The impacts of COVID-19 on Health Visiting in England

First Results

Authors:

Gabriella Conti (UCL) and Abigail Dow (UCL)

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1. Executive summary and policy recommendations

The COVID-19 pandemic, NHS England's prioritisation of community health services (19 March to 3 June) and the government-imposed lockdown have placed significant pressures on the health visiting workforce and the services it provides, at a time when public health is already under strain from years of repeated budget cuts. A large number of health visitors across England were also redeployed out of their teams to support the COVID-19 workforce. Health visitors help children get the best possible start in life by providing a universal service to all families that does not discriminate, and additional support proportionate to need, to prevent and reduce health inequalities. Our first findings provide concerning evidence on the impacts of COVID-19, lockdown restrictions and redeployment on the ability of health visitors to deliver these benefits for young children and families.

This briefing note presents the first key findings from new survey data collected between 19 June to 10 September 2020. We find that:

- There has been widespread redeployment of health visiting staff, and in some local areas teams have suffered large reductions in size. 61% of respondents reported that at least one member of their health visiting team was redeployed during the time period of 19 March to 3 June.

- Managers of health visiting teams report redeployment of 0-80% of health visitors in their team, and 10% of managers surveyed lost over 50% of the health visitors in their team.

- Redeployment of staff due to COVID-19 meant that in many cases the number of children a health visitor was responsible for increased. 38% of the respondents reported an increase in the number of children they were responsible for during the time period of 19 March to 3 June.

- Health Visitors continued to provide some face-to-face contacts, but were at risk of contracting COVID-19 due to close contact with clients with symptoms and inadequate PPE. Among respondents who delivered any face-to-face visits, 34% did not have appropriate Personal Protective Equipment (PPE) at some point from 19 March to 3 June - even basic items such as masks, aprons and hand gel.

- With face-to-face contacts limited and increased caseload size, there was widespread concern amongst health visitors that the needs of many children would be missed from 19 March to 3 June. 96% of respondents were concerned about children in homes at risk of domestic violence and abuse.

- The increased workload and pressures have had significant negative impacts on staff wellbeing and mental health. 68% of respondents reported that their stress levels at work have increased over the past year; of these, over a third (37%) told us that if they could leave health visiting, they would.

It is essential that lessons are learned from the COVID-19 experience to bring about positive change and inform better system preparedness to meet the needs of children and families in the future. We make the following policy recommendations:

- Whilst the country still faces considerable infection control challenges due to COVID-19, health visiting services should be reinstated (where not happened already) as a matter of urgency as a vital support and safety-net for children, with appropriate measures put in place, including the use of PPE, to reduce the spread of the virus.
- Health visiting services must be fully prepared for any future waves of COVID-19. NHS England should revise the Community Prioritisation Plan (for phase one pandemic management) and develop clear messages on the importance of continuation of the health visiting service to ensure the needs of children are prioritised. This should include removing wording on the redeployment of health visitors.

- A clear workforce plan is needed to ensure that the health visiting service has sufficient surge capacity to manage the backlog of missed appointments, as well as demand for support due to the secondary impacts of the pandemic, with predicted increases in the number of vulnerable babies and young children due to associated increases in family stress, domestic violence and abuse, mental health problems and safeguarding.

- An evaluation of the use of virtual, non face-to-face service delivery methods is urgently needed to determine their effectiveness for identification of vulnerabilities and risks, impact on child and family outcomes and reducing inequalities to inform future digital change. It is important that we learn from both the successes and failures of the COVID-19 service "workarounds" to support service improvement.

- Whilst all families are impacted by COVID-19, the most detrimental effects are felt by those who are already disadvantaged - in particular, our most vulnerable infants and children whose needs are often hidden from sight. A cross-government strategy is needed to reduce inequalities and "level-up" our society - this will require investment to strengthen the health visiting service which plays a crucial role in the early identification and support of the most disadvantaged families.

- The impact of working during the COVID-19 pandemic on staff wellbeing cannot be underestimated - a proactive plan is needed to ensure staff have the right support during the restoration of services and to create high quality workplaces for all staff in the future. This requires leaders at all levels to support a workplace culture built on collaboration, inclusion and compassion. Professional competence and control requires staff to have sufficient autonomy to lead a personalised health visiting service, rather than being overwhelmed by excessive chronic workload and overly bureaucratic processes.

2. Key findings

a. There has been widespread redeployment of health visiting staff, and in some local areas teams have suffered large reductions in size.

There was wide variation in the redeployment of health visitors across the country, which was determined at the level of the local authority. 61% of respondents reported that at least one member of their health visiting team was redeployed during the time period of 19 March to 3 June. In 40% of the teams which experienced redeployment, at least one staff was assigned to a hospital COVID-19 ward.

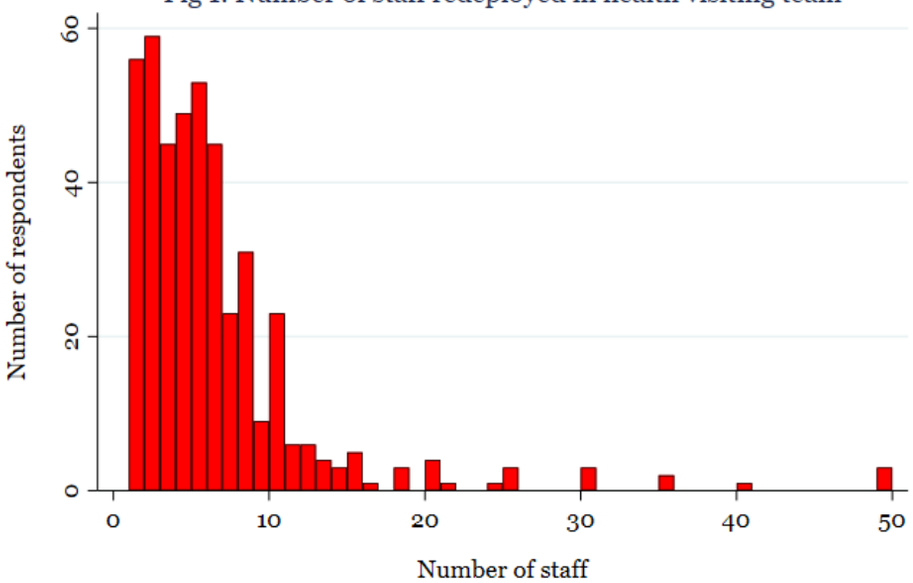
Figure 1 and Table 1 below show the distribution of responses to the question "*How many staff in your health visiting team were redeployed?*" Although many teams had a small number of staff redeployed, some experienced a substantial loss: 40% of the respondents belonging to teams which experienced a loss reported that between 6 and 50 staff members were redeployed. In approximately 12% of teams which experienced a loss, this means a redeployment of at least half of their staff.

Table 1: Number of staff redeployed in health visiting team

Number of staff	Frequency	Percent
0	286	39.4
1-5	262	36.1
6-10	131	18.1
11-15	24	3.3
16-20	8	1.1
21-30	8	1.1
31-50	6	0.8
Observations	725	100.0

Note: we exclude one individual from the sample who reported that at times some team members were redeployed and respondents who did not know how many staff were redeployed.

Fig 1: Number of staff redeployed in health visiting team



Note: the sample is restricted to respondents who had team members redeployed.

Few teams (8% among those with personnel redeployed) gained additional staff to fill the gaps during the time period of 19 March to 3 June; when given the opportunity to provide more detail, some respondents said that staff sickness exacerbated the availability of personnel. At the time of the data collection, in approximately half of the teams which experienced redeployment there were still some staff who had not returned to their role.

b. *Redeployment of staff due to COVID-19 meant that in many cases the number of children a health visitor was responsible for increased.*

Health visitors who were not redeployed were faced with increased caseloads during a time of great uncertainty and difficulty for many families. 38% of respondents reported an increase in the caseload size - the number of children they were responsible for - during the time period of 19 March to 3 June. While approximately three quarters of the respondents were already caseload holders, one in five of those without prior caseload acquired it after 19 March.

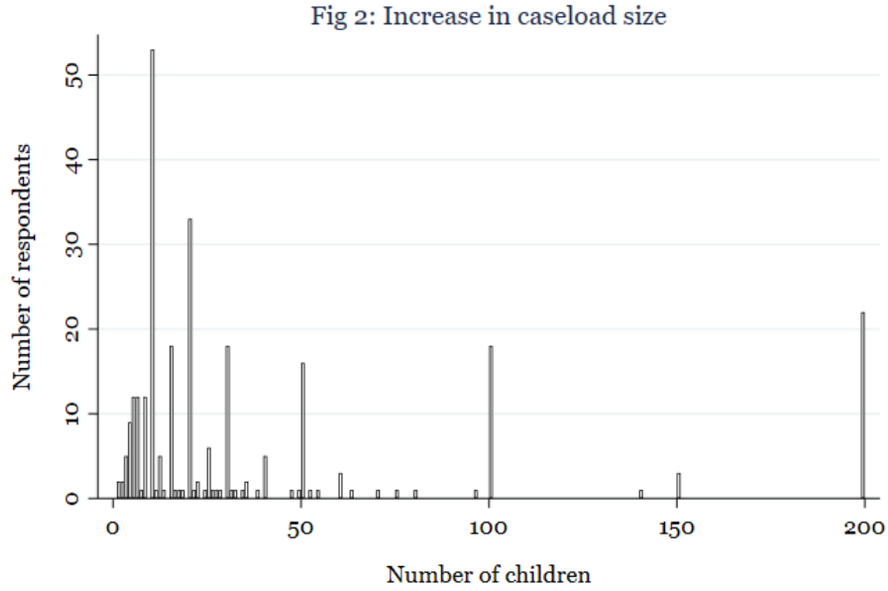
The distribution of increases in caseload size is displayed in Figure 2 and Table 2 below. A number of respondents had their caseload increased by up to 200 children: for few of them, this means increases by 50% or more. Furthermore, some respondents reported that remaining health visiting staff were left to manage increased caseloads of complex families and a higher proportion of child safeguarding work.

Table 2: Increase in caseload size

Number of children	Frequency	Percent
1-10	108	38.2
11-20	61	21.6
21-30	31	11.0
31-40	11	3.9
41-50	18	6.4
51-100	28	9.9
101-200	26	9.2
Observations	283	100.0

Note: the sample is restricted to respondents that had an increase in caseload size during 19th March-3rd June.

Fig 2: Increase in caseload size



Note: the sample is restricted to respondents that had an increase in caseload size during 19th March-3rd June.

Despite the supposed restoration of community health services for children and young people on 3 June, of the health visitors who experienced a change in caseload size after 19 March, 73% reported that their caseload had not returned to their usual caseload size but remained higher.

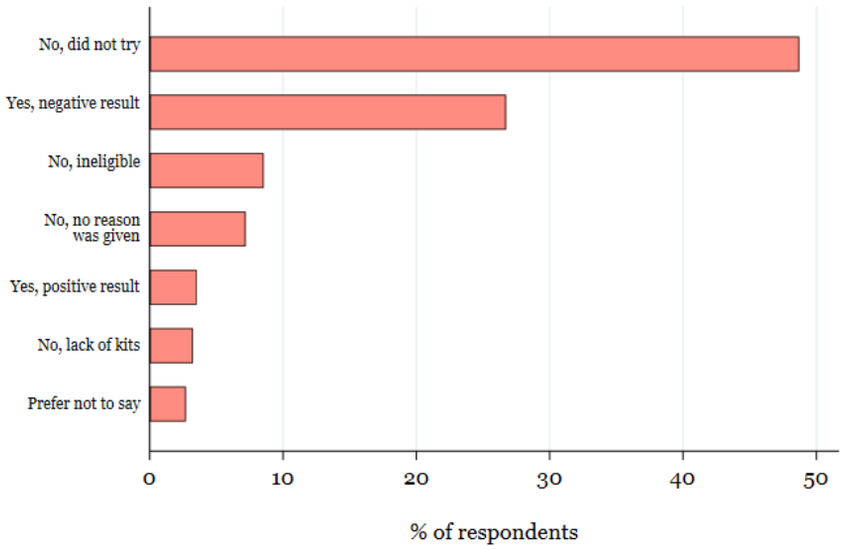
c. *Health Visitors continued to provide some face-to-face visits, but were at risk of contracting COVID-19 due to close contact with clients with symptoms and inadequate PPE.*

Health visitors were asked to deliver across the following key priority areas between 19 March and 3 June, according to the COVID-19 Prioritisation within Community Health Services Plan: antenatal contacts (virtual), new baby visits (or when indicated virtual contact), and other contacts to be assessed and stratified for vulnerable or clinical need (e.g. child safeguarding). 80% of respondents reported to deliver across all the following key priority areas: antenatal contacts, new baby visits, stratified contacts where there is a clinical need, safeguarding work, and children with special needs.

Face-to-face visits were to be considered after risk stratification and assessment, according to the guidance. And indeed, most services were provided virtually, mostly via phone or video call: for example, 93% of respondents delivering antenatal contacts did so by phone, and 45% by video call. However, a significant number of respondents delivering across the key priority areas reported carrying out also face-to-face visits: from 16% in case of antenatal visits, to 47% for new birth visits and 62% for safeguarding visits. Additionally, many respondents carrying out face-to-face visits delivered them inside the house: this ranged from 79% for safeguarding visits, 86% for antenatal visits and 84% for new birth visits.

Among respondents who delivered any face-to-face visits, 10% were in contact with clients experiencing COVID-19 symptoms at less than two metres between 19 March and 3 June. Also among respondents who delivered any face-to-face visits, 34% did not have appropriate Personal Protective Equipment (PPE) at some point during the time period of 19 March to 3 June - including basic items such as masks, aprons and hand gel. Multiple respondents told us that they didn't get any PPE until April, May and as late as June. One reported '*1st week of doing a face to face clinic we were told there was no need for ppe. This was 8/4/2020*'. Only a small proportion (4%) of respondents tested positive for COVID-19, but the majority of health visiting staff that responded to our survey indicated that they did not try to get tested. Of concern is that 9% of respondents reported that they did not get tested because they were ineligible.

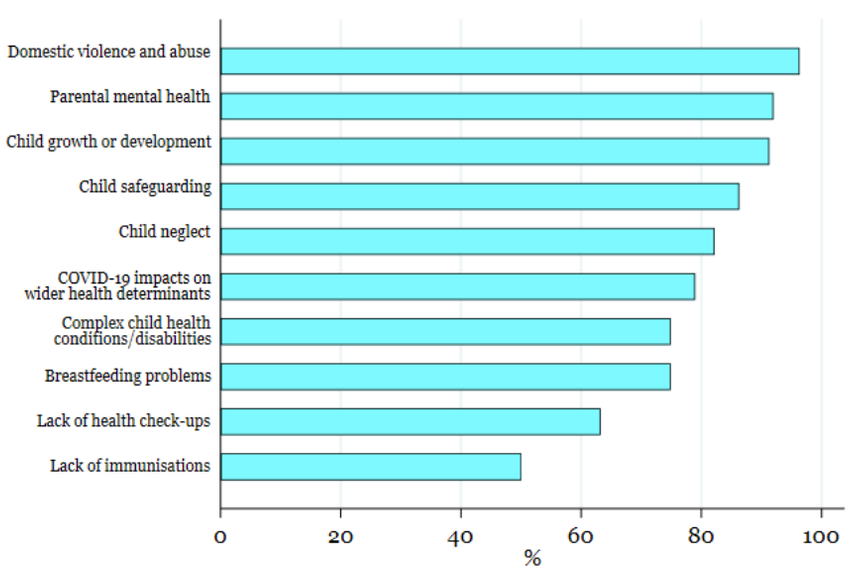
Fig 3: Have you been tested for COVID-19?



d. *With face-to-face contacts limited and increased caseload size, there was widespread concern amongst health visitors that the needs of many children would be missed.*

Many respondents were concerned about the impacts of reduced face-to-face contacts on families and children. We asked respondents what they think are the main risks and concerns for children who have had their needs missed during lockdown. The responses are shown in Figure 3. Vulnerable children were a key concern - 96% of respondents were concerned about domestic violence and abuse, 86% about child safeguarding, and 82% about child neglect. The impact of missed needs on the child's growth (84%) and development (79%) was also cited by the majority of respondents, as were parental mental health conditions (92%), breastfeeding (75%) and unmet need for support to manage the impact of COVID-19 on wider determinants of health (e.g. poverty, social isolation, worklessness). In addition to these, health visiting staff told us of a wide range of further concerns they had for families and children including: inability to make an accurate assessment of a child's needs virtually, late diagnosis of medical conditions such as autism and the limited child socialisation opportunities during lockdown (such as baby groups). One respondent told us '*I have always thought that when we visit families it's not so much what they are telling us it's what they aren't telling us ie the body language the non-verbal cues. I think this is an important part of health visiting and we have missed all that*'.

Fig 4: Risks to children during lockdown: % of staff with concerns

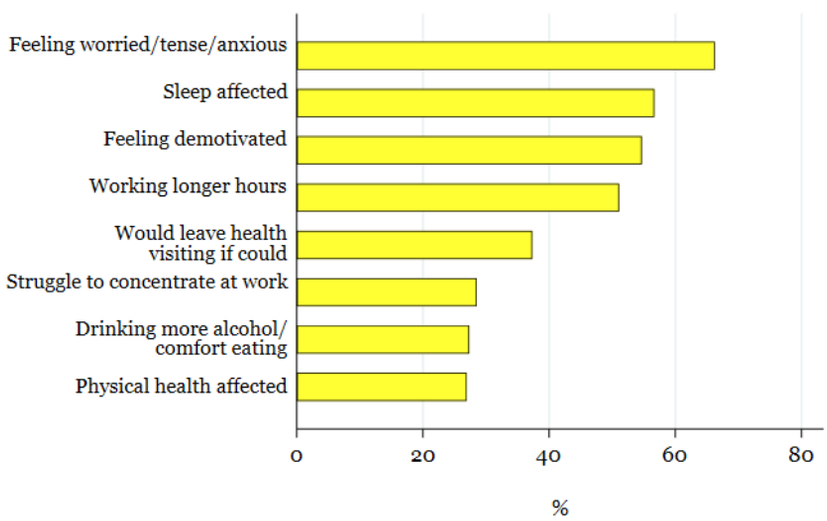


e. The increased workload and pressures have had significant negative impacts on staff wellbeing and mental health.

The COVID-19 pandemic, lockdown and associated changes to the health visiting service have put the health visiting workforce under significant stress at a time when the service has already sustained significant funding and workforce cuts over the past few years. Our survey data paints a bleak picture of the wellbeing and mental health of staff working in health visiting during COVID-19. 68% of respondents reported that their stress levels at work have increased over the past year.

Among those reporting higher levels of stress: 51% are working longer hours; 66% say that the stress is making them feel more worried, tense and anxious; 28% say that are managing the stress in negative ways like drinking more alcohol or comfort eating, and another 27% report that their physical health is negatively affected, and over half (57%) state that their sleep is affected. Higher stress is also affecting how health visitors feel about their work: 55% of those with increased stress levels report feeling demotivated, 29% struggle to concentrate and over a third (37%) told us that if they could leave health visiting, they would.

Fig 5: Impacts of stress: % of staff with impacts



Note: the sample is restricted to respondents reporting increased levels of stress.

We also asked health visiting staff the Short-Form 12 Health Survey (SF-12), a 12-item questionnaire that measures self-reported physical and mental health. Composite mental and physical health scores ranging from 0 to 100 are derived from the 12 questions, with higher scores representing better states of health. We use a large sample (n=16,548) of SF-12 composite physical and mental health scores from the 2018 UK Understanding Society wave 9 data[i] to provide a comparison of composite physical and mental health scores in the wider population. We restrict the UK sample to females in the same age range as the respondents of our survey.

The average composite mental health score of health visiting staff surveyed is 43.3, which is below the average score of 47.4 for the UK sample, indicating poorer mental health. The distribution of raw composite mental health scores for the health visiting sample (figure 6) shows the variation in mental health scores of health visiting staff, and that many respondents have low mental health scores.

Fig 6: SF-12 composite mental health score (survey sample)

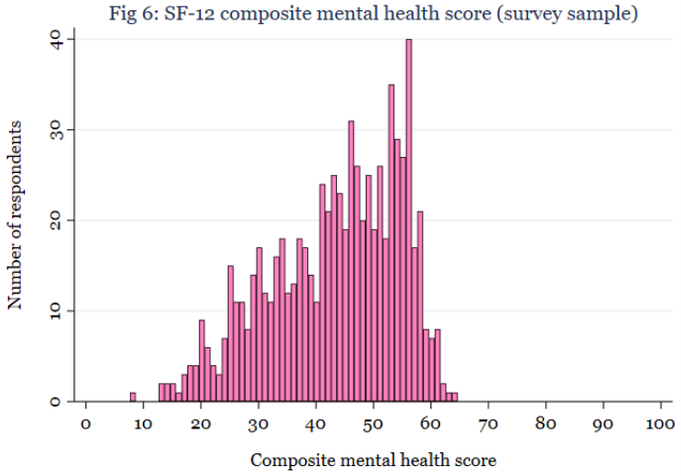
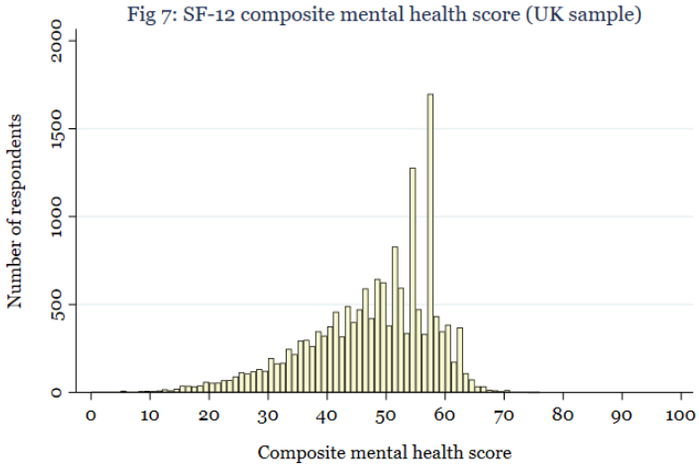


Fig 7: SF-12 composite mental health score (UK sample)



Note: n=16548 from a female sample with the same age range as our survey.

The health visiting staff provided us with many sad and worrying accounts. Respondents expressed feelings of panic and anxiety, of feeling overwhelmed and being exhausted. We received reports of extremely low morale and finding the job demoralising. Feeling undervalued by managers and their employer was cited by a number of respondents – one individual told us that '*the job is now, more than ever, about ticking boxes and not assessing and determining health needs*'.

Reassuringly, staff physical health appears to be less of a concern. Using the SF-12 composite physical health scores, we find that the average composite physical score is 52.7 for our sample of health visiting professionals, higher than the average of 49.6 for the UK sample. The SF-12 physical health subdomain asks questions on ability to perform moderate activities (such as moving a table), climbing stairs, bodily pain, energy and limitations due to physical health.

Fig 8: SF-12 composite physical health score (survey sample)

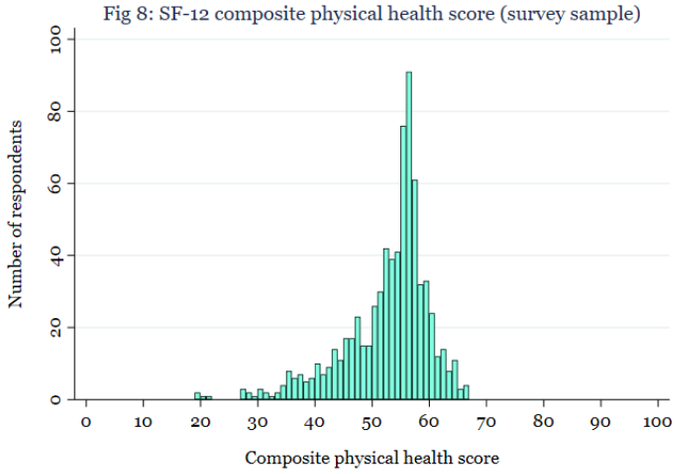
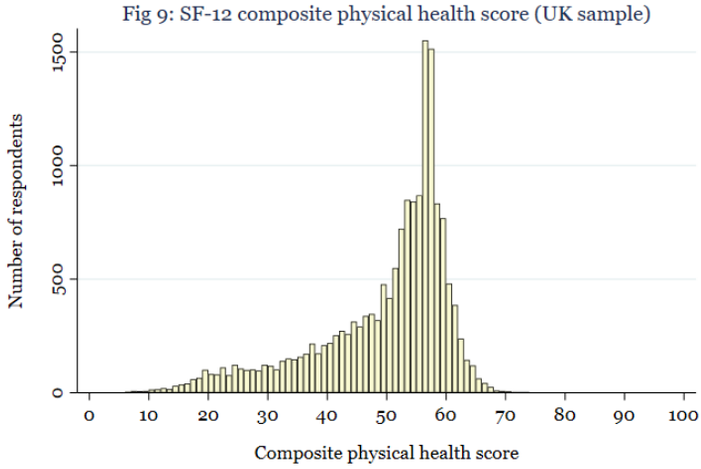


Fig 9: SF-12 composite physical health score (UK sample)

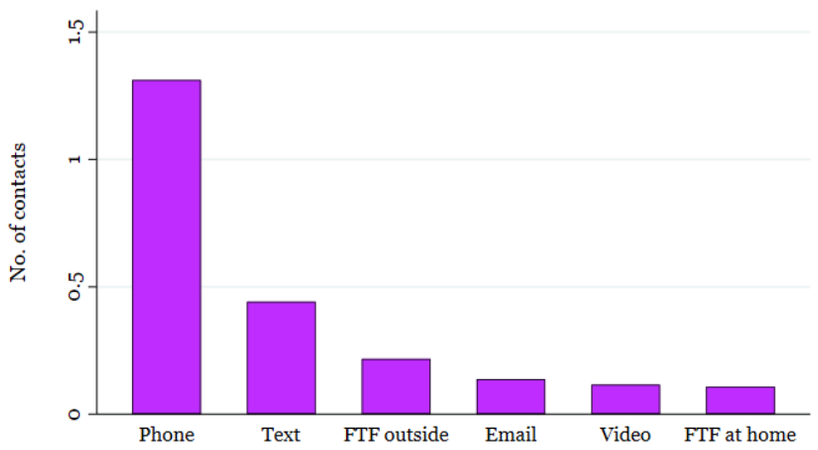


Note: n=16548 from a female sample with the same age range as our survey.

f. Evidence from parents aligns with health visitors' reports of phone contact as a prevalent form of contact and of limited face-to-face meetings.

A second survey of parents of young children provides us with the parent perspective on health visiting services prior to and during lockdown. 40% of parents of children under 3 who have ever had some form of contact with a health visiting professional reported having a health visiting contact during lockdown. Parents were largely communicating with health visiting staff by phone; 89% of these parents who had contact with a health visiting professional during lockdown had at least one phone contact, which aligns with our survey evidence from health visitors. Face-to-face contact was less common during lockdown - 12% of these parents had at least one face-to-face contact outside the home and 7% had at least one face-to-face contact inside the home. On average, the number of contacts was small, as indicated in figure 10.

Fig 10: Average no. of contacts with a health visiting professional since lockdown began



Note: the sample is restricted to parents of children under 3 who have had contact with a health visiting professional during lockdown

3. Data collection

We collected primary survey data on a sample of adult individuals working in the health visiting profession in England (n=740) who are on the membership and wider profession email databases held with consent by the Institute of Health Visiting. The survey data used in this brief was collected via the online survey platform Qualtrics by the researchers, from 19 June to 10 September 2020. This was after the restoration of community health services for children and young people published by NHS England and NHS Improvement on 3 June.

98% of the sample is female, 88% is White British or Irish, and the average age of respondents is 50. 54% of the sample have worked in health visiting for 10 years or more.

We also collected primary survey data on a geographically representative sample of first-time parents with a child less than four years old (n=560). We collected the data using Qualtrics, from 12 July to 6 September, and recruited participants using the online research participant platform Prolific.

79% of the sample is female and 21% male. The average age of the child of respondents was 2. 19% of the sample had a child aged under 1, 33% had a child aged 1, and 28% had a child aged 2.

Our survey data collection is still ongoing and we will be publishing a report with further findings and updated figures in due course.

Authors: Gabriella Conti (Ph.D.) is Associate Professor in Economics, Department of Economics and Department of Social Science, University College London; and Research Fellow, Institute for Fiscal Studies. Abigail Dow (M.Sc.) is Research Assistant in the Department of Economics, University College London.

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[i] University of Essex, Institute for Social and Economic Research. (2020). Understanding Society: Waves 1-9, 2009-2018 and Harmonised BHPS: Waves 1-18, 1991-2009. [data collection]. 12th Edition. UK Data Service. SN: 6614, http://doi.org/10.5255/UKDA-SN-6614-13