Witness Name: ALISON MORTON
Statement No.: 1
Exhibits: AM/1 [INQ000347025] – AM/183 [INQ000400036]
Dated: 7 February 2024

UK COVID-19 INQUIRY

WITNESS STATEMENT OF ALISON MORTON

In relation to the issues raised by the Rule 9 request dated 20/06/2023 in connection with Module 3, I, ALISON MORTON will say as follows:

Personal details – aims of the Institute of Health Visiting ("iHV") and context:

1. My name is Alison Morton. I was appointed as Director of Policy and Quality at the Institute of Health Visiting in March 2019, and subsequently as its Acting Executive Director from January 2021, and Chief Executive Officer from April 2021.

2. The iHV is an independent charity, professional body, member organisation and Centre of Excellence for health visiting, established to strengthen the quality and consistency of health visiting for the benefit of all children, families and communities. The iHV is registered with the Charity Commission for England and Wales, but also has a growing membership in Scotland and Northern Ireland.

3. This witness statement relates to the matters addressed by the Inquiry's Module 3, which is examining the impact of the COVID-19 pandemic on health systems across the UK, between: 1 March 2020 and 28 June 2022 (the "relevant period").

4. I have prepared this statement myself, with the support of relevant factual information supplied by staff at the iHV.

5. Healthcare and public health are devolved responsibilities across the UK. As such, there is variation in terms of health visiting policy, funding and workforce capacity. The evidence provided will focus predominantly on England as this is the nation where we had the greatest involvement in national policy during the pandemic.

6. During the relevant period, the iHV was in regular correspondence with the Chief Public Health Nursing Directorate at Public Health England (PHE - subsequently the Office for Health Improvement and Disparities, OHID). From 26 March 2020, the iHV attended weekly Professional Organisations meetings established by PHE to support 2-way communication between national policy and practice. The frequency of these meetings reduced to fortnightly in August 2020, and approximately quarterly from the end of 2021. Examples of our response during the pandemic include:
    a. The development and publication of open access "Health Visiting Advice" to augment national policy and guidance.
    b. The development of two bespoke COVID-19 sections of the iHV website – one with advice and national guidance for practitioners and the other for parents with babies and young children.
    c. The development of a bespoke suite of "iHV Parent Tips" for parenting in the pandemic, on a range of topics including coping with crying, managing common minor illnesses and the 6-week baby check.
    d. The development of regular online iHV Insights webinars and Networking events for practitioners, to support information sharing and discussion on key priority topics relevant to health visiting during the pandemic.
    e. The collation of frontline practitioner intelligence on the state of health visiting through iHV national health visiting surveys, as well as meetings, webinars and correspondence with our members. The iHV also supported research on health visiting in the pandemic led by universities.
    f. The adaptation and delivery of iHV's established Continuous Professional Development programmes and training using virtual delivery methods.
    g. The development of a bespoke iHV Emotional Wellbeing at Work programme to support practitioners manage the additional stressors of working as a health visitor during the pandemic.

7. Context: Prior to the pandemic, there was indisputable evidence that the first years of a child's life are the most crucial period of human development, providing a foundation for health, wellbeing, educational and economic success across the life-course. In England, the Government has committed to improve the health of babies, children, and their families to provide the "best start in life". Every family in England has access to health visiting services through the national Healthy Child Programme (HCP) (AM/1 [INQ000347025]) which offers universal prevention, health promotion, and early intervention to families with children, from pregnancy through to 5 years.

8. All families should receive five mandated universal health visiting assessment contacts (antenatal contact, New Birth Visit at 10-14 days after the birth, a 6-8 week review, a 12-month review and a 2-2½ year review), with additional targeted and specialist support proportionate to identified need. Delivery of the HCP is led by health visitors. Health visitors have a background in nursing or midwifery, with further training (now at post-graduate diploma or master's level) to become health visitors, registered as Specialist Community Public Health Nurses with the Nursing and Midwifery Council (NMC), who regulate the profession to set standards and protect the public. Through their universal reach to all families, health visitors are able to build relationships with parents, identify need, and provide support across key early years' "High Impact Areas" for physical health and mental health needs for babies, young children and adults; child development; social needs; and safeguarding - the High Impact Areas are listed in Public Health England (2021) Health visiting and school nursing delivery model (AM/2 [INQ000347118]).

9. In October 2022, the UNICEF UK Policy report: "Early Moments Matter" (AM/3 [INQ000347129]), reported that the *"pandemic and subsequent lockdowns increased isolation from vital networks (both family and community) for parents, carers, and families, while also decreasing access and face-to-face trusted support via formal services. This has led to the reduction in early identification of issues and referrals to additional support. In parallel, there has been an increase in household stress for families with young children".*

   Health visiting was described by UNICEF UK in this report (AM/3 [INQ000347129]) as, *"the backbone of early years services across the UK… the safety net around all families"*, identifying those with health issues who are otherwise easily hidden from

sight. UNICEF UK launched the "Early Moments Matter" campaign calling for a national "Baby and Toddler Guarantee" which would ensure that all families have access to a high-quality health visiting service.

Topic 1: The impact of government decision-making on health visiting during the pandemic.

10. In this section we set out the chronology of government decision-making and leadership within the healthcare systems that impacted on health visiting practice; our assessment of the consequences of these decisions; our submissions and representations to PHE, NHS England and government; and the extent to which government policy changed over the relevant period.

THE HEALTH VISITING CONTEXT WHEN IT ENTERED THE PANDEMIC

11. Health visiting entered the pandemic in an already depleted state due to the cumulative impacts of four compounding factors: the poor state of child health; cuts to the public health grant since 2015; variation in health visiting provision between local authorities; and health visitor workforce shortages.

12. State of child health:
    a. Entering the pandemic, we had some of the worst child health outcomes compared to other similar nations, with widening health inequalities and more children harmed by conditions that are almost entirely preventable. The state of child health across the UK in 2020 was summarised in the Royal College of Paediatrics and Child Health "State of Child Health 2020" report (AM/4 [INQ000347140]), published on 4 March 2020. Data consistently show that poverty and inequality impact a child's whole life, affecting their education, housing and social environment and in turn impacting their health outcomes. The State of Child Health indicators reveal a widening gap between the health of children from wealthy and deprived backgrounds. Similar findings were reported in "Health Equity in England: the Marmot Review 10 years On" report published in February 2020 (AM/5 **[INQ000108755]**]).

b. The growing number of *"invisible vulnerable children"* was flagged by the Children's Commissioner for England as a national concern in her report "Childhood vulnerability in numbers" published in 2019, with 2.3 million children in England living in vulnerable family circumstances and more than a third were not known to services (AM/6 [INQ000347162]). This is particularly relevant to health visiting as it is the only service that provides a systematic and proactive way of reaching all babies and young children (from pregnancy to age 5 years).

c. Focusing on child health is important as overall, as a nation, we are becoming less healthy. Lives are being cut short and more people are living with multiple, co-existing conditions and disadvantage that take root in early childhood. The Institute of Health Visiting summarised the role that health visitors can play in addressing these issues in its submission to the government's Major Conditions Strategy consultation on 26 June 2023 (AM/7 [INQ000347175]).

d. This situation pre-dates the pandemic but has been exacerbated by it (see Topic 3).

13. Funding for health visiting in England is provided to local authorities through the Public Health Grant from the Department of Health and Social Care. The Grant is ring fenced funding and must be spent on the public health service areas specified in the grant conditions published in the local authority circular from the Department of Health and Social Care (AM/9 [INQ000347197]). These conditions include commissioning health visiting services in accordance with the guidance contained in "Guidance: Commissioning health visitors and school nurses for public health services for children aged 0 to 19" published by Public Health England (AM/8 [INQ000347186]). The public health grant has been cut year-on-year since 2015. These cuts in real terms continued throughout the pandemic and have driven health visiting service cuts which are ongoing. Compared to 2015/16, the public health grant in 2021/22 was 24%, or £1 billion, lower in real terms. In the financial year 2022/23, the total public health grant was £3.417 billion. Each local authority decides how to spend its grant; this has led to unwarranted variation in core health visiting provision

across England, highlighted in the Institute of Health Visiting's annual survey report published in February 2020 (AM/10 [INQ000347026]).

14. The King's Fund report, "Public health: our position" published on 14 October 2021 reinforced the need for a much greater focus on, and investment in, prevention and public health (AM/11 [INQ000347037]). The reports stated that the cuts to the Public Health Grant had *"led to reductions in vital services such as health visiting… putting people at risk of poorer health and storing up problems for the future".*

15. Workforce: At the start of the pandemic, there were 30% fewer health visitors working in England in March 2020, compared to the number reported by the Government at the end of the Health Visiting implementation Plan, "A Call to Action", in September 2015. Published workforce data reports that:
    - In March 2020, there were 7,961 Full Time Equivalent (FTE) health visitors were recorded as employed in NHS and non-NHS organisations.
    - In comparison, the government reported that there were 11,377 FTE health visitors at the end of their Call to Action plan in September 2015.
    - In April 2023 there were 6,651 FTE HVs employed in England (both NHS and non-NHS data).

    These data are presented in an iHV summary (AM/12 [INQ000347048]); NHS workforce statistics (AM/13 [INQ000347059]); and Independent Healthcare Provider workforce statistics (AM/14 [INQ000347070]). As a result of falling workforce numbers, there weren't enough health visitors to meet the level of need before, or during, the pandemic. The iHV's annual health visitor survey report (published in February 2020, reporting data from 2018-2019) highlighted that, despite health visitors' best efforts, many families with babies and young children were not receiving the care and support that they needed prior to the pandemic – the level of health visiting support also varied considerably between local authority areas (AM/10 [INQ000347026]).

16. Based on data collected through Freedom of Information requests, analysed by Professor Gabriella Conti prior to the pandemic, on 1 February 2020 the mean caseload was 409 children per full-time equivalent (FTE) caseload-holding health visitor (AM/15 [INQ000347081]). This was higher than the recommended average

caseload of 250 children per FTE health visitor suggested in the Institute of Health Visiting's Vision for health visiting published in 2019 [the iHV's Vision provides a policy blueprint for health visiting, based on the best available evidence and developed in response to the government's request for stakeholder engagement in 2019 to inform their plans to refresh the health visiting model for England and the Healthy Child Programme (AM/16 [INQ000347092])]. In December 2020, Conti and Dow published the findings from their study, "The impacts of COVID-19 on Health Visiting Services in England: FOI Evidence for the First Wave" which reported that in 80% of areas, health visitor caseloads were greater than 250 children per full-time equivalent (FTE) staff. In 22% of areas, caseloads were greater than 500 children; and in 10% of areas, greater than 700 children (AM/17 [INQ000347103]).

THE GOVERNMENT'S EMERGENCY RESPONSE PLAN – PRIOR TO MARCH 2020

17. The limitations of the national emergency response planning and its suitability for the COVID-19 pandemic and national lockdowns have been well critiqued in the COVID-19 inquiry submission by Professor Clare Bambra and Professor Sir Michael Marmot, (2023). The emergency plans identified that pregnant women, people with underlying medical conditions, and children under 5 were "at risk" groups. However, the plans predominantly focused on avoiding infection and treating disease, rather than protecting babies, children and families from the wider impacts of a pandemic.

18. Early warnings were not incorporated into existing emergency plans: In March 2020, early publications on the experiences of countries including Italy, Spain, China and Brazil, that had experienced the COVID-19 pandemic and the impacts of lockdown regimes earlier than the UK, provided some important warnings on the pandemic's wider impacts on babies, children and families – for example, in The Guardian (AM/18 **[INQ000176550]**), Sixthtone news from China (AM/19 [INQ000347117]) and commentary in The World Economic Forum (AM/20 [INQ000347119]). There was strong evidence available at the time that babies and children living in homes with domestic abuse and parental mental illness would be at greater risk of poor health, delayed development and child maltreatment. In our opinion, this was not given sufficient consideration in the initial emergency plans. As expected, a similar pattern was seen in the UK within days of lockdown commencing. On 5 April 2020, Christina Lamb published a news story in the Sunday Times "Coronavirus lockdown: If you

have a garden, you're OK. In my flat it's hell" which reported concerns about the impacts of early lockdown that were being felt disproportionately by families living in cramped accommodation (AM/21 [INQ000347120]).

19. In March 2020, there was no agreed national definition of what constituted "vulnerability" for babies, children and families. This led to variations in the application of the term across government departments, services working in the early years, and health visiting provision between local authority areas across England. It took until September 2020 for the Government to publish its definition of child vulnerability in Public Health England's publication "No child left behind: understanding and quantifying vulnerability". Vulnerability incorporated *"children at greater risk of experiencing physical or emotional harm and/or experiencing poor outcomes because of one or more factors in their lives"* (AM/22 [INQ000347121]).

THE GOVERNMENT'S EMERGENCY RESPONSE – COVID-19 PANDEMIC FIRST WAVE (FROM MARCH 2020 TO MAY 2020) INCLUDING iHV RESPONSE

MARCH 2020

20. On 17 March 2020, healthcare in England was reprioritised as part of the national COVID-19 response in a letter from Sir Simon Stevens (NHS Chief Executive) and Amanda Pritchard (NHS Chief Operating Officer) (AM/23 **[INQ000087317]**). Acute healthcare was prioritised as all efforts focused on stemming the spread of COVID-19 and treating infected patients, mostly adults. Initially, very little consideration was given to the wider impacts of the pandemic on babies, children and families, or the health visiting service that supports them. "Protect the NHS" became a national slogan.

21. Initial lack of national guidance for health visiting: The letter from Sir Simon Stevens (NHS Chief Executive) and Amanda Pritchard (NHS Chief Operating Officer) on 17 March 2020 (AM/23 **[INQ000087317]**, provided no information on the practicalities of implementing these changes in health visiting. The iHV was not consulted on the content of the letter prior to its publication, or its impacts on health visiting – to the best of our knowledge, neither were any of the other professional bodies that represent health visiting. In our opinion, if the wider impacts of the pandemic on babies, children and families had been taken into consideration at this time, it may

have influenced the plans to "stop" the health visiting service and redeploy health visiting staff. Section 3 d) of the letter stated:

> *"All appropriate registered Nurses, Midwives and AHPs currently in nonpatient-facing roles will be asked to support direct clinical practice in the NHS in the next few weeks, following appropriate local induction and support. Clinically qualified staff at NHSE/I are now being redeployed to frontline clinical practice."*

22. In March 2020, the iHV developed a dedicated section of its website to consolidate any relevant information for health visiting as soon as it became available. We communicated updates via news stories (AM/24 [INQ000347123]) on our website, social media, and direct emails to members. We also developed a similar dedicated section of our website aimed at parents of babies and young children. This was recognised as an exemplar by the WHO/ UNICEF UK as one of the first sites of its type at the start of the pandemic in England. The second iteration of the NHS COVID-19 Prioritisation within Community Services plan, published on 2 April 2020 (AM/25 **[INQ000269920]**, encouraged health visitors to share the resources on the iHV website with parents.

23. On 20 March 2020, I was providing cover for Dr Cheryll Adams CBE, iHV Executive Director, who was on leave, and wrote to Viv Bennett CBE (the Chief Nurse) and Wendy Nicholson (the Deputy Chief Nurse) in The Chief Nurse Directorate at PHE, via email alerting them to the concerns about the lack of national guidance for health visiting. In particular, the email highlighted concerns about meeting the needs of vulnerable children during the pandemic (AM/26 [INQ000347125]).

    PHE responded promptly to this email and made the iHV aware that the "COVID-19 Prioritisation within Community Health Services" plan was due to be published later that day (AM/27 [INQ000347126]). We alerted our members via an iHV news story and email (AM/28 [INQ000347127]). In my email response to Viv Bennett, I raised concerns about the lack of advice being received by non-NHS health visiting providers from the government as they did not have access to NHS daily briefings (AM/27 [INQ000347126]).

24. At 15:29 on Friday 20 March 2020, Viv Bennett, the Chief Nurse at PHE, alerted the iHV by email (AM/27 [INQ000347126]) that NHS England & NHS Improvement (NHSE/I) had published the first iteration of the "COVID-19 Prioritisation within Community Health Services" Plan [the Plan] (AM/29 **[INQ000049706]**. The iHV alerted its members via direct email and a news story on its website (AM/30 [INQ000347130]). The Plan was focused on measures to reduce the spread of COVID-19 and build hospital capacity. Providers of community services were requested to *"release capacity"*. All health visiting services were categorised to *"stop"*, apart from a partial service incorporating a significantly reduced number of contacts. In our opinion, this was a profound mistake.

This categorisation to *"stop"* within the Plan resulted in significant scaling back of health visiting support to families. Research by Professor Gabriella Conti based on Freedom of Information data found that up to 63% of health visitors were redeployed in some areas **(AM/15 [INQ000347081])**. The extent of redeployment varied between local authority areas - redeployment of health visitors ranged from 0% to 63%, and of clinical skill mix staff supporting health visitors from 0% to 100%. Instead of offering all families at least five mandated universal health visitor contacts, with additional support proportionate to need, all health visitor services were categorised to *"stop"* except:

- The antenatal contact
- The new baby visit.

The guidance stated that other contacts should be assessed and stratified for vulnerability or clinical need; face-to-face contacts were only advised for those with *"compelling need"* and with personal protective equipment (PPE).

25. Following these national policy announcements (listed in paragraphs 20 and 24), the iHV received correspondence (through our Facebook group, direct emails to our enquiries inbox, and personal emails to named members of staff) from frontline health visitors, health visiting service leads and commissioners requesting information on a range of topics including:

    a. Redeployment and how to interpret the guidance.

b. Personal Protective Equipment and the application of NHS guidance for infection prevention and control for health visiting staff working in communities, including home visiting.
c. Acceptable adaptations of the health visiting service delivery model, including risk assessments using non-face-to-face methods.
d. Implementing video-enabled contacts safely.

Health visitors and service leads were concerned about the categorisation of health visiting as a partial "stop" service and the potential impacts that this would have on families with babies and young children, particularly the most vulnerable.

26. On 23 March 2020, I emailed Viv Bennett, the Chief Public Health Nurse alerting her to evidence from the Center on the Developing Child, Harvard University published on 20 March 2020. This highlighted the need to protect babies and young children from the potential harms of the pandemic due to increase stress in families, stating, *"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".* In my email, I highlighted the importance of health visitors' universal contacts with families and asked whether the national guidance was likely to change (AM/32 [INQ000347132]).

27. On 24 March 2020, Viv Bennett responded by email and informed us that PHE were aware that *"families understandably did not want home visits"* (AM/32 [INQ000347132]) and suggested that services prepared advice ahead of more detailed Standard Operating Procedures that were expected from NHSE, with the following holding advice for the iHV to share with services:

    "I think that what is clear is that the presumption should be that contacts will be virtual – skype, facetime and, failing that, phone call. There will need to be individual assessment of compelling need for face-to-face contacts and then decisions re PPE" (AM/32 [INQ000347132]).

    [circulated via iHV news story published on 24 March 2020] (AM/33 [INQ000347133]).

28. In a subsequent Parliamentary Question response on 25 June 2020, Jo Churchill MP, The Parliamentary Under-Secretary of State (Minister for Prevention, Public

Health and Primary Care), justified health visiting redeployment decisions stating that, *"With the onset of COVID-19, some public health nurses were redeployed into hospitals where their expertise was most needed to care for acutely ill patients"* (AM/34 [INQ000347134]). At face value, "saving lives" presented a compelling reason for the redeployment of health visitors. However, in our opinion, these decisions did not fully consider the wider impacts of the pandemic on babies, children and families (see Topic 4 on redeployment).

29. On 24 March 2020, in an email to the iHV, Viv Bennett, the Chief Nurse at PHE, suggested that the iHV develop "practical advice" for health visiting in partnership with members of the Chief Nursing Directorate at PHE (AM/32 [INQ000347132]). In a further email on 25 March 2020, we were instructed that the term "practical advice" (rather than guidance) was PHE's preferred term (AM/35 [INQ000347135]); and the Community Prioritisation Plan (AM/29 **[INQ000049706]**) would remain the official national guidance for health visiting. On 24 March 2020, the iHV responded by email and highlighted the importance of balancing the "Stay at Home" advice, with the need to protect babies and young children from the collateral harms of the pandemic (AM/36 [INQ000347136]).

30. On 27 March 2020, the iHV published a series of short practical advice resources for health visiting during the pandemic (including professional advice for: the Antenatal Contact (AM/37 [INQ000347137]), New Birth Visit (AM/38 **[INQ000300107]**), Virtual Contacts (AM/39 [INQ000347139]), and Working with Vulnerable Families (AM/40 [INQ000347141]). Professional advice for Family Perinatal Mental Health (AM/41 [INQ000347142]) was published the following week. These were developed in collaboration with colleagues in the Chief Nurse Directorate at PHE. The advice was not intended to be an operations manual or national policy. Rather, it was a suite of short advice to assist health visiting providers to apply national guidance in practice. The iHV waivered its usual restrictions and these resources were made available as open access on our website; we promoted the resources via an iHV news story (AM/42 [INQ000347143]).

31. In the last week of March 2020, the Chief Nurse Directorate at PHE instated weekly update meetings with the nursing professional bodies and unions to facilitate two-

way communication. These enabled the timely sharing of frontline practitioner intelligence with policymakers, alongside rapid dissemination of national directives to practice.

APRIL 2020

32. On 2 April 2020, version 2 of the "COVID-19 Prioritisation within Community Health Services" Plan was published (AM/25 **[INQ000269920]**). This continued to classify health visiting as a partial *"stop"* service, with some additional wording stating that changes needed to be agreed with Directors of Public Health who had raised concerns that they had not been consulted about decisions to stop health visiting services and redeploy health visitors. The updated Plan also gave greater weight to the importance of risk stratification, stating that *"Other contacts to be assessed and stratified for vulnerable or clinical need (e.g. maternal mental health)"*.

33. On 2 April 2020, the iHV contacted health visitors through its open Facebook page to understand the impact that COVID-19 was having on their practice and the families on their caseloads. 4,198 practitioners engaged in the post and 187 comments were received. Qualitative data were analysed with support from colleagues at the University of Oxford. On 8 April 2020, the findings were published in a short report, "Health Visiting during COVID-19: an iHV report" (AM/43 [INQ000347144]).

    Seven key concerns were identified:

    i. Importance of clear information and guidance to avoid mixed messages.
    ii. Redeployment - variation in interpretation and implementation.
    iii. Needs of vulnerable families - challenges of virtual contacts and reduced staffing.
    iv. IT equipment requirements to enable virtual contacts.
    v. Access to Personal Protective Equipment - personal safety.
    vi. Health visitors' emotional wellbeing at work.
    vii. Student health visitors – support needs in practice.

    In the report, the iHV made the following recommendations to the Government:

i. Urgent workforce remodelling is needed where local redeployment calculations have not accounted for the predicted increased demand for health visiting services.
ii. A system to support on-going review and remodelling of workforce capacity.
iii. Support for the physical protection of health visitors and the families that they visit from COVID-19 - access to PPE and clarity on guidance for pregnant members of staff.
iv. Ensure all health visitors have access to the equipment needed to support video-enabled contacts.
v. Support for the mental health/ psychosocial needs of health visitors.
vi. 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 the application of PPE guidance to health visiting.
vii. Clarification of plans for student health visitors.

This report was shared via email on 8 April 2020 to officials in PHE, NHS Safeguarding, Ruth May CNO England, Mark Radford CNO Health Education England, DfE, LGA and ADPH (AM/44 [INQ000347145]), with responses confirming receipt received from Kenny Gibson Head of Safeguarding, NHS England (with a subsequent meeting on 14 April 2020 between Dr Cheryll Adams, iHV Executive Director, Kenny Gibson and Hilary Garratt, Deputy Chief Nurse NHSE) (AM/45 [INQ000347146]); and on behalf of Ruth May CNO England, passing actions to Hilary Garratt (AM/46 [INQ000347147]).

I also shared the findings with the members of the national Children and Young People's Transformation Stakeholder Council at its meeting on 9 April 2020. At this meeting, the content was described as *"anecdotal"* by Viv Bennett, Chief Nurse at PHE (AM/47 [INQ000347148]), who asked the iHV to provide names of sites that were redeploying health visitors. To our knowledge, there was no national dataset collating information on the numbers of health visitors who had been redeployed, or the duration of redeployment.

34. On 6 April 2020, Dr Cheryll Adams CBE, the iHV's Executive Director at the time, published a Voices Blog "Is a secondary pandemic on its way?" (AM/48

[INQ000347149]) - raising concerns about the secondary impacts of the pandemic including the impact of redeployment, lack of PPE, increase in parental stress, lack of support for families, and concerns about safeguarding vulnerable babies and young children.

35. On 9 April 2020, over 40 leading mental health, family and children's charities and professional bodies (including the iHV) called on national and local decision makers to give urgent attention to the wellbeing of babies, toddlers and their parents during the COVID-19 crisis. The First 1001 Days Movement joint statement (AM/49 [INQ000347150]) stated:

"It has already been widely recognised that for some people, home is not a safe haven. Across the UK, there are babies and children in lockdown in poor quality and overcrowded housing, with shortages of basic supplies, cared for by parents under immense pressure. Babies, born and unborn, are particularly vulnerable to physical and emotional harm because they are at a critical stage in their development, are fragile, totally dependent on adults for their care, and unable to speak out or seek help. Therefore, it is essential that Government is keeping their needs in mind."

36. On 15 April 2020, NHS England and NHS Improvement published the more detailed "Novel coronavirus Standard Operating Procedure: Community health services" (AM/50 **[INQ000330841]**). This stated that,

"Health visitors and school nurses continue to deliver the Healthy Child Programme…

"Children and families will be anxious and pressured at this time, particularly the more vulnerable and at risk. For some, the transition to parenthood places pressure on relationships, and there is the potential for domestic violence and abuse to escalate…

"Identifying vulnerable children and young people who are at risk of health inequalities is challenging and they are at risk of poorer outcomes."

37. On 17 April 2020, the iHV published a short paper "Health visiting during COVID-19: Unpacking redeployment decisions and support for health visitors' wellbeing" (AM/51 [INQ000347153]). This raised concerns about the redeployment of health visitors,

provided advice on support available for professionals, information on challenging redeployment decisions, and risk stratification for vulnerable families.

38. In April 2020, concerns about the secondary impacts of the pandemic on families were growing across the sector. On 28 April 2020, an editorial titled "A shift in focus is needed to avoid an irreversible scarring of a generation", by Dr Peter Green (Designated Doctor and Chair of the National Network of Designated Healthcare Professionals for Children), was published in the BMJ (AM/52 [INQ000347154]). Dr Green called for the needs of children to be given much greater attention by policymakers.

39. On 29 April 2020, Simon Stevens (NHS Chief Executive) and Amanda Pritchard (NHS Chief Operating Officer) wrote a second letter (AM/53 **[INQ000087412]**) outlining the Second phase of the NHS response to COVID-19. Of relevance to health visiting, the annex to the letter advised that, *"Essential community health services must continue to be provided, with other services phased back in wherever local capacity is available. Prioritise home visits where there is a child safeguarding concern* [annex p.8]."

40. The rate at which health visiting services were reinstated following this changed directive varied considerably across England. At the time of writing this evidence in August 2023, there is wide variation in delivery of the five mandated health visitor reviews (see Topic 3). Workarounds that were intended to be temporary, and better than nothing during this time, have continued as business as usual in some areas - for example, the completion of mandated universal health visiting assessments of babies, children and families using virtual methods (see Topic 2). This represents a significant change in health visiting service delivery which has been implemented despite the lack of evidence for their safety or efficacy to identify risk and vulnerability. In our opinion, these untested practices are providing false assurance of the reach and quality of health visiting service delivery; they mask the underlying root cause of insufficient funding in the Public Health Grant and health visitor workforce shortages that are driving these decisions, rather than the best interests of babies, children and families.

MAY 2020

41. On 6 May 2020, following ongoing concerns about the lack of attention being given to the secondary impacts of the pandemic on babies, children and families, Dr Cheryll Adams, the iHV's Executive Director at the time, wrote to the Prime Minister. The letter (AM/54 [INQ000347156]) called for investment in health visiting. Dr Adams has informed me that the Prime Minister did not respond to her letter.

42. On 7 May 2020, Dr Cheryll Adams appeared before the House of Commons Petitions Committee on the impact of COVID-19 on maternity leave (AM/55 [INQ000347157]), providing oral evidence on the impact of the pandemic on pregnant women and families with babies. Dr Adams' statement included an overview of the significant impact that the pandemic had on health visiting, with the scaling back of home visiting, variation in health visiting support between areas, and the introduction of video contacts. Dr Adams highlighted how health visitors had found creative ways to reach families with the introduction of online groups, with the advice to parents to contact their health visitor if they had any concerns. Dr Adams highlighted the wider impact of the pandemic, including social isolation, on family mental health, and the importance of health visitor contacts to identify vulnerability, as well as concerns about the redeployment of health visitors. This attracted considerable media attention, including a feature on BBC Women's Hour on 19 May 2020 (AM/56 [INQ000347158]); Dr Cheryll Adams was interviewed on the programme and discussed extended maternity leave and the importance of health visiting support for parents during the pandemic.

43. On 27 May 2020, Dr Cheryll Adams sent an email to Viv Bennett and Ruth May, CNO England, outlining the lack of data on the scale of health visiting redeployment and the urgency needed to end this practice due to its impacts on families and practitioners. In the email responses, Viv Bennett and Hilary Garratt (Deputy Chief Nurse, on behalf of Ruth May) reiterated their support for an end to health visiting redeployment, stating *"As you know, all us in the email list are absolutely with you on this"* (AM/57 [INQ000347159]).

GOVERNMENT AMENDMENTS TO THE EMERGENCY RESPONSE - END OF FIRST WAVE/ SECOND WAVE (JUNE 2020 ONWARDS)

44. On 3 June 2020, NHSE/I produced the third iteration of guidance for community services - the "Restoration of Community Health Services guidance" (AM/58 [INQ000347160]). The most significant change for health visiting was the change in categorisation of the service, with a move from "partial stop" to "continue". At the iHV, we welcomed the changes in an iHV news story (AM/59 [INQ000347161]); in particular, we welcomed greater prioritisation of the role of health visitors as an essential part of the country's support structure for children and their parents. It was significant that the wording on the redeployment of health visitors had been removed. Other important changes included:
    - The reinstatement of the mandated health visitor 6-8 week review.
    - The inclusion of additional safeguards to protect vulnerable children – the guidance stated that, *"Face-to-face contacts should be prioritised for families who are not known to services to mitigate known limitations of virtual contacts and support effective assessment of needs/ risks".*
    - Prioritisation of home visits where there is a child safeguarding concern.

45. On 8 June 2020, the leaders of nearly 80 organisations, including the iHV, signed a letter to the Prime Minister (AM/60 [INQ000347163]). This called on him to make the youngest children a national priority to mitigate the secondary and potentially long-term impact of the COVID-19 crisis.

46. On 10 June 2020, Dr Cheryll Adams sent details of ongoing redeployment practices in an email to Viv Bennett at PHE (AM/61 [INQ000347164]). This intelligence was based on health visitors' accounts of redeployment in their area, following a request to health visitors on the Institute of Health Visiting's Facebook page. The information was collected at the end of May and the first week in June via open and closed messages (AM/62 [INQ000347167]; AM/63 [INQ000347168]). The intelligence highlighted that redeployment was an ongoing concern and was having a detrimental impact on the level of support that the remaining health visitors were able to offer to families, as well as the mental wellbeing of practitioners.

47. On 19 June 2020, in partnership with PHE, the iHV updated its Professional Advice for health visiting (version 2) (AM/64 [INQ000347169]). This superseded the first versions that were published on 27 March 2020 and included the advice that,

> *"Where services have been interrupted this requires the restoration of elements of the service that were stopped, paused or reduced during the earliest phase of the pandemic and the return of any redeployed members of the health visiting team where this has been the case".*

48. On 25 June 2020, a Parliamentary Question by Catherine West MP to the Secretary of State for Health and Social Care asked, *"whether he plans to make an assessment of the effect of the redeployment of health visitors on the wellbeing of babies and families during the COVID-19 outbreak?"* In the response (AM/34 [INQ000347134]), Jo Churchill MP, The Parliamentary Under-Secretary for Health and Social Care, stated, *"With the onset of COVID-19, some public health nurses were redeployed into hospitals where their expertise was most needed to care for acutely ill patients. It is important that these nurses return to help mitigate the negative impacts of the pandemic on families with young children."*

    In our opinion, from the start of the pandemic, health visitors were most needed supporting families with babies and young children – but it was encouraging to see the directive that they should now return to their substantive posts.

49. On 30 June 2020, the iHV submitted written evidence (AM/65 [INQ000347170]) to the Government's Parliamentary Education Committee. This set out our ongoing concerns that the secondary impacts of the pandemic on babies, children and families had been significant - with increased levels of vulnerability and a backlog of unmet need.

50. On 8 July 2020, a Parliamentary Question by Catherine West MP to the Secretary of State for Health and Social Care asked, "*What assessment he has made of the effect of the COVID-19 outbreak on the backlog of Healthy Child Programme appointments; and what steps he is taking to reduce that backlog"*. In response (AM/66 [INQ000347171]), Jo Churchill MP, The Parliamentary Under-Secretary for Health and Social Care, reiterated the guidance to restore health visiting services, stating:

"The framework recommends that community health services move to restore health visiting services, following their prioritisation during the containment phase of the pandemic. The guidance recommends continuation of essential services, including antenatal, new birth and six to eight-week contacts, and the need for face-to-face support for vulnerable families."

51. On 15 July 2020, the Government announced that Andrea Leadsom MP would chair a review of early years services which was welcomed in a news story by the iHV (AM/67 [INQ000347172]). Amongst its functions, the review was tasked to *"look to understand lessons learnt from COVID-19, including minimising the risks from the pandemic to very young children, and better using technology".* The iHV was consulted during the review process and Dr Cheryll Adams (the iHV's Executive Director at the time) provided written feedback on the draft recommendations (AM/182 [INQ000400035]) – this feedback was sent via email to the Early Years Review team and Andrea Leadsom MP on 15 January 2021 (AM/183 [INQ000400036]). The iHV is not aware of any "lessons learnt" evaluation specifically focused on the breadth of the impacts of the COVID-19 pandemic to very young children, or any formal evaluation on the use of technology in health visiting. We are aware that an NIHR research study, "Health visiting in the UK in light of the COVID-19 pandemic experience (RReHOPE): a realist review" is in progress (led by King, E., Gadsby, E., Bell, M., 2023) (AM/68 [INQ000347173]).

52. On 22 July 2020, Dr Cheryll Adams forwarded an email by Professor Gabriella Conti, on her behalf, to government officials (Matt Hancock MP, Secretary of State for Health and Social Care; Jo Churchill MP, Health Minister; Nadine Dorries MP, Health Minister; Viv Bennett, Chief Public Health Nurse; **Name Redacted** Head of Healthy Child Programme PHE; Ruth May, CNO England; Anne Longfield, Children's Commissioner; AM/69 [INQ000347174]). The email contained a policy briefing (AM/70 [INQ000347176]) by Professor Conti with early findings of survey data on health visiting in England (sample of 663 practitioners), raising concerns about the impacts of COVID-19, lockdown restrictions and redeployment on the ability of health visitors to deliver their services for young children and families, stating:

"We find evidence of widespread redeployment of health visiting staff, which led to an increase in the number of children a health visitor is responsible for,

inadequate PPE for staff despite the continuation of face-to-face contacts, concern amongst health visitors of children's missed needs, and significant negative effects of increased workload and pressures on staff wellbeing and mental health."

53. On 29 July 2020, there was growing concern within the children's sector about the impacts of the ongoing redeployment of health visitors in some areas. Professor Russell Viner, the President of the Royal College of Paediatrics and Child Health, published a statement (AM/71 [INQ000347177]) calling for proper resourcing of the health visiting profession, stating *"During lockdown, when their contribution was more important than ever, the crucial work of health visitors has been hampered by a lack of PPE and by frequently – and often needlessly – being redeployed into areas away from children and families. This can never be allowed to happen again. Children now need to be at the heart of planning in the event of either local or national lockdowns and for the demands of the coming winter. These findings paint an extremely bleak picture. The health visitor workforce is absolutely vital to the health of children and now more so than ever. Health visitors act as a frontline defence against multiple child health problems."*

54. On 31July 2020, plans for the next (third) phase of the NHS response to the COVID-19 pandemic, effective from 1 August 2020, were set out in a letter (AM/72 **[INQ000051407]**) from NHS England and NHS Improvement. The NHS Emergency Preparedness, Resilience and Response (EPRR) incident level would move from Level 4 (national) to Level 3 (regional) with effect from 1 August 2020. The rationale was that the approach matched the differential regional measures that the Government was deploying and built on the guidance set out in the Restoration of Community Health Services guidance (AM/58 [INQ000347160]). This included the directive that health visiting services should be *"fully restored"*, with the caveat that this was *"with some prioritisation, where indicated, and as capacity dictates"*.

We were informed at this point that there would be no further national guidance for health visiting and service restoration would be left to *"local decision making"*. The concern for the iHV was obviously that where the service was already inadequate due to COVID-19 decision making, alongside pre-existing health visitor workforce

shortages and service cuts prior to the pandemic, there were few national levers to improve it, to the detriment of child and family health.

55. On 25 August 2020, Dr Cheryll Adams wrote a letter to Jo Churchill MP, The Parliamentary Under-Secretary for Health and Social Care (AM/73 [INQ000347179]), urging the Minister to "Act Now" and rebuild the health visiting service in England to ensure that it was able to meet the rising levels of need, with three key asks: a workforce plan for health visiting; new investment (ring fenced) and sustainable for full delivery of the Healthy Child Programme; and a national quality assurance framework which ensures equity of access across all local authority areas.

56. On 18 September 2020, Dr Cheryll Adams wrote to Ruth May (CNO England) and Professor Viv Bennett (Chief Nurse, PHE) raising concerns about the ongoing redeployment of health visitors (AM/74 [INQ000347180]) and the challenges faced by health visiting service leads who were managing these redeployments.

57. On 23 September 2020, the iHV was part of a joint representation on local public health funding to HM Treasury, alongside 57 other organisations as part of the Health Policy Influencing Group's #GiveUsAChancellor campaign, led by the National Children's Bureau (AM/75 [INQ000347181]). This highlighted that it would not be possible to increase healthy life expectancy, reduce health inequalities and appropriately respond to, and recover from, the COVID-19 pandemic if local authorities were unable to provide vital public health and preventative services for babies, children, young people and families. The representation urged the UK Government to sustainably fund local public health as a priority in the Comprehensive Spending Review. The iHV submitted its own submission to the Spending Review, calling for investment in health visiting on 24 September 2020 (AM/76 [INQ000347182]).

58. On 1 October 2020, the iHV sent a further email (AM/77 [INQ000347183]) to Ruth May, Viv Bennett and Mark Radford (CNO Health Education England) reiterating the request for a national directive to stop the redeployment of health visitors, and student health visitors, as we were concerned that some areas were planning

further redeployment due to predicted waves of the pandemic in the autumn/ winter.

59. On 2 October 2020, a joint letter (AM/78 [INQ000347184]) was sent to all Directors of Nursing from Ruth May (CNO England), Professor Viv Bennett (Chief Nurse PHE), and Councillor Ian Hudspeth (Chairman Community Wellbeing Board, Local Government Association). The letter highlighted concerns about rising levels of vulnerability and unmet need experienced by pregnant women, children and families and included a directive to end all redeployment of health visiting staff:

> *"Therefore, we advise that professionals supporting children and families, such as health visitors, school nurses, designated safeguarding officers and nurses supporting children with special educational needs should not be redeployed to other services and should be supported to provide services through in pregnancy, early years (0-19) and to the most vulnerable families".*

Despite this announcement, the rebuilding of health visiting services was left to local decision making without any additional COVID-19 recovery funding, or a national workforce plan, to support areas to provide services at the scale that was needed *"through in pregnancy, early years (0-19) and to the most vulnerable families".*

60. On 18 November 2020, I joined a new COVID-19 Task and Finish group led by NR Clinical Team Leader for children, schools and universities and WHO CC Nurse Advisor, Nursing, Maternity and Early Years Directorate, PHE, who had been tasked with leading the COVID-19 recovery for 0-19 public health nursing services at PHE. At the first meeting, concerns about non-face-to-face health visiting visits becoming the *"acceptable norm"* were raised by PHE Regional Leads – captured in personal notes that I made on the meeting shared by email with Dr Cheryll Adams, iHV Executive Director at the time (AM/79 [INQ000347185]). PHE acknowledged that they had no national data on: missed health visiting mandated contacts; the ratio of contacts that were delivered virtual vs face-to-face; and the impact of COVID-19 on staff wellbeing. They asked the iHV to share any intelligence that had been gathered on these topics. On 19 November 2020, I shared the preliminary findings from our annual health visiting survey to PHE via email (AM/80 [INQ000347187]; AM/81 [INQ000347188]). I

confirmed that the iHV did not collate data on the national delivery of the Healthy Child Programme health visiting mandated contacts. I also shared data on health visitors' concerns about the safety and effectiveness of virtual contacts for mandated health visiting reviews and impacts of the pandemic on staff wellbeing.

61. On 23 November 2020, the iHV was a joint signatory to a letter (AM/82 [INQ000347189]) to the Chancellor (comprising 48 organisations, led by Cancer Research UK) calling for increased sustainable funding for the Public Health Grant to support COVID-19 recovery in the Spending Review. To date, no additional funding has been allocated to health visiting for COVID-19 recovery.

62. On 1 December 2020, at the Professional Organisations meeting "Update from PHE's Deputy Chief Nurse Children, Young People & Families", redeployment in health visiting was noted as *"still potentially an issue",* with concerns that some areas would redeploy health visitors to deliver COVID-19 vaccinations - recorded in the minutes of the meeting (AM/83 [INQ000347190]). The scale of redeployment (current or proposed) was not known by PHE. PHE asked the iHV to share any intelligence that we could gather on this.

63. On 4 January 2021, I contacted Viv Bennett at PHE to enquire whether the Government's position on the redeployment of health visitors had changed. Viv Bennett confirmed that it had not, and health visitors should not be redeployed. On 8 January 2021, the iHV sent an email containing a brief update on information received through the iHV enquiries inbox over the previous few weeks with Viv Bennett at PHE (AM/84 [INQ000347191]). This highlighted ongoing concerns about redeployment in two sites, prioritisation of contacts, staff access to COVID-19 testing, and concerns about temporary COVID-19 workarounds/ virtual contacts becoming business as usual.

64. On 20 January 2021, in House of Lords Questions (AM/85 [INQ000347192]), Baroness Watkins of Tavistock and Baroness Walmsley highlighted the importance of a properly resourced health visiting service for parents and young children, particularly the most vulnerable families, post Covid. They called for assurance from the Government that there would be additional resources for the health visitor

workforce, in particular, to help them to catch up with missed visits to vulnerable young families during the pandemic.

Baroness Watkins of Tavistock also challenged the Minister to rigorously evaluate the effectiveness of video contacts with parents before their widespread adoption and highlighted concerns about protecting babies under the age of one that are at the highest risk of harm, asking, *"My Lords, health visiting has continued during lockdown, using video contacts with parents instead of face-to-face visits. Can the Minister assure the House that this approach will be rigorously evaluated before widespread adoption? This is particularly important given the recent stark findings from the child safeguarding practice review, which showed that the number of children dying or being seriously harmed after suspected abuse or neglect rose by a quarter, to 285 notifications, during April to September in England. Of these, 102 involved babies under the age of one. Does the Minister agree that it is vital that a properly resourced health visiting service is available to parents and young children, particularly the most vulnerable families, post Covid?"*

65. On 3 November 2021, I wrote to CNO England, Viv Bennett, Mark Radford, and Hilary Garratt, highlighting our ongoing concerns about falling health visitor workforce numbers and to share preliminary findings from our annual health visiting survey of 1,291 practitioners (AM/86 [INQ000347193]). This highlighted concerns about the wide variation in uptake of health visiting contacts between the highest and lowest performing local authorities (LA). For example, new birth visits by 14 days - reported by LA ranged between 27.9% - 99.9%; 6-week review by 8 weeks – ranged from 6.1%-99.6%. In response, a national health visitor workforce roundtable meeting was scheduled for 2 December 2021. The iHV provided a briefing note for the meeting (AM/88 [INQ000347195]) which I sent by email (AM/87 [INQ000347194]) to the Start for Life team on 2 December 2021 (email sent to: Andrea Leadsom MP, Name Redacted DHSC, Name Redacted Name Redacted and OHID Team Wendy Nicholson, Name Redacted Name Redacted containing details of health visiting workforce, funding, unwarranted variation and increased population need, with proposed solutions.

66. At the time of writing this evidence in August 2023, health visiting services in England have not been fully reinstated to pre-pandemic or optimum levels: there is

wide variation in the quality of health visiting support between local authority areas (see Topic 3); health visitor workforce numbers continue to fall (see summary in paragraph 15, AM/12 [INQ000347048] and Topic 4); and the practice of delivering health visitor mandated contacts using virtual methods (video calls, telephone, or letter) persists in some areas – and are still counted in the national health visiting performance metrics, despite the absence of evidence that these methods are a safe and effective way of completing a holistic assessment of babies', young children's and families' health and wellbeing (see Topic 2).

Topic 2: The use of technology to conduct appointments and meetings

67. The health visiting service provides three distinct levels of support to families at an individual level (universal, targeted and specialist), alongside community support. The application, suitability, effectiveness and acceptability of the use of technology/ virtual contacts in health visiting was unknown and untested at the start of the pandemic and will depend on the purpose of the intervention. For example, giving quick straightforward advice over the telephone is very different to completing a holistic assessment of a baby/ young child's health, wellbeing, development and safety at a mandated universal health review appointment.

NATIONAL GUIDANCE ON THE USE OF VIRTUAL CONTACTS IN HEALTH VISITING – INCLUDING iHV ACTION CALLING FOR A CHANGE OF POLICY

68. As set out in Topic 1, at the start of the pandemic, the first version of the Community Prioritisation Plan **[AM/29 INQ0000049706]** contained a directive that health visitor contacts should be *"virtual by default".* Face-to-face contacts were only advised for those with *"compelling need"* and with personal protective equipment (PPE). Due to the urgency to reach as many families as possible in the early weeks of the pandemic, virtual contacts were introduced without the usual quality assurance testing, and checks for safety, efficacy and unintended consequences, that would normally be applied when a new mode of healthcare treatment is implemented at scale. This represented a significant shift in the health visiting service delivery model. Previously, all health visiting mandated contacts were completed face-to-face and often as home visits; follow-up contacts were either completed as face-to-face contacts, group interventions, or telephone contacts, depending on the individual circumstances.

The iHV was not involved in the development of this directive. We are not aware of any equality impact assessments completed to inform this directive and determine the appropriateness of remote consultations, or potential access and inclusion issues for patients with disabilities. And in particular, those with: sensory impairments; patients whose first language is not English; those with literacy issues; or those who might find access more difficult due to poverty, particularly "digital poverty" that acts as a barrier to online consultations and methods of healthcare delivery. At the time of this directive, the body of health visiting research, [summarised in the 2018 publication "What makes health visiting successful—or not?", by Sarah Cowley, emeritus professor Dame, King's College London; Karen Whittaker, reader child and family health, University of Central Lancashire; Mary Malone, head of department of adult nursing, King's College London; Sara Donetto, lecturer, King's College London; Astrida Grigulis, King's College London; Jill Maben professor of health services research and nursing, University of Surrey (AM/89 [INQ000347196])], is clear that home visiting, trusting relationships, and health visitors' ability to identify need (which may be unknown, or hidden, and changes over time) are important elements of successful health visiting practice. The full impact of removing, or changing, these elements was, and remains, unknown.

69. On 3 June 2020, NHSE/I produced the third iteration of the Community Health Services prioritisation guidance - the "Restoration of Community Health Services guidance" (AM/58 [INQ000347160]). The guidance stated that,

    - Face-to-face contacts should be prioritised for families who are not known to services to *"mitigate known limitations of virtual contacts and support effective assessment of needs/ risks".*
    - Home visits should be prioritised where there was a child safeguarding concern.

70. On 19 May 2021, the Health Visiting and School Nursing delivery model (**(AM/2 [INQ000347118]**) was updated by PHE. With regards to the mode of delivery, the guidance stated: *"There are 5 mandated reviews for early years, which are offered to all families. These should be face to face, delivered by a health visitor, or under their supervision.*

At these mandated reviews, health visitors will identify a range of health and development needs for some families. They will then work with the family to agree how these needs will be met through additional targeted support. The guidance provides the following advice on mode of delivery for additional targeted support: *"Health visitors should use their clinical judgement to identify whether virtual, other digital or blended approaches can be used to support the needs of a child or family."*

71. On 21 October 2021, at the OHID Professional Organisations meeting, it was recorded in the minutes (AM/91 [INQ000347199]) that I raised concerns, *"around virtual contacts and how this was being communicated, particularly around data collection, because of the absence of evidence and risks to children with virtual-only approaches. WN [Wendy Nicholson (Deputy Chief Nurse, OHID)] suggested to members this will be explored, and the position was set out in the HV/SN model. There was also a systematic review on evidence for 'virtual approaches' and CYP [children and young people]."*

72. On 16 November 2021, I emailed Wendy Nicholson, Deputy Chief Public Health Nurse (who was deputising for Viv Bennett), escalating our concerns about the Office for Health Improvement and Disparities' plan to continue counting non-face-to-face health visitor mandated contacts in 2022, seeking clarification of the underpinning evidence base to support this decision and asking for our concerns to be formally recorded (AM/92 [INQ000347200]). On 17 November 2021, Wendy Nicholson cancelled the Professional Organisations Meeting scheduled for 18 November 2021. No response to our request for underpinning evidence to support the use of virtual contacts for mandated health visitor reviews was ever received.

73. On 15 December 2021, Sarah Olney MP, (Lib Dem: Richmond Park) published an open letter (AM/93 [INQ000347201]) to Rt Hon Sajid Javid MP, the Secretary of State for Health and Social Care, on behalf of a group of MPs (Wendy Chamberlain MP; Daisy Cooper MP; Tim Farron MP; Wera Hobhouse MP; Christine Jardine MP; Kim Johnson MP; Layla Moran MP; Bell Ribeiro-Addy MP; Jamie Stone MP). The letter expressed serious concerns about the safeguarding risks posed by the

ongoing virtual delivery of the health visiting mandated reviews. The letter urged the Government to act, stating,

> *"It should not become 'business as usual' to conduct the five mandated health and development checks virtually, without evidence that this is a safe and effective method. We know that the earliest years of life are a time of heightened vulnerability… To prevent more tragic deaths, we ask that you urgently invest in the health visiting service, as the frontline 'eyes and ears' for vulnerable children. Health visitors are well placed to see every child before they start school and a well-resourced service can identify families' needs and risks, and deliver appropriate support."*

74. On 24 March 2022, Tim Loughton MP asked a Parliamentary Question, *"To ask the Secretary of State for Health and Social Care, when the Government plans to revert back to the criteria that only face-to-face contacts are counted for health visitor mandated contacts"* (AM/94 [INQ000347202]). Maria Caulfield MP, Parliamentary Under Secretary of State, responded with the assurance that, "*The collection of health visitor service metrics is currently under review and associated guidance for 2022/23 will be updated shortly. This follows the changes made during initial phases of the COVID-19 pandemic and advice on use of virtual contacts. The review on data collection will reflect the national service model, which confirms that mandated reviews should be conducted face to face."*

75. On 16 May 2022, a group of 25 children's charities and organisations, including the iHV, and 14 cross-party MPs wrote an open letter (AM/95 [INQ000347203]) to The Rt Hon Sajid Javid MP, Secretary of State for Health and Social Care, as part of the "Fight for a Fair Start" campaign, with a policy briefing (AM/96 [INQ000347204]) urging the Government to rebuild the health visiting service, to ensure that all parents receive five mandated face-to-face contacts with a health visitor and to improve access to mental health services for new parents. On 17 June 2022, Sir Peter Wanless, CEO, NSPCC, received a letter from Rt Hon Sajid Javid MP (AM/97 [INQ000347205]), in response. The letter stated, *"The government is committed to improving mental health and wellbeing outcomes as a key part of our commitment to 'level up' and address unequal outcomes and life chances across the country. Delivering a universal offer to families remains essential for meeting*

the needs of children and families. The Public Health Grant was confirmed at Spending Review 2021. Health visitors have an important leadership function as part to the offer to families, including community staff nurses, nursery nurses and other health professionals. As part of the £500 million Family Hubs and Start for Life programme, we are planning to invest £100 million in supporting perinatal mental health and parent-infant relationships in 75 local authorities". [Note: this investment was not targeted at health visiting service delivery or offsetting the national shortfall of more than 5,000 health visitor substantive posts that have been lost since 2015].

76. On 26 July 2022, the Office for Health Improvement and Disparities published the updated guidance, *"Children's public health 0 to 5 years Interim national reporting process for the universal health visiting service. Full guidance for local authority members of staff 2022 to 2023"* (AM/98 [INQ000347206]). We were disappointed that, despite the assurances provided in Maria Caulfield MP's response to the Parliamentary Question on 24 March 2022 (AM/94 [INQ000347202]), the definition of the data collection metric for mode of delivery only stipulated that the antenatal contact and New Birth Visit contact were face-to-face contacts.

Bearing in mind that all babies and young children are only seen four times by the health visiting service in England between birth and 2-2 ½ years (and no other agency proactively and systematically sees all babies and young children, who represent our most vulnerable citizens, from birth to aged 5 years), it is important that these contacts are delivered using methods that can achieve the full specification, as set out in the Healthy Child Programme Schedule of Interventions Guide (AM/99 [INQ000347207}). It is impossible to achieve this Schedule using non-face-to-face methods as the baby/ young child may not be present or in view. When completed using non-face-to-face methods, the assessment is based solely on what the health visitor is told, rather than also including what these highly skilled practitioners can observe using their clinical assessment skills. At these contacts the HCP Schedule guidance (AM/99 [INQ000347207]) stipulates that the practitioner is required to:

- Measure and plot growth, including weight and head circumference.

- Review health, wellbeing and development of the infant. Parental self-report is known to be an unreliable method to identify the signs of clinical conditions and disability, or safeguarding concerns (these may be unknown by the parent, or hidden). Health visitors' direct observations of the child provide an important part of the assessment of child health and development. Late presentation of child health and development concerns, including neurodevelopmental conditions, hearing and vision problems, were highlighted as a growing concern in a report by the First 1001 Days Movement, (AM/100 [INQ000347027]), and a survey of paediatricians in the UK and Ireland on delayed access to care and late presentations in children during the COVID-19 pandemic (AM/101 [INQ000347028]).
- Identify infants requiring targeted or specialist interventions for infant mental health. This requires observation of parent-infant interaction which is not possible using non-face-to-face methods.
- Review the mother's mental wellbeing and that of any partner. This is more challenging on a telephone call which typically only involves one person (usually the mother).
- Identify safeguarding concerns due to the significant limitations of non-face-to-face methods in identifying vulnerability and risk.

RESEARCH/ PRACTITIONER FEEDBACK/ DATA ON THE IMPLEMENTATION OF VIRTUAL CONTACTS IN HEALTH VISITING DURING THE PANDEMIC

77. At the start of the pandemic, there was no evidence base to support the implementation of virtual contacts in health visiting. The evidence and research, on the use of video-consultations in healthcare available at the time, had been conducted with purposefully-designed GP or hospital services, and evaluated with patients who have an identified "problem" and the economic and technological capacity to choose to use this approach (Greenhalgh, 2018 – AM/102 [INQ000347029]). In contrast, health visitors' work is focused on preventative public health, the identification of needs which may not be known (or are hidden), and early intervention. Greenhalgh's study (AM/102 [INQ000347029]) highlighted that the use of video consultations was more beneficial when the clinician and the patient had an established relationship or for ad hoc encounters that supported

self- management; the review highlighted complex challenges to embedding video consultation services within routine practice.

A research paper published in BMC Medicine, in 2015 by Professor May, "Making sense of technology adoption in healthcare: meso-level considerations", highlights how the implementation of telecare requires consideration of demand, choices about services, expectations of patients, and requirements of healthcare workers that all form a set of moral and political assumptions that are frequently left outside from debates regarding patient empowerment through new healthcare systems (AM/103 [INQ000347030]). The effectiveness and safety of non-face-to-face methods for health visiting service delivery remains unknown.

78. At the start of the pandemic, the implementation of virtual contacts in health visiting was challenging. On 17 April 2020, a rapid qualitative scoping review was published on the impact of the pandemic on health visiting, using data collated through the iHV Facebook page (AM/43 [INQ000347144]) which engaged 4,198 individuals, with 187 comments. Whilst this was a small sample, and it is not possible to provide any sense of the scale of the concerns raised or pace of introduction of virtual contacts, the findings provided valuable insight into the types of problems that areas faced. These included, the lack of IT equipment, and/or the experience/ knowledge on how to safely implement virtual contacts. 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.

79. Early research led by Professor Jane Barlow at the University of Oxford, "The impact of the COVID-19 pandemic on services from pregnancy through age 5 years for families who are high risk or have complex social needs" (AM/104 [INQ000347031]), was published in June 2020, (presenting findings from a sample of 905 respondents). This identified that, during the first wave of the pandemic, two-thirds of health visitors were having less than 10% of their contact with families in the home/clinic. Of those respondents who were providing virtual contacts, around two-thirds had not received any training for this. IT problems and insufficient training were the main reasons for not providing such support. Although

two-thirds of respondents would consider delivering some aspects of the health visiting service virtually after the pandemic, most did not recommend their use for work with vulnerable clients going forward, suggesting that they should be used as a supplement to home visits for low-risk families.

Concerns about the safety of virtual contacts in terms of rendering vulnerable children invisible were raised, concluding that they *"significantly hindered their ability to safeguard vulnerable children due to its limitations in terms of actually seeing and assessing the children in person".*

The research raised concerns that virtual consultations: make it more difficult for practitioners to pick up on risk factors, like bruising or evidence of substance misuse or domestic abuse; risked excluding families experiencing digital poverty; and disproportionately affected children who were clinically vulnerable because they cannot be clinically assessed for symptoms like prolonged jaundice, faltering growth, or poor muscle tone.

80. Research findings published by Professor Conti and Abigail Dow, University College London, in September 2020 (AM/105 [INQ000347032]) reported that face-to-face health visiting contacts were prioritised for some purposes more than others (presenting findings from a sample size of 740 health visiting practitioners): from 16% for antenatal visits, to 47% for new birth visits and 62% for safeguarding visits. Many respondents were concerned about the impacts of reduced face-to-face contacts on families and children, particularly vulnerable children: 96% 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 (reported by 84%) and development (by 79%) were also cited, as were parental mental health conditions (by 92%), breastfeeding (by 75%) and the impact of COVID-19 on wider determinants of health. Respondents were concerned that needs would be missed due to their *"inability to make an accurate assessment of a child's needs virtually".*

81. Findings from the iHV State of Health Visiting Survey of 1,012 health visitors (data collected in October and November 2020; report published in December 2020)

reported that most health visiting services rapidly adapted to incorporate virtual delivery methods. 84% of health visitors reported that they were able to undertake virtual contacts within the first six months of the pandemic starting (AM/106 [INQ000347033]).

82. The iHV asked health visitors for their views on the use of virtual contacts in its annual survey six months after the start of the pandemic in 2020 (AM/106 [INQ000347033]) (sample=1,012 practitioners), and again 20 months after the start of the pandemic in 2021 (AM/107 [INQ000347034]) (sample=1,291 practitioners):
   - In 2020, 89% of health visitors disagreed or strongly disagreed that virtual contacts were as effective as face-to-face contacts for identifying needs or enabling disclosure of risk factors in vulnerable families. This increased to 93.8% in 2021.
   - In 2020, 85% of health visitors agreed or strongly agreed that virtual contacts can be used effectively to provide families with quick access to advice for straightforward concerns between universal contacts. This increased to 88.6% in 2021.
   - In 2020, only 26% of health visitors felt that there was enough evidence to safely roll out virtual contacts in health visiting. This reduced to 16% in 2021. Many respondents were concerned that virtual contacts would become the "new normal" as a replacement for face-to-face contacts, without consideration of the wider impact on quality of care or effectiveness, once the lockdown restrictions had eased.
   - Health visitors were concerned that some of the most vulnerable families would not have access to phone credit or Wi-Fi, making calls or virtual contacts impossible and putting their children at enhanced risk and greater disadvantage.

83. On 15 March 2021, I published a blog, "Zooming in but missing out" that set out the grounds for our ongoing concerns that the use of virtual methods for the delivery of health visiting mandated contacts would increase risks and the likelihood that vulnerable families and children would not have their needs identified or supported (AM/108 [INQ000347035]).

84. A thematic analysis of 43 cases of child death or Serious Incidents, published in 2021 by the Child Safeguarding Review Practice Panel, identified the key impacts of COVID-19 on vulnerable children and families (AM/109 **[INQ000103841]**). The review identified four key factors which, in combination, increased vulnerability and risk:

- Parental and family stressors.
- Exacerbated vulnerabilities for children and young people.
- Impact of school closures.
- Impact of adaptations for Covid-safe practice (typically, this related to circumstances where face-to-face home visits or booked appointments were replaced by telephone contacts or virtual visits).

It is noteworthy that the impact of adaptations for Covid-safe practices were considered to have had a significant impact in 16 out of the 43 cases reviewed; and some impact in 2 out of 43 cases.

85. In March 2021, Rt Hon Matt Hancock MP, the Secretary of State for Health and Social Care announced the national policy imperative to rapidly introduce digital technologies and virtual methods across the health and care system as a means to make the NHS more sustainable (AM/110 [INQ000347038]). HM Government "The Best Start for Life: a vision for the first 1001 Critical Days" (AM/111 [INQ000347039]) set out the findings of a review led by Rt Hon Andrea Leadsom MP, with six action areas to ensure that families have access to the services they need. Action area 3 is focused on providing, *"The information families need when they need it: designing digital, virtual and telephone offers around the needs of the family"*, with further guidance that, *"Digital services should be developed to complement face to face services and provide clear information and guidance".*

86. There have been some reported benefits of virtual contacts in health visiting:

- For professional meetings and case conferences (reported in research by The Nuffield Family Justice Observatory: Baginsky et.al., 2020 (AM/112 [INQ000347040]).
- For some follow up appointments and straightforward advice between mandated assessment contacts (reported in the iHV Annual Health Visiting Survey, December 2020 (AM/106 [INQ000347033]).

- For delivery of some targeted support once a need has been identified. Reported in the iHV report "Making History: health visiting during COVID-19" (AM/113 [INQ000347041]) which contains some good practice case studies on the use of virtual contacts to provide targeted support, including group interventions (for example, for breastfeeding and perinatal mental health problems, particularly to women living in remote areas).

87. Current OHID guidance on counting non-face-to-face contacts in health visitor metrics was published on 4 July 2023 (**(AM/98 [INQ000347206])**), with the following commentary from Dr Helen Duncan, National Lead for Life course Intelligence, OHID, provided in an email to me on 8 August 2023 (AM/115 [INQ000347043]): *"Our published guidance (PHE/OHID) on the reporting for health visitor service delivery is explicit, in the data definitions, that the antenatal contact and new birth visit are face to face contacts but is agnostic on the method/mode of delivery for the other universal health visitor reviews. The data collection guidance for 2020/21 and 2021/22 was modified to contain additional statements to the effect that where universal health visitor reviews were delivered virtually then they could still be counted. This guidance only relates to data collection and is independent of any clinical advice and guidance on service delivery issued by our nursing colleagues."*

88. Current situation – November 2023: There is no national dataset with reliable data on the extent of the use of virtual non-face-to-face methods for delivery of health visitor mandated reviews across England. Unpublished findings from the iHV Annual State of Health Visiting Survey that closed on 6 November 2023 (due to be published in January 2024 after full data analysis) are provided to the Inquiry (AM/116 [INQ000347044]). Findings from frontline practitioners (n=1,052) collected in this survey, indicate that whilst it has taken some time for services to return to face-to-face delivery of the mandated health visiting review contacts, it is reassuring that our survey findings have confirmed that the majority of practitioners now deliver the universal reviews face-to-face "all or most of the time" and virtual contacts are not "routine practice" for these reviews in most areas:
    - Only 0.1% of practitioners reported routine delivery of the New Birth Visit using non-face-to-face methods.

- 2% routinely delivered the 6-8 week review using non-face-to-face methods.
- 3.7% routinely delivered the 12-month review using non-face-to-face methods.
- 3.3% routinely delivered the 2-2½ year review using non-face-to-face methods.
- 17.3% routinely delivered the antenatal contact using non-face-to-face methods.

Most (90.82%) are using face-to-face methods for delivery of all or most New Birth Visits. However, a small proportion had adopted a blended approach for some of the reviews, using non-face-to-face methods occasionally – on average, for one out of every five contacts or less (for 6-week contact, 1 year review and 2-2 ½ year review). Only 1/3 of practitioners are offering face-to-face contacts for all or most of their antenatal contacts, despite this being stipulated as the mode of delivery in the OHID Data Collection guidance **(AM/98 [INQ000347206])** – see Figure 1 below:

iHV Annual Health Visiting Survey 2023 (preliminary findings; sample=1,052 practitioners)	
Percentage of health visiting mandated contacts delivered face-to-face (all or most of the time)	
Antenatal	34.12%
New Birth visit	90.82%
6-8 week	77.05%
One year	76.43%
2-2 ½ year	75.93%

Figure 1: Preliminary (unpublished) findings from iHV Annual State of Health Visiting Survey, 2023 (AM/116 [INQ000347044]) – Percentage of health visiting mandated contacts delivered face-to-face (all or most of the time).

89. Virtual contacts and digital technologies clearly have a place in health visiting. However, we are concerned that there is an assumption that virtual contacts are more efficient in all circumstances. Any shift in mode of delivery needs to be supported by the usual rigour of testing for safety, efficacy and unintended consequences that is given to implementing other new modes of treatment – for

example a new drug treatment. There is now strong evidence that there are serious unintended consequences linked to virtual contacts in health visiting in terms of reduced identification of clinical and safeguarding vulnerability, potential access and inclusion issues, and they are not suitable for health visitor mandated assessment contacts (presented in paragraphs 76, 79, 80, 82 and 84). In our opinion, virtual contacts should not be counted in the data definitions in OHID Guidance for health visiting metrics **(AM/98 [INQ000347206])**.

PARENTS' VIEWS OF VIRTUAL CONTACTS

90. There is limited data on the effectiveness of non-face-to-face methods from the parent/carer/child's perspective. A survey of 5,000 parents published in the "Babies in Lockdown: listening to parents to build back better" report (AM/117 [INQ000347045]), published in August 2020 by Best Beginnings, Home-Start UK, and the Parent-Infant Foundation, reported that just 1 in 10 (11%) parents of under-twos had seen a health visitor face-to-face. Whilst some respondents valued virtual health appointments, they left others feeling exposed and humiliated. Digital inequities were also exposed, impacting poor families' ability to engage in services when face-to-face contacts were reduced due to *"lacking the devices, data, Wi-Fi and/or safe, calm space to engage [in virtual support]".*

91. Parents overwhelmingly reported to a Government Petitions Committee Inquiry (2020) that virtual contacts were *"not enough,"* and it was very hard to build trusting relationships with professionals who they hardly saw (AM/118 **[INQ000176399]**).

92. A qualitative study, of 23 women who gave birth in London between March 2020 and August 2020, by Silverio et.al., "Women's experiences of maternity service reconfiguration during the COVID-19 pandemic: A qualitative investigation", reported their mixed views of virtual contacts (AM/119 [INQ000347047]). They reported, *"Virtual care was often discussed as an inappropriate medium through which to conduct health checks, especially postnatally, during which time both newborns and new mothers required attention: "I was also referred by my health visitor for a breastfeeding Zoom call. That was ridiculous. I needed to see someone face-to-face because they have to check your position, your latch and whether your baby has tongue tie. Feeding support has to be there face-to-face and it needs to*

be available" (Participant-005). Whilst not favoured in the postnatal period as much as it had been accepted for certain aspects of antenatal care, virtual care was tolerated as a better alternative to no care at all".

Participants felt that their mental wellbeing was not considered adequately through this medium, and this led to some turning to friends/family for advice rather than to professionals accessed remotely. As this is qualitative research, no prevalence data are provided.

93. According to a report by the NHS Confederation published in 2020 (AM/120 [INQ000347049]), in the UK, 16% of the population are unable to access the internet. And those facing social deprivation are disproportionately affected, are the most likely to be without technology, and are at the highest level of need for intervention.

94. The second Babies in Lockdown report "No one wants to see my baby" (AM/121 [INQ000347050]) was published in November 2021 by the Parent-Infant Foundation, Best Beginnings and Home-Start. The findings from in-depth interviews of parents and a survey of professionals, highlighted that, whilst many areas had restored face-to-face contacts, 28% of parents were still having health visitor appointments via the telephone or online and explained how this left them feeling *"unsupported"* and *"alone".* The review recognised that digital and telephone delivery work on some occasions. Parents also reported some benefits to some form of digital service delivery. The report's authors conclude that, *"there are many challenges to offering effective remote services particularly when working with babies, who can be invisible through such contacts. Although digital service delivery may have worked as a backup during the pandemic, this should not be confused with it being a sustainable and effective delivery mechanism in a different context."*

95. A report by UNICEF UK, "Early Moments Matter", published in October 2022 (AM/3 [INQ000347129]) identified that the *"pandemic and subsequent lockdowns increased isolation from vital networks for parents, carers, and families, while also decreasing access and face-to-face trusted support via formal services. This has*

led to the reduction in early identification of issues and referrals to additional support. In parallel, there has been an increase in household stress for families with young children". UNICEF UK launched the "Early Moments Matter" campaign calling for a national "Baby and Toddler Guarantee" which would ensure that all families have access to a high-quality health visiting service.

Topic 3: The impact of COVID-19 on people's experience of healthcare and quality of care – the impact on those requiring care for reasons other than COVID-19.

96. In this section we set out the impact of COVID-19 on people's experiences of health visiting. This section also includes evidence of babies', children and families' increased need for health visiting support during the relevant period.

97. The iHV annual survey of health visitors (sample of 1,012 health visitors, published in December 2020, AM/106 [INQ000347033]), identified that the impact of the pandemic on health visiting was twofold:

    i. A reduction in the capacity of the service to support families due to:
        - the initial categorisation of the health visiting service as a "partial stop" service in the NHS Community Prioritisation Plan (Topic 1).
        - the redeployment of up to 63% of health visitors in some areas away from supporting families (Topic 4)
        - requiring access to PPE to visit families (Topic 5)
        - the introduction of virtual contacts, initially often without the IT systems in place, or evidence on how to implement this safely (Topic 2)
        - ever falling workforce numbers (covered in Topic 1 and 4).

    ii. Families' increased risk and need – Alongside the universal support that health visitors routinely provide to all families, more families with babies and young children required additional health visiting support. Health visitors reported increases in cases of domestic abuse, mental health problems and safeguarding concerns. When parental stress increases, there are knock-on consequences for child health, development and safety concerns that have all increased in recent years.

THE IMPACT OF THE COVID-19 PANDEMIC ON FAMILIES' EXPERIENCE OF HEALTH VISITING - HEALTH VISITOR MANDATED UNIVERSAL CONTACTS

98. OHID England level data (AM/122 [INQ000347051]) show a slight fall in uptake of health visiting mandated contacts during the pandemic (Figure 2).

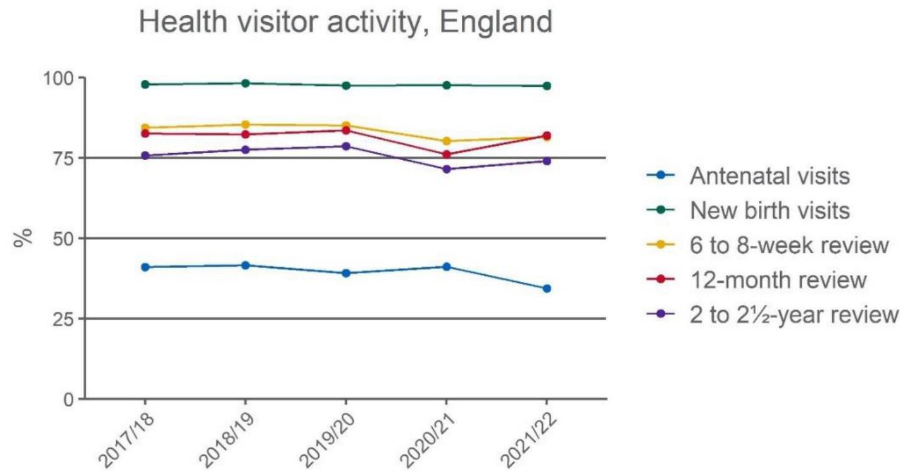

Figure 2: Universal health visitor reviews – % of those eligible receiving a review or visit.

99. However, the national picture masks significant variation between the lowest and highest performing local authority areas in England (Figure 3).

Health visitor performance metrics: Mandated contacts – data published November 2021 (Include non-face-to-face contacts 1 April 2020 to 31 March 2021)		
	Lowest performing local authority	Highest performing local authority
New Birth Visit by 14 days	27.9% (Kirklees)	99.9% (Bradford)
6-week review by 8 weeks	6.1% (Luton)	98.8% (Derby)
12-month review by 15 months	0.1% (Enfield)	99.1% (Blackburn with Darwen)
2-2 ½ year review	5.0% (Central Bedfordshire)	99.4% (Middlesbrough)

Figure 3: Health visitor performance metrics (1 April 2020 to 31 March 2021), Office for Health Improvement and Disparities (AM/123 [INQ000347052]).

100. Scatterplots (AM/124 [INQ000347053]) based on OHID data (AM/123 [INQ000347052]) on delivery of the health visitor new birth visit, 6-8 week review, and one-year review across all local authority areas during the pandemic show that

there is no correlation between uptake of these contacts and area level deprivation. The experiences that families had of the health visiting services depended on where they lived and local decision making on the level of health visiting service provision. Some families received all the mandated contacts, whereas others received none, or only some of the universal contacts with a health visitor.

Based on OHID Health Visitor Performance Metrics (AM/123 [INQ000347052]), in total, 441,332 children missed out on vital health visitor reviews (inclusive of New Birth Visits, 6-week reviews, 12-month and 2-2½ year reviews) during the year (1 April 2020 to 31 March 2021). In addition, only 229,959 pregnant women received the antenatal contact, out of around 550,000 who would have been eligible for this contact – although no national denominator is provided. Within this group, there will have been babies and young children living with vulnerability (AM/22 [INQ000347121]) who were not known to services and, as a result, would not be getting the support that they needed for their health, development and/ or safety. OHID's analysis shows that children from Black, Asian and minority ethnic communities are much more likely to miss out on these checks and will be under-represented in the data (AM/125 [INQ000347054]).

101. This variation in health visiting provision is ongoing and is due to what has been described by the government as "local decision making". From our experience, these decisions are largely based on funding and workforce capacity to deliver these contacts, rather than in the best interests of the child/ family. The purpose of these contacts is to identify need which is unknown beforehand. The period between pregnancy and the age of 2 is a dynamic period of change for a baby/ young child and its family – a single snapshot assessment has no predictive value for vulnerability at subsequent mandated health visitor contacts (for example, a family may be categorised as "universal" level of need at the antenatal contact and this might change at any of the subsequent contacts for a multitude of reasons that heighten their vulnerability or need for additional support). In our view, the key public health priorities for babies, children and families do not vary significantly between local authority areas to justify such large deviations from the national health visiting model for England (AM/2 [INQ000347118]) and the blueprint for the

Schedule of Interventions in the national Healthy Child Programme (AM/99 [INQ000347207]).

102. Counting non-face-to-face contacts: In April 2020, PHE suspended the routine collection of health visiting performance metrics (AM/126 [INQ000347055]). We understand that this decision was taken to reduce the reporting burden on local authorities during the prioritisation of services set out in the "Community Prioritisation Plan" at the start of the pandemic (AM/29 **[INQ000049706]**). No other organisations, including the iHV, had the means to fill this gap in data collection between April and September 2020.

The data was collected retrospectively by PHE when routine collection was reinstated with a notification on 10 September 2020 which stated that: "The national interim reporting system, suspended in April 2020 due to the COVID-19 pandemic, will restart on 21 September 2020" (AM/126 [INQ000347055]). In this notification, local authorities were advised that non-face-to-face delivery methods for mandated reviews would be counted during the pandemic. Therefore, caution needs to be taken when interpreting national health visiting metrics data. There is no way of determining the method of delivery (face-to-face, telephone call, virtual contact or simply a letter sent in the post), or the quality/ effectiveness of these reviews using these methods, as this is not captured in the national dataset. In our opinion, counting non-face-to-face mandated reviews in this dataset provides false reassurance of the extent of disruption of the health visiting service and delivery of the Healthy Child Programme during the pandemic, and a disincentive for services to return to face-to-face delivery of the mandated reviews.

THE QUALITY OF CARE – DELIVERY OF ADDITIONAL HEALTH VISITING TARGETED AND SPECIALIST SUPPORT FOR IDENTIFIED NEEDS.

103. The national health visiting service delivery model recognises that *"Mandated reviews are not the full extent of the health visiting service offer where families may require additional contact and support"* (AM/2 [INQ000347118]). The mandated universal contacts provide a "gateway" into the health visiting service. They provide the only systematic and proactive way of reaching all families with babies and young children in England. The purpose of these contacts is to identify need, family

vulnerability and risks – and then to ensure that these needs are met through additional targeted and specialist support to improve child health, development, and safety outcomes, and to reduce inequalities.

104. Additional health visiting support (targeted and specialist support) is provided to families based on the principles of proportionate universalism and across a breadth of physical and mental health conditions (for babies, children and adults), child development, social needs and safeguarding, as set out in the Health Visiting Delivery Model (AM/2 [INQ000347118]) and Healthy Child Programme (AM/1 [INQ000347025]; AM/99 [INQ000347207]). Health visitors provide additional support to families directly, but also work in partnership with other agencies to plan the most appropriate support, brokering engagement in services, and managing referrals as needed. There are no national data metrics on health visiting interventions for targeted and specialist support. As such, it is not easy to determine the extent of the disruption to this aspect of the health visiting service during the pandemic.

105. The iHV's survey of health visiting published in December 2020 (AM/106 [INQ000347033]) reported that only 17% of health visitors (sample of 1,012 health visitors) felt that they were able to "make a difference" to families with babies and young children. This was due to a number of factors including families' increased need and health visitors' inability to provide continuity of care and follow up needs identified. 90% of health visitors reported that their workload had increased compared to previous years. More than 60% of health visitors stated that focusing solely on those most at risk (child protection cases) left them with limited capacity to provide "upstream" early intervention and prevention. Health visitors also reported less availability of other support services for families and higher thresholds of need for referrals to be accepted (for example, to children's social care and children's therapy services). 90% of practitioners reported a reduction in children's centre services and children's social services. As a direct consequence, health visitors reported role drift towards carrying risk for other agencies (child protection) at the expense of preventative public health.

FAMILIES' EXPERIENCES OF HEALTH VISITING

106. On 6 July 2020, in response to their public engagement, The Petitions Committee Enquiry (AM/118 **[INQ000176399]**) reported that many parents experienced negative impacts of giving birth during lockdown, increased social isolation and the closure of the usual support networks, groups, classes and community services for families with babies and young children. Regarding health visiting, the report stated: *"There is some great support available within the UK, and we've heard about the fantastic work of health visitors; professional and volunteer-led support groups and baby groups which all play a crucial role in supporting new parents. Like many essential services, however, this support has not been available during the pandemic. This is not through want of trying: Health visitors and other medical professionals have done their best using technology and many support groups have been able to take place online—but we have been told that this has not been enough".*

107. A survey of 5,000 parents published in August 2020 in "Babies in Lockdown: listening to parents to build back better" (AM/117 [INQ000347045]) by Best Beginnings, Home-Start UK, and the Parent-Infant Foundation, reported that just 1 in 10 (11%) parents of under-twos had seen a health visitor face-to-face, and whilst some respondents valued virtual health appointments, they left others feeling exposed and humiliated. Digital inequities were also exposed, impacting poor families' ability to engage in services when face-to-face contacts were reduced – citing, *"While it is clear what the rationale is for switching from face-to-face to digital consultations, the emotional impact for mothers receiving care in this way must not be underestimated. Whether it was being helped with breastfeeding via video and the discomfort of filming a baby trying to make a latch onto the breast, or the experience of seeking medical help for an infected wound after birth, the mothers in our survey made clear how difficult this was for them."* Alongside GPs, the survey reported that health visitors had the highest rate of contact with families (using all methods including non-face-to-face) than any other service providing support to families (with just over 60% of families having contact with a health visitor during this time – see Figure 14 p.53, AM/117 [INQ000347045]).

108. On 23 March 2021, The First 1001 Days Movement - which is an alliance of more than 150 charities and professional bodies spanning the children, family, mental health, maternity and baby sectors - launched a national campaign called #WhatAboutUs (AM/127 [INQ000347056]) to raise awareness of the impact of the pandemic on babies and ensure that they were not forgotten in the Government's COVID-19 recovery plans. The campaign followed the Government's announcement of £1.7bn COVID catch-up funding for school children. The message was, *"If babies could speak, they would say, 'What about us?'"*. The widespread view across the sector was that the needs of our youngest citizens were invisible in the national COVID-19 recovery plans, with no support for babies who are at risk having experienced lockdown during a particularly important period in their development.

109. On 7 October 2021, in response to numerous petitions highlighting the difficulties that new parents and the services they rely on have continued to face since the start of the COVID-19 pandemic – including a petition to "Provide funding to local authorities to protect health visiting provision" (AM/128 [INQ000347057]) – the Petitions Committee published their "Impact of Covid-19 on new parents: one year on" report (AM/129 **[INQ000176381]**). This highlighted that *"new parents' access to [health visiting] services remains reduced… Since last July, new and expectant parents have continued to face severe limits on the formal and informal support for their wellbeing and their child's development that they would normally expect. Following a further 12 months of restrictions, the cohort of parents and children in need of catch-up support is now even larger, and the cumulative impact on parents' health and children's development has only increased"*.

110. In November 2021, the findings from a survey of professionals and volunteers working with families were published in a report titled "No one wants to see my baby", by the Parent-Infant Foundation, Best Beginnings and Home-Start (AM/121 [INQ000347050]) - findings based on a professional survey of 224 people during October 2021 and qualitative interviews with parents (n=11). This reported that parents were still struggling to access essential services to help them through pregnancy and beyond, with problems including accessing face-to-face medical care, reduced access to health visitors, and a lack of community parent and baby groups – all of which are taking a toll on parents' mental health:

- 30% said health visitor drop-in clinics were no longer operating in their area.
- whilst many areas had restored face-to-face contacts, 28% of parents were still having health visitor appointments via the telephone or online in their area and explained how this left them feeling "unsupported" and "alone".
- 12% said baby and toddler groups were no longer running in their area.

LEARNING FROM BEST PRACTICE

111. Working as health visitors (Specialist Community Public Health Nurses), in the biggest public health pandemic in living memory, tested health visitors' skills and leadership capabilities. Alongside the challenges described in this submission, this time also provided a unique opportunity for the health visiting profession to demonstrate its crucial role in supporting children and families across the breadth of clinical, social and statutory need. During the pandemic, health visitors across the UK supported thousands and thousands of families every week. Their work is often hidden behind front doors, poorly understood and does not get the recognition that it deserves. As the Inquiry focuses on points of learning, it will be important that the vital contribution that health visitors made to so many families, particularly the most vulnerable, is not overlooked.

Health visitors adapted service specifications and developed innovative workarounds including digital innovations, collaborative working initiatives and "rapid response teams" to support as many families as possible. Different areas responded in different ways. In a report by the First 1001 Days Movement, "Working for Babies" (AM/130 [INQ000347060]), the most successful areas had:

- Strong and committed leadership.
- Mature partnerships or quickly established collaborations with partner agencies to maximise efforts and reduce duplication/ gaps in provision.
- A dynamic understanding of need.
- An innovative culture.

In many areas, during the early weeks of the pandemic, the health visiting service was the only service still offering some home visits to parents with babies and young children.

112. Local areas were keen to learn from each other, but there was no national mechanism for sharing best practice/ innovations in response to the pandemic. To support dissemination of learning, following a call for case studies and peer review, on 10 September 2020, the iHV published a series of good practice case studies "Making history: health visiting during COVID-19" (AM/113 [INQ000347041]). On 20 November 2020, best practice case studies of health visiting during COVID-19 were also published by the Local Government Association (AM/131 [INQ000347061]).

INCREASED LEVELS OF NEED AND VULNERABILITY: BABIES, YOUNG CHILDREN AND FAMILIES

113. Alongside falling workforce numbers, the health visiting service was also impacted by rising levels of need during the pandemic, with more families needing health visiting support for a range of issues covered in this section. On 7 May 2020, the Royal College of Paediatrics and Child Health highlighted in their report "The impact of COVID-19 on child health services" that babies and young children were suffering from significant indirect impacts of the pandemic on their health and wellbeing, with warnings of potential long-term adverse effects (AM/132 [INQ000347062]).

114. An evidence review of the impacts of the COVID-19 pandemic on health visiting was completed by Morton and Adams in 2021 (AM/133 [INQ000347063]), comprising a focused sample of data from a range of published evidence sources, including eight national survey studies providing data from 2,585 health visitors, 141 employers, and 36,000 parents/families. All data sources reviewed reported that, whilst a few families experienced some benefits of the pandemic (for example, some reported enjoying the benefits of a slower life and more time together at home), many more reported anxiety, confusion, grief and loss. The experiences were unequal, and the negative impacts led to an increase in families in need and requiring health visiting support.

115. The House of Commons Petitions Committee Inquiry report (AM/118 **[INQ000176399]**) on the impact of COVID-19 on maternity leave was published on 6 July 2020. Catherine McKinnell MP, stated that, *"the impact of this pandemic on*

new parents has been profound, and a failure to act now risks impacting the mental and physical health and wellbeing not just of new parents in the immediate term but of their babies in the long term. We were told in stark terms that we are the first generation of legislators to know about the impact of maternal mental health on the development of children. We therefore have no excuse not to act."

116. A report by Ofsted, published in December 2020, reported that the pandemic had impacted on child health, safety and development (AM/134 [INQ000347064]), with family factors impacting on child wellbeing, *"Children who experienced particularly challenging family circumstances, such as bereavement, domestic violence or neglect, during this period have been finding it harder to cope"*.

PERINATAL MENTAL HEALTH

117. The pandemic's impact on parental perinatal mental health (PMH) was a significant concern. Identifying and treating parental perinatal mental illness (PMI) is important as, whilst not inevitable, it can have a broad range of negative impacts on the child and their cognitive, behavioural, social, and emotional developmental outcomes – these were well documented prior to the pandemic in the high-profile Lancet series "Effects of perinatal mental disorders on the fetus and child" published in 2014 by Stein et.al., (AM/135 [INQ000347065]). Socioeconomic disadvantages and social isolation are well-established risk factors for PMH problems (highlighted in research on maternal perinatal anxiety by Leach, 2017, AM/136 [INQ000347066]).

118. A report by Best Beginnings, Home-Start UK and the Parent Infant Foundation, published in August 2020, reported that other consequences of social distancing, such as the organisation of maternity departments which restricted partners and visitors, also increased psychological distress for pregnant women and posed additional risk factors (AM/117 [INQ000347045]). 81% of health visitors reported an increase in PMI in 2020 (compared to previous years) in an iHV survey of 1,012 health visitors published in December 2020 (AM/106 [INQ000347033]).

119. UK studies reported extremely high prevalence of PMI. A survey of 614 mothers in 2020 by Fallon et. al., (AM/137 [INQ000347067]) reported that rates of clinically relevant postpartum maternal depression and anxiety were 27% and 47% higher, respectively, when compared to pre-pandemic studies. A large survey of 1,329

mothers with a child under the age of 12 months in 2020 by Dib et. al., (AM/138 [INQ000347068]) found that the majority reported feeling down (56%), lonely (59%), irritable (62%), and worried (71%) to some extent since lockdown began, but 70% felt able to cope. In a study of 162 London-based mothers carried out by Myers and Emmott in May and June 2020 (AM/139 [INQ000347069]), 47.5% met a screening tool cutoff for postnatal depression. The pandemic exacerbated already existing health inequalities for people from black and minority ethnic groups who experienced increased rates of PMI (report by Centre for Mental Health published in 2021) (AM/140 [INQ000347071]).

CLINICAL VULNERABILITY

120. Access to urgent care: Concerns were raised that the care of children with clinical conditions would be compromised by reduced access to healthcare. In the earliest weeks of the pandemic, NHS data on emergency department (ED) attendances by children in April 2020 were 57% lower in England than the previous year (AM/141 [INQ000347072]). 32% of paediatric consultants surveyed in April 2020 by the British Paediatric Surveillance Unit (completed by 2,433 paediatric consultants in the UK and Ireland) reported delayed presentations for serious conditions and safeguarding concerns **(AM/101 [INQ000347028])** A rapid multi-centre surveillance project by Rowland et.al. in 2020 suggested that any delay in presentation did not substantially affect outcomes and normal ED activity resumed quickly. ED attendances for children 0-4 years remain high and above pre-pandemic levels (AM/143 [INQ000347074]). And contact with health professionals varied by region (AM/117 [INQ000347045]).

Health visitors have a central role in supporting parental health literacy to manage childhood illnesses and many areas responded quickly by promoting their non-face-to-face support; a rapid review completed by Southern Health NHS Foundation Trust (Hampshire) in March and April 2020 identified that, whilst their health visiting child health clinics had closed, contacts through their health visitor telephone advice lines and Chat Health text messaging services increased by 44% in the first months of lockdown with many parents seeking support for childhood illnesses (AM/144 [INQ000347075]).

121. Clinical vulnerability: Management of clinical conditions - A report by the Nuffield Trust on the management of childhood health conditions during the pandemic, published on 18 February 2022, (AM/145 [INQ000442225]) reported:

- A 6% reduction in children with long-term conditions feeling supported.
- A 79% drop in urgent GP referrals to hospitals for children and young people in April 2020. The referral rate then increased by 47% in December 2021, reflecting that this may be a worrying sign of deteriorating child health which impacts on all child health services, including health visiting.
- The waiting list for planned paediatric hospital care grew by 22% in seven months, leaving 300,465 children and young people waiting and reliant on other services, like health visiting, for support in the interim.
- The report concluded that the pandemic's effect on children and young people's health, care and wellbeing has been dramatic and concerning.

122. Management of children with disabilities - In a survey of 4,000 parents by the Disabled Children's Partnership published in 2020 (AM/146 [INQ000347077]), 76% of parents reported that the external support and care that they relied upon for their disabled child had been stopped altogether during the pandemic. Parents overwhelmingly reported that they felt, *"locked out and abandoned"* and were fearful for their own physical and mental health (p.22). The Government's review by Ofsted, published in 2021 (AM/147 [INQ000347078]), identified that children with Special Educational Needs and Disabilities (SEND) were disproportionately affected during the pandemic. The report states, *"Some areas quickly managed to adapt; others struggled… However, although there were areas where professionals managed to adapt well and where different parts of the system worked together effectively, it is evident that children and young people with SEND are now even more vulnerable than they were before… Missed support for physical health, communication needs and mental health has had a seriously detrimental, and in some cases potentially permanent, impact. Some children and young people with SEND have been out of sight of safeguarding professionals."*

SAFEGUARDING/ STATUTORY VULNERABILITY

123. Safeguarding/statutory vulnerability – Based on data from other countries, in April 2020, it was predicted that parental factors that are linked to poorer child health,

development and safety outcomes would increase during the pandemic, including domestic abuse (DA), parental stress/mental health problems, safeguarding concerns and substance misuse (presented in a paper by the Center on the Developing Child, Harvard University published on 20 March 2020, (AM/32 [INQ000347132]); and frontline health visiting practitioner intelligence collated in a rapid qualitative scoping review of the impacts of the pandemic on health visiting published by the Institute of Health Visiting on 17 April 2020, (AM/43 [INQ000347144]).

In the iHV annual State of Health Visiting survey report published in December 2020, health visitors expressed concerns that they were only reaching the "tip of the iceberg", highlighting the invisibility of babies and young children living with risk and vulnerability who were not being seen by services (AM/106 [INQ000347033]). In a speech on 6 November 2020, Amanda Spielman, Ofsted Chief Inspector (AM/148 [INQ000347079]), highlighted the "alarming trend" in cases of serious harm to, or deaths of, children under one from suspected abuse or neglect, amid the "toxic mix" of poverty, isolation and family proximity – these were labelled "pressure cooker homes".

124. Safeguarding – Serious Incidents: National data published by the Department for Education on notifiable serious incidents in 2020, involving "death or serious harm to a child where abuse or neglect is known or suspected, and any death of a looked after child" (AM/149 [INQ000347080]), reported an increase of 27% during the first 6 months of the pandemic, compared to the same period the previous year. 35.8% of incidents related to children under the age of 1, who, according to statistics from the Office for National Statistics (AM/150 [INQ000347082]), have the highest rate of homicide compared to any other age group.

125. Safeguarding – national data: Referrals to children's social care were variable during the pandemic. Average referrals were slightly reduced compared to previous years (presented in national Children in Need statistics 2020, AM/151 [INQ000347083]) with rates falling by 1% in 2020 compared to 2019; the rate fell further in 2021, with referrals 7% lower than 2020 (AM/152 [INQ000347084]). The rate of referrals also significantly reduced during school holiday periods – see

Figure 4. This pattern demonstrates the important role that adults outside the family play in the identification and referral of vulnerable children.

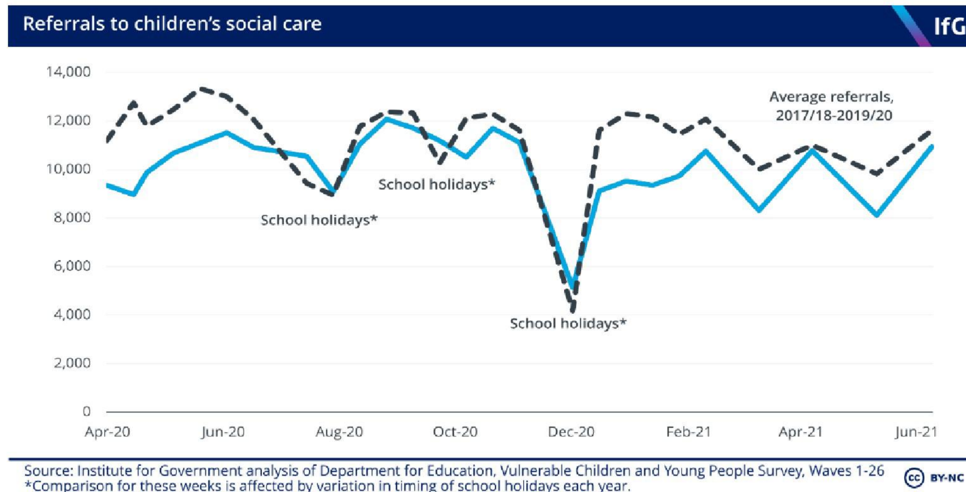

Figure 4: Referrals to Children's social care – April 2020 to June 2021 (Source data: Department for Education – graph by the Institute for Government).

If schools play such a vital role in the recognition of older children at risk of harm, it is therefore imperative that there is an equally robust mechanism (like universal health visiting) for proactively and systematically reaching all families with babies and young children who are not afforded the same protections that vulnerable school-age children have from schools.

It is too early to know the extent of the harm experienced by babies and young children who were invisible to services during the pandemic. The most recent government data on Children in Need, published on 26 October 2023, show that the number of referrals to children's social care has fallen by 1.5% or 9,800 since 2022; the number of children on a child protection plan has fallen by 0.3% or 100 since 2022; the number of Children in Need has fallen by 0.3% or 1,200 since 2022. There have been some notably tragic cases of child abuse during the pandemic (cited in the Child Safeguarding Practice Review Panel Report, 2020, (AM/109 **[INQ000103841]**); and the National Review into the murders of Arthur Labinjo-Hughes and Star Hobson, 2022, (AM/153 [INQ000347085]). In the iHV State of Health Visiting annual survey, published in January 2023, health visitors expressed concerns that national Child in Need data are misleading and mask the true extent of harm and increased risk experienced by babies and young children –

for two main reasons: cases are not being detected due to health visitors' reduced contact with families; and increased thresholds for children's social care only represent the "tip of the iceberg" of hidden abuse and child maltreatment (AM/154 [INQ000347086]).

126. Early in the pandemic, findings from research by Barlow et al. "The impact of the COVID-19 pandemic on services from pregnancy through age 5 years for families who are high risk or have complex social needs" (AM/104 [INQ000347031]) and the iHV report, "Health visiting during COVID-19" (AM/43 [INQ000347144]), reported concerns that the scaled-down health visiting service, and the limitations of virtual contacts, would reduce the identification of those at risk of significant harm. Health visitors highlighted that the impact of lockdown was not evenly distributed, with babies and young children in disadvantaged families experiencing the most detrimental consequences. This was due to compounding factors like overcrowded housing with lack of outdoor space, the impact of poverty, and parental stress and anxiety. In the iHV annual State of Health Visiting survey report published in December 2020 (AM/106 [INQ000347033]), 61% of health visitors reported an increase in child neglect. Despite these growing concerns, many health visitors reported that when services should have been building capacity to respond to rising levels of need, this was not the case.

127. A thematic analysis commissioned by the Child Safeguarding Review Practice Panel published in 2021 (AM/109 **[INQ000103841]**) identified the key impacts of COVID-19 on vulnerable children and families. The review identified four key factors which, in combination, increased vulnerability and risk:

- Parental and family stressors
- Exacerbated vulnerabilities for children and young people
- Impact of school closures: Identification of, contact with, and support for vulnerable children and young people
- Impact of adaptations for Covid-safe practice (typically, this related to circumstances where face-to-face home visits or booked appointments were replaced by telephone contacts or virtual visits).

128. Safeguarding - Domestic abuse: Due to its devastating impact, children are recognised as victims of domestic abuse (DA) in the Domestic Abuse Act, 2021 (AM/155 [INQ000347087]). There were widespread concerns that lockdown restrictions would exacerbate DA; it would also make it more difficult for victims to leave or speak out, with the scaling back of support and the lack of face-to-face contacts creating difficulties in identifying affected families and reducing opportunities for intervention and support. Published national data by the Office for National Statistics (AM/156 [INQ000347088]) reported a 7% increase in recorded offences for DA during the period March to June 2020, compared to the same period in 2019. However, as DA is often a hidden crime that is not reported to the police, these data only provide a partial picture of the actual level of DA experienced. 82% of health visitors surveyed in England (sample size= 862 frontline health visitors) reported an increase in DA in 2020 compared to previous years in the Institute of Health Visiting's survey published in December 2020 (AM/106 [INQ000347033]). Data reported by Refuge, the UK National Domestic Abuse Helpline, collected between April and June 2020 recorded a 66% increase in calls, a 950% increase in website visits, and an associated increase in demand for refuge places (AM/157 [INQ000347089]).

POVERTY AND WIDENING INEQUALITIES

129. The pandemic exposed and amplified pre-existing inequalities, with the poorest families and those already disadvantaged disproportionately affected (highlighted in the "Build back fairer: The COVID-19 Marmot Review", (AM/158 **[INQ000130491]**); and a review of priorities for the child health response to the COVID-19 pandemic recovery in England, by Hefferon et al, (AM/159 [INQ000347091]). In response to the Petitions Committee Inquiry (AM/118 **[INQ000176399]**), many families reported increased financial pressures. In the iHV annual State of Health Visiting survey published in December 2020 (AM/106 [INQ000347033]), 81% of health visitors reported an increase in families experiencing poverty, and (76%) an increase in the use of food banks.

130. A survey of 5,000 parents by Best Beginnings, Home Start UK and the Parent Infant Foundation published in August 2020 (AM/117 [INQ000347045]) reported that parents whose voices are "seldom heard" and whose children are at higher

risk of poor outcomes, such as families with a low household income, young parents and those from Black, Asian and minority ethnic communities, were more likely to have a difficult experience of lockdown, further exacerbating existing inequalities. Digital inequities were also exposed, impacting poor families' ability to engage in services when face-to-face contacts were reduced due to *"lacking the devices, data, Wi-Fi and/or safe, calm space to engage [in virtual support]".* In December 2020, the NHS Confederation report, "Digital inclusion in mental health" estimated that, in the UK, 16% of the population are unable to access the internet; those facing social deprivation are disproportionately affected, they are the most likely to be without technology and are at the highest level of need for intervention (AM/120 [INQ000347049]).

131. Between 1 April 2020 and 31 March 2021, the Trussell Trust foodbanks (one provider in this sector, and therefore an underestimate of total need) distributed 2.5 million emergency food parcels to people in crisis, a 33% increase on the previous year; an estimated 980,000 food parcels went to children. The Trussel Trust statistics (AM/160 [INQ000347093]) show year on year increases in the number of food parcels distributed to children from 2017 to 2022/23 (the number provided to children in 2017/18 was 491,799; this has increased to 1,139,533 in 2022/23.

CHILD DEVELOPMENT

132. Evidence from research by iCAN, the children's speech and language charity, published in October 2021 (AM/161 [INQ000347094]), national reviews by Ofsted (AM/162 [INQ000347095]), and the Government's own child development data published by OHID (AM/163 [INQ000347096]-see Figure 5) collected at the health visiting 2-2½ year review, show that a significant and growing minority of babies born in the pandemic have fallen behind with their development, with widening inequalities.

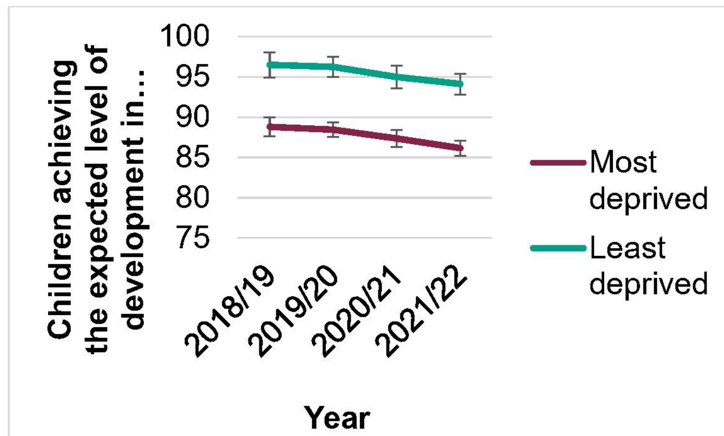

Figure 5: Child development outcomes: Children achieving the expected level of development in communication skills at 2–2½ years – gap between the most deprived and least deprived deciles over time (source: OHID).

Topic 4: Staffing capacity including the redeployment of health visiting practitioners from one area to another

133. This section provides an overview of staffing capacity including the redeployment of health visitors which reduced an already depleted workforce. Health visiting workforce capacity issues prior to the pandemic and the timeline of national redeployment policy decisions are presented in Topic 1.

CONTEXT OF REDEPLOYMENT DECISIONS

134. At face value, redeploying health visitors who are registered as Specialist Community Public Health Nurses into non-public health roles during the biggest global public health emergency we have experienced in living memory would appear to be counterintuitive. To understand the decisions made, it is important to avoid hindsight bias. The early weeks of the pandemic were characterised by incomplete information and an unpredictable and complex situation that impacted all aspects of life, including healthcare decision-making which focused on protecting the NHS.

135. The decision to redeploy health visitors from their work with families was justified by Jo Churchill MP, The Parliamentary Under-Secretary of State (Minister for Prevention, Public Health and Primary Care), in a response to a parliamentary

question on 25 June 2020, on the grounds that health visitors should work where their skills were *"most needed to care for acutely ill patients"* (AM/34 [INQ000347134]), even though many health visitors had not worked in acute settings for many years.

SCALE OF REDEPLOYMENT OF HEALTH VISITORS AND ITS IMPACTS ON PRACTICE

136. In April 2020, an initial qualitative scoping review of the impact of the pandemic on health visiting was published by the iHV (AM/43 [INQ000347144]). This provided early estimates that redeployment would result in the health visiting workforce being reduced by 50–70% in some locations, with considerable unwarranted variation between different local authorities in England. Some health visitors reported that they were happy to be redeployed given the circumstances, others were upset that health visiting was not seen as essential. Most respondents were alarmed that redeployment decisions had not considered the full impact of the pandemic across all services. 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 identify need and support families.

137. National data on the actual scope and scale of health visitor redeployment were not routinely collected by the government. This hampered national policy decisions as there was no available information on the extent or impact of redeployment practices on the health visiting service. It also meant that there was no reliable means to provide assurance on the restoration of the health visiting service once the national policy directive changed.

138. A study by Barlow et.al., (2020), "The impact of the COVID-19 pandemic on services from pregnancy through age 5 years for families who are high risk or have complex social needs", comprising a national survey and in-depth interviews with frontline health visitors during the first lockdown (AM/104 [INQ000347031]; AM/164 [INQ000347097]), reported that health visitors faced the highest rate of redeployment - compared to midwives, community paediatricians and social workers. Two-thirds of health visitor respondents reported that they had experienced redeployment within their team. This increased the caseloads of

health visitors who were not redeployed. Many respondents were also unclear why some staff were redeployed, and others were not. This made them question the whole redeployment process as many were sent to work in other areas, and for which some felt that they had no expertise and inadequate preparation, and that were perceived not to have utilised their public health skills.

139. On 29 July 2020, a study by Professor Conti at University College London (AM/105 [INQ000347032]), raised concerns that the needs of children had been missed due to health visitor redeployment to support the COVID-19 workforce and increased caseloads. The survey of 663 health visitors in England, conducted between 19 June and 21 July 2020, found that 41% of respondents in teams which lost staff had between 6 and 50 team members redeployed between 19 March to 3 June 2020. In approximately 10% of teams, which experienced a loss, this was a redeployment of at least half of their staff. Few teams (9% among those with staff redeployed) gained additional staff to fill the gaps. This meant that 253 respondents (38%) had their caseload increase, some with an increase of 50% or more, and 73% of those who experienced a change reported that their caseload had not returned to its usual size, *"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. Increased caseloads for a significant proportion of health visitors, along with reports of a lack of PPE for home visits, has created a lot of additional stress and anxiety, during a time of great uncertainty and difficulty."*

140. The most comprehensive review of health visiting redeployment in England during the pandemic was completed by Professor Conti and her team (AM/15 [INQ000347081]) using Freedom of Information Requests to local authorities. The findings showed a wide range of redeployment practices between health visiting services:
    - 66% of local authorities redeployed at least one FTE member of staff from health visiting teams.
    - Redeployment of health visitors ranged from 0% to 63%.
    - Redeployment of clinical skill mix staff supporting health visitors ranged from 0% to 100%.

- Health visiting staff were redeployed from 19 March 2020, as England went into its first national lockdown, for an average duration of over 2 months.
- Redeployment was still in place until September 2020 and, in 73% of local authorities that redeployed staff, it continued past 3 June 2020 (the date of the supposed restoration of health visiting services by NHS England).
- There was also a large decline in job postings for health visiting roles at the start of the pandemic, suggesting that the posts lost due to redeployment were not replaced.

Staff working in NHS Trusts and private providers were more likely to be redeployed although reassuringly rates of redeployment were lower in areas of high deprivation (for map of redeployment of health visitors, see Figure 3 in the research paper by Professor Conti, AM/15 [INQ000347081]). The authors conclude that *"The findings show extensive and unequal redeployment of health visiting staff during the first COVID-19 wave across English local authorities. This happened on top of a state of high pressures on health visiting teams prior to the pandemic, with staff responsible for worryingly high caseloads. This situation threatens the universality of the Healthy Child Programme, and calls for appropriate policy responses to avoid the possible worsening of inequalities in maternal wellbeing and child health and development."*

141. Redeployment significantly increased caseload sizes of the remaining health visitors and consequently their capacity to respond to rising levels of need (cited in the Institute of Health Visiting state of health visiting survey report published in December 2020, AM/106 [INQ000347033]; and a paper in the Journal of Health Visiting by Morton in July 2020, AM/165 [INQ000347098]).

142. A survey of 5,000 parents, "Babies in Lockdown: listening to parents to build back better" report, published in August 2020 by Best Beginnings, Home-Start UK, and the Parent-Infant Foundation (AM/117 [INQ000347045]), reported that redeployment variations meant that a family's access to support was largely determined by where they lived. 43% of respondents were not confident that they could access help with their mental health if required. Many parents reported to the Petitions Committee that they did not know how to access the service or who their health visitor was (AM/118 **[INQ000176399]**).

WERE HEALTH VISITOR SKILLS 'NEEDED MOST' IN REDEPLOYED ROLES?

143. It is unsurprising that the skills of health visitors, as Specialist Community Public Health Nurses, were in demand. They are a highly skilled workforce, used to managing complex situations and multiple competing priorities. However, the Government's initial EPRR and Community Prioritisation Plan (AM/29 [INQ000347128]) did not consider the wider impacts of the pandemic on babies, young children and families and, as a result, did not deploy health visitors' skills to where they were needed most, remaining in 0-19 public health nursing services.

144. In an early scoping exercise to understand redeployment practices in health visiting led by the iHV in April 2020 (qualitative data collected through Facebook engagement from 4,198 individuals, with 187 comments), health visitors reported that they were redeployed to support acute NHS services; they were also redeployed to non-clinical administrative roles (AM/43 [INQ000347144]).

145. In research led by Barlow et.al., in 2020, "The impact of the COVID-19 pandemic on services from pregnancy through age 5 years for families who are high risk or have complex social needs", practitioners reported that little consideration had been given to the risks that redeployment decisions posed to children and families (interim findings, AM/104 [INQ000347031]; final report, AM/164 [INQ000347097]). Health visitors made a considerable difference as leaders, or as nurses treating seriously ill patients in acute hospitals and community settings. Others were redeployed to work as band 3 ward clerks, healthcare support workers, or administrators where their skills were, arguably, not needed or maximised to best effect, as highlighted in the following quote:

> *"I have been redeployed from health visiting into the children's community nursing team since the beginning of April … I understand we were placed there in anticipation of children being discharged out of hospital and the possibility of staff contracting COVID-19. This, fortunately, didn't happen. However, we have remained in these positions despite our colleagues in health visiting being overwhelmed with huge volumes of work… The team I am in are not busy and really do not need us. We have been used to make deliveries, make up packs of PPE and make phone calls."* [Health visitor] (AM/165 [INQ000347098]).

PREPARATION FOR REDEPLOYMENT

146. Limited communication from national government and lack of clarity on the implications of emergency planning for health visiting were a source of concern at the start of the pandemic. This fuelled rumours and increased anxiety amongst practitioners around redeployment plans for health visitors. In an early qualitative scoping exercise to understand redeployment practices in health visiting led by the iHV in April 2020 (engagement from 4,198 individuals, with 187 comments), health visitors raised concerns that they had not been consulted or included in decision-making around redeployment (AM/43 [INQ000347144]). They felt that it would be beneficial to public health if health visitors stayed in their roles, as their specialist public health skills were needed more than ever. They also expressed concern about the current level of their transferable skills.

147. In research led by Barlow et.al., in 2020, "The impact of the COVID-19 pandemic on services from pregnancy through age 5 years for families who are high risk or have complex social needs" (interim findings, AM/104 [INQ000347031]; final report, AM/164 [INQ000347097]), one third of all redeployed practitioners stated that they had received inadequate preparation for their new role and worried about the families they were leaving without the support they needed:

> *"I was told to get rid of my caseload and stay at home to await redeployment details. I was not allowed to contact any of my caseload, even though the health visitors who had been left behind were drowning in work."*
>
> [Health visitor respondent, published in paper in the Journal of Health Visiting by Morton, 2020, AM/165 [INQ000347098]; source "Health Visiting during COVID-19: an iHV Report", published in April 2020, AM/43 [INQ000347144].

GOVERNMENT DIRECTIVE TO END REDEPLOYMENT AND ITS IMPLEMENTATION

148. The iHV is not specifically aware of any government/ NHS national data collection on the extent or duration of health visitor redeployment. PHE asked the iHV to share any intelligence that it had on the extent of health visiting redeployment [note the iHV does not manage a national dataset on health visiting workforce]. On 10 June 2020, Dr Cheryll Adams sent details of ongoing redeployment practices in an email to Viv Bennett at PHE (email AM/61 [INQ000347164]; redeployment messages, AM/62 [INQ000347167]; redeployment summary AM/63

[INQ000347168). This intelligence was based on health visitors' accounts of redeployment in their area, following a request to health visitors on the Institute of Health Visiting's Facebook page. The information was collected at the end of May and the first week in June via open and closed messages (AM/62 [INQ000347167]; AM/63 **INQ00034716**. The intelligence highlighted that redeployment was an ongoing concern and was having a detrimental impact on the level of support that the remaining health visitors were able to offer to families, as well as the mental wellbeing of practitioners.

149. To our knowledge, the only robust measure of redeployment in health visiting was collated through research by Professor Conti which collated data on the extent of redeployment in health visiting using Freedom of Information requests (AM/15 [INQ000347081]). This reported: *"Health visiting staff were redeployed from 19 March 2020, as soon as NHS guidance was issued. The average duration of redeployment up to 1 September was 65.7 days (2.2 months). In 95% (91/96) of local authorities that redeployed staff, redeployment started before May. Despite the supposed restoration of health visiting services issued on 3 June 2020, redeployment of staff was still in place well past this date and up to 1 September: indeed, in 73% (68/93) of local authorities that redeployed staff, redeployment was ongoing beyond 3 June."*

This prolonged period of uncertainty about when redeployment would end had a detrimental effect on the wellbeing of some health visitors:

"I have found myself suffering high levels of anxiety and uncertainty over the past 10 weeks, but have stuck with it and tried to embrace the experience. This has been hard knowing I should be using my skills elsewhere in the job I feel passionate about and trained hard for."

[Health visitor respondent, published in paper by Morton, 2020, source AM/43 [INQ000347144]; published in AM/165 [INQ000347098].

150. On 2 October 2020, in response to growing concerns about the delays experienced in returning health visitors (and other redeployed staff from health visiting teams) from their redeployed posts, a joint letter (AM/78 [INQ000347184]) was sent to all Directors of Nursing from Ruth May (CNO England), Professor Viv Bennett (Chief

Nurse PHE), and Councillor Ian Hudspeth (Chairman Community Wellbeing Board, Local Government Association). The letter provided a clear directive to end health visiting redeployment:

"We advise that professionals supporting children and families, such as health visitors, school nurses, designated safeguarding officers and nurses supporting children with special educational needs should not be redeployed to other services and should be supported to provide services through in pregnancy, early years (0-19) and to the most vulnerable families."

151. Despite this announcement, the restoration of health visiting services was left to "local decision-making". There is no national data on when redeployment practices in health visiting stopped. However, we have heard through our conversations with health visitors and service leads that some health visitors never returned to their health visiting posts. Some chose to remain in their redeployed posts, others chose to leave health visiting and/ or nursing positions entirely. Others left on the grounds of ill-health, linked to work-related stress or long-term sickness. We do not have data to confirm the extent of these practices, however, the number of health visitors recorded as employed in the NHS, and Independent Healthcare Workforce datasets fell from 7,961 Full Time Equivalent (FTE) health visitors in March 2020 to 6,651 FTE in April 2023 (AM/12 [INQ000347048]).

Topic 5: Infection prevention and control. The availability of appropriate personal protective equipment (PPE) for those working in the health visiting during the pandemic. The effect of national guidance on infection control within healthcare settings

152. On 17 March 2020, healthcare was prioritised as part of the national COVID-19 response in a letter from Sir Simon Stevens (NHS Chief Executive) and Amanda Pritchard (NHS Chief Operating Officer) (AM/23 **[INQ000087317]** Following the publication of this letter, the iHV received correspondence from health visiting service leads and commissioners requesting further clarification and information on obtaining Personal Protective Equipment (PPE) and the application of NHS guidance for infection prevention and control for health visiting staff working in communities, including home visiting. The initial NHS guidance focused on

"donning and doffing" in hospital settings. The practicalities of carrying supplies in the community, "donning and doffing" from the boot of a car, or outside a family's home, and disposing of clinical waste were provided to community services later – with some information provided by PHE on 2 April 2020 (AM/166 **[INQ000348324]**) and by the UKHSA on 31 July 2020 (AM/167 [INQ000347100]).

153. Like most other community health services, the health visiting service in England struggled to access Personal Protective Equipment (PPE) in the early months of the pandemic as the needs of staff working in hospitals were prioritised. This was reported by the Public Accounts Committee (AM/168 **[INQ000145899]**) on 10 February 2021 in "Public Accounts Committee (2021) COVID-19: Government procurement and supply of Personal Protective Equipment". The Committee highlights that:
"Early in the pandemic, the Department of Health & Social Care lacked information on how much PPE was needed by health and social care providers and which ones had the greatest need. Its decision to prioritise hospitals meant social care providers did not receive anywhere near enough to meet their needs, leaving them exposed. Many workers at the front line in health and social care were put in the appalling situation of having to care for people with COVID-19 or suspected COVID-19 without sufficient PPE to protect themselves from infection."

154. On 31 March 2020, Unite the Union which supports health visitors across England called on the Government to provide equipment such as gloves, masks and hand sanitiser to those working on the frontline of the crisis (Unite the Union press release, AM/169 [INQ000347102]). Unite's Lead Professional Officer for health visiting, Obi Amadi, said: *"Our community practitioner members are working really hard to provide services in the community. In many areas, they have been struggling to keep themselves and those they are visiting safe because of the lack of PPE. There is also a reported lack of hand sanitisers… they have not had access to enough PPE, nor been sufficiently recognised for their tireless below-the radar efforts at this time of national emergency."*

155. Lack of PPE was identified as a significant concern to health visitors in an early qualitative review by the iHV, "Health visiting during COVID-19: an iHV report"

(AM/43 [INQ000347144]) published on 17 April 2020 (containing key themes from practice collated through responses to iHV questions posed to practitioners through its open Facebook page on 2 April 2020; engagement with 4,198 individuals, with 187 comments). Health visitors who continued to meet clients face-to-face were required to follow the national guidelines for PPE. However, many reported a lack of appropriate equipment and were also fearful that they were not sufficiently protected. Health visitors felt that there had been a lack of consideration of their specific working conditions in the national PPE guidelines and asked that national guidance was applied to health visiting practice. They reported feeling concerned that they may transmit or contract COVID-19 as:

- They were unable to categorise families as COVID-19 positive, as some individuals may be asymptomatic.
- They would 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 assessments.
- They had 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.

PPE difficulties due to the physical attributes of practitioners, or communication barriers caused by wearing PPE, were not reported by respondents to our survey. This report was shared with the Chief Public Health Nursing Directorate in PHE, by email (AM/44 [INQ000347145]), who assured us that they were taking steps to ensure that all health visiting practitioners had access to PPE. The iHV regularly raised concerns about ongoing lack of PPE to the Chief Public Health Nursing Directorate in the weekly Professional Organisations meetings between March and July 2020. We received no further correspondence from health visiting services highlighting lack of PPE as a concern from July 2020 and were assured that the supply chain issues had been resolved.

156. Whilst this point does not relate specifically to PPE for staff, in July 2020, health visitors also raised concerns about the confusion around national guidance on face

coverings for babies and young children. The iHV escalated these concerns to PHE via the Chief Nursing directorate. This led to the publication of a PHE statement that babies and young children should not wear face masks due to risk of suffocation on 23 July 2020 (AM/170 [INQ000347104]). In terms of learning for future pandemics, it will be vital that the needs of babies and young children are not overlooked in similar national guidance for the population.

157. On 29 July 2020, a study by Conti et.al., (AM/105 [INQ000347032]) published the findings from a survey of 663 health visitors in England, conducted between 19 June and 21 July 2020. The findings reported that, 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. 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 Personal Protective Equipment (PPE).

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 reported that they didn't get any PPE until April, May or as late as June 2020. 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 the 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.

158. Sickness absence for health visitors is now presented as aggregate data with all nurses by NHS Digital (AM/171 [INQ000347105]). This reported that, in April 2020, at the height of the PPE shortage, nurses' (including health visitors) sickness absence due to COVID-19 peaked at 36.7% of Full Time Equivalent (FTE) days lost due to all reasons. This gradually reduced over the summer of 2020, falling to

4.5% of FTE days lost due to all reasons in August 2020. Over the winter, the rate increased again with new variants of COVID-19, peaking again at 30.7% of FTE days lost to all reasons in January 2021.

159. Prevalence of self-reported long Covid is reported to be highest among those working in health or social care compared to other occupations among the UK population, according to figures from the Office for National Statistics (ONS) (AM/172 **[INQ000272181]**). To our knowledge, there are no data on rates of long Covid amongst health visitors but, due to the nature of their work, working in families' homes, often without adequate ventilation and without PPE at the start of the pandemic, they would have been left exposed to COVID-19 infection. A feature in the Nursing Times by Dr Ruth Oshikanlu, on 15 October 2021 (AM/173 [INQ000347107]), who worked as an agency health visitor at the start of the pandemic and contracted long Covid, highlights the risk to the profession from continuing face-to-face contacts without adequate PPE.

Topic 6: The impact of the COVID-19 pandemic on the Institute of Health Visiting and its members/ practitioners working in health visiting teams, including those in training

160. This section provides an overview of the impact of the pandemic on staff working in health visiting teams and those in training.

IMPACT OF THE PANDEMIC ON STAFF WORKING IN HEALTH VISITING TEAMS

161. An early qualitative review of the impacts of the COVID-19 pandemic on health visitors, nurses and other practitioners working in health visiting teams was published by the iHV in April 2020 (engagement from 4,198 individuals, with 187 comments) (AM/43 [INQ000347144]). Respondents described feeling anxious and unsettled by the rapid pace of change, loss of control, and the wider impact of COVID-19 on many aspects of their work. Practitioners' experiences varied, depending on where they worked in England and their personal experiences of:

- Personal redeployments and the loss of other members of their team through redeployment.
- Increased workload: due to increased levels of need in the population that health visiting serves, and reduced capacity within teams to meet this need.

Pre-existing staff shortages were exacerbated by staff sickness, shielding and redeployment.

- Ability to meet the needs of babies, children and families. This was impacted by:
    - Access to PPE to enable home visiting and face-to-face contacts.
    - Support/ capability to adapt the health visiting model to practise safely (particularly IT software and hardware capabilities to provide video-contacts).
- Professional self-worth: practitioners felt that the role of health visiting was poorly understood and not valued by policymakers. The decision to "stop" the health visiting service left many staff feeling demoralised.
- Fear for personal health and safety, with increased risk of contracting COVID-19: Practitioners were also concerned for the safety of the families that they worked with, as well as their own families.
- High risk groups: Some staff experienced additional worries if they were in high-risk groups that were shielding due to underlying medical conditions or pregnancy.

162. Early findings from research by Barlow et al. "The impact of the COVID-19 pandemic on services from pregnancy through age 5 years for families who are high risk or have complex social needs" (AM/104 [INQ000347031]) published in June 2020, identified that, during the first wave of the pandemic, around one-fifth of respondents (n=905, of whom three-quarters were health visitors) reported that the pandemic had had a significant impact on their mental health. Four-fifths of respondents had experienced additional organisational support for their wellbeing. However, 10% felt that this was inadequate. Changes that were described as being needed to reduce stress levels, mostly related to service management, and in particular the need for:

- Clearer and more supportive communications from practice managers.
- More empathic management and leadership during these stressful times.
- The opportunity to be consulted and have their concerns heard.
- Less 'micro-management' in terms of being trusted to make decisions.

In terms of immediate changes that were perceived to be needed, the majority of respondents identified the need to end the redeployment process, and for health

visitors and social workers in particular to be enabled to conduct safe in-person visits to vulnerable families and clients.

163. A survey review by Conti and Dow, "The impacts of COVID-19 on health visiting in England first results" (AM/105 [INQ000347032]), using data collected from health visiting practitioners between 19 June to 10 September 2020 (sample=740 practitioners), found that the increased workload and pressures of working in the COVID-19 pandemic had significant negative impacts on staff wellbeing and mental health. The authors noted that these additional pressures occurred at a time when the service had already sustained significant funding and workforce cuts over the previous few years. They stated that the findings *"paint 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 had increased over the past year. Among those reporting higher levels of stress:

- 51% were working longer hours.
- 66% said that the stress was making them feel more worried, tense and anxious.
- 28% said they were managing the stress in negative ways like drinking more alcohol or comfort eating.
- 27% reported that their physical health was negatively affected.
- 57% stated that their sleep was affected.

Higher stress also affected how health visitors felt about their work:

- 55% of those with increased stress levels reported feeling demotivated.
- 29% struggled to concentrate.
- 37% reported that if they could leave health visiting, they would.

On a Short-Form 12 Health Survey (SF-12; a 12-item questionnaire that measures self-reported physical and mental health), the average composite mental health score of health visiting staff surveyed was 43.3, which is below the average score of 47.4 for the UK sample, indicating poorer mental health. Reassuringly, staff physical health was less of a concern.

164. During the pandemic, the iHV experienced ongoing growth in its membership which increased by 58% during the relevant period. The reasons for joining included

access to iHV professional resources, networking events, webinars and professional support. Practitioners also reported that they wanted to support our work to influence policy for babies, children and families, and health visiting – to have their voices heard.

165. By the early autumn of 2020, greater attention was being given to supporting practitioners' wellbeing at work. NHS England and some nursing charities made funding available to develop innovative and rapid ways of supporting staff. The iHV received funding from the RCN Foundation (AM/174 [INQ000347108]) to develop and deliver an emotional wellbeing at work (EWW) programme for health visitors. This was the only national programme available that was specifically developed for health visitors and the challenges that they faced in practice. This programme was well evaluated by participants. It improved staff wellbeing by reducing their levels of stress and anxiety, helping them gain and/or maintain a sense of control and professional self-worth, and providing support to build capacity to cope better with work demands. Improvements in average scores relating to mental well-being, perceived stress, compassion satisfaction, burnout and secondary traumatic stress were seen across all three validated tools (the findings were reported in several nursing journal papers: AM/175 [INQ000347109]; AM/176 [INQ000347110]; AM/177 [INQ000347111]; AM/178 [INQ000347112]). Participants' feedback included (from AM/176 [INQ000347110]):

"The value of the group discussion was just so massive I cannot describe it. I have found it so helpful, the whole process, and will really miss it. Thank you."
"I have learnt a lot, I must say. I hope to incorporate this in my day-to-day work with both my colleagues and in my personal life."
"I feel that my well-being has improved and that I am better able to name my emotions."
"I have learned some techniques through this course that help me to cope with stress and feel more positive."
The EWW programme also achieved recognition for the difference that it made to the emotional wellbeing of health visiting practitioners as finalists in national awards (RCN Nursing Awards, Nursing Times Awards and HSJ Awards).

166. The iHV's survey of 1,012 health visitors in October and November 2020 (survey report published in December 2020, AM/106 [INQ000347033]) reported that many health visiting staff were working under greater levels of pressure, feeling isolated, anxious and unsettled. The survey findings were consistent with the earlier research by Conti and Dow (in section 163 – AM/105 [INQ000347032]). 75% of health visitors reported increased stress levels. As a direct result:

- 40% were working longer hours.
- 69% reported feeling worried, tense and anxious.
- 51% reported that their work was affecting their sleep.
- 48% were feeling demotivated.
- 40% were experiencing low mood due to work-related stress.
- 22% were managing stress in negative ways like drinking more alcohol or comfort eating.
- 11% reported more sickness absence/ time off work.

167. Transmission of COVID-19: The iHV did not collect information on the extent of COVID-19 infection amongst its members, or number of deaths. In their submission to the COVID-19 Inquiry (Mortimer, 202[(AM/178(a) [INQ000147815])]cited in COVID-19 Inquiry submission by Professor Clare Bambra and Professor Sir Michael Marmot, May 2023, AM/179 [INQ000195843]), The NHS Confederation noted that, *"There was further concern that in addition to being disproportionately exposed to the virus, NHS and social care staff were being exposed to psychological distress and extreme, sustained pressure in their working conditions. There was deep concern that BAME people were disproportionately affected and more likely to have adverse outcomes, exacerbating existing inequalities"*.

168. The impact of the pandemic on people from Black, Asian and minority backgrounds: the pandemic disproportionately impacted groups that were already disadvantaged; this will have included practitioners working in health visiting. The report, "Build back fairer: the COVID-19 Marmot Review" (AM/158 [INQ000130491]) highlighted that Black British people and those of South Asian descent faced an elevated risk of catching and dying from COVID-19.

In a BMJ blog, "Nursing whilst black during COVID-19", (AM/180 [INQ000347115]) published in January 2021, Dame Donna Kinnair, Chief Executive and General

Secretary of the Royal College of Nursing, advocated on behalf of nurses (including health visitors) from Black, Asian and minority backgrounds, stating that, *"The COVID-19 pandemic has revealed a lot about health inequalities and wider structural disadvantage in our society. And those from some black and minority ethnic backgrounds are among the groups that face an elevated risk of catching and dying from COVID-19. The full impact COVID-19 on different groups of health care workers is not yet fully understood and further research and study is needed to explain the gaps in our knowledge and understanding. But in a survey of RCN members during the first wave of the COVID-19 pandemic in 2020, our BAME members reported they felt unsafe in the workplace because of a lack of PPE and felt unsupported by their employers who tolerate bullying and discrimination."*

In this quote, Dame Kinnair cited the findings from a survey by the Royal College of Nursing, "Building a Better Future for Nursing: RCN members have their say" (AM/181 **[INQ000176038]**). The survey was open to all RCN members from 20 May - 17 June 2020 and received 41,798 completed responses.

IMPACT OF THE PANDEMIC ON HEALTH VISITORS IN TRAINING

169. In the early months of the pandemic, lack of information on the impacts of COVID-19 on health visitors in training was a source of concern. The iHV completed an early review of practitioners through its open Facebook page on 2 April 2020 (with engagement from 4,198 individuals, with 187 comments). The iHV also received emails from health visiting (SCPHN) course leads requesting information and national guidance on plans for student health visitors. The findings were published on 8 April 2020 in the iHV report "Health visiting during COVID-19" (AM/43 [INQ000347144]). This reported concerns raised by student health visitors (Specialist Community Public Health Nursing programme – SCPHN (Health visitor)) at the time, who did not know whether they would be able to continue with their training programme. Some stated that they had been selected for redeployment, but this varied across the country. SCPHN Programme Leads reported that the lack of information at the start of the pandemic was the biggest challenge and hampered planning: *"I'm course leader at XX University. We have had no advice from HEE (Health Education England), NMC (Nursing and Midwifery Council) 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 January, even the following September. We made local decisions based on whether students will reach their competencies. Any guidance would be welcomed." [SCPHN Programme Lead].

We shared these concerns and the findings of the iHV report "Health visiting during COVID-19" (AM/43 [INQ000347144]) with the Chief Public Health Nursing Directorate in PHE and HEE by email (AM/44 [INQ000347145]) on 8 April 2020, requesting clarification of their plans - who assured us in the weekly Professional Organisations meetings that they were taking steps to ensure that all student health visitors were supported during the pandemic response.

170. Prior to the pandemic, 50% of the health visitor (SCPHN) training programme was taught in universities and the remaining 50% whilst on placement in practice. Both elements of the programme were disrupted during the pandemic and the mode of training delivery was rapidly adapted. There are no published national data on the number of health visiting students that completed the health visitor (SCPHN) programme in England during the pandemic, or the number that were redeployed. As part of our information scoping for this Inquiry, the iHV contacted The United Kingdom Standing Conference on Specialist Community Public Health Nurse Education (UKSC) which is a UK-wide forum for Health Visitor Educationalists. The UKSC confirmed that they did not hold this information. Instead, they provided a broad overview of the impact of the pandemic on student health visitors collated from health visitor educationalists/ SCPHN Programme Leads who worked during this time. Their feedback is presented below:

    i. Universities moved the taught elements of the programme to online teaching, with peer support provided through MS Teams. One SCPHN Programme Lead commented, *"The 20-21 cohort started in September 20 but did not physically enter university until May 21. All their learning was on Microsoft Teams. They did not get the same opportunities for peer support as they did not physically meet each other"*. Since the pandemic, many programmes have maintained an element of online teaching or increased blended learning, commenting, *"This is the new normal and, coupled with a*

cost-of-living crisis, a sensible sustainable move in meeting the needs of a diverse range of postgraduate students".

ii. Practice placements were impacted: Face-to-face contacts with families were significantly reduced, clinics were closed, visits were as brief as possible - babies were weighed on doorsteps. This inhibited learning and reduced the students' opportunities to assess important issues like mental health, safeguarding and domestic abuse, and learn practical skills, for example ways to support breastfeeding. Prescribing opportunities were also limited, alongside experiences of working with interpreters for families who did not speak English. SCPHN Programme Leads felt that these significantly curtailed students' opportunities to develop their skills in building therapeutic relationships with families and home visiting that are integral components of successful health visiting.

iii. Travelling to home visits was challenging: Prior to the pandemic, the Practice Supervisor/ mentor would normally share a car with the student health visitor. During the pandemic, some travelled in separate cars which impacted on the time that they had for discussion prior to the visit and reflection afterwards which are integral components of learning. Others shared a car and wore PPE – a SCPHN Programme Lead commented, "[*Health visitor students] did not get the feedback on visits or wisdom of experienced practitioners as they would pre-pandemic so vastly inhibited their learning. One student health visitor travelled in the back seat of her supervisor's car in apron, gloves and mask for six months".*

iv. Learning from the wider team: Prior to the pandemic, student health visitors were located within health visiting teams and had the opportunity to learn from the wider team and observe more experienced health visitors managing complex issues in the office. This experiential learning and emotional containment from the office environment was no longer available during the pandemic. And, in some Trusts, it has not returned as health visitor offices have now closed following a permanent shift to mobile/ home working that was instigated during the pandemic.

v. Alternative practice placements to other members of the multi-disciplinary team were no longer available to many students.

vi. Completion of the programme: The majority of health visitor students did complete the programme, despite the disruption to training methods and placements – some courses offered extensions and part-time courses to provide flexibility to support completion (no data on the overall rate of course completion was provided to the iHV). Overall, more health visitor students did not complete the programme during the pandemic, compared to non-completion in previous years. Some SCPHN Programme Leads reported that some students had left the course due to poor health – for example, in one university, out of 13 health visitor students, three left due to mental health problems and one left due to long Covid.

vii. Staff sickness, health and wellbeing: The emotional toll of completing the health visitor programme during the pandemic was high due to the course disruption listed above, alongside concerns about contracting COVID-19 whilst on placement.

viii. Redeployment: Students were protected from redeployment in some trusts, but this was not the case in all areas (to our knowledge there is no national data on redeployment levels amongst student health visitors). Those who were redeployed, reported that they were given little notice, little or no choice, or debriefing around their redeployment. Some areas managed the situation by offering an extended programme to facilitate part-time redeployment. Staff reported to their course leads that they were traumatised by their nursing experiences whilst redeployed and the processes of redeployment. Students were very aware of the effect on SCPHN team members. Students faced challenges in supervision and assessment with staff being moved from teams. When staff were returned, this had a huge impact, some teams felt unable to support students due to the trauma of the change in the team, and their health.

ix. Progression to health visitor post on completion of the course: Many student health visitors transitioned into health visitor posts on completion of

the course. SCPHN programme course leads reported that in contrast to previous years when almost all students would have progressed to health visitor posts, they reported that a small but significant number had chosen not to. Instead, they moved back into nursing posts, or left the profession entirely – this was a notable shift in behaviour that they attributed to the disruption in training and the pressures of working as a health visitor during the pandemic. These comments from a SCPHN Programme Lead capture this theme: *"Miraculous they did all complete, but in the 20-21 cohort, three of the students did not take up a SCPHN post which had not happened before or since".*

"Several of the students in this cohort did not stay in health visiting and school nursing post qualification but returned to previous roles or took up different opportunities".

They noted that vacancy levels remain high in SCPHN practice (health visitor). Some suggestions are that the pandemic has changed the role of health visitors, with higher levels of child protection and mental health issues across the lifespan, and this may not suit the traditional cohort of applicants for health visitor roles.

SUMMARY:

171. Overall, based on the evidence presented in this report, we conclude that health visiting entered the pandemic ill-prepared due to: the cumulative impacts of the poor state of child health; cuts to the public health grant since 2015; variation in health visiting provision between local authorities; and health visitor workforce shortages.

172. The Emergency Preparedness Resilience and Response plan (EPRR) and Community Prioritisation Plan did not properly consider the wider impacts of the pandemic on babies, young children and families and the health visiting services that support them. Early warnings from other countries, of the COVID-19 pandemic's wider harms, were not incorporated into existing emergency plans. This led to the designation to "stop" most elements of the health visiting service

and the national directive to redeploy staff working in health visiting teams. In our opinion, this was a profound mistake – health visitors were most needed in their role, supporting families with babies and young children. If the wider impacts of the pandemic on babies, children and families had been taken into consideration at this time - and the plans had been co-produced with health visitors and their representative bodies - this may have influenced these plans to "stop" the service and redeploy health visiting staff which, in turn, would have enabled more families to receive health visiting support.

173. The Government's response to rectify this, when they were alerted to the risks, was too slow. When national directives were issued to restore the health visiting service, the pace of restoration was left to local decision-making and there were no robust national levers to ensure their implementation. As a result, families faced a postcode lottery of health visiting support; this left many babies, children and families without adequate support and increased risk and harm to vulnerable children.

174. The COVID-19 pandemic had a significant impact on families with babies and young children, and the health visiting services that support them. The impact was twofold:

- Increased risk and need – The COVID-19 pandemic made parenting harder for most parents. It exacerbated pre-existing inequalities, increasing vulnerability factors across health, child development, social factors and safeguarding needs. Alongside the scaling back of other support for families, this increased the demand for health visiting support.
- Lack of capacity within the health visiting service to meet the scale of increased need.

175. Due to the urgency to reach as many families as possible in the early weeks of the pandemic, virtual contacts were introduced without the usual quality assurance testing, and checks for safety, efficacy and unintended consequences, that would normally be applied when a new mode of healthcare treatment is implemented at scale. Whilst there have been some benefits, early research by Professor Jane Barlow (cited in paragraph 126 - AM/104 [INQ000347031]), and the findings from a thematic analysis of Serious Case Reviews commissioned by the Child

Safeguarding Review Practice Panel (cited in paragraph 127 – AM/109 [INQ000103841]) have highlighted that virtual contacts increase the likelihood that vulnerable babies and young children will be missed, thereby increasing their risk of significant harm. In our opinion, these are safety critical findings that cannot be ignored.

176. Changes to national health visitor performance metric data collection – to "count" non-face-to-face contacts – that were intended to be temporary when introduced, are ongoing. This practice has masked the extent of health visiting service disruption experienced by families with babies and young children during the pandemic. It is also driving practices that are not evidence-based and provides false reassurance of the quality of health visiting service provision.

177. Lack of national data on the scale and impact of health visitor redeployment hampered national policy decisions. It also meant that there was no reliable means to provide assurance on the restoration of health visiting services when national policy changed. The pandemic has exposed significant flaws in the way this nationally-funded health visiting service is prioritised and delivered locally, with unwarranted variation in redeployment practices.

178. The lack of sufficient PPE in the early months of the pandemic, and the prioritisation of acute services, meant that many health visiting practitioners could not access PPE for use in their face-to-face work with families in the community. The national guidance on the use of PPE was initially tailored to staff working in hospital and clinic settings, rather than the specific needs of health visitors working in the community. Maintaining good infection, prevention and control measures and social distancing in people's homes was challenging and placed health visiting practitioners at heightened risk of contracting COVID-19.

179. Working in the COVID-19 pandemic was immensely challenging for health visiting practitioners. Their experiences were varied and depended on where they worked and the cumulative impact of a range of factors that increased work-related stress and affected health and wellbeing. These included experiences of redeployment, reduced workforce capacity, increased workload, and access to PPE and IT equipment, to support rapid changes to their practice.

180. In our opinion, if a national plan with the investment needed to rebuild health visiting services, and respond to rising levels of need, had been implemented in June 2020 to coincide with the directive for restoration of services, this would have left services in a much stronger position today and better able to respond to the poor health of our nation's youngest children and widening inequalities. Our children's health is too important to leave to chance as the main public health priorities for babies, children and families do not vary considerably between local authority areas – in hindsight, this represents an important point of learning for national policy on health visiting.

RECOMMENDATIONS

Based on the evidence and analysis conducted within this report, we make the following recommendations to ensure that health visiting is prepared for any future pandemics or national emergencies:

181. A cross-government strategy is needed to reduce health inequalities that have their roots in the earliest years of life and are largely preventable. This will require investment to address the four compounding factors that weakened the health visiting service prior to the pandemic: the poor state of child health; cuts to the public health grant since 2015; variation in health visiting provision between local authorities; and health visitor workforce shortages.

182. Review NHS England's Emergency Preparedness Resilience and Response Plan and the Prioritisation within Community Health Services Plan to ensure that:
    - The wider impacts of a pandemic on pregnant women, babies, young children and their families are included in the scope, and national emergency plans take account of their needs.
    - The health visiting service is designated to "continue" rather than "partial stop".
    - Health visitors are not redeployed. Health visitors' skills and capacity to proactively, and systematically, reach all families with babies and young children are needed most within a continuing health visiting service.

183. Pandemic planning and preparation are needed to ensure that health visiting practitioners have access to:

- Suitable and sufficient PPE, and bespoke guidance on its use in the health visiting context, from the start of any pandemic to protect the workforce from infection during face-to-face contacts with families.
- Appropriate IT equipment and software to facilitate virtual contacts and digital support to augment face-to-face health visiting contacts.
- Standard Operating procedures and guidance for health visiting to support rapid local area service transformation at the start of a pandemic and in response to different scenarios and levels of risk.
- Effective communication channels for national pandemic directives, emergency plans, and updates from national government to all local health visiting providers, including non-NHS providers.
- Mechanisms to support the dissemination of best practice adaptations and learning related to health visiting during pandemic conditions.

184. A clear workforce plan for health visiting is needed, with:

- Sufficient funding to rebuild the health visiting workforce and ensure that the national Health Visiting Model for England and Schedule of Interventions set out in the updated Healthy Child Programme are provided to all families proportionate to their level of need, regardless of where they live.
- Demand-driven workforce modelling based on population need to inform workforce forecasting and planning.
- Measures to support health visitor recruitment, retention, career progression, return to practice, and staff wellbeing at work.
- Sufficient surge capacity to manage the backlog of missed appointments, as well as the increased demand for support due to the secondary impacts of the pandemic. These have been significant and are likely to be ongoing and have cumulative impacts across the life course without effective action to address the growing numbers of vulnerable babies and young children requiring additional support.
- Plans to support health visitors in training in any future pandemics or emergency situations.

185. National levers and quality assurance mechanisms are needed to ensure that the national Healthy Child Programme is indeed a "national" programme which is provided to all babies, young children and their families, with a level of intervention proportionate to need, regardless of where they live. Whilst a degree of local flexibility is beneficial to flex approaches to suit local population need, this should not be used as justification for not providing the full scope of the Healthy Child Programme in all local authority areas in England. The most pressing public health priorities for babies, young children and families do not vary that much between local authority areas to warrant the current variation in health visiting services across the UK.

186. Agreed, reliable national health visiting metrics are needed to provide assurance and between area comparisons of health visiting performance. The temporary arrangement of "counting" virtual and non-face-to-face health visitor mandated universal assessment contacts must be stopped; these are safety-critical contacts and can only be completed in their entirety, face-to-face. Counting non-face-to-face contacts produces misleading data, does not enable fair comparisons of health visiting performance metrics between local authorities in England, and provides false reassurance of the quality of health visiting service delivery in some areas. Virtual and non-face-to-face contacts should not be used for delivery of the universal health visiting mandated assessments. There is sufficient evidence that non-face-to-face contacts increase the likelihood that vulnerable children and child protection cases will be missed; developmental delay and childhood conditions and disabilities are also less likely to be identified.

187. An innovation fund to support the evaluation of the use of virtual, non-face-to-face service delivery methods is urgently needed to determine the safety and effectiveness of their applications for different elements of the Health Visiting Service Delivery Model and to inform digital change strategies, including:
    a. Their effectiveness for identification of vulnerabilities and risks.
    b. Their underpinning theory for use in health visiting and impact on interventions to improve child and family outcomes and reduce inequalities.
    c. Any unintended consequences, including safety considerations and increased risk for vulnerable babies and children.
    d. How the intervention interacts with the context in which it is used.

e. Factors that affect their implementation in practice, as well as ways that the intervention can be refined to inform digital change.

188. Ensure ongoing support for the health and wellbeing of staff. The impact of working during the COVID-19 pandemic on staff wellbeing cannot be underestimated. A proactive plan is needed to ensure that staff have the right support for their health and wellbeing during the restoration of services and to create high quality workplaces for all staff in the future. Special considerations need to be given to high-risk groups that were disproportionately impacted by the COVID-19 pandemic.

189. Overall, greater recognition needs to be given to the vital role that health visitors play in supporting the health, development and safety of babies and young children. The benefits of an effective health visiting service accrue to numerous government departments and across the life course. It is imperative that the role of health visitors is protected and strengthened – they are the only service that proactively and systematically reaches all families with babies and young children who are not afforded the same protections that school-age children have from schools. The most disadvantaged and vulnerable babies and young children are often invisible to other services without an effective health visiting service to identify needs and risks that may change over time.

Statement of Truth

I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

Signed: ____**Personal Data**__________________________

Dated: _________7 February 2024______________________