

Greater support, recognition and research for health visiting post pandemic

Traditionally, appointments between families and health visitors have taken place face-to-face in families' homes, local community venues and primary care settings alongside GPs (1). Working across these settings has been recognised as important for the early identification of problems and the delivery of early interventions (2). Despite the importance of Health Visiting support to primary care, the service has faced a decline in investment, a decline in numbers of staff, and variation in services (3) and a lack of evaluative research (4). A previous article in the BJGP (5) documented significant annual budget cuts for the NHS and disinvestment by over 50% of local authorities since 2015 but during the Covid-19 pandemic, the service needed to adapt even further.

Health visiting currently faces a cumulation of new delivery models and lack of support and investment which, without change, will damage efforts to address health inequalities and will heighten the vulnerability of many families and their infants.

In response to high maternal and infant mortality rates in the UK well into the 20th century, health visiting as a service developed with a focus on the welfare of women and young children (6). In England, health visitors are central to provision of the Healthy Child programme 0-19, aiming to provide a universal service that can meet individual need and identify additional/ complex needs (2).

Specifically, the 0-5 years provision offered by health visitors includes '*continuity of family public healthcare, contributing to safeguarding, identifying and supporting vulnerable children and families and addressing inequalities*' (2). Health visiting intertwines home visiting, needs assessment and relationship formation, so that families can have access to a service they trust which can understand their needs. The service provides a universal contact with families which allows for equitable provision, and for families that need it, health promoting activities (7). The features of health visiting as a profession are also consistent with the WHO Nurturing Care Framework for investing in child maternal health and wellbeing (8).

The Covid-19 pandemic response included health visiting services being categorised as 'partial-stop' (some elements remaining and some having the potential to be postponed) and a shift to virtual/remote contacts and high caseloads (3). Prior to the Covid-19 pandemic the mean caseload was already exceedingly high at 409 (recommended maximum of 250) (9). Local Authorities reported that during the pandemic, redeployment of health visitors ranged from 0%-63%. At least one staff member was redeployed at 66% of all local authorities in England and a decline in job postings suggested redeployed posts were not all replaced.(9)

In 2021 the 1,291 respondents to the Institute of Health Visiting (iHV) UK survey, described greater than 12 months of challenges related to staffing levels, widening inequalities and an increase in safeguarding and vulnerability issues (10). These findings will not come as a surprise to GPs, but amongst survey respondents, 72% reported an increase in poverty affecting children and families, 80% reported an increase in domestic abuse and 71% reported an increase in child safeguarding risk. During 2021, over 90% of survey respondents worked with a greater caseload than recommended (10). Concerns have understandably been raised that the response measures employed in response to Covid-19 will have economic and social effects which will worsen physical and mental health and widen health inequalities (11).

Health visitors have historically supplemented home visiting with telephone consultations when providing programmes of child health promotion (12), but over the past two years remote appointments have been used increasingly as a means of service delivery. The iHV report found that following 20 months of use, health visitors' attitudes towards the effectiveness of video calls depends on the context in which they are used. A large percentage of respondents agreed that video-enabled contacts can be used effectively for 'straightforward concerns' (88.6%). However, '93.8% of practitioners 'disagree' or 'strongly disagree' that video contacts are as effective as face-to-face contacts for identifying needs or enabling disclosure of risk factors in vulnerable families' (10). Several research priorities to assess the impact of health visiting on babies, young children and families have been identified(4). Of particular interest are comparisons of current remote delivery methods vs "optimum" caseload and in-person care, and effects of reduced services since the pandemic on outcomes such as child maltreatment, abuse, and social services(4).

With a history in universal child health provision spanning more than 150 years(13), health visiting is one of the most established and important public health initiatives in the UK, promoting equity from infancy in the community. We write to all primary care clinicians to help us issue a call to action for greater investment in a service which is needed for workloads across primary care to be manageable and allow health visitors to reduce inequalities and safeguard children and families. Primary and secondary care health professionals, researchers and regulators are also urged to explore and understand the change in service delivery to remote contacts. Health outcomes, family experiences, health inequalities and the morale and experiences of staff, all need to be researched before up to date guidance for supporting families and staff can be developed. We all need greater support, recognition and research for health visiting post pandemic.

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