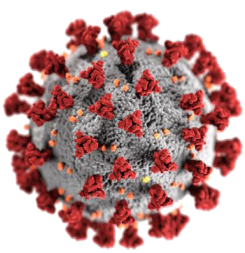
Institute of Health Visiting
Excellence in Practice

Making history:

Health visiting during COVID-19

Good practice case studies



September 2020

www.ihv.org.uk

Foreword

We are delighted to present this set of case studies, family stories and creative submissions gathered to help tell the health visiting COVID-19 story. The lockdown was suddenly upon us all, but it didn't seem to take health visitors long to find new and innovative was to adapt their services so that parents could still access their vital support. This didn't surprise me, since I became Chair of the Institute of Health Visiting I have been endlessly impressed by this profession and their heartfelt desire and determination to support families at one of the most vulnerable times in their lives how ever difficult their own working environment might be.

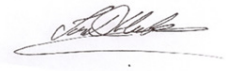
What these contributions provide is a historical snapshot into health visitor innovation and how families were affected by the lockdown. We know that all families in need couldn't be reached, especially where large numbers of health visitors were redeployed into nursing roles, but many benefited from these innovations. Attend Anywhere and other video conferencing platforms have become a new tool in the health visitors' toolkit and whilst they can never replace a face to face home visit they have clearly provided a helpful workaround when this option was no longer possible. How much better to see the person you are speaking to, especially when they are a stranger, than just speak to them on the phone.

I hope that readers will read to the end of these case studies and other creative submissions you will find them both informative and inspiring.

Pamela Goldberg OBE, Chair
Institute of Health Visiting

"Councils are incredibly proud of how their public health workforce has responded over the last 6 months. This report is testimony to the commitment and resilience of health visitors and illustrates the pivotal role they play in ensuring children and families get the support they need in challenging times.

In the upcoming Spending Review, we are asking the Government to reverse the £700 million of public health reductions, to enable councils to strengthen this workforce and ensure we can continue to support families when they need us most."



Councillor Ian Hudspeth
Chairman of the Local Government Association Community Wellbeing Board

ACKNOWLEDGEMENTS

We are deeply grateful to all the health visitors who took the time to write up their experiences of working during COVID-19 as case studies, families' stories and creative submissions. Without your input, we would not have been able to capture this time in history. You have generously shared your experiences of leading change in practice, sharing your successes, as well as failures to improve care as part of a learning culture.

This has been a collaborative project which was first proposed by colleagues in the Nursing, Maternity and Early Years Directorate at Public Health England. We are particularly indebted to Wendy Nicholson who provided the case study template and encouraged submissions through the PHE Regional networks.

The publication was developed by the team at the Institute of Health Visiting. With special thanks to our panel of peer reviewers, Lisa Jacobs for design, Megan Whittle for project management, Julie Cooper for communications and Alison Morton as the lead author.

"Downton in Lockdown" Illustrations ©Charlotte Foley @designbytot - with thanks from the iHV for granting rights for their use in this publication.

Contents

Introduction

This collation of health visiting case studies, families' stories and creative pieces mark a time in history that most health visitors will never forget – presenting a window into the working lives of health visitors and families navigating the ups and downs of the COVID-19 pandemic. A time when the world "locked down" and health visiting services were partially stopped and adapted to a socially distanced way of working. Yet many aspects of the world did not stop – babies kept being born and the normal struggles of parenthood became amplified for many. Some families enjoyed the relative peace of an enforced slower pace of life; however, most families were negatively impacted by lockdown and home was not a safe place for some with rates of domestic violence and abuse, mental health problems and safeguarding concerns quickly became a source of concern.

Working as specialist public health nurses in the biggest public health pandemic in living memory tested health visitors' skills and leadership capabilities in ways that many had never experienced before. Alongside the many challenges, this time also provided a unique opportunity for the health visiting profession to demonstrate its crucial role, supporting children and families across the breadth of clinical, social and statutory need. The health visiting service is unique in its reach into all homes, providing a vital safety net for babies and young children, identifying those in need and at risk of poor outcomes.

The pace and scale of change has been second to none and health visitors have risen to this challenge with professionalism and autonomy, flexing and developing innovative service "workarounds" to ensure that families receive the best possible support. Different areas have responded in different ways. No doubt some innovations have worked better than others – it is only by testing and refining that we can really learn and drive quality improvement.

The case studies, families' stories and creative submissions contained in this record capture a few of these experiences, although every health visitor and family will have their own very personal story to tell in the fullness of time.

Background

The Institute of Health Visiting worked collaboratively with Public Health England to collate "good practice" case studies of health visiting practice during COVID-19. In order to capture the breadth of experiences, in June 2020 the Institute put out a call for health visiting teams to submit:

- Service level case studies
- Family stories
- Creative submission

We received a large number of high-quality submissions which were assessed using a rigorous peer review process. Due to the limited capacity of the "Making History" publication we have only been able to include a small selection of submissions to represent a breadth of topics. Unfortunately this has meant that only the highest scoring submissions for popular topics like perinatal mental health have been included. We know that this has inevitably been disappointing for the authors of the equally fabulous case studies that were not included. But you still deserve to feel very proud of all your achievements which are in no way diminished. There are many other ways that you can still share your great work – we encourage all health visitors to join us and raise the profile of your innovation and service transformation in as many ways as possible using social media, radio, television and written publications. We are also always on the "look-out" for authors to write blogs for our website – so please get in touch if you are interested.

Policy context

Following an increase in the spread of COVID-19 in the United Kingdom, on the 16th March 2020, the Government announced measures to:

- Reduce the spread of COVID-19 across the country
- Prepare for, and respond to, the anticipated large numbers of COVID-19 patients who will need respiratory support.

NHS England and NHS Improvement published guidance on the plans for health visiting services in "**COVID-19 Prioritisation within Community Health Services**"[1]. Providers of community services were requested to "release

1 NHS England and NHS Improvement (2020) COVID-19 Prioritisation within Community Health Services. https://www.england.nhs.uk/coronavirus/publication/covid-19-prioritisation-within-community-health-services-with-annex_19-march-2020/

capacity to support the COVID-19 preparedness and response"; provide services "virtual by default"; ensure the use of Personal Protective Equipment (PPE) as required for all face to face contacts, with workplace adjustments and shielding of staff at higher risk. The guidance also contained details of whether services should "Stop – partial stop – continue"; health visiting was categorised as a "partial stop" service.

All health visiting services were advised to "Stop" except:

- Antenatal contact
- New baby visits
- Other contacts to be assessed and stratified for vulnerable or clinical need (e.g. maternal mental health)

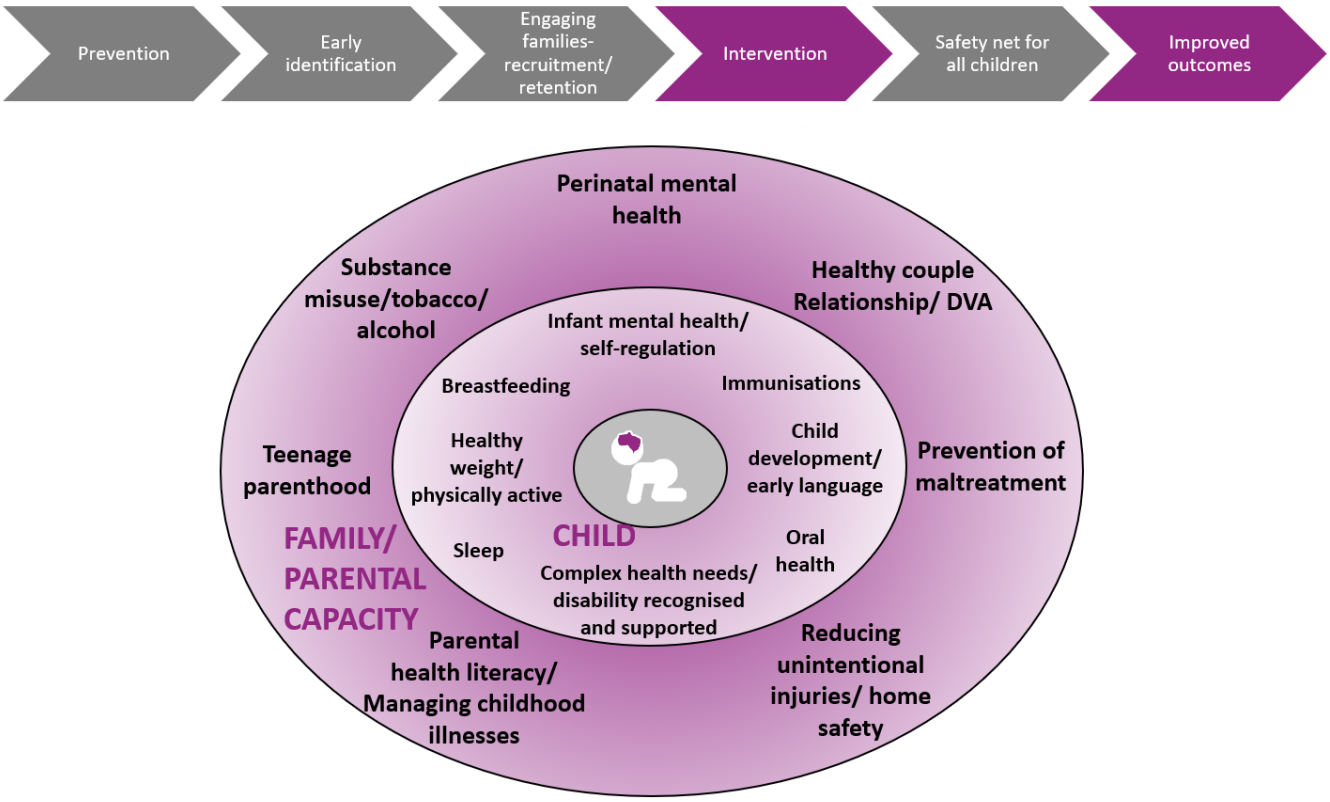
Additional advice was provided by Public Health England that,

"The presumption should be that all contacts will be virtual – using video-enabled technology or, failing that, telephone contacts. There will need to be an individual assessment of compelling need for face to face contacts at home and then decisions re PPE".

Services rapidly adapted in response to this national guidance which focused on the treatment of infected patients, predominantly adults. While children appeared to be protected from the clinical effects of the virus, the secondary impact of the pandemic remains significant.

Over time, the guidance was gradually changed with the subsequent publications of the "**COVID-19 restoration of community health services for children and young people: second phase of NHS response**"[2] and "**Implementing phase 3 of the NHS response to the COVID-19 pandemic**"[3]. Services were advised on ways to restore the delivery of the Healthy Child Programme in response to growing concerns about the needs of children and families.

The impact of "lockdown" on babies and young children is not evenly distributed, and is likely to be far-reaching, with the most disadvantaged experiencing the most detrimental consequences. Achieving the "best start in life" requires effective measures to strengthen the health visiting service in order to tackle a breadth of issues linked to poor outcomes and make the best use of health visitors' skills to address numerous cross government department priorities set out in the image below:



2 NHS England and NHS Improvement (2020) COVID-19 restoration of community health services for children and young people: second phase of NHS response 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

3 NHS England and NHS Improvement (2020) Implementing phase 3 of the NHS response to the COVID-19 pandemic. https://www.england.nhs.uk/publication/implementing-phase-3-of-the-nhs-response-to-the-covid-19-pandemic/

COVID-19 is the biggest challenge that the health visiting service has faced in living memory. As we collectively face an uncertain future with no end to the pandemic in current sight, it is imperative that we learn from these experiences. Across the country solutions are being found that contain considerable transferable learning to benefit all health visitors – we need to quickly learn from what has worked, our partial successes, as well as the things that, with the benefit of hindsight, we would choose to do differently next time. The learning coming out of this experience provide a unique opportunity to ensure that we are better prepared to meet the needs of parents and young children as the pandemic continues.

© Charlotte Foley - used with permission

Health Visiting in Blackpool during COVID-19 Lockdown

by Sara Jones

In Blackpool we are known for providing an improved level of service from the health visiting teams. We conduct 8 core / universal visits to all families within the Blackpool area, from the antenatal period through to the 3 - 3.5 year development check. In 'normal' circumstances, these would all be conducted in the home, clinics or nurseries and all carried out face-to-face with the children and families.

COVID-19 brought with it a huge amount of uncertainty for all staff, anxiety shot up, mixtures of emotions as many of us prepared for redeployment; some scared, some excited at the opportunity to help out, and others un-phased and waiting for further instruction (quite possibly the best way to look at it). Personally, I was a mixture of all of the emotions, terrified of being redeployed to the hospital thinking that I would be placed on a ward where I had no experience, but also feeling excited for the opportunity.

The initial weeks were very uncertain for the majority of people; team leaders being bombarded with questions around whether redeployment was imminent, whether it was safe to visit, PPE questions, shielding etc. Staff receiving email upon email regarding coronavirus updates, visit guidelines, PPE guidelines, alongside the ever increasing number of cases in Blackpool, and of course the death rates. Then outside of work there were shortages of toilet roll, hand wash and alcohol gel, they almost became the new currency! Everyone in the teams bringing loo roll to the office for those who hadn't a chance to find any, work places labelling the alcohol gel to prevent it finding its way into staff handbags and going home with them! Further to this, constant emails back and forth to acquire alcohol gel for the office.

Eventually though, things calmed down and became almost a new normal! Loo roll was no longer the new currency and hand wash was back in the shops. However things have changed, social distancing is a thing, a real thing. The office numbers have halved and a divide has occurred, a necessary evil you could say. Team A and Team B! Each team has been split in two, working opposite each other, one week in the office and one working from home. Team meetings via Microsoft Teams every two weeks, and waiting for check in from the team leaders when working from home, and making sure your hair is done and at least your top half is dressed!

Working from home brings a whole other level of frustration! Firstly, internet connection - if you are one of the lucky few with a stable home broadband system that hasn't decided that it's going to run slow because everyone in the country is at home using the broadband …. Then … well you are lucky! Unfortunately most others find that the internet drops out now and then which leads to several complications - the online database stopping in the middle of a lengthy consultation that has taken 45 minutes to write and not saving, so you have to write it all again, is one of them! Another fun experience is dealing with a fraught parent on the phone and trying to state that their new baby's poo is absolutely fine to look like korma, in fact it's perfect, but just as you are about to explain that the internet drops and hangs up your call… then it takes 10 minutes to upload again and you can't get back in contact with said parent.

Another great benefit of working from home is your colleagues …. No, I don't mean those highly skilled professionals from your office who you rely on to keep you sane and debriefed regarding your families! Oh no! I mean those 0-16 year olds who like to play on their consoles, to talk to their mates and shout at the television screen, whilst you're on the phone in the other room trying to console a new mum with baby blues. Or those four legged, bouncy, barking mad pets, that like to have the zoomies whilst you are trying to explain the benefits of waiting until 6 months to start weaning their baby to a mum that has been told that baby rice at 12 weeks is fine! Or the bored husband who is furloughed who lovingly checks up on you every ten minutes and wants to tell you about some Brazillian Jiu Jitsu moves he's just seen on YouTube, but at least brings you a cup of tea whilst he disturbs you! I am grateful, I promise.

Now this all seems like doom and gloom, but it's not. It's these things that you have to look back on and have a little giggle to keep some semblance of sanity. Working from home is hard, dealing with the above, but if you have those people in the house it's also nice to know that your nearest and dearest are there, and they can see and appreciate the hard work you are putting in. My favourite point thus far, is finishing my day and my husband telling me how proud he is of me.

Working from home allows for far more contacts to be completed, not distracted by colleagues in the office wanting to debrief or advice (although this is welcomed) or the office duty phone ringing regularly. It allows for more headspace and concentration. It allows you to be able to nip for a hug on your toilet break with your little ones.

When it comes to service offer, I feel we are doing an amazing job! As a service in normal circumstances we offer the following contacts face-to-face in the home:

Type of visit:	When:	Where:
Antenatal		
Early infancy visit 1	0-14 days	home
Early infancy visit 2	3-5 weeks	home
Early infancy visit 3	6-8 weeks	home
Weaning contact	3-6 months	home
1 year development	9-12 months	home
Desktop review	15-18 months	computer review of referrals and care
2 year development	24-30 months	home
3 year development	36 -42 months	home/nursery

Due to COVID-19 restrictions, we are offering the antenatal and one of the early infancy contacts as a home contact if family are agreeable to a home contact, as long as there are no people with COVID-19 symptoms within the home. We are all provided with correct level 2 PPE: surgical face mask, gloves, apron and a face shield. We are also being provided with training for donning and doffing said PPE. All PPE is to be doffed on leaving the properties, double bagged and left for the occupant to hold onto for three days before disposing in general waste bins.

So, visits that are taking place! I am finding that most pregnant mums are happy to conduct the antenatal contact over the phone, mainly due to them shielding at this time. Most early infancy contacts are completed over the phone and I am generally seeing the families at either 3-5 weeks or 6-8 weeks, due to midwives doing weights in the hospital. I have completed earlier visits where the child has struggled to gain weight or mum is struggling with her mental health. We are also continuing contact with safeguarding families or those with ongoing health needs that require weights or development checks where the child needs to be seen.

Working from the office is welcomed from my perspective, being able to debrief about the day's work as it's happening and having instant access to colleagues' fountains of knowledge. The social aspect of working in the office is definitely missed when working from home, so when you are back in, the inevitable catch up occurs over the morning cup of tea!

Monday mornings are generally filled with updating the birth books, and sending out necessary resources to families that you inevitably forgot to bring home for the week, and replenishing PPE. Continuing then for the week with telephone contacts, of the above listed universal contacts, duty telephone and emails.

Core groups, conferences and child in need meetings continue, but these are done via Skype, Microsoft Teams, or conference call; these are far more difficult. In Blackpool, we recently started a new model for children's social services child protection conferences, where the conference is led by the families and less focused on reports from professionals - this is difficult to manage over the phone, and frequently families aren't able to dial in to core groups as they haven't managed to download the correct software. It also produces issues when families get irate over the phone or leave when they are angry, as it is difficult to diffuse the situation. I personally find these easier at home due to being able (to a point) to keep the noise to a minimum, because in the office the rest of the team are continuing with their telephone contacts and conversations, however there is the option of booking a room for these conferences for your privacy.

As a whole, the pandemic has increased the anxiety of everyone continuing to work through it, not being able to stay at home with their family and minimise contact with the outside world. However, I feel grateful for being able to continue to work, as without it I feel my mental health would have deteriorated, and then also being the only one in the house with an income has increased the pressure.

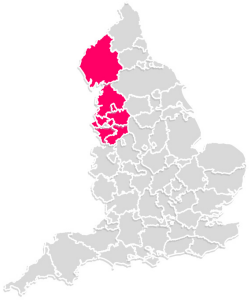
Everyone has their own issues going on outside of work and, as a team, we are beginning to recognise this more and more. The pandemic only serves to highlight these and add to the anxiety, and we are working towards keeping everyone sane, happy and working well with each other. The team has been completing two weekly team meetings which have been welcomed and joined by the majority of staff; they have been positive and it has been helpful to highlight any concerns between the two teams, it keeps us together as a team even though there is a divide.

The pandemic has highlighted how important the health visiting service is to the families in Blackpool, and how even telephone contacts are making a huge impact on families, it is appreciated by them and they feel that they are cared for. ***I, for one, am proud to work for the Blackpool health visiting service, and proud that we continue to deliver our universal service in these unprecedented times.***

CONTACT DETAILS:

Name:	Sara Jones
Job Title:	Health Visitor
Address:	Central East Health Visiting Team, Newton Drive, Health Centre, Newton Drive, Blackpool FY3 8NX
Email Address:	sara.jones24@nhs.net

Region: North West

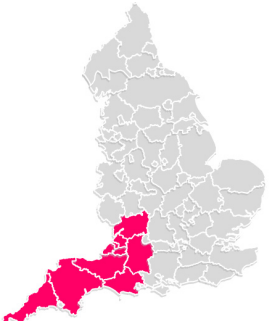


CASE STUDY 1 A Public Health Nursing Infant Feeding Service during COVID-19

CONTACT DETAILS:

Name:	Gail Barker
Job Title:	Infant Feeding Coordinator SCPHN
Address:	Devon Public Health Nursing Service
Email Address:	g.barker3@nhs.net

Region: South West



All case studies demonstrate that they are child- and family-centred and built on the importance of relationships as central to everything that health visitors do. In addition, this example demonstrates the following "Key elements" of the iHV "Health Visiting in England: A Vision for the Future":

Background:

A Global Pandemic, one of the largest global public health challenges of our time, a new way of thinking, supporting, communicating, assessing and working for us all.

Health Visitors, at the beginning of life, encouraging brain development, supporting infant feeding, and building close and loving relationships whilst making history.

The problem:

Staff were scared, families vulnerable. We needed to continue to keep everyone, families and staff alike safe, informed and supported with infant feeding challenges. We needed to be able to: assess latch, build peer relationships, support growth and development, promote, protect and support breastfeeding; all whilst working in an integrated manner with our partners and parents. It was important to ensure that all staff were equipped with the knowledge to effectively support infant feeding within the confines of lockdown restrictions, be responsive and ensure we met the needs of these children and families at this challenging time. We needed to do all of this whilst personalising our service, and through providing families with choice about the way that contacts and support was provided. This case study sets out our twelve learning points which were captured during the first 12 weeks of working differently during COVID-19:

What we did:

1

VIDEO TELECONFERENCING:

We introduced infant feeding video teleconferencing:
98 video teleconferences in twelve weeks and many more to go…
The launch of our video teleconferencing special interest infant feeding health visiting service enabled us to have video contact with mothers in order to provide virtual face-to-face support to families. Furthermore, we supported staff to consider the New Birth contact or follow up support to be undertaken, in part, by video teleconference.

2

SUPPORTING STAFF:

We supported staff in decision making around infant feeding. Supporting them to adapt their skills to support families. We did this through responsiveness to queries, training and building support and information. Building relationships encouraged staff to access supervision, support and ask questions, recognising it was a safe environment. We trained 123 staff members to use Microsoft Teams video teleconferencing with parents, so that we could build robust assessment into our service at all levels, including those New Birth and feeding assessment points. Furthermore, we undertook infant feeding training using Microsoft Teams, building into this how to assess and support over the phone or video – recognising that different skills are required in providing that support rather than during face-to-face support. In building responsive relationships with staff, we built a trust with staff that enabled them to ask simple questions and to double check plans.

COMMUNICATE:

We communicated across not only our own service, but within the infant feeding leads across our four STP trusts. This was key to leading infant feeding services at such a challenging and changeable time. This had a significant impact on consistency of messages for families at this time.

3

4

INNOVATION:

We used innovation to build on our service at a time when many services were reducing services. We altered or added, whilst responding to and adhering to government guidelines. We considered service need, and in doing this we recognised the need to maintain and add to our specialist service through increasing, rather than reducing, appointment slots, training, and supervision. We recognised that infant feeding would be a key vulnerability at this time, when we had less face-to-face contact with babies in order to make assessment. Therefore, our service, and the support we were able to provide, grew as the need grew.

VIRTUAL LATCH AND ATTACH:

We developed a virtual Latch and Attach clinic offer - providing virtual group support to mothers with latch issues. This enabled our infant feeding appointments to be protected for complex feeding challenges and allowed us to build peer support.

5

6

LEARNING:

We chose to learn when things went wrong. We investigated across the region any baby admitted from within our service with low weight gain, to unpick if there were lessons to learn from. Theming learning and sharing this with our own Public Health Nursing Service and our Local Maternity System to build learning and service improvement across the whole system.

7

WORK WITH OUR PARTNERS:

We reached out to our peer support networks, provided infant feeding training for our partners in our Children's Centre and shared children centre venues. We also worked together on our Healthy Start Vitamin processes at this time with Public Health, Children's Centre and Public Health Nursing all working together to make vitamins accessible. To enhance collaborative working we also offered online catch ups with our Breastfeeding peer support partners.

RECOGNISE OUR UNIQUE SKILL:

We recognised our skill as health visitors in promoting and building community capacity, delivering a universal service and developing our Universal Plus infant feeding service. In twelve weeks, we celebrated all elements and made steps within each area to support and develop through a very challenging time. Over fourteen weeks, we then started to cement our virtual family focus sessions, which form a virtual opportunity for families to have a facilitated discussion about a range of elements including starting solids, responsive feeding, building close and loving relationships and early feeding.

8

9

PROVIDING STRONG, RESPONSIVE AND DECISIVE LEADERSHIP WHILST BEING BRAVE:

We provided strong leadership across our infant feeding decisions and support at this difficult time. It was the beginnings of the UK's COVID-19 experience, but we used the experience within our leadership team to drive forward our infant feeding service, develop clear messages, and clear guidance – acknowledging that it might change. It was a time of huge change and multiple messages, however whilst we were learning together, we worked together as a system that had strong leadership that valued ourselves and our staff. We were brave. Some of the largest steps needed the bravest belief that we could do this and that technology could support our aims. On those days when technology did not work (we are in Devon and connectivity is still an issue), we also had to believe in our backup plan.

RESPONDING TO FAMILIES FEEDBACK WHILST KEEPING IT REAL AND REFLECTIVE:

We continued to obtain family feedback and we responded to that feedback throughout. This feedback informed how we continued our infant feeding service at this time and how quickly we developed it further. We had to be realistic with what we could achieve, and we reflected and learnt as we went along. Part of this was supported through constructive criticism and working together as a team, and part of this was supported through using and reflecting on our feedback from staff as much as from families.

10

11

STAFF ARE AFFECTED BY THE REAL-LIFE ISSUES DURING CHANGE. THIS MIGHT AFFECT THEIR ABILITY TO EMBRACE CHANGE AND NEW SKILLS:

We talked and we listened. A quick lesson to learn – we could not assume staff knowledge, staff skill and staff engagement. Equally, if staff were involved in decision making, understood the need for change, recognised the benefits for families and were supported through this, then they quickly embraced this.

DON'T LOSE THE CHILD:

At times of change it is easy to be reactive rather than reflective. However, the key to our success in providing ongoing infant feeding support was to keep the child in mind at all times, by responding to the current situation and the current population need. The needs of the child remained central to all of our plans and these changed as the situation and guidance changed.

12

TWELVE WEEKS, TWELVE LEARNING POINTS

How do we know we have made a difference?

OUTCOMES OVER THE TWELVE WEEKS

1578

Babies had a universal feeding assessment at day 10-16.

163

Families had support from our special interest health visiting service either via telephone, video teleconference or face-to-face.

123

Members of staff were trained to use video teleconferencing.

149

Public health nursing staff team messages were asked and responded to about feeding questions.

84

Public Health nursing staff received infant feeding updates, focusing on new ways to assess feeding during a pandemic.

What does this mean?

FOR FAMILIES, THIS WAS WHAT IT MEANT...

"Practitioner was brilliant - very helpful and supportive."

"The video teleconference worked really well, not quite as good as seeing someone in person but at this time I felt really well supported by it."

"Practitioner was very understanding and non-judgemental."

"It's not widely known as a support option - would be great to know about it"

"This session was so useful. Full of information and very supportive in approach. It would be so valuable to have accessed support like this in hospital to start breastfeeding in a positive and confident way."

"Was pleased to be encouraged to get in touch again as the feeding progresses to get more support."

"The practitioner was truly engaged and caring, we're lucky to have access to this service." "Thank you."

"Having a video conference made so much sense. The issue I had was resolved easily over the video conference"

"Really supportive with lots of advice."

"So supportive and listens to all concerns no matter how small. Feel so much more relaxed about feeding and confident in that I am doing it right."

"Would be nice if midwives could refer or if self-referral was an option."

FOR THE FAMILIES WE SUPPORT:

UNICEF (2019) highlights that, "*A key aspect of improving breastfeeding rates is the provision of face-to-face, ongoing, predictable support to families across all public services, and social support in the local community.*"

Improving the UK's breastfeeding rates is acknowledged as a key factor in improving the health of a population. Through being able to continue to support infant feeding via video teleconferencing at such a challenging time, we were able to support and promote the health of each baby and mother supported by our service.

Furthermore, we know that infant feeding supports not only the building of close and loving relationships, which in turn promotes mental health of both mother and baby (UNICEF, 2019), but it also has significant health impacts and reduces health inequalities (Victora et al, 2016). At this time of COVID-19 it has never been more important to focus on children in view of these considerations for now and for the future, not just in the UK, but globally.

FOR THE SERVICE:

We were able to support staff in providing feeding support, building confidence and skill at such a challenging time. We were able to provide infant feeding training for our partners within the Children's Centre who were launching an online universal parenting offer. Furthermore, the reputation of the service has been increased as parents have received a service that they recognise as positive and our staff recognise the impact they have had.

References:

Unicef The Baby Friendly Initiative (2019) Breastfeeding in the UK: a public health issue [ONLINE] Available from https://www.unicef.org.uk/babyfriendly/about/breastfeeding-in-the-uk/ [Accessed 22/05/20]

Unicef The Baby Friendly Initiative (2019) The importance of relationship building video [ONLINE] Available from https://www.unicef.org.uk/babyfriendly/baby-friendly-resources/relationship-building-resources/importance-of-relationship-building-video/ [Accessed 12/05/20]

Victora CG, Bahl R, Barros AJD, Franca GVA, Horton S, Krasevec J, Murch S, Sankar MJ, Walker N, Rollins NC (2016) Breastfeeding in the 21st century: epidemiology, mechanisms, and lifelong effect. The Lancet Series: Breastfeeding 1. Volume 387, No. 10017, p475–490, 30 January

© Institute of Health Visiting - illustration by Charlotte Foley @designbytot

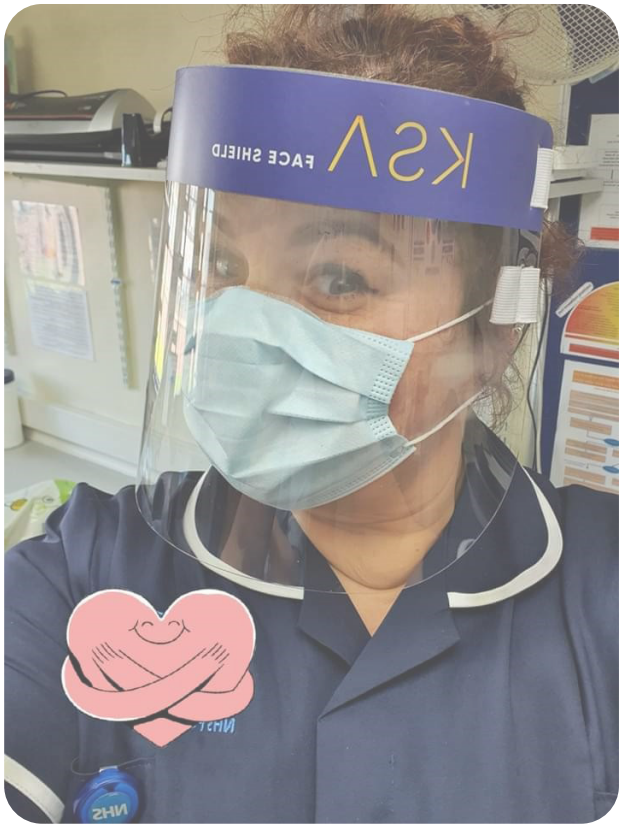
The Smile Behind the Mask

by Sarah Heaney

When I go on my visits **I wonder if they can see the smile behind my mask?**

Looking at beautiful newborn babies, and the families I work with, I wonder how they will see this world. I smile hoping that they can see the smile in my eyes.

This week I visited a 'universal' family as I was unable to contact them by phone. The joy this family had for their new baby was beautiful. The joy they had for being visited by an actual person (with the mask and all appropriate PPE) was equally heart-warming. The mum spoke of how her family live in another country and her mother was desperate to meet her new baby. Her husband was due to go back to work and she worried about being alone. No meetings with friends. No baby groups. No 'ladies that lunch'. I feel her frustrations. I comfort her. I smile, hoping she can see the smile in my eyes.



I have mainly been visiting vulnerable families. I enjoy this, don't get me wrong, but it's hard going. The reports that domestic abuse is rising is a reality in my working world. I try to imagine how the children feel when hearing, seeing, sensing the abuse. Many families are finding parenting challenging during COVID-19 and my role as a health visitor is to support them to face these challenges and keep their children safe. I try to show them a smile to let them know I care and am here to help, I hope they can see the smile in my eyes.

Mental health is tough. Self isolation is hard. Although being scared to go out and being a single mum with 5 children in a cluttered 3 bedroom house is really hard. I visit (in my PPE). I try to offer reassurance, but I don't know what will happen. So I smile, I hope they can see the smile in my eyes.

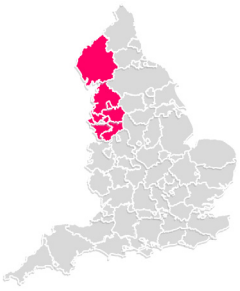
My role has changed significantly. I have collected a large number of food bank supplies during this period. I'm amazed at the staff who work there. I'm amazed at the world for donating. I help the families in need. I smile, I hope they can see the smile in my eyes.

I could talk forever on the heartbreak I have seen during this lockdown. I realise its affected me too. I'm human. I'm lucky, I have wonderful friends and family. But occasionally I still feel sad. But that's ok. I look in the mirror, **I smile, I hope I can see the smile in my eyes.**

CONTACT DETAILS:

Name:	Sarah Heaney
Job Title:	Health Visitor
Address:	Stockport NHS Foundation Trust
Email Address:	sarah.heaney1@nhs.net

Region: North West



CASE STUDY 2 Understanding Your Baby – taking a support group for mothers with low mood and anxiety online during the pandemic

CONTACT DETAILS:

Name:	Ettie Dolman
Job Title:	Specialist Health Visitor for Perinatal and Infant Mental Health
Address:	Central London Community Healthcare NHS Trust
Email Address:	esther.dolman@nhs.net

Region: London

This case study example demonstrates the following "Key elements" of the iHV "Health visiting in England: A Vision for the Future":

Background:

Mental illness affects an estimated 1 in 4 women, making it the most common serious health problem that a woman can experience in the perinatal period[1]. Not only are perinatal mental health problems of major importance as a public health issue because of their adverse effect on the mother, but they have also been shown to have the potential to compromise the healthy development of the child[2]. It is therefore essential that health visitors not only support mothers with their mental health, but also work to promote sensitive and consistent parent-infant relationships, which in turn build strong foundations for the infant's future social and emotional health and wellbeing.

Before the COVID-19 pandemic, the health visiting service in Wandsworth and Richmond was offering Solihull Approach 'Understanding Your Baby' groups for mothers with low mood and/or anxiety. The Solihull Approach is a well-established method of improving emotional wellbeing for the parent and child and is included in the UK Department of Health's Healthy Child Programme. These groups were run by myself, the Specialist Health Visitor for Perinatal Mental Health. Mothers attending had a variety of perinatal mental health difficulties ranging from mild to severe and many were also under the care of the specialist perinatal mental health team. The groups were held in local children's centres and mothers attended with their babies. When lockdown measures were introduced on 23rd March, children's centres closed abruptly and group gatherings were no longer permitted[3]. This meant that the groups had to be cancelled immediately despite the mothers only having been able to attend four out of the eight programmed sessions and there was very little known about how long lockdown measures would need to be enforced.

What did you do?

Immediately, my Trust - Central London Community Healthcare - set about purchasing software to undertake client contacts virtually and to completely change the way the whole health visiting service operated. I was involved in the trialing of this new software and after a three week break - during which I kept in touch with the clients and provided weekly individual telephone support - the three paused groups were able to start up again online. This meant that the clients were able to connect and support one another again which is the main rationale for the group-based support.

Over the next month, the remaining four sessions were then delivered via video conference call. The mothers were then not only able to share their experiences of postnatal depression and anxiety, but also their experience of being a mother of a small baby in lockdown. Consequently, the groups took on an even greater role in that they provided social contact with other mothers when almost all other normal opportunities for this were no longer possible.

Outcomes and Impact

Before clients attend the group they have an individual pre-group contact during which we discuss their current mental health, their relationship with their baby and their family/friends, as well as any mental health history and past and present treatment. During this assessment, the Edinburgh Postnatal Depression Scale, GAD 7 and the Karitane Parenting Confidence Scale are used to get a better idea of what is going on for the client at that time. These assessment tools are then completed again in the final group session, to provide a comparison, along with an evaluation in order to measure outcomes of the group. These scores have always demonstrated an overall improvement in mood and confidence at each group's close. Qualitative data is also obtained from the evaluations and below are some quotes from mothers who attended the most recent virtual groups:

These are another couple of quotes from mothers who have just started the new set of virtual groups:

Lessons Learned and Recommendations:

Since taking the groups online, I have learned many lessons about what worked well and what didn't work well when it came to virtual delivery. For example, when the groups were in the children's centres we would always end the session doing a short relaxation or meditation. When face-face, I would try and entertain or settle babies to help enable the mothers to engage but I wasn't able to do this virtually - very often the mothers had to attend to their babies so it wasn't as effective promoting a relaxing environment through a computer screen. Instead, I have taken to emailing links to the relaxation and encouraging clients to try it on their own.

I also found that it was harder to allow silences and space for mothers to contribute and respond as it was difficult sitting with silence on a video call. Consequently, I found that I had to be a bit more directive in terms of facilitating the discussion.

When the first set of virtual groups ended, I emailed the post-group assessments and evaluations to clients but found that very few were returned. These clients are very busy looking after their babies and so it was much easier to capture this information when they were actually present at the children's centre rather than asking them to complete it in their own time. In order to capture the outcome measures, I therefore had to undertake individual post-group assessments and ask the questions myself over the phone which, whilst a useful exercise, was extremely time-consuming and might inhibit or influence feedback. For future virtual groups, I feel I would have to allow a lot of time for post-group assessments and explore different options.

I have now subsequently started another set of three groups and, for these groups, I am trying to utilise the technology more and intermittently share my screen and use it as I would use a flipchart to pull themes out of the discussion and provide information. Although a lot of the time I try to just have the mothers on screen to foster better relationships, I've found that it can be useful to write onscreen too as a way of focusing discussion and making clear what the learning from that session has been. I plan to try and use it more in this way. I also plan to then send the slides to the clients so that they have a reminder of everything we have covered.

I have also found that I have been able to be more flexible when it comes to accepting referrals for clients with babies of varying ages to the virtual group. Whereas previously it may have been too much of a challenge for mothers with babies only a few weeks old to attend, this is now much easier as they don't have to travel. Similarly, it is sometimes easier for mothers of multiple children to join as they don't need to source childcare.

Overall, the feedback from the virtual groups has been overwhelmingly positive. Although it is likely that most mothers would prefer to meet face-face if they had the choice, at the moment they have all reported that it is really valuable to still be able to connect with other mothers in a way which would not be possible otherwise. In the immediate future it is likely that the groups will remain online and my Trust is currently analysing what new ways of working can be incorporated into the service delivery model moving forward. Although I hope to see the groups return to face-to-face, as I think this can foster better relationships between the mothers and just the opportunity to get out of the house itself can benefit their mental health, I feel very proud of the way as health visitors we have adapted in these challenging circumstances to still provide support to our most vulnerable families.

References

(1) Howard, L. M., Ryan, E. G., Trevillion, K., Anderson, F., Bick, D., Bye, A., Byford, S., O'Conner, S., Sands, P., Demilew, J., Milgrom, J and Pickles, A (2018) Accuracy of the Whooley questions and the Edinburgh Postnatal Depression Scale in identifying depression and other mental disorders in early pregnancy. The British Journal of Psychiatry, 211(1): 50-56

(2) Bauer at al (2014) Centre for Mental Health and London School of Economics: The costs of perinatal mental health problems. https://bit.ly/3iut0wu

(3) NHS England, NHS Improvement (2020) COVID-19 prioritisation within community health services. https://bit.ly/2UlRz5z

Creative Submission 3

Reflection

by Charlotte Crisswell

The health visiting team provided 20 words that summed up the last 3 months of working during the COVID-19 pandemic. These were used to create a word-cloud in the shape of R. R represents the Roundabout Children's Centre (our base) and R rate, presented in rainbow colours. There was a really positive response from the team - it promoted reflection on the positives and negatives of the shifting sands that the past 3 months have presented. The words represent how amazingly flexible they have been, working together to meet the needs of children and families in such a complicated backdrop of a global pandemic.

CONTACT DETAILS:

Name:	Charlotte Crisswell
Job Title:	HCP Team Lead
Address:	Roundabout Children's Centre, Whitehawk Road, Brighton BN2 5FL
Email Address:	charlotte.crisswell@nhs.net

Region: South East

CASE STUDY 3

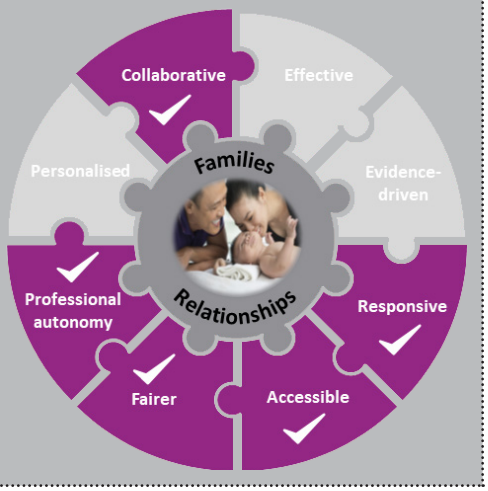
Responding to the challenge of the COVID-19 pandemic and delivering a rapid and responsive health visiting service in City and Hackney during the period of lockdown

CONTACT DETAILS:

Name:	Elizabeth Begley
Job Title:	Senior Nurse Health Visiting and Early Years
Address:	Children & Families Diagnostics and Outpatients, St Leonards, A Block, 2nd Floor, Nuttall Street London N1 5LZ
Email Address:	e.begley@nhs.net

Region: London

This case study example demonstrates the following "Key elements" of the iHV "Health Visiting in England: A Vision for the Future":



Authors:

Elizabeth Begley, Paula Carr, Christeen Bartlett, Jo Eley

"We are Homerton Health Visiting Service for Hackney and the City of London"

Photo credits: Kurt Geiger 2020

Background:

At the start of February 2020, Homerton began initial discussions about the pending spread of the Coronavirus. As the weeks went by, it became more apparent that the situation was rapidly evolving and the virus posed a risk to all those in the UK. Health services were being asked by the Government and PHE to prepare for the COVID-19 pandemic.

The pace of change and the unpredictability of the pandemic required the service to 'think on its feet'. At the beginning of March, the health visiting service rapidly needed to think about the safety both of the staff and of our local families. We were conscious that, working in an inner London borough, our staff were travelling into work and making visits using public transport, and visiting homes where the health status of families was uncertain. Many of our families had relatives that continued to arrive in the UK from abroad. We were also concerned how we could continue to meet the health needs of our most vulnerable families. This also came at a time when we were asked to identify staff for redeployment and possibly ourselves as leaders of the HV service. We were very aware we needed to show a cohesive leadership response which was both clear and compassionate[1] for our staff, alongside the responsibility we held to children and families impacted by the pandemic. We anticipated that the health needs of the families would escalate and generate issues particularly in relation to domestic abuse and perinatal mental ill health, as well as a reduction in services from all partnership agencies working with children and families with additional health and social care needs[2].

What did you do?

From the start of the lockdown, the health visiting challenge was to safely step down the current face-to-face (F2F) led service and to start to provide a responsive service to those most in need. As we entered the two weeks before lockdown, we identified the areas of the Healthy Child Programme[3] that we believed needed to continue, whilst being very aware that we had a reduced workforce due to redeployment, staff shielding, and the staff who were now working from home. The leadership team took a number of measures to redesign the service in response to government direction, PHE requirements[4,5] and local Trust directives. The development of a rapid response team began and was managed by two operational health visitor leads. A system was developed to centralise the service. This enabled us to: monitor and triage all communications; manage referrals into the service; coordinate universal services; support ongoing safeguarding meetings and conferences; and provide F2F for families needing rapid support. As health visitors we were mindful that A&E attendances for children had reduced, GP practices were closed, midwifery services had reduced their offer and anxiety, particularly in new parents, was high.

Action:

The health visiting service developed a Rapid Response Team (RRT) which consisted of a core number of health visitors, some with specialist roles, and team administrators rostered to be on duty at a central site. Oversight and leadership was provided by the operational managers and two senior health visitors managed allocations of universal services to staff working from home or shielding. We took a three strategy approach:

1 - Internal: Strategy Workforce

- Review our workforce to identify those at risk/ those who were displaying symptoms – managing COVID-19-related absence
- Identify core staff to work within RRT
- Managing redeployment – this was based on the available pool of staff who could be redeployed; there were many difficult conversations as staff felt passionate about the need to provide a HV service as well as going into clinical areas which were often unfamiliar[6]. Additional skills training was provided to those going to the acute sector including ITU. The service proactively managed some of the redeployment to best fit staff's clinical background and skills set.
- Staff access to work – consider travel arrangement – the Local Authority allowed staff to park free
- Reduced staff footfall – pods of teams on rota to be on site
- Support for staff – daily dial in, safeguarding supervision, management supervision, reflective supervision, webinar e.g. BAME, Staff wellbeing; support for staff e.g. Talking Therapies
- Training for staff – upskill – use of virtual platforms; how to have conversations on the phone related to domestic violence and abuse (DVA)
- Review management and support for SCPHN students; creating different learning opportunities in the RRT[7]
- PPE equipment access and availability to staff, including safe disposal (waste management)

2 - Internal: Service Provision - How and what we provided

- Reviewed the health visitor offer for the Health Child Programme[8]. Part of this was to provide assurance of the baseline of universal provision as well as continuing the work with vulnerable families and those requiring clinical follow up services
- Identify base to house RRT and to support access for families to face-to-face health visiting input – consider travel, locations and access to other buildings e.g. electronic doors, ground floor, car park, bus routes – limited options with other site users having more influence and ownership for prioritised use
- Risk assess the service - monthly, with weekly updates outlining concerns to the major incident centre
- Move to corporate way of working
- Looking at the data to identify possible numbers of face-to-face contact
- Ensure capacity within the RRT
- Review the delivery of HCP – ensure priority families based on health needs assessment and/or referrals from other services such as midwifery, Children's Social Care[9]
- Central list for those children on Child Protection Plan/ Child in Need/ Looked After Children / Unborn – audit these – came post lockdown
- Update Homerton HV website
- Development of specialist caseloads – mental health, DVA, SEND, non-accidental injuries/ increase in head injuries (Serious Case Reviews)
- Reviewing of iHV COVID/PHE updates to help inform practice

3 - External: Partnerships - How we worked with other agencies

- Interface with key partners e.g. Early Years, Social Care and GPs
- Communication and regular weekly discuss as part of the Children and Young People's network
- Work with midwifery to review the process to both streamline – opportunity for health visiting
- Management of newborn blood spot screening/ jaundice pathway/ infant feeding support
- Communicate our plans with service and key partners
- Weekly senior health visitor meeting to monitor, discuss and review any emerging issues
- Increase MARAC – how the service has expanded their role knowing that DVA would be dominating issues families faced
- Extra resources in fast team to support interface
- Regular discussions with Nicky Brown, PHE, Maggie Fisher iHV and NE London-wide network sharing ideas
- Stepping down the service had an impact on the delivery of some of the KPIs. Ongoing discussion with the commissioners, weekly conversations to keep them abreast of the challenges and the new ways of working has been invaluable in the support of the service.

Immediate outcomes and impact

The remodelling of the health visiting service has resulted in a number of different outcomes; many of them remain in progress as this new way of working develops. Throughout the pandemic we have been able to carry out the following:

✓	Work to support our KPI targets for key targets; weekly supportive conversation with commissioners discussing challenges and new ways of working
✓	Provide immediate access with a central point of telephone contact and email to families and partners
✓	Provide up to date relevant COVID-19 information on our HV website
✓	Provide access for a face-to-face contact with a health visitor or breastfeeding lead following any universal contact made over the phone, based on clinical need.
✓	Provide face-to-face contact within 24 hours following referrals from partnership agencies based on clinical need and vulnerability.
✓	Direct referrals from midwives into the rapid response team for allocation and follow up regarding infant feeding or weight concerns due to a redesign in their services of not providing a 10-day face-to-face contact.
✓	Prioritisation of safeguarding services to families. Attendance at virtual Children's Social Care meetings, reinforcing the essential role of the health visitor to support families during lockdown.
✓	Delivery of care, using virtual platforms to support contact with: patients, team meetings and training.
✓	Audit of all the families under Children Social Care, on CIN and CP Plans ensuring all families had received support and plans and meetings continued
✓	Audit of all the 165 families with children with additional needs ensuring all families had received support
✓	Audit of all the 150 families under the care of the perinatal team and mental health services ensuring all families had received support. Attendance by the specialist HV at the virtual daily team meeting led by the Consultant in the perinatal mental health service sharing relevant information and triaging mothers and infants requiring a home contact.

Lessons learnt, challenges, longer term possibilities and highlights:

- Our key lesson was not to under estimate the anxiety and uncertainty amongst the staff for them as professionals and for them in their own family units.
- Act fast and in a responsive manner; the Government directive on social distancing the service had to safely step down the full commissioned service to meet the requirements of core deliverables of the HCP.
- Use established and new processes within your organisation to support both structural changes and staffing resources; ongoing risk assessments were completed against the delivery of the business continuity plan
- Conversations around redeployment were some of the hardest; balancing the needs of families as well as the needs of those who were directly impacted by COVID-19 within the hospital. The service redeployed 11 staff and this was mainly based on where their skill base was. Some enjoyed their experience and felt well supported in the areas they went to, whilst others found it more difficult as it reminded them of why they had come to health visiting.
- Opportunity to deliver the service differently; remodelling the service and the development of the rapid response team aligned well with homeworking. Health visitors at home had less travelling which was a bonus in a large city, they suggested that they missed the opportunity for peer supervision that working in an office provided. We also found that, at a time when many communications with partner agencies were through email or planned virtual meetings, a central number and an experienced health visitor at the end to the phone enabled that personal contact and the opportunity for case discussion had significant added value.
- Specialist roles were really able to evidence their added value to the clinical delivery of the service. Ability to identify caseloads and begin to gather an overview of level of need. Their expert advice, supervision and partnerships with other agencies were key to enabling the service and met the needs of our most vulnerable families. This model has the potential to be developed further within the ongoing development of the team. In particular, in relation to domestic abuse and drug and alcohol misuse specialist roles.

- Creating a learning environment: an opportunity created by the RRT, welcomed by the SCPHN students where they were able to witness a rapidly changing service keeping the child as the focus. Students divided their time between the RRT and working from home and study.
- For all staff in the RRT, there was always someone to ask questions, review records, debrief and reflect with and on the complexity of some of the cases arriving in the RRT. This learning was extended to those staff working from home.
- Staff wellbeing and keeping in contact: there was a lot of support for staff wellbeing from within the Homerton and within the service. Important to keep the dialogue open with staff and to explore ways to support the resilience in the workforce.
- **Challenges**: For many staff, homeworking has been a challenge; having somewhere safe to work from, connectivity issues, own children being around, caring responsibilities and for some faced with their own vulnerabilities due to their health needs or partners being furloughed. Access to management supervision, safeguarding supervision and reflective supervision, as well as team meetings, has been crucial to maintain staff wellbeing through the pandemic.
- **Longer term possibilities**: Work has started on the recovery plan. The concept of the RRT will remain whilst staff start to return back in 'bubbles' to their respective teams and conversations continue with partners, senior management and commissioners about the current gaps and ways to address the emerging themes from the impact of lockdown.

Increased insight into new possibilities related to the use of virtual platforms as realised through live virtual webinars on domestic violence and Listening Support Contacts, advancing staff skills in safe assessments and providing support using virtual platforms.

Feedback:

Feedback from parents: '*the response time was great to being seen by the health visitor in the RRT*'

MASH Health team and Children's Social Care: '*This is much better for us we can speak with someone straight away and clarify the information we need.*'

Feedback from RRT staff: '*Our huddle in the morning is great. My colleagues run-through who we need to visit that day – last thing I do is reflect on my day, share my thoughts with my colleagues or talk about a particular family to offload.*'

Feedback from redeployed HV: Highlighting the importance of the health visitors' role in baby observation and hearing the "voice" of the child - '*I realised how sensitive to babies I had become being in SCBU, hearing them cry was so much more difficult. I was worried about their little brain pathways and I realised our need to actually be there in person in people's homes and how important our community HV service is.*'

Conclusion:

Together we will learn from it and continue to promote the importance of our most valuable asset, the health visitor, by strengthening the role in a changing public health environment and supporting vulnerable children.

References:

(1) Gilbert, P. (2010). The Compassionate Mind: a new approach to life's challenges. London: Constable.

(2) https://www.gov.uk/government/publications/working-together-to-safeguard-children--2

(3) Royal College of Paediatrics and Child Health, RCPCH (2019) In Emond, A. (Eds) Health for all Children 5th Edition Oxford University Press

(4) https://www.gov.uk/government/collections/wuhan-novel-coronavirus

(5) https://www.england.nhs.uk/coronavirus/

(6) Pettit, A. Stephen, R. Nettleton, R. 2015. Developing Resilience in the Workforce: A Health Visiting Framework Guide for Employers, Managers and Team Leaders. London: Institute of Health Visiting, Health Education England and the Department of Health

(7) HEE London Region and HEI Principles for managing SCPHN and SPQDN course during COVID-19 April 2020

(8) https://www.gov.uk/government/publications/healthy-child-programme-pregnancy-and-the-first-5-years-of-life

(9) NHS England and NHS Improvement (London Region) Monthly COVID 19 Safeguarding Bulletin July 2020

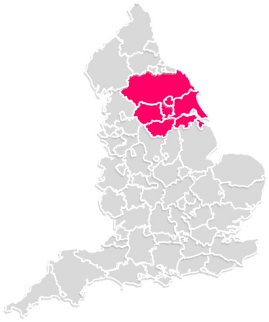
CASE STUDY 4

Provision of a Health Visiting service when Home visiting is not an option. Use of video calling during a global pandemic.

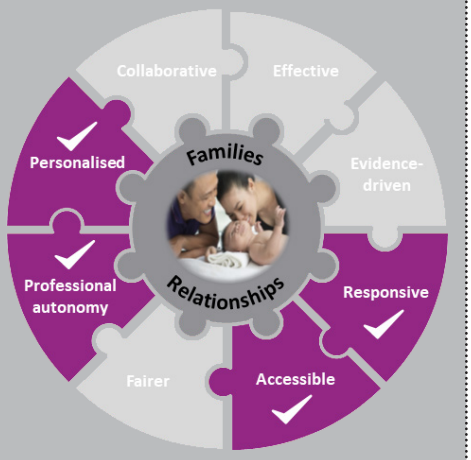
CONTACT DETAILS:

Name:	Alison Binns
Job Title:	Specialist Community Public Health Practice Development Nurse
Address:	North East Lincolnshire Council
Email Address:	Alison.Binns@nelincs.gov.uk

Region: Yorkshire & Humber



This case study example demonstrates the following "Key elements" of the iHV "Health Visiting in England: A Vision for the Future":



Background:

When home visits were unable to be completed, the health visiting service began to use video calls for consultations with families with the aim of supporting the building of parent/professional relationships and increasing validity and reliability of assessment decisions.

What was the aim?

Social distancing measures introduced by the UK Government presented a significant challenge to provision of the health visiting service locally. Staff were required to work from home following the closure of offices, children's centres and drop-in clinics. Contact with service users traditionally occurred either face-to-face, or on the telephone, with very little use made of social media and virtual methods.

NHS guidance recommended a reduction in the provision of HCP contacts (NHS 2020 A), however this significant change to practice occurred at a particularly stressful time for many families. Concerns were identified that the lack of home visits, alongside reduced face-to-face contact with families, would negatively affect them in mutiple ways. There could be difficulty in health visitors' formation of positive relationships with families, identified as key to effective practice and important to parents (iHV, 2020). Problems were also identified in the assessment of parental attachment and interaction with infants and children, perinatal mental health issues, family relationships, social situations, home conditions and parental self-efficacy, to name a few.

What did you do?

Routine home visits ceased, unless there was an exceptional reason, and video consultation calls were initiated. These could be used for any contact but were, in the main, felt to be beneficial for the initial contact as a minimum, generally the antenatal or new birth visit. Videocalls were able to provide practitioners with more information to base their assessment on, as faces could be seen and situations in the home could be glimpsed. This would help with identification of concerns with home conditions, family relationships and perinatal mental health. Parents and practitioners were also afforded the opportunity to visualise each other, putting a face to a name, thereby enhancing the relationship.

Security was a significant concern identified and an appropriate assessment was undertaken by the IT department with the provision of a clear policy prior to commencing. NHS video consultation methods could not be used as our service was delivered through a Local Authority provider, so the IT department had to look towards other platforms for this service.

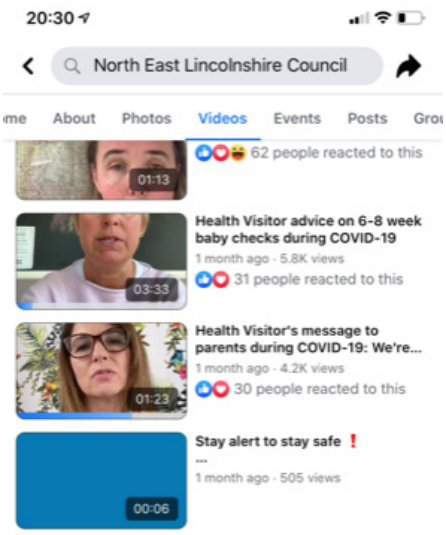
What difference did you make?

Many health visitors have reported the use of videocalls to be beneficial in making assessments that cannot be completed face-to-face as they can enable a deeper level of information in comparison to telephone contacts. Practitioners report a range of benefits:

✓	"Using video calls is positive as you can see your client and infant, and their interactions together"
✓	"Videocall enabled me to see the mother's facial expressions and from this I could identify she was struggling emotionally and was then able to support her with this. In follow up calls I was able to see as she started to feel better"
✓	"Videocall has been useful for 3-way calling when an interpreter has been required, as they enable us to recognise non-verbal cues associated with turn taking which are difficult when faces can't be seen"
✓	"On a videocall, parent showed me the baby who was asleep in the crib. I was able to see parents were not following safe sleep guidance and was then able to discuss this with them. I would not have seen this if I had just made telephone contact"

Through the use of a free app, this has been a zero-cost exercise since all staff already held smart phones with capability for video calling. Staff have made alterations to privacy settings to comply with IT security policy to ensure calls are private and secure.

Key learning points



Occasionally, some parents have appeared reluctant to participate in videocalls. Practitioners found greater success if prior discussion promoted the method of contact as the first choice when home visiting is not an option. Most parents have smiled and interacted well with professionals and appear to enjoy the novelty of seeing the health visitor on screen. Now would appear to be an appropriate time to survey families around the use of this method to gauge the benefits for potential use in the longer term.

Some professionals have struggled to engage with this practice, largely because it is new to them. Whilst not all have been persuaded to use it, those that have find it beneficial. One practitioner reported:

> *"I felt uncomfortable using video calls at first but pushed myself through my comfort zone and now feel very confident using them. I find it very easy asking parents to show me the new baby or the sleep environment via this now."*

Decisions around use of this method were made quickly and perhaps it is time to give further consideration to the support available to staff who are not using this method - because they are uncomfortable and it is alien to them. There is a risk of service inequality for families if all members of staff are not following the same practices - and this will be an appropriate time to survey staff to identify barriers to ensure that support is provided.

Prior to lockdown, the health visiting service was somewhat lagging in the use of alternative methods of contact and it could be argued this situation has forced more contemporary practice. Following updated PHE guidance (NHS 2020 B), the service is beginning to consider undertaking more home visits, however there appears to be some benefits to the use of videocalls at non face-to-face contacts now and post pandemic. These assumptions require further testing to ensure the safe and effective use of this method of engaging with families. Occasionally, poor connection has caused audio and visual problems and forward planning may require exploration of different platforms and service providers to ensure this is able to be used equitably with all families where indicated.

References

iHV (2020) What do parents want from a health visiting service? https://bit.ly/2PKW0DT

NHS (2020) A COVID-19 prioritisation within community health services: 1 April https://bit.ly/3gPdNFO

NHS (2020) B COVID-19 Restoration of Community Health Services – key changes from prioritisation guidance published on 1/4/2020 https://bit.ly/3auOTJv

What about the socially vulnerable?

by Eve McElveen

Background:

I am a health visitor working in a deprived, inner city area in the North of England. Four months ago we were advised that we would need to start offering the health visiting service virtually wherever possible due to the COVID-19 pandemic.

After spending the first week feeling quite useless at times, I spoke to a lady on my caseload who changed my perspective completely. I realised what now sounds quite obvious – we are public health nurses working in the biggest public health crisis any of us have ever known. We owe it to the families on our caseload to support them as best as we can.

The government quickly announced some much needed support for the medically vulnerable. They were to get priority for online supermarket shopping and help with essential supplies. After speaking to this lady, I started to wonder what about the socially vulnerable? How could they be supported too? This is her story.

Client story:

I first met Aisha (name changed to maintain confidentiality) a few weeks before lockdown following the birth of her second child. I learnt that she and her young son had moved to the area just a few weeks earlier due to fleeing a violent relationship. She was supported to move by a domestic abuse agency and, at around the time I first met her, they closed their case as she was safe and successfully living independently with the support of her friend.

I called Aisha in the first week of lockdown to ask how she was and to see if she needed any support from our service.

Aisha is a quiet and determined lady. She told me she was fine but I felt from the tone of her voice that she wasn't being completely honest. I arranged to call her again a week later and this time she was more open.

She was running out of food and her friend was now shielding so unable to help with shopping. Aisha was frightened to take the children out – partly in case her husband found out where she was living and partly in case her children were exposed to the virus.

Aisha told me that she has a painful medical condition that had deteriorated since the birth of her second child. She was upset to find out that her treatment was being delayed due to COVID-19 restrictions.

Together, over the last few months, we have worked out a plan to manage these challenges.

I referred Aisha to a local charitable organisation who provide food parcels and also offer some emotional support over the phone. Prior to leaving her husband, Aisha was completely dependent on his family. I worried that, without this support, there was a risk Aisha would feel she had no choice but to return to an abusive relationship. Our aim was for her to continue to be safe by putting strategies in place to enable her to live independently.

We spoke with her GP who has liaised with her consultant about managing her medical condition until she can be seen in hospital. Her GP has been very supportive.

I call Aisha every two weeks and I feel that she now trusts me enough to ask for help. On one occasion she told me that she would love to make chapatis for her son but the food parcels do not come with flour or oil. Although these items may not seem essential, I have got to know her enough to realise she would not ask for something that wasn't important to her. She wanted a sense of normality and to do something nice for her son. I was able to request these items for her and felt it would be beneficial for her mental wellbeing.

Aisha and I have spent time discussing the impact that her physical health is having on her mentally. Unfortunately, we cannot resolve her physical health issues but we have discussed managing her feelings around this. We have focused on the relationship between her own wellbeing and the mental health of her children.

When offering our service virtually, it is more difficult to observe and assess parent / infant attachment and we have had to adapt this in the absence of a face-to-face contact. I have encouraged parents to tell me what they enjoy about their baby and what they are finding difficult. This has been useful for exploring their relationship. Our assessment skills have had to quickly develop due to these changes. It has been an unexpected positive benefit to note that some parents have found it easier to open up about their mental health over the phone. This maybe something to consider further moving forward.

We have discussed the challenges of parenting two young children alone and how difficult this can be at times.

Parenting can be hard at any time but the additional pressures due to the pandemic can increase these difficulties. I have noticed with a lot of families that encouraging people to talk about these challenges can be helpful. Their concerns are common but when people can no longer chat with other parents on the school run, or their local toddler group is closed, they often think they are the only people feeling this way.

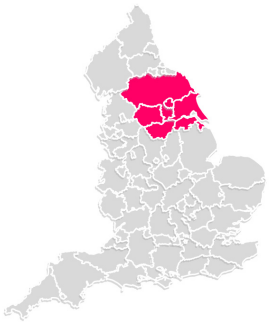
When lockdown restrictions are lifted, I am aware that Aisha will still be vulnerable and isolated in the local community. We plan to focus on reducing isolation and trying to develop some peer support in the local area when it is safe to do so.

© Charlotte Foley - used with permission

CONTACT DETAILS:

Name:	Eve McElveen
Job Title:	Health Visitor
Address:	Bradford East Health Visiting Team, c/o Clinical Admin Services, New Mill, Victoria Road, Saltaire Shipley, BD18 3LD
Email Address:	Eve.mcelveen@bdct.nhs.uk

Region: Yorkshire & Humber

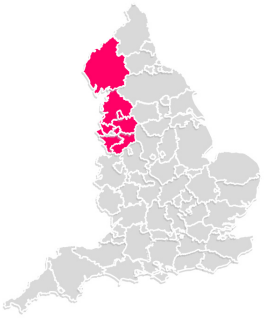


CASE STUDY 5 Specialist Case Planning within Health Visiting during COVID-19 lockdown

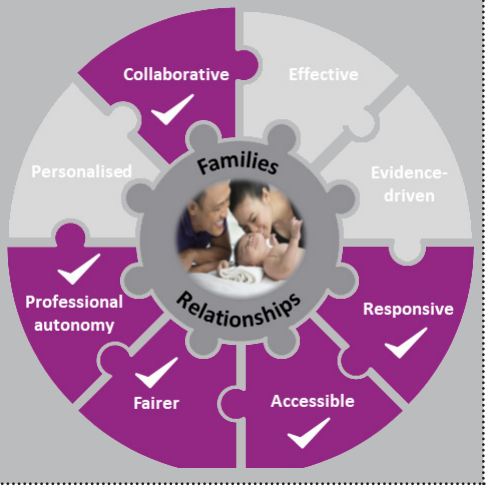
CONTACT DETAILS:

Name:	Kathryn Anderson
Job Title:	Specialist Case Planning Lead (Health Visiting)
Address:	Rusholme Health Centre. Walmer Street. Manchester. M145NB
Email Address:	kathryn.anderson@mft.nhs.uk

Region: North West



This case study example demonstrates the following "Key elements" of the iHV "Health Visiting in England: A Vision for the Future":



Context

In March 2020, England went into lockdown due to the COVID-19 pandemic. Schools and nurseries closed meaning that children were at home continuously; access to health and other support was severely limited. Marmot (2020) highlighted the growing health gap between wealthy and poor areas; Manchester already had some worrying health statistics (MSCB 2019) and the effects of lockdown could have long-term consequences for our families.

The Early Help Specialist Case Planning Model aims to keep children safe and reduce the risks of harm by impairment of health or development as defined by the Children's Act 1989 and 2004. Early Help Specialist Case Planning organises and facilitates multi-agency meetings with the family which inform a detailed Case Plan that is reviewed within a timeframe.

Within this framework, the focus is to target issues before they are embedded, in order to prevent greater or longer term neglect to the child/ren while supporting the family to meet their needs. A holistic approach is taken which considers the health and wellbeing of all those living within the family home including older siblings.

Early Help Specialist Case Planning is a partner agency of the Manchester City Council Early Help Hubs ensuring that the families of Manchester are offered the most appropriate and timely service in line with the Early Help Strategy (2015).

We faced the challenge of devising a way to case plan without having face-to-face meetings.

Solution

There was minimal redeployment among health visitors in Manchester due to high levels of deprivation (MSCB 2019) within our population, so our team remained intact. We had to quickly find a way to continue to communicate with our families and identify their current problems. The first step was to make maximum use of electronic communication.

Manchester already used electronic records, shared by community children's health services. Access to GP electronic records was granted and we had access to some in-patient electronic records for the hospitals within the trust. All health visitors in Manchester have electronic tablets, so electronic communication could take place even when working away from an office base. The tablets also gave us access to video conferencing.

The solution to the COVID-19 situation changed over the period of lockdown. Initially we relied on telephone and email communication with families and professionals, and gradually moved onto some video conferencing. As restrictions relaxed, face-to-face meetings were re-introduced using correct social distancing and PPE if appropriate.

Action

Good communication is identified as paramount in Working Together (HM Government 2018). We devised an email template to send to the professionals normally invited to meetings asking for an update from their services. If clarification was needed, this was followed up by a phone discussion. The case planner then telephoned the parents to discuss the information and to gain their views and any new problems. This information was then collated onto a COVID-19 case plan template. Our existing template, which gave clear actions and timescales, was found to be unsuitable under the circumstance; many actions were unachievable through no fault of the families. Some actions from the previous plan had to be suspended and new actions identified. The template also contained an up-to-date list of professionals, and COVID-19 contact details. A new template was designed for the electronic records so that clear rationale could be documented to outline the support offered during restrictions. The plan was then circulated.

To become competent with using video-conferencing facilities, we practised between ourselves and used it to conduct team meetings before using with clients. Concerns around confidentiality were raised as it is difficult to be clear who is in earshot within a client's home. We also had to consider if the clients had the equipment and data to accept the video call. To try to offer a solution to this, we were able to book time at designated health visitor clinic sessions throughout the city, where the named health visitor could meet the family and using PPE, share her tablet in a secure setting.

As restrictions lifted, we started to plan face-to-face meetings. As social distancing had to be maintained, only one parent and key professional could attend. Other parties were included by video calls or by emailing information.

Outcome and Impact

The pace of change during lockdown has been fast and we have had to remain flexible and keep adapting. The team has rarely been together during lockdown as we have had to adhere to social distancing, self-isolation guidelines etc. At times, this has felt isolating and lacking in support.

Almost all families have remained engaged with the service throughout COVID-19 lockdown. The exceptions to this are one family that required escalation to Children's Social Care and one who refused further support. The updates emailed from professionals were mainly received in a timely manner and contained useful information. The parents made themselves accessible for a phone discussion with the case planner. As the calls were often over 30 minutes duration, and the parents had young children at home, this demonstrated the value they placed on the discussion. Since the beginning of lockdown, we have been able to accept 9 new referrals. For some of these families, we are still waiting to meet them face-to-face.

Some parents seemed to feel more comfortable discussing their concerns by phone, rather than in a face-to-face meeting. For example, one lady disclosed details of domestic abuse that she had minimised when asked in a meeting. In contrast, for others, the lack of face-to-face contact was challenging and made it more difficult to build a trusting relationship.

We worked with families to ensure that their expectations were realistic. All services were severely impacted by lockdown restrictions and this led to frustration that waiting times for services (often already lengthy) were now further extended. This was particularly evident for families experiencing housing problems, who were spending most of their time in their homes and becoming more frustrated with poor conditions.

We have found that it is more difficult to gather information and identify health needs and vulnerability without a face-to-face meeting, both with families and other professionals. The non-verbal element of communication is lost and it is challenging to offer solutions without the breadth of knowledge offered by having a number of professionals in one room. The role of 'chair' became blurred and it is difficult to delegate. The process was more time consuming; we were frequently waiting for a vital piece of information from a professional, which led to delaying the call to the parent.

For most families, new problems emerged over the period of lockdown, and frequently these had to take priority over existing issues. Some of these were related to the practicalities of lockdown, such as accessing volunteers to collect shopping, but they also included exacerbation of issues such as mental health problems and domestic abuse.

Lessons Learned and Recommendations

We have learned that we can respond quickly and work in usual ways in an ever-changing situation. Parents have given positive feedback with one parent saying '*I do not know what would have happened if you weren't there to support over the phone every step of the way*'.

Although we are anxious to return to face-to-face meetings, we have learned that remote methods are useful, they support our efforts to reduce the spread of the virus and have a role to play in the future. We are a city-wide service and often struggle to have all invited professionals present at a meeting. This can be particularly difficult for hospital- based staff who are unable to leave their bases for a meeting. Professionals could join a meeting remotely, thus allowing them to stay within their base and avoid travelling time. Involving both parents in a meeting can often be a challenge whether it be due to relationship breakdown, or work commitments. Engaging fathers is frequently discussed as an area for development (Health and Social Care Committee 2019). Remote access to a meeting may offer a way of including a second parent.

Electronic records had been introduced in Manchester approximately two years before lockdown. These have proved invaluable as they allow a wide range of professionals to access patient information and the ability to communicate between each other. The use of tablets has allowed off-site working. The electronic record template designed specifically for COVID-19 restrictions has proved useful and will be further adapted but remain in use long term.

Electronic information gathering has broadened our knowledge of available services and the support they can offer. It has renewed our awareness of online support offered by charities that can be accessed by people who struggle to leave their homes.

Some families have been able to concentrate on specific issues during lockdown that were difficult to tackle when life was busier. For example, toilet training and sleep management are easier when staying at home.

Non-verbal cues are a large part of communication (NMC 2015) and these are easily missed if meetings are conducted remotely. We may need to re-visit previously discussed issues to ensure that parents' concerns have been fully understood. It is also difficult to tap into the 'team' knowledge without everyone being in one room. Combined with actions simply having to be suspended due to services being unavailable, we have to accept that there will be a great deal of catching up to do as services resume. We need to be honest with our families and set realistic timescales for future actions.

It is important to be confident with using video-conferencing platforms prior to conducting a meeting. Time is a precious commodity and IT problems can create a frustrating delay.

References

Early Help Manchester (2015) Multi-Agency Levels of Need and Response Framework

Manchester Safeguarding Children Board 2018/19 Annual Report (2019) MSCB

Working Together to Safeguard Children A guide to inter-agency working to safeguard and promote the welfare of children (2018) HM government

First 1000 days of life (2019) House of Commons Health and Social Care Committee

The Code Professional standards of practice and behaviour for nurses, midwives and nursing associates (2015) NMC

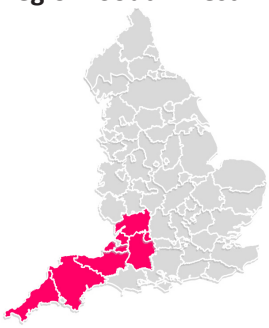
Children Act (1989 and 2004). Available at: http://www.legislation.gov.uk/ukpga/2004/31/contents (accessed 28.06.20)

CASE STUDY 6 Supporting the families of Somerset through COVID-19

CONTACT DETAILS:

Name:	Melody Lane and Lucy Gregory
Job Title:	Assistant Practitioners
Address:	Yeovil PHN Team
Email Address:	mlane@somerset.gov.uk / lgregory@somerset.gov.uk

Region: South West



This case study example demonstrates the following "Key elements" of the iHV "Health Visiting in England: A Vision for the Future":

Background:

March 2020 - a month and year that very few people will forget. The time that that the United Kingdom went into lockdown.

Having worked as part of the health visiting team as assistant practitioners for a combined total of twelve years, we knew it was going to impact our service and service users dramatically: face-to-face contacts were cancelled and put on hold; well baby clinics were instantly closed until further notice; developmental reviews changed to being completed over the telephone; postnatal groups, parenting groups (including those for young parents) and infant feeding support groups all stopped. Health visitors adapted to either completing their contacts via the telephone or at a Children's Centre with PPE.

Everyone working in the team based themselves at home and we instantly hit the ground running with this new way of working. Not only did we need to continue meeting the same health targets, but we knew our families were going to be more isolated than ever before. We needed to do something and work out a way to deliver our service safely, and we needed to act fast. We are fortunate that we work amongst incredible professionals, all of whom are proactive and work endlessly to ensure that we are offering the best possible level of care to the families in our local community.

Solution:

It quickly became apparent that new and first-time parents were isolated and struggling emotionally due to a lack of social contact, and therefore could be more at risk from emotional health issues going forward. We quickly adapted to try and offer a platform for them to meet other parents and ask questions in a safe environment.

Action:

Shortly after adjusting to delivering our service from the safety of our homes (whilst juggling our own children and family life), we decided to embrace something we felt anxious about and take some of our groups online. We were anxious about using the technology which was very new to us. We asked ourselves: Can we adapt our resources to virtual delivery? How will parents interact with each other in the sessions? Will anyone attend our groups? However, we wanted to deliver some sort of service to our families as it was likely that this was a time when they needed support from us the most.

After some adaptation, practice and development, we initially launched our virtual infant feeding group, shortly followed by our postnatal group which is usually delivered face-to-face and based on the review of the evidence within the Healthy Child Programme (PHE, 2015).

We then progressed to running more virtual groups for our local community including a new Emotion Coaching course, which focuses on the emotional connection between parent and child, based on our existing Tuning into Kids Programme (Havighurst and Harley, 1999).

The groups have continued to be run by two nursery nurses (assistant practitioners) with support from health visitors for some of the sessions. We have also invited outside speakers to keep the programmes interesting. Two practitioners are required per session to manage the technology, to let people into the group and support one another if the technology lets us down, which has happened. This also allows us to keep an eye on parents who want to speak.

We have shortened our virtual sessions to keep participants engaged and provided resources for parents to use between sessions. We encourage participation with questions and gentle prompting. We explain how to use the technology in detail via an email in advance, or when we speak to parents in person. Several participants have done a test run with one of us before joining the group. Participants have used both laptops and phones, but the laptop enables participants to see more people in the group.

Outcome and impact:

Our postnatal and infant feeding groups were all attended by mums and our our emotion coaching group was a mixture of mums and grandparents. The groups were as well attended as our face-to-face groups apart from the infant feeding and postnatal groups which have had slightly lower attendance.

Some participants have found benefits to virtual support in the flexibility of accessing groups from their home, and some reported this being less scary than coming to an unknown venue for the first time. Others have declined to attend, preferring to wait for a face-to-face group to restart.

These virtual sessions have filled a need in a time of great anxiety and change but we feel they are not a substitute for our face-to-face sessions which are beneficial to parents in a different way - allowing them to see each other, make connections and share experiences - particularly for those who could not access the virtual groups. We also feel we have more opportunity to support people individually when we are able to meet the groups face-to-face. However, throughout the pandemic, the virtual courses and groups have worked well and can continue for as long as we need them to.

We are proud to have achieved the development of virtual support in such a short space of time. It has enabled parents to receive health promoting advice and social contact with other parents, and without the use of technology this would not have been possible.

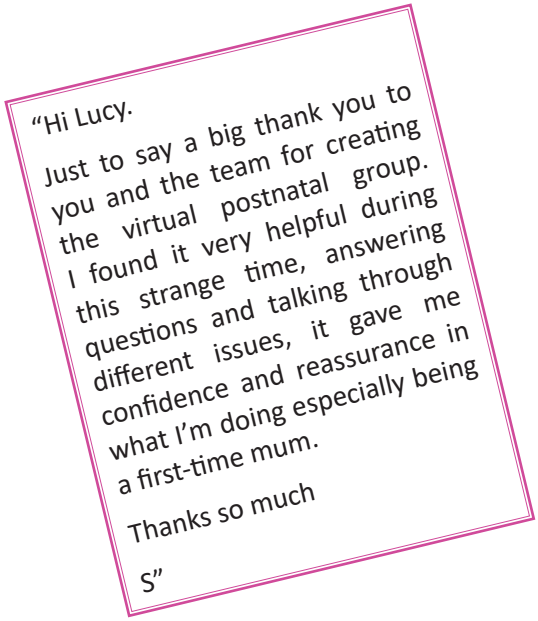
Lessons learned and recommendations:

Learning from our first few sessions enabled us to be better prepared by shortening sessions and providing resources in advance, and we identified a need to include more instructions on how to use the technology for parents. The technology did sometimes cause issues and logging in was a problem for some participants. We had some difficulties with sound quality and people losing connection, but in general the response has been very positive from parents and some of their quotations are included below.

We are continuing to tweak how we deliver support to ensure that it is the best it can be for our clients. We know that, moving forward, we can develop the service and it is going to change for the better, and this is exciting. We plan to evaluate future sessions by asking participants questions and recording the answers as qualitative evidence.

We are continually learning how to help parents and streamline processes to offer parents preferences as to how they receive support.

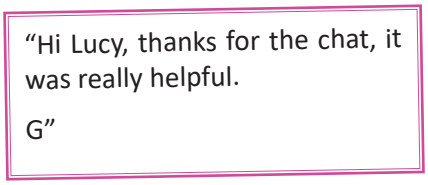
In these early stages of delivery, we have already had some incredibly positive feedback from parents and service users regarding this new virtual service:


"Hi Lucy.

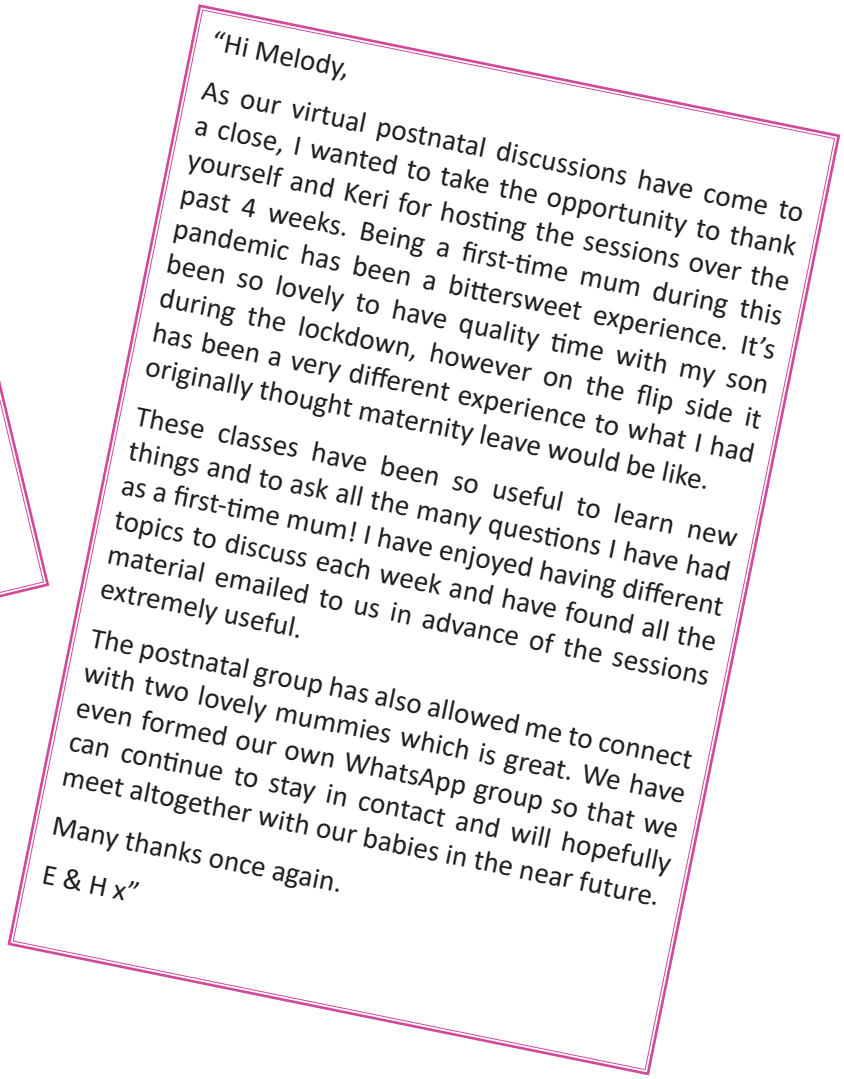
Just to say a big thank you to you and the team for creating the virtual postnatal group. I found it very helpful during this strange time, answering questions and talking through different issues, it gave me confidence and reassurance in what I'm doing especially being a first-time mum.

Thanks so much

S"


"Hi Lucy, thanks for the chat, it was really helpful.

G"


"Hi Melody,

As our virtual postnatal discussions have come to a close, I wanted to take the opportunity to thank yourself and Keri for hosting the sessions over the past 4 weeks. Being a first-time mum during this pandemic has been a bittersweet experience. It's been so lovely to have quality time with my son during the lockdown, however on the flip side it has been a very different experience to what I had originally thought maternity leave would be like.

These classes have been so useful to learn new things and to ask all the many questions I have had as a first-time mum! I have enjoyed having different topics to discuss each week and have found all the material emailed to us in advance of the sessions extremely useful.

The postnatal group has also allowed me to connect with two lovely mummies which is great. We have even formed our own WhatsApp group so that we can continue to stay in contact and will hopefully meet altogether with our babies in the near future.

Many thanks once again.

E & H x"

References:

Tuning into Kids (1999) Havighurst,S. and Harley,A.

Public Health England (2015) Rapid Review to Update Evidence for the Healthy Child Programme 0-5. s.l. : PHE, 2015.

Creative Submission 3

COVID-19: A poem

by Emma Carey

COVID-19

It started with the media
And people weren't sure how to take it
Were we being given frightening facts
Or were the papers trying to fake it?

For a while, our perceptions differed
Some likened it to the flu
They said "*not to worry*" and "*we will all be just fine*"
"*The media just tries to scare you.*"

Others were riddled with anxiety and fear
They placed a mask upon their face
They weaved in and out of our crowded streets
Feeling claustrophobic and grappling for space

Then suddenly, mass panic, mass death in Italy
And united, we all listened then.
England's fate foretold and accepted
We are only two weeks behind them

Our nation became mostly united
As, at quite an alarming pace, schools and work places were closing
And shop shutters were shutting
Our world now a quaint, noiseless space

I'm classed as a Key Worker
Yet I am safe and working from home
Health Visiting is now Health Phoning
And I sit on my laptop, alone

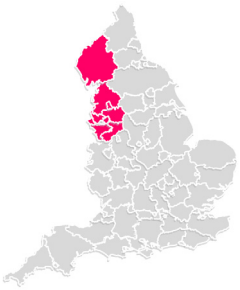
And although I know my own children are safe
As a registered nurse, I feel torn
I feel that I should be back out there
To care for the sick, the scared and forlorn

All this while trying to maintain
Some hope, when we can feel so hopeless and worn
That we'll get through this united and stronger,
And enjoy those rainbows after this storm.

CONTACT DETAILS:

Name:	Emma Carey
Job Title:	Health Visitor
Address:	HMR Children's Community Services Brook House, Middleton, M24 1AY
Email Address:	emma.carey11@nhs.net

Region: North West

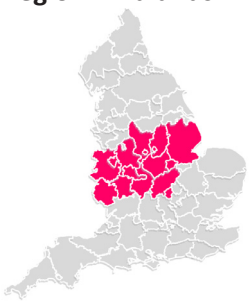


CASE STUDY 7 Stronger together: Specialist Health Visitors Parent and Infant Mental Health

CONTACT DETAILS:

Names:	Nadine Anderson, Claire Townsend and Eileen O'Sullivan
Job TItle:	Specialist Health Visitors Parent and Infant Mental Health
Address:	South Warwickshire NHS Foundation Trust
Email Address:	Nadine.Anderson@swft.nhs.uk

Region: Midlands



This case study example demonstrates the following "Key elements" of the iHV "Health Visiting in England: A Vision for the Future":

What was the problem/ issue the family or service was facing?

Myself, Nadine Anderson, together with Claire Townsend and Eileen O'Sullivan are three specialist health visitors covering a large demographic in Warwickshire and Coventry. We were three months into our new specialist HV Parent and Infant Mental health role (which didn't previously exist) when lockdown began, so we were very much just forging links within the Perinatal and Infant Mental Health (PIMH) network and establishing what this role might look like.

We have been working hard throughout the pandemic and we have very quickly had to adapt our support for parents. As part of the wider health visiting team, we are finding our new norm and we have had to learn and adapt to new ways of working as well as supporting our colleagues through the process.

What did you do about it?

We created a resource pack with links and ideas for parents who were struggling with their mental health, home schooling and local information, collating it all in one place which we have been sending to all parents electronically.

We held lunch time support groups for staff – this was over MS Teams so staff could come to us seeking new ideas of working with families, guidance with new platforms such as Zoom or to sound off ideas.

We have teamed up with local peer support organisations Parents in Mind and By Your Side and have been attending virtual support groups via Zoom where we are able to answer general health visiting questions and offer reassurance to parents. Mothers who appear to need a little more support are contacted privately outside of the group. The feeling is that parents like to see a friendly face.

During Maternal Mental Health awareness week, we were working really hard to raise awareness:

- The week began with a virtual walk which was turned into a beautiful video: https://youtu.be/cqvQ9t6Xfqc. Eileen attended a relaxation session for parents, hosted again by 'By Your Side'.
- We were raising awareness on social media in a variety of ways with the message that parents should seek support from health visitors and that **we are here to help**: https://youtu.be/hlseRplJdnw. We helped to create a newsletter for professionals and sent a 'thought for the day' to the health visiting team for which we have received fabulous feedback and an increased awareness in maternal mental health whilst adapting to new ways of working.
- Eileen found fame when she was published in the Huffington post and what a fabulous article she wrote!https://www.huffingtonpost.co.uk/entry/invisible-children-coronavirus-lockdown-health-visitor_uk_5eac0d27c5b6995f13ffa2d8?x7k She also attended a roundtable discussion with the NSPCC about the role

of Specialist health visitors and how services have adapted to support parents during this difficult time. https://twitter.com/NSPCC/status/1258035638806491137

- I took part in a 'Ask your Health Visitor' session led by Institute of Health Visiting with other Specialist health visitors nationally https://twitter.com/melita_walker/status/1259474836985970688
- We were also very active throughout Infant Mental Health Awareness week and we used lots of the resources shared by the Parent Infant Foundation, the theme being 'The world through babies' eyes.' We created a video about serve and return. https://twitter.com/i/status/1270997020053045249

We have continued throughout the pandemic to offer Video Interaction Guidance (VIG) in a virtual way which is so powerful for families at a time when relationships with their child may be strained. This offers reflective functioning which enables parents to really seek to understand their child better by meeting them in their child's world. Perhaps because we are familiar with video recording with parents for VIG and seeing ourselves on screen, we have been fairly confident about holding video calls with parents, if of course that is what they want. We have also completed our training on schedule and are now fully-fledged VIG practitioners.

We are urging parents to contact us by telephone or via our established text service, which as you might imagine, is busy but it is fabulous to see parents reaching out. All of the updates to service delivery and resources and information to parents have been published on our Facebook pages.

What difference did it make?

Here is some feedback from VIG.

> *"Not sure how to put into words how much this process has helped me. I've always known I'm a good parent and I do the best for my children. But this process allowed me to see it from a third person view. To begin with, I thought it was a bit pointless and didn't see the benefit. By the second session, VIG really resonated with me and I had the "light bulb moment" - it was about letting the child lead the play and you going into their world without forcing play or interaction. I realised that in these sessions with Nadine, I had been really understanding William's interests and taking the time to really sit and let him lead and enjoy our play. Doing this was changing the way we interacted and I didn't even realise I had been doing it. Watching the videos back was always very emotional as seeing William from another angle was heart warming. Seeing how he looked at me and waited for my interaction with him and he looked so happy and involved. This process has massively helped me to realise that what I do is enough and, if I give William choices and the lead, we can really connect well. Nadine was always a great listener and always had something positive to say. Thank you Nadine"*

I suppose the difference we are making is indeed anecdotal but I, for certain, feel that we are making a difference to parents and the feedback we receive from them, and from our colleagues supports this. The support is welcomed in whatever way we can manage. We all just want to be heard. Reading this all back fills my heart as it highlights the many ways that we, as a team, have worked tirelessly to deliver at a time of pandemic to help to ease things, even if only a little for our families. And as I write this, I feel like my upcoming week of annual leave is well overdue!

Becoming a parent in lockdown

by Kate Allan and Hilda Beauchamp

The story

Noah (name changed to maintain confidentiality) was born the night before the UK went into lockdown due to COVID-19. His parents emerged from hospital into a world that was new, not only to Noah, but to themselves. Suddenly the challenge was not just about recovering from a long and traumatic birth experience, or about learning how to breastfeed effectively, or about navigating the transition to parenthood, nor even about ensuring that Noah's mother's previous history of depression did not impact on her relationship with him. Each of these issues alone, identified in the 15 high impact areas of the recent document 'Health Visiting in England: a vision for the future' (2019), would have warranted early intervention by a health visitor to ensure the best outcomes for the family.

Suddenly, now the challenge was how to do all that in the new COVID World, where: support from family and friends was no longer easily accessible; local community provision of stay and play groups, baby sensory classes and pram walks was suddenly removed; and where previous easy access to health advice and support was now complicated by the uncertainty of service provision, technology and PPE. Parental leave was no longer marked by the traditional 'rites of passage': presenting Noah to his grandparents; returning from the Registry Office with the paperwork that suddenly made Noah 'real'; the first tentative attendance at baby clinic; the uncertainty of where to put his 'red book'. Mum reflected on her 'disembodied experience' of becoming a parent and how alone they felt.

The plan

The health visitor (HV) was responsible for delivering the essential service including universal contacts, ensuring continuity of practitioner and regular re-assessment of need. Contacts were guided by the Solihull principles of reciprocity and containment, assessment of parent-infant relationship, using observation and reflection to understand the perspective of mum and baby. A strengths-based and salutogenic approach was used to identify needs, establish goals and develop a plan of support via telephone contacts. Video consultation was not yet available to offer to families as this was in the first weeks of the pandemic in the UK.

Due to the problems the mother reported with feeding, the health visitor offered a face-to-face appointment at the essential weight clinic at three weeks old. Baby Noah had not been weighed since the midwife's visit on day 5 due to the significantly limited face-to-face visits from health professionals. Alongside the weight review, referral was made to the infant feeding advisor (IFA) for additional support with feeding. The IFA is trained to UNICEF Baby Friendly standards, supported and supervised by Specialist Lead (HV) for infant feeding, and offers 1:1 support for breastfeeding via telephone and video consultation. Individual breastfeeding support over the phone and in person has good evidence for improving the duration of breastfeeding.

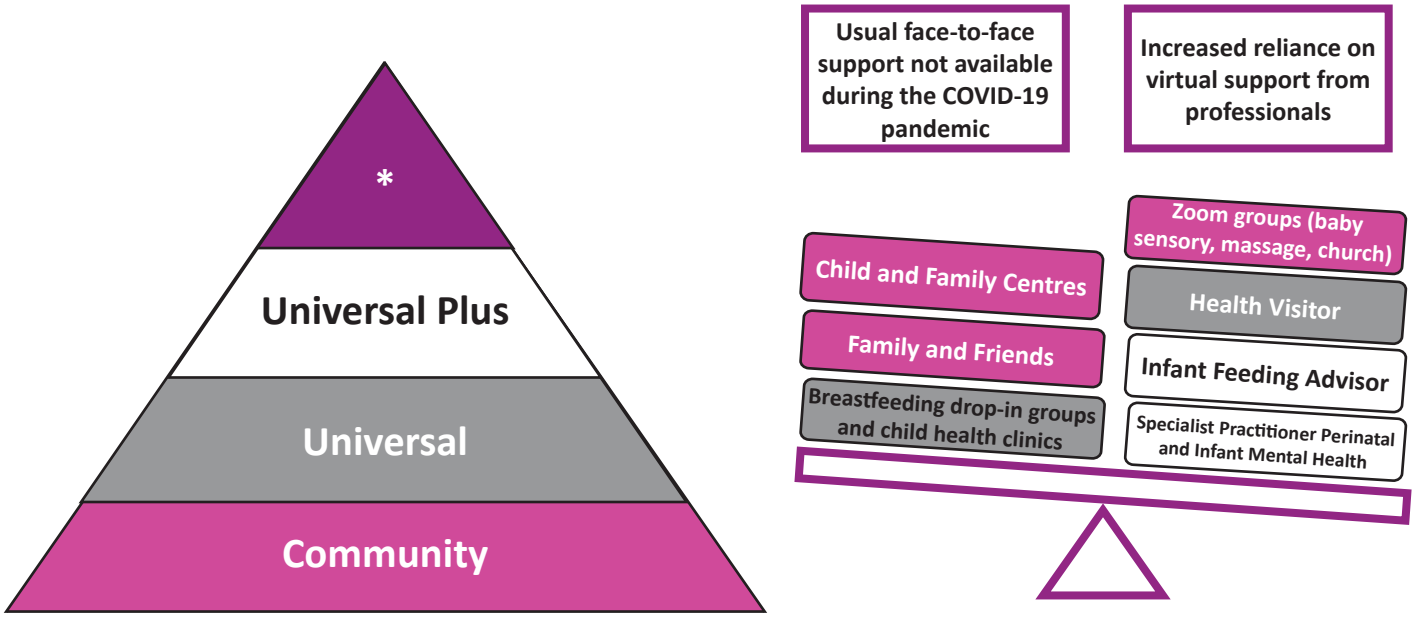
The health visitor specialist for perinatal and infant mental health provided consultation and supervision for the health visitor. Following this supervision, it was agreed to offer the family a referral to an evidence-based intervention to support maternal sensitivity and attunement, a role advocated by Health Education England . The HV specialist was able to provide this intervention via Attend Anywhere video consultation.

The family had an existing community network and were able to attend an online 'Baby Steps' Zoom group hosted by their local church. They also enrolled on online baby sensory and massage classes. These online experiences will have likely consolidated the intervention provided by the specialist health visitor.

The care delivered demonstrated an effective skill-mix model of service delivery aligned with evidence-based recommendations in Health for All Children – fifth edition (2019). Universal and targeted interventions were delivered by the team. This episode of care was contained within the health visiting service, alongside community support and universal GP services such as the 6-8 week postnatal health check.

Diagram 1: Model of service delivery

*Universal Partnership Plus (not utilised in this episode of care)



The difference: (parent quotations and practitioner observations before and after the health visiting intervention)

Painful, difficult feeds, unsettled baby.

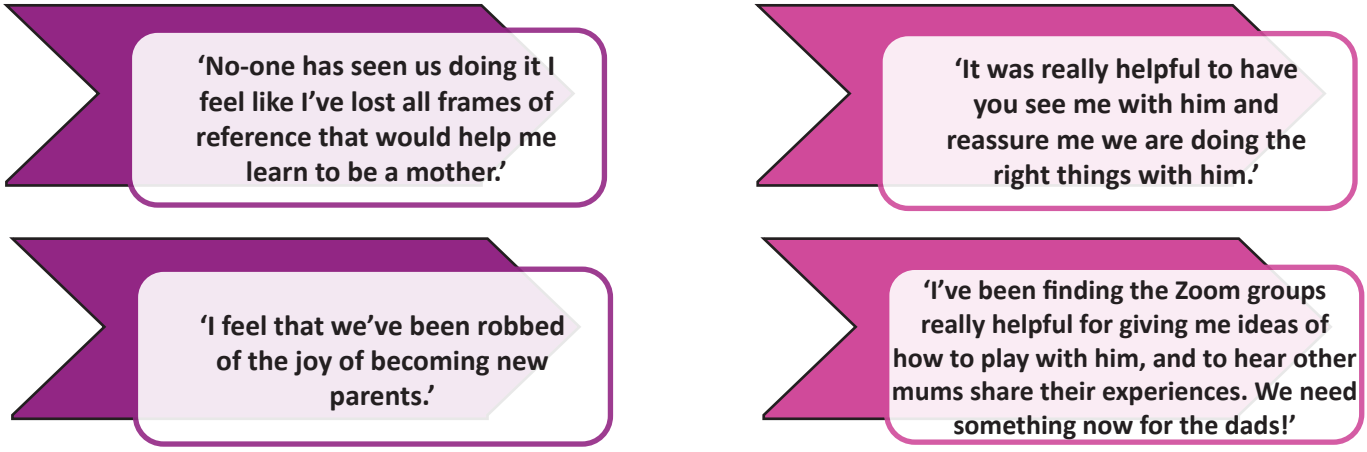
Breastfeeding exclusively, comfortably and confidently at 12 weeks, content baby, gaining weight well.

'I find it difficult to look at him, it makes me sad. He doesn't really love me. I haven't got anything to offer that he'd want.'

'I love when he smiles at me. I feel I know what his different cries mean and what he needs me to do. He really enjoys when I play 'peekaboo' with my silk scarf.'

Feeling overwhelmed, not being able to make decisions, uncertainty about where to seek help.

Feeling contained, improved confidence in basic care of baby, increased health literacy and ability to manage minor illnesses, healthy couple relationship supported.



The alternative

Without the support to establish and sustain breastfeeding, Noah could have been at risk of increased incidence of ear, chest and gut infections, and added to the cost burden of the NHS due to increased GP consultations and hospital admissions .

There is a significant body of evidence that demonstrates the importance of sensitive, attuned parenting on the development of the baby's brain and in promoting secure attachment and the foundations for early language. Failing to intervene early to address attachment and parenting issues could have had an impact on Noah's resilience and his physical, mental and socio-economic outcomes in later life.

Multidimensional social support is key in helping to minimise anxiety and depression, and moderating the potential negative perceptions a mother might have about her relationship with her baby . Without access to the online support groups and classes that have helped to build maternal confidence, identity and capacity, Noah may not have experienced the supportive 'holding environment' so crucial for his optimal development.

The learning

Conducting the first new birth visit and offering breastfeeding support via telephone highlighted the difficulties in undertaking comprehensive assessments when visual prompts and non-verbal cues are absent. The health visitor quickly identified that different assessment skills were needed, and that several phone consultations were required in order to establish a fuller picture of needs. The introduction of a video-conferencing platform addressed some of these issues and particularly enabled the specialist health visitor to observe many examples of attuned interactions that she was then able to reflect on with Noah's mother. However, there were also technical difficulties on occasions because of time lags and freezing screens that made it difficult for the health visitor to attune well to parents.

The team feel that communication within the service during lockdown has felt more robust. They also feel liaison within the skill mix team is easier as most staff have been working remotely from home and have been able to answer phones or respond to emails promptly to ensure regular updates and review of care plans for the family.

This case highlights the anecdotal evidence from other professionals that there has been an increase in perinatal and infant mental health concerns during the lockdown period, often presenting as feeding difficulties in the early weeks. Health visitors have been recognising the need to contain anxieties and offer more reassurance to families than previously due to the normal mechanisms of wider family and community support being so limited. It is also a reminder that there can be several 'entry points' for a therapeutic relationship – in this case, offering appropriate support to establish breastfeeding increased maternal confidence which, in turn, helped to build a more positive parent-infant relationship.

References

i. Institute of Health Visiting (2019) Health Visiting in England: A Vision for the Future https://ihv.org.uk/wp-content/uploads/2019/11/7.11.19-Health-Visiting-in-England-Vision-FINAL-VERSION.pdf accessed 12/6/20

ii. Early Intervention Foundation (2018) WHAT WORKS TO ENHANCE THE EFFECTIVENESS OF THE HEALTHY CHILD PROGRAMME: AN EVIDENCE UPDATE

iii. Health Education England (2016) Specialist Health Visitors in Perinatal & Infant Mental Health; What they do and why they matter. https://www.hee.nhs.uk. Accessed 24/6/20

iv. https://www.eif.org.uk/report/what-works-to-enhance-the-effectiveness-of-the-healthy-child-programme-an-evidence-update

v. Royal College of Paediatrics and Child Health - Edited by Emond A (2019) Health for All Children: fifth edition. Oxford University Press, Oxford

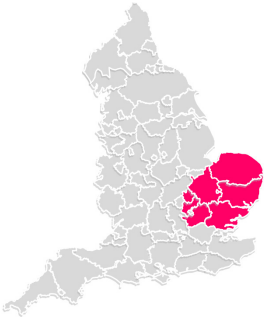
vi. Public Health England (2016) Commissioning infant feeding services: a toolkit for local authorities. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/538344/Commissioning_infant_feeding_services_a_toolkit_for_local_authorities__Part_2_.pdf

vii. Voices Blog, John Oates ihv.org.uk/newsandviews/promoting-infant-mental-health-through-focusing-on-social-support-for-mothers-during-lockdown

CONTACT DETAILS:

Name and Job Title:	Kate Allan, Health Visitor, and Hilda Beauchamp, Specialist Practitioner for Perinatal and Infant Mental Health
Address:	0-19 Healthy Child Programme, Cambridgeshire and Peterborough, Units 7/8, Meadow Lane, St Ives, Cambridgeshire, PE27 4LG
Email Address:	kate.allan1@nhs.net / hilda.beauchamp@nhs.net

Region: East of England



CASE STUDY 8 A Snapshot from Parents into the Impact of Lockdown on the Progress of their 2-year old

CONTACT DETAILS:

Names:	Pauline Bigwood
Job TItle:	Professional Developmental Lead Health Visiting
Address:	Children and Family Health Surrey
Email Address:	Pauline.bigwood@nhs.net

Region: South East

This case study example demonstrates the following "Key elements" of the iHV "Health Visiting in England: A Vision for the Future":

Context:

Nationally, professionals have worked to understand and resolve the number of children commencing school without the skills to enable them to achieve their potential. The Department for Education (2018) identified the home learning environment (HLE) as a key influence on children's early language development and future success. An environment where parents can talk, play and read with their children will have positive outcomes. The quality of the HLE is a key predictor of a child's early language ability and future success.

The Institute of Health Visiting demonstrated the importance of child development, including speech, language and communication needs and school readiness by including this as one of their 15 high impact areas (iHV Health Visiting in England: A Vision for the Future, 2019).

The impact of poor language is associated with a range of poor outcomes. Children without this opportunity are more likely to arrive at school with below average language skills and leave educationally disadvantaged. Bercow (2018) highlighted that, when a child commences school with poor language skills at age 5, they are twice as likely to be unemployed when they reach adulthood.

Solution:

During lockdown, Children and Family Health Surrey was fortunate to not be significantly affected by redeployment. The team decided from 1 May 2020 to recommence our 2 year universal offer (antenatal and new birth contacts, as well as vulnerable and safeguarding families contacts which had not been stopped and were already prioritised). As the teams were unable to offer a universal face-to-face contact during lockdown, a model of booked appointments both virtual (Attend Anywhere) and telephone contacts incorporating ASQ Questionnaires online (courtesy of ASQ https://agesandstages.com/resources-to-help-during-COVID-19/ - free English version agreement until Sept 2020) and via post was offered.

This allowed the team an opportunity to connect with families during lockdown, for parents to share their anxieties, child's progress, concerns, challenges, and successes during this potentially difficult time and to raise awareness of the health visiting and community support continuing to be offered. Revised guidance was developed to support potential COVID issues, including understanding of family finances and ability to arrange foodbank vouchers, delivering these personally where needed, access to Healthy Start vitamins and importantly a professional who had time to listen, hear their challenges and have knowledge of support available.

Action:

Following discussions with our health visiting team delivering 2-year reviews during lockdown, we reflected on the following questions:

- Has lockdown empowered some families to experience the value of a positive home learning environment and spend more time with their children talking, playing and reading?
- If so, what is the impact of this potentially improved home learning environment on child development?
- Could this potentially support school readiness?

The impact of lockdown on child development is currently untested. This case study describes our approach to review the anecdotal evidence provided by:

- Feedback from our health visiting team following the virtual delivery of the mandated 2 year review during lockdown using online ASQ
- Survey feedback from those parents with 2-year olds who engaged in our "Voice of the parents of young children survey" during lockdown.

Outcome, Impact

Responses from 120 parents with young children were received following a one week survey (June 2020). This was self-reported data as parents shared their thoughts on the impact of lockdown following the 2-year review. This paper reports the preliminary findings drawn from 38 parents responding to our survey following a 2-year review. Only one parent within the survey stated nothing positive.

These preliminary findings do not include any detailed analysis according to level of need. We also recognise the limitations of the small sample size and self-report nature of the survey, however the findings do present some reported benefits of lockdown for some children which parents reported to be significant. However, this reflection does not minimise the significant impact from lockdown on increasing health inequalities, the increase in safeguarding workloads and children living in heightened at risk family relationships.

Key Outcome

Parenting issues the team would routinely have expected during a 2-year review were not occurring, resulting in significantly reduced speech and language referrals, reduced parenting support strategies in relation to pre-lockdown reviews.

Most frequently mentioned outcomes:

Improvement in speech: 'so many more words', 'now talking in sentences', 'his speech has rocketed', 'Loved watching how his speech has developed'.

More children toilet trained: fewer questions on challenges of toilet training. 'This has given me time to toilet train her', 'with no rushing around we can toilet train'

Improved independence skills: 'I have had time to let her try and put on her shoes', 'I can not believe how independent she has become'

Time to be together: 'I have had time to listen and we talk together we are not rushing around.' 'The quality family time.' 'The boys being able to bond and spend time together.'

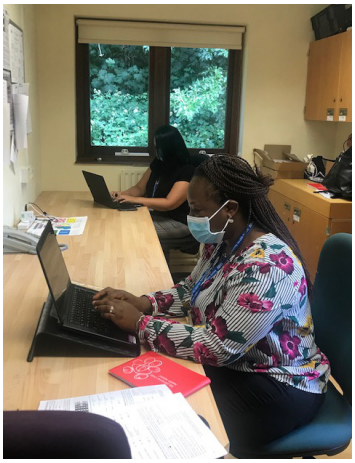
Behaviour improved: 'I have loved spending time with the children', 'better routine', 'calmer house', 'meal times better', 'children's behaviour better'.

'Everything better.' 'I love the way life is now, slower pace of life, love our little bubbles.'

'Eating meals together.'

'See more of my children'. Have more time for cuddles and kisses'.

'Less rushed mornings and enjoying seeing the children more'.



Lessons Learned and Recommendations:

Reflecting on this small scale anecdotal evidence from parents - Has lockdown offered children the potential for improved school readiness by giving families time to be still, listen and play?

Lockdown has offered some families the opportunity for improved home learning, with ultimately time to be together without the rushing around/ competing against the increasing societal demands of many families' lifestyles.

I recognise a virtual contact for the 2-year review is not tested; our team offered any family with highlighted concerns a face-to-face contact. The value was an opportunity to share anxieties, challenges and we found parents were delighted to share their child's success and progress, few shared negative outcomes.

The impact of lockdown has not been felt equally by families. Against the documented increasing safeguarding, domestic abuse and health inequalities inequalities experienced by some families, lockdown has also given other families the gift to reconnect and the gift of time.

However, to reduce health inequalities we need a societal shift and investment in valuing time to parent.

References:

Department of Education National Literacy Trust (2018) Improving the home learning environment A behaviour change approach Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/756020/Improving_the_home_learning_environment.pdf

ICAN (2018) The Bercow Report 10 years on Report. Available at: http://www.bercow10yearson.com/wp-content/uploads/2018/03/337644-ICAN-Bercow-Report-WEB.pdf

Institute of Health Visiting (2019) Health Visiting in England: Vision for Future Available at: https://ihv.org.uk/wp-content/uploads/2019/11/7.11.19-Health-Visiting-in-England-Vision-FINAL-VERSION.pdf

Creative Submission 5

From Consolidated to COVID: Working as a newly qualified Health Visitor during the Coronavirus Pandemic

by Rebecca Hanks

How much can you achieve in a working week as a Specialist Community Public Health Nurse? How many Healthy Child Program contacts, support visits for parents with poor mental health, child protection meetings, child health hubs, referrals to physiotherapists, respite for disabled children or for those with developmental delay are in your diary to complete? How many calls from worried first-time parents, development assessments, visits to the refuge, feeding support contacts, food bank referrals, SCBU outreach visits fit into 37 hours?

I was registered as a Health Visitor for 15 working days when the UK went into lockdown on 23 March 2020. This is my reflection of working as the only newly qualified Health Visitor within the organisation, employed by a local authority during the COVID-19 pandemic.

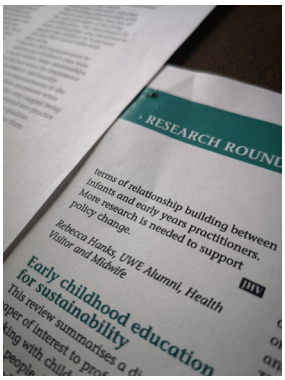
From consolidated practice to COVID-19,
From writing essays and referencing to managing a caseload,
The clue is in the name, Health Visitors visit families. Corona virus made this too unsafe to do,
The only universal service for families with children under 5 years old.

Home visiting changing to phone calls, exceptions for priority contacts,
SCBU discharges, failure to thrive, breastfeeding support and newborn blood spot screening,
IT issues, poor connection, no connection,
Risk assessments, desk assessments, symptom screening,
PPE, washing hands in boots of cars, smiling behind the mask,
Socially-distanced appointments, doorstep weight reviews, and garden contacts,
Evidenced-based practice, without the evidence base. A new phenomenon,
Lone working, home working, team working.

A rise in parental mental health, domestic abuse and isolation,
An increase in Universal Plus and Universal Partnership Plus levels of service,
More support calls and additional contacts between 'routine' visits than ever before,
More calls and texts from worried parents looking for a reassuring voice,
New parents exhausted and upset they have not ever seen a health professional at home or someone face to face after day 10 at the Midwife 'hub',
Positive feedback from parents, thankful to have you as a lifeline at the end of the phone but saying 'it's not the same'.

A cohort of children, where parents have not seen the face of their named Health Visitor,
Relying on what parents report to us on the phone, our only senses being hearing and 'gut feeling',
A rise in the number of contacts we can complete within the teams, an increase in the key performance indicators,
Taking each call on face value, unaware of the whole picture,
Being unable to see the shed of a tear of a Mum with postnatal depression or bruise on an immobile baby,
Unable to smell smoke, damp or the distinctive smell of neglect,
Children at the centre of every piece of work, without even knowing what they look like.

Trying to keep up-to-date with workload, blinking and 14 weeks passing by,
One thing taken off of the 'to do list' to add three more,
Learning more each day than I thought was possible,
Adapting to change, new, temporary ways of working,
Writing journal articles and becoming involved in changes in practice,
A preceptorship program on pause, current student courses suspended,
Relying on my team for support more than ever, socially-distanced shoulders to laugh and cry on,
Eager to 'get back out there',
Finding my feet, whilst mostly sat at my desk,
Aiming to be the best Health Visitor I can be.



CONTACT DETAILS:

Name:	Rebecca Hanks
Job Title:	Health Visitor (Midwife)
Address:	The Meadow, Leigh Road, Penhill, Swindon, Wiltshire, SN2 5DE
Email Address:	rhanks@swindon.gov.uk

Region: South West

CASE STUDY 9

An example of how social media effectively supported the Health Visiting team to meet the health needs of a local family during the COVID-19 pandemic

CONTACT DETAILS:

Names:	Sophie Uzelac
Job TItle:	Health Visitor
Address:	Rotherham Doncaster and South Humber NHS Foundation Trust, Tickhill Road, Doncaster
Email Address:	sophie.uzelac@nhs.net

Region: Yorkshire & Humber

This case study example demonstrates the following "Key elements" of the iHV "Health Visiting in England: A Vision for the Future":

Context:

The Health Visiting Team has an established Facebook page which enables parents to send direct messages to us confidentially. This provides a medium for families within the Doncaster area to make contact with a member of the Health Visiting Team at a time that suits them, knowing they will receive a timely response from a professional. This forms part of the universal health visiting service.

The Institute of Health Visiting (2019) highlighted the importance of the health visitor's role in reducing the demand on GPs by providing support with everyday parenting concerns. This particular example shows the essential role the health visiting service has in addressing a range of parenting concerns, and the health visitor's ability to work autonomously within their professional capabilities to address needs within communities. It also demonstrates the value of online communication with parents; particularly during a time when face-to-face contacts were suddenly reduced, creating a situation where families could have otherwise faced limitations in accessing support from services.

> Hi, I'm looking for some advice as I've nowhere else to get it due to current situation. My 11 week old has these dry flaky patches on him, there appears to be more coming quite frequently. He is eating fine and having plenty wet and full nappies. They are raised and feel dry, and pimply on his abdomen. I've tried to ring drs but can't get advice and we are self isolating so can't attend walk in x

In the early weeks of the COVID-19 pandemic, we received a direct message from a parent with concerns regarding their 11-week old baby who had developed a skin problem. The family was self-isolating and therefore unable to attend the GP. At this early stage of the COVID-19 pandemic, virtual appointments were not yet available and the parent felt she had nowhere else she could seek advice. Accompanying the direct message was a set of images of the child's skin which enabled the health visitor to begin forming part of her assessment.

With the wealth of information available to parents online, described as 'immense' by Plantin & Danebeck (2009), it is important that parents feel they can easily access evidence-based and personalised advice from a trustworthy source such as their health visitor. A study by Baker et al (2017) concluded that the internet provides an opportunity for evidence-based parenting support to be offered to a broad range of parents including those more vulnerable.

Solution:

Despite the COVID-19 restrictions reducing service provision for face-to-face contacts, having a messaging service already established meant the Health Visiting Team could continue to offer an accessible and responsive means of communication with families via Facebook. Whilst other services had to quickly find new ways of working, we were already prepared to meet some of this need.

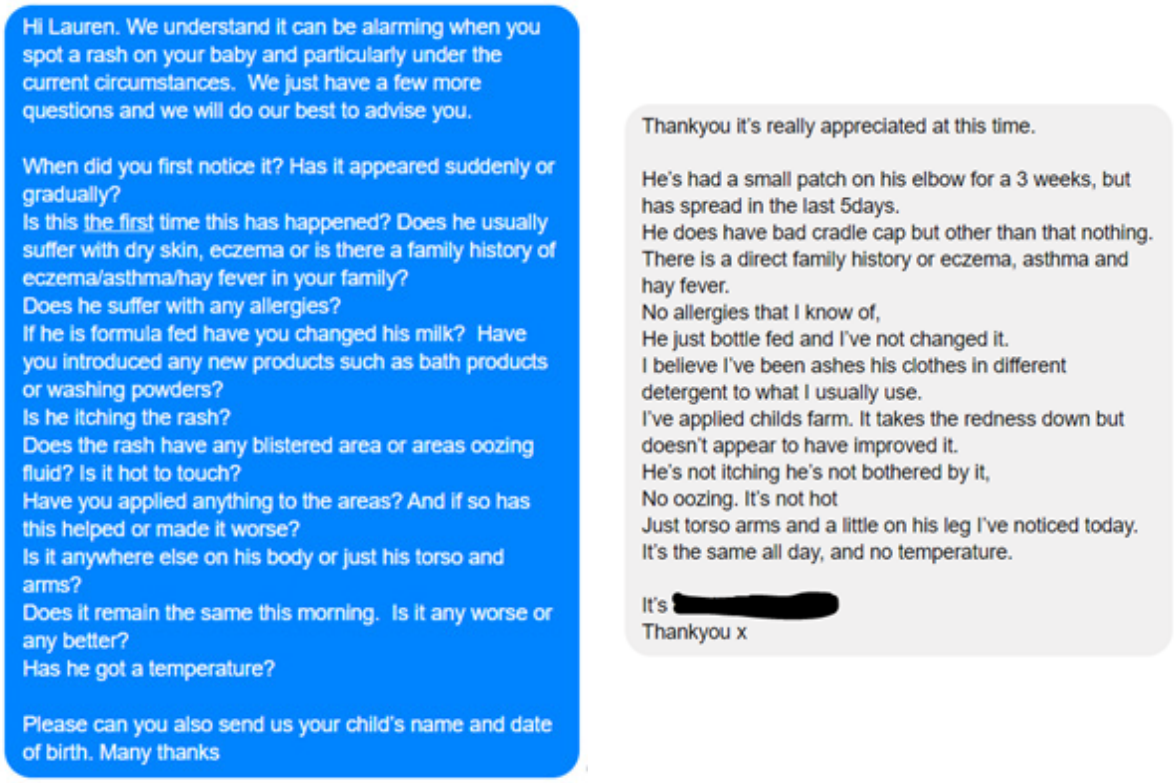
According to Johnson (2020), Facebook is the most visited social network in Great Britain with 67% of online adults accessing the site in November 2017. It is evident from the steadily increasing number of followers to the Health Visitors' Facebook page, that it is a popular and growing method for parents to seek support. The number of page followers currently stands at 7,948 and this is growing week on week. This makes it an ideal platform for the health visiting service to engage with families.

Also providing a telephone service means parents have a choice about how they wish to contact us. Verbal feedback from families using the direct messaging service demonstrates that parents like the convenience of contacting us online because they can do this at a time that fits in with them; day or night, weekend or weekday. Parents also like being able to send a message instantly without having to call us or wait for a call back.

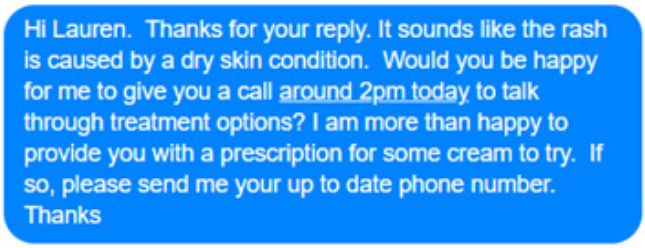
Action:

What? The health visitor's aim was to offer reassurance and support to the parent whilst forming a thorough evidence-based assessment and plan of care to meet the needs of the child and family. Having already received images of the child's skin, it was possible to complete the rest of the assessment via direct messages and a phone call with the parent.

How? The first stage of the assessment was to establish the cause of the skin condition. By obtaining the child's name and date of birth, we were able to check their medical record to see if any advice had already been provided and check the child's allergy history as well as current medications. It also enabled us to record this contact in the child's medical record and share information with the allocated family health visitor.



Why? The combination of the images of the child's skin and parent's response to the health visitor's questions enabled a diagnosis to be made and a prescription to be considered. In normal circumstances, it is preferable to see the child face-to-face before issuing a prescription, but as the family was self-isolating this was not possible.



According to Barton and Allan (2015), an effective consultation that incorporates a full and in depth history of the patient is of greatest importance to ensure safe prescribing. Therefore, to achieve this, a more in depth conversation happened with the parent over the phone. The health visitor agreed a choice of product using the mnemonic EASE which, according to Nuttall and Rutt-Howard (2016), supports the prescriber to choose a product that is cost effective and most appropriate for the patient. A contract was also negotiated with the parent in accordance with The Prescribing Pyramid which is an essential part of the prescribing process (Nuttall and Howard, 2016). Involving the parent in the prescribing decision demonstrates collaborative working between the parent and health visitor which effectively met the need of the child and family.

Outcome and impact:

The health visitor agreed with the parent to hand-deliver the prescription to the family home. This ensured the safe and timely delivery of the prescription whilst maintaining confidentiality.

The intervention was communicated with the family GP and the family health visitor. Local non-medical prescribing (NMP) policy (NMP Lead, 2020) advises community nurse prescribers to notify the GP of any change to treatment as soon as possible. As the GP and health visitor shared the same record system, it was possible for the GP to see the medication change entry in the child's record as recorded by the health visitor. The health visitor also provided written correspondence to the GP via a task as per local NMP policy (NMP Lead, 2020).

Since its launch in 2016, the messaging service has become a popular means for local parents to get in touch with our service. Between 1 March 2020 and 31 May 2020, the health visitor's Facebook page received 131 direct messages from parents. 46% of these messages were received outside of normal working hours (Monday-Friday 9am-4.30pm). Enquiries ranged from simple questions regarding appointments, to more in-depth assessments requiring referrals to other services. The cost to run this service equates to 7.5 hours per week of a band 6 health visitor and a full-time band 5 staff member who manages the social media across The Children's Care Group for the NHS Trust. For parents, the service costs nothing. All they need is access to the internet and a Facebook account.

According to Dowden (2016), non-medical prescribers are saving the NHS £777million annually. Community prescribers benefit patients and services as they create a reduced need for access to unnecessary appointments, and patients experience less delay in receiving medicines (Dowden, 2016). Certainly in the example provided for this case study, the child received treatment quickly and, within a week, the parent reported noticing an improvement in the child's skin. Had treatment been delayed, the outcome may have been different. This was all achieved without the child accessing a face-to-face appointment. According to NHS England (2019), a GP appointment costs on average around £30.

A review of the treatment was completed with the parent over the phone in accordance with the next step on The Prescribing Pyramid. A medicine review is advised to check whether the treatment is effective, safe and acceptable (Barton and Allan, 2015). The parent reported the treatment was effective and the skin was much improved. The health visitor contacted the GP and asked for a repeat prescription to be provided. Feedback was provided to the child's parent and the family health visitor.

Lessons learned and recommendations:

Overall, the effectiveness of this intervention and the positive outcome for the child and family demonstrates the value of the health visitor's role as well as the positive impact that social media can have for the health visiting service. Despite being faced with the challenges of the COVID-19 pandemic, the health visitor worked autonomously and collaboratively with the parent to deliver a quality service whilst also reducing demand on the GP. This example incorporates the 8 key elements of an effective family-centred health visiting service as outlined in Health Visiting in England: A Vision for The Future (Institute of Health Visiting, 2019).

There are evidently many benefits to the use of social media and its ability to enhance the health visiting service. However, this is not without its limitations. For example, communicating over social media can be more time consuming for a practitioner than having a telephone conversation. This is mainly due to the consideration required to ensure written responses are clear and that any information provided is not likely to be misinterpreted. That said, record keeping becomes much quicker as the text can be copied and pasted into the health record.

Another limitation is that the health visitor doesn't see the patient face-to-face. As explained earlier, it is best practice to see a patient prior to providing a prescription. The health visitor attempted to mitigate any risks in not doing this and still managed to follow the appropriate steps required as part of the prescribing process. The photos which the parent provided were key to the assessment. This process was again more time consuming via social media than it would have been face-to-face. However, the lockdown situation was unique and the health visitor had to adapt to the circumstances within her professional competency.

It is likely that in normal circumstances, the parent would have accessed a GP appointment prior to contacting the health visiting service. As the family was self-isolating and virtual contacts were not yet available, this was not an option. For the parent, our support felt like her only choice. In considering the family circumstances and the limitations of the community and primary care services at that time, the health visitor had to make a judgement taking into account the risks, benefits and outcomes for the child, family and wider services which led to the decisions made as outlined in this case study.

Overall, the Facebook page and direct messaging facility is intended to support the wider Health Visiting Team and meet the needs of families who prefer to use online services on an ad-hoc basis. In future, we expect the demand for this service to increase based on parent need and it is important that we are prepared to meet this demand. Our Management Team has now extended the Facebook messaging offer into mental health and school nursing services.

As a team we recognise the need to develop our approach to obtaining feedback from families who use the Facebook page. We have recently launched a satisfaction survey which is sent to each parent via messenger once a contact has been completed and we are in the process of collating data from these responses.

See feedback from parent below:

References:

Baker, S, Sanders, M and Morawska, A. (2017). Why Use Online Parenting Support? A Cross-sectional survey Exploring Australian Parents' Internet Use for parenting. Journal of Child and Family Studies, 26, 916-927 https://link.springer.com

Barton, T and Allan, D. (2015). Advanced Nursing Practice: Changing Healthcare in a Changing World. Retrieved from https://books.google.co.uk

Dowden, A. (2016). The Expanding Role of Nurse Prescribers. Prescriber, 24-27, Retrieved from https://onlinelibrary.wiley.com

Institute of Health Visiting. (2019). Health Visiting in England: A Vision for the Future. Retrieved from https://ihv.org.uk

Johnson, J. (2020). Social Media Usage in the United Kingdom (UK) – Statistics and Facts. Retrieved from https://www.statista.com

NHS England. (2019). Missed GP appointments costing millions. Retrieved from https://www.england.nhs.uk

Non-medical Prescribing Lead. (2020). Rotherham Doncaster and South Humber NHS Foundation Trust: Non-medical Prescribing Policy. Version 6.4. Retrieved from https://www.rdash.nhs.uk

Nuttall, D and Rutt-Howard, J. (2016). The Textbook of Non-Medical Prescribing (2nd Edition). Retrieved from https://download.e-bookshelf.de/download

Plantin, L and Danebeck, K. (2009). Parenthood, Information and Support on the internet. A literature review of research on parents and professionals online. BMC Family Practice, 10, https://bmcfampract.biomedcentral.com

Changing the way we practice to meet the needs of vulnerable children who need to isolate/shield during COVID-19

by Alex Laidler

T is nearly 3 years old. He is a delightful and happy little boy and he has a diagnosis of Glycogen Storage Disease Type IV. He has restricted mobility and difficulties maintaining his weight due to his condition. As this family's health visitor, I have been supporting them by providing regular weighings/support visits whilst T was on the waiting list for a gastrostomy. T had the gastrostomy surgery a week prior to the start of the COVID-19 lockdown. Due to T's vulnerability, it was advised that shielding was necessary.

T still required regular weight checks due to his recent surgery, however face-to-face home visits in the home would increase the risk of COVID-19 virus transmission. Therefore, it was decided that the best way to facilitate this was to work in partnership with T's parents and for weighing scales to be left on the doorstep and collected by parents and taken into the home. T would be weighed by his parents, during this time I would wait in my car outside the house and communicate with T's parents by telephone. T's weight was then recorded and interpreted using the centile chart and shared with the dietician. During the phone call, I was also able to provide any additional advice and support required by T's parents.

Meeting the needs of children like T with a range of additional needs during COVID-19 has posed new challenges to our services which we have captured using the medium of photography. Prior to lockdown, T would attend an inclusive parent and baby group called "Jolly Josh". Jolly Josh aims to relieve the needs of those with additional needs, complex needs, disabilities and those with Profound and Multiple Learning Disabilities, their families and carers within Rochdale and the wider area. Our mission is now to '*enable families who have a loved one with additional/complex needs, disability and/or profound and multiple learning disabilities to connect, support and thrive. Jolly Josh aims to inspire inclusion.*'

Jolly Josh is a registered charity which has recently collaborated with the award-winning photographer Asia Burrill to capture the lives of its families during lockdown.

As a trustee for Jolly Josh, and the health visiting representative for the group, I have been lucky to be part of this amazing project which has captured the beautiful, positive images of the resilience of these families and adaptability of the services that support them.

Jolly Josh celebrated its 2nd Anniversary in 2019 by starting the build of our very own venue!

Our Place To Call Home is a much needed venue in Rochdale, we are proud to reveal that we will have a 'Changing Place' and Hydrotherapy Pool!

T's parents said "*having a health visitor available during shielding has been really helpful for us as a family as we have to monitor T's weight and this would have been more stressful without having our excellent health visitor, Alex Laidler, on hand to provide us with the scales and also be there if we had any concerns*".

Achievements:

As a direct result of our service adaptations, T and his extended family have been able to remain shielding at home whilst having continued support and advice regarding his health and development.

Personally, having the opportunity to be part of such an amazing project and being able to capture how adaptable our health visiting service has been during the challenges of COVID-19 has been inspiring.

As a service, we have changed our ways of working. This includes video conference calls, home working, door-step contacts, risk assessing families and multi-agency working to enable safe delivery of the health visiting provision to all families.

These changes were implemented quickly and, although this was challenging, staff embraced the changes positively.

Benefits:

The family has continued to receive a health visiting service which has adapted to their needs and supported them through collaborative working with members of the wider multi-disciplinary team. This has enabled T, who initially had faltering growth, to access support around his feeding requirements, enabling him to become the little boy who today is thriving.

Following each health visiting contact the family/health visitor have been able to liaise with other professionals involved in T's care to ensure that T is achieving his full potential.

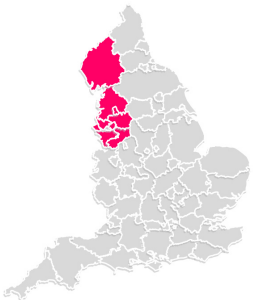
Challenges:

As a service, our day-to-day delivery of care has been adapted according to each family's needs. This has had its challenges due to the requirements involved in protecting both staff and families from COVID-19 infection, particularly those families whose children are vulnerable and at increased risk during these unprecedented times.

CONTACT DETAILS:

Name:	Alex Laidler
Job Title:	Health Visitor
Address:	Pennine Care NHS Foundation Trust
Email Address:	alex.laidler@nhs.net

Region: North West



CASE STUDY 10 Introduction of a 4-week and 12-week contact utilising the skill-mixed team to provide additional support to parents during the COVID-19 pandemic

CONTACT DETAILS:

Names and Job Titles:	Samantha Hutchinson (Community Nursery Nurse) and Tonya Curtis (Community Practice Teacher)
Address:	Whitley Health and Social Services Centre, 268 Northumberland Avenue, Reading, RG2 7PJ
Email Address:	samantha.hutchinson@berkshire.nhs.uk / tonya.curtis@berkshire.nhs.uk

Region: South East

This case study example demonstrates the following "Key elements" of the iHV "Health Visiting in England: A Vision for the Future":

Description:

Introduction of a universal 4-week and 12-week virtual contact utilising skill mix team, to increase support to parents and with the aim of reducing risk to infants.

Aim:

We introduced two new contacts to the universal offer at 4 and 12 weeks to support parents, this offer was on-going during the COVID-19 pandemic.

Objectives:

- To provide additional support to parents of newborn babies
- To identify parents whose mental health might be deteriorating
- To reduce the sense of isolation
- To reduce the risk of non-accidental injuries

The stimulus for a rapid review, and decision to undertake an enhancement of the universal service for newborn babies up to the age of 3 months, was the reporting of three non-accidental injuries (NAIs) and an infant death within this age range within the first 3-4 weeks of the COVID-19 pandemic and resulting lockdown. Baird (2020) also identified an increase in NAIs within the first few weeks of lockdown and highlights a lack of access to healthcare services, as well as support that parents would usually rely upon, as being contributing factors. Health visitors have been identified as playing a key role in reducing the risk of NAIs (iHV, 2019), however, we were highly aware that access to the health visiting service had been severely curtailed as a result of restrictions put in place as a result of COVID-19. The change to the service was therefore aiming to negate this and to increase the level of support available to parents in a uniquely challenging set of circumstances; particularly given how fundamental the early weeks and months of a child's life are in laying the foundations of their future health, wellbeing and development (Parent-Infant Foundation, 2020).

Whilst the enhancement of the service was delivered across the whole of the trust, this case study relates to the implementation of the new contacts within one specific locality. This locality is considerably ethnically and socio-economically diverse, with many families not having English as their first language.

Method:

The 4- and 12-week contacts were to be rolled out universally and an immediate question was who could deliver these new contacts - given that within our locality health visitors were already at capacity delivering the new birth and 6-8 week contacts, as well as maintaining regular contact with vulnerable and child protection families. In line with the

NHS guidance regarding prioritisation of community services, since updated, (NHS, 2020), nine-month and two-year developmental reviews had been suspended, as had child health clinics for the foreseeable future. This meant that our community nursery nurses and staff nurses had a significantly reduced workload and were available to undertake these contacts; some had been redeployed and were subsequently recalled. Supervision and case management of these contacts were provided by the health visitor who had undertaken the new birth assessment. Calls were undertaken from the office, with social distancing in place, allowing easy access to the duty safeguarding health visitor for any urgent concerns.

Careful consideration was given to what should be focused on within these new contacts; and a clear outline for the contacts was developed. This formed a guide for documenting the contact, as well as ensuring that every family received the same quality of contact. Given that 1 in 10 new mothers will experience postnatal depression within the first year of their baby's birth (NHS, 2018), it was essential that all staff delivering these contacts felt confident exploring this, as well as being alert to any potential safeguarding red flags.

A specific training session to support the sensitive and skilled delivery of these contacts was rapidly developed and rolled out, this built on existing training that staff had received. Competence was assessed through calls being observed by a health visitor and scenario questions being explored, specific competencies supported this.

A range of methods were used when delivering this contact. Initially they were carried out via telephone but, as we progressed and adapted, the team realised a more long-term solution would be via One Consultation. One Consultation is an online video consultation platform which can enhance the care of the service user from their own homes. Telephone translators were also utilised as needed, to ensure that no families were excluded from the contacts through not speaking English.

Outcomes:

These contacts appear to have been well received, although they are yet to be formally evaluated. Parents are informed at the new birth visit that the contact will be taking place; currently, only a small percentage of families are not reached for the 4-week contact, whilst the vast majority are accepting of the calls and then look forward to the 12-week call. Verbal feedback from parents has been positive, with many expressing gratitude for having an opportunity to have additional contacts from a healthcare professional, stating that they have felt supported in those very early days. The same practitioner calls at 4 weeks and at 12 weeks providing much valued continuity of care (iHV, 2019).

The increased contacts offered to all families have provided an opportunity to explore support required and to further embed key public health messages, particularly in relation to transition to parenthood, maternal and paternal mental health and reducing NAIs (iHV 2019). Discussion regarding coping with crying was a fundamental aspect of this and parents are routinely signposted to resources from CRYSIS and ICON - "Babies cry, you can cope". A newly initiated blog was also signposted to service users where the biggest reach was in the crying and breastfeeding week. Additionally, these contacts reflect the Healthy Child Programme's overarching aims of providing a universal service seeking to reduce health inequalities and identify families in need of an enhanced service (Public Health England, 2018).

The training provided upskilled the staff delivering the contacts, and caused them to consider how the contacts could be delivered in a meaningful and client-centered way. A significant focus of the training was on communication, considering the importance of using open-ended questions when contacting families to give families the opportunity to voice any concerns and allowing practitioners to focus and listen to what is being said. Similarly, the importance of establishing a rapport with the family was highlighted, and strategies to support this were identified. For example, staff were encouraged before contacting the family to read through the previous notes in order that the support could be tailored and personalised. The Solihull approach was used to underpin the contacts. This approach recognises the importance of containment and reciprocity between parent and child to support both parental and infant emotional health and wellbeing (Solihull Approach, 2015).

To ensure our services were accessible to our multicultural population, telephone interpreters have been used to overcome language barriers, this has been well received and ensured a more meaningful contact.

The use of the One Consultation secure video platform was seen as positive - the video call allowed babies to be seen for the first time in weeks, as well as allowing staff to view how mother was presenting and any other family members in the home.

Reducing isolation was identified as another key outcome. Recognition and discussion of the role that potentially heightened stresses in the family home, and lack of access to normal support structure might have on mental wellbeing, allowed parents to normalise how they were feeling and also for additional support needs to be discussed.

The running of an appointment-only child health clinic additionally meant that parents could, in consultation with a health visitor, be given an appointment to have their baby weighed or for breastfeeding support if problems could not be resolved over the phone. Additionally, families would be rapidly escalated to a health visitor if any concerns regarding maternal mental health or safeguarding were identified. Throughout the initial lockdown period, health visitors continued with home visits, whilst wearing PPE if these were deemed necessary. Communication with partner agencies has also been seen to be very effective during this time with information sharing to ensure that the most vulnerable families are safeguarded.

Key Learning Points:

1. The additional 4-week and 12-week universal contacts have been received positively by parents. It is now essential that formal data is collected to evidence this, in order that consideration can be given to whether these contacts should be commissioned as a part of our service offer in the future.
2. With appropriate training and assessment of competence, skill mix staff were upskilled to undertake these new contacts, under health visitor supervision, within a short space of time. The success of these contacts will have to be determined over a longer period of time.
3. Ready access to a health visiting colleague, the ability for babies to be seen in clinic and close partnership working with other agencies, supported our work to safeguard vulnerable children and their families and provide safer working practices for staff taking on a new role beyond their usual scope of practice.
4. Use of video contacts have been welcomed by clients, and despite some initial challenges, these are seen as being a positive manner of communication by staff as they add to the quality of contact and enable non-verbal cues to be picked up more easily. We recognise that further evaluation is still needed to determine the benefits and limitations of virtual contacts.
5. Telephone interpreting has been easy to access ensuring that all clients can receive the enhanced service.

References:

Baird. E (2020). Non accidental injury in children in the time of COVID-19 pandemic [Online]. Available at: https://www.boa.ac.uk/policy-engagement/journal-of-trauma-orthopaedics/journal-of-trauma-orthopaedics-and-coronavirus/non-accidental-injury-in-children-in-the-time-of.html [Accessed on 18.06.2020].

Institute of Health Visiting (2019). Health visiting in England: A vision for the future [Online] Available at: https://ihv.org.uk/wp-content/uploads/2019/11/7.11.19-Health-Visiting-in-England-Vision-FINAL-VERSION.pdf [Accessed on 19.06.2020]

NHS (2018). Mental health problems and pregnancy [Online] Available at: https://www.nhs.uk/conditions/pregnancy-and-baby/mental-health-problems-pregnant/ [Accessed on 19.06.2020]

NHS England (2020). COVID-19 Prioritisation within Community Services [Online] Available at: https://www.england.nhs.uk/coronavirus/publication/covid-19-prioritisation-within-community-health-services-with-annex_19-march-2020/. [Accessed on 20.06.2020].

Parent-Infant Foundation (2020). The First 1001 Days Movement is a group of organizations and professionals working together to campaign about the importance of the emotional wellbeing of babies [Online] Available at: http://www.1001criticaldays.co.uk/ [Accessed on 19.06.2020]

Public Health England (2018). Healthy child programme 0 to 19: health visitor and school nurse commissioning [Online] Available at: https://www.gov.uk/government/publications/healthy-child-programme-0-to-19-health-visitor-and-school-nurse-commissioning [Accessed on 19.06.2020]

Solihull (2015). Quick guide to the Solihull approach [Online] Available at: https://solihullapproachparenting.com/quick-guide-to-the-solihull-approach/ [Accessed: 22.06.2020]

Conclusion

These case studies, family stories and creative pieces have provided a historical window into health visiting practice during the COVID-19 pandemic in 2020. They contain examples of the many innovative solutions developed by resourceful professionals to ensure that they continued to provide the best service possible to families facing their own considerable challenges. Over the past six months health visiting teams have provided hope to families by transforming the way services are delivered and with the simple message, "***You are not alone***". Despite the backdrop of an already depleted health visiting service and significant workforce pressures due to redeployment, shielding and staff sickness, health visiting teams have risen to the challenge of these circumstances with professionalism and immense selflessness.

The pace and scale of change has provided a wealth of learning from practitioners and feedback from parents - what a joy it is to hear how families have valued the support they have received from health visiting teams during these challenging and uncertain times.

We must grasp this learning which has taken place and use it to continually build a service that is fit for the future. The past few months have reinforced the value of an effective health visiting service and the importance of ensuring that parents have easy access to health visitors with a breadth of specialist skills, providing a vital universal "safety net" for children. This time has also taught us that staff must have autonomy to drive innovative solutions which place the needs of children and families at the centre. They are best placed to do this as they are so experienced in understanding how families function.

What next ?

If any good is to come out of this pandemic, it is surely a recognition by those with the power to make a difference that public health is the backbone to the future prosperity of any country. If the country is to be levelled up as the government pledged, the important contribution that health visiting makes will need a renewed focus and investment to rebuild a service fit for the future. We support the call of the Children's Commissioner for a "Nightingale effort" to be focused on our country's children. All efforts to target support to those in greatest need will only work if there is an effective universal service to identify vulnerable children and their families.

Our recommendations for restoration of the health visiting service are:

- Health visiting services should be reinstated (where they have not been) as a matter of urgency as a vital support and safety-net for children, with appropriate measures put in place, including the use of PPE, to reduce the spread of the virus.
- Health visiting services must be fully prepared for any future waves of COVID-19. NHS England should revise the Community Prioritisation Plan (for phase one pandemic management) and develop clear messages on the importance of continuation of the service to ensure the needs of children are prioritised. This should include removing wording on the redeployment of health visitors.
- A clear workforce plan is needed to ensure that the service has sufficient surge capacity to manage the backlog of missed appointments, as well as demand for support due to the secondary impacts of the pandemic.
- An evaluation of the use of virtual, non face-to-face service delivery methods is urgently needed to determine their effectiveness for identification of vulnerabilities and risks, impact on child and family outcomes and reducing inequalities to inform future digital change.
- A cross-government strategy is needed to reduce inequalities and "level-up" our society - this will require investment to strengthen the health visiting service which plays a crucial role in the early identification and support of the most disadvantaged families.
- The impact of working during the COVID-19 pandemic on staff wellbeing cannot be underestimated - a proactive plan is needed to ensure staff have the right support during the restoration of services and to create high quality workplaces for all staff in the future.

Institute of Health Visiting
A Registered Charity Number 1149745
c/o Royal Society for Public Health, John Snow House, 59 Mansell Street, London E1 8AN
Telephone: +44 (0) 207 265 7352 | Email: info@ihv.org.uk
www.ihv.org.uk