postnatal transitions from midwifery to health visiting, strengthened and standardised handover from health visiting to school nursing, and improved clarity and consistency of referral pathways into speech and language therapy, paediatrics and early years services. HCWP should also be more explicitly aligned with relevant national frameworks and programmes, including immunisation, the First 1,000 Days and Talk With Me, to support coherent delivery across the early years system.

Recommendation 9

Welsh Government should proceed cautiously with Prosiect Pengwin and not move to national rollout within HCWP until key enabling conditions are in place. Instead, a phased and evaluated implementation approach should be adopted, to include an initial pilot in one area, contingent on workforce capacity and protected time, clear role boundaries and training for health visitors, sufficient speech and language therapy capacity to respond to increased identification, developmentally appropriate assessment points, and improved digital recording systems. Decisions about wider rollout should be based on evaluation evidence demonstrating feasibility, acceptability and impact over time.

Recommendation 10

Health boards, supported by Welsh Government, should improve communication with parents and families about HCWP. This should include providing clear, accessible information on the purpose and timing of contacts, offering better reminders and flexible appointment options, and promoting greater continuity of relationship with a health visitor where possible.

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Annex A: Research instruments

Discussion guide 1: Strategic Stakeholders

A. Introduction

1. Briefly describe your role and how you are connected to the Healthy Child Wales Programme (HCWP).
    - How long have you been involved, and in what capacity (policy, implementation, oversight, advisory)?

B. Programme design and delivery

2. From your perspective, what does HCWP aim to achieve?
    - How well do you feel HCWP's original aims (bonding, attachment, developmental milestones, safe environment) remain relevant today?
    - How did COVID-19 and its legacy affect the programme? Has recovery been achieved?
3. Do the nine scheduled universal contacts (10 days to 3.5 years) still feel fit for purpose?
    - Do you think that HCWP contacts are happening at the right times to identify and address developmental or health concerns?
    - If not, what changes would you make to the contacts and why?
4. In practice, how consistently is HCWP delivered across Health Boards in the way it was intended?

C. Workforce and capacity

5. What is your perception of the current state of the health visiting workforce?
    - *Probe:* recruitment, retention, morale, workload, ageing profile
    - What are the main workforce barriers to delivering the programme in full?
6. How might workforce planning at national level better support sustainable delivery of HCWP?
7. How should HCWP balance existing HV priorities (safeguarding, maternal mental health, breastfeeding standards, immunisation) with its own core contacts?

D. Data, accountability and performance

8. How is accountability for HCWP structured at present?
    - Is there a clear line of governance from Welsh Government through Public Health Wales to Health Boards?

- Are there any gaps in national oversight? (If yes), what are they?
- How effectively is performance monitored and managed?
- How could performance management be improved?

9. How effective is the current system for recording and reporting HCWP contacts (CYPrIS, NCCHD)?
    - What are the known issues with timeliness, completeness, duplication, or under-reporting?
10. How well is outcome data (e.g. developmental milestones, feeding, language, safeguarding) captured, beyond simple contact counts?
11. Could national reporting be improved to support both policy and operational needs? If so, how?
12. What would a “fit for purpose” digital data system look like, and what barriers exist to achieving it?

E. Integration with wider policy

13. How well does HCWP align with other early years programmes and policies?
    - *Probe re:* Flying Start, Designed to Smile, Healthy Weight Healthy Wales, Early Years Transformation Programme.
    - What lessons have been learned about multi-agency working in HCWP (health, education, social care)?
14. How well is the transition managed between:
    - maternity services and HCWP?
    - HCWP and school nursing services?
    - How (if at all) could this be improved?
15. How familiar are you with the Prosiect Pengwin package currently under development?
    - *[Provide explanation if necessary]*
16. What role do you see for HVs in the identification of speech, language and communication needs using the Prosiect Pengwin tool?
    - For each of the screening points (15m, 27m and 42m), would it currently be feasible to
        - use the Prosiect Pengwin tools?

    - signpost to and/ or provide the relevant Prosiect Pengwin intervention during contact(s) with the family?

- What are the potential barriers and enablers to using the tools and interventions?
- What could be changed or implemented within HCWP that would make it easier for Prosiect Pengwin to be implemented?

F. Equity and variation

17. How well does HCWP achieve the right balance between universal provision and targeted services?

    - Is additional support targeted at the right families? If not, how can this best be achieved?

18. Are there any groups of families at risk of being underserved?

    - Probe re: families outside Flying Start areas, rural families, minority ethnic groups, Welsh-speaking families, home educated)?

G. Outcomes and impact

19. What outcomes and impacts should be achieved by HCWP?

20. To what extent do you believe HCWP is achieving its intended outcomes?

    - What is your sense of how HCWP contributes to
        - child development?
        - long-term child well-being?
    - What evidence do we currently have about HCWP's impact on children's health and development?

21. How, if at all, could outcome measurement be improved to demonstrate HCWP's effectiveness?

    - Should HCWP place more emphasis on outcomes rather than contact counts?
    - What should it measure?

H. Future direction and priorities

22. Looking forward, what are the top three priorities for HCWP?

23. Are there examples of good delivery or innovation that could be scaled nationally?

24. What would help Health Boards deliver HCWP more effectively?

    - Probe re: resources, leadership, guidance, training

25. What risks or sensitivities should be managed in any redesign or refresh of HCWP?

I. Close

26. Is there anything important we haven’t covered that you think should be included in the review?

27. Do you have any recommendations for specific contacts, or examples we should explore further?

Discussion guide 2: Strategic Health Visiting Leads

A. Introduction

1. Can you describe your role and responsibilities in relation to the Healthy Child Wales Programme (HCWP)?

B. Programme design and delivery

2. How would you describe what HCWP sets out to achieve?
    - How well do you feel HCWP's original aims (bonding, attachment, developmental milestones, safe environment) remain relevant today?

3. How is HCWP structured and delivered in your Health Board?
    - How is responsibility for HCWP organised within your Health Board?
    - Who delivers which contacts (HVs, nursery nurses, band 4/5s)?
    - Where do contacts take place (home, clinic, digital)?

4. How well do you think HCWP is working in your Health Board/region?
    - How has the COVID-19 pandemic, industrial action, or other system pressures affected delivery locally?

5. Do you think the scheduled universal contacts reflect children's and families' needs in your area?
    - *Probe:* How appropriate are the contacts at 10-day, 6-week, 6-month, 15-month, 27-month, 3.5-year)?
    - Which contact points are most challenging to deliver consistently, and why?
    - Do any of these need to change, if so, why?
    - How do you manage non-attendance or missed contacts?

6. Can you share examples of adaptations or innovations (e.g. virtual contacts, flexible scheduling) that have worked well?

C. Workforce and capacity

7. How (if at all) do other HV priorities (safeguarding, maternal mental health, breastfeeding standards, immunisation) impact the capacity to deliver the nine universal contacts?

8. How would you describe the current capacity of your health visiting workforce?
    Probe re: caseloads, recruitment, retention, morale, age profile, turnover.
    - What changes would most improve workforce sustainability and resilience locally?

9. To what extent is there sufficient training and development opportunities for HVs and other staff to deliver HCWP effectively?

D. Data, accountability and performance

10. How is HCWP data collected and processed in your Board?
    - *Probe:* paper forms, admin staff, HVs entering data directly, CYPrIS

11. How confident are you that the data reported for your region at a national level reflect what is happening on the ground?

12. What are the main challenges you experience around data capturing and reporting?
    - Probe re: timeliness, completeness, technology, duplication, errors?

13. How, if at all, is data used locally to improve practice and monitor quality?
    - *Probe re:* internal dashboards, feedback loops, reporting to the Board
    - How is variation or underperformance addressed locally?

14. To what extent do you feel accountable to Welsh Government or Public Health Wales for HCWP performance?

15. What would help you most to strengthen HCWP data quality and reporting?

E. Integration with wider policy

16. How effective is the transition
    - from midwifery to health visitors at 10-14 days?
    - from health visitors to school nurses at 3.5 years?
    - How (if at all) could this be improved?

17. What is your view on whether the programme should continue only until 3.5 years, or extend through to school entry?

18. How do you link HCWP with:
    - local early years teams,
    - primary care,
    - midwifery,
    - safeguarding (social services),
    - speech and language therapy,
    - community paediatrics?
    - Where are the strongest partnerships? Why is that? Where are the gaps?

19. How familiar are you with the Prosiect Pengwin package currently under development?
    - *Provide explanation if necessary*

20. For each of the screening points (15m, 27m and 42m), would it currently be feasible for health visitors to:
    - use the Prosiect Pengwin tools during contact with the family?

- signpost to and/ or provide the relevant Prosiect Pengwin intervention during contact(s) with the family?

21. What could be changed or implemented within HCWP that would make it easier for Prosiect Pengwin to be implemented?
    - What are the potential barriers and enablers?
    - What needs to happen for Prosiect Pengwin to be feasible at each contact?
    - What needs to happen to make speech, language and communication (SLC) intervention(s) easier for health visitors to implement? (Probe re: capacity, skill mix)
    - Are there any other considerations about the implementation of Prosiect Pengwin that you would like to highlight?

F. Equity and variation

22. How does delivery of the HCWP look different in Flying Start areas compared with universal-only areas (e.g. caseload size, multi-agency support, additional contacts)?

    - How well does HCWP achieve the right balance between universal provision and targeted services?
    - Is additional support targeted at the right families? If not, how can this best be achieved?

23. Are there particular communities or groups who face barriers in accessing HCWP locally?
    - *Probe:* families outside Flying Start, rural populations, Welsh-speaking families, minority ethnic groups etc.
    - What strategies have you used to promote equitable access to HCWP?
    - How do you manage the political sensitivities, if any, around Flying Start boundaries?
    - What could be done to improve access to HCWP?

G. Outcomes and Impact

24. From your perspective, what difference (if at all) is HCWP making to children and families in your Health Board?
    - How does HCWP ensure children are ready to learn when they start their education?
    - How does HCWP contribute to long-term child health locally?
    - What stories or case studies illustrate HCWP's value in your area?

25. How do you measure or track outcomes (beyond completion of contacts)?

26. Where do you feel the programme is underperforming or not meeting its intended outcomes?

27. Should HCWP place more emphasis on outcomes rather than contact counts?
    - What should it measure?

H. Future direction and priorities

28. What are your top priorities for improving HCWP locally?

29. If the programme were to evolve, what would you like to see change?
    - Probe re: timing of contacts, scope beyond 3.5 years, enhanced services?

30. What additional support from Welsh Government or Public Health Wales would make the biggest difference for you?

I. Close

31. Is there anything important we haven't covered that should be included in the review?

32. Are there other colleagues you think we should speak to?

Discussion guide 3: Health Visiting Staff

A. Introduction

1. Please introduce yourself and your role.
    - How long have you worked in health visiting/community child health?
    - Are you working in a Flying Start area, a non-Flying Start area, or both?
    - How has your way of working changed since COVID-19?

B. Programme design and delivery

2. From your perspective, what is the main purpose of HCWP?
    - In a few words, how would you describe HCWP to someone who doesn't know about it?
    - To what extent does HCWP capture the wider scope of your health visiting work?
        - What additional activity (if at all) is not captured?

3. Do the nine scheduled universal contacts (10-14 days to 3.5 years) feel appropriate and meaningful in practice?
    - Probe: which contacts feel most valuable for families?
    - Do you feel that HCWP contacts are happening at the right times to identify and address developmental or health concerns?
    - Do any feel too early, too late, or less useful?
    - What changes (if any) would you make to the contacts and why?

4. Can you describe how you deliver the universal contacts in practice?
    - *Probe:* where do they usually happen (home, clinic, virtual)?
    - How long do they last?
    - What do you typically cover?

5. Which contact points are hardest to deliver (e.g. 6-month, 15-month, 3.5-year)?
    - Why?
    - How do you manage missed or delayed contacts?
    - Do you prioritise any of the 9 contacts at your Health Board? If so, which ones and why?

6. How does delivery look different in Flying Start areas compared with universal-only areas (e.g. caseloads, intensity, additional support)?
    - Does HCWP achieve the right balance between universal provision and targeted services?
    - Is additional support targeted at the right families? If not, how could this be better achieved?

7. Are there examples of adaptations or innovations that helped you deliver HCWP more effectively?

C. Workforce and capacity

8. How manageable is your current caseload?
    - How does the workload of HCWP fit alongside your other responsibilities (safeguarding, maternal mental health, immunisation, breastfeeding support)?

9. What challenges do you face in keeping up with the demands of HCWP?
    - What would help you to overcome these challenges?

D. Data, accountability and performance

10. How do you record HCWP contacts (paper forms, digital, CYPrIS)?

11. What challenges do you experience with recording and reporting (duplication, delays, missing data, triple entry)?
    - How does data entry affect your workload - is it manageable?
    - Do you ever see the data you submit being used (e.g. feedback, dashboards, performance reports)?

12. Are you given clear expectations for HCWP delivery (e.g. which contacts must be done, targets)?
    - How, if at all, is your performance on HCWP measured or fed back to you?

13. What would make HCWP data collection and reporting easier for you?

E. Integration with wider services

14. How effectively do you work with:
    - local early years teams,
    - primary care,
    - midwifery,
    - safeguarding (social services),
    - speech and language therapy,
    - community paediatrics?
    - What is working well? Where are the challenges?

15. How smooth is the handover:
    - from midwifery led support at 10 days?
    - to school nursing at 3.5 years?
    - How (if at all) could this be improved?

16. How familiar are you with the Prosiect Pengwin package currently under development?
    - *Provide explanation if necessary*

17. For each of the screening points (15m, 27m and 42m), would it currently be feasible for health visitors to:
    - use the Prosiect Pengwin tools during contact with the family?
    - signpost to and/ or provide the relevant Prosiect Pengwin intervention during contact(s) with the family?

18. What could be changed within HCWP that would make it easier for Prosiect Pengwin to be implemented?
    - What are the potential barriers and enablers?
    - What needs to happen for Prosiect Pengwin to be feasible at each contact?
    - What needs to happen to make SLC intervention(s) easier for health visitors to implement? (Probe re: knowledge, skill mix, capacity)
    - Are there any other considerations about the implementation of Prosiect Pengwin that you would like to highlight?

F. Equity and variation

19. Are there particular communities or groups who face barriers in accessing or benefiting from HCWP locally?
    - *Probe:* families outside Flying Start, rural populations, Welsh-speaking families, minority ethnic groups etc.
    - How do you try to overcome barriers such as language, culture, transport, or digital access?
    - What could be done to improve access to HCWP?

20. How do families in Flying Start areas experience HCWP differently from those in receipt of universal HV?
    - *Probe:* access to multi-agency teams, smaller caseloads, richer support vs stretched provision in non-Flying Start areas.

G. Outcomes and impact

21. In your experience, what difference does HCWP make for children and families?
    - *Probe:* in terms of bonding/attachment, health, immunisation, developmental milestones, being ready to continue their learning when they start school/their education.

22. Can you share an example of where HCWP made a real positive impact for a family?

23. Are there cases where the programme did not meet families' needs? Can you share an example?

24. Should HCWP place more emphasis on outcomes rather than contact counts?
    - Why do you think this?
    - What should it measure?

H. Future direction and priorities

25. What would make it easier for you to deliver HCWP well?

26. If you could change one thing about HCWP to make your job easier and improve outcomes, what would it be?

I. Close

27. Is there anything we haven't covered that you think is important to the review?

28. Do you have suggestions of colleagues, that we should speak with as part of this review of HCWP?

Discussion guide 4: Other professionals

A. Introduction

1. Please introduce yourself and your role.

- How does your work connect to children and families in the early years?
- In what way are you involved with the Healthy Child Wales Programme (HCWP)?

B. Programme design and delivery

2. From your perspective, what do you think HCWP is aiming to achieve?

- How clear is the scope of HCWP to professionals outside health visiting?

3. Do the nine scheduled universal contacts (10 days to 3.5 years) make sense from your professional point of view?

- Do you feel that HCWP contacts are happening at the right times to identify and address developmental or health concerns?
- If not, what changes would you make to the contacts and why?

4. How does HCWP integrate with your service in practice?

- *GPs:*
    - What is your role in the 6-week check, immunisations, or referrals?
    - Are you familiar with the NIPEC guidance related to the 6-week postnatal check?
    - Have you undertaken any training or CPD modules via HEIW that relate to the 6-week check or NIPEC standards?
    - Was the training sufficient in preparing you for the practical aspects of the check?
    - Do you feel you need further advice or guidance to meet the NIPEC standards effectively?
    - What additional support or resources would help you feel more confident in delivering the 6-week check?
    - What works well during this 6-week check?
    - What are the challenges or barriers faced during the 6-week check?
    - How (if at all) could the 6-week check be improved?

- *Midwives:*
    - How does the transition from maternity care to HVs/HCWP work in practice?
    - What works well in the transition between maternity care to HVs/HCWP?
    - What are the challenges and barriers faced in the transition between maternity care and HVs/HCWP?
    - How (if at all) could the transition from maternity care to HVs/HCWP be improved?
- *SLTs/Paediatricians:*
    - How often do referrals come from HVs/HCWP?
    - How timely are they?
    - How appropriate are they?
    - What works well in terms of referrals from HVs/HCWP?
    - What are the challenges or barriers associated with referrals from HVs/HCWP?
    - How (if at all) could the referral process be improved?
- *School nurses:*
    - How does the transition from HCWP to school nursing work in practice?
    - What works well in the transition from HVs/HCWP to school nursing?
    - What are the challenges and barriers faced in the transition between HVs/HCWP to school nursing?
    - How effective is the 3.5-year contact in preparing children for school entry?
    - How (if at all) could the transition to school nursing be improved?

5. How does HCWP help you deliver your own service and objectives?

- Are there strong pathways for families needing extra support (Probe as relevant re: safeguarding, speech & language therapy, paediatrics)?
- Have things improved or changed since the HCWP been introduced?
- Where (if at all) do you see duplication, gaps, or breakdowns in coordination?

6. Do you observe differences in how families in Flying Start vs non-Flying Start areas experience support?

- What are the implications of this?

C. Workforce and capacity

1. How do workforce pressures in your own service affect your ability to engage with HCWP (e.g. referral waiting times, communication)?

2. From your perspective, how do health visitor workloads impact their ability to collaborate with you?

3. [SLTs] Do you think health visitors have the skills and time to deliver developmental assessments such as those designed to identify speech, language and communication needs(e.g. the Prosiect Pengwin tools)?

4. Is there any duplication in the work of health visitors and other professionals?

- If so, what are they and how could they be resolved?

D. Data, accountability and performance

1. How well does information flow between HVs and your service?

- Probe: referrals, shared records, follow-up information.
- Do you receive information or feedback about HCWP contacts. If so, how useful is it?
- Do data gaps or delays from HCWP affect your ability to plan or deliver services?
- What would make information sharing easier or more consistent?

E. Equity and variation

1. Do you see differences in how families access HCWP support depending on where they live (Flying Start vs non-Flying Start, rural vs urban)?

2. Are there particular groups of families who are less likely to benefit from HCWP?

- Probe re: ethnic minorities, Welsh-speaking, gypsy-traveller families, home schooled)?
- How do those gaps affect your service (e.g. late referrals, unmet needs)?

F. Outcomes and impact

1. In your view, what difference does HCWP make to children and families?

- What evidence do you see that it improves bonding, child development, or health outcomes?

2. Are there particular contacts or elements of HCWP that most support your own service aims?

3. Where does HCWP underperform, leading to missed opportunities for prevention or early intervention?

4. Should HCWP place more emphasis on outcomes rather than contact counts?

- What should it measure?

G. Future directions and priorities

1. From your perspective, what changes would make HCWP more effective?

- Probe: timing of contacts, referral pathways, communication, workforce, integration

2. If HCWP were redesigned, what role should your profession play in its delivery and success?

H. Close

1. Is there anything we haven’t covered that you think is important for the review?

2. Do you have examples of best practice in integration with HCWP that should be highlighted?

3. Who else should we speak to in your profession or network to capture a full picture?

Discussion guide 5: Parents and primary caregiver focus groups

A. Welcome

B. Warm-Up / Introductions

C. Awareness of the service

- When your child was born, what did you know about the health visiting service and what to expect?
- Did anyone explain what visits or support you would get?
- How easy was it to know who your health visitor was and how to get in touch with them?
- Did you feel you had enough information about the health visiting service and what it offers?
- Is there any additional information that would be useful - either before your child is born or afterwards? If so, in what format? (Probe re: paper, digital, app-based)
- For those with more than one child: was your experience of health visiting the same for each child, or different?

D. Frequency and nature of contact

- About how often did you see or hear from your health visitor in your child's first few years?
- Did you get visits at home, in a clinic, or somewhere else? Which worked best for you?
- Did you attend all the appointments that were offered to you? If not, why not?
- Did the amount of contact feel right, or would you have liked more/less?

E. Health checks and support

- Did your health visitor check your baby's weight and growth? How often, and was that useful?
- What advice were you given about feeding (breastfeeding, formula, weaning)?
- How involved were they in explaining vaccinations and supporting you with them?
- Did they check on your child's development - things like movement, play, and talking? Was that helpful?
- Did they ever ask how *you* were coping as a parent? Did you feel able to be honest?

- Were you provided with any resources to read or access? What were they? How helpful were they?

F. Extra support and referrals

- Sometimes families get more frequent visits, or extra help such as parenting groups, play sessions, nursery places or advice from other professionals.
    - Were you offered anything like that? Did you take it up?
    - If yes: was it useful, and did it make a difference?
    - If not: would you have liked that kind of extra support - what and why specifically?
- Were you ever referred or signposted to other services or help (e.g. speech and language, paediatrics, parenting programmes, mental health)?
    - Did those referrals work smoothly? Did you get the help you needed?

G. Transitions and continuity

- Thinking back to the handover from midwives: how smooth was the move from maternity care to health visiting?
- And later, when your child started nursery or school: how smooth was the move to school health services?
- Did you feel supported through those transitions, or did they just stop?
- Did the transitions feel as though they happened at the right time?

H. Differences in experience

- Did you ever notice other parents getting more or less support than you (e.g. more frequent visits, access to local groups, parenting courses, nursery places)?
- Were there things that made it harder or easier for you to use the service (like transport, childcare, work, language, or culture)?
- For those raising children in Welsh: were you able to use the service in your preferred language?

I. Overall impact

- What difference did the health visiting service make for you and your child?
- Did it help you feel more confident as a parent?
- Did it help your child be healthy?
- Did it help your child be ready for nursery or school?

- Was anything important missing from the support you received?

J. Future improvements

- What would have made the service better for you and your family?
- How could visits be more flexible or helpful (timing, location, length, what was covered)?
- Would you like to see more use of phone calls, texts, or video calls, or do you prefer face-to-face?
- If you could change one thing about the health visiting service in Wales, what would it be?

K. Close

- Is there anything else about your experience that we haven’t covered?
- If you could give one message directly to decision-makers in Welsh Government about health visiting, what would it be?

Survey tools can be made available upon request.