Institute of Health Visiting
Excellence in Practice

Health visiting during COVID-19:

An iHV report

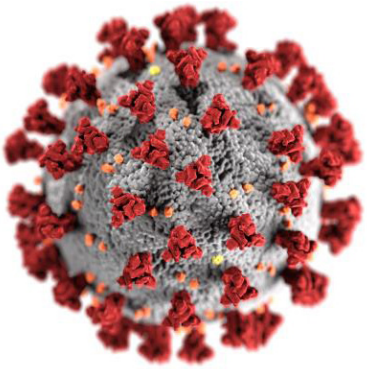

Illustration of the ultrastructure of the Covid-19 virus - CDC/SCIENCE PHOTO LIBRARY

April 2020

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Brief Summary

On April 2nd, the Institute of Health Visiting contacted health visitors through the iHV open Facebook page in an attempt to understand the impact that COVID-19 was having on their practice and the families on their caseloads.

Health visitors were asked to respond to two questions?

1. We are exploring how local health visiting services are responding to COVID-19. If you would be prepared to share what is happening in your organisation please do so here, private message or email us, ideally tell us where you work so we can match up feedback and map it across the country. Your feedback will be collated and used by the iHV to support its core goal of improved services for children and families. Please share what is going well that others can learn from, and what the challenges are that you maybe facing. If you have had to be redeployed, what arrangements for backfill are in place? Please note that iHV never exposes the sources of any information without consent so please do get back to us.
2. Is there anything that you think the national government need to do to **help the health visiting service respond** in the best way possible now? If so, please list here, private message or email us if you prefer.

The Facebook questions achieved engagement from 4,198 individuals, with 187 comments directly onto the post, or through private messages. In addition, the iHV has also received numerous direct emails from health visiting members and non-members through the "Contact us" portal on the Institute of Health Visiting's website and comments directed to us through Twitter. Responses were received from across the UK and the data from all sources were included in this rapid qualitative analysis and identification of key themes.

It is important to keep in mind that these responses are not representative because of self-selection (those who are unhappy with the situation are more likely to respond).

Data were analysed with support from colleagues at the University of Oxford and are set out in seven key themes:

1.	Importance of clear information and guidance to avoid mixed messages
2.	Redeployment - variation in interpretation and implementation across the country/ depleted workforce/ concerns about skill gap
3.	Needs of vulnerable families - challenges of virtual contacts and reduced staffing/ reduced onward referral options for support
4.	IT equipment requirements to enable virtual contacts
5.	Personal Protective Equipment - personal safety
6.	Health visitors' emotional wellbeing at work
7.	Student health visitors

Based on these key themes, the Institute of Health Visiting makes the following recommendations to support the health visiting workforce maximise their contribution and impact as part of the wider COVID-19 response:

1. Urgent 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[1].
2. A system to support on-going review and remodelling of workforce capacity is needed to ensure that the health visiting workforce is responsive to emerging need which may increase over time.
3. 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.
4. Ensure all health visitors have access to the equipment needed to support video-enabled contacts where this is lacking in provider organisations.
5. Support for the mental health/psychosocial support of health visitors – including informal support, alongside more formal access to supervision and mental health/psychosocial support services.
6. Clear lines of communication are needed 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.
7. Clarification of plans for student health visitors who have had their training disrupted during the pandemic.

Findings

1. Importance of clear information and guidance to avoid mixed messages

The respondents spoke about their need for clear leadership that takes account of the breadth of priorities across the healthcare system at a time of national emergency and significant change. Many described a **lack of national and local leadership and communication from the Government** regarding health visiting and protection of vulnerable families. Consequently, there is great variability in how health visiting services respond to COVID-19 with decisions being taken locally.

Decision making and communication:

It is evident that decision making and communication is also variable with a few examples of daily briefing from the Chief Executive in some provider organisations and updating of procedures in response to iHV / PHE guidance which practitioners found helpful:

> *"Staff across the whole board are receiving a daily update from chief exec with a message and any updates. Overall I think our board area are dealing quite well in a situation that is ever evolving."*

Poor communication and lack of clarity was a widespread concern:

> *"There feels to be a lack of real leadership from the top at present."*

> *"We need a national direction on risk stratification for either doing face to face, or telephone contacts. How are we to determine who gets what?"*

> *"The response from our managers so far has been mixed and lacking real direction."*

> *"No one is communicating with us and I feel like we have been treated badly. Our manager has been trying to fight our cause but is being ignored by the head of services."*

> *"There is no HV in our management chain… they have been so slow in responding. I feel we have been let down."*

Rumours of local variation in the COVID-19 response between different health visiting organisations was a source of concern and fuelled anxiety:

> *"There is currently huge disparity between service providers across the country in relation to what health visiting services are being offered."*

> *"I heard that in some areas in the North of England, the health visiting service has been withdrawn... This needs addressing. The union and the government should step in and refuse to let this happen. I don't have any more details.."*

Influencing decision making:

Many health visitors felt that they had not been consulted or included in decision making:

> *"The tone of the communication from management has been hostile when questions are asked."*

Whereas other health visitors appear to have considerable discretion as to how to restructure health visiting provision:

> *"Just to email you to say what I have decided I am doing in my team. I have chosen personally to keep the same three people on the face-to-face clinic drop ins each week. This is because I can very quickly know who they have been in contact with and also importantly to the staff - I am able to quickly isolate set staff they have interacted with and if needed isolate all my clinic staff to then bring in a total fresh set of staff to replace the ones that are in isolation."*

Locations vary in terms of the extent to which they continue to see families face-to-face, but overall locations appear to be trying to minimise face-to-face visits to families with urgent needs. Most other communication is being conducted via the phone (text, call or skype) and some locations have set up health visiting hubs where families with more urgent or compelling needs can come for a face-to-face meeting.

Many locations continue face-to-face assessments for some prioritised contacts:

> *"We are doing all New Birth Visits (NBVs) face-to-face and vulnerable families as required."*

> *"Currently we are undertaking face-to-face new birth visits. Child protection visits and visits for families under our XXX programme (which is an enhanced HV programme for vulnerable families) have been advised to be assessed and only do face-to-face if needed. This is decided by the practitioner. We are also offering clinics by appointment, one at a time for 15 minute slots. There is a lot of discrepancy between practitioners. The more anxious HVs are doing everything by the phone apart from new births, while others are still visiting those they deem need face-to-face support which is subjective."*

> *"We are also 'not allowed' to work from home and are travelling to work to sit in an office, trying to socially distance as much as possible. We have been given side rooms to work in but a) we are expected to continue face-to-face visits and b) the IT technology does not allow for decent connection to complete those visits that we do have to complete virtually/remotely."*

That said, the majority have shifted to doing most of the work over the phone, **with in-person meeting being reserved for families with a compelling need**:

> *"We still have a clinic once a week, so if after a telephone assessment we are concerned we can book them in."*

> *"We are only doing home visits if absolutely required. All contacts are by phone, for NBV calls are made day 4-7, 7-10, and day 10-14. We rotate into hubs to provide HV telephone support daily and offer one clinic a week which is risk assessed by HV and they have to have an appointment. We are being very well protected and the feedback from clients is very positive too."*

Limitations of virtual contacts:

Whilst most health visitors supported the infection control reasons for limiting face-to-face contacts, they also shared their concerns about the risks that this posed to vulnerable children and families having their needs overlooked:

> *"I've raised concerns with a GP and my line manager that telephone contacts are not suitable. If a baby is born early, or is low birth weight/ failing to thrive, seeing them at that birth visit is key to seeing how much support is needed. Mums are extremely vulnerable - even more so. I thought that some contacts could still be done safely if they were called into a clinical setting with obvious safety in place, but at least babies can be weighed etc."*

2. Redeployment - variation in interpretation and implementation across the UK/depleted workforce/ concerns about skill gap

Variation in redeployment across the UK:

The findings from this snapshot review suggest that there is **considerable variation in the way that redeployment is being implemented** across the UK. Respondents described how health visiting is being reduced by 50-70% in some locations, with staff redeployed to support other prioritised parts of the healthcare system and little consideration of the risks to children as the service is removed. In some instances, highly trained health visitors with Specialist Community Public Health Nursing skills were being asked to pick up Healthcare Assistant and ward clerk roles. In contrast, we also heard of a minority of areas that are increasing their health visiting capacity, or not redeploying any staff, to ensure that they are as well-equipped as possible to manage the anticipated increased demand related to the secondary impact of COVID-19 on children and families.

> *"I am pleased to say XXX health visiting service is increasing. 34 staff are being redeployed back in from various services within the trust. Health Visiting in XXX is considered critical to life service at the moment."*

Health visitors' willingness to be redeployed:

Some of the health visitors are happy to be redeployed given the circumstances, others are upset that health visiting is not seen as essential. The majority of respondents are alarmed about the way that the initial focus of redeployment has been on frontline NHS capacity to treat COVID-19 patients, rather than considering the full impact of the pandemic, including the secondary impact across all services.

Here are examples of responses where health visitors are supportive of redeployment:

> *"I have been out of the acute sector for 14 years, but I have volunteered to go back and help if needed. So far I haven't been asked to [respondent is a HV and a practice teacher]."*

> *"The response from our managers so far has been mixed and lacking real direction. I feel they have forgotten they have a large workforce of skilled registered nurses."*

And their concerns:

> *"Obviously, COVID19 is a massive health emergency and I can see that we need to pull out all the stops to deal with this. However, other areas of health provision will suffer and this needs to be mitigated as far as possible."*

Consultation and planning for redeployment, including backfill and remaining service capacity to meet priority needs:

Concerns that there is already a very serious gap in provision and that now **the already overstretched workforce is being reduced to 50% or less**. Prior to the pandemic in 2019, 29% of health visitors were already responsible for 500-1000+ children (Institute for Health Visiting, 2020). The iHV recommends a maximum of 250 children per health visitor.

> *"With less than a days notice, our service was reduced by 50% as half of us were redeployed to other areas, not necessarily ones we had any experience in. There was no opportunity to prepare our caseload or families, or conduct any kind of handover to colleagues left in post. There have been mixed messages to staff about what kind of service they should now be providing. Most contacts are reduced, taking place by phone but by staff who don't even work in our area, so have no local knowledge. It is purely a tick box exercise so they can say a service was provided, but the reality is, it simply will not meet our families needs."*

> *"Management are calculating what numbers of staff are needed for a reduced skeleton service as we all prepare for redeployment."*

"The gaps where the nurses and support staff who have been redeployed has not been filled, the remaining staff will be expected to absorb their caseloads."

"No plan for backfilling HV posts, just that there will be minimal HVs left running our trust's telephone advice service and carrying out phone calls for new births and essential safeguarding."

Questioning whether it is appropriate to redeploy health visitors given their skill set

Several respondents felt that it would be beneficial to public health if health visitors stayed in their roles as their specialist public health skills were needed now, more than ever. They also expressed concern about the current level of their transferable skills. Many have been out of clinical nursing for many years and feel conflicted about being pulled into a role for which they would need additional training, or an unskilled support role, at the expense of being able to meet the increasing demand for the specialist skills that they do have.

All the following quotes are from different participants:

"We are registered Specialist Community Public Health Nurses with post graduate education, skills and experience to support the complex health and social needs of children and families. I would argue that this is way beyond the capability of volunteers... As public health professionals we should be recognised as critical during this public health emergency supported by other services and volunteers… It isn't in any way clear who will have eyes on the families on their caseloads as this crisis deepens.... We may not be in hospitals saving lives, but if our work isn't recognised at the highest level and we are not given the resources to continue to do this vital role, I fear there will be another public health emergency for our children around the corner."

"Trust plan to redeploy adult trained HVs but after 36 years out of clinical nursing am feeling very confused about what I will be able to do."

"We are to complete workshops to refresh skills and most have been out of clinical practice including myself for at least 10 years."

"Our operations managers then phoned to ask about our skill set, of which [mine] is just midwifery, but had no information on where we are being redeployed to. Anything other than midwifery would be out of our scope of practice. I argued that we would be best suited to stay within the HV team."

"I'm a newly qualified HV who went straight into HV after qualifying as a children's nurse. In my trust, management are calculating what numbers of staff are needed for a reduced skeleton service as we all prepare for redeployment (there has been discussions of this being as Health Care Assistants on adult wards)."

3. Needs of vulnerable families - challenges of virtual contacts and reduced staffing/ reduced onward referral options for support

Redeployment will put a lot of stress on the remaining health visitors who are required to absorb the larger caseloads. This is of significant concern given that learning from countries like China and Italy suggest that domestic violence and abuse, safeguarding and mental health needs of vulnerable populations are going to increase as the crisis continues. Health visitors have a good understanding of the needs of their local population and, in particular, vulnerable groups. Respondents highlighted that services should be planning for the secondary impact of COVID-19 on children and families and concerns that in many areas this was not the case.

Identification of vulnerable children:

There was widespread concern that the scaled-down health visiting service and limitations of virtual contacts would reduce the identification of vulnerable children and those at risk of significant harm.

> *"I realise other services are struggling but I really worry about these vulnerable children, hidden away in dangerous homes, away from professionals who safeguard them. I will support other services but are the families on my caseload now insignificant?"*

> *"We are being asked to flag families that are Child Protection, Child in Need and also 'cause for concern.' This is so the skeleton team left after redeployment can prioritise these cases. This seems an impossible task as our assessment of these families is only a reflection of how things stand at the time, and isn't robust enough in a fast moving situation. Also we have no tool to inform this decision making, so it's unlikely to be applied consistently throughout the service. What if we haven't highlighted a family as a cause for concern and they spiral into crisis? Who will be accountable and what organisational risk assessment is in place to help protect us?"*

> *"Those vulnerable children, now shielded from the eyes of early years provision and schools, are the ones we strive to make contact with. When the parents of these children decline our support (citing the need to be in isolation) the judgements we are forced to make weigh heavily on our shoulders."*

Reduced workforce capacity to meet identified need:

Respondents expressed concerns that the widespread reduction in the health visiting workforce due to existing vacancies, staff redeployments and increased absence due to self-isolation, or illness, would lead to reduced capacity to meet identified need.

> *"Work load seems to have increased we are all doing our very best, but nervous that redeployment will leave our vulnerable and special medical needs caseloads at severe risk!"*

> *"No clear direction really about how to protect vulnerable families . I am concerned about children needing safeguarding and not enough experienced HVs like myself left to do the work."*

> *"When I have raised concerns [about lack of support for families] I have been told it is no longer my responsibility as I am no longer the caseload holder. I have also been told that it is likely all staff will end up redeployed and that there will temporarily be no HV service at all where I work during this pandemic."*

Increased demand for support:

Health visitors also reported increasing incidences of domestic abuse, safeguarding and mental health conditions since the start of "lockdown". The ability to support families was further hampered by the reduction/ closure of usual onward referral agencies and other support options for families, including childcare.

> *"Our police concern reports have increased already along with SW referrals whilst covering other bases. It's expected 50 per cent of our staff will be deployed but unsure where."*

> *"Oh my goodness – so many families are calling our health visitors – maternal loss, prem babies, anxious, pregnant women without support. Undercover abuse. Health visitors are needed just as much as staff on the ward."*

> *"I am concerned about the families on my caseload and the risks posed to them during these difficult times. Many families who are no longer in work, nursery or school provision, have now suddenly become even more vulnerable. […]"*

> *"COVID-19 is stressful and uncertain, but may also increase time for building family relationships. I'm recognising patterns seen when families are placed in temporary accommodation. Strengths and weaknesses are exacerbated. Health visitors can be crucial in supporting families to be resilient."*

> *"As much as we want to help there are concerns about this felt across the team. I am extremely worried about our families in XXX especially the most vulnerable. I had a mother suicidal ringing me this week and I was able to help her and immediately respond. What happens when the named HVs are no longer there and this is only going to get worse as time goes by with increased mental health issues and child vulnerability being put of sight and at home all of the time. […] We need to stand our ground and keep health visiting up and running at a critical time where the vulnerable need us the most."*

4. IT equipment requirements to enable virtual contacts

Health visitors will be prioritising their work and will only be doing a face-to-face contact if it is deemed absolutely essential. That means the majority of the support they provide is being done remotely - even for vulnerable families. Some areas are further ahead with this than others and are able to use video-enabled technology, but some are reliant on having conversations over the telephone.

Some respondents shared positive stories about the use of virtual contacts:

> *"I have found the telephone contacts I make to be pretty comprehensive and the women I have spoken to have been really appreciative."*

> *"Our digital offer [Name] is coming into its own with COVID. We also have a health visitor moderated parents' forum for new mums in the county to communicate with each other."*

> *"We are using digital solutions to continue supporting children and families."*

Many areas do not have the capability, including necessary IT software and hardware to support video-consultations:

> *"We are only doing a specialist HV led clinic once a week by appointment only, new births and postnatal universal contacts via telephone and we are still trying to set up video appointments."*

> *"We were told we would be provided with technology for virtual face to face, this is not yet enabled."*

Obviously, the concern is that it is harder for health visitors to spot the signs of problems when not seeing families face-to-face – there is a particular risk for vulnerable families in terms of helping identify safeguarding issues, domestic abuse or mental health problems.

5. Personal Protective Equipment - personal safety

Health visitors that continue to meet clients face-to-face are required to follow the national guidelines for Personal Protective Equipment, however, many report lack of appropriate protective equipment and are also fearful that they are not sufficiently protected.

Lack of PPE:

"We are being told to continue home visits for new births as normal. We have no PPE, not even hand gel! Staff are understandably frightened for themselves, their own families and our clients! The midwives locally are using aprons, masks and gloves for all contacts and seeing them on their own with baby in a clinic. We then turn up at their home with no PPE whatsoever which makes parents feel very anxious and no one understands why this is OK!"

"There is no PPE available and we were advised at one point to buy handwash and towels for ourselves (name of area supplied)."

"We have no PPE as of yet and one bottle of hand sanitiser left for about 20 staff."

"As yet we have not been provided with any PPE for face-to-face contacts which is very worrying and have not received any guidance to say if we will be receiving any yet (name of area supplied)."

Lack of consideration of the specific working conditions of health visitors in the national PPE guidelines:

Health visitors asked that national guidance was applied to health visiting practice. They reported feeling concerned that they may transmit or contract COVID-19 as:

- They are unable to categorise families as COVID-19 positive as some individuals may be asymptomatic
- they will be unable to maintain 2 metre social distancing in many homes due to lack of space and the number of people who may be present at a home visit, including other children, as well as the need to be within 1 metre of the mother/ baby in order to complete the assessment
- they have no control over the level of hygiene or air flow and may therefore come into contact with the virus and transmit this from one home to the next, as well as feeling concerned about their own safety.

"A clear national decision needs to be made on visiting or not and if we are to visit clear guidelines how this is to be carried out and given full PPE."

"We are currently working on the advice from senior HV management to continue FACE TO FACE contacts unless the families have symptoms, which we are expected to judge via telephone triage prior to home visiting. In some cases, families have informed the HV that they are well and, upon attendance for face-to-face visiting, they disclose some recent illness."

"A further concern is that we do not know if we are carriers, positive, negative for Covid-19 and yet we are expected to carry out as many face to face contacts as possible."

"We have been told that we can have PPE if families have symptoms but if no symptoms-then we cannot have PPE."

"We are told to do the visits with nothing unless parents say they are suffering COVID19 symptoms."

"As for PPE we are permitted to use apron and gloves in clinic but otherwise face-to-face contacts are only permitted if not symptomatic and so PPE is not allowed."

Specific concerns related to the needs of members of the health visiting team who are pregnant during the COVID-19 pandemic:

"I have been told that I must also come and work alternate weeks from the office despite being 14 weeks pregnant and therefore being classed as 'at increased risk of severe illness from coronavirus'. Both [my trust] and government guidance states that pregnant women are advised to be 'particularly stringent about social distancing'. The offices I have to choose from are not large and are used by many people which will make it very hard to follow social distancing measures at all, let alone to be 'particularly stringent' of them. It will not benefit the role I am being asked to do in any way if I go into the office, the only difference is that I will be exposing myself and my baby to a much greater risk of contracting coronavirus."

"The RCOG has also published advice that suggests that I should be supported to work from home if this is my choice."

6. Health visitors' emotional wellbeing at work

It is no surprise that many respondents described feeling anxious and unsettled by the rapid pace of change, loss of control, sense of professional self-worth and the wider impact of COVID-19 on many aspects of their work:

"The anxiety and stress and worry for our Pin, our livelihoods-being asked to practice outside of competence, and our families is raw and ongoing. I am absolutely shocked and dismayed at how the iHV, unions and the Government could allow this to happen. We were told in writing of our redeployment on the 27th March and deployed by the 30th. We had NO time to handover our caseloads of vulnerable families. There is so much more I want to write but I do not have the energy. I very much doubt I will be returning to Health visiting when this is over."

"I am concerned that not only are we NOT helping in protecting our families from this pandemic virus but our voices as Health Visitors and PUBLIC HEALTH specialists are not being listened to. This is, of course, causing some anxiety and poor morale amongst staff members."

"I'm sure we will find our feet in the new roles and prove useful in some way but currently there is a lot of ill feeling and talk of leaving the trust completely."

"It is all very sad… This is having a huge effect on staff morale in feeling supported and safe in our practice in the previous days and weeks in addition to the weeks ahead."

"I think this is something we have overlooked, staff safety and well-being. We are bending over backwards to ensure families are safe."

"I feel that health visiting is undervalued, which is very demoralising."

7. Student health visitors

Student health visitors (Specialist Community Public Health Nursing programme - SCPHNs) have responded with concerns that they do not know how, whether or when they will be able to complete their professional programmes preparing them to practise as health visitors. Some are being redeployed into other nursing roles as described for the wider health visiting workforce. They express anxiety about completing their training and whether they will have a future in health visiting.

> *"I'm a student health visitor, half way through the training, we are really keen to know what will happen to us."*

> *"I have my research module essay to write and just can't get my head into it. Placement is due to start on Monday and I can't plan what I should be doing. Hope you get some answers soon."*

Concerns about lack of information on SCPHN training were also raised by course leads:

> *"I'm course leader at XX University. we have had no advice from HEE, NMC on managing students. HVs have been redeployed in some areas, just phone calls in others. As for students 3/4 providers have agreed to intermit students until August. This has an impact on recruitment so we will not recruit until Jan. even the following Sept.. We made local decisions based on whether students will reach their competencies. Any guidance would be welcomed."*

Another example of local HEE and university collaboration indicates students having an extended programme to facilitate part-time redeployment. The Institute of Health Visiting has received numerous emails from SCPHN course leads requesting information and national guidance on plans for the current SCPHN students.

Discussion

The findings from this snapshot of the experiences of health visitors 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 concerns have been raised by leading academics throughout the world who are following the course of this pandemic in other countries. Early evidence from China[2], 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[3]. 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.

The World Health Organisation (WHO)[4] 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."*

COVID-19 is non-discriminating – its impact will be felt across the population as a whole and 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 by Jack Shonkoff[5] 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."*

It is therefore imperative that the national response to COVID-19 incorporates both the immediate focus to treat people who are infected with the virus, as well as children and families at risk of harm from the secondary impact of the pandemic, including domestic violence and abuse, safeguarding and mental health conditions. Health visitors are Specialist Community Public Health Nurses with a focus on child and family public health. They are therefore ideally placed to make best use of their public health skills during this public health emergency. Like all parts of the healthcare system, the first priority will be to ensure that the core functions of the health visiting service set out in the Community Prioritisation Plan[6] can

be met. Careful consideration and workforce modelling are needed to inform any decisions on workforce redeployment. This is essential to ensure that the needs of children and families are not overlooked and that the health visiting service is equipped to manage the expected increase in demand for support for all families adjusting to the wider impact of the pandemic and the most vulnerable in particular. Already, health visitors are reporting that more families are seeking their advice as they are finding GPs harder to access and it inappropriate to attend A&E, rather turning the clock back to how it was 15 years ago before HV numbers started to be reduced.

The findings from this review also highlight the considerable stress being experienced by the health visiting workforce at the time. It is important that all staff are protected as far as possible from the physical and emotional impact of working in this pandemic – this includes the provision of PPE to minimise the risk of virus transmission, as well as support for their mental wellbeing. The WHO[7] highlights that,

> *"Keeping all staff protected from chronic stress and poor mental health during this response means that they will have a better capacity to fulfil their roles. Be sure to keep in mind that the current situation will not go away overnight and you should focus on longer-term occupational capacity rather than repeated short-term crisis responses."*

The WHO also highlight the importance of organisations building-in time for colleagues to provide social support to each other, alongside more formal access to supervision and mental health/ psychosocial support services are also recommended. It is important that the above provisions and strategies are in place for both workers and managers, and that managers can be role-models for self-care strategies to mitigate stress. Due to requests, the iHV are looking at what we might develop to support the workforce in managing their high levels of stress.

Finally, the respondents in this review have highlighted the avoidable confusion caused by mixed messages and the lack of clear national and local guidance. It has been argued by many that we are in unprecedented times and, as a result, the way forward has not been clear at times and the lack of clear messaging has therefore been unavoidable. However, in its recent guidance on "Mental health and psychosocial considerations during the COVID-19" outbreak, the WHO[8] has highlighted the importance of ensuring that good quality communication and accurate information updates are provided to all staff and workers. Health visitors are asking for accurate information on the way that services are being reconfigured, with support for implementation, including local/ national support to expedite the provision of resources to support home working and video-enabled contacts where this is currently lacking.

Recommendations

1. Urgent 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[9].
2. A system to support on-going review and remodelling of workforce capacity is needed to ensure that the health visiting workforce is responsive to emerging need which may increase over time.
3. 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.
4. Ensure all health visitors have access to the equipment needed to support video-enabled contacts where this is lacking in provider organisations.
5. Support for the mental health/psychosocial support of health visitors – including informal support, alongside more formal access to supervision and mental health/psychosocial support services.
6. Clear lines of communication are needed 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.
7. Clarification of plans for student health visitors who have had their training disrupted during the pandemic.

References

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“Health visitors are vital to families during this pandemic.

We build relationships with these families, they know us, reach out to us.

We are a safety net for some of these families.

The fallout from all of this is going to be huge.

I understand that there is immediate threat to life but mental health, domestic violence, child abuse are all life threatening.

Our roles needs protecting.”

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