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Synopsis

Health visiting in the UK in light of the COVID-19 pandemic experience (RReHOPE): study synopsis

Erica Gadsby,[1*] Emma King,[1] Madeline Bell,[2] Geoff Wong[3] and Sally Kendall[4]

[1]Faculty of Health Sciences and Sport, University of Stirling, Stirling, UK
[2]PPI Lead, UK
[3]Nuffield Department of Primary Care Health Sciences, University of Oxford, Oxford, UK
[4]Centre for Health Services Studies, University of Kent, Canterbury, UK

[*]**Corresponding author** e.j.gadsby@stir.ac.uk

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Abstract

Background: The COVID-19 pandemic interrupted and, in some cases, transformed the way health visiting teams work, the way they interact with families and children and with the wider community and other service providers. Health visiting services are organised, delivered and experienced differently in different places, with little evidence to suggest what works best, for whom and in what contexts.

Objective: To synthesise the evidence on changes during the pandemic to identify the potential for improving health visiting services and their delivery in the United Kingdom.

Methods: This realist review engaged professional stakeholders (*N* = 28) and those caring for babies during the pandemic (*N* = 6) throughout the process. We searched five electronic databases for publications on health visiting during the COVID-19 pandemic from October 2022 to April 2023. This was followed by citation searching and review of organisational websites. Programme theory was iteratively refined through discussions with the team, professional stakeholders and people with lived experience and was translated into key findings and recommendations.

Results: One hundred and eighteen documents informed this review; most focused on health visiting in England (56%) or the United Kingdom (34%), with relatively few from Wales (6%), Scotland (3%) and Northern Ireland (1%). Documents highlighted the widespread, uneven and lasting impact of the COVID-19 pandemic on babies and families. Findings revealed significant concerns expressed by both families and practitioners and corresponding actions taken by health visiting services. These concerns and responses emphasised the flexibility and resourcefulness of health visitors, the vital role of trusting relationships between health visitors and families and the importance of holistic assessments for early intervention. Changes in service delivery were varied and were not always evaluated or sustainable. While the data illuminated some of the hidden complexities of health visiting practice, limited evidence was found on decision-making at organisational and managerial levels during the pandemic response.

Evidence limitations: Included papers were predominantly from an advocacy or practitioner perspective, and few focused on health visiting in Scotland, Wales and Northern Ireland. Our focus on the universal health visiting pathways meant that documents pertaining to additional support received by the most vulnerable families might have been excluded. Experiences of Black, Asian and minority ethnic families and staff were illustrated in several papers.

Conclusions: The COVID-19 pandemic highlighted the essential role of health visitors in safeguarding child and family well-being in the United Kingdom. While digital adaptations provide necessary continuity, face-to-face interactions remain essential for effective health visiting. The crisis exposed pre-existing workforce pressures and inconsistencies in service provision, emphasising the need for adequate support and funding. Policy-makers must recognise the complexity of health visiting and ensure sustained investment in universal home visiting services. Future resilience requires a realistic understanding of health visitors' work, integration into broader child health policies and enhanced interagency collaboration to address inequalities and improve long-term public health outcomes.

This synopsis should be referenced as follows:
Gadsby E, King E, Bell M, Wong G, Kendall S. Health visiting in the UK in light of the COVID-19 pandemic experience (RReHOPE): study synopsis. *Health Soc Care Deliv Res* 2025;**13**(42): 1–28. https://doi.org/10.3310/GJEG0402

Future work: Our implications for policy-makers will be translated into reflexive questions to prompt critical thinking about health visiting services in local areas. The small number of documents from countries outside England highlights this as a key area for future research.
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Introduction

In this paper, we present a summary of the work undertaken to learn lessons about the positive and negative impacts of the COVID-19 pandemic on health visiting services across the UK to identify implications for the services' future organisation and delivery. The realist review arose from our engagement with the Institute of Health Visiting's (iHV) work on examining the impact of the COVID-19 pandemic and from previous work that examined the impact of the pandemic response on paediatric services in north of Scotland and the north east of England.[2] Our interactions with health visitors, and with new parents who had encountered health visiting services during the pandemic, helped to shape the ideas behind this research. The work incorporated a realist review of literature with associated professional stakeholder and public involvement. The study team brought together expertise in realist methodology, health visiting and health services research as well as practice-based and lay knowledge and lived experience.

Our methods are detailed in Research Article 1,[1] and our findings are presented and discussed in Research Article 2.[3] In this synopsis paper, we reflect in more detail on the extent to which the research objectives were met and on the stakeholder and public involvement carried out during the study. We also consider the documents that were contained in the final review and reflect on the diversity of our sample and the implications for learning and future research.

The two research papers summarised in this synopsis

Research Article 1 (protocol): King E, Gadsby E, Bell M, Duddy C, Kendall S, Wong G. Health visiting in the UK in light of the COVID-19 pandemic experience (RReHOPE): a realist review protocol. *BMJ Open* 2023;**13**:e068544. https://doi.org/10.1136/bmjopen-2022-068544

Research Article 2: King E, Gadsby E, Bell M, Wong G, Kendall S. Health visiting in the UK in light of the COVID-19 pandemic experience (RReHOPE): findings from a realist review [published online ahead of print September 11 2024]. *Health Soc Care Deliv Res* 2024. https://doi.org/10.3310/myrt5921

Rationale for research and background

The UK has witnessed a continued downward trend in health outcomes for children and young people compared to other countries.[4] In addition, there has been a lack of investment in universal services for this demographic[5–7] along with a significant reallocation from proactive early years' provision to reactive statutory services.[8] With the COVID-19 pandemic and associated cost-of-living crisis exacerbating the situation, there is a now overwhelming consensus that we need to do better for our children by meeting their needs before they reach the point of requiring acute care and crisis services.

Universal child health programmes (CHPs) are an important means of doing this; they are grounded in a commitment to early intervention and preventive care. They play a pivotal role in safeguarding and promoting the health and development of babies and children, thereby shaping the future outcomes of the population.[9] Health visiting, as a cornerstone of these programmes, combines nursing expertise with a holistic understanding of family dynamics and community contexts. It bridges clinical knowledge and the lived experiences of families, allowing experienced practitioners to tailor interventions to the specific needs of each household.

The importance of health visiting services in supporting babies, children and families is widely recognised.[9] However, there are conflicting ideas about what these services look like in practice and how (best) to organise and deliver them. There are ongoing tensions to manage within resource-poor environments (where both funding

and staffing levels are suboptimal) between routine contacts for universal service provision and targeted contacts, particularly for children with identified needs. The dynamic nature of health policies and funding streams further complicates the organisation of health visiting services, with shifting priorities and financial constraints impacting the continuity and accessibility of preventive services. Consequently, even before the pandemic, there was a considerable variation in service delivery, and in families' experiences of the services, across the UK.

Devolution in the UK has allowed the regional governments to shape national policies on early childhood health and development. The implementation of CHPs differs across the four nations due to varying policy and strategic frameworks, though there is limited insight into how health visiting services are structured and delivered in each country. In England, where local authorities commission a variety of providers, evidence indicates substantial variation in both the delivery and uptake of required health visits as well as differences in the professionals conducting them.[10,11] In Scotland and Wales, there is no purchaser–provider split, and the CHP is delivered by health boards. In Scotland, the roll-out of the universal health visiting pathway (2015) was intended to provide more consistency in delivery across the country. An evaluation of this pathway implementation was commissioned but was not completed. However, the completed phase 1 of the evaluation (focusing on routine data analysis and child health reviews) found that, overall, the universal pathway is being delivered consistently across Scotland, with high coverage rates, increasing use of recommended development tools and a focus on conducting reviews in the child's home by qualified health visitors. There remain areas for improvement, for example in addressing the slight disparities in coverage across socioeconomic groups.[12] In Wales, there are signs that regional variations in service delivery persist, with the completion rates for the nine specified contact points varying widely by contact point and by local health board. This inconsistency is influenced by factors such as workforce capacity as well as parental uptake.[13] In Northern Ireland, there is a fully integrated Health and Social Care system which is unique in the UK. The CHP is delivered by the health and social care trusts. There is little information available to assess the consistency or variation in the delivery of health visiting services across the region.

During the COVID-19 pandemic, the variation in health visiting service delivery was compounded; the rules and circumstances governing how health visiting services are delivered, as well as the contexts in which they were delivered, were rapidly and dramatically altered.[14,15] From a realist perspective, we understand outcomes to be generated by a complex interplay of mechanisms that take effect in certain 'activating' contexts. As researchers, we felt that the dramatic shake-up of delivery had the potential to reveal new understandings of these contexts and mechanisms, enabling new learning in relation to what works, for whom and in what circumstances. The need for this new learning is especially great, given the well-documented and wide-ranging impacts of the pandemic on families and children in relation to their physical and mental health and well-being and their social and economic circumstances.[16,17]

Aim

As stated in our study protocol (Research Article 1),[1] the aim of this study was to understand the ways in which the COVID-19 pandemic impacted on health visiting services in the UK in order to identify how the organisation and delivery of health visiting services might be improved for a stronger post-pandemic recovery in service delivery. This was done by means of a realist review of the literature and with key stakeholder engagement across the UK.

The study sought to answer the question: How can the organisation and delivery of health visiting services in the UK be improved in light of the COVID-19 pandemic to provide equitable, effective and efficient services for young children and their families?

Objectives

1. To conduct a realist review of the literature to examine what the impacts (both positive and negative) of the COVID-19 pandemic have been on health visiting services in the UK, for whom, in different contexts.
2. To engage with key policy, practice and research stakeholders in England, Scotland, Wales and Northern Ireland to understand important contextual differences across the UK in relation to the planning, organisation and delivery of health visiting services.
3. To identify recommendations for improving the organisation and delivery and ongoing post-pandemic recovery of health visiting services in different settings for different groups.

The project ran from 1 June 2022 to 30 November 2023.

Methods

We chose a realist review to synthesise the literature on health visiting services during the COVID-19 pandemic, since this approach is well suited to the nuanced and

context-dependent nature of the interventions and outcomes associated with health visiting. Realist reviews offer a methodological approach that goes beyond merely identifying what works to exploring how, why and in what circumstances desired outcomes are achieved. Given the varied responses and adaptations to services implemented during the pandemic, this approach had the potential to elucidate the contextual factors that contribute to the effectiveness or limitations of health visiting interventions.

Also important is that a realist review takes a unique and context-sensitive approach to the type of literature included in the review, emphasising the importance of theory-driven analysis rather than just aggregating empirical evidence. The context of the pandemic and the timing of this study meant that many of the valuable sources of evidence were grey literature, case studies and qualitative studies.

Our methods are detailed in our protocol (Research Article 1)[1] and are summarised in our findings paper (Research Article 2).[3] Our research pathway is represented in *Figure 1*. To generate initial programme theories, we conducted scoping searches (in June 2022) for terms describing health visitors or UK CHPs. We searched PubMed, Cumulative Index to Nursing and Allied Health Literature (CINAHL) and Google Scholar, UK government web domains and relevant government websites from the four UK nations. To identify evidence for further developing and refining the initial programme theory (PT) [via the generation of context, mechanism, outcome configurations (CMOCs)], our search strategy combined free text and subject heading search terms describing health visiting and relevant UK policies and programmes, with terms describing the COVID-19 pandemic, with a date limit from 2020 onwards. Five databases (MEDLINE, CINAHL, EMBASE, Health Management Information Consortium and Google Scholar) and relevant organisational websites (identified by project team and stakeholders) were systematically searched (from October to December 2022) for relevant research articles, reports, position papers, policy and programme documentation and other non-research materials. An additional focused search was conducted in April 2023 to look for evidence related to the organisation and delivery of health visiting, specifically from a managerial/organisational level. These searches were supplemented by forward and backward citation searching (in May 2023) by a Google Scholar search alert active throughout the project and by requests to our professional stakeholder group.

In the document screening process, criteria were kept broad to ensure that all potentially relevant evidence was included. In realist reviews, evidence is selected based on

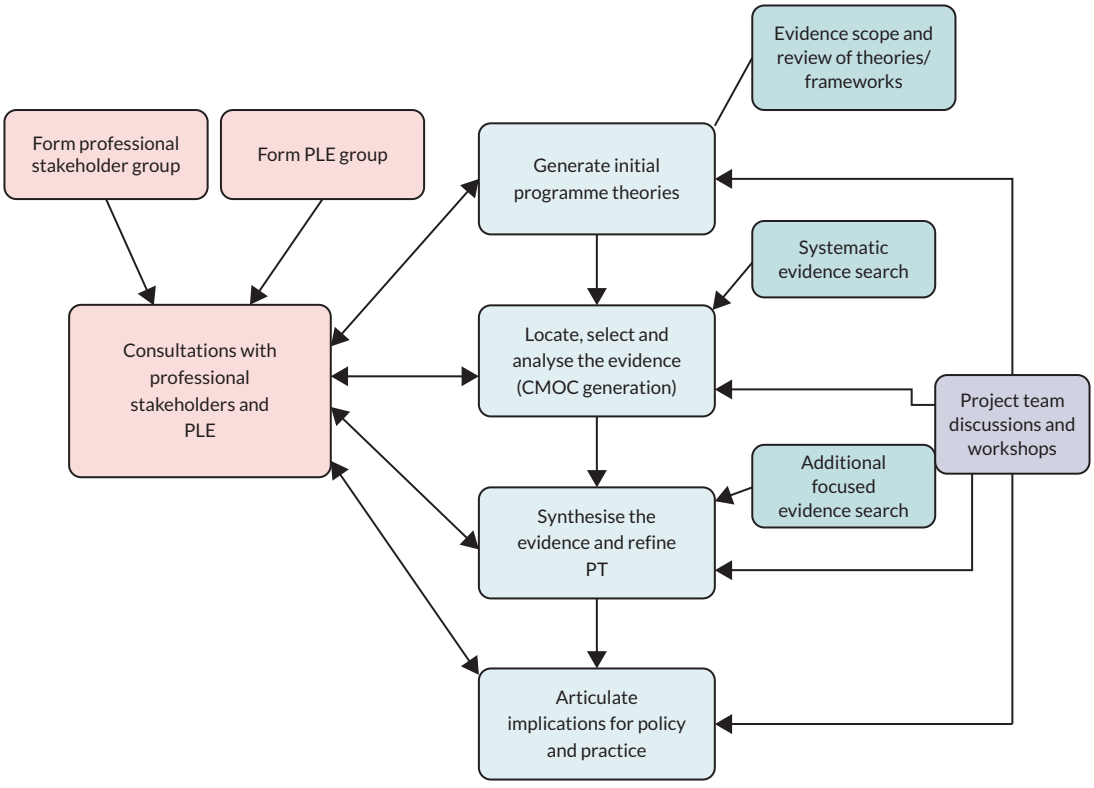

FIGURE 1 Diagram of research pathway. PLE, people with lived experience.

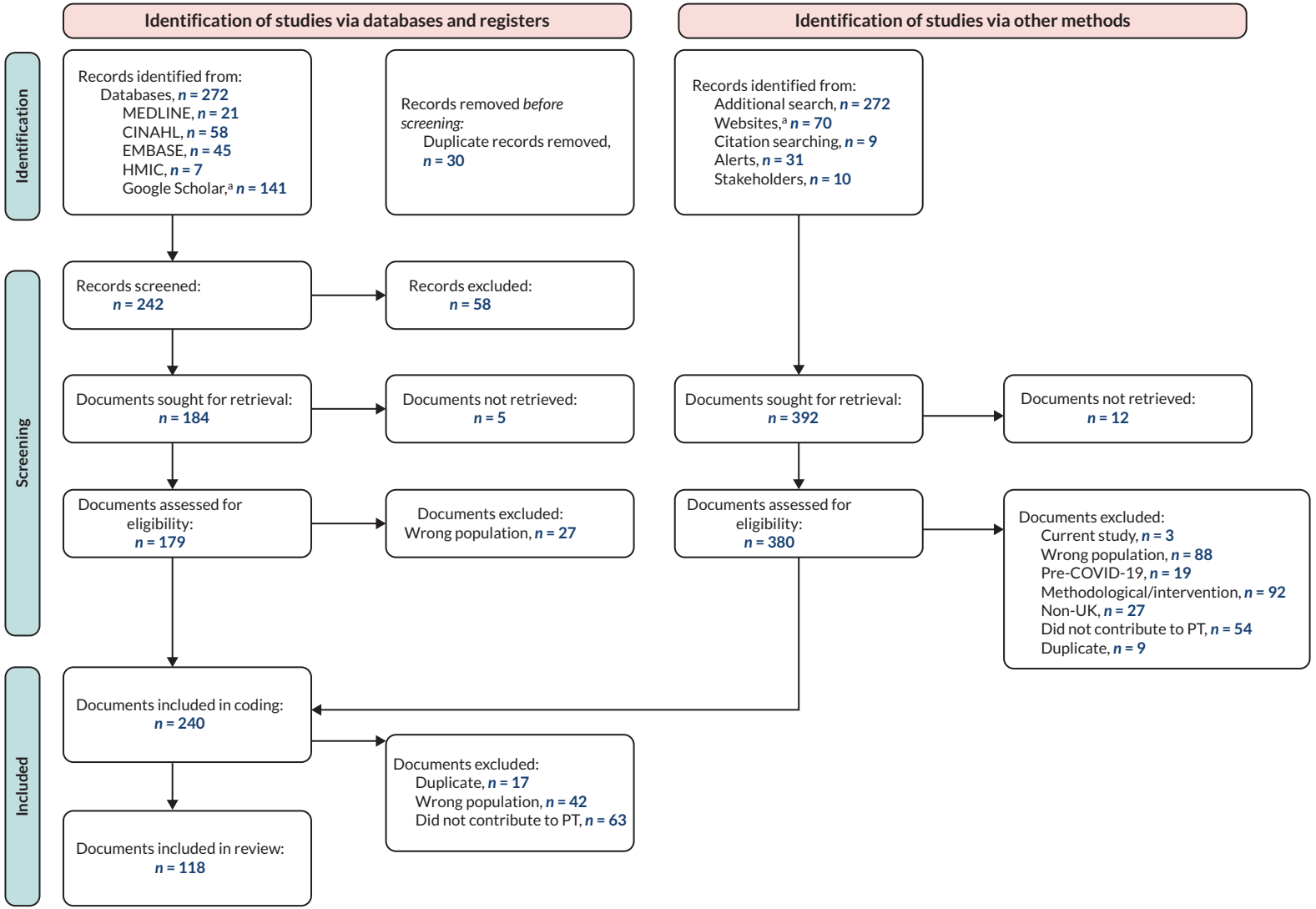

FIGURE 2 The PRISMA diagram showing the identification, screening and inclusion of documents. a, Google Scholar and website search results were screened 'on screen'; see Research Article 2[3] for details. HMIC, Health Management Information Consortium; PRISMA, Preferred Reporting Items for Systematic Reviews and Meta-Analyses.

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its potential to inform theory development and testing. We were therefore open to any evidence, including both academic and non-academic materials, related to health visiting services or the health visiting programme in any part of the UK. We included documents based on an assessment of their relevance, rigour and richness. Relevance was assessed in relation to whether the documents contained data that could inform some aspect of the PT. If deemed relevant, judgements were made at the level of the included data about richness (the depth of insight the data provide) and rigour (the credibility of the methods used to generate the data).[18] A random sample of 10% of documents were selected and independently assessed by the co-Principal Investigators (co-PIs). Decisions to include/exclude were discussed between the three researchers to ensure that they were made consistently. Any disagreements that were not resolved between the three researchers were resolved by the team through majority vote. Any uncertainties about relevance and/or rigour in the remaining 90% of documents were treated in the same way: first through discussion with the co-PIs, then, if necessary, these were resolved by the team.

We excluded models or programmes similar to health visiting run in countries other than the UK, and documents focused exclusively on specialist/targeted CHPs (beyond universal health visiting). *Figure 2* shows the identification, screening and inclusion of documents.

Results summary

Initial programme theory

Prior to the main evidence searches, we developed an initial PT, drawing on the background literature and our discussions with stakeholders and people with lived experience (PLE). This initial PT is presented in *Figure 3*. This acknowledges that before the pandemic, the delivery of health visiting services was already complex, with significant variations at both regional and local levels. This complexity was further influenced by challenges such as public sector funding cuts, high health visitor caseloads, workforce composition and staffing pressures, organisational restructuring and persistent social factors driving service demand, including poverty, adverse childhood experiences and health inequalities. The initial PT points to the interplay between two key factors that we wanted to explore in this review: the pandemic response and the organisation and delivery of health visiting services. Specifically, we sought to understand how these factors influenced each other, the mechanisms involved, the contexts in which changes occurred, the extent of their impact and the populations affected. To achieve this, we analysed literature documenting shifts in service delivery, changes in parent and child behaviours, and developments in the broader support environment during the pandemic response (from March 2020 onwards).

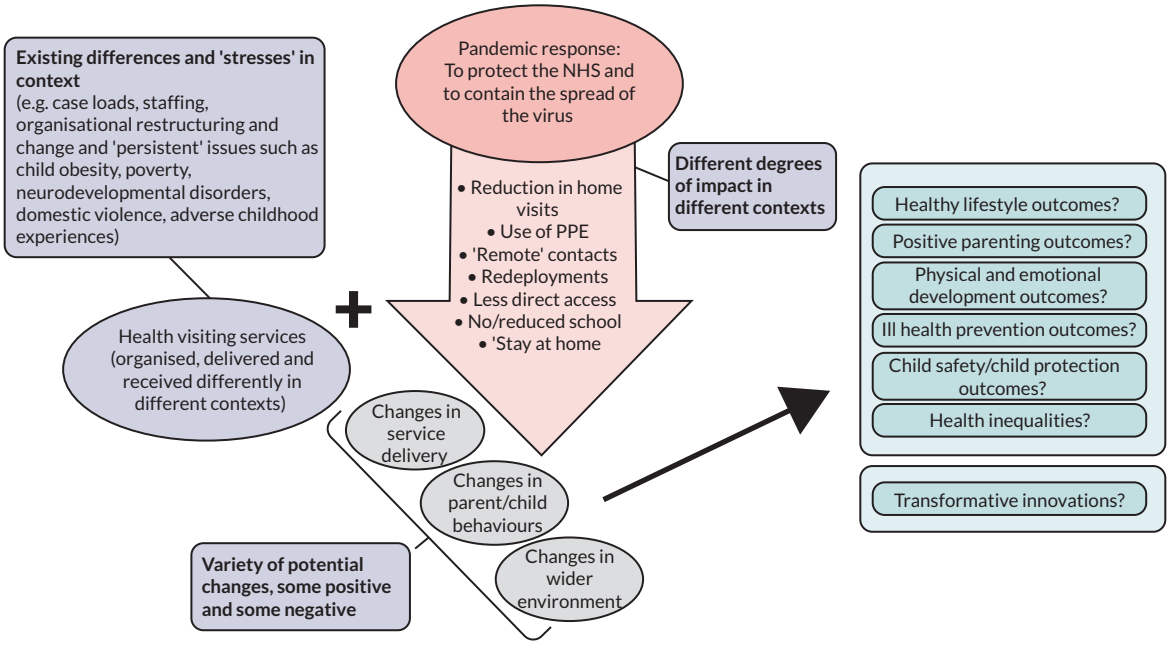

FIGURE 3 Initial PT. PPE, personal protective equipment.

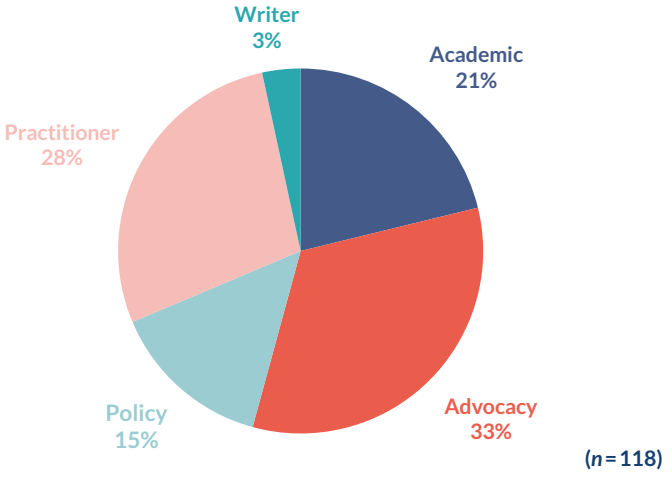

FIGURE 4 Primary perspective of documents.

Developing the programme theory

From our search of evidence to inform the development of this initial PT, we found and screened 242 documents. A total of 118 documents were included in the review. Given the temporal context of our review, it is perhaps unsurprising that the majority of included documents were from an advocacy perspective (33%), which included charities and organisations such as the iHV. This was followed by perspectives of practitioners' (mainly health visitors but also some related clinical roles such as paediatricians), and academics' perspectives. There were some articles from a policy or government perspective and a very small number of articles from independent writers/journalists (3%). An analysis of the primary perspectives of our included documents is shown in *Figure 4*. We obtained very few documents from professional stakeholders that evidenced decision-making at local organisational/managerial level and no further documents from our additional search. Our assumption, therefore, is that much of this learning about the way that health visiting decisions were made during the pandemic has not been documented.

A key aspect of this research was that it sought to analyse the situation across the four countries of the UK, where there are distinct differences in child health policies and programmes, in health visiting service delivery and in pandemic responses. However, the documents we identified were overwhelmingly focused on health visiting in England or the UK, with very few documents describing health visiting in Scotland, Wales or Northern Ireland. We noted that multiple documents came from organisations purporting to be UK-wide but described only the health visiting pathway in England, or used case studies only from England. This supports comments by stakeholder group members that literature on health visiting is often England-centric. In these cases, we placed the document in the England category. The analysis of country of focus for our documents is shown in *Figure 5*.

The full realist analysis and review findings (and full data extraction table) were reported in Research Article 2.[3] Findings were organised into three broad categories: health visiting contacts, health visiting connections and the health visiting workforce. All our findings and recommendations were fed back to our stakeholder group and lived experience group and fully discussed and agreed as presented here.

The 21 CMOCs, summary review findings and 24 recommendations are presented together below to demonstrate the relationships between them.

Health visiting contacts

CMOC01: When health visiting teams are not picking up issues through routine surveillance (C), educators and health professionals might see differences in their cases (O) because issues (e.g. developmental issues) are not recognised in a timely way (M).

Finding: When routine, universal contacts were not being made by health visiting teams, potential needs were likely missed.

Recommendation: (1) Service managers should ensure that all families receive the full proactive schedule of health visiting universal contacts (set out in each nation's service specification) and that services are easily accessible and responsive to families' changing needs between these contacts.

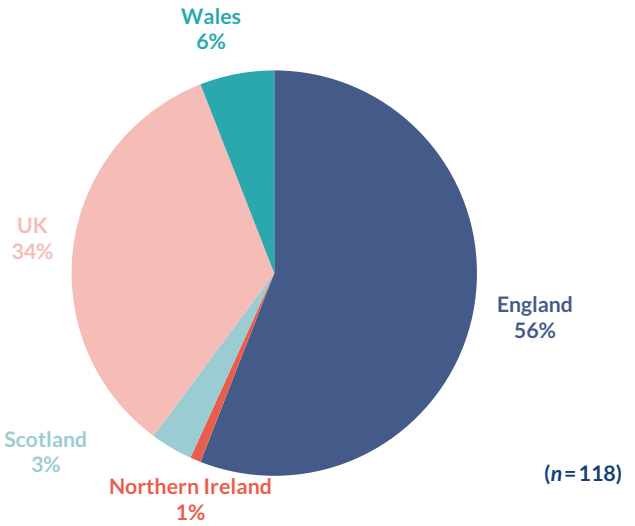

FIGURE 5 Country of focus for documents included in review.

CMOC02: When a family is contacted by phone/video soon after the birth (C), health visiting staff might be able to detect concerns that they can raise with the health visitor (O) because some forms of assessment are relatively easy to do remotely (M).
Finding: Remote contacts (such as a phone or video call) sometimes provided useful opportunities to gather additional information from families in between the universal assessment reviews.
Recommendation: (2) Health visiting teams should consider all relevant forms of contact with families as useful opportunities to gather information that might be important for a health visitor's assessment of need, recognising the benefits of home visiting over remote contact.

CMOC03: When there are fewer face-to-face contacts between a health visitor and the family (C), health visitors might miss important information or cues related to needs (O) because physical observations are an important part of assessing needs (M).
Finding: Face-to-face contacts (with personal protective equipment) continued to play a crucial role in some circumstances, in eliciting the needs, risks and vulnerabilities of babies, young children and their families. Face-to-face contacts enable the gathering of information through physical observations, which might otherwise be missed.
Recommendation: (3) Service specifications should ensure that there are some contacts (e.g. all universal assessment contacts/mandated reviews and child safeguarding concerns) that are always conducted face to face with all families. These should increase based on professional judgement and needs of families.

CMOC04: When health visitors have a manageable workload (C), they are more able to provide holistic support to the family (O) because they are not just in 'firefighting' mode (responding to most immediate/high priority needs amongst prioritised families) (M).
Finding: The pandemic significantly impacted staff workload at a time when many teams were already under a lot of pressure. Unmanageable workloads impact the ability of health visitors to provide holistic, preventive support to families.
Recommendation: (4) Service managers should ensure that health visiting teams have sufficient capacity to be able to provide preventive, holistic support and early intervention. (Note, what we do not know, from the data, is what 'sufficient' looks like, nor how teams might be organised to make best use of the existing capacity.)

CMOC05: When there are very few or no contacts between health visiting teams and families (C), some families will feel less supported (O) because they feel they have been 'abandoned' by the health visiting service (M).
Finding: Families' needs change over time and more so during a time of crisis (such as that caused by the pandemic). Regular contacts with the health visiting team helped families to feel more supported.
Recommendation: (5) Health visiting teams should ensure that their services are responsive to families' changing needs over time. This requires regular universal contacts with all families to review their needs alongside accessible services to make it easy for families to get additional support between these contacts when they need it.

CMOC06: When a family is contacted by phone/video (C), staff might be able to direct families to digital interventions or other support (O) because some forms of information and guidance are easy to give this way (M).
Finding: Some forms of information and guidance were easily delivered by health visiting teams in a digital format (e.g. apps, videos and links to support groups). However, many of these digital interventions are currently unevaluated and different teams were putting resources into producing similar digital information. Such resources do not help to meet the needs of families living with digital poverty who might be excluded. Lack of consideration to this could inadvertently widen inequalities in access and outcomes.
Recommendations: (6) Digital interventions and support should become part of the health visiting delivery toolkit, but these should be evidence-driven, accessible, tailored to meet the diverse needs of different families and evaluated.
(7) National bodies could create a bank of evidence-based and evaluated resources that health visiting teams know are of good quality and can be shared with families.
(8) Health visitors could be encouraged to review and share existing resources to save duplication in the creation of digital information.

CMOC07: When COVID-19 prompted the creation of new digital resources (C), health visitors had different

opportunities to provide information and support to families (O) because such resources are easily shared via remote contacts (M).

Finding: The COVID-19 pandemic promoted the creation of new digital resources, providing health visitors with different opportunities to deliver information and support to families.

Recommendation: (9) New digital resources should be reviewed, piloted and evaluated for their potential value to health visitors and impact on improving access, experience, outcomes and reducing health inequalities for babies, children and families.

CMOC08: When assessing babies and very young children face to face (C), parents are potentially less anxious/more reassured (O) because assessments are more thorough and being carried out by a trained professional (M).

CMOC09: When there are fewer face-to-face health visiting contacts (C), some families will feel less supported (O) because they do not have the opportunity to build a relationship with their health visitor (M).

Finding: Some families felt more supported when they had an opportunity to build a relationship with their health visitor through face-to-face contacts. Such contacts facilitate a better understanding of the family context and trusting relationships with families.

Recommendation: (10) Face–to-face visits should remain a key method of health visiting delivery, given their important role in building trusted relationships. They have been shown to be a common element of effective family support. In addition to this, regular contact using a range of methods can provide parents with increased choice.

CMOC10: When support is offered online (C), some families may not be able to engage meaningfully (O) because they do not have the resources or desire to do so (M).

Finding: Some families did not have the resources or desire to engage meaningfully with remote contact methods. Remote contact methods also exclude babies and young children.

Recommendations: (11) Health visiting teams must ensure their service delivery is inclusive and that families without the resources or desire to engage with remote contact methods are not disadvantaged. Families could be given a choice about whether contacts in between the regular universal contacts are face to face, at home or in another setting, digital or on the phone.

(12) The choice of method of contact must take account of the needs of babies and young children to ensure that it does not reduce the quality of care and support they receive or have an adverse impact on their outcomes. Regular universal contacts should always be conducted face to face.

CMOC11: When health visitors judge it is appropriate (C), they may use remote connections (O) because this is a way to keep in touch with all their case load in a safe way (M).

Finding: Health visitors sometimes used remote and digital contact methods to keep in touch with families on their caseloads, for example when parents preferred this or when workloads were particularly high.

Recommendation: (13) Remote communication methods could be considered, for example as a way of helping to manage high caseloads, but they should be piloted and evaluated, especially for their impact on inclusivity, access, experience, identification of need and vulnerability, outcomes and the reduction of inequalities. Service managers should carefully consider what 'remote contact' entails and what is appropriate or suitable when, with whom and for what purpose.

CMOC12: When health visiting teams use remote connections to maintain an open and responsive channel of communication with parents (C), parents feel supported (O) because they feel somebody is taking an interest in them (M).

Finding: When health visiting teams used remote contact methods to maintain open and responsive channels of communication, parents felt supported because trusted relationships could be maintained in some capacity.

Recommendation: (14) Health visiting teams should consider a range of methods by which they can provide open channels of communication for families to get in touch and seek help or information.

Health visiting connections

CMOC13: When there is closure of other local services/groups/organisations that health visitors can refer families to (C), health visitors cannot perform a vital part of their role (e.g. signpost/refer onwards) (O) because they have limited access to do so (M).

Finding: Closure of other services (or those services exceeding capacity) meant that health visitors

could not perform a vital part of their role, signposting and referring families for additional help. During the pandemic, this happened at a time when families' needs for support increased and when many more babies became vulnerable to a range of adverse childhood experiences.

Recommendation: (15) Establishing, supporting and sustaining a range of local services for children and families should be a high priority.

CMOC14: When there is closure of other local services/groups/organisations that health visitors can refer families to (C), health visitors will potentially feel compelled to do more 'extracurricular' tasks (O) because they feel professionally obliged to do so (M).

- Finding: The pandemic caused many community services to close, reduce capacity or become less accessible, for example by increasing their thresholds for support. When other local services for children and families closed (or exceeded capacity), health visitors sometimes took on additional tasks (such as cases that would previously have been managed by children's social care, children awaiting diagnosis of Special Educational Needs and Disabilities, translation, form-filling and picking up prescriptions) because there was nobody else to help families.

  Recommendation: (16) In order to contain their role, health visitors should be supported to highlight where the local service provision is missing and to advocate for additional local investment to strengthen the system of support for families across a range of health, education and social needs.

CMOC15: When there is closure of other local services/groups/organisations that health visitors can refer families to (C), families may become concerned that some of their child(ren)'s development may be affected (O), because they are unable to socialise with other children and access different activities (M).

Finding: During the pandemic, there was a lack of local groups that supported families coming together. Children and families missed out on opportunities to socialise and engage in activities, increasing the risk of social isolation and stress on new parents and limiting babies' developmental opportunities.

Recommendation: (17) A range of different activities for families and young children should be available and accessible locally, especially for those who may otherwise lack resources or opportunities. Many of these activities/opportunities are traditionally provided by charitable organisations in accessible community venues (such as libraries or children's centres). Both the charities and the venues should be sustained as part of the system of support for families and children.

CMOC16: When health visitors have reduced informal contact with other health visitors and clinicians (e.g. with social distancing or online working) (C), they are under more stress and isolation (O) because they have reduced opportunity for informal discussion, feedback and debriefing within health visiting teams, and between health visitors and other colleagues (e.g. general practitioners).

Finding: During the pandemic, fewer opportunities for informal contact between members of health visiting teams and clinicians meant fewer opportunities for informal discussion, support and peer review, alongside any formal clinical supervision and reflection. This led to increased stress and isolation, resulting in a range of mental and physical health impacts for some health visitors.

Recommendation: (18) Working arrangements must ensure that members of health visiting teams spend time together on a regular basis, for discussion, debriefing and peer review.

CMOC17: When health visitors have the option of using online meetings to work or train with colleagues and other health and care professionals (C), this can save them time (O) because they do not have to travel to these (M).

Finding: Use of digital and remote technologies to enable peer discussions, team meetings, interagency working and delivery of some types of education sometimes proved to be an efficient use of time and facilitated opportunities particularly for those in remote areas.

Recommendation: (19) Online delivery methods should be considered for certain staff training, team meetings and collaborative opportunities.

CMOC18: When multiagency working was reduced and outside agencies closed (C), health visitors struggled to safeguard children (O) because there were fewer opportunities for children to be seen and assessed (M).

Finding: During the pandemic, health visitors had to adapt their safeguarding response to children in ways that were, at times, suboptimal. This is because they had less contact with families and so many other agencies, schools and child-care settings were not seeing children face to face.

There were also not enough health visitors in many areas to meet the scale of need (due to redeployment, sickness and workforce shortages).
Recommendation: (20) Health visiting and other services/agencies involved in safeguarding children must support each other and co-ordinate service delivery so that, during times of crises, some children and families do not become invisible. A systematic and proactive way of reaching all families to identify children with clinical and safeguarding vulnerabilities is needed.

Health visiting workforce

CMOC19: When some of the health visitor workforce is moved into other roles (C), this leads to increased service delivery challenges for the remaining health visitors (O1) and a feeling of health visitors being devalued (O2) due to increased workloads when health visitors are already spread thinly (M1) and when health visitors are seen as dispensable and able to move to other roles (M2).
Finding: When health visitors were seen, during the pandemic response, as dispensable and able to be redeployed, this led to them feeling devalued.
Recommendation: (21) Universal home visiting services, dedicated to new parents and young children, are seen as 'vital services' and therefore should be protected, as far as possible, in any future emergency.

CMOC20: When the response by policy-makers and decision-makers to COVID-19 was focused on short-term acute issues and not longer-term public health support (C), this led to health visiting and younger children being largely ignored for policy and funding decisions (O) because they were not considered to be a priority (M).
Finding: Younger children were not considered as a priority for policy-makers and decision-makers during the COVID-19 pandemic response. The divergence in policy across the devolved nations also led to different models of support for parents with babies and young children.
Recommendations: (22) Future emergency plans and policy-making should prioritise outcomes, including the well-being, learning and development of babies and children, alongside disease control and acute care.
(23) A robust COVID-19 recovery plan for children is needed to address the scale of unmet need that is now known and to ensure that action is taken to identify the needs of children that have been missed during the gaps in service provision.

CMOC21: With the health visiting service close to the breaking point of pre-COVID-19 (C), there were negative consequences for staff, families and children during the pandemic (O) because it did not have the capacity to manage any additional pressures (M).
Finding: Child health and health visiting services in many areas were close to crisis point prior to the pandemic. The COVID-19 response exacerbated this situation, which led to negative consequences for many staff, families and children.
Recommendation: (24) Additional support and effort are required to mitigate the negative impacts of the pandemic response on health visiting teams, particularly to build capacity/resource and protect staff well-being.

Refined programme theory

Our findings highlighted the key concerns of families and practitioners throughout the COVID-19 pandemic, in relation to health visiting service delivery, and how the service responded in light of the pandemic. Health visitors recognised that strong, trusting relationships with families were essential for effective support even when in-person visits were not possible. The findings highlighted that positive relationships between parents and health visitors improve child health outcomes by enabling tailored support and encouraging disclosure of sensitive issues. During the pandemic, many face-to-face contacts were suspended, but families appreciated alternative communication methods like phone calls and messaging apps. However, some families felt that health visitors focused too much on procedural checklists rather than genuine engagement, reinforcing that relationship-building skills remain a priority regardless of communication method.

Findings highlighted that health visitors play a crucial role in identifying health, developmental and social concerns early. These assessments need to be ongoing, as family circumstances and child vulnerabilities change over time. While face-to-face visits are seen to be vital for holistic assessments, remote methods can still help monitor emerging needs and reduce family isolation. A key concern was ensuring that identified support needs were met, particularly as services became less accessible during the pandemic. Health visitors adapted their roles by signposting families to appropriate services and tailoring support to local contexts. The pandemic also highlighted the potential for digital tools to provide quick, scalable information and facilitate peer support among parents.

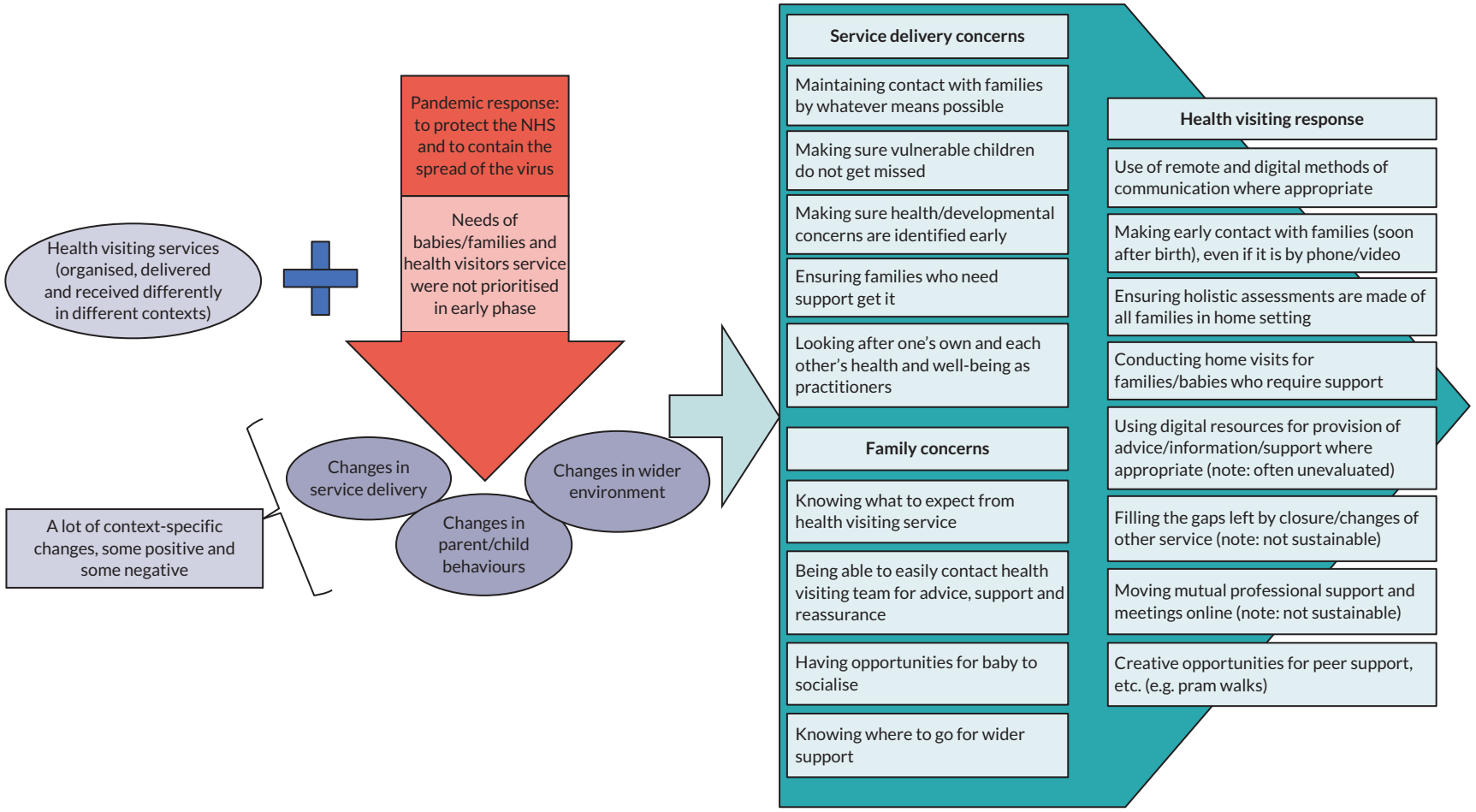

FIGURE 6 Refined PT.

The pandemic exposed significant variations in how health visiting services were delivered and how the profession was understood by policy-makers and the public. We observed a gap between the idealised version of health visiting and the reality of practice. Using Shorrock's concept of 'varieties of human work',[19] our study distinguished between:

- Work-as-imagined – policy-makers' and the public's expectations of how health visiting should function.
- Work-as-prescribed – formal guidelines on how services should be delivered.
- Work-as-disclosed – how health visitors described their work, which may align with the prescribed expectations or highlight discrepancies.
- Work-as-done – the actual work carried out in practice, often in complex and resource-limited conditions.

The pandemic introduced further inconsistencies in health visiting services due to local interpretations of COVID-19 rules and varying service adaptations. The evidence in this review underlined the difficulties associated with both describing and understanding health visiting work, which is inevitably more complex and constrained than imagined or described.

Our refined PT diagram summarises our findings and is presented in *Figure 6*.

Discussion/interpretation

Our realist review identified and analysed literature that gave a partial view of the impacts (both positive and negative) of the COVID-19 pandemic on health visiting services in different contexts in the UK. The view was partial in two key ways.

First, most documents reported on the situation in England or the UK as a whole, as opposed to Wales, Northern Ireland or Scotland. It was a clear intention of our review to consider situations across the four countries of the UK, where the contexts are quite different.[20] We noted in our rationale for this research that there is little detailed knowledge about how health visiting services are organised and delivered across the UK. While one ongoing study is attempting to categorise models of delivery across England (where there is most variation),[21] this is hampered by issues of data quality and completeness.[22] We are not aware of any studies attempting to do the same in Scotland, Northern Ireland or Wales. With very little new data related specifically to Wales, Northern Ireland or Scotland, we were limited in the extent to which we could analyse the evidence in a comparative way, considering the differences in policy and service delivery, and the differences in impact of the pandemic, across the four countries of the UK. Our discussions with professional stakeholders consistently highlighted the differences in country contexts and demonstrated the importance of carefully interpreting our findings in relation to their relevance outside of England. Unfortunately, our policy stakeholder in Northern Ireland left their post soon after the study began, and no replacement could be found, so insights into the context in Northern Ireland were limited.

Second, most documents presented the perspective of advocacy organisations and practitioners as opposed to academic or policy perspectives. This data set gave us rich insights into the impacts on babies, young children and families. For example, The First 1001 Days Movement (The First 1001 Days Movement is a group of organisations and professionals who work with the Conception to Age Two All-Party Parliamentary Group to raise awareness of the importance of the earliest years of life) published a statement in response to COVID-19 (April 2020) expressing the considerable concern felt by many regarding the secondary impacts of COVID-19 on babies, the enormous pressure on already vulnerable families and the scaling back of community services that support them.[23] This collective of organisations and professionals subsequently published several reports, including one, in November 2022, summarising a review of relevant reports, research and national data and a new survey of 555 professionals and volunteers who work with babies and their families across a range of services. This report concluded that the pandemic 'is having a lasting effect on many babies' and children's wellbeing and development' (p. 3), with more babies exposed to stresses and adversity at home, reduced access to positive activities, for example for the development of communication and social skills, increased parental mental health problems, an increase in child poverty[24] and the potential for poorer physical health due to, for example, less physical activity, reduction in vaccination uptake, missed dental checks and food insecurity.

Practitioner and advocacy organisation perspectives, together with a few publications of research studies, also gave us rich insights into the impact of the COVID-19 pandemic on health visitors and other members of the health visiting teams.[14,25] For example, the iHV's 2021 report of its annual health visiting survey, completed by 1291 practitioners (1186 of whom were from across England), highlighted the extent to which services in some areas are 'so stretched' that health visitors 'can only reach

the "tip of the iceberg" of need due to reduced workforce capacity' (p. 3).[26] This report describes significant impacts of the pandemic on staff well-being and mental health.

Our data set reporting practitioners' lived experiences articulated some of the new ways health visiting teams were delivering services. Some of these changes (e.g. like the move to providing online resources, or contacting families by phone or video call) were simply a progression of a trend that had already started. Our data suggested that practitioners worked in these different ways to ensure that they could continue to provide support to families with babies and to ensure that families remained visible. They prioritised the building and maintaining of trusting relationships with families by diversifying their communication methods, by making themselves more 'available' (e.g. through private messaging or out of hours contacts) and by working innovatively around the constraints of the COVID-19 rules. However, the additional variety in work-as-done is likely to have widened the gap between that and work-as-imagined. This can have important implications both in terms of families' experiences vis-à-vis their expectations and in terms of health visitors' professional identities.[27] In a review (focusing on England only) that drew on data from national surveys of health visitors, a freedom of information request to employers and published research and national data, Morton and Adams identified variations in the local implementation of national policy decisions during the pandemic. The context of pre-existing workforce capacity issues was particularly important, with rising caseload numbers leading to more prescribed ways of working and a stifling of innovation.[15]

Beyond these more practical changes to service delivery, it is likely, given what we understood from engaging with stakeholders, that the situation was changing the decisions being made by health visitors in their day-to-day practice, perhaps quite implicitly. Our data revealed little of this. For example, in a situation where the ability to conduct holistic needs assessments for all families was considerably challenged, there was little learning in relation to *how* universal assessments should be organised and done to ensure that vulnerable babies and families are visible and their needs are not missed. Similarly, where the ability to provide or arrange targeted support was significantly hindered, it is unclear how professional judgements were affected, for example in relation to prioritising referrals. This might reflect a situation where practitioners reporting their experiences disclosed some version of work-as-done, perhaps omitting discussions around things that are out of sync with work-as-prescribed or imagined.

Other insights were notably lacking from our data set. For example, there were no data that helped to examine how service managers and local or regional decision-makers responded to the situation. Our prior work, and our discussions with professional stakeholders throughout this project, suggested that, at a team level, things were being done differently in response to the evolving situation. For example, in response to significant staff shortages, some managers were making different decisions about skill mixes, roles and responsibilities. We heard how, sometimes, different decisions were being made about how to manage caseloads, who (within caseloads) to prioritise and how, and about changing criteria for service delivery. We know that there was, pre-COVID-19, already considerable geographic variation in these matters; it is likely that such a variation was amplified during the pandemic. Indeed, a report published by The First 1001 Days Movement (September 2021), summarising conversations with 138 professionals and local leaders across England, noted that 'The extent to which the first 1001 days are being prioritised and considered in local long-term recovery planning is highly varied by area'.[28] Our extensive searches did not identify data that specifically evidenced such changes and variations in service organisation. However, the First 1001 Days Movement report did suggest some commonalities, such as close working to respond to local demand; listening more actively to the needs and demands of families and being responsive to trying and then reviewing changes.

A previous qualitative study of the experiences of child healthcare providers in general and acute paediatrics, mental health and secondary care therapy services in two regions of England and Scotland identified a number of positive opportunities for change highlighted by the pandemic experience.[2] These included challenging pre-existing mindsets and 'normal' ways of doing things, changing rules and norms, and processes and systems that empower 'bottom-up' ways of working and relieve 'bureaucratic barriers'. Some of this positivity was also captured in other work focusing on clinical innovations during the pandemic, for example in Powis and Hassell (2020).[29] Our review did not reveal similar opportunities for change beyond perhaps the potential for increased use of digital resources and communications (with strong caveats that they must be carefully evaluated and are only suitable for some people, some of the time). This does not necessarily mean that they did not occur; it is rather that the data did not speak of them. It might also reflect some differences in roles and context, with health visitors working in the community potentially having a greater degree of flexibility and 'power' to work in new ways than clinical staff in more acute settings.

In this data set, then, our insight into the extent to which things were done differently was limited. One of the perennial problems in explaining how an 'intervention' like health visiting *works* is its complexity. The core principles of health visiting are understood to incorporate universality, relationships, continuity, co-ordination and professional autonomy.[9,30–33] The skills, attitudes and values of health visitors and their application in practice have previously been analysed, and the 'craft' of health visiting practice has been detailed.[9] This work has informed policies and standards that make up work-as-prescribed. During our data analysis process, we drew on these understandings of the 'craft' of health visiting practice to develop a conceptual map (using Kumu relationship mapping software) (Kumu Inc. Los Gatos, CA, USA). This conceptual map of why/how health visiting is perceived to 'work' makes no claims to be complete or comprehensive. It summarises some of the elements of health visiting practice and explores the interconnections between them and anticipated/expected outcomes and impact. This 'map' served to orient ourselves as we processed our thoughts from our stakeholder and PLE group members and from our data analysis (see *Report Supplementary Material 1*).

One of the key elements of practice for health visitors is identifying opportunities for early intervention or support – depicted in blue circles in our conceptual map. This might be to prevent immediate harm (as in child protection/safeguarding cases); medium-term harm (such as conditions that might worsen to the extent that they require acute care); or longer-term harm (such as those brought about by poor parental attachment, inadequate housing and suboptimal nutrition). An important concept here is 'vulnerability'; health visitors must decide whether a child (or parent/family) is vulnerable at any given time and in relation to any specific aspect, or not. Where vulnerability is identified, there is an opportunity for early intervention/support. In conducting our review, we were struck by how, during a time of considerable turbulence and complexity, in which nothing was clear, and everything kept changing, there was so little discussion within the literature of how these decisions were affected. There was little sense of how health visitors *engaged* with the change and uncertainty brought about by the pandemic response; or how health visitors *reflected* on the decisions they made in this situation; or what *opportunities* were taken for health visitors to make a 'second-order practice shift'.

Second-order practice is used to mean taking a step back from something to consider your relationship with it such that the practitioner considers themselves to be part of, rather than separate to, the system in question.[34,35] Applying second-order thinking to health visiting practice would involve critically examining the assumptions, frameworks and contexts that shape their practice. This involves questioning the underlying structures, policies and ideologies that define when, how and why health visitors intervene. Health visitors, in making a second-order 'identity' shift,[36] might question framings for assessments (of vulnerability) and referrals (for intervention) rather than, perhaps, using assessment tools instrumentally. A second-order identity shift for health visiting could involve critically engaging in a dialogue with those who stand to benefit from the service (both commissioners, from a population perspective, and families) to discuss and scrutinise the 'terms of reference'. This should aim to expose and question the underlying purpose of their work, ultimately fostering an environment conducive to implementing systemic improvements within the context of their practice. Discussions in the PLE group, which identified conflicting expectations of the service, suggested the potential value of such dialogue with families. A recognition of the gap between work-as-prescribed (locally as well as nationally) and work-as-done suggests the potential value of such dialogue with commissioners and policy-makers.

From a management/organisational point of view, there were opportunities for a 'methodological' shift from sustaining business as usual (e.g. keeping on top of caseloads and performing mandated contacts) to encouraging innovation and continuous viability in the context of rapid change. A second-order methodological shift would involve understanding, designing and improving structures and processes related to health visiting service delivery in order to ensure the viability, adaptability and effective functioning in a changing environment. The documented negative impacts of the pandemic on health visiting staff, which exacerbated pre-existing workforce constraints, highlight the need for such a shift.

However, the literature, work-as-prescribed, work-as-described and conceptual maps like ours do not fully take into account the messy reality of health visiting service delivery in context. We need to ask serious questions about the viability of the imagined work of health visitors, the relevance of the prescribed work and the gap between how health visiting work is described and done. It appears that there remains a need to get further inside the black box of health visiting: to critically examine the theories that underlie health visiting services and guide the day-to-day interactions of health visitors and to scrutinise them for consistency and relevance within current contexts.

Community engagement and involvement

Aims of stakeholder involvement

Our stakeholder groups were established to help us develop our PT and review focus, including sense checking; to provide individual and collective perspectives to our review findings and recommendations; and to contribute to the dissemination of our findings, making sure that they are applicable to the needs of different groups.

We set up two separate groups: a PLE group and a professional stakeholder group. After feedback from previous studies, we made the decision to hold these groups separately to make it easier for both groups to speak freely.[37] Our patient and public involvement (PPI) lead (MB) was present at both groups and provided updates from the PLE group at the stakeholder meetings.

Stakeholder engagement methods

For our PLE group, we recruited people who had had a baby/young child (below the age of 5 years) during the pandemic and therefore should have had some contact with the health visiting service. We advertised the opportunity through social media and targeted e-mails to potential gatekeepers (e.g. health visitors with established parents' groups). Interested individuals were directed to a short online survey that asked screening questions, including the month and year of birth of children born or under the age of 5 years during the pandemic period, their postcode and their contact details. Optional demographic questions included ethnicity and gender (answered by all but two respondents). Postcodes were used to calculate the Index of Multiple Deprivation relevant to the respondent's UK country.[38–41] Thirty-seven relevant responses were received overall, 43% from England, 35% from Scotland, 5% from Wales and 13% from Northern Ireland. A group of eight (two from each country) was felt to be suitable in terms of allowing diversity in perspectives but still being manageable to allow meaningful discussion and contribution during online meetings. The research fellow and PPI lead met to select 8 participants from the 37 responses. Firstly, we selected the only male respondent and both respondents from Wales (as there were only two). We then considered the remaining applicants from each country and selected the best diversity possible regarding deprivation index, geography (e.g. rural/urban) and number of children (*Table 1*). We were mindful of the limitations of this, particularly that our national advertising had resulted in so few respondents from Wales and Northern Ireland. Our PPI lead was instrumental in helping us to select as wide a spread of demographics as possible. All other interested people were informed that they would be placed on a reserve list (with their permission).

Participants selected weekday evenings for meetings, which were conducted online and each lasted 1.5 hours. The meetings were recorded (with permission) for note-taking purposes and to share with members who were not able to attend. Full notes of all meetings were taken for the research team's benefit, and a condensed version of the notes was shared with the PLE group to check for accuracy.

TABLE 1 Demographics of initial PLE members

Member ID	Country	Number of children aged under 5 years and looked after during the pandemic	Ethnicity (self-reported)	Gender	Index of deprivation[a]
A	England	2	White British	Male	4
B	England	1	Chinese	Female	5
C	Northern Ireland	3	White	Female	9
D	Northern Ireland	3	White	Female	1
E	Scotland	1	White European	Female	10
F	Scotland	1	White British	Female	No data available
G	Wales	1	White	Female	9
H	Wales	2	British	Female	4

a Index of deprivation decile 1 = most deprived, 10 = least deprived.[31–34]

Note
Indices are ranked within countries so are not directly comparable across UK countries.

TABLE 2 Attendance at PLE meetings

	PLE meeting date			
Member ID	14 September 2022	7 February 2023	2 May 2023	12 October 2023
A	Attended	Attended	Apologies	Attended
B	Did not attend	Lost to follow-up		
C	Attended	Feedback after meeting	Feedback after meeting	Attended
D	Did not attend	Lost to follow-up		
E	Attended	Attended	Attended	Attended
F	Did not attend	Lost to follow-up		
G	Attended	Feedback after meeting	Attended	Attended
H	Attended	Feedback after meeting	Attended	Attended

As this work constitutes PPI, and not research data, no direct quotes from meetings are used in any publication.

Despite initial enthusiasm, three members did not attend the initial group and were lost to follow-up. Attempts to replace these members using the reserve list were unsuccessful due to non-response or non-attendance. The group continued with five members, two from Wales and one member each from Scotland, Northern Ireland and England. Not every member was able to make every group (*Table 2*). Non-attendees were able to watch the recording of the meeting and were offered a follow-up call with the research fellow or the PPI lead; this option was regularly taken up. All members who participated were thanked (with shopping vouchers) for their time.

The opportunity to receive training was raised with the group at meetings, and some examples of potential trainings were suggested. None of the PLE group members took up this offer.

The professional stakeholder group was recruited through direct contact with potential stakeholders. We attempted to obtain representation for national policy, commissioning/local policy, practice, academia and advocacy perspectives from each of the four UK countries and/or with UK-wide remits. In practice, we struggled to recruit anyone from Wales. In total, we recruited 28 stakeholders, including 4 practising health visitors (1 from Northern Ireland, 1 from Scotland and 2 from England), and 3 stakeholders responsible for local practice and commissioning. We also recruited eight policy representatives and three from academia. Included in our 28 stakeholders were 8 'other', including those from charities, advocacy groups or medical colleagues with a particular interest in child health (*Table 3*). Meetings took place online and were scheduled

TABLE 3 Professional stakeholder group composition

	Northern Ireland	Scotland	Wales	England
Policy	Health and Social Care Public Health Agency Department of Health	Scottish Government Public Health Scotland	Public Health Wales	Office for Health Improvement and Disparities × 2 NHS Safeguarding
Commissioning/local policy		Glasgow City Health and Social Care Partnership		Harrogate and District NHS Hampshire NHS
Practice	Belfast	Glasgow × 2		Harrogate and District × 2
Academia	Queens University Belfast	Edinburgh University Stirling University		University College London
Advocacy/other	iHV; Sands and Tommy's Joint Policy Unit; Parent-Infant Foundation; independent consultant (charity advisor); National Children's Bureau early childhood unit; Royal Aberdeen Children's Hospital/Aberdeen University; Child health and wellbeing network North East North Cumbria × 2			

on weekday afternoons, with dates set at least 1 month in advance. Despite this, stakeholders were regularly unable to attend meetings due to diary clashes, annual leave, clinical shifts, etc. Some individuals delegated to colleagues.

Stakeholder outcomes

A summary of meetings and their focus for the research team and for the professional stakeholder and PLE groups is shown in *Report Supplementary Material 2*, Table 4.

Both groups contributed to emerging findings throughout the project and critically commented on the outputs from each stage of the research. Below, we reflect on some examples of important contributions from each group.

The PLE group discussed their very different experiences as parents during the COVID-19 pandemic. In some cases, personal experiences of the health visiting service differed from the official messages about what to expect, for example in relation to the number and type of contacts received. The group discussed their personal experience of the closure of outside agencies, which was a key finding from the review. It was particularly useful to hear real-world examples of the lack of accessibility to these services and the impact on parents. Some parents had had a child pre pandemic and were able to reflect on the changes between these two times. Parents discussed a range of changes in service delivery in their local area during the pandemic, with some areas continuing with face-to-face visiting throughout and others carrying out most visits by remote methods. This resonated with what we found in the review documents and with our professional stakeholder discussions. Parents' expectations of the health visiting service were frequently discussed within the group, especially upon hearing the wide range of different experiences from different PLE members across the UK, both between and within countries. We did not ask members to disclose if they were receiving anything other than the universal health visiting pathway, although some were happy to share experiences of additional help for postpartum depression or children with long-term conditions.

Our professional stakeholder group gave us critical feedback on data interpretation and the wording that was used during our drafting of CMOCs, findings and policy implications. We discussed at length the documents from which we derived our findings and sought to mitigate for limitations in the data set, for example by discussing phrases used in documents, trying to identify sources of data underpinning some of the statements made by advocacy organisations and exploring contextual differences in experiences that were not necessarily reflected in the data.

Our professional stakeholders and PLE group discussed the importance of a period of recovery and reflection following the COVID-19 pandemic response. Some members felt that, given the longevity of the pandemic, and the combination of that with the ongoing cost-of-living crisis, opportunities for learning from that all may have been missed.

Reflections on stakeholder engagement in this study

While our PLE group was smaller and less diverse than we originally intended, we had at least one person from each of the four countries, and the dynamics of the group worked very well with lots of time for everybody to contribute. We gleaned many valuable insights into their experiences of the health visiting service during COVID-19, as parents.

Attendance at some of our professional stakeholder group meetings was lower than we had hoped, given the competing commitments of our members. It was particularly difficult to get sustained engagement from Northern Ireland stakeholders.

Stakeholder reflections on involvement in the study

At the end of the study, members of both the PLE and professional stakeholder groups were invited to give feedback on their involvement in the study. We used the Guidance for Reporting Involvement of Patients and the Public, 2nd edition reporting feedback questions, which were sent via e-mail:

1. What was your overall experience of being part of the research team?
2. What influence do you feel you were able to have on the review? Can you describe any particular examples?
3. What influence do you feel being involved in the working group has had on you and/or your work?
4. Was there anything about the working group you feel could have been improved, and if so, what?

No responses were received from the PLE group, but a small number of the professional stakeholders opted to give feedback. Direct quotes are used with permission, and we had obtained additional ethical approval for that (see *Ethics statement* in *Additional information*).

'The experience was very positive. The online calls were well-organised with information provided in advance

to allow for reflection prior to meeting'. Members also reported that they felt their opinions were of value to the research team. They would have preferred face-to-face meetings, reflecting that these allow for more natural discussion, with one suggestion being that perhaps the first and last meetings should have been face to face. The smaller breakout discussions were felt to have worked well.

The stakeholders noted the challenge of covering such a large geographical area, with the differences in health visiting provision and COVID-19 response across the UK. At the start, we had been very clear that we would discuss both positive and negative changes during the pandemic, and this was reflected in the feedback: '[I] think it was good to reflect on the positives Covid brought i.e. increased use of IT, some choice in the right circumstances for telephone/teams contact reducing travel for both staff and patients'. Stakeholders who worked in practice appreciated being able to share their experiences of their local area, and to hear about other areas, reflecting that their local area had actually had a positive experience compared to some.

Stakeholders gave good feedback about the practical aspects of the group, that the team had stuck to the original time scales given, had given information in advance and had allowed adequate time for reflection. '[I] thought it gave a good example of how to set out to do something and get it done (something I think we are not always good at)'.

Reflection from our patient and public involvement lead

We asked our PPI lead, Madeline Bell, to reflect on working with our PLE group. Madeline reflected that the PLE group fostered a safe, inclusive and respectful environment for discussions. Flexibility in participation and the validation of all experiences contributed to a meaningful engagement process. While concerns existed about the complexity of the realist review, key areas of focus were effectively communicated. Given the importance of these reflections, we have included them in the *Report Supplementary Material 3*.

Dissemination plan

We will be disseminating the study results in a variety of ways, including:

- working with the iHV to produce infographics
- involving the members of our PLE group in producing appropriate lay outputs, sharing findings and checking for applicability and accessibility to a lay audience
- involving our professional stakeholder group in converting our draft 'implications for policy' into reflexive questions
- presenting and discussing our work at health visiting and health services research conferences.

Equality, diversity and inclusion

Equality, diversity and inclusion (EDI) is an important consideration as part of a realist review. Given that our topic focused on the health visiting service during the COVID-19 pandemic, we were mindful that COVID-19 affected some ethnic minority communities more than others. We reflected on this both in relation to our lived experience group and the literature reviewed.

It is a limitation of this review that we were not able to secure an ethnically diverse PLE group. We did start the process with parents from a range of backgrounds, but due to time constraints and other commitments, not all were able to participate. However, we remain confident that those who did participate were able to provide a full range of their experiences that contributed to value of the research evidence in the review itself.

Here, we reflect on methodological decisions and the extent to which EDI are discussed in the documents included in our final review and the implications this has for our findings.

After the first scoping of documents to form our initial PT, and discussions with the research team and our professional stakeholder group, we made the decision to focus on the universal health visiting pathway for each UK country as set out in the CHPs. All UK countries also have additional pathways for families who require extra support, although the names and provision of these vary. Examples include the Family Nurse Partnership in England and Scotland[42,43] and Flying Start in Wales.[44] Reasons why a family may be offered additional support include child health needs, young parents and vulnerable or 'looked-after' children. This additional support generally consists of an enhanced number of face-to-face visits and support to learn about aspects of parenting. Some areas also have specialist health visitors or services for certain groups, for example asylum seekers or Gypsy, Roma and Traveller communities.[45]

We made the decision not to include documents about these specialist programmes in our review. This was primarily because we wished to focus on the universal

service for all children who had been affected during the pandemic. We also heard from our stakeholders that specialist programmes had been prioritised and may not have seen the implications of the pandemic in the same way as the universal service. It is important to consider that documents which focused exclusively on these specialist services were excluded from our review.

Our review does contain important information about these additional services, where they were included in documents which primarily focused on the universal service. Most of our documents also give an overview of families and children in the UK during the pandemic, which included families with increased need. Indeed, the documents included in our review, particularly those from an advocacy perspective, painted an extremely dire picture of the impact of the pandemic on families. This included job losses, being confined to small flats during lockdown, increased mental health issues, increased domestic violence and safeguarding issues. There was little mention of families who went through the pandemic in better circumstances, for example with both parents working from home or with generous furlough arrangements.

Of the 118 articles in our final review, a number highlighted the impacts of the pandemic on families living in deprivation, or on Black, Asian and minority ethnic families. These families suffered more during the pandemic, widening the existing inequalities in child health and well-being across the UK.[46] Black, Asian and minority parents reported wanting support more than White parents, but they were less likely to feel that they had access to that support and were less likely to be referred for parenting programmes.[47] One document particularly focused on the experiences of Black nursing professionals, who reflected on their nursing practice and the patients they care for. At the beginning of the pandemic, healthcare staff from minority backgrounds were more likely to die from COVID-19, prompting fear and anxiety about contracting the virus through their work. One health visitor had set up two virtual platforms to support pregnant women and new mothers and a service to allow healthcare professionals to connect with colleagues.[48] Black and Black British parents were less likely to have used the web or apps to access parenting information or support,[46] and it is important that digital poverty and accessibility across the whole population is something that healthcare providers remain mindful of when designing new services. As an example, the Baby Buddy app has been designed to be inclusive and accessible to people whose first language is not English. The app shows a comparatively high usage by Black, Asian and minority ethnic communities, and people who speak English as a second language, compared to other pregnancy apps.[49] It is helpful also to see documents which use case studies of particular local areas, for example Nottingham[50] and South Gloucester,[51] or real-world examples of approaching and making information accessible to communities with different language requirements and social norms,[52] which highlight the particular circumstances faced by different communities. Other studies highlighted the lack of Black, Asian and minority ethnic respondents in their data collection and called for further research specifically looking at the experiences of these populations.[53] While our data did highlight the disparities between Black, Asian and minority ethnic communities, we lacked tangible examples of the impacts on the health visiting service. For example, we had anecdotally heard that health visitors were having to do more with translation due to the closure of local charities, but there was a lack of evidence to support this in the documents included in our final review.

As highlighted in our Research Article 2,[3] the closure of outside services, playgroups and charities was a major theme of our review and has been mentioned in many of the documents. Some groups have now reopened, but many are using booking systems and waiting lists, removing the flexibility which often attracted parents in the first place.[54] Services such as child care are also beneficial at addressing gaps in children's development, meaning a lack of services or accessibility to services is also likely to leave behind the poorest and most vulnerable children.[23] Access to indoor and outdoor spaces to play, toddler groups and children's centres is particularly important for children living in overcrowded accommodation.[55]

Impact and learning

An objective of the RReHOPE study was to identify recommendations for improving the organisation and delivery and ongoing post-pandemic recovery of health visiting services in different settings for different groups.[1] Through our engagement with our professional stakeholders, we developed draft implications for policy and practice, which map onto our CMOCs and findings. As part of our dissemination plan, we will be engaging our professional stakeholders to turn these implications for policy-makers into reflexive questions. Our aim is that these reflexive questions will prompt people at every level of the health visiting service (practitioners, managers, commissioners and policy-makers) to think critically about the service in their area and how this can be improved. A central principle of health visiting is to influence the policies affecting health.[26] It is therefore essential that the

findings reach the health visiting profession itself. We will work with the iHV to help ensure that this happens.

We will explore the potential, with our professional stakeholder group, to design outputs that are applicable to each of the different UK countries and tailored to the specific CHP in each country. However, this might not be deemed worthwhile, given the caveat around England-centric bias in the evidence (as we have also seen in our review documents).

Implications for decision-makers

A more detailed list of implications for policy and practice from our review findings is shown in Research Article 2.[3] As we have reflected on in this synopsis paper, the current literature on health visiting is extremely England-centric, and decision-makers should consider the applicability of current health visiting literature to the other UK countries. We are aware that recommendations made from our data may not be relevant in different UK countries, or in different local areas. The reflexive questions we are developing will overcome this bias and allow decision-makers to consider the state of health visiting in their local area.

We were conscious during our study of the high number of documents written from an advocacy perspective. In some cases, underlying data behind sweeping statements made, for example about the impact on child health, were missing. While advocacy perspectives are important, decision-makers should be aware that these documents may not always provide the most balanced viewpoint, or have data to support some of the statements made.

Research recommendations

This synopsis paper highlights some areas for future research. More detailed data are required on the health visiting services in UK countries other than England, with research that takes account of the different health visiting pathways and governance in Scotland, Wales and Northern Ireland. We also call on authors to specifically detail the country of focus in future documents, as documents purporting to be about the UK often focused solely on England, or did not specify which UK country was being referred to.

This study only afforded a partial glimpse inside the 'black box' of health visiting. Given the complexities of health visitor work, and how much of that work goes undescribed, either in policy or in the literature, new observational studies, both in-depth qualitative as well as cohort studies, of health visiting activity and outcomes are vital for further examining the theories that underlie health visiting services and that guide the day-to-day interactions of health visitors and to scrutinise them for consistency and relevance within current contexts. We are aware of a number of studies funded by National Institute for Health Research commenced since this review was conducted, which are contributing to unpacking the 'black box' from both a quantitative and qualitative perspective.

Our review included a number of documents focusing on Black, Asian and minority ethnic populations and their experiences during the pandemic. We know that these populations have fared worse during the pandemic and our documents spoke about the impact of this on widening inequalities. Further research is needed to address the current lack of information about the interactions with the health visiting services and the particular impacts during the pandemic, for example access to translation services with the closure of outside charities and agencies.

Conclusions

This realist review of the literature on the universal work of health visitors during the COVID-19 pandemic included 118 documents from across sources that includes advocacy organisations, professional practice and some academic research. We also included the significant input of stakeholders and parents with lived experience of the health visiting service during the pandemic. While the intention was to cover the whole of the UK, the final selection of papers was heavily skewed towards England. The conclusion, therefore, needs to be seen in this context and may vary in terms of its relevance to Scotland, Wales and Northern Ireland. The detailed recommendations are provided in the findings report (Research Article 2)[3] based on the PT that emerged from the findings. In summary, we found that, unsurprisingly, there were both service concerns and family concerns during the pandemic, and the health visiting services had to respond to both. The responses varied and were not always evaluated or sustainable. For example, the use of digital methods for contacting families, providing information and undertaking assessments met some of the need to manage the services more efficiently but did not always meet family concerns or expectations regarding the health and well-being of their baby or child. This resulted in families expressing a lack of continuity, communication and holistic care, leading to fragmentation and the sense that problems could be overlooked or missed.

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Overall, there was evidence that the health visiting service was not prepared for managing the universal public health role for children and families during a global pandemic. Future planning for any potential crisis must consider the evidence of how an uncertain service provision can impact on babies, children and families. This uncertainty can undermine the ability of health visitors to ensure that babies and children are safe, healthy, meeting their milestones and having their social and emotional needs met.

It is critically important that policy-makers and health visitors themselves create a dialogue around issues that remain in the 'black box' of health visiting, some of which are exposed in this study through the involvement of both stakeholders and parents. A key principle of health visiting is to 'influence the policies affecting health'.[26] This proactive aspect of the health visitor's professional duty can be further strengthened through second-order shifts in health visiting praxis. This, we suggest, entails reflecting on the choices for ways of working in complex and changing situations and identifying ways of overcoming systemic issues that impact the effectiveness of health visiting services and the well-being of those they serve.

At a time when increasing numbers of babies are born into challenging and uncertain times, when children in the UK have very poor health outcomes compared to the rest of Europe and when child health services in the UK are lagging behind, it is more important than ever to reflect on what needs to change to ensure that we rise to the challenge.

Additional information

CRediT contribution statement

Erica Gadsby (https://orcid.org/0000-0002-4151-5911): Conceptualisation, Methodology, Funding acquisition, Writing – original draft, Writing – reviewing and editing.

Emma King (https://orcid.org/0000-0003-3611-9647): Methodology, Project administration, Formal analysis, Writing – original draft, Writing – reviewing and editing.

Madeline Bell (https://orcid.org/0000-0003-2846-7318): Conceptualisation, Writing –reviewing and editing.

Geoff Wong (https://orcid.org/0000-0002-5384-4157): Conceptualisation, Methodology, Funding acquisition, Supervision, Writing – review and editing.

Sally Kendall (https://orcid.org/0000-0002-2507-0350): Conceptualisation, Methodology, Funding acquisition, Supervision, Writing – review and editing.

Other contributions

Madeline Bell (https://orcid.org/0000-0003-2846-7318): Writing – reflections.

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Data-sharing statement

This realist review uses secondary data and therefore the data generated are not suitable for sharing beyond that contained within the manuscript. Further information can be obtained from the corresponding author.

Ethics statement

Ethical approval obtained from University of Stirling General University Ethics Panel, application reference RReHOPE 7662 on 26 April 2022.

Additional ethical approval to publish quotes from stakeholders was obtained from University of Stirling General University Ethics Panel, application reference RReHOPE-PPI Evaluation 16808 on 27 November 2023.

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Full disclosure of interests: Completed ICMJE forms for all authors, including all related interests, are available in the toolkit on the NIHR Journals Library report publication page at https://doi.org/10.3310/GJEG0402

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This synopsis was published based on current knowledge at the time and date of publication. NIHR is committed to being inclusive and will continually monitor best practice and guidance in relation to terminology and language to ensure that we remain relevant to our stakeholders.

Publications

King E, Gadsby E, Bell M, Duddy C, Kendall S, Wong G. Health visiting in the UK in light of the COVID-19 pandemic experience (RReHOPE): a realist review protocol. *BMJ Open* 2023;**13**:e068544. https://doi.org/10.1136/bmjopen-2022-068544

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Presentations

Kendall S. The RReHOPE study. UCL, Multi-Project Meeting to Share and Discuss Health Visiting Studies, London, July 2023.

King E. Realist Review of Health visiting in the UK in light of the COVID-19 pandemic experience (RReHOPE). European Forum of Primary Care Conference, Barcelona, September 2023.

King E, Gadsby E. Realist Review of Health visiting in the UK in light of the COVID-19 pandemic experience (RReHOPE). Stirling University Faculty of Health Sciences and Sport, Research Day. Stirling, November 2023.

Gadsby E, Kendall S. Health visiting in light of the COVID-19 pandemic experience. iHV Evidence Based Practice Conference, Manchester, July 2024.

Gadsby E. Health visiting in light of the COVID-19 pandemic experience. 0–19 Research Network (Yorks and Humber), Online, March 2025.

Gadsby E. Calling for a second-order practice shift in health visiting. ICCHNR (International Collaboration for Community Health Nursing Research Conference), London, April 2025.

Press release

Institute of Health Visiting. Health visiting study seeks to learn lessons from pandemic. June 2022. URL: https://ihv.org.uk/news-and-views/news/health-visiting-study-seeks-to-learn-lessons-from-pandemic/ (accessed 1 September 2025).

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List of supplementary material

Report Supplementary Material 1
RReHOPE conceptual map – why/how does health visiting 'work?'

Report Supplementary Material 2 Table 4: Stakeholder meetings

Report Supplementary Material 3
Reflections from patient and public involvement lead on working with the people with lived experience group

Supplementary material can be found on the NIHR Journals Library report page (https://doi.org/10.3310/GJEG0402).

Supplementary material has been provided by the authors to support the article and any files provided at submission will have been seen by peer reviewers, but not extensively reviewed. Any supplementary material provided at a later stage in the process may not have been peer reviewed.

The supplementary materials (which include but are not limited to related publications, patient information leaflets and questionnaires) are provided to support and contextualise the publication. Every effort has been made to obtain the necessary permissions for reproduction, to credit original sources appropriately, and to respect copyright requirements. However, despite our diligence, we acknowledge the possibility of unintentional omissions or errors and we welcome notifications of any concerns regarding copyright or permissions.

List of abbreviations

CHP	child health programme
CINAHL	Cumulative Index to Nursing and Allied Health Literature
CMOC	context, mechanism, outcome configuration
EDI	equality, diversity and inclusion
IHV	Institute of Health Visiting
PLE	people with lived experience
PPI	patient and public involvement
PT	programme theory

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