The impact of COVID-19 on education and children's services

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Submission to Parliamentary Education Committee by: Institute of Health Visiting

Author: Dr Robert Nettleton, Education Lead

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1. About the Institute of Health Visiting

1.1 The Institute of Health Visiting (iHV) was established with the support of the Cabinet Office and Department of Health in 2012. We are a charity, self-funding through our membership scheme, professional development/training programmes and successful partnership work. Our aim is to strengthen the quality and consistency of health visiting services for the benefit of all children, families and communities and to reduce health inequalities.

2. Our evidence

2.1 In our evidence, we wish to assist the Committee to achieve a broadly based perspective on education and children's services. These services are many and varied, but we wish to draw attention to the capacity of **children's services to support vulnerable children and those who they depend on.** This is particularly pertinent to their **mental and physical health and safety outside of the structure and oversight of in-person education** or other setting or provision outside the home. We will also provide evidence on disadvantaged groups.

3. Key points

- The importance of services for babies and young children – we highlight the significance of infancy and early childhood for outcomes when children enter education and beyond.
- Health visitors (HVs) as a crucial universal preventative service for families of children in these years.
- The impact of COVID-19 on:
  - Rising levels of need;
  - Reduction in support available for families and mechanisms for identifying families who might need help; compounded by
  - Redeployment of health visitors into the wider health service.
- Vulnerable and disadvantaged groups reached systematically by health visitors as a universal service.
- The impact of COVID-19 on families and young children includes a toxic mix of adverse childhood experiences with immediate and long-lasting effects.
- The impact of COVID-19 on health visitors and their service is highly variable but, in many cases, it is drastically pared back.
- The health visiting service capacity prior to COVID-19 had already been reduced and during COVID-19 pandemic is weakened further by redeployment.
- A whole-system approach is needed for recovery from lockdown, key to which is resilience of health visiting service provided to all families.
- Health visiting is key to tackling key cross-government priorities for children.
- We outline next steps and recommended actions: immediate, medium and long term.

4. The importance of services for babies and young children

4.1 We welcome the opportunity to present evidence on the importance of early childhood for childhood health, development and learning throughout the life course. There is rightly concern COVID-19 'lockdown' measures deny school age children many of the crucial benefits of school. However, there is substantial evidence that the greatest influence on children's prospects comes from their first 2-3 years of life from conception, most of which is spent in the home environment and community.

5. Health visitors (HVs)

5.1 Health visitors are Specialist Community Public Health Nurses registered with the Nursing and Midwifery Council (NMC). Health visitors are nurses or midwives who have undertaken additional public health training at graduate or masters level. Their training equips HVs to use their understanding of public health, the wider determinants of health and impact of health inequalities in their skilful work, recognising and responding to individual needs with the aim of improving health outcomes for every child and family.

> *"Health visitors are an essential part of the country's support structure for young children and their parents – especially those who are struggling to cope. But they can only do this if they have the time and capacity to develop good, trusting relationships with families. I am very concerned that the huge pressure on health visitor services is making it harder for them to do this, meaning some vulnerable children are in danger of falling through the gaps."*
>
> **Anne Longfield, Children's Commissioner for England**

5.2 Health visiting is the only service that proactively reaches out to all children and families with babies and children under the age of five to systematically assess health and developmental needs and provide support proportionate to that need. The impact of the COVID-19 pandemic has been three-fold:

- **Rising levels of need:** Living through a pandemic has imposed pressures on families who have been largely confined to the home and may have been facing concerns for employment and family finances, the additional demands of providing 24-hour childcare and the physical and emotional impact of the virus itself on the health of family members.

- **Reduction in support available for families and mechanisms for identifying families who might need help:** The effects of "lockdown" have created an increased level of need at a time when access to usual support from either friends and family or local services, have been removed, or reduced for families with known need and new cases of emerging need. All the usual ways to identify if a family is struggling are also far more limited now.

- **Redeployment of health visitors:** The status of health visitors as registered nurses makes them subject to calls upon them that would not be applied to the wider children's workforce: teachers, social workers, early years practitioners and so on may be challenged by the COVID-19 pandemic but, unlike health visitors, their services have not been reduced by redeployment as nurses to the NHS.

5.3 The NHS guidance on prioritisation of Community Services[1] drastically reduces the health visitor-led Healthy Child Programme to two of the five minimum mandated contacts in the antenatal period and the New Birth review and more limited targeted support for some families. To comply with the government's social distancing rules, most health visiting contacts are also largely taking place remotely, unless there is a compelling need for a face-to-face contact. It can already be hard for parents to share personal worries or problems like domestic violence and abuse, mental health or substance misuse with a stranger, and eliciting needs like these will be even harder over the phone, creating an additional challenge if either parent wants to speak privately about the things that are really worrying them and may be placing them and their children at risk. Breastfeeding support and physical assessments for growth or minor illnesses over a telephone or video call are also far from straightforward. This prioritisation of services means that universal health visitor reviews for older babies and toddlers will only take place where there is known risk but, as we shall show, there are increasingly large numbers of children whose health and other needs will remain hidden, especially

[1] https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/C0145-COVID-19-prioritisation-within-community-health-services-1-April-2020.pdf

the most vulnerable or disadvantaged. **NB. The Guidance on prioritization was revised on 03.06.2020[2] to allow limited restoration of community health services for children. However, the impact of COVID restrictions remain significant.**

5.4 Altogether, health, education and local authority services are the source of half of all referrals into Children's Social Care[3]. Without the services having regular contact with children and families there is a real danger that children will fall through the gaps, going without essential help and intervention from social workers, or early help from the wider health visiting and local early years support services for those below the statutory thresholds.

5.5 For babies there is no substitute for proactively seeking out those who missed checks or haven't been seen; nor for identifying parents who are struggling with mental health or other issues that impact on their parenting capacity without support. The needs of these babies and very young children may therefore remain hidden for a considerable time or remain unknown and therefore unmet.

6. Vulnerable and disadvantaged groups

6.1 Concerns around the needs of 'hidden' children have been exacerbated by the pandemic. Last year the Children's Commissioner[4] drew attention to the large numbers of '*hidden*' vulnerable children, estimating that in total 2.3 million children are living with risk because of a vulnerable family background. Within this group more than a third are "invisible" (i.e. *not known* to services) and therefore not getting any support. At the most extreme end of the spectrum, as in previous years, currently the highest rate of homicide for any age group is in babies under the age of 1[5] . Now, under COVID-19 restrictions, far more children are 'hidden'.

Figure 1: Percentage of health visitors reporting they work with each of vulnerable groups (iHV survey, 2019):

Travellers	64%
Homeless families	77%
Looked After Children	91%
Families of concern	95%
Families with children subject to a Child protection Plan	93%
Teenage parents	90%
Refugees/ Asylum seekers	83%
Perinatal mental health	95%
Adults/ children with disabilities	93%
People with drug/ alcohol problems	94%
People who need interpreters	92%
Children with speech, language and communication needs	94%

6.2 The above table demonstrates that within health visitors' work with *all* families the many faces of vulnerability and disadvantage are mainstream to their work. The health visiting service is recognised as important to both safeguarding and child protection "because it **safeguards all children"[6].** This is because health visiting, uniquely reaches out, proactively, to every family with a child under the age of five in order to identify need and provide or facilitate support across the full spectrum of need.

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[2] https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/C0552-Restoration-of-Community-Health-Services-Guidance-CYP-version-3-June-2020-1.pdf

[3] Characteristics of Children in Need, 2019, Table C2

[4] Children's Commissioner (2019) Childhood vulnerability in England 2019. https://www.childrenscommissioner.gov.uk/publication/childhood-vulnerability-in-england-2019/

[5] Office for National Statistics (2018) Homicide in England and Wales: year ending March 2018. https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/homicideinenglandandwales/yearendingmarch2018

[6] Public Health England (2017) National Health Visitor Programme: Benefits realisation. http://qna.files.parliament.uk/qna-attachments/804278/original/PHE%20Benefits%20Realisation%20Report.pdf

6.3 Our survey provides a snapshot of the experiences of health visitors that highlights their overriding concern that the needs of children and families may be overlooked unless the focus of the national response is broadened to include the secondary impact of COVID-19, alongside the immediate treatment of COVID-19 infected patients. Similar warnings have been raised by leading academics throughout the world who are following the course of this pandemic in other countries. Early evidence from China[7], France and Italy suggests that the lockdown conditions created by the pandemic, particularly the isolation of families, could lead to the doubling of the number of victims of domestic abuse at a time when there is a significant scaling back of the services available to support victims. A similar pattern is emerging in the UK, with the National Domestic Abuse helpline reporting that it has already seen a 25% increase in calls and online requests for help since the lockdown.

6.4 The World Health Organisation (WHO)[8] has reported that the coronavirus pandemic is also inducing a considerable degree of fear, worry and concern in the population:

> *"In public mental health terms, the main psychological impact to date is elevated rates of stress or anxiety… levels of loneliness, depression, harmful alcohol and drug use, and self-harm or suicidal behaviour are also expected to rise."*

6.5 The impact of COVID-19 will be felt across the population as a whole but is likely to have the most detrimental effect on those who are already disadvantaged and, in particular, our most vulnerable infants and children whose needs are at risk of being hidden from sight. A recent paper from Jack Shonkoff[9] warns that:

> *"We cannot lose sight of the massive consequences of these threats to the health and development of our most vulnerable children and their families - now and for years to come… As we pull out all the stops to prevent broader infection, we must also remain vigilant in caring proactively for those who are especially vulnerable to the threat and consequences of social isolation."*

6.6 Our survey also highlights risks to the capacity of the health visiting service to meet these concerns both now and as the longer-term outturn of the pandemic unfolds. There is a risk that the capacity of the health visiting service will be further reduced due to COVID-19 related workforce issues. Health visitors redeployed from health visiting services may not return due to a combination of disillusionment that their specialist skills as health visitors are not valued or their position is not secure; feeling burned-out from their redeployed role and the well-documented stress of working in an emergency pandemic scenario; or concerns that returning to a significantly depleted health visiting service with dangerously high caseloads will leave them unable to deliver the care for which their professional education has prepared them. In addition, the numbers of newly qualified students entering the profession will be reduced as many HV training programmes have been interrupted during the pandemic.

7. The impact of COVID-19 on families and young children

7.1 There is evidence of the impact of COVID-19 lockdown on families from increased calls to help-lines for child abuse, domestic violence and mental health concerns. These three factors combine to form a 'toxic trio'[10] of risk to the physical and mental health of children including babies. Paradoxically, however, there is a reduced rate of referral to statutory children's services for child protection and safeguarding. The universal health visiting service acts as a gateway to other levels of health visiting provision, promoting, supporting and safeguarding the wellbeing of children through its interagency

[7] https://www.sixthtone.com/news/1005253/domestic-violence-cases-surge-during-covid-19-epidemic
[8] World Health Organisation (Europe) (2020) Mental Health and COVID-19 http://www.euro.who.int/en/health-topics/health-emergencies/coronavirus-covid-19/novel-coronavirus-2019-ncov-technical-guidance/coronavirus-disease-covid-19-outbreak-technical-guidance-europe/mental-health-and-covid-19
[9] Shonkoff J (2020) Stress, Resilience and the Role of Science: Responding to the Pandemic. https://developingchild.harvard.edu/guide/a-guide-to-covid-19-and-early-childhood-development/
[10] https://www.childrenscommissioner.gov.uk/publication/are-they-shouting-because-of-me/

and referral work. Under COVID-19 lockdown conditions the capacity of health visiting services to identify and facilitate help to the hidden children and their parents is severely compromised.

8. The impact of COVID-19 on health visitors and their service

8.1 Health visiting is now operating under PHE guidance for prioritisation and risk reduction. This means that the five mandatory minimum contacts, for which best practice would be home visits, are now reduced to one antenatal and one New Birth virtual contact, normally by phone. Paradoxically, this has improved the achievement for these contacts as 'key performance indicators': an 'improvement' in efficiency at the expense of effectiveness – a case of 'ticking box, but missing the point'.[11] This is both a drastic paring back of the universal health visiting service offer and a major change in working practices. It is not, however, inevitable. For example, in Blackpool and enhanced programme[12] of 8 contacts is being maintained of which two are home visits, even under COVID-19. However, this is the exception. In order to inform alternative practices, the Early Intervention Foundation[13] has undertaken a rapid review of the evidence relating to the virtual and digital delivery of interventions for children and young people. The review underlines the key precondition to the uptake of virtual methods of a trusting relationship and 'therapeutic alignment'. This accords with the core practices of health visiting. What parents most value about health visiting is the opportunity for a trusted and knowledgeable practitioner who is readily accessible to them[14]. This particularly applies to the most disadvantaged families who are less likely to access formal or centre-based services. To be effective, services need to be built around the needs of infants, children and their families, with relationships at the core of all health visiting provision. *Continuity of relationships with a known health visitor* and collaboration with other services are essential to the early identification of need and the provision of effective support for families with young children and should be a priority for the rebasing of the service as the strictest requirements of social distancing are eased.

9. The health visiting service capacity prior to and during COVID-19 pandemic

9.1 In November 2019 we surveyed frontline health visitors working with families and communities. Our survey[15], the latest of six conducted annually from 2014, indicates the impact on the quality of the service available to families, and workforce capacity and morale from sustained reductions in funding. It found:

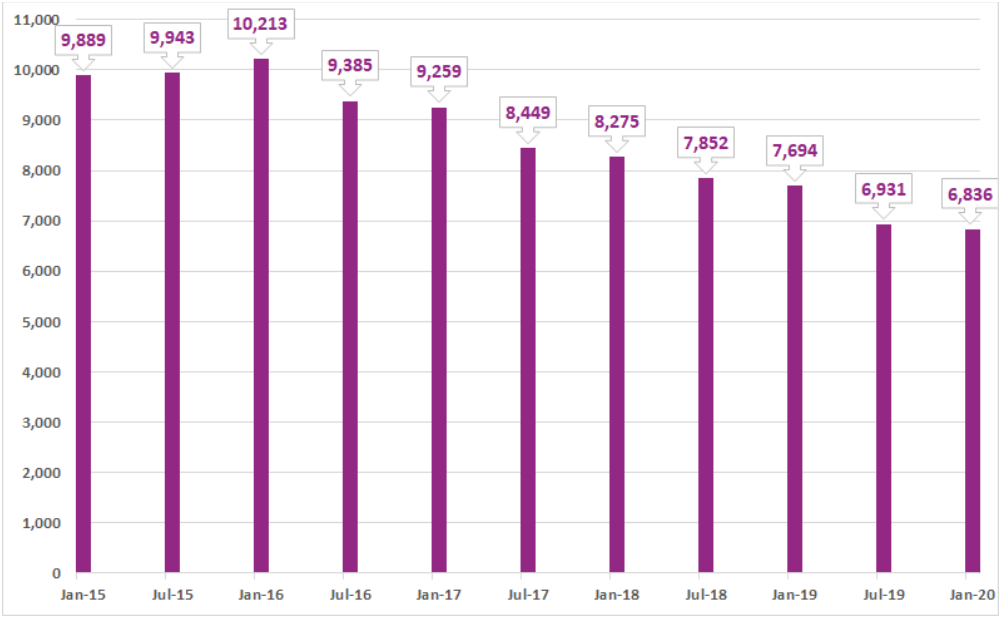
- There is considerable unwarranted variation between local authorities in the quality of the health visiting service that health visitors are able to provide which may not be based on best practice or the family's level of need.
- The health visiting service has become increasingly driven to demonstrate compliance to key performance indicators, reducing their capacity to respond to identified needs and utilise their skills to address key public health priorities and reduce inequalities.
- 'Continuity of health visitor' is increasingly difficult to deliver in practice despite being highly valued by parents and strongly associated with improved outcomes.
- Health visitors report high levels of work-related stress and distress from concerns about the risks to which "hidden" vulnerable children and families are exposed and how many are now left unsupported.

9.2 Key to delivering an effective, quality service is a well-trained professional workforce in sufficient numbers that is well motivated and supported to provide a personalised public health approach to families with young children. In our 'State of Health Visiting' survey in 2019 we describe the increase in health visitors' caseload size due to service cuts. This is due to the fall in the numbers of NHS

[11] https://ihv.org.uk/news-and-views/news/worrying-cuts-to-health-visiting-services-across-england-ticking-the-box-but-missing-the-point/
[12] https://blackpoolbetterstart.org.uk/pregnant-under1/enhanced-health-visitor/
[13] https://www.eif.org.uk/report/covid-19-and-early-intervention-evidence-challenges-and-risks-relating-to-virtual-and-digital-delivery
[14] https://ihv.org.uk/wp-content/uploads/2020/01/HV-Vision-Channel-Mum-Study-FINAL-VERSION-24.1.20.pdf
[15] https://ihv.org.uk/wp-content/uploads/2020/02/State-of-Health-Visiting-survey-FINAL-VERSION-18.2.20.pdf

employed health visitors in England since 2015, see Figure 2 below. (An increasing minority of health visitors are now employed by Local Authorities or independent providers. Anecdotal evidence suggests that the downward trend is steeper outside the NHS).

Figure 2. Fall in the numbers of NHS employed health visitors in England since 2015 and before COVID-19*



Data source: NHS Digital: NHS Hospital & Community Health Service (HCHS) monthly workforce statistics

9.3 Redeployment of health visitors for COVID has drastically reduced the service further in many locations to support the capacity for the NHS to meet the COVID-19 demand. We are concerned that an already very serious gap in provision and overstretched workforce **is being reduced to 50% or less**. Prior to the pandemic in 2019, 29% of health visitors we surveyed were already responsible for 500-1000+ children (iHV, 2020). The recommended maximum number of children per health visitor is 250.

10. Recovery from lockdown and resilience of health visiting within an integrated system

10.1 The COVID-19 pandemic has exposed how fragmented the service landscape is for our youngest children whose health, development and learning are not determined by specific agencies, settings or other categories but the way they combine and support their key relationships and experiences at home and beyond.

10.2 It is widely recognised[16] that reducing inequalities requires a whole-system, integrated approach as prevention and intervention cut across a range of stakeholders working with children and their families[17]. This is also affected by wider determinants of health like poverty, housing and government policy. Health visiting is part of a "system" – we maximise the impact of the service by working collaboratively with partners. Effective strategic leadership across the system is needed to ensure place-based co-ordination across those responsible for the wider determinants of health to enable integrated pathways to:

- Support all children and their families to reduce inequalities in key priority areas;
- Identify children at risk of poor outcomes;
- Provide a continuum of support for a continuum of need, to address multiple key priorities across government departments.

[16] Black M, et. al. (2019) Learning across the UK: a review of public health systems and policy approaches to early child development since political devolution. Journal of Public Health. https://doi.org/10.1093/pubmed/ fdz012

[17] Public Health England (2019) PHE Strategy 2020-25. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/830105/PHE_Strategy__2020-25__Executive_Summary.pdf

11. Tackling key government priorities for children:

11.1 The health visiting service should provide an important part of the solution to numerous current national priorities including:

- Improving early language development and the home learning environment; identifying and supporting families with children with Special Educational Needs or Disabilities (SEND); and safeguarding children from abuse and neglect (Department for Education (DfE));
- Supporting Troubled Families (Ministry of Housing, Communities and Local Government);
- Reducing parental conflict (Department for Work and Pensions);
- Improving parental health literacy to reduce unnecessary A&E attendance in children; improving immunisation uptake; supporting families at risk of, or experiencing, infant and perinatal mental health problems; reducing childhood obesity and poor oral health; and early identification and support for families with children with developmental delay and/or complex health needs (NHS England/ Department of Health and Social Care (DHSC));
- Support to help children living with alcohol-dependent parents (DHSC);
- Improving uptake of child benefit (HMRC), Healthy Start benefits (DHSC) and free education and childcare for two-year olds (DfE) by eligible families;
- Early support to reduce demand on general practitioners by parents with everyday parenting concerns such as feeding difficulties (DHSC).

12. Next steps and recommended actions

12.1 The COVID-19 pandemic has highlighted the weaknesses of the rather fragmented and short-term policies for babies and young children in recent years, particularly in England. It is time for a bold shift in national policy which prioritises the needs of babies, young children and their families which are frequently hidden from sight.

12.2 Health visitors play an important role as part of this solution, providing invaluable universal support to all families and intensive support to those that need it the most. It is imperative that we have a national strategy to rebuild this important service.

12.3 Immediate actions

NB. The publication of revised guidance[18] on the restoration of community health services for children goes some way towards these immediate actions.

I. Deployment of health visitors during the COVID-19 pandemic should ensure the best use of their specialist skills at this time to address the impact of the disease on children and families and only secondarily where there is capacity to support the pressures on the acute healthcare system.

II. Support for the physical protection of health visitors and the families that they visit from transmission of the virus is needed – this will include access to PPE and clarity on guidance for pregnant members of staff.

III. The reduced service offering only an antenatal and new birth virtual contacts should be expanded to include a 6-8 week postnatal contact to assess maternal and paternal mental health and provide support to families in their transition into parenthood and for perinatal mental health problems.

[18] https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/C0552-Restoration-of-Community-Health-Services-Guidance-CYP-version-3-June-2020-1.pdf

IV. Continuity of relationship with named health visitors should be a priority for the service-offer to build trust and confidence for parents; this is particularly important when virtual contacts are the main mechanism for identifying need and providing support.

V. There should be plans to rebase the workforce as soon as possible to strengthen the universal service.

12.4 Medium term actions

I. Urgent (and ongoing) workforce remodelling is needed where local redeployment calculations have not accounted for the predicted increased demand for health visiting services (including, additional advice being requested due to the difficulties in accessing GP advice, supporting vulnerable families, domestic violence and abuse, safeguarding and mental health conditions), as well as the delivery of the current service prioritisation plan.

II. Ensure all health visitors have access to the equipment needed to support video-enabled contacts where this is lacking in provider organisations.

III. Support for the mental health/psychosocial wellbeing of health visitors.

IV. Clear lines of communication to ensure all health visitors are aware of the health visiting service specification during COVID-19, prioritisation of vulnerable families and application of PPE guidance to the settings in which health visitors work.

V. Clarification of plans for student health visitors who have had their training disrupted during the pandemic.

12.5 Medium to long term actions

We set out our recommendations in detail in our Vision for Health Visiting (2019)[19]. The COVID-19 pandemic priorities in the light of the COVID-19 pandemic include:

1. **Workforce:** A workforce plan for health visiting is urgently needed to ensure that the workforce has sufficient capacity to deliver the Healthy Child Programme in full and make good on the depletion of the workforce due to Public Health Grant cuts since 2015; redeployment due to COVID crisis actions; and ensuring a training pipeline by funding training places with a confident vision for a health visiting career.

2. **Funding:** Significant investment in the health visiting service is needed to ensure that the public health grant (or equivalent) supports delivery of the Healthy Child Programme in full to all children through a universal evidence based service that can identify and support the continuum of needs within a wider, integrated system.

3. **Quality:** A cross government department, long-term, post-COVID strategy for children is needed, with clear lines of accountability to address widening inequalities and improve outcomes for all children, particularly in the First 1001 days. This will require greater integration both at national and local level to reduce the current unwarranted variation through a national refreshed Healthy Child Programme. Rigorous evaluation of COVID-19 workarounds are urgently needed and we recommend that an innovation fund is established to support the rebuilding of evidence driven local services.

[19] https://ihv.org.uk/wp-content/uploads/2019/11/7.11.19-Health-Visiting-in-England-Vision-FINAL-VERSION.pdf