NIHR | Policy Research Unit Children and Families

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

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About

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Changes to health and social care practice following the lockdown restrictions that were put in place in response to the SARS coronavirus-2 outbreak have led to concerns about the ability of key practitioners (midwives; health visitors; community paediatricians; and social workers) to continue to safeguard the wellbeing of the youngest children living in families with complex social issues. These changes to the way in which care is delivered, have been implemented at a time when the stresses on all families due to the secondary impact of the virus has been significant. This survey aimed to assess the impact of such changes on the ability of key community practitioners to safeguard and deliver services to the most vulnerable preschool children.

Methods

An online survey was undertaken of key professionals and commissioners of services to vulnerable preschool children, using closed questions with opportunities for free text comment. The second part of this study, comprises in-depth interviews with a purposive sample of respondents to explore further, issues arising from the survey.

Key Findings

Surveys were completed by 905 respondents, three quarters of whom were health visitors.

- Respondents across professional groups and commissioners reported that social need had increased 'significantly' among preschool children and their families during the pandemic.
- Health visitors appeared to have experienced the highest level of redeployment across the four professional groups, with a third of all redeployed practitioners saying that the overall process had not been successful including inadequate preparation for the new role.
- Up to a third of practitioners believed that forty percent or more of the vulnerable families on their caseload did not receive the level of contact needed to safeguard their children during the pandemic, with health visitors being the most likely to report this.
- Health visitors also expressed concern that the retraction of universal services during the pandemic had prevented them from identifying 'new' or increased need, and safeguarding issues. They also noted that urgent planning was now needed for 'missed cohorts'.
- Services for vulnerable children were perceived to have been significantly affected by the changes to practice, with a third of social workers reporting they had not been able to provide some critical services including face-to-face visits in the home to assess home conditions; and Section 17 services for Children in Need.
- Commissioners also described the level of financial provision to support vulnerable families during the pandemic as being 'moderately' or 'significantly' below the level needed.
- While around 70% of practitioners were offering some in-person contact in the home or the clinic, health visitors were the least likely to be working in this way as a result of the move to remote support with two-thirds having less than 10% of their contact with clients in the home/clinic.
- Most of the care being provided virtually was delivered by health visitors, social workers and community paediatricians; around two-thirds of practitioners had not received additional training for this.
- Two-thirds of practitioners were willing to provide virtual services going forward to work with universal level families.
- Most participants described working from home 'some' or 'all of the time' and one-fifth reported an increase of more than 40% in their workload as a result of this.

- Around one-fifth of practitioners reported that the pandemic had had a significant impact on their mental health, with health visitors being the largest group to experience such stress, and the way in which the service was managed being one of the main reasons cited for it.
- A range of suggestions were made to improve things going forward (see below for further detail), perhaps mostly important being the restoration of in-person visits at home or a clinic, and an end to the redeployment process.

Preliminary Recommendations

The findings of these surveys suggest that the redeployment of health visitors in particular, in addition to the requirement that some services be delivered virtually, have impacted the ability of the practitioners surveyed to safeguard the most vulnerable preschool children.

A number of preliminary recommendations have been made to address these issues, some of which were explored in more depth, in the second stage of the research.

Executive Summary

Background

Following the outbreak of the SARS coronavirus-2, the UK Government announced a range of 'lockdown' restrictions that were aimed primarily at limiting the spread of the disease. In response to these, NHS England issued guidance regarding the prioritisation of services being delivered both in hospital and the community.

Perhaps most importantly this guidance required limited contact in terms of the delivery of services, and required that prioritised contacts should be delivered using virtual methods, with in-person contact in the home or clinic only being provided when there was a 'compelling reason' to do so. These guidelines required considerable change to the practice of all health and social care professionals with significant implications for the families being supported. They have also occurred alongside redeployment of some frontline practitioners to secondary care to support the SARS-COV-2 response, reducing an already depleted workforce.

These changes to practice raised particular concerns about the ability of key practitioners (midwives; health visitors; community paediatricians; social workers) to continue to safeguard the wellbeing of the youngest children living in families with complex social issues, at a time when the stresses on families due to the secondary impact of the disease (i.e. poverty and food insecurity; and increased mental health, alcohol/substance use, and domestic abuse) was significant.

The aim of this study was therefore to identify the impact of the above changes on the ability of community practitioners to safeguard and deliver services to the most vulnerable preschool children, and to identify what changes are needed going forward during the gradual lifting of the lockdown and to inform practice in the case of future lockdowns.

For the purpose of this research the vulnerable populations of interest included pregnant women facing complex social problems; families with preschool children faced with complex social problems; preschool children with disabilities, or on the edge of care or designation as Children in Need; and Children on Child Protection Plans.

Methods

The study involved a two-stage mixed-methods design including: i) an online survey of professionals delivering and commissioning services to the above populations across England and; ii) in-depth interviews with a sample of survey respondents aimed at exploring some of the issues in more depth. This report presents the results of the online survey.

Online surveys comprising a mixture of open- and closed-ended questions were used to collect data from: a) key community-based professionals working directly with the above families - midwives; health visitors; community paediatricians; and social workers; and b) commissioners of services for these families. An invitation email was sent to respondents via key organisations (e.g. BAACH; BASW; NHSCC; ADCS etc). Where it was not possible to email respondents directly, a letter with a link to the survey was posted in relevant newsletters and using Twitter.

The surveys focused primarily on the impact of change to service guidelines on service provision including the use of virtual care, in addition to the wider impact of the pandemic on practitioner case/ workload, and personal wellbeing.

The data from the closed-ended questions was analysed using descriptive statistics and the open-ended data was analysed thematically.

Ethics committee approval was provided by the University of Oxford Central Research Ethics Committee.

Key Findings

The professionals survey was completed by a total of 861 practitioners (74% health visitors; 6% midwives; 7% social workers; and 11% community paediatricians), and the commissioners survey was completed by 44 in total (34% Commissioners of Health Visiting and School Nursing Services; 25% of Local Authority Children's Commissioners; 9% Children's Services Commissioners; 23% Service Leads; and 9% of commissioners of other public health services or Local Authority Early Help).

Despite many respondents reporting a 'significant' increase in concerns about families on their caseload since the start of the pandemic, around half of the respondents stated that their role was not protected during the pandemic, and **the group reporting the highest level of redeployment were health visitors.** Two-thirds of respondents also had colleagues within their team/practice who had been redeployed. Of those redeployed two-thirds received preparation for this role, of whom **half described feeling inadequately prepared to take up their new role**. **Redeployment was described as affecting all aspects of service provision including safeguarding**, and to have been inadequately implemented.

Up to 33% of respondents believed that **at least half of the vulnerable families on their caseload did not receive the level of contact needed compared with normal** in order to keep their children safe, with health visitors being most likely to report this. **A third of social workers also reported that they had not been able to provide some critical services** including face-to-face visits in the home to assess home conditions; and Section 17 (Children in Need) services.

While around 70% of respondents had been offering **in-person contact in the home or the clinic there were large differences across professional groups** with midwives and social workers being most likely to be continuing to offer such in-person visits. Two-thirds of health visitors reported that less than 10% of their contact with clients was delivered in this way. Health visitors indicated that retraction of universal services during the pandemic placed vulnerable children at risk because they were no longer able to identify 'new' or increased need. **Personal Protective Equipment (PPE) was described as being inadequate in terms of need** by a quarter of social workers and midwives. The main reasons for providing in-person contacts across all professional groups, were safeguarding concerns; needs assessment and ongoing support; and parental mental health issues.

Social workers, health visitors, and community paediatricians were much more likely to **provide services virtually** than midwives. Of those respondents who were

providing virtual contact around **two-thirds had not received any training** for this. IT problems and insufficient training were the main reasons for not providing such support. A range of benefits and limitations of such provision were described, and although two-thirds of respondents would consider using delivering services 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.**

Most of the participants (90%) described themselves as working from home, some (54%) or all of the time (35%), with midwives being the least likely to work from home. Around half of respondents had experienced an increase in their overall workload as a result of this, **around one-fifth reporting an increase of more than 40%.**

Around one-fifth of respondents reported that the pandemic had had a significant impact on their mental health, and while all but a fifth of respondents had experienced additional organisational support for their wellbeing, 10% felt that this was inadequate.

Changes that were described as being needed to improve stress levels, mostly related to service management, and in particular the need for clearer and more supportive communications from practice managers, the opportunity to be consulted and have their concerns heard, and less 'micro-management' in terms of being trusted to make decisions.

Up to a third of commissioners described a slight or significant increase during the pandemic in vulnerable children in terms of Child Protection (s47); Children in Need (s17); Universal Plus/Partner Plus HV; or families with Open Early Assessment Plans. Three-quarters of commissioners reported that they had been able to provide all of the services for vulnerable pregnant women and families with preschool children specified in the key priority areas set out in the Community Prioritisation Plan or as specified in law to safeguard children. The majority described these services as 'adequate' or 'highly adequate'. This finding contrasts with that for the level of financial provision to support for vulnerable families during the pandemic which was reported as being moderately (34%) or significantly (25%) below the level needed. Around a fifth of commissioners reported having a slight increase in financial resources during the pandemic However, **such additional resources were described as being allocated against already overspent budgets,** with core funding being described as 'remaining under significant pressure'.

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. Many health visitors identified the need to restore universal services to enable them to identify children in need of support, in addition to the facilities needed to enable them to do this. Respondents also highlighted the need for more coordinated services and better information sharing; improvements to the organisation and management of staff such as the use of 'hot and cold teams'; and urgent planning for the 'missed cohorts'. Commissioners

further identified the need for additional funding to deal with the anticipated surge in vulnerable families who will become visible as the lockdown is lifted; improved co-ordination of services; and improved cross-sectoral data sharing so that services are aware of other agencies also involved in safeguarding a family.

Preliminary Recommendations

A range of preliminary recommendations (i.e. conditional on the findings of stage 2 of the study) have been suggested for changes going forward on the part of local commissioners and providers, in addition to national policy makers (i.e. DHSC and PHE) focusing primarily on methods of contact with families and the planning and co-ordination of services.

Contact with families

In-person visits are perceived to be essential for adequately protecting children known to be vulnerable both during a pandemic, and going forward. We recommend that practitioners should be able to provide assessment, ongoing support, and safeguarding activities to vulnerable families, using in-person visits in the home or the clinic through the provision of adequate PPE and strategic use of existing community spaces and appointment times. More work is needed to ascertain whether support for in-person contact with vulnerable families is as strong across England as it was among these survey respondents.

Virtual delivery of face-to-face services using online platforms may have a role in the delivery of services to families with no known vulnerabilities, or where vulnerable families are self-isolating.

To protect children with newly emerging vulnerabilities, universal contacts should be recommenced as soon as possible for health visitors with a focus on the new-birth and 6-month visits.

Training and support should be provided to key frontline practitioners, particularly in regard to the delivery of virtual services.

The NIHR should commission research regarding the benefits of virtual contacts for families including those experiencing risk, in order to support decision-making about its use in the future.

Families with a preschool child should be sent information regarding services that have been restored following the lockdown, to encourage re-engagement.

Planning and coordination of services

Joint needs assessment and action plans should be conducted with regard to vulnerable preschool children in each locality across key agencies (Healthy Child Programme, Early Help, Midwifery, Children's Centres, Early Years, Children's Social Care) and should be used to guide service provision going forward.

Financial resources should be increased in the short-term to address the anticipated surge in need within vulnerable families.

In order to ensure that at least one professional is in contact with families with known and serious vulnerabilities, action plans should include a lead practitioner for each case.

The childcare offer for key community-based practitioners should be extended to enable them to reduce their home working.

Lead frontline practitioners should be consulted by managers going forward, to establish the local challenges and the changes that are needed to enable them to provide the level of care that is needed. This should include discussion between practitioners and commissioners as well as providers.

Channels are needed for lead practitioners to communicate directly with commissioners and not just providers.

Direct line managers of practitioners should adopt a collaborative approach to working with practitioners that includes consulting them about the best approaches going forward.

All communication with staff, and particularly those using email, should provide a) transparency with regard to decision-making processes; and b) the opportunity for staff to be heard with regard to key changes going forward.

Preparation needs to be made to identify and support the ‘missed cohorts’ of vulnerable children, including those with newly emerging need.

Introduction

The Issue

Following the outbreak of SARS coronavirus-2 (SARS-CoV-2), which was declared a Public Health Emergency of International Concern in January 2020, the UK Government announced a range of 'lockdown' restrictions, that were aimed at limiting the spread of the disease. Initially put in place for 3 weeks, they were after that extended at regular intervals, until on the 18th May some restrictions were lifted. In terms of the public, the lockdown restrictions required social isolating measures that involved only leaving the house for essential items.

In response to these lockdown restrictions, NHS England issued guidance regarding the prioritisation of hospital and community services.[1] These specified the key services that should continue to be provided during the lockdown to pregnant and newly delivered women and preschool children. Guidance for practitioners delivering prebirth and 0 to 5 services specified that all services should be discontinued other than the Antenatal contact (virtual) and New baby visits (or when indicated virtual contact) and other contacts to be assessed and stratified for vulnerable or clinical need (e.g. maternal mental health). The guidance suggested that sustained services were likely to include interventions for identified vulnerable families, e.g. intensive home visiting programmes such as Family Nurse Partnership and Maternal Early Childhood Sustained Home-Visiting (MESCH), – child safeguarding work such as Multi-agency Safeguarding Hubs; statutory child protection meetings and home visits, phone and text advice and digital signposting. For all community practitioners, where possible all contact with families was required to be 'virtual'.

Priority services identified for midwives included key antenatal and prebirth visits, and the postbirth visit. Community paediatric services were limited to services/interventions deemed a clinical priority; child protection medicals; telephone advice to families; risk stratification and initial health Assessments (urgent referrals to continue; some routine referrals may be delayed with appropriate support, e.g. initial basic advice to parents/carers).

In terms of Children's Social Care services, the duties to the most vulnerable children that are set out in primary legislation (such as in section 22(3) of the Children Act 1989 and section 1 of the Adoption and Children Act 2002) remained in place, but with greater flexibility in terms of their delivery.

Overall, these guidelines required significant changes to the practice of all community-based practitioners with significant implications for the services being provided to all families.

In addition, emergency legislation was enacted that involved the National Pandemic Influenza Service being implemented, which involved non-urgent operations and services being cancelled or delayed, aimed at releasing staff who could be deployed to other critical services.[2]

[1] https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/C0552-Restoration-of-Community-Health-Services-Guidance-CYP-with-note-31-July.pdf accessed 10th November 2020

[2] https://www.gov.uk/government/publications/coronavirus-bill-summary-of-impacts/coronavirus-bill-summary-of-impacts#section-1--enhanced-capacity-and-flexible-deployment-of-staff accessed 10th November 2020.

Concern about these changes began to emerge during the early stages of the pandemic. For example, a Facebook contact with health visitors on the part of the Institute of Health Visitors (iHV) identified three areas of concern:

- inconsistent practice across the country in terms of the use of face-to-face visits and availability/use of PPE;
- redeployment of an already depleted workforce of health visitors to other areas of health care, and a severely stressed remaining workforce;
- concerns regarding the secondary impact of SARS-CoV-2 on children and families through the predicted, significant increases in domestic violence and abuse, safeguarding, mental health problems and substance misuse.

The Secondary Impact of SARS-CoV-2 on Vulnerable Children

Vulnerable children in England

A recent technical paper produced by the Office for the Children's Commissioner identified seven formal categories of vulnerability with regard to children, which for the purpose of the current report in terms of its focus on unborn and preschool children includes: families with preschool children faced with complex social problems; children with disabilities; children on the edge of care or Children in Need; and Children on Child Protection plans.[3]

In terms of the number of children in England who are assessed as being 'vulnerable', a recent report produced by the Commissioner for Children, estimated that 2.3 children are 'living with risk because of a vulnerable family background' and that within that group, more than a third are invisible in terms of not being known to services. It also estimated that while a third were known to services, the level of support being provided was unclear. The report goes on to conclude that these figures suggest that overall there are in the region of 1.6 million children living in vulnerable families for whom 'the support is either patchy or non-existent'. [4]

Changes as the pandemic progressed

While the number of vulnerable children in the UK was high prior to the start of the pandemic, available data suggests that many of the sources of children's vulnerability relating to the complex family situations within which they live (i.e. in terms of poverty, and issues such as parental mental health problems, substance dependence and domestic abuse), have increased significantly as the pandemic has progressed.

For example, data from a number of sources (i.e. police; helplines; national charities) has suggested that domestic abuse increased significantly during the course of the pandemic, and it was reported that 'calls and contacts to the national domestic abuse helpline run by the charity Refuge were 49% higher in the week prior to 15 April than the average prior to the pandemic, and that on 6 April, traffic to the helpline website increased by 700% compared to the previous day'.[5] Exposure to such violence in the

[3] https://www.childrenscommissioner.gov.uk/wp-content/uploads/2019/07/cco-vulnerability-2019-tech-report-1.pdf accessed 10th November 2020.

[4] https://www.childrenscommissioner.gov.uk/publication/childhood-vulnerability-in-england-2019/ accessed 10th November 2020

[5] https://publications.parliament.uk/pa/cm5801/cmselect/cmhaff/321/32105.htm#footnote-112 accessed 10th November 2020

home on the part of children is now widely recognised to be a significant Adverse Childhood Experience (ACE), [6] and is one of the most common reasons for classification as Children in Need (CiN) by local authorities.[7] Children's exposure to such abuse, has also increased as a result of the lockdown measures, which has resulted in them being permanently in the home setting, while the opportunity to share their concerns/worries with others at nursery/school, or in other settings, has been significantly reduced.

The pandemic has also had a significant impact on poverty in terms of increasing the number of people who are struggling financially including individuals who are on low incomes or in precarious work situations; or who are dealing with long-term physical or mental health conditions. For example, the results of a YouGov survey by the Food Foundation found that *"More than 1.5 million adults in Britain say they cannot obtain enough food, 53% of NHS workers are worried about getting food, and half of parents with children eligible for Free School Meals have not received any substitute meals to keep their children fed... This means that 830,000 children could be going without daily sustenance on which they usually rely."*[8]

The Wider Service Context

In addition to the above issues, a decade of austerity measures has had a significant impact on service provision for children, and the current changes to service delivery, are as such occurring within the context of a significant scaling back of universal and targeted services, including universal health visiting, children centre services; and closure of many early year's settings.

A 2020 report by the Children's Commissioner found that current public spending on children was 10,000 per child, the same level in real terms as it was in 2006/07. Furthermore, half of the available spend was on Looked After Children, while spending on early and preventative interventions, such as Sure Start and young people's services, were cut by around 60% in real terms between 2009–10 and 2016–17,[9] resulting in the closure of many children's centres.[10]

In terms of the impact of austerity on practitioners, a recent survey of health visitors by the iHV, found that 29% of health visitors were now responsible for between 500 and more than 1000 children; despite being mandatory only 34% of health visitors reported that they were able to offer an antenatal contact to families; and that 81% of health visitors reported that they are not conducting 12-month reviews of children and 90% were not completing the 2 to 2.5-year review.[11]

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[6] https://www.cdc.gov/violenceprevention/childabuseandneglect/acestudy/about.html accessed 10th November 2020

[7] https://www.childrenscommissioner.gov.uk/wp-content/uploads/2020/04/cco-briefing-children-domestic-abuse-coronavirus.pdf accessed 10th November 2020

[8] https://foodfoundation.org.uk/SARS-COV-2 -latest-impact-on-food-2/ accessed 10th November 2020

[9] https://pdfs.semanticscholar.org/6164/b1c1ed02504be49dab8ea09fa242a3554b00.pdf accessed 10th November 2020

[10] https://www.suttontrust.com/wp-content/uploads/2018/04/StopStart-FINAL.pdf accessed 10th November 2020

[11] https://ihv.org.uk/news-and-views/news/health-visitors-fear-for-childrens-wellbeing-due-to-relentless-service-cuts/ accessed 10th November 2020

The Consequences for Children

Children are one of the major groups to be affected by the secondary effects of SARS-COV-2 in terms of some of the social distancing measures that have been put in place (i.e. children being schooled at home), the additional stress of illness and loss of income on parents, and the wider impact on parental wellbeing including but not limited to their experience of extreme isolation, increased food and other types of poverty, increased mental health problems, stress in the couple relationship and intimate partner violence; and in alcohol consumption/substance misuse.

There is, as such, now significant concern that some children will experience an increase in the risk factors to which they are exposed both directly (i.e. loss of contact with friends etc) and indirectly (i.e. as a result of their impact of SARS-COV-2 on their parents, leading to strong frequent or prolonged adversity (or Adverse Childhood Experiences (ACES)) and toxic stress, both of which have been found to have a significant impact on the long-term wellbeing and development of children.[12]

Aims

This survey was aimed at developing a set of responsive recommendations addressing current areas of concern in terms of service provision, and thereby reduce the secondary impact of SARS-COV-2 on vulnerable families with preschool children going forward.

Methodology

Research questions

- What has been the impact of SARS-SARS-COV-2 in terms of the required changes to health and social care practices on the provision of services in England for vulnerable pregnant women and families with preschool children?
- What are the key priorities for these groups going forward following the gradual lifting of the lockdown?

Design

The study involved a two-stage mixed-methods design including: a) an online survey of commissioners and key professionals working with vulnerable pregnant women and families with preschool children, across England; and b) in-depth interviews with a purposive sample of respondents using the results of the survey to inform the questions posed. Vulnerability was defined using the criteria in the technical paper produced by the Children's Commissioner that apply to preschool children.[13] The results of the rapid surveys are presented in this report.

Ethics committee approval was obtained from the University of Oxford Central University Research Ethics Committee (CUREC): Number: SPICUREC1a 20 010.

Survey[14]

[12] https://www.cdc.gov/violenceprevention/childabuseandneglect/acestudy/about.html accessed 10th November 2020

[13] https://www.childrenscommissioner.gov.uk/wp-content/uploads/2018/07/Vulnerability-Technical-Paper-2-2017-Defining-Vulnerability.pdf accessed 5th November 2020

[14] Copies of the two surveys will be made available on the CPRU website.

Sample – The sample comprised two groups of professionals

1. Commissioners of services for children across England including the following:
    - Commissioner of health visiting and school nursing services
    - Local Authority Children's Commissioner
    - Clinical Commissioning Group Maternity Commissioner
    - Children's Services Commissioner
    - Service Lead
    - Commissioner of other public health services
    - Local Authority Early Help

2. Professionals involved in the delivery of services including
    - Health visitors
    - Midwives
    - Community paediatricians
    - Social workers

Data collection

An invitation email was sent to respondents via the organisations listed in the box below. Where it was not possible to email respondents directly, a link to the survey was posted in relevant newsletters and using Twitter, by the organisation. The survey was open for 10 days (7th -17th May 2020), but some groups were not notified about the survey until after it had opened due to difficulties in accessing key individuals who could give permission for the survey to be distributed via their organisation during the pandemic. In addition, some newsletter mail outs had to wait until the regular mailing date.

Organisation	Target group
Institute of Health Visiting (iHV)	Health visitors via listserv email
Association of Directors of Public Health	Commissioners of HV and Children's Social Care through DPH cascading
Association of Directors of Children's Services (ADCS)	Commissioners of Children's Services via listserv email
British Association of Community Child Health (BACCH)	Community paediatricians via listserv email
British Association of Social Work (BASW)	Children's Social Care Workers via listserv email
Coram BAAF – Adoption and Fostering Academy	Children's Social Care Workers via listserv email
Public Health England (PHE)	Regional health visiting commissioners via listserv email Child and maternal health and wellbeing knowledge update newsletter
Royal College of Midwives (RCM)	Midwives via tweets and tagged in the RCM, Midirs digest and public health midwives

An information sheet and consent form were provided at the beginning of each survey.

The surveys comprised a mixture of open- and closed-ended questions that addressed the following topics:

- Commissioners: Demographics; Service provision; Financial Services; Transition out of the pandemic
- Professionals: Demographics; Service provision; Virtual care; Impact on caseload; Workload; Personal wellbeing.

Both surveys concluded with an invitation to take part in an interview to discuss these issues further. The full surveys are included in Appendix 1 and 2.

Data analysis

Data was transferred from Oxford Survey Tool into SPSS. Descriptive analysis of the quantitative data included frequencies and cross-tabulations. For all tables, where the percentage columns add up to less or more than 100% this is because invalid responses have not been presented, or percentages have been rounded up. The qualitative responses to the open-ended questions were transferred into and organised via Excel, and then analysed thematically.Results

Introduction

The professionals survey was completed by a total of 861 professionals, of whom 74% (n=641) were health visitors; 6% (n=58) were midwives; 7% (n=64) were social workers; and 11% (n=98) were community paediatricians. A total of 44 commissioners responded to the survey, of whom one-third were commissioning health visiting and school nursing services, with a further 25% and 23% being Local Authority Children's Commissioners and Service Leads respectively. Nine percent were commissioners of other services (i.e. Local Authority Early Help and other public health services).

Part 1: Survey of practitioners

Demographics

In terms of the demographics of the participating sample (see Annex 1 – Table 1), almost all (97% n=832) were female, with 57% (n=487) being over 50 years of age, and 70% (n=599) having over six year of experience in their professional role. Two-thirds (64% n=547) reported being at the top of their paygrade, with the remainder being spread over the middle (22%, n=190); or bottom pay-grades (6%, n=65). Fifty-five percent (n=469) were located in Greater London, South East, or South West; 32% (n=271) in North West or Yorkshire and the Humber; the remaining respondents were distributed fairly evenly over North East, East Midlands, and East Anglia.

Service Delivery

In terms of in-person contact at home or the clinic, around 79% (n=46) of midwives and 38% (n=24) of social workers reported that more than 40% of contacts with clients were received face-to-face. **However, less than 10% of contacts were made in-person by 47% (n=293) by the health visitors and 61% (n=59) of the community paediatricians**. Around 22% to 33% of social workers, health visitors and community paediatricians reported not providing any in-person contacts during the pandemic (See Annex 1 – Tables 2 to 6 for a full breakdown of type of delivery for each professional group).

In terms of reasons for face-to-face contacts, midwives delivered half (n=84) of such visits for needs assessments and ongoing support, followed by parental mental health issues (17%, n=29) and child safeguarding concerns (16%, n=27). Health visitors provided face-to-face contacts mostly for safeguarding (22%, n=361), followed by needs assessment (18%, n=296), parental mental health problems (17%, n=277), and ongoing support (15%, n=248). Safeguarding (41%, n=58) was the main reason for paediatricians, followed by needs assessment (23%, n=32). Safeguarding (22%, n=36) and ongoing support (21%, n=35) were the major reasons for social workers, with the remaining contacts divided fairly evenly over other concerns. Overall, child

safeguarding was the main reason for face-to-face contacts for all professionals (Annex 1 - Table 7).

Between 16 and 33% of respondents believed that more than 40% of vulnerable families did not receive the level of contact needed, with health visitors (33%, 210) being the most likely to report this (Annex 1 - Table 8). A third of social workers (n=22) reported that they had not been able to provide some critical services during the pandemic including face-to-face visits in the home to assess home conditions; Section 17 services where most parents were refusing such visits; visits to CIN children who are disabled due to families shielding; some carers unable to continue supporting families as part of ongoing CIN work; therapeutic and support work; some respite care which has been cancelled or put on hold. Mental health; direct work; outcomes of housing applications; referrals to food banks.

Respondents identified a range of issues that should be addressed to improve the ability of practitioners to conduct their work effectively. Most of these suggestions were recurring across different service categories and focused most frequently on suggestions regarding how to better reach vulnerable clients and families (see Annex 2 - Box 1). For example, **one of the biggest and most frequently recurring themes across all professional groups related to the need to conduct in-person visits for vulnerable families and clients.** Many health visitors expressed concern about not being able to adequately assess the risk of vulnerable children by means of video and phone contact and worried that harm might be overlooked. Concern about risk of harm was especially apparent for clients at risk of domestic abuse and the importance of establishing support for domestic abuse victims was strongly emphasised.

Many respondents also identified the need to restore universal services as soon as possible to enable them to identify newly emerging vulnerability, in addition to the better utilisation of available community assets in terms of buildings, to enable them to do this.

However, the reintroduction of such services was recognised as necessitating appropriate support and availability of personal protective equipment (PPE) for staff.

Respondents also highlighted the need for more coordinated services and better information sharing, improvements to the organisation and management of staff such as the use of ‘hot and cold teams’, and urgent planning for the ‘missed cohorts’.

Virtual service provision

Seventy percent (n=603) of respondents stated that they were delivering services virtually. Table 9 (Annex 1) shows that **health visitors (73%, n=465), community paediatricians (65%, n=64), and social workers (81%, n=52) were more likely to provide virtual contacts, than midwives (38%, n=22).**

A range of platforms were being used including: Zoom (12%, n=111), Skype (12%, n=107), Facetime (7%, n=65), Facebook (1%, n=10), WhatsApp (30%, n=267), and a range of other platforms (38%, n=342, such as AccuRx, Attend Anywhere, BlueJeans, Google Meet, and Microsoft Teams) (Annex 1 - Table 10).

The main reasons for not providing face-to-face contact using online platforms were IT problems (36%, n=119); insufficient training/preparation (30%, n=100); of that they were perceived as not being needed (24%, n=81) (Annex 1 - Table 11). Other reasons (Annex 2 – Box 2) for not being able to deliver remote services included clients not being reliably able to attend online meetings, either due to not knowing how to manage the online platform or as a result of a lack the necessary resources (smartphone or internet access) to do so. It was also reported that some practitioners did not feel comfortable to undertake their work from home using video calls, as this felt intrusive and jeopardised the professional distance required to undertake their work.

Of those respondents who were providing online contact around two-thirds (n=369) of respondents had not received any training for this. Health visitors (39%, n=182) and community paediatricians (44%, n=28) were more likely to receive training, whereas only 9% (n=2) of midwives and 8% (n=4) of social workers received online platform training (Annex 1 - Table 12).

In terms of the benefits of online face-to-face contact, respondents believed that it saved time (24%, n=278), matched clients' preferences (24%, n=284), and provided better access to families (20%, n=237). Social workers (18%, n=18) were also more likely than other professionals to identify the benefit of cost-saving (Annex 1 - Table 13).

Of the limitations of using online face-to-face contact, inability to access all families (23%, n=469), difficulty in providing some aspects of care (23%, n=457), and IT issues (20%, n=410) were the three top concerns across all professional groups, followed by privacy or security problems for clients (12%, n=239) (Annex 1 - Table 14).

A number of other benefits related to delivering online services were identified (Annex 2 - Box 3). For example, it was reported that the online platform increased attendance and openness by certain clients. Some respondents reported that it was easier to coordinate the attendance of experts from different services for remote meetings. Other limitations that were described are listed below. Many reported that video-calls could not substitute in-person visits because practitioners could not assess non-verbal cues or evaluate the conditions of the home environment.

Two-thirds of respondents stated that they would consider using online platforms to deliver face-to-face care *after the pandemic,* although most respondents did not recommend using online platforms to work with vulnerable clients going forward,

> "I think that they may have a role in certain situations but I don't anticipate it being a routine way of
>
> "Perhaps for some contacts for some families, but definitely not for all contacts and not for all vulnerable families." [Health Visitor]
>
> "I would use online platforms for universal families but prefer face-to-face for those with vulnerabilities" [Health Visitor]
>
> engaging with vulnerable families." [Health Visitor]

They were also felt to be appropriate as a supplement to home visits particularly for low risk families:

"Only to supplement face-to-face contacts in the home" [Health Visitor]

"Only to provide additional support rather than instead of face-to-face." [Health Visitor]

Changes to caseload

Of those respondents reporting a 'significant' increase in concerns in terms of their caseload, the majority of the caseload increase in concerns for midwives (72%, n=13) and community paediatricians (56%, n=14) were due to more families experiencing mental health issues. Health visitors and social workers had substantial concerns due to both mental health issues and domestic abuse, followed by child safeguarding issues (Annex 1 - Table 15).

A number of immediate actions to address caseload changes were identified, the primary suggestion being to bring back redeployed staff such that services could return to full capacity (Annex 2 – Box 4).

An increased capacity to delivery remote services was also identified:

"Ability to offer emotional wellbeing visits (listening visits) via telephone/video - currently we do not have capacity so would need more staff to enable this." [Health Visitor]

"Being able to offer more support video calls while the lockdown continues instead of feeling you can't due to taking on more work from colleagues who have been redeployed." [Health Visitor]

Restoration of universal services and increasing access by using clinics to meet with families, were also identified:

"As soon as deemed safe to do so universal health visiting should resume, needs assessment should continue and home visits as a matter of priority should recommence. Health visitors need deploying back in to the service to support the children that are right now 'invisible'. Social care needs to recommence announced and unannounced home visits as soon as possible. It is patchy in my area as to who is seen 'virtually' or face to face." [Health Visitor]

"Opening up access to health visiting service via more clinics and we have also scrapped the important 8-week contact at present as well which often identifies mental health concerns earlier". [Health Visitor]

Additionally, staff voiced frustration with not having sufficient guidelines and support in delivering remote services. For example, it was suggested that the reach and effectiveness of virtual services could be improved if practitioners were allowed a social media presence; a request that was denied.

Redeployment

In terms of redeployment a total of 441 (51%) of the respondents stated that their role was not protected during the pandemic, of whom, most were health visitors (60%, n=382).

Of those redeployed (n=78), two-thirds (n=60) received preparation for this role of whom half felt that the preparation was inadequate (Annex 1 - Table 16).

Although online training was provided, many practitioners felt that this was insufficient and requested more staff support and in-person training:

"Although some of the online training offered appropriate and relevant, it did not prepare me for working in an environment where the culture of abbreviation makes the understanding of abbreviation very difficult and open to interpretation." [Health Visitor]

"Had 3 days accompanying a district nurse then sent out alone. Not aware of what dressings were appropriate for what wound and care plans and dressings in the home did not always match. Unsure of area, so driving back and forth to properties for a few weeks until used to the routes. No idea about systems in the office, paperwork, updating care plans etc so felt I was constantly asking questions." [Health Visitor]

"Half a day training to perform in a nursing discipline not practiced for 35 years." [Health Visitor]

The findings suggest that many respondents were also unclear why some staff were redeployed and others were not, which made them question the whole redeployment process:

"Not specific why we were being redeployed to an adult district nursing service when we could have supported community midwives, domestic abuse services, 111 which is our skill set. Also, we had not been set up on their record systems either which was an unsafe practice" [Health Visitor]

Two-thirds of respondents (n=548) also had colleagues within their team/practice who had been redeployed to a range of areas (primarily hospitals, health visiting, district and community nursing, and adult services), two-thirds (n=325) of whom had 5 or more colleagues who had been redeployed. Health visitors (71%, n=457) and community paediatricians (64%, n=63) were much more likely to have redeployed colleagues than midwives (26%, n=15)) and social workers (20%, n=13) (Annex 1 - Table 17).

A range of services were described as having been impacted by redeployment with some respondents reporting that the redeployment influenced all aspects of their services negatively. The most commonly reported issue was that it had increased their general workload, which was perceived to have reduced the ability of practitioners to conduct their work in accordance with usual standards. Further, **safeguarding was also identified to have been compromised by redeployment**. Other services that were reported to have been influenced included breastfeeding support, health visiting, reviews and assessments, and services for domestic abuse victims (Annex 2 – Box 5).

Just under half (n=343) of respondents experienced an increase in workload due to working at home. For those with an increased workload, nearly a third reported an increase of more than 40% (Annex 1 - Table 18).

Sixteen percent (n=140) of respondents felt that they had received inadequate information/guidance (Annex 1 – Table 19) and Personal Protective Equipment (PPE) was felt to be inadequate by around 10% (n=96) of respondents, with social workers (25%, n=16) and midwives (21%, n=12) being more likely to have inadequate supplies (Annex 1 - Table 20). Key items of PPE that were difficult to access masks (11%, n=97) and N95/FF2/FF3 masks (7%, 61) (Annex 1 - Table 21).

Personal wellbeing

Table 22 (Annex 1) shows that around one-fifth (n=171) of respondents reported that the pandemic had had a significant impact on their mental health. Around 47% (n=401) rated their stress as being 7 or above on a ten-point scale.

Around 80% described their organisation as having provided some support for their wellbeing, of which 10% felt that the support provided was not adequate.

A number of types of additional support were described as being needed, many of which related to having more supportive management. For example, some practitioners felt that the communication from management had been confusing and unhelpful. They also reported that management had dismissed concerns to the detriment of employee mental health, and that they micro-managed staff and disregarded their comments and expertise, which was perceived to have caused unnecessary stress and frustration (Annex 2 – Box 6).

To address these issues, respondents requested more empathic management and leadership during these stressful times.

> *"An abundance of clinical managers who are not undertaking any clinical work. I would like managers to stop making veiled threats, to stop constantly looking at our caseloads and daily diaries, to stop negativity and to begin offering some positive support. I would like clinical managers to lead from the front and to undertake home visit and face-to-face contacts as they are instructing HV staff to do." [Health Visitor]*

> *"More visible management and more transparency as there has been so much secrecy and treating us like children." [Health Visitor]*

> *"Just better communication" [Health Visitor]*

Part 2: Survey of Commissioners

Demographics

The commissioners survey was completed by 44 respondents in total of whom a third (n=15) were Commissioner of Health Visiting and School Nursing Services; 25% (n=11) were Local Authority Children's Commissioners; 9% (n=4) were Children's Services Commissioner; 23% (n=10) were Service Leads; and 9% (n=4) were commissioners of other public health services or Local Authority Early Help (Annex 1 - Table 23).

Just under a half (n=18) of commissioners were located in Greater London or the South East, with the remaining respondents being fairly evenly divided over the remaining regions apart from the West Midlands where there was only one respondent. Just under half (n=48) of the commissioners were serving populations in which there was up to 20,000 families having at least one child under five years of age, with 14% (n=6) service the largest population of 50,000. A total of 73% (n=29) of respondents had more than six years of experience of commissioning services, with few differences across services being commissioned (Annex 1 – Table 24).

Service Provision

Between 12% and 15% of commissioners described having a slight or significant increase in service provision to vulnerable children during the pandemic in terms of the following categories - Child Protection (s47); Children in Need (s17); Universal Plus/Partner Plus HV; or with Open Early Assessment Plans (Annex 1 – Table 25). Local Authority Children's Commissioners were generally more likely to report an increase in all categories except Open Early Assessment Plans, which were increased for Children's Services Commissioners and other commissioners.

Seventy-three percent (n=32) of commissioners reported that they had been able to provide all of the services for vulnerable pregnant women and families with preschool children specified in the key priority areas of the Community Prioritisation Plan or as specified in law to safeguard children (Annex 1 - Table 26).

In terms of the adequacy of these services in keeping children safe from harm, only 11% (n=5) described services as being inadequate or highly inadequate, with the majority (82%, n=36) being described as 'adequate'. Commissioners in other services (50%, n=2) were more likely to report the services as being inadequate (Annex 1 – Table 27).

See Annex 2 – Box 7 for further comments regarding current service provision.

Financial Provision

Most commissioners described the level of financial provision available to support vulnerable families during the pandemic as being moderately (34%, n=15) or significantly (25%, n=11) below the level needed (Annex 1 - Table 28).

Twenty-eight percent (n=12) of respondents had experienced a change in financial resources during the pandemic (Annex 1 - Table 29).

One-third of commissioners (n=15) anticipated that the financial resources available for this client group would change in the next three months (Annex 1 – Table 30). Of respondents who anticipated a change, sixty percent (n=9) expected slight or significant increases and 34% (n=5) expected a decrease (Annex 1 – Table 31).

Effects of this change on service provision focused primarily on the need for additional resources to address the increase in need as the lockdown is raised (Annex 2 – Box 8):

> *"May need extra resourcing to increase capacity to support mental health". [Commissioner of Health Visiting and School Nursing Services]*
>
> *"We are fully expecting a child protection 'surge' as lockdown eases. Maternal mental health is also a concern, specifically when linked to domestic abuse". [Children's Services Commissioner]*
>
> *"Additional resource allocation is demand led and in response to an increase in children coming into care." [Local Authority Children's Commissioner]*
>
> *"Surge in the demand may not be matched by the existing resource even if operating at full capacity". [Service Lead]*

Thirty-nine percent of respondents (n=17) had undertaken modelling to estimate the effect of full or partial lockdown during the next three to six months (Annex 1 – Table 33).

A number of concerns were raised with regard to the worse-cases scenario in terms of their ability to keep vulnerable children safe with an increased caseload after easing of the restrictions due to the anticipated surge in safeguarding and other problems, and the need to 'sacrifice universal services' to protect vulnerable children.

> *"Partial easing is expected to reveal significant numbers of previously 'just about managing' families that have been tipped into crisis. The 15 reduction in MASH referrals may swing back to a 15 increase on normal levels" [Children's Services Commissioner]*
>
> *"Worst case estimates prioritise first time families and those considered vulnerable (open to Children Social Care or Early Help) moreover universal activity, therefore measures are being taken to ensure the provider focuses on keeping children safe from harm" [Commissioner of Health Visiting and School Nursing Services]*
>
> *"Universal services will need to be sacrificed, in order to support the most vulnerable children and families." [Commissioner of Health Visiting and School Nursing Services]*

The majority (75%-89%) of the commissioners reported that less than half of the health visitors, social workers, midwives, nursery nurses, GPs, community paediatricians, and CAMHS workers were unavailable to work due to sickness, caring responsibilities and redeployment. Three to twelve percent (n=1 to 3) of respondents reported that

more than 90% of the statutory health and social care workforce were affected and unavailable during the pandemic (Annex 1 - Table 33).

Moving out of lockdown

A number of further factors were identified as being necessary to support vulnerable families of preschool children as the lockdown is lifted, including direct financial support for vulnerable families; clear communication regarding the availability of services for families; joint action plans across key agencies (Healthy Child Programme, Early Help, Midwifery, Children's Centres, Early Years, Children's Social Care) with key 'at risk' groups identified or cohorts of children about which there is concern; use of data on emerging trends and innovative practice; ongoing availability of PPE and testing (Annex 2 – Box 9).

Conclusions

Although these surveys secured over 900 responses in total, the rapid nature of the research at a time that it was also difficult to access the key individuals within organisations to give permission for the survey to be mailed out, means that it was difficult to ensure that the link to the surveys were distributed as widely as possible, and there is no doubt that some practitioners will not have received it in time to complete the survey (i.e. before it closed). While this potential source of bias was not systematic, we cannot be certain that the survey was completed by representative populations across each of the professional and commissioner categories. It may also be the case, that individuals who elected to respond to the survey at such a difficult time, were more dissatisfied than the wider population of eligible respondents. The results should as such be treated with caution.

The results of these surveys of key community-based practitioners and commissioners of services for vulnerable children living in families facing complex problems, or who are on the edge of care or on child protection plans, suggest that changes to health and social care practice required as a result of government guidance in response to the SARS coronavirus-2 pandemic, and in particular the requirement for 'social distancing', had significantly undermined the ability of health and social care practitioners to safeguard these children. Furthermore, this had occurred at a time of significantly increased risk to young children due to increased levels of domestic abuse, mental health problems, and poverty, in conjunction with the removal of the standard safety net that is provided by nurseries and schools.

The redeployment of health visitors is of significant concern given the key role that they play in safeguarding vulnerable children, and suggests a prioritisation of services for both adults and in particular those focusing on physical health needs. The latter is reflected in the contrast between the practice of midwives who have continued to provide most of their services in-person at home or the clinic, compared with health visitors, two-thirds of whom delivered most of their services virtually, despite limited preparation to do so, and many concerns about its use with families with complex needs. The results also suggest that while there is a willingness to provide services virtually following the lifting of the lockdown restrictions, this was not felt to be suitable for vulnerable families.

The finding that many social workers were also not able to provide critical services, specifically in terms of conducting home visits to assess the condition and safety of the home, and also to conduct need assessment in the case of Children in Need, means that in the absence of home visits on the part of health visitors, in all likelihood the majority of children whose vulnerability related specifically to the pandemic were invisible to virtually everyone; it also suggests that children already within the system living in highly complex family situations, were not safeguarded at this critical time when in all likelihood their circumstances had deteriorated significantly. This occurred largely as a result of the redeployment process particularly of health visitors, and the failure to provide key community-based practitioners with the PPE and necessary training to continue home visits to high risk families. Indeed, some practitioners described their teams as having five or more colleagues who had been redeployed,

potentially affecting thereby all aspects of service delivery, including safeguarding. Overall, it could be argued that while the care needs of vulnerable adults in the community (e.g. those cared for by district nurses and care of the elderly teams) continued to be met using home visits, the needs of vulnerable parents and children were not.

The fact that all service providers believed that the most vulnerable children were not adequately safeguarded at this critical time, represents a continuation of the situation prior to the pandemic in which austerity measures had resulted in the bulk of funding for children's care being spent on Looked After Children,[15] while the caseloads of health visitors doubled and in some cases quadrupled vis-a-vis the recommended caseload,[16] and children's social care services had their funding cut by a third.[17]

The provision of care from their own homes, some or all of the time, also added to the difficulties experienced by many practitioners, with a fifth saying that that this had increased their workload by more than 40%. Similarly, the absence of safe office space within which to deliver virtual online care, meant that practitioners such as health visitors and social workers had difficulty undertaking the type of confidential conversations that were often needed, in addition to 'not knowing who else was listening'; furthermore, this was also felt to represent a threat to the patient-client boundary. The absence of access to IT on the part of many of these families also meant that there was potentially an equity issue for some of the families facing the most significant problems.

The data also suggest a significant impact of the new working arrangements on practitioners, and particularly health visitors and social workers. Although all but a fifth of respondents had experienced additional organisational support for their wellbeing, 10% felt that this was inadequate. Furthermore, some of the key factors that were described as contributing to their stress, related to the performance of management. Specifically, respondents highlighted a need for significant improvements in terms of clearer and more supportive communication, a reduction of the micro-management of staff, and more consultation to take account of their expertise.

[15] https://www.childrenscommissioner.gov.uk/publication/childhood-vulnerability-in-england-2019/ accessed 5th November 2020

[16] https://ihv.org.uk/news-and-views/news/health-visitors-fear-for-childrens-wellbeing-due-to-relentless-service-cuts/ accessed 5th November 2020

[17] https://www.childrenscommissioner.gov.uk/publication/childhood-vulnerability-in-england-2019/ accessed 5th November 2020

Annex 1

TABLE 1 DEMOGRAPHIC FACTORS BY KEY PROFESSIONAL GROUPS

Professional group										
Demography	Midwives		Health visitors		Community Paediatricians		Social workers		Total	
Total	N=58		N=641		N=98		N=64		N=861	
	(n)	%	(n)	%	(n)	%	(n)	%	(n)	%
Age										
- **20 to 29**	(3)	5	(16)	2	(0)	0	(3)	5	(22)	3
- **30 to 49**	(29)	50	(239)	37	(45)	46	(31)	48	(344)	40
- **50 and above**	(26)	45	(380)	59	(52)	53	(29)	45	(487)	57
Gender										
- **Male**	(0)	0	(4)	1	(11)	11	(9)	14	(24)	3
- **Female**	(57)	98	(636)	99	(85)	87	(54)	84	(832)	97
- **Other**	(0)	0	(0)	0	(1)	0	(0)	0	(1)	0
Region										
- **Greater London**	(12)	21	(118)	18	(14)	14	(4)	6	(148)	17
- **South East**	(22)	38	(139)	22	(17)	17	(9)	14	(187)	22
- **South West**	(6)	10	(74)	12	(21)	21	(33)	52	(134)	16
- **West Midlands**	(6)	10	(50)	8	(6)	6	(5)	8	(67)	8
- **North West**	(6)	10	(90)	14	(13)	13	(3)	5	(112)	13
- **North East**	(1)	2	(33)	5	(4)	4	(0)	0	(38)	4
- **Yorkshire and the Humber**	(1)	2	(82)	13	(3)	3	(6)	9	(92)	11
- **East Midlands**	(2)	3	(22)	3	(11)	11	(1)	2	(36)	4
- **East Anglia**	(0)	0	(25)	4	(8)	8	(2)	3	(35)	4
Years in role										
- **Less than 1 year**	(2)	3	(27)	4	(4)	4	(9)	14	(42)	5
- **1 to 5 years**	(11)	19	(157)	24	(22)	22	(26)	41	(216)	25
- **6 to 10 years**	(13)	22	(152)	24	(13)	13	(8)	13	(186)	22
- **More than 10 years**	(31)	53	(303)	47	(58)	59	(21)	33	(413)	48
Point in paygrade										
- **Top**	(31)	53	(445)	70	(42)	43	(28)	44	(546)	63
- **Middle**	(15)	26	(123)	19	(33)	34	(16)	25	(187)	22
- **Bottom**	(6)	10	(41)	6	(5)	5	(11)	17	(63)	7

Note: Values for "Prefer not to Say" and "Don't Know", as well as invalid answers, are not presented in this table

TABLE 2 METHODS OF DELIVERY FOR PRIORITY SERVICES BY HEALTH VISITORS

Type of contact												
Service	Phone		Text		Email		Video-call		Face-to-face home/clinic		Not providing	
	(n)	%	(n)	%	(n)	%	(n)	%	(n)	%	(n)	%

Antenatal contacts	(519)	49	(64)	6	(41)	4	(261)	25	(127)	12	(50)	5
Prebirth visits	(467)	38	(59)	5	(37)	3	(298)	24	(356)	29	(15)	1
Stratified contacts where there is clinical need	(468)	35	(87)	6	(46)	3	(280)	21	(444)	33	(21)	2
Safeguarding work (MASH; statutory child protection and home visits)	(459)	34	(72)	5	(59)	4	(361)	26	(401)	29	(18)	1
Children with special needs	(475)	44	(66)	6	(39)	4	(229)	21	(201)	18	(78)	7

Health visitors providing other services		
other services	(n)	%
	(279)	44

TABLE 3 METHODS OF DELIVERY FOR PRIORITY SERVICES DELIVERED BY COMMUNITY MIDWIVES

	Type of contact											
Service	Phone		Text		Email		Video-call		Face-to-face home/clinic		Not providing	
	(n)	%	(n)	%	(n)	%	(n)	%	(n)	%	(n)	%
Antenatal contacts	(51)	30	(22)	13	(11)	7	(10)	6	(74)	44	(1)	1
Prebirth visits	(48)	33	(12)	8	(1)	1	(10)	7	(75)	51	(1)	1
Other	(7)	21	(4)	12	(2)	6	(5)	15	(15)	45	(0)	0

TABLE 4 METHODS OF DELIVERY FOR PRIORITY SERVICES DELIVERED BY COMMUNITY PAEDIATRICIANS

	Community paediatrician											
Service	Phone		Text		Email		Video-call		Face-to-face home/clinic		Not providing	
	(n)	%	(n)	%	(n)	%	(n)	%	(n)	%	(n)	%
Services for families deemed to be a clinical priority	(85)	41	(6)	3	(19)	9	(55)	27	(40)	19	(2)	1
Child protection medicals (or advice)	(22)	16	(1)	1	(4)	3	(15)	11	(84)	62	(10)	7
Risk assessme	(73)	44	(4)	2	(19)	11	(34)	20	(24)	14	(13)	8

nt for urgent referrals												
Telephone advice to families	(96)	68	(2)	1	(13)	9	(26)	18	(3)	2	(2)	1

Community paediatricians providing other services		
other services	(n)	%
	(54)	55

TABLE 5 METHODS OF DELIVERY FOR PRIORITY SERVICES DELIVERED BY SOCIAL WORKERS

Children in Need (s17 Children Act 1989)												
Service	Phone		Text		Email		Video-call		Face-to-face home/clinic		Not providing	
	(n)	%	(n)	%	(n)	%	(n)	%	(n)	%	(n)	%
Assessment	(42)	24	(24)	14	(26)	15	(36)	21	(34)	20	(10)	6
Plans	(32)	23	(18)	13	(23)	16	(34)	24	(24)	17	(11)	8
Ongoing support	(38)	22	(26)	15	(33)	19	(33)	19	(34)	20	(8)	5
Reviews	(31)	24	(15)	12	(22)	17	(38)	29	(14)	11	(9)	7
Child Protection (s47 Children Act 1989)												
Service	Phone		Text		Email		Video-call		Face-to-face home/clinic		Not providing	
	(n)	%	(n)	%	(n)	%	(n)	%	(n)	%	(n)	%
Assessment	(31)	21	(19)	13	(21)	14	(26)	18	(33)	23	(15)	10
Plans	(31)	22	(19)	14	(21)	15	(30)	22	(23)	17	(15)	11
Ongoing support	(33)	22	(25)	17	(24)	16	(25)	17	(29)	19	(14)	9
Reviews	(26)	23	(11)	10	(17)	15	(31)	28	(12)	11	(15)	13
Looked after children												
Service	Phone		Text		Email		Video-call		Face-to-face home/clinic		Not providing	
	(n)	%	(n)	%	(n)	%	(n)	%	(n)	%	(n)	%
Ongoing support	(38)	22	(28)	16	(29)	17	(31)	18	(29)	17	(15)	9
Reviews	(29)	23	(15)	12	(20)	16	(32)	26	(13)	10	(15)	12
Adoption												
Service	Phone		Text		Email		Video-call		Face-to-face home/clinic		Not providing	
	(n)	%	(n)	%	(n)	%	(n)	%	(n)	%	(n)	%
Adoption work	(11)	15	(5)	7	(11)	15	(11)	15	(4)	5	(31)	42

TABLE 6 PROPORTION RECEIVING FACE-TO-FACE CONTACT AT HOME OR CLINIC BY PROFESSIONAL GROUP

Professional group

Proportion	Midwives		Health visitors		Community Paediatricians		Social workers	
	(n)	%	(n)	%	(n)	%	(n)	%
None	(4)	7	(160)	25	(32)	33	(14)	22
Less than 10%	(3)	5	(293)	47	(59)	61	(12)	19
10 to 20%	(2)	3	(102)	16	(4)	4	(6)	10
20 to 40%	(3)	5	(53)	8	(0)	0	(7)	11
More than 40%	(46)	79	(22)	3	(2)	2	(24)	38

Note: Invalid answers are not presented in this table

TABLE 7 REASONS FOR FACE-TO-FACE CONTACT AT HOME OR OTHER SETTING

	Professional group									
Proportion	Midwives		Health visitors		Community Paediatricians		Social workers		Total	
	(n)	%	(n)	%	(n)	%	(n)	%	(n)	%
Needs assessment	(42)	25	(296)	18	(32)	23	(24)	15	(394)	19
Safeguarding concern	(27)	16	(361)	22	(58)	41	(36)	22	(482)	23
Domestic abuse	(14)	8	(187)	12	(7)	5	(22)	13	(230)	11
Parental mental health problems	(29)	17	(277)	17	(7)	5	(24)	15	(337)	16
Substance dependence	(4)	2	(100)	6	(4)	3	(16)	10	(124)	6
Ongoing support	(42)	25	(248)	15	(12)	9	(35)	21	(337)	16
Other	(10)	6	(141)	9	(21)	15	(6)	4	(178)	9

TABLE 8 VULNERABLE FAMILIES NOT RECEIVING LEVEL OF CONTACT NEEDED BY PROFESSIONAL GROUP

	Professional group							
Proportion	Midwives		Health visitors		Community Paediatricians		Social workers	
	(n)	%	(n)	%	(n)	%	(n)	%
No families receiving insufficient contact	(18)	31	(103)	16	(14)	15	(17)	27
Under 20% receiving insufficient contact	(12)	21	(78)	12	(18)	19	(8)	13
20 to 40% receiving insufficient contact	(9)	16	(138)	22	(21)	22	(10)	16
40 to 60% receiving insufficient contact	(6)	10	(81)	13	(11)	12	(4)	6
More than 60% receiving insufficient contact	(8)	14	(129)	20	(8)	8	(6)	10

Note: Values for "Don't Know" are not presented in this table

TABLE 9 PROVISION OF VIDEO CONSULTATION BY ONLINE PLATFORMS BY PROFESSIONAL GROUPS

	Use of online platform			
Professional group	Using online platforms		Not using online platforms	
	(n)	%	(n)	%
Midwives	(22)	38	(36)	62
Health visitors	(465)	73	(170)	27
Community Paediatricians	(64)	65	(34)	35
Social workers	(52)	81	(12)	19

Note: Values for "Prefer not to Say" are not presented in this table

TABLE 10 TYPE OF ONLINE PLATFORMS USED

	Online platforms used	
	(n)	%
Zoom	(111)	12
Skype	(107)	12
Facetime	(65)	7
Facebook	(10)	1
WhatsApp	(267)	30
Other	(342)	38

TABLE 11 REASONS FOR NOT USING ONLINE PLATFORMS FOR FACE-TO-FACE CONTACT

	Professional group									
Reasons not using online platforms	Midwives		Health visitors		Community Paediatricians		Social workers		Total	
	(n)	%	(n)	%	(n)	%	(n)	%	(n)	%
IT problems	(12)	24	(93)	41	(12)	32	(2)	13	(119)	36
Insufficient knowledge/preparation	(15)	30	(71)	31	(9)	24	(5)	33	(100)	30
Not needed	(14)	28	(10)	4	(4)	11	(3)	20	(31)	9
Other	(9)	18	(54)	24	(13)	34	(5)	33	(81)	24

Note: Values for "Prefer not to Say" are not presented in this table

TABLE 12 ONLINE PLATFORM TRAINING BY PROFESSIONAL GROUP AND REGION

	Online platform training			
	Received		Not Received	
	(n)	%	(n)	%
Total	(216)	36	(369)	61
Professional group				
- **Midwives**	(2)	9	(18)	82
- **Health visitors**	(182)	39	(269)	58
- **Community paediatricians**	(28)	44	(35)	55
- **Social workers**	(4)	8	(47)	90

Note: Values for "Prefer not to Say" are not presented in this table

TABLE 13 BENEFITS OF USING ONLINE FACE-TO-FACE CONTACT WITH VULNERABLE FAMILIES

	Professional group									
Benefits	Midwives		Health visitors		Community Paediatricians		Social workers		Total	
	(n)	%	(n)	%	(n)	%	(n)	%	(n)	%
Time saving	(14)	29	(195)	22	(34)	24	(35)	35	(278)	24
Cost saving	(8)	16	(115)	13	(20)	14	(18)	18	(161)	14
Better access to families	(11)	22	(186)	21	(30)	21	(10)	10	(237)	20
Some clients prefer it	(12)	24	(219)	25	(30)	21	(23)	23	(284)	24
No benefits identified	(1)	2	(85)	10	(8)	6	(6)	6	(100)	9
Other	(3)	6	(84)	10	(18)	13	(9)	9	(114)	10

TABLE 14 LIMITATIONS OF USING ONLINE FACE-TO-FACE CONTACT WITH VULNERABLE FAMILIES

	Professional group									
Limitations	Midwives		Health visitors		Community Paediatricians		Social workers		Total	
	(n)	%	(n)	%	(n)	%	(n)	%	(n)	%
Inadequate preparation	(10)	5	(141)	9	(2)	4	(18)	10	(171)	8
IT problems	(41)	21	(317)	20	(11)	20	(41)	24	(410)	20
Can't access all families	(46)	24	(371)	23	(12)	22	(40)	23	(469)	23
Privacy/security problems for client	(15)	8	(197)	12	(8)	15	(19)	11	(239)	12
Privacy/security problems for self	(11)	6	(132)	8	(4)	7	(12)	7	(159)	8
Difficulty in providing some aspects of care	(55)	28	(359)	22	(14)	25	(29)	17	(457)	23
No limitations identified	(0)	0	(11)	1	(3)	5	(1)	1	(15)	1
Other	(15)	8	(69)	4	(1)	2	(12)	7	(97)	5

TABLE 15 CHANGES IN CASELOAD DURING PANDEMIC BY PROFESSIONAL GROUP IN TERMS OF SIGNIFICANT INCREASE IN CONCERNS

	Professional group							
	Midwives		Health visitors		Community Paediatricians		Social workers	
	(n)	%	(n)	%	(n)	%	(n)	%
Safeguarding	(2)	11	(136)	25	(5)	20	(10)	23

Domestic abuse	(3)	17	(171)	31	(3)	12	(15)	35
Substance dependence	(0)	0	(31)	6	(3)	12	(4)	9
Mental health problems	(13)	72	(211)	38	(14)	56	(14)	33

Note: Values for "Don't Know" are not presented in this table

TABLE 16 PROTECTED STATUS AND REDEPLOYMENT BY PROFESSIONAL GROUP AND DEMOGRAPHY

	Protected role			
	Protected		Not Protected	
	(n)	%	(n)	%
Total	(328)	38	(441)	51
Professional group				
- **Midwives**	(39)	67	(7)	12
- **Health visitors**	(200)	31	(382)	60
- **Community paediatricians**	(45)	46	(43)	44
- **Social workers**	(44)	69	(9)	14
	Redeployment			
	Redeployed		Not Redeployed	
	(n)	%	(n)	%
Total	(91)	21	(348)	79
Professional group				
- **Midwives**	(3)	43	(4)	57
- **Health visitors**	(78)	20	(302)	79
- **Community paediatricians**	(8)	19	(35)	81
- **Social workers**	(2)	22	(7)	78

	Training to Support Redeployment			
	Received		Not Received	
	(n)	%	(n)	%
Total	(60)	66	(31)	24
Professional group				
- **Midwives**	(0)	0	(3)	100
- **Health visitors**	(53)	68	(25)	32
- **Community paediatricians**	(7)	88	(1)	13
- **Social workers**	(0)	0	(2)	100

Note: Values for "Prefer not to Say" and "Don't Know", as well as invalid answers, are not presented in this table

TABLE 17 COLLEAGUE REDEPLOYMENT STATUS

	Colleagues Redeployment			
	Colleagues Redeployed		Colleagues Not Redeployed	
	(n)	%	(n)	%
Total	(548)	64	(272)	32
Midwife	(15)	26	(36)	62
Health Visitor	(457)	71	(165)	26

Community Paediatrician	(63)	64	(32)	33
Social Worker	(13)	20	(39)	61

Number of Colleagues Redeployed		
	(n)	%
Only 1	(30)	5
2 to 4	(173)	32
5 or more	(325)	59

Note: Values for "Don't Know" are not presented in this table

TABLE 18 INCREASE IN WORKLOAD AS A RESULT OF WORKING AT HOME

Professional group										
	Midwives		Health visitors		Community Paediatricians		Social workers		Total	
	(n)	%	(n)	%	(n)	%	(n)	%	(n)	%
Increased	(9)	16	(281)	44	(31)	32	(22)	34	(343)	40
Not increased	(23)	40	(289)	45	(56)	57	(38)	59	(406)	47
Proportion of Increase										
	Midwives		Health visitors		Community Paediatricians		Social workers		Total	
	(n)	%	(n)	%	(n)	%	(n)	%	(n)	%
Less than 20	(2)	22	(99)	35	(10)	32	(3)	14	(114)	33
20 to 40	(4)	44	(118)	42	(18)	58	(12)	55	(152)	44
40 to 60	(3)	33	(45)	16	(3)	10	(4)	18	(55)	16
60 to 80	(0)	0	(12)	4	(0)	0	(2)	9	(14)	4
More than 80	(0)	0	(6)	2	(0)	0	(1)	5	(7)	2

Note: Values for "Prefer not to Say" are not presented in this table

TABLE 19 PROFESSIONAL GUIDANCE ON SARS-COV-2

Guidance on SARS-COV-2				
	Adequate		Not Adequate	
	(n)	%	(n)	%
Total	(671)	78	(140)	16
Midwife	(43)	74	(12)	21
Health Visitor	(506)	79	(94)	15
Community Paediatrician	(85)	87	(12)	12
Social Worker	(37)	58	(22)	34

Note: Values for "Prefer not to Say" are not presented in this table

TABLE 20 PERSONAL PROTECTIVE EQUIPMENT (PPE) ACCESS BY PROFESSIONAL GROUP AND REGION

	PPE Access			
	Adequate		Not Adequate	
	(n)	%	(n)	%
Total	(714)	83	(96)	11
Professional group				
- **Midwives**	(44)	76	(12)	21
- **Health visitors**	(540)	84	(60)	9
- **Community paediatricians**	(89)	91	(8)	8
- **Social workers**	(41)	64	(16)	25

Note: Values for "Prefer not to Say" are not presented in this table

TABLE 21 PERSONAL PROTECTIVE EQUIPMENT (PPE) THAT WERE DIFFICULT TO ACCESS

	PPE that were difficult to access	
	(n)	%
Surgical mask	(97)	11
N95/FF2/FF3 mask	(61)	7
Surgical gloves	(15)	2
Eye goggles	(30)	3
Visor	(32)	4
Hood	(3)	0
Plastic apron	(33)	4
Fluid-repellent gown	(16)	2
No difficulties accessing any needed PPE	(574)	67

TABLE 22 RESPONDENTS FOR WHOM THE PANDEMIC HAD A SIGNIFICANT IMPACT ON THEIR MENTAL HEALTH

	Professional group									
	Midwives		Health visitors		Community Paediatricians		Social workers		Total	
	(n)	%	(n)	%	(n)	%	(n)	%	(n)	%
Significant impact on mental health	(17)	29	(137)	21	(9)	9	(8)	13	(171)	20
Level of Stress	(n)	%	(n)	%	(n)	%	(n)	%	(n)	%
6 or below	(28)	48	(338)	53	(65)	66	(29)	45	(460)	53
7 or above	(30)	52	(303)	47	(33)	34	(35)	55	(401)	47

Note: Values for "Don't Know" and "Prefer not to Say", as well as invalid answers are not presented in this table

TABLE 23 DESIGNATION OF RESPONDENTS

Designation		
Total	N=44	
	(n)	%
Commissioner of Health Visiting and School Nursing Services	(15)	34
Local Authority Children's Commissioner	(11)	25
Children's Services Commissioner	(4)	9
Service Lead	(10)	23
Other - **Local Authority Early Help** - **Commissioner of other public health services**	(4)	9

TABLE 24 YEARS IN COMMISSIONING

Designation											
Years in commissioning	Commissioner of Health Visiting and School Nursing Services		Local Authority Children's Commissioner		Children's Services Commissioner		Service Lead		Other		Total	
	(n)	%	(n)	%	(n)	%	(n)	%	(n)	%	(n)	%
Under a year	(0)	0	(0)	0	(0)	0	(0)	0	(2)	50	(2)	5
1 to 5	(8)	53	(0)	0	(0)	0	(2)	20	(1)	25	(11)	25
6 to 10	(5)	33	(5)	45	(1)	25	(3)	30	(0)	0	(14)	32
Over 10 years	(2)	13	(6)	55	(3)	75	(4)	40	(1)	25	(16)	36

Note: Values for "Prefer not to Say" are not presented in this table

TABLE 25 PROPORTION OF PRACTITIONERS REPORTING A *SLIGHT OR SIGNIFICANT* INCREASE IN SERVICES COMMISSIONING DURING THE PANDEMIC ACROSS KEY RISK CATEGORIES

Designation											
Type of Case	Commissioner of Health Visiting and School Nursing Services		Local Authority Children's Commissioner		Children's Services Commissioner		Service Lead		Other		Total	
	(n)	%	(n)	%	(n)	%	(n)	%	(n)	%	(n)	%
Child protection	(5)	33	(5)	45	(1)	25	(2)	20	(1)	25	(14)	32
Children in Need	(4)	27	(5)	45	(1)	25	(4)	40	(1)	25	(15)	34

Universal Plus/Partner Plus HV	(4)	27	(4)	36	(1)	25	(2)	20	(1)	25	(12)	29
Open Early Assessment Plan	(2)	13	(3)	27	(2)	50	(4)	40	(2)	50	(13)	30

Note: Values for "Don't Know" and "Not Applicable" are not presented in this table.

TABLE 26 PROVISION OF ALL PRIORITY SERVICES

Whether providing all services in key priority areas				
	Yes		No	
	(n)	%	(n)	%
Total	(32)	73	(6)	14
Designation				
	(n)	%	(n)	%
Commissioner of Health Visiting and School Nursing Services	(12)	80	(3)	20
Local Authority Children's Commissioner	(10)	91	(0)	0
Children's Services Commissioner	(2)	50	(0)	0
Service Lead	(7)	70	(2)	20
Other	(1)	25	(1)	25

Note: Values for "Don't Know" and "Prefer not to Say" are not presented in this table

TABLE 27 FINANCIAL PROVISION TO SUPPORT VULNERABLE FAMILIES

	Level of financial provision							
	Moderately above the level of need		Reflective of the level of need		Moderately below the level of need		Significantly below the level of need	
	(n)	%	(n)	%	(n)	%	(n)	%
Total	(1)	2	(12)	27	(15)	34	(11)	25
Designation								
	(n)	%	(n)	%	(n)	%	(n)	%
Commissioner of Health Visiting and School Nursing Services	(0)	0	(3)	20	(5)	33	(5)	33
Local Authority Children's Commissioner	(0)	0	(4)	36	(5)	45	(2)	18
Children's Services Commissioner	(0)	0	(0)	0	(3)	75	(1)	25
Service Lead	(0)	0	(4)	40	(2)	20	(2)	20
Other	(1)	25	(1)	25	(0)	0	(1)	25

Note: Values for "Don't Know" are not being presented in this table.

TABLE 28 CHANGE IN FINANCIAL RESOURCES SINCE SARS-COV-2

Change in Financial Resources				
	Yes		No	
	(n)	%	(n)	%
Total	(12)	28	(24)	55
Designation				
	(n)	%	(n)	%
Commissioner of Health Visiting and School Nursing Services	(1)	7	(12)	80
Local Authority Children's Commissioner	(5)	45	(5)	45
Children's Services Commissioner	(0)	0	(3)	75
Service Lead	(5)	50	(3)	30
Other	(1)	25	(1)	25

Note: Values for "Don't Know" and "Prefer not to Say" are not presented in this table

TABLE 29 LEVEL OF CHANGE IN FINANCIAL RESOURCES SINCE SARS-COV-2

Level of Change in Financial Resources				
	Slightly increased		Decreased	
	(n)	%	(n)	%
Total	(10)	83	(1)	8
Designation				
	(n)	%	(n)	%
Commissioner of Health Visiting and School Nursing Services	(0)	0	(0)	0
Local Authority Children's Commissioner	(5)	100	(0)	0
Children's Services Commissioner	(0)	0	(0)	0
Service Lead	(5)	100	(0)	0
Other	(0)	0	(1)	100

Note: Values for "Don't Know" are not presented in this table

TABLE 30 ANTICIPATION OF CHANGE IN FINANCIAL RESOURCES IN THE NEXT THREE MONTHS

Anticipation of change				
	Will change		Will not change	
	(n)	%	(n)	%
Total	(15)	34	(18)	41
Designation				
	(n)	%	(n)	%
Commissioner of Health Visiting and School Nursing Services	(2)	13	(9)	60

Local Authority Children's Commissioner	(6)	55	(2)	18
Children's Services Commissioner	(2)	50	(1)	25
Service Lead	(4)	40	(5)	50
Other	(1)	25	(1)	25

Note: Values for "Don't Know" and "Prefer not to Say" are not being presented in this table

TABLE 31 ANTICIPATION OF THE LEVEL OF CHANGE IN FINANCIAL RESOURCES IN THE NEXT THREE MONTHS

Anticipation of Level of Change										
Type of Case	Significantly increase		Slightly increase		Stay the same		Decrease		Significantly decrease	
	(n)	%	(n)	%	(n)	%	(n)	%	(n)	%
Total	(3)	20	(6)	40	(1)	7	(4)	27	(1)	7
Designation										
	(n)	%	(n)	%	(n)	%	(n)	%	(n)	%
Commissioner of Health Visiting and School Nursing Services	(0)	0	(2)	100	(0)	0	(0)	0	(0)	0
Local Authority Children's Commissioner	(0)	0	(3)	50	(1)	17	(2)	33	(0)	0
Children's Services Commissioner	(0)	0	(1)	50	(0)	0	(0)	0	(1)	50
Service Lead	(3)	75	(0)	0	(0)	0	(1)	25	(0)	0
Other	(0)	0	(0)	0	(0)	0	(1)	100	(0)	0

TABLE 32 MODELLING TO ESTIMATE THE EFFECT OF LOCKDOWN FOR THE NEXT THREE TO SIX MONTHS ON SERVICE PROVISION

Modelling			
	Yes		No
	(n)	%	(n)
Total	(17)	39	(19)
Designation			
	(n)	%	(n)
Commissioner of Health Visiting and School Nursing Services	(5)	33	(10)
Local Authority Children's Commissioner	(5)	45	(5)
Children's Services Commissioner	(2)	50	(1)

Service Lead	(4)	40	(3)	
Other	(1)	25	(0)	

Note: Values for "Don't Know" and "Prefer not to Say" are not being presented in this table.

TABLE 33 PERCENTAGE OF THE STATUTORY HEALTH AND SOCIAL CARE WORKFORCE UNAVAILABLE TO WORK

	Designation									
Adequacy of services	Less than 50%		50 - 70%		70 - 80%		80 - 90%		Above 90%	
	(n)	%	(n)	%	(n)	%	(n)	%	(n)	%
Health visitors	(30)	75	(4)	10	(2)	5	(3)	8	(1)	3
Social workers	(23)	89	(0)	0	(0)	0	(0)	0	(3)	12
Midwives	(15)	79	(1)	5	(1)	5	(0)	0	(2)	11
Nursery nurses	(22)	76	(3)	10	(1)	3	(2)	7	(1)	3
GPs	(13)	87	(1)	7	(0)	0	(0)	0	(1)	7
Community paediatricians	(13)	87	(0)	0	(1)	7	(0)	0	(1)	7
CAMHS workers	(14)	82	(1)	6	(0)	0	(0)	0	(2)	12

Annex 2

Box 1: Immediate actions to improve services that were identified by one or more respondents

Main themes	Example quotations
Allow face to face visits	"Face-to-face contact is required - especially for increased case load families - no visual field to identify concerns - parents not really willing to engage on the telephone (UP/UPP caseload). Unable to make contact due to current health pandemic is placing vulnerable children more at risk of potential harm / undisclosed abuse." [Health Visitor] "I'm not home visiting and not assessing needs…there are many many children that are right now 'invisible' and therefore one could argue the greatest risk of harm for a long time with no safety net of nursery, children's centres or schools providing support, assessment or signposting." [Health Visitor]
Better provision for vulnerable and newly vulnerable families	"We have to go through our manager to arrange a Child protection contacts and then try to obtain PPE. Vulnerable children are not on the radar of managers. we need either PPE or specialist clinics or specialist sessions at nurseries to support and monitor families. […]. Vulnerable children don't count in the KPI's, the whole commissioning process needs review urgently, all the changes to different providers cause mayhem and many providers don't really have a clue about the complexities of the Heath visitor role. Hence the total lack of effective working or planning with vulnerable families during Covid." [Health Visitor] "All children with a social worker - including those who became vulnerable after the pandemic should be offered nursery or school provision, at the moment they only get provision if they were vulnerable before. This is the most effective way of ensuring they are getting seen, have a stimulating environment and having play and getting a meal." [Health Visitor]
Restoration of universal services and better utilisation of community assets	"Offer delivery of services to all families, many of the most vulnerable families don't meet social care thresholds and are isolated with no support" [Health Visitor] "Health visitors need to be able to pick up their universal plus work again - I agree safeguarding families need our support however there are also social care monitoring the children - our UP work (maternal mental health in particular) has been ceased and I worry about the impact on these mothers and the relationship with their children" [Health Visitor] "Reinstate a universal delivery of services. Virtual development reviews either over the phone or virtually should be completed and where significant needs identified for example with communication a list of children that need face to face follow up as soon as safe to do so put in place" [Health Visitor]
Need for redeployed staff to be returned	"Get the health visiting staff that have been redeployed back to their designated roles as health visitors and employ sufficient staff to ensure neighbourhood teams are properly staffed. That was the issue before we went into SARS-COV-2 redeployment. we are just covering for poor staffing before we went into this crisis" [Health Visitor] "Bring our health visitors back most are out on redeployment - to district nursing - since when has end of life care been more important than new life care [?]" [Health Visitor]
Availability of personal protective equipment (PPE)	"More PPE availability and extend remit for face to face contacts via clinic or home visit" [Health Visitor] "Appropriate PPE provided for contacts" [Health Visitor]
Assessing staff risks	"Assessment of the risk of the virus, further research into its mechanism of transmission and who is affected and why. Testing of all NHS staff and testing all NHS for antibodies with a rolling out to the general public" [Health Visitor] "Better organisation of staff, i.e. risk assessment of staff - splitting to "hot and cold" teams so high-risk staff complete telephone/video contacts and other team can

	continue with face to face contacts including home visits using correct PPE to ensure staff and family safety. Asking families what they consider acceptable" [Health Visitor]
Better information sharing and co-ordinated care/partnership working	"There should be coordinated effort with local council, health, charities to help all the families struggling financially, mental health issues and domestic violence. More health visitors to deal with the pressures families face in the lock down." [Health Visitor] "We are building, very quickly, some robust partnership working and sharing of pertinent information between ourselves and our LA colleagues and so this will help to protect children and families as we will develop a more robust contact pattern utilising multi-agency approach " [Community Paediatrician]
Organisation and management of staff	"An appropriate plan - management inform us of changes to our working daily and it feels that we can't keep up. Do we ring or not ring management to advise of visit required, do management have to request our PPE or can we, using our professional judgement and this being accepted by management." [Health Visitor] "Allow Hv's to return to our practice and follow up our own caseloads with vulnerable families who we have built relationships with. For remaining HV skeleton staff to make 'safe and well' phone contact initially to vulnerable families however this is unlikely due to staffing levels within the service" [Health Visitor]
Support to adapt to remote delivery of services	"Better equipment, training and knowledge to use video calls so feel more confident in using this form of contact. Facility to offer video interpreting calls including BSL as currently all contacts requiring interpreter have to be telephone only" [Health Visitor] "Unfortunately, we do not have smart phones to enable us to do this via facetime or similar" [Health Visitor]
Better guidelines	"More robust guidance on detailed family health needs assessments during pandemic." [Health Visitor] "Commissioner and management to set clear guidelines." [Health Visitor] "Communication to be better with midwifery and social care." [Health Visitor]
Barriers to delivering virtual and remote services	"Due to complexities within these families most do not have access to WIFI. Financial limitations mean they do not always have mobile data on their phones and therefore cannot use virtual contact apps. such as Microsoft teams/whatsapp/skype etc. Also due to the chaotic lifestyles and or learning needs for some parents it is difficult to get them to answer a phone call. Therefore, Face2face contact are the only true way of getting these families to engage. So, we need to be home visiting as soon as possible" [Health Visitor] "There are vulnerable families who do not have access to internet/computer/ laptop or phone with WiFi so it's difficult to do video consultation. There should be coordinated effort with local council, health, charities to help all the families struggling financially, mental health issues and domestic violence. More health visitors to deal with the pressures families face in the lock down." [Health Visitor]
Planning for missed cohorts	"We need to start planning for the missed cohorts. The children that have missed out on developments need to be seen and assessed, the women who have not been able to build a trusting therapeutic relationship with a health visitor as they have only had a phone call primary birth need supporting and signposting." [Health Visitor]
Better support from other services	"Review of how other allied health professionals are delivering services - there is currently no one to refer to help these families." [Health Visitor]
Staff testing	"Parents are worried about the risk of catching Covid19. SW [social work] testing may alleviate some of the concerns." [Social Worker]

Box 2: Other main reasons for not providing face-to-face contacts using online platforms (n= 81)

Main themes	Example quotations
Limited technological capacity and access by clients	"Clients not always able to download/run approved platforms, such as Microsoft Teams. We have been advised not to use facetime and WhatsApp" [Midwife]

	"Clients not having adequate data/no access to WIFI to facilitate the call" [Health Visitor] "1. Parents not having video calling for what's app or not wanting to do a video call. 2. we are now moving to attend anywhere - families just need an email address" [Health Visitor]
Feels uncomfortable doing work from own home	"Feels intrusive into own home. I feel this changes the relationship. We tread a very fine line between building a relationship yet keeping it professional. Giving them a window into our home blurs these lines" [Health Visitor] "I find it intrusive as the video calls are from my home which I view as my own personal space." [Health Visitor] "Don't feel comfortable using WhatsApp from my home with a very busy household" [Health Visitor]
Lack of support	"No access to equipment to enable video calls" [Midwife] "Not having laptops" [Health Visitor]

Box 3: Other benefits of using online platforms with vulnerable clients during the pandemic (n=107)

Main themes	Example quotations
Ability to continue safeguarding work via video calls	"Ability to view inside a family home where there are safe guarding concerns. Ability to visual inspect development / examination of skin/ look at parent child interaction - given the limitations of the pandemic." [Community Paediatrician] "Able to see the parent and child face-to-face which gives valuable non-verbal information, allows assessment of a child's development through visual observation during the pandemic rather than relying solely on a parents opinion/observation. Able to see interaction between parents that I may not have seen if I had been in the property. Face-to-face contact even by video call feels so much more 'personal' than a telephone call. Able to read non-verbal communication and body language, make 'eye contact'" [Health Visitor]
Higher attendance	"For some families it is much easier to 'attend' the clinic. They do not need to find transport, childcare etc. However, those who don't attend clinic also don't always answer their phone either but it is easier for them to do so." [Community Paediatrician] "Easier to get variety of professionals 'in the room' who might not otherwise be able to attend" [Community Paediatrician]
Increased openness by some clients	"Clients seem to feel freer to talk more openly." [Health Visitor] "Some clients find it less threatening/intimidating in a CP/CiN meeting and sometimes seem freer to express their views. They often join the meeting by phone and decline the video option - perhaps they feel more anonymous? For individual consultations HV can be shown potential symptoms of concern." [Health Visitor]

Box: 4 Immediate actions needed to address caseload changes

Main theme	Example quotations
Need for redeployed staff to be returned	"Be able to provide home visits. Staff redeployed has made huge shortfalls in ability to provide service" [Health Visitor] "Bring back redeployed staff & increase PPE availability for visits to be completed." [Health Visitor]

	"Bring back those health visitors and nursery nurses who have been redeployed and improved access to mental health support" [Health Visitor]
Increased capacity to deliver remote services	"Ability to offer emotional wellbeing visits (listening visits) via telephone/video - currently we do not have capacity so would need more staff to enable this." [Health Visitor] "Being able to offer more support video calls while the lockdown continues instead of feeling you can't due to taking on more work from colleagues who have been redeployed." [Health Visitor] "We would like to have a social media presence to reach people but are not allowed any presence which is hugely frustrating. We feel we could reach vulnerable clients through a Facebook page but are not allowed to set one up." [Health Visitor]
Restore home visits with appropriate risk assessment and PPE	"Providing PPE to social workers so that they can visit with confidence. So far, I have seen social workers visiting on the door step and looking throughout windows at children and completing video calls, this is clearly not sufficient. Injuries and signs of substance misuse or neglect can easily be hidden by video calls and children cannot be seen or spoken to alone through the window. At a time when risk increases those safeguarding practices have decreased" [Health Visitor] "As soon as deemed safe to do so universal health visiting should resume, needs assessment should continue and home visits as a matter of priority should recommence. Health visitors need deploying back in to the service to support the children that are right now 'invisible'. Social care needs to recommence announced and unannounced home visits as soon as possible. It is patchy in my area as to who is seen 'virtually' or face to face." [Health Visitor]
Safeguarding concerns	"[I] think the anxiety for staff about safeguarding concerns within families is more of an issue at the moment. They worry about what they cannot see in a phone call. The real information about what has been happening to children during this time will only really become apparent after the lockdown is lifted and children are visible to health staff and nurseries/schools." [Health Visitor] "Since the pandemic as progressed calls to DV helplines have increased which has illustrated the restrictions have increased or exacerbated abuse in the home. Equally, job losses and the impact on mental health may have increased alcohol/drug abuse. Especially in the case of domestic abuse victim's strategies have been put in place as a response to this. I feel families have felt dropped because all services have retracted due to the outbreak and perhaps skeleton" [Health Visitor]
Financial support	"Better financial support for parents to access services provided to support them and their children and that it is safe to go out to shops maintaining the 2-meter distance and to use their back garden so that children can have space to play and run around" [Health Visitor] "Mental health services still need significant investment. Women who are waiting for psychological support are now even more anxious and depressed due to corona virus and hospitals restricting visiting of partners" [Midwife] "Having more resources available to signpost without concerns that services are overwhelmed" [Health Visitor]
Better guidance	"Clear step by step guidance to set clear standard of practice across all organisations" [Health Visitor] "Discussing the social distance guidelines in context of their families; I have encountered much confusion around government messages." [Health Visitor]
Access to services	"Opening up access to health visiting service via more clinics and we have also scrapped the important 8-week contact at present as well which often identifies mental health concerns earlier"[Health Visitor] "more information and support on access to services still being provided" [Midwife]
Access to support and safe space for victims of domestic abuse	"Abilities of family members to leave their homes and access support change in external circumstances e.g. lockdown/isolation out of agency control" [Health Visitor]

	“A safe haven that women could go to, for example a “clinic” that women can go to which they will have to do on their own due to social distancing, so will be a safe place to talk and get advice on what to do” [Midwife] “mothers and children being able to access places of safety. For instance, mothers being able to stay on school premises if her children are attending” [Health Visitor]
Leadership	“More leadership from our local mental health teams. As well as our HCP perinatal mental health lead perhaps have a link practitioner from talking therapy and local mental health team we knew we could access for supervision? Especially while so many staff are redeployed.” [Health Visitor] “We need more support for our own mental health and from management to be able to do this work” {Health Visitor]
Support for parents	“More support for parents of preschool children - not just psychological / but practical e.g. limited childcare support / some financial for those most vulnerable families / help with groceries etc these simple pressures add to the burden of these families who are stuck at home.” [Community Paediatrician] “Offering more frequent contacts from the same practitioner. Enabling appointment only clinic appointments for all first-time parents.” [Health Visitor]
Clearer communication	“We do in fact have a good extra help line we can use for referrals. We are only accessing a small number of people, we need better public information sent out with a hot line for people to access locally.” [Health Visitor] “Parents don't know where to access support from so if they knew, it would be easier for them to find support.” [Community Paediatrician]
Referrals	“More video calls and referrals to other services, food banks, MAST and social care. Assessments on families via video calls and working in partnership with the family to determine their immediate needs. Working with social care and other agencies” [Health Visitor]
Additional staff	“More Social Workers” [Health Visitor] “More staff across all Agencies” [Health Visitor]

Box 5 - Key services that have been affected by redeployment of staff (n=456)

Main theme	Example quotations
All service aspects	“50% of HVs have been redeployed or reportedly will be redeployed - All our services impacted little time for practitioners to handover to other HVs and cuts to routine contacts for 1 or 2-year routine contacts” [Health Visitor] “1 and 2-year universal health reviews and universal antenatal groups have stopped, child health clinics have stopped, less staff all round to support families when they call for advice and less staff to deal with safeguarding cases” [Health Visitor] “All areas of our services as we have less staff on ground to provide these services, as such those on ground are seeing more clients per staff” [Health Visitor]
Development reviews and assessments	“6-8 week check stopped. Development reviews stopped. Vulnerable families not on CP or CIN plans belonging to redeployed staff are not being followed up due to lack of capacity.” [Health Visitor] “Development reviews and all visits types. No development reviews are being completed and all allocation of work has increased.” [Health Visitor]
Breastfeeding support	“Breastfeeding support. I have a team of 4 and it was reduced by 75%- I was the team. I was overwhelmed by the work load and worked 12-hour days Mon- Friday” [Health Visitor]
Health visiting	“Health reviews and clinics have been stopped.” [Health Visitor] “Health Visitors unable to provide home visits as a routine” [Midwife]
Increased caseload	“Increased workload distributed within the team, increased number of New birth contacts/ 6-week contacts etc” [Health Visitor]

	“Massive impact on caseload numbers. I have taken a substantial part of colleagues UP and UPP cases.” [Health Visitor]
Safeguarding	“Our safeguarding caseload has increased significantly. We are not able to follow up concerns being raised and have been told to only contact those safeguarding families once. We are no longer allowed to offer follow up support contacts or if we do, this is to be one phone call only. The safeguarding families are hardly having any contact from the HV team and those of us who are left have had to take on cases without any handover of information.” [Health Visitor] “Increased safeguarding load for remaining staff.” [Health Visitor]
Services for domestic abuse victims	“Support services for mothers experiencing Domestic Violence such as attending the Freedom Programme, support from peer group such as Postnatal group, Children's activities at Family Centres” [Health Visitor] “All of them especially vulnerable and domestic abuse” [Health Visitor]
None	“None as contingency plans had been put in place to support this” [Health Visitor] “None as one has just joined the team as a staff nurse and so didn’t have an established caseload and the other a student HV who has had her training suspended.” [Health Visitor]

Box 6: Additional support that respondents would like their organisation to support their personal well-being (n=63)

Main theme	Example quotations
More empathic management and leadership	“An abundance of clinical managers who are not undertaking any clinical work. I would like managers to stop making veiled threats, to stop constantly looking at our caseloads and daily diaries, to stop negativity and to begin offering some positive support. I would like clinical managers to lead from the front and to undertake home visit and face-to-face contacts as they are instructing HV staff to do.” [Health Visitor] “Communication around team workload has been poor and this has caused significant stress. Any concerns have also been dismissed. For example, when concerns about lack of PPE were brought up in a team meeting our manager claimed we were ‘panicking’ and said that ‘Fear will kill you first’” [Health Visitor]
Less micromanagement	“Management have insisted we work one week from home and one week office based even though we cannot safely social distance, there are many shared pieces of equipment. We asked for the rationale behind demanding office-based work even though it goes against the guidelines. Our line manager told us that senior management did not want us working from home as it's "unfair on the acute sector" and we are "very lucky to be able to work from home every other week", we must "make the best of a bad situation". The response from management is what has caused more unnecessary stress. It's almost as though they fear home working means not working, however just yesterday I worked from home and was one hour and twenty minutes late finishing. It really saddens me when a "micromanagement" approach is used on highly qualified autonomous practitioners.” [Health Visitor] “An occasional thank you might be nice but mostly less idiotic diktats via email which often indicate they have no idea what we do....I'm a professional they could try asking us instead of all the information flowing from the top down ...” [Health Visitor]
More support from front line managers	“Regular support from my manager” [Health Visitor] “More time from my mentor or team leader on a one to one or even a courtesy call” [Health Visitor] “More visible management and more transparency as there has been so much secrecy and treating us like children.” [Health Visitor]

	"Corporate support in place but poor support from leadership team within the service" [Health Visitor]
Clearer communication	"Be nicer to know how long being redeployed for. Team to know why we redeployed & our responsibilities instead of expecting us to do everything" [Health Visitor] "Just better communication" [Health Visitor]
More staff	"There has been an offer of occupational health but the solution is more staffing. I can learn to cope with my own mental health needs but it makes no difference when you go back out there and cannot cope with the workload. I feel offering mental health support is like putting a plaster on something - the real solution is we need more health visitors!!!" [Health Visitor]
More reflective time	"More time for supervision and reflection" [Health Visitor] "More personal assessment and a buddying scheme where there is time out for reflection with a chosen by the individual -buddy. this is being done in general but needs to be recognised by management-Managers should not be the buddy" [Health Visitor]

Box 7 - Current service provision

Main themes	Representative quotes
Redeployment	"The minimum service requirements are being met but the almost wholesale transfer to remote appointments for health visiting is a worry in particular no F2F New Birth Visits for all but the very most vulnerable." [Commissioner of Health Visiting and School Nursing Services] "In spite of 25 of staff being redeployed the service has continued to deliver all mandated renews remotely. The services have also continued with NB Visits face-to-face and also stayed in contact with UPP children face-to-face visiting some highly vulnerable children has continued if necessary. April's data suggest a 10% drop in delivery of mandated checks" [Commissioner of Health Visiting and School Nursing Services]
Joint working with commissioners and providers	"I think our safeguarding teams could have worked better with us as commissioners rather than direct meetings just with providers-this is being addressed soon." [Commissioner of Health Visiting and School Nursing Services]
Changed working	"The services are having to use a remote model which has its own challenges so where possible contact has been enhanced providing a regular pattern of contact. Where responses are not given this is followed up with a face to face visit with social distancing. This is challenging as many of these families have not yet built up trust with services so skilful practitioners need to make these approaches carefully." [Service Lead]
Invisibility of most vulnerable families	"Referrals to the local MASH are down considerably raising concerns about children and young people who are invisible to services." [Service Lead]
Proactive engagement	"In addition to meeting the requirements of the community prioritisation guidance, the health visiting services has been proactively contacting families living in the two most deprived quintiles at the key contact points for the service." [Local Authority Children's Commissioner] "Children's Centres are supporting families virtually - contact by phone and also via social media (parenting support and advice etc); ante-natal education offer now online. Some f2f (socially distanced) work with the most vulnerable families. Midwifery clinics operating in some children's centres; children's centre staff are based in other CC buildings, to enable separation and social distancing. HVs are prioritising NBV review with vulnerable/1st time families." [Local Authority Children's Commissioner]

Box 8 - Immediate changes required to improve practice

Main themes	Example quotations
More funding after lockdown	"Funding for resources to support outreach services additional proportionate funding based on levels of deprivation allocated from the government to LA to deal with financial pressures that LA face as result of OCVID-19. Without this the risk that services will

	need to make efficiencies in the coming months and years which will result in cuts to services available for vulnerable cohorts" [Service Lead] "Commitment to higher level and ring-fenced ongoing PH funding (including pandemic preparedness and community testing)." [Commissioner of Health Visiting and School Nursing Services] "Greater recognition across of the system of the impact of lockdown on children, and therefore more focussed resource to consider comms campaigns etc." [Commissioner of Health Visiting and School Nursing Services] "Additional resources will be required to ensure that services can continue to operate safely with the expected increase in need." [Service Lead]
Better communication of long-term strategy	"More information on the long-term plan, more focus on recovery." [Commissioner of Health Visiting and School Nursing Services] "Funding and much greater join-up across recovery planning with the needs of vulnerable families recognised and meeting their needs designed in - they simply don't feature in NHS and Govt plans" [Local Authority Children's Commissioner]
Face-to-face home visits with appropriate PPE	"Undertaking face-to-face home visits. Online virtual sessions, Children's Centres open for drop ins and pre-arranged face-to-face appointments." [Local Authority Early Help] "Continued access to quality PPE to facilitate safe face-to-face work." [Commissioner of Health Visiting and School Nursing Services]
Improved coordination of services	"Better joint working across children's services and education to share the load-no infrastructure in place to do this." [Commissioner of Health Visiting and School Nursing Services] "We have worked with health visitors and school nurses to be able to offer a service in line with national guidance. This has been about ensuring a comprehensive service that is also 'smart' i.e. working very closely with social care so that there is not unnecessary duplication and staff remain safe" [Commissioner of Health Visiting and School Nursing Services]
Need to end redeployment	"Recall of deployed health visitors as 50 of the service was deployed out very quickly at the outset of the crisis." [Commissioner of Health Visiting and School Nursing Services]
Reinstate face to face contact with vulnerable clients	"Relaxation of lockdown rules to insist parents bring their children to see their HV for mandated contacts, children attending school, reduced anxiety amongst families and staff" [Service Lead]
Data sharing	"Improved data sharing across the system of child/family services so that services are aware of any other agencies also involved in safeguarding a family so that risk is shared and monitored across the system - collective responsibility." [Commissioner of Health Visiting and School Nursing Services]
Family support	"Supporting families virtually and keeping in touch and dropping off activity packs, food parcels as door to door task weekly" [Children's Services Commissioner]
Management	"Please just stop the constant shuffling of NHS leadership structures. It's a constant distraction and deeply unedifying to watch" [Children's Services Commissioner]
Improved child care for frontline staff	"Better child-care offer so that more staff available for face-to-face contact. Current offer from schools and nurseries is woefully inadequate and staff are being discouraged from using it by schools." [Service Lead]

Box 9: Changes required going forward

Main themes	Example quotations
Adequate funding and support for vulnerable families influenced by lockdown	"Understanding what to look for to identify vulnerable families early. Improved access to wider financial support/advice for families hit by COVID 19. Easier access to housing support following family breakdown and support for maternal and infant mental health services - moderate not high-end services which are already in place" [Commissioner of Health Visiting and School Nursing Services] "Quicker delivery of resources for vulnerable families, their inclusion in vulnerable lists (community hubs) and much more proactive support taking a strengths-based approach

	and enhanced access/insight for child protection." [Local Authority Children's Commissioner] "Additional funding to enable more whole family work in the context of economic and health inequalities in particular for new and existing vulnerable families that fall outside statutory service provision." [Commissioner of Health Visiting and School Nursing Services]
Clear communication	"Ensuring vulnerable client groups are aware of how to access public services - we are not closed and are still here to support - comms around this" [Local Authority Children's Commissioner] "Widespread communications that services are available and people should look at their local authority website for signposting." [Commissioner of Health Visiting and School Nursing Services]
Develop joint action plan	"Joint action plan across key agencies (Healthy Child Programme, Early Help, Midwifery, Children's Centres, Early Years, Children's Social Care) with key 'at risk' groups identified or cohorts of children we are concerned about." [Commissioner of Health Visiting and School Nursing Services] "In my area, we have excellent joint working between NHS and LA services under the Children's Trust and Safeguarding Partnership. This helps joint working on children at risk hugely." [Children's Services Commissioner]
Using data to improve practice	"Evidence-based data on emerging trends, both as we respond to Covid and as we enter a recovery period." [Local Authority Children's Commissioner] "Any emerging evidence on the pros and cons of virtual vs. face to face contacts with families and any innovative practice to inform how services adapt their practice looking forward." [Local Authority Children's Commissioner]
Ongoing availability of PPE and testing	"Ongoing testing and PPE provision. Less disconnect between central and local government" [Commissioner of Health Visiting and School Nursing Services]