First 1001 Days Movement

isos partnership

Working for babies

Lockdown lessons from local systems

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with
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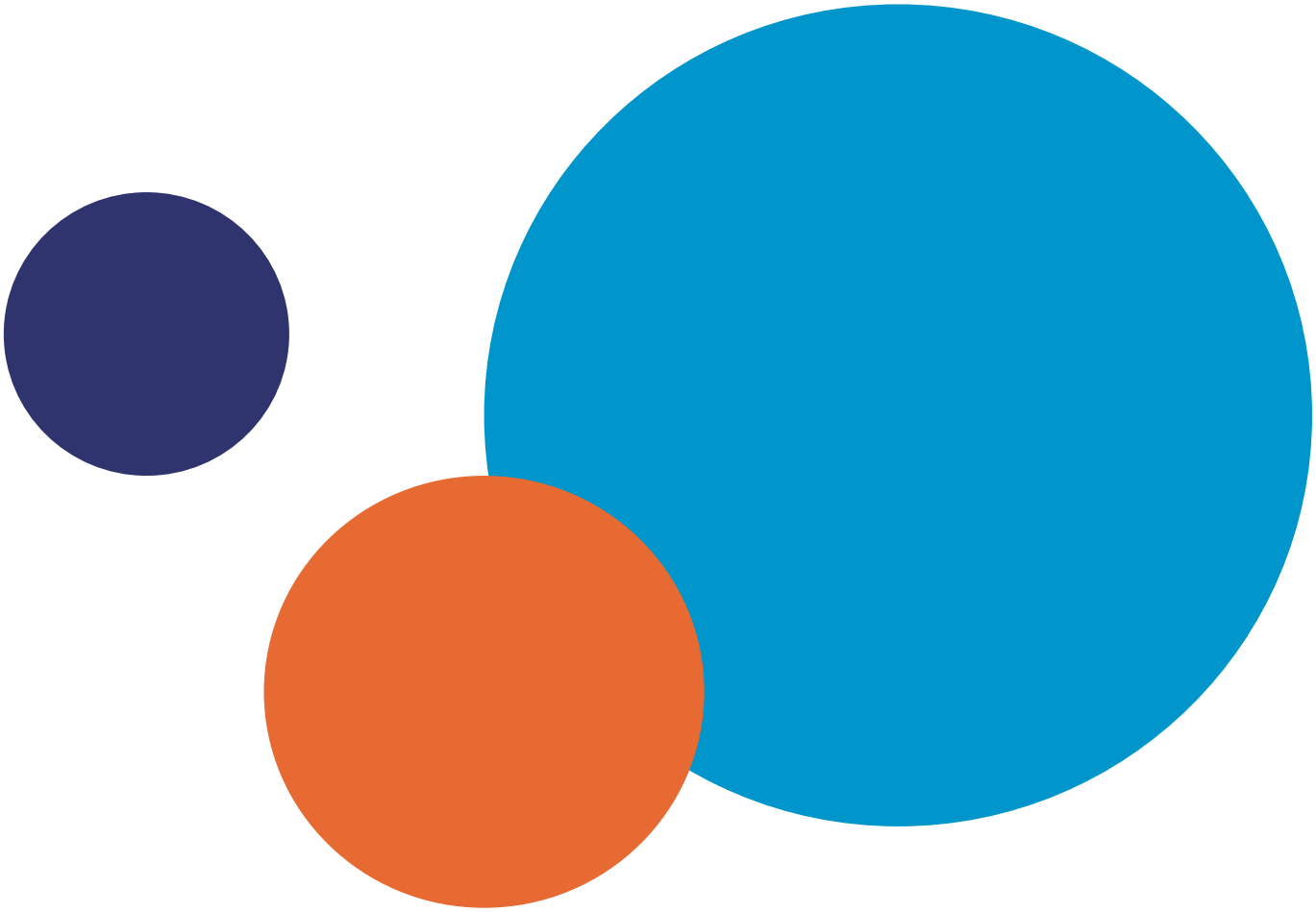

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Foreword

The first 1001 days, from pregnancy to age two, are an age of opportunity. This is a critically important period of rapid development that lays the foundations for later health, wellbeing and happiness. It is also a period of unique vulnerability, when babies are particularly reliant on adults and susceptible to their environment. There is a strong moral, social and economic case for ensuring local services and systems work effectively to support babies and their families during this formative life stage.

In Spring 2020, as coronavirus hit the UK and the nation went into lockdown, local services had to adapt to deliver under new restrictions and to react to the growing and changing needs of their communities. At that time, we observed differences in how local systems responded to the needs of babies and their families. We were keen to understand these differences, and what they might tell us more generally about why babies' needs are understood, prioritised and addressed more in some places than others.

Our goal with this project was not to tell a historical story of what happened in Spring 2020, but to learn lessons that can help us in the future. We do not want to return to normal after the pandemic, because for many babies and their families in the UK, normal was not good enough. Our services were fragmented and depleted, and inequalities in outcomes were growing. We must build back better and fairer, so that more babies have the best chance of a happy and healthy future. We hope that this work can support that goal.

We are very grateful to Cattanach for agreeing to fund this research, and to Jodie and the Isos partnership team for undertaking such a fantastically useful piece of work. We would also like to thank all those who participated in the research, the First 1001 Steering Group and Parent-Infant Foundation team for their support in the production of the final report.

This hugely rich report has useful messages for policy makers, commissioners and service providers across the UK. It describes how, in responding to the pandemic, local decision makers and providers have had to fulfil many of the same objectives they always face: to identify and understand the needs of babies and their families, and to provide effective and accessible services to meet these needs.

The pandemic has, however, provided a very different context in which to do this. This context highlights the importance of factors which we have known for a long time to be important: clear and committed leadership; mature and strong local partnerships; and professionals who are connected to each other and to their communities and empowered to meet families' needs.

This research shows, yet again, that babies' needs are often not prioritised by decision makers, despite the increased vulnerability of infancy and the enormous importance of early childhood development. There continues to be a 'baby blind-spot'.

The pandemic has tested systems in ways they have not been tested before and is shining a spotlight on their strengths and their weaknesses. In places it has catalysed cooperation and innovation and removed longstanding barriers to change. Many services are depleted, and hard-working staff are exhausted, but we must try to find ways to build on the best of what has happened. This report helps us to understand the opportunities and how we can seize them. It paints a picture of the different experiences of babies in the UK, but will hopefully leave you inspired and optimistic about what can be done in the future.

When we commissioned this report, we never imagined we would launch it in another lockdown. This is a year of ongoing hardship, but also of possibility. Andrea Leadsom's review on early years healthy development is soon to set out a vision for the first 1001 days of life. Later this year, the Chancellor will set out a three-year spending plan. These are important opportunities to improve and invest in systems that support the first 1001 days. They must be grasped, because more than ever, babies cannot wait.

Sally Hogg
Head of Policy and Campaigning at the Parent-Infant Foundation and Coordinator of the First 1001 Days Movement

Executive Summary

In June 2020 the First 1001 Days Movement engaged Jodie Reed and Isos Partnership to explore the impacts of the coronavirus crisis on babies in the first 1001 days and their families, across the UK. The project sought to bring together an evolving picture of how babies' lives have been affected, and crucially, to understand the experiences of systems and services which support them.

Specific project aims were to:

- Summarise the impacts of COVID-19 and the Spring 2020 national lockdown on babies
- Explore the nature of the lockdown challenge for the local systems and services which support babies and their families
- Understand the factors which have shaped and driven local lockdown responses relating to 0-2s, drawing lessons for the future[i].

All services working with families during this time, including, but not limited to, health visiting, perinatal support services, social care, family support, early help and childcare were in scope.

Research took place from July to November 2020. Insights were gathered via: a rapid review of the evolving literature from a wide range of sources, an online snapshot survey of service providers, a series of semi-structured interviews with senior local decision makers and three area-focused deliberative workshops. Altogether we spoke to 38 people via virtual platforms and canvassed the views of 235 more through the online survey.

Each of these research activities sought to address all three research aims, with findings used to refine and inform the focus and questions posed in the next stage. In a final stage, findings from all components were analysed thematically and combined into a single narrative which informs this report.

Impact of COVID-19 and Spring 2020 lockdown on 0-2s

- The evidence to date suggests that the direct impacts of COVID-19 on babies were very limited for the vast majority, but the 'hidden harms' of lockdown on 0-2s are broad, significant and experienced unevenly depending on family background and circumstance.
- Pregnancy, birth, the early months and, to some extent, the first two years should be considered as an additional 'risk factor' for lockdown harms to children due to the specific needs and vulnerabilities in this age range. These can be summarised as:
  - Susceptibility to the environment
  - Dependency on parents
  - Dependency on services
  - Dependency on social support
  - Invisibility to professionals.
- Reductions in direct contact with most services are widely viewed to have removed key protections to many 0-2s, just at the moment they were most needed.
- For some families with babies, Spring lockdown brought some broad benefits, for example around increases in quality family time, father/partner involvement, protected time to establish breastfeeding specifically, and potentially some reduction in premature births. However, these have not been evenly distributed. Babies in families already experiencing disadvantage appear less likely to have seen many of these benefits.

i. Throughout this report the terms 'babies' and '0-2s' are used to refer to the period from conception, through pregnancy to age two. When we talk about services that support them, we are also referring to services that support their mothers, fathers and other primary caregivers. 'The coronavirus crisis' is used throughout to refer to the COVID-19 pandemic as experienced in the UK up to the point of writing in December 2020. Due to the timing of the research there is a particular focus on the national Spring 2020 lockdown and its immediate aftermath. The term 'baby-positive responses' refers to a set of actions and services within an area which most effectively meet the needs of 0-2s. This is unpacked further within the report.

Impact on services for 0-2s:

- Services supporting 0-2s were highly depleted during the national Spring lockdown (March-June). A minority – around 18% based on our survey – ceased to provide any service at all, and the majority scaled back their offer.
- The majority of services for 0-2s did not bounce back quickly as lockdown measures eased, although the rate of return was highly variable. Our survey suggests those seeing the biggest fall-off in their full face-to-face offer intially were also most likely to be 'a long way off a full service offer' in September 2020. There are instances where the 'slow return' to services was down to families as well as services, such as in relation to childcare.
- What was on offer during the lockdown varied largely between services.
  - Health visiting was heavily depleted due to large scale redeployment.
  - Many targeted preventative services reaching families below the social care threshold appear to have been significantly impacted.
  - Maternity services were more likely to have continued with face-to-face support
  - Childcare providers including childminders largely shut, even to vulnerable children.
- The picture also varied notably between localities. There are multiple examples of differences in the local application of COVID-19 safety rules, resource prioritisation and the extent and breadth of adaptations made. For example, over 90% of respondents said that their service had adapted to provide support remotely – with similar proportions using interactive digital and regular phone contact instead. But while around half (51% and 45% respectively for digital and phone) had adapted services to reach all or most families, many others only adapted for some or a few families.
- In many areas, flexible and innovative working to solve problems and meet needs went well beyond moving onto phone and online offers. The research heard examples of the rapid co-location of essential services such as maternity in children's centres, the creation of 'safe spaces' indoors and outdoors for in-person support, the rapid development of new protocols and referral systems for new parents, the provision of technology to families with young children, new approaches to parental conflict and multiple new collaborations.
- Service providers have identified wide benefits from remote working in terms of reach and efficiency and, for some, the quality of what they could do professionally exceeded expectations. It was clear that the majority intended to maintain at least some elements of this in their practice longer term. However, many professionals remain sceptical about services delivered wholly or mostly online, with particular concerns around safety/invisibility. Further evaluation is required.

The local challenge

- The nature of the local challenge was, at the highest level, not dissimilar to normal times:
  a) To understand quickly which families with babies needed help and what was required, including ensuring no baby was 'invisible'
  b) To provide good access to and engagement with effective essential support via maintained and adapted services
  c) To continue to ensure local capacity to meet the future needs of 0-2s.
- Yet the local context and feeling on the ground was radically different to 'normal'. Many reported an initial short hiatus or quiet time in the first few days after lockdown was announced, followed by a frenetic period as new systems and platforms were set up and established. Across the board, leaders, professionals and frontline staff faced demands to meet old needs as well as rapidly evolving new ones, without many of the contact points and tools usually available to them. Staff often had to do this whilst working from home, with limited technology and whilst juggling personal pressures related to the pandemic. The nature and scale of this challenge was described in common terms by many of those we spoke to using words such as: change, uncertainty, adaptation.
- At the same time, we have found evidence that many of those responsible for adapting and delivering frontline services were significantly energised by the changes that they were putting in place and exceptionally motivated to ensure families continued to receive care and support at such a challenging time. Time and again we were told of staff going that 'extra mile'.
- The national crisis response is very widely perceived to have made it harder for local decision makers to do the right thing for babies.

Of 150 respondents in our survey, 117 (78%) were clear that the government in their nation had not taken action to ensure that families with babies under two received the support they needed during lockdown.

- A consistent complaint about the national response was the copious weight of fast-changing, hard-to-navigate guidance and, in some cases, constant requests from government and national agencies, which significantly added to the burden of local decision makers. For some, who had not been the direct subject of specific guidance, this burden was exacerbated from a sense of having to 'piece it all together'. For others it was the sheer number of bodies issuing guidance. There was also a general feeling that central governments had been 'learning-on-the-go'.
- At the same time, policy gaps from government and national agencies often left major areas of confusion and significant leeway for different decisions to be made. Sometimes the issue behind the perceived gap was contradiction. At other times, decisions had understandably been left to local judgement, but without a consistent, broad or balanced framework to assist those choices. In other cases there appear to have been simple 'blind-spots'. A common perception amongst professionals we spoke to was that behind this lay a low prioritisation of babies' needs. This appeared to be the product of:
  a) a long-established notion that government historically and routinely fails to give babies the same level of focus as other age groups (especially in England),
  b) a strong feeling that during the Spring 2020 lockdown national decision makers had a myopic focus on COVID-19 risks which hampered a local focus on wider risks to communities.
- A number of long-term national policy challenges also contributed to the local challenge. Fault lines between different national agencies and frameworks relating to 0-2s caused confusion. We were told that the level of redeployment of health visitors was more to do with the nature of the employer organisation than anything else. And long-standing inadequate or insecure funding, along with a rising tide of need, put some services and some areas at weaker starting points when the crisis hit.

"78% of survey respondents were clear that the government in their nation had not taken action to ensure that families with 0-2s received the support they needed during lockdown."

Baby-positive local responses

- What did good – or baby-positive – local responses look like at this exceptional time? Our research identified a reasonably consistent set of actions and activities which helped local systems to deliver on the three lockdown outcomes outlined above (understanding need, providing good access to essential support and ensuring local capacity to meet future needs). These are summarised in **Figure 8** on page 35 followed by an illustration of what weaker responses looked like.
- So what kinds of local systems were most likely to put baby-positive responses in place? Through our analysis we have identified 10 key enablers for baby-positive responses during the Spring 2020 lockdown which fit within four dimensions:

Strong, committed leadership

Strong, committed leadership emerged as a powerful local enabler both at the political and strategic/operational management levels. **Local political commitment** to the 0-2s agenda could pay dividends in terms of direct pressure to maintain services. More often, it delivered benefits through the articulation of a clear commitment to babies, a clear vision of the offer and good investment in services and infrastructure.

This in turn, supported good capacity to respond in the crisis, prioritisation of services and trust in operational leaders to act decisively to make necessary changes. But for this to have effect, **management that was clear-sighted, stable and well-connected** to staff at the front line was also required.

Mature partnerships

Where genuinely mature partnerships existed already, these endured during the crisis and often came into their own. Conversely, where health/local authority partnership arrangements did not extend meaningfully beyond frontline working relationships, or where partnership structures were not fully embedded and driving decisions and accountability, there could be a tendency toward retrenchment to silos during the crisis. The strongest **strategic partnerships** provided a basis for key decisions to be informed by a balance of perspectives. A strong history of close working and **collaboration across operational delivery and at the frontline** laid the ground for good crisis communication, swift and creative adaptions of services and effective use of resources.

Dynamic understanding of need

Areas able to keep abreast of new births and identify and respond to new needs as they arose, were better placed during the crisis. In practice this was helped by having **systems for sharing live data** about vulnerable and potentially vulnerable families with babies, as well as a **culture of communication and sharing information** between staff across and within agencies.

Those areas with a history of service co-production with the voluntary sector and parents found the connections they had further facilitated **deep reach into the community**, enabling services to pick up information about families in need or those becoming vulnerable but not previously on any agency's radar.

Innovative culture

Higher levels of **prior investment in technology** was a critical factor enabling baby-positive local responses, although no area we came across felt that investment had been sufficient.

More broadly, a culture of **creativity and problem-solving** that extended to the frontline enabled professionals in some areas to feel more confident about making and enacting changes to their services and coming up with effective new adaptations.

Those areas which were part of **active peer learning networks** were well placed to learn from others and effectively reflect on their own practice during the crisis.

Future for 0-2 services

- The coronavirus crisis has been an immense challenge for babies and the services that support them, and the end is not yet in sight. In the coming months and years services supporting 0-2s can expect to face pressures from growing need and an increasingly harsh financial climate. They will have to start to rise to these in 2021 whilst managing significant risks around workforce burn-out, and with the pandemic ongoing.
- Yet despite the profound hardships, the coronavirus crisis has also provided unparalleled opportunities to build on new-found strengths and momentum and create a stronger offer of support for babies. Professionals across the country report how the crisis catalysed local advances, for example enhancing understanding of families who may need support, improving effective use and implementation of virtual technology and the forging of new local partnerships and collaborations. The temptation to move forward without appropriate evaluation is something to guard against, but if new learning can be captured and embedded there is a chance that many longstanding difficulties can be overcome.
- More widely, there is an opportunity for national and local system leaders to use the lessons of 2020 to nurture better policies and ways of working in the future. All ten of the baby-positive system enablers identified within this report, build on established bodies of thinking about the features of good local systems, effective support for children and good leadership. The message is to double-down and sharpen the focus on these areas. In addition there is an opportunity to reflect on how babies' needs can be more systematically factored into thinking about risk in wider policy making. And to improve planning and communication between the national and local levels in any future crisis.
- If there is one additional message that cuts across the findings it is the value of human connection across a system. The loss of connection brought by lockdown poses not only a significant challenge to babies and their families but also to the services and systems that support them. Those best able to overcome these have often done so by maintaining connections by whatever means they could. Local services and systems with a history of strong connections across agencies, between areas, across staff working at different levels, and with communities, have been best placed of all.
- The report ends by drawing on the learning and themes throughout to pose seven high-level questions about how we can build better systems for babies and others in the future.

"If there is one additional message that cuts across the findings it is the value of human connection across a system."

1. Introduction

In June 2020, we were commissioned by the First 1001 Days Movement to look at the broader impacts of the coronavirus crisis from conception to age two across the UK. This was not to be a detailed academic analysis of the science or of any single sector but a bird's-eye view on the immediate and prospective future impacts on babies and the services which support them. All services working with families were in scope, including but not limited to health visiting, perinatal support services, social care, family support, early help and childcare.

The first aim of the project was to summarise the broad national picture on how babies in the first 1001 days and their families have been affected. Building on the emerging picture from early academic studies and sector-specific reports, and bringing to bear the views of professionals and leaders we have canvassed, we seek to give an overview of the direct and indirect impacts of COVID-19 on babies, their families, and the support offer available to them. This includes summarising the hidden harms of the lockdown for babies. This is covered in the first section on *Impacts of the Coronavirus Crisis on 0-2s* (page 14).

The second aim was to explore the nature of the lockdown challenge for the systems and services supporting 0-2s. We draw primarily on our own research to look at how the huge rupture to 'normality' was experienced by those leading and delivering services for babies on the ground. How did they go about meeting old and new, rapidly evolving needs, often without the tools usually available to them and frequently whilst working from home? And what role did the national crisis response play from a local service perspective? We also briefly consider the local implications of the longer-term national policy and funding context. Our findings here are set out in the section on *The local challenge* (page 25).

The third aim was to identify the factors which have shaped and driven lockdown responses to 0-2s locally, drawing lessons for the future. In this uniquely difficult environment, local responses varied significantly. What did a good (or baby-positive) response look like? Where and why were the needs of babies given due consideration? And what were the obstacles? The section on *'Baby-positive' local responses* (from page 34) seeks to address these questions.

Our more in-depth conversations with leaders and professionals delved into the reasons why some areas appeared better equipped to respond well for babies. This section identifies the key enabling factors which positively influenced local actions and decisions in the period from March to August 2020.

The final section on *The future for 0-2s services* (page 48) draws on all of the above and more to reflect on the challenge at the start of 2021. In the wake of the initial phase of the crisis, what are the new demands, risks and opportunities? And how can we acknowledge the difficulties but also make a virtue of the experiences of 2020 to build future systems which are even more resilient and capable of improving the future life chances of our youngest citizens?

A small note about language: Throughout the rest of this report the terms '0-2s' and 'babies' are used to refer to the period from conception to age two, inclusive of foetus in-utero and pregnant mothers and young toddlers. Early relationships are critically important and babies are generally seen by services alongside their primary caregiver, so we generally describe policies and services that also affect the mothers, fathers and other primary caregivers for babies in their first 1001 days. The term 'the coronavirus crisis' is used throughout to refer to the COVID-19 pandemic as experienced in the UK up to the point of writing in December 2020, but with a particular focus on the national Spring 2020 lockdown and its immediate aftermath (i.e. March to August 2020). We differentiate within this period as necessary as we go along. The term 'baby-positive responses' is used to refer to a set of actions and activities within an area which effectively meet the needs of 0-2s. This is unpacked further in the named section within the publication.

2. Aims and approach

The three specific aims of the research were to:

1. Summarise the impacts of COVID-19 and the Spring 2020 national lockdown on 0-2s and their families across the UK
2. Explore the nature of the lockdown challenge for the services which support them locally
3. Identify the factors which have shaped local lockdown responses relating to 0-2s, drawing lessons for the future.

We used a combination of research methods over July to November 2020 to explore the issues. These consisted of a rapid review of the literature, a small-scale snapshot survey of service providers from across the UK, a series of semi-structured stakeholder interviews and three area-focused online deliberative workshops. In total, we spoke directly via virtual platforms to 38 people and canvassed the views of 235 more online.

Each of these research activities sought to address all, with findings being used to refine and inform the focus and questions posed in the next stage. In a final stage, material from all three research aims were analysed thematically, with findings and messages triangulated and woven together into this single report narrative.

Box 1: Methodology

Rapid literature review

We conducted a rapid review of literature published since April 2020 detailing the impact of the pandemic on 0-2s in the UK, and on the services that support them. The review pulls out key headlines from over 60 publications, including academic studies, policy reports, national data releases and press articles. The bulk of the reviewing was conducted in July 2020 in order to support the framing of the other elements of research, although key new reports and studies were added on an ongoing basis up to November 2020.

Service provider survey

We conducted an online snapshot survey of service providers, targeted at senior leaders of key 0-2 services over the last three weeks of September 2020. The survey was promoted via the First 1001 Days Movement's email circulation lists and Twitter account, and respondents were asked to answer on behalf of their organisation, rather than as individuals. 235 service leaders responded, with 65% (153) of respondents completing it to the very end. Amongst them were individuals responsible for health visiting services, perinatal and infant mental health support services, parenting or child behaviour support services and breastfeeding support services which were all highly represented (20%+ of respondents). We also heard from leaders of home visiting services, maternity and neonatal services, early help, children's centres, childcare providers, baby banks and a range of specialist support services. 75% of respondents were England based, with others working either UK wide or in Wales, Northern Ireland and Scotland. A further summary of respondents and survey questions is in **Annex 1**.

Semi-structured interviews with local leaders

Semi-structured interviews were conducted with ten senior decision makers across seven local authorities in England, Wales and Scotland. The interview locations were selected in order to ascertain responses from areas with varying levels of prior commitment to 0-2s (as indicated by the proportion of two year-old checks taking place and whether CAMHS services took referrals for children aged two and under). Each took place face-to-face online via Zoom or MS Teams. Interviewees included: Local Authority Director of Children's Services, Director or Early Intervention and Prevention, Head of Early Years, Programme Managers on Starting Well in Public Health, Public Health Child Health Commissioner, Assistant Director of Public Health and Strategic Head of Early Help. In each interview a series of questions were asked about the local background context in relation to 0-2s policy and services, what happened during lockdown and as measures eased in relation to those services and why and how those changes came about. We also conducted interviews with two national policy experts.

Deliberative online workshops

We conducted three remote deliberative workshops, each with multi-professional groups from one or two local authorities. Participants included leaders working at the local strategic and delivery level in health and children's services and spanned four local authorities in England and Scotland. Each workshop consisted of 8-12 participants and focused on the local experience prompted by a combination of open broad questions and hypotheses where participants were asked to collectively reflect on whether a set of statements were true of their experience. Statements related to the impacts of national policy, the role of local leadership and political commitment, local understanding of need, resourcing and capacity of key services, integration and collaboration across services and the role of innovation. Throughout the workshops we used the online tool Mentimeter to gather rapid written and graphic responses on key issues.

3. Impacts of the coronavirus crisis on 0-2s

In this section we look at the impacts of the coronavirus crisis on 0-2s. We summarise what is currently known about the direct impacts of COVID-19 before giving an overview of the emerging evidence on the impacts of the national Spring 2020 lockdown and accompanying restrictions. The final part of this section summarises our findings on how, at a high level, lockdown affected services supporting 0-2s and the offer available to them. We draw largely on the literature and our own provider survey.

3.1 Direct impacts of COVID-19

The direct impacts of COVID-19 itself amongst babies and young toddlers in the UK have been minimal. At the time of writing, only two out of over 59,549 deaths registered in England and Wales involving the coronavirus (COVID-19) involved children under the age of one, none involved children aged one to four years and no child deaths have been reported in Scotland or Northern Ireland[1]. Professional consensus continues to grow amongst doctors and epidemiologists that babies and toddlers, like other young children, are largely asymptomatic or exhibit mild symptoms from current known strains of COVID-19.

Considering pregnancy and newborns, the Royal College of Paediatric and Child Health find that "Mothers and their babies in general appear to do well, with few reports of neonates requiring NICU admission[2]". However, recent European and UK studies also find that age under one month and prematurity are risk factors for Intensive Care Unit admissions among children with the virus[3]. There is some evidence of a small increase in the rates of preterm or earlier birth and signals of an increase in the rates of foetal loss/stillborn delivery when a pregnant woman has the virus, although this is based on limited data[2]. Pregnancy and postpartum women do not appear to be at higher risk of severe COVID-19 than non-pregnant women overall. Based on a very small number of deaths, women from Black, Asian and minority ethnic communities appear at higher risk compared to other pregnant women and new mothers[4].

In May 2020, a new COVID-19 related multisystem inflammatory syndrome in children was identified. This has been shown to pose a more significant risk to the lives of young children – one significant study finds the death rate for children with that syndrome are comparable to that observed in adults with severe COVID-19 between the ages of 55–64 years[5]. However, the infection remains extremely rare and the chances of treatment increasingly good.

The age profile of COVID-19 mortalities suggests death of a parent is rare amongst 0-2s. Of deaths registered to COVID-19 in England and Wales up to 17th July just 1% were adults aged 15-44, with a minority of these likely to have been parents to infants or toddlers[6]. A far larger proportion of 0-2s will have lost a grandparent during the pandemic. The clear weighting in adult deaths from COVID-19 toward those living in disadvantaged communities and those of Black and Asian ethnicity means that babies from these communities stand the greatest chance of having experienced loss.

3.2 Impacts of the Spring 2020 lockdown on 0-2s

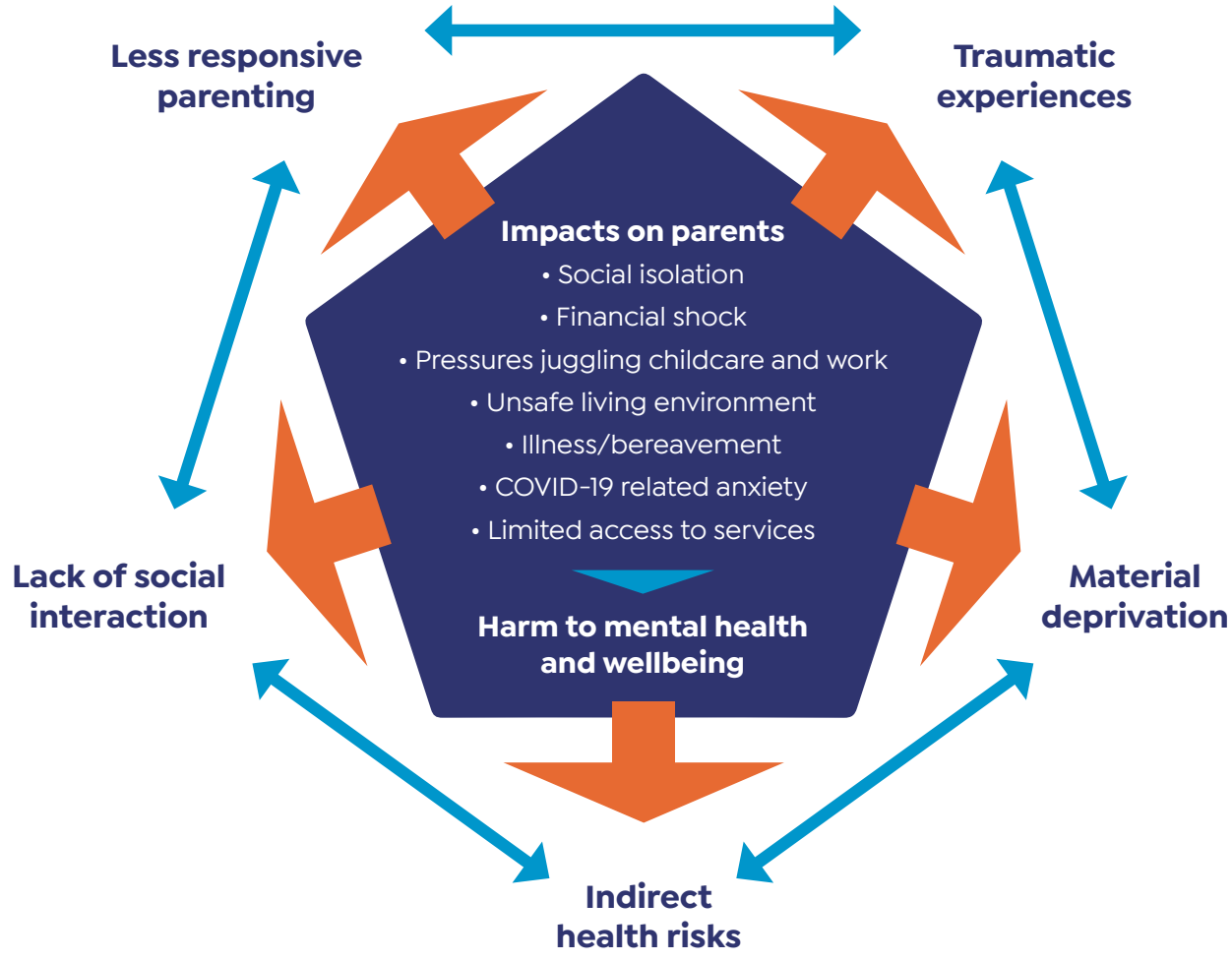
Hidden harms

The 'hidden harms' of the Spring lockdown were broad, significant and experienced unevenly. There is a wide range of emerging evidence of 'harm' to 0-2s in five broad, overlapping areas as a consequence of lockdown. These all apply, albeit in slightly different ways, to older children too. The five are:

1. An increased likelihood of exposure to traumatic experiences
2. Indirect health risks from time confined indoors and reduced contact with health services
3. Risks of harm to development from restricted social interaction
4. Risk of increased parental stress, less responsive parenting and harms to caregiving relationships
5. Increased likelihood of hunger or material deprivation

Figure 1 is a graphic summary of lockdown harms to young children, illustrating that harms are largely mutually reinforcing and in large part driven by the negative impacts on parents. **Box 2** explains harms further.

Figure 1: Hidden harms of Spring 2020 lockdown on 0-2s



Box 2: Hidden harms of lockdown on young children

Traumatic experiences

Increased likelihood of exposure to traumatic experiences as families spent extended periods confined at home, with parents often under exceptional pressures and with limited access to their usual support.

- International and UK evidence shows that the rates of domestic abuse increased during lockdown, and that it became harder for victims to escape or report abuse[7]. Numerous charities also reported signs of increased couple and parental conflict[8].
- Children were more likely to experience neglect or come to serious physical harm[9]. Meanwhile, child safeguarding referrals dropped by more than 50% during the first few weeks of the pandemic[10] and children's social care referrals dropped by a fifth over the Spring lockdown period compared to the same period in previous years[11]. There is a high likelihood of many incidents going unseen.

Increased parental stress

Increased perinatal and parental anxiety and stress with potential to impact pre-birth development and posing risks to nurturing, responsive caregiving.

- The Babies in Lockdown survey of over 5,000 parents of 0-2s found nine out of 10 experienced higher anxiety during lockdown. 25% reported concern about their relationship with their baby. The impacts were particularly pronounced for some groups.[12]
- One qualitative study of new mothers found "Virus-related anxiety was ubiquitous sometimes leading to self-enforced lockdown, an increased sense of sole responsibility, a sense of feeling cheated of the joys of pregnancy, guilt around a number of associated things (infant feeding decisions, care for older children, feelings around partners being excluded from scans etc), and a bleak feeling about the future"[13].
- The strains of juggling work, children and perhaps also home-schooling siblings was widely acknowledged to have compounded general stress. Well documented pronounced gender inequalities in domestic responsibilities during lockdown[14] are likely to have exacerbated this for mothers.

Indirect health risks

Threats to physical health and development as a result of lockdown, reduced health services and parental reluctance to access them.

- Reduced external play, more sedentary behaviour, and disrupted sleep patterns have all been identified as lockdown trends with the potential to damage long term development[15].
- Risks from other illnesses increased as interactions with health services declined due to more limited access to provision, warnings to stay at home or parent nervousness around coming forward. During lockdown children presented late to emergency departments leading to delayed diagnosis and hence a delay in treatment[16]. Reduced take-up of immunisations could have further long-term repercussions[17].
- Lockdown exacerbated risk factors for some types of baby loss, such as sudden unexpected death in infants (SUDI), sometimes linked to deprivation. After a loss, isolation has contributed to negative impacts on women and partners' mental health, and their ability to access support[18].

Social isolation	**Social isolation reduced opportunities for healthy play and interaction and significantly limited valued support to parents** • Research suggests parents of babies relied highly on family and friends via telephone and social platforms during the crisis. However, access to social support, and specifically grandparent care was largely stopped. • Young children also 'missed out' on normal opportunities to interact with other people and environments, which are important for their development especially for older babies and toddlers.
Material deprivation	**Poverty, financial security and income shock has impacted many families with babies** • Parents were more than twice as likely than non-parents to report reduced income during lockdown, with less than half able to cover a large necessary expense. They were also more likely to have been furloughed than adults without children. Over 20% found childcare impacted their work[19]. • Food poverty increased during lockdown as indicated by a reported rise in demand in foodbanks, and 'babybanks'[20]. • Families living in poverty were more likely to experience the impact of digital exclusion, and to have to isolate in poor and cramped living conditions.

Professional insights from service leaders in our 0-2s provider survey lend further weight to the notion that many babies have been seriously and negatively impacted by lockdown, with some impacts near ubiquitous and others affecting a very significant minority:

Nearly all respondents (98%) said the babies their organisation works with had been impacted by parental anxiety/stress/depression affecting bonding/responsive care. This was widespread with 73% of respondents reporting that many of the babies they work with were impacted.

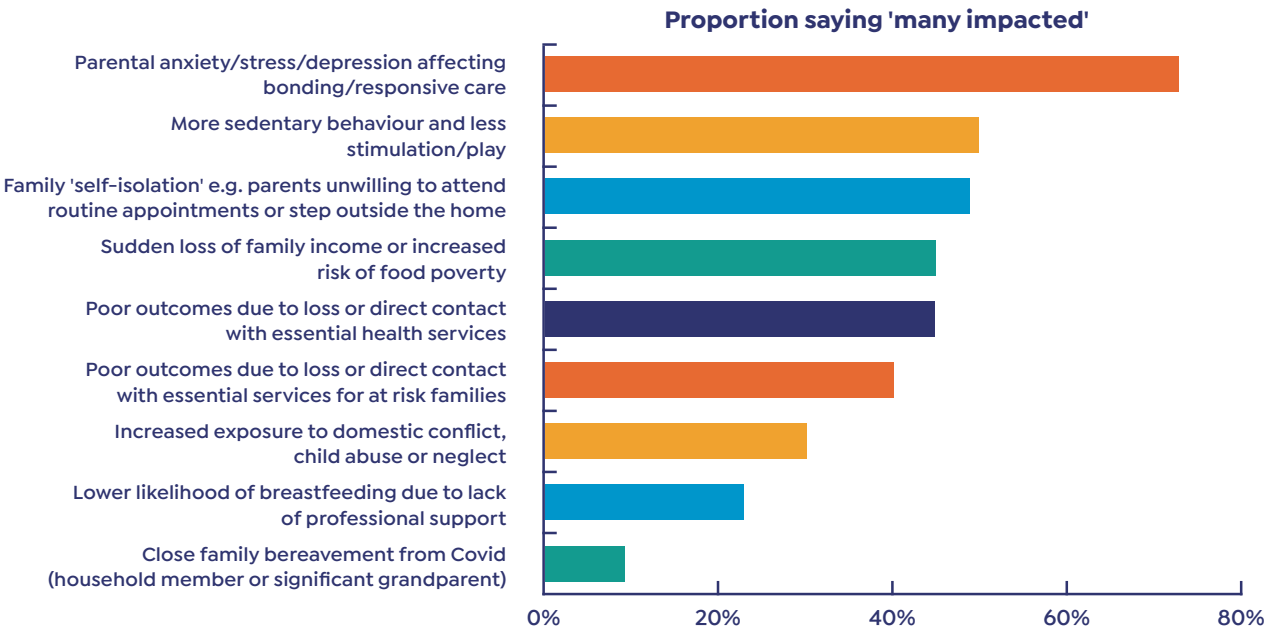
Nearly all respondents had observed more sedentary behaviour and less stimulation/ play (90%), with just under 50% saying many babies were impacted.

Nearly all respondents (91%) had observed a sudden loss of family income or increased risk of food poverty, with 45% saying many of the babies they work with were impacted.

The majority (80%) said that those they work with had experienced increased exposure to domestic conflict, child abuse or neglect, with 29% saying many babies they work with had been impacted.

Figure 2: Professionals' concerns about babies

Answers to the survey question: *"To what extent were the babies you work with negatively impacted by any of the following during lockdown? – please answer based on direct observations within your service"*



*In relation to each of these concerns, respondents were given the options:
Families not impacted / Yes some impacted / Yes many impacted / Don't know

Risk factors

The harms outlined above were not experienced evenly across the population but varied by family circumstance. Children and families who are already vulnerable due to social exclusion or those who live in overcrowded conditions are acknowledged to be at greater risk of wider harms during outbreaks of infectious disease in general[21]. A variety of studies have suggested this to be the case during in the UK Spring 2020 lockdown. For example, the Babies in Lockdown[22] study, found that families with lower incomes, from Black, Asian and minority ethnic communities and young parents had been hit harder by the COVID-19 pandemic (this was despite their online survey being unlikely to have reached families with very highest needs).

Another study looking in-depth at how pregnant women and new mothers were coping in England in May 2020 found that those with additional vulnerabilities including financial insecurity, birth trauma, poor social relationships, physical and mental health conditions as well as Black, Asian and minority groups faced the most acute impacts[23]. Often 'risk factors' intersect within families, with profound consequences for some children.

There is clear evidence that pregnancy, birth, the early months and to some extent the first two years were an additional 'risk factor' for lockdown harms to children.

Perhaps the starkest illustration of this has been the news that more than 300 serious incident notifications of injury and death involving children were reported by local authorities between April and October 2020 – up by a fifth on the same time last year. Of these, an increased proportion (almost 40%) involved children under the age of one[24].

There are a series of specific characteristics and needs of babies which make them particularly vulnerable to the effects of lockdown, whether serious safeguarding risks or lower level harms. These include:

- **Susceptibility to the environment:** the first 1001 days is a period of rapid brain development when babies are particularly susceptible to environmental influence. Experiencing the pandemic during this important developmental phase is likely to have had an impact.
- **Dependency on parents:** babies are completely dependent on their primary caregivers in a way that an older child might not be. At the same time new parents are susceptible to feelings of isolation, anxiety and perinatal mental health issues, all of which were likely to be heightened during lockdown, impacting parental capacity for responsive caregiving, attachment and brain development.
- **Dependency on social support:** babies and their parents have a high dependency on a range of social support and informal childcare including from peers and grandparents who they were not able to see in person.
- **Dependency on services:** babies and their parents have a high dependency on a range of universal and specialist health services in pregnancy, during birth and over the first months of life. Lockdown reduced both the quality and quantity of contacts with services for most families.
- **Invisibility to professionals:** there is a higher likelihood, especially for first babies, of families being previously unknown to services and not easily identifiable as needing targeted or specialist support. Unlike older children, babies do not have routine regular contact with other services like schools or childcare settings so there is often no professional who regularly sees or gets to know a baby. When services are delivered remotely/digitally babies are less likely to be seen and heard by professionals compared to older children.

In these multiple senses, being aged 0-2 could be seen to increase the chances of being negatively impacted by lockdown irrespective of exposure to other risks. Or in other words, being a baby or toddler was a lockdown 'risk factor' in its own terms.

Those who have been exposed to other risk factors in addition, for example babies from families living in poverty, could be considered as having been subject to 'double jeopardy'.

The general fear and uncertainty surrounding the health risks from COVID-19 to pregnant women and perceptions of dangers of breastfed babies contracting the illness also deserve a mention. Although breastfeeding fears were unsubstantiated, concern about this was prevalent in public discourse[25] and at that stage there was still a great deal of confusion about the dangers of the illness posed to babies.

In our survey nearly all respondents (92%) said within their organisation they had observed family 'self-isolation', for example where parents were unwilling to attend routine appointments or step outside the home for fear of COVID-19, with 49% saying that *many* babies they work with were impacted. This has been reflected in qualitative academic studies too[26].

Protective factors

Reductions in direct contact with most services – whether as a result of changes in provision or families' use of it – is widely viewed to have removed key protections to many 0-2s, just at the moment many needed it most. This is a widely shared concern[27] and has been documented for children in general, for example in relation to dramatic drops in referrals to social services, drops in visits to A&E and lack of visibility of those children just below the threshold for children's social care[28].

In relation to babies specifically, the Babies in Lockdown research found that only one in ten parents with children under the age of two saw a health visitor face-to-face during lockdown and only one in five mothers with a baby under two months old had seen a health visitor face-to-face[29]. Elsewhere there is evidence of mothers having to change birth plans and have shorter stays in hospitals[30]. A UK-wide study of neonatologists highlighted major concerns around late presentations during labour resulting in adverse maternal/neonatal outcomes and early hospital discharges after birth with infants then returning with feeding difficulties and severe dehydration[31].

Our survey similarly suggests the majority of service leaders from a variety of sectors believed a lack of contact with services to be a problem for 0-2s.

- Many (88%) respondents said that those they work with were at risk of poorer outcomes due to loss of direct contact with essential services for at risk families (e.g. social services, early help, perinatal mental health), with 45% saying many babies they work with were impacted.
- Many (87%) said that those they work with were at risk of poorer outcomes due to loss of direct contact with essential health services (e.g. maternity care, health visitors, GPs, A&E), with 40% saying many babies were impacted.
- Over half (57%) had observed lower likelihood of breastfeeding due to a lack of professional support, rising to 72% of specific breastfeeding support organisations. Views on the proportion impacted were split with 23% saying many had been impacted and 17% saying no impact at all.

"In the first half of lockdown Perinatal [mental health] referrals dropped to floor. Then June, in short space, there was an uptick again. GPs started saying they'd had women turning up at surgeries who were really struggling, who hadn't had any contact with the health visiting service. The question now is: are there more women who are lost to us? Are these just the second wave of women? There are women at the moment who have never met their health visitor with a 3, 4, 5 month-old baby."
Start Well Programme Manager (interviewee)

There are some signs from the wider literature that babies in other parts of the UK did not experience as much of a dip in access to services as those in England. Scottish parents reported more positive experiences and more continued access to information in the Babies in Lockdown survey.[32] Other evidence also suggests that Scotland maintained immunisation rates whereas England did not[33]. Delayed child presentation to A&E was found to be lower in Wales[34]. This is worthy of fuller investigation.

Simultaneous to lockdown harms, there are clear indications from the literature and from comments in our survey that **lockdown has brought some broad benefits for 0-2s. Although again, these have not been experienced evenly with families already disadvantaged prior to the pandemic less likely to benefit**.

- Many families with 0-2s appreciated the unique opportunity for **quality family time and increased father/partner involvement**. However, these benefits were not experienced across the board. One study found that while 90% of families with babies and toddlers reported an increase in **enriching activities** during lockdown, parents experiencing socio-economic disadvantage were less likely to engage in enriching activities including spending less time doing activities that require outdoor space and access to books[35]. As one of our Family Nurse Partnership survey respondents put it, ***"Where families are not grappling with meeting their basic needs and where there are positive family relations parents have enjoyed spending time with their babies"***.
- On **breastfeeding** specifically, UK research has highlighted two very different types of experience among new mothers, with some (41% according to one study) feeling that breastfeeding was protected due to lockdown, but others (29% according to the same study) struggling to get support and facing numerous lockdown related barriers.[36]

Mothers with a lower education, with more challenging living circumstances and those who were Black, Asian or within a minority ethnic group were more likely to find the impact of lockdown challenging and stop breastfeeding. Digital exclusion may have played a role here as breastfeeding support was suggested by many professionals as a service which translated particularly well to a virtual environment, enabling mothers to access help from the comfort of their own home at a time when getting out was difficult. However there may be other explanations, for example the Babies in Lockdown research found some mothers to be uncomfortable accessing such physically personal support on camera.

- International studies have suggested that whilst there may be an increased risk of pre-term birth for women infected with COVID-19, in general over lockdown there was a reduction in **premature births** over March and April 2020, with speculation this is due to reduced work/ travel pressure[37]. There are broad indications this is aligned with prior economic circumstances, with a very large-scale Dutch study indicating that the drop in preterm births was limited to wealthier neighbourhoods[38].

3.3 Impacts of lockdown on services for 0-2s

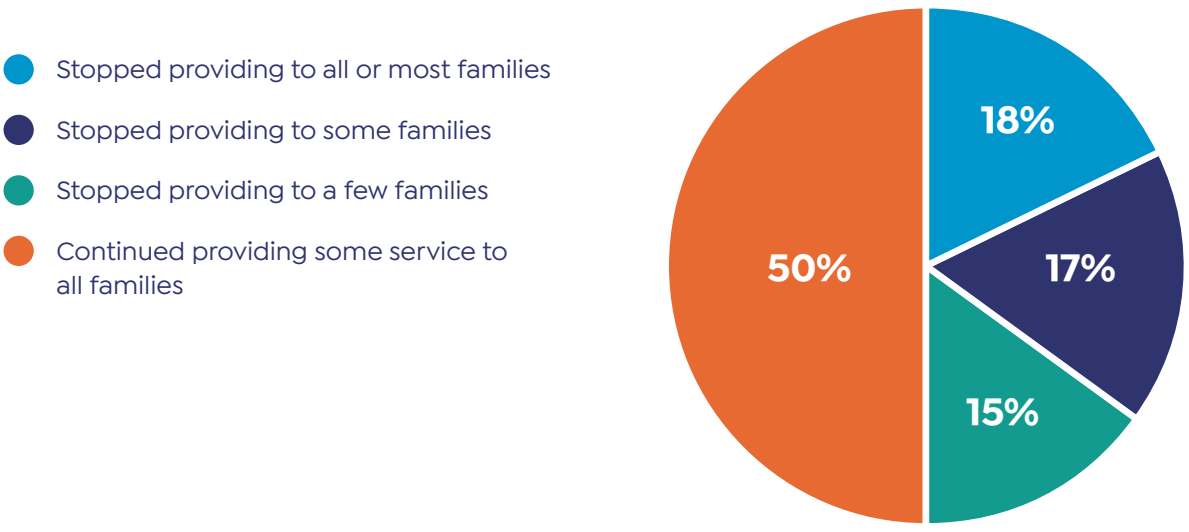
Services supporting 0-2s were highly depleted during lockdown (March-June). A minority ceased to provide any service at all and the majority scaled back their offer. From 166 service leaders responding in our survey:

- Half of respondents (50%) said their organisation *was not able* to continue to give support, beyond information on a website, to all of the parents/babies they usually work with in person. 18% said they stopped providing a service to all or most families.
- 35% were *not* able to see *any* families at all in person.
- Only 13.5% continued face-to-face contact with all or most families in person throughout lockdown.

We found that the majority of 0-2s services did not bounce back quickly as lockdown measures eased, although rate of return was highly variable.

Figure 3: Organisations whose work stopped in lockdown

Answers to the survey question: *"Tell us about how your service continued to support the parents/babies who you usually work with in person during the height of lockdown (March to June)"*



Of 158 related responses gathered in our late September survey 61% said they were 'still a long way off a full-service offer' and only 25% said their service had mostly returned to normal. There were some examples of where the slow return to services was down to families as well as services themselves, such as childcare which is discussed further below.[39]

Variation across the sector

The offer to 0-2s and their families varied largely between services. We summarise the extent to which the offer was affected in relation to some of the key services below.

- **Maternity Services were** more likely to have continued with face-to-face support than many other services. From a small sample our survey found 70% had continued to see at least some or most families in person. A similar picture was painted by the Babies in Lockdown survey of parents which found 74% pregnant respondents had face-to-face contact with midwives, in contrast to 11% of parents under 2s being in face-to-face contact with health visitors[40].
- **Health visiting** was heavily impacted following the NHS Community Prioritisation Plan in March which marked it as a service which should "partially stop", setting the scene for large scale redeployment. Similar plans were announced across the UK. The best estimate from England suggests 60% of health visitors had at least one member of their team redeployed and increased case loads for those remaining in significantly depleted services[41]. The Institute for Health Visiting estimated up to 50% of professionals were redeployed[42].
- **Targeted, preventative and 'early help' services and services reaching families below the social care threshold** appear to have been significantly impacted, although much work went online. There is evidence that most areas had to close children's centres and family hubs where much of this work is located[43]. Comparing groups in our survey where we have a reasonable sample size (>35), the services most likely *not* to have been able to continue face-to-face support for anyone, or only to have continued for a few families, are ones likely focused on targeted work or with families not necessarily requiring statutory intervention: perinatal or infant mental health support services (76%) and parenting and child behaviour support (78%).
- Only a small number of **childcare providers** filled in our survey but we know that this would have tipped the balance significantly in terms of who was able to continue to offer a service. During the Spring lockdown period, around 40% of children aged four and under were eligible for childcare due to being either vulnerable or the child of a key worker – but only around a third of childcare settings remained open and these typically served very few children[44]. All childminders were required to stay shut until mid-May.

Additionally, we found indications that those services seeing the biggest initial fall-off in their full face-to-face offer were also most likely to say they were 'still a long way off a full-service offer' in September. In our survey, over two thirds (64%) of those providing parenting and child behaviour support, perinatal or infant mental health support, home visiting and breastfeeding support said they were still a long way off a full offer by then. Health visitors were less likely to say this but the proportion still a long way off providing a full offer was significant (42%). National data on childcare also shows that even by mid-July, 40% of early years settings remained closed and only around a quarter of the registered places filled[45].

Variation between areas

It is evident that national social distancing measures and NHS-wide re-prioritisation of resources were a key driver for services closing and scaling back. But this did not always lead to the service offer for 0-2s being impacted uniformly across areas as one might expect. The full reasons behind this are explored in greater depth in the following sections but there are some specific areas of difference that families experienced depending on where they lived.

One is neonatal and maternity services. Research has highlighted differences in application of COVID-19 safety rules, for example around mask wearing requirements in neonatal wards[46]. Initially the majority of maternity services enforced tight restrictions on partners attending antenatal visits and scans, pre and post labour and in neonatal wards, but as national rules eased on hospital visiting, the experience of new parents varied wildly. A Freedom of Information request revealed a major 'postcode lottery' by August – at that time some services had started to reverse policies, but 43% had not[47].

Health visiting also showed significant local divergence. The most significant study on health visiting during the pandemic found wide variation in redeployment levels across the country and the extent to which the service was maintained, which was determined at local authority level[48]. Our survey findings line up with this. Of the 56 health visiting organisations answering, over half (54%) reported not continuing face-to-face visits with any families or only a few families, whilst 34% continued to see some families and 12% continued to see most or all families.

More broadly, variation in the experience of 0-2s and their families across areas during lockdown will have depended on differences in the extent and breadth of adaptation of local services. In our survey, over 90% of respondents reported that their organisation had adapted to provide services remotely – with similar proportions moving to interactive digital and to regular phone contact and most using a combination of both (see **Figure 4**). But while around half had adapted services to reach all or most families, others had only adapted for some or a few. This suggests those not known to services or not in the highest priority groups experienced significant variation in services.

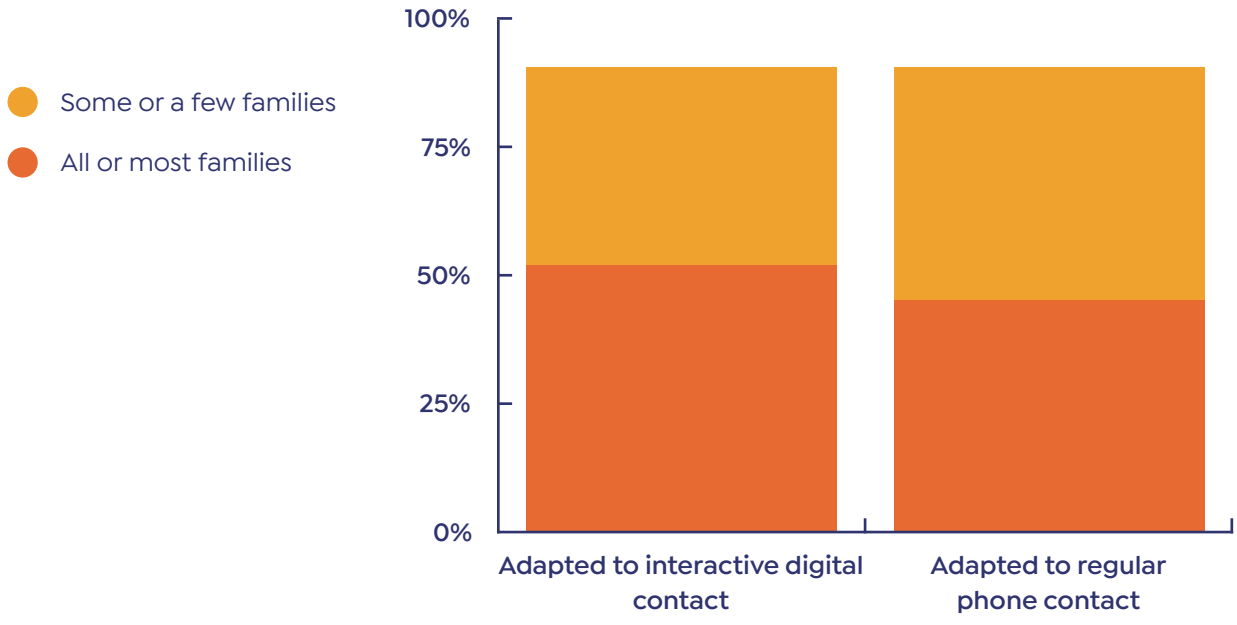
Across our interviews, and our survey, professionals and service leaders in general reported wide benefits from remote working in terms of reach and efficiency and for some the quality of what they could do professionally exceeded expectations. It was clear that the majority intended to maintain at least elements of this in their practice longer term. However, doubts remained about the impacts of rapidly adapted services.

Evaluation evidence about the effectiveness of adapted services is limited[49] and many professionals remain sceptical about services delivered wholly/mostly online – with particular concerns around safety/invisibility of babies. In our survey only 17% believed their adapted services definitely had delivered the same benefits and 25% believing it had not, the remainder seeing it as "mixed". Services mentioned as working particularly well online included: parenting classes, online groups and therapy.

Those providing breastfeeding support and perinatal support were most likely to say their adapted service delivered broadly the same benefits as the usual service. **Box 3** summarises the benefits and concerns of remote working as reported to us by professionals.

Figure 4: Service adaption to provide services remotely

Answers to the survey question: *"How did your service continue to support the parents/babies who you usually work with in person during the height of lockdown (March to June)?"*



Box 3: Professional perceptions of remote working

Benefits	Concerns
Popular with parents Phone or online offers were reported to be preferable for many parents due to COVID-19 safety, convenience, greater flexibility around timings and less travel. This was seen as a particular advantage for new parents for whom getting out is hard.	**Digital exclusion** There was a concern that many families at higher risk, such as finanancially disadvantaged families, those with complex needs and families where parents don't speak good English would struggle to access or use the technology.
Increased reach It was widely reported that remote working has increased the reach of services, especially to families who don't usually engage with physical services and to more fathers.	**Hard to spot need** Professionals perceived a significant risk that difficulties for those without an already diagnosed 'need' may be missed. Distress signs from body language are hard to identify via a screen, especially for babies who can't speak for themselves. Wider contextual cues can be missed. As one senior health visitor we spoke to said, "*you can't spot vulnerability down a telephone line*".
Good relationships Some professionals commented that they were surprised at the extent to which they had been able to develop relationships – including therapeutic relationships – with parents over Zoom. Others saw future potential in combining face-to-face with remote visits and building stronger relationships based on more frequent contact.	**Relationship drop-off** Some professionals also commented that some services worked well digitally initially but this could not be sustained over time due to the challenges with establishing or maintaining new relationships online. Parent-Infant teams have reported that the nature of relationships is different online and it is harder to develop the therapeutic alliance required for effective work[50].
Increased efficiency Time and expense saved from travel to see families, less time wasted for all-staff/cross-sites meetings and reduced staff sickness all emerged repeatedly as benefits with the potential to increase time with parents and improved staff capacity in the longer term.	**Unsustainable pressure** Some professionals commented on the relentless nature of back-to-back video conferences and calls and questioned how sustainable that might be.

In addition to services moving onto telephone or online, there were other examples of flexible working and innovative adaptations. These included:

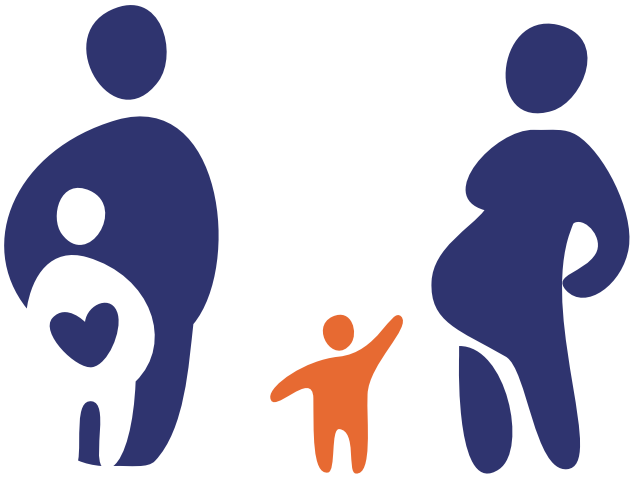
- Rapid co-location of essential services such as maternity in children's centres
- Creation of 'safe spaces' indoors and outdoors for in-person support
- Rapid development of new protocols and referral systems for new parents
- Provision of technology to families with young children
- New approaches to preventing and addressing parental conflict
- Productive collaborations, including with voluntary sector organisations such as foodbanks and baby-banks.

"Very early we reached out to all new mums. We asked our health partners to inform us about all new mums, we made contact with them through family hubs, we sent out new birth packs and we made sure that they had a link worker." Director of Children's Services (interviewee)

"Our parenting team went to be offered in our [children's centre] 'front door' so they could offer low level advice about parental conflict... And one of the children's centres became a massively expanded foodbank with delivery service for families with children 0-5, part of emergency response "food cell" run by a voluntary sector organisation." Head of Early Years (interviewee)

"We very quickly realised that we wanted to partner up with our midwifery and antenatal colleagues so that pregnant women had somewhere safe for all their antenatal appointments. We used the children's centres." Assistant Director, Early Years (interviewee)

An early lockdown study by the Early Intervention Foundation presents a similar picture of an exceptional service in a minority of children's centres and family hubs which were kept open to provide multi-agency support to families: *"This support included face-to-face support from social workers or family support workers for particularly vulnerable families, along with support for children with special educational needs, or midwifery and health visiting services no longer able to work out of hospitals or health centres. Others had used children's centres as emergency hubs providing food and other essential supplies to families*[51]*"*. Again, the extent to which 0-2s will have benefited from these will have depended on whether they were being offered in the area in which they live.



4. The local challenge

In this section we look at how the coronavirus crisis presented itself to those working at a local level. We describe the nature of the challenge in terms of how it felt on the ground to local leaders and frontline decision makers responsible for 0-2s services. We then look at the national crisis response as perceived by those decision makers, identifying and unpacking the additional pressures this created for them. The final part of this section summarises aspects of the longer-term policy context which have contributed to the local lockdown challenge. Throughout this section we draw on all elements of our research, with particular focus on insights gathered from the survey, interviews and workshops we conducted.

4.1 How it felt on the ground

The primary goals of local systems and system leaders during the Spring 2020 national lockdown were, at a high level, consistent across areas and not dissimilar to those in normal times. Broadly these were:

- To understand quickly which families with babies needed help and what was required, including ensuring no baby was 'invisible'
- To provide good access to and engagement with effective essential support via maintained and adapted services
- To continue to ensure local capacity to meet the future needs of 0-2s.

Yet despite these consistent goals, the local context and feeling on the ground was radically different to 'normal'. Across the board, leaders, professionals and frontline staff faced demands to meet old needs as well as rapidly evolving new ones, without many of the contact points and tools usually available. The nature and scale of this challenge was described in common terms by many of those we spoke to using words such as: *change, uncertainty, adaptation.*

"Very quickly social workers, health visitors and early years practitioners who could recognise additional stresses for families were looking for different/alternative ways of having contact – very quickly using IT, moving to Zoom etc. Frontline workers across the board were very keen to find different ways and were asking for the equipment, the guidance, the PPE to provide services." Head of Family Services (workshop participant)

"From March to April the main question was how do we adjust? Our buildings are closed but we want to open them? What can we open? What are our priority activities? And how can we stay connected?" Assistant Director, Early Years (interviewee)

"We have had a constant process of trying options, reviewing and adapting to try and meet the needs of families as best we can in the circumstances." Leader of behaviour and mental health support service (survey respondent)

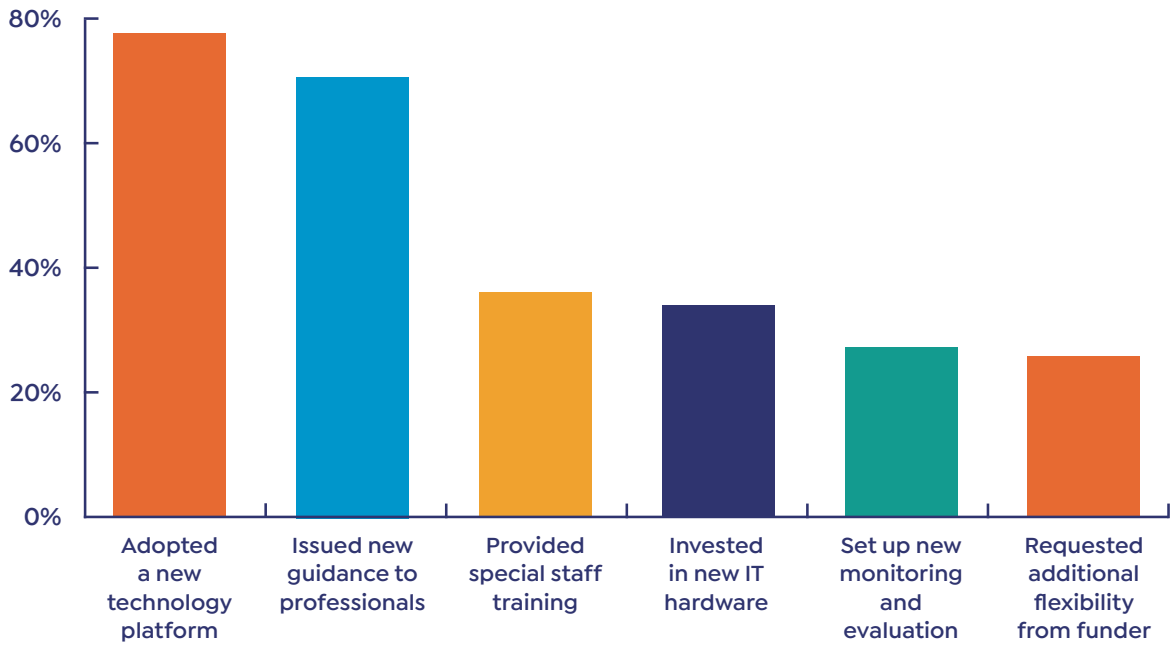
"The greatest challenge has been managing the business as usual, for example getting the [service] reform process already underway through the political process at a time when we all have an extraordinary situation on our hands, making time for the processes still to happen for necessary decisions." Director of Early Intervention (interviewee)

A common description was an initial short hiatus or quiet time in the first few days after lockdown was announced, followed by a frenetic period as new systems and platforms were established. This inevitably involved a lot of work. In our survey, of the 80% of services that adapted, the majority reported that they issued new guidance to frontline professionals (72%) and adopted a new technology platform (78%) (see **Figure 5**).

"There was a gap in service delivery where everything kind of stopped. We needed to understand what was possible, think creatively, understand the technologies." Head of Early Years (interviewee)

Figure 5: Tasks involved in adapting services

Answers to the survey question: *"Where your organisation adapted or re-designed its service, which of the following steps were involved?"*



"When we went into shutdown the Quality Assurance service reviewed all our child protection plans and all our looked after children plans and they were revised to be relevant for lockdown so we weren't asking parents or staff to do things that weren't viable. The Children in Need teams were doing things that were asked to do the same, paying particular attention to those families where domestic violence was an issue. Every visit there was a risk assessment to determine whether it should be face-to-face or digital." Director of Children's Services (interviewee)

Many of those responsible for adapting and delivering frontline services were to a significant degree energised by the changes that they were putting in place. Time and again we were told of examples of staff going that 'extra mile' to meet families' needs. Most (85%) survey respondents felt they were making changes for reasons of impact (see **Figure 6**) and many across the survey and the interviews reported unanticipated benefits as administrative obstacles evaporated, new partnerships and collaborations formed and they found more flexible and effective ways of reaching people.

"Across the piste some of the challenges and blocks in the system that were previously in place were alleviated. Particularly in relation to the digital and virtual – for example permission to use zoom, using online tools, ensuring staff have laptops and connectivity, quickly working out data sharing requirements, what do safe online conversations look like, what's the conversation you were going to have with the parent sitting there with a toddler or at risk of domestic violence. The practice standard, the policy and the doing – all of that just happened really quickly." Assistant Director, Early Years (interviewee)

However, at the same time many of our survey respondents reported that they were concerned about the effectiveness and risks of the adaptations they were making. In some cases, senior staff felt stymied by their lack of control and ability to exercise professional judgement in the situation. This was a particular theme in our Scottish workshop.

"We [in social work] risk assess situations, that is what we do and it felt like that was almost being taken away into a different forum." Senior Children's Social Worker (workshop participant)

Figure 6: Motivating factors for service adaption

Answers to the survey question: *"Where your organisation adapted all or part of its service to maintain contact with families during lockdown, which factor/s significantly influenced your decision to make this change?"*

"We had closed down most of our buildings, including the ones that facilitate contact visits [for children in foster care]. So we felt like we were being frustrated by this blanket risk assessment of buildings – and it became buildings as opposed to services and people. [Contact] was happening in the park where there are other risks around toddlers running off, and sometimes very cold and wet, as opposed to a safe room which you could make sure was cleaned and could be managed… the assessment of risk about Covid overcame risk about everything else." Head of Children's Services (workshop participant)

Across the board, many frontline leaders emphasised the difficulties of having to meet delivery demands whilst working from home, often with limited technology and whilst juggling personal pressures related to the pandemic. Particular strains were noted for those working 100% of their time at home throughout the period, and those in frequent remote contact with high-risk families and having to make difficult judgement calls from home.

The challenge here was not only about deciding when/how to act where risk was detected remotely (often revised practice guidance supported this) but also the loss of normal boundaries of home/work separation and loss of informal face-to-face support from colleagues. Examples were shared in the workshops of domestic violence incidents taking place whilst professionals were in remote contact with families from their homes and the toll this had taken.

"It has been really hard to make decisions from a strategic perspective. As clinical leads we have also had to work from home and manage the stresses of living in a pandemic." Perinatal Mental Health Professional (survey respondent)

"The lockdown has been hard for all of us and it has been a massive adjustment to the way we all work, to the support we are able to give and for families who are just becoming parents it has been a massive learning curve overall to do this alone and not having much support around… I think we all have been really careful and making sure we have been really clear on what we are able to do." Service Manager, home visiting behaviour support service (survey respondent)

4.2 National crisis response

It is widely understood that the pandemic put immense pressure on central government and national agencies to produce coherent emergency policies. Notwithstanding the appreciation of how difficult this was, the majority of our workshop attendees agreed that national policy during the crisis made it harder for local decision makers here to do the right thing for babies'.

Of 150 respondents in our survey, 78% were clear that the government in their nation had not taken action to ensure that families with babies under two received the support they needed during lockdown – only 8% felt they had. Those operating services in England were substantially more likely to say that the government had not taken action to support babies, than those from Scotland, Wales and Northern Ireland combined (81% compared to 46%), although our sample in the latter group was too small to say whether this difference is statistically significant.

From the perspective of local decision makers, the problem with the national response manifested, paradoxically, in terms of both the weight of guidance and the absence of it.

Weight of guidance

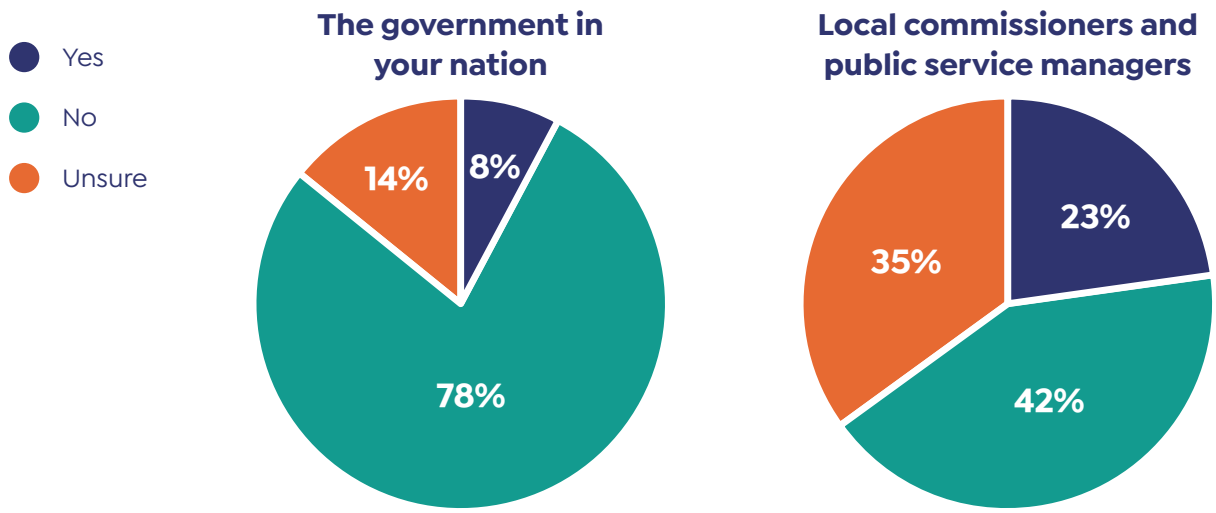
Copious, fast changing, hard-to-navigate guidance from government and national agencies, and constant central requests were strongly felt to have significantly added to the burden of local decision makers. The weight of information provided was remarked on consistently in every workshop and interview as well as being a strong theme in the survey. This finding was across the board, with those in devolved administrations sometimes also citing additional pressure due to having to an 'extra layer' of guidance.

"I've never had so much guidance thrust upon me at any other time in my career. You'd just read one to get another not to know which bits were different only to get more the next afternoon and more the next. What an absolute waste of everyone's time." Director of Children's Services (interviewee)

"It felt like there was a very intense period where the guidance changed almost on a daily basis and it wasn't always easy to find. Sometimes it came under different headings." Early Help Manager (workshop participant)

Figure 7: Views on whether local and national decision makers took necessary action to ensure 0-2s received the support they needed

Answers to the survey questions: *"Do you believe that local commissioners and public service managers (in the local authority or CCG) took necessary action to ensure that families with babies under 2 received the support they needed during lockdown?"*



"The amount of guidance and details of guidance that was coming in every day was overwhelming – the UK guidance, the Scottish guidance and the local authority and local health board guidance – and some of that didn't match. There was some confusion for example about use of PPE and some parts of the service saying we're not doing face-to-face visits and others saying we have to do face-to-face work. So much, so detailed and so changing – it became very top down." Family Nurse Partnership manager (workshop participant)

"The rapid pace of constant updates, constant reminders really took over the world for a long time." Health Visiting Service Manager (workshop participant)

For some service providers who had not been the direct subject of specific guidance, such as those leading children's centres and parts of the voluntary sector, this burden was exacerbated from having to piece guidance together from different sources. For others the situation was intensified by the sheer number of bodies issuing guidance.

"The continuous adaption to the changes of Government guidance has been a real challenge especially for Children's Centre Services because there were no specific ones for this sector so we had/have to make sense of Early Years, Health and Voluntary Sector guidance." Children's Centre Leader (survey respondent)

"There was NHS guidance, there was Scottish gov guidance, there was council guidance, there was properties guidance and sometimes that did cause problems – things like PPE and who was using it when, could we go into families and what kind of protocols should we all be doing?" Early Years Lead (workshop participant)

In considering the reason behind this, several of the people we spoke to suggested that this burden became more acute by the government's failure to plan ahead, reflecting strong wider criticism on the lack of national pandemic planning[52]. There was a feeling instead that central governments had been learning-on-the-go, and that this had made the pressure significantly greater.

"DfE have been contact with us on a fortnightly basis – we thought initially it was to share information with us but they were in contact to get information from us to piece it together... it's always felt like they're one step behind local areas." Director of Children's Services (interviewee)

Gaps in guidance

At the same time, often national policy gaps – or **"baby blind-spots"** – from government and national agencies left huge areas of confusion and significant leeway for personal and professional judgement at the local level.

Sometimes the issue behind the perceived gap was contradiction. Centrally issued directions were ostensibly clear and strong initially – for example NHS England advice in March that GPs should aim to continue immunisations and postnatal checks "regardless of the virus outbreak"; the direction that health visitors should "continue antenatal and birth contacts"; the instruction to social workers that statutory visits to the homes of children on child protection plans should continue. Only for this to unravel in the face of further advice in tension with the former, for example with the direction from the NHS to "partially stop" health visiting services in order to redeploy staff to acute wards; the positive encouragement of GPs to conduct postnatal visits virtually or over the phone, and the instruction to social workers to limit the need to enter homes by using alternatives to face-to-face contact[53].

In many other policy areas, decisions were understandably left to local judgement and discretion but without a consistent, broad or balanced framework to assist those choices. The redeployment of health visitors is again a case in point. No clear guidance on the full balance of factors that should be considered in weighing up the level of that redeployment was provided, and evidence of wide and unwarranted variation in the redeployment of health visitors across the country, was witnessed[54]. The NHS Prioritisation Plan simply advised this decision should be taken locally on the basis of the need for additional capacity to man acute services due to COVID-19, with no suggestion of the process or weighting that should be given to other factors. Professionals recounted to us how this enabled a situation where redeployment levels more closely reflected personal and professional judgements around COVID-19 or local infrastructure arrangements than true levels of COVID-19 pressure in acute wards.

It was felt that the capacity to meet the needs of babies often did not feature in the decision process[55]. Similarly, after the initial period of severe lockdown when discretion was given to hospital trusts to decide about the inclusion or exclusion of partners antenatally, during birth and postnatally this was not accompanied by very clear guidance or a requirement for a balanced risk assessment. The resultant 'postcode lottery' did not reflect levels of COVID-19 in local areas[56].

"I think that some parents who had their babies during the crisis felt abandoned. One mother said this to me. By the way midwifery services were organised, by confusion about whether partners were there." Bumps and Babies Manager (workshop participant)

Meanwhile in other policy areas there have been simple "baby blind-spots". Some of these related to guidance to professionals. Our research heard from professionals who felt well informed about how to prioritise and risk assess their contact with older children but not babies; frontline workers who felt hampered specifically by a lack of guidance on the use of PPE and social distancing when dealing with babies, and from voluntary sector support organisations who felt unclear as to whether they could continue their services for babies at all.

"The last communication we received from NHS England or PHE regarding prioritising elements of the health visiting services was in June and was very conservative. We need more pragmatic central guidance to support a return to business as usual. Better PPE guidance would have been helpful. It was very focused on clinical activity and home care for the elderly." Community Health Manager (survey respondent)

"As a GP I have heard absolutely nothing regarding thinking about babies in the pandemic." GP (survey respondent)

Some policy 'blind-spots' related to financial support, for example:

- Children under four were not initially included in the provision of food vouchers to families.
- Pregnant women were told in March that they should isolate for 12 weeks but without any accompanying guidance being provided to employers, leading many in public facing health and social care roles facing pressure to continue working or hardship as they were forced onto Statutory Sick Pay and missed the opportunity of furlough[57].
- The financial support available to support childminders and childcare providers was arguably more of a 'long silence' than a blind-spot.

A full package was eventually announced but in the interim many private, voluntary sector and independent (PVI) providers are reported to have shut entirely due to uncertainty around their financial position. Analysis by the Institute for Fiscal Studies (IFS) suggests that the funding investment will not be enough to ensure all providers recover, with those in disadvantaged areas and those providing more non-subsidised places (potentially those with a heavy weighting of baby places) at particular risk[58].

Box 4: Summary of the issues with the national coronavirus crisis policy response

Area	Issue
Pregnancy	• The 'stay at home' message at the start of Spring lockdown and the impact on appointments. Some women reported being turned away by health services when they raised concerns, for example about baby movements. A cancellation of many routine maternity appointments and scans meaning growth checks were missed[59]. • Initially partners were banned from antenatal appointments and scans across the UK. By June/July the position was reversed in Scotland, Wales and Northern Ireland but left to the 'discretion' of hospital trusts in England without a clear framework for decisions. Hospital policies did not always correlate with the level of pressure from COVID-19[60]. • Pregnant women were classed as vulnerable and told in March to isolate for 12 weeks, but no follow-up guidance was provided to employers on how to treat pregnant employees. There is evidence that some in frontline social/health care roles were required to work or take sick leave[61].
Birth and postnatal	• Clear guidance to maternity services on whether partners should be attending births and postnatal appointments was not provided in England until the Autumn[62]. • Initially national guidance in England put in place a one parent rule for neonatal intensive care units (NICUs). Many units started to amend their policies to ensure both parents could be present and some units returned to full unrestricted access but local variation remained throughout[63]. Some hospitals required – and continue to require – parents to wear masks with newborns.
Health visiting	• The NHS published guidance on prioritisation within community health services in March 2020 stopping many elements of the Healthy Child Programme except for antenatal and new birth contacts, with advice that other contacts should be assessed and stratified for 'vulnerable or clinical need'. Services were asked to 'prepare staff for redeployment' without specifying how and on what basis[64]. Redeployment instruction was later reversed in a speech by the Chief Nurse and confirmed in writing in September 2020.
Childcare	• Providers were able to access the furlough scheme to cover up to the proportion of their wage bill that was notionally paid from private income, but it took over three weeks before the government issued guidance clarifying how it would interact with continued free entitlement funding. Some providers shut entirely due to lack of clarity on the financial position. Employees could not be furloughed for part of their hours[65]. • Childminders largely had to rely on the grant for the self-employed but this did not fully cover costs, nor was it claimable by an estimated 10% of childminders who were newly established. After much silence on childminders and nannies, those in England were told, with 24 hours' notice, they could reopen in mid-May if they were caring for children from the same household. However, separate government documents stated different dates for when this could happen[66].
Wider family support	• There was no explicit guidance was given for children's centres or the voluntary sector. • There was an absence of advice to professionals and community groups about what was permitted around the use of PPE and social distancing with babies.
Food	• Children aged under four years were not initially included in the provision of food vouchers to families.

There was a common perception amongst those we engaged that what lay behind these national policy gaps, blind-spots and contradictions was a low prioritisation of babies' needs during the crisis. This viewpoint was based on two trains of thought:

i. a widely-held, long-established notion that government historically and routinely fails to give babies the same level of focus as other age groups (especially in England).

"At times during lockdown it seemed like the government thought that childhood started at four. Children in early years are often forgotten and policy around early years often comes last." Local Authority Head of Early Years (interviewee)

"I'm not sure there was any thinking about babies' needs. We heard a lot about school age children and parents working from home but little about babies' needs." Parent Infant Psychoanalytic Psychotherapist, private practice (survey respondent)

"I think the early years sector wasn't as prioritised as the schools sector and the financial aid wasn't as good." Director of Children's Services (interviewee)

ii. a strong feeling amongst some across all four nations that during the Spring lockdown national decision makers had an almost myopic focus on COVID-19 risks which obscured other risks. This view was prevalent across our fieldwork.

"It's been Covid above everything else. The redeployment shouldn't have happened. Vulnerable families have just been left." Senior Nurse for health visiting (interviewee)

"NHS Community Prioritisation Plan prioritised the needs of Covid patients above everyone else- who was looking out for the needs of babies?" Service Manager, health visiting (survey respondent)

"Priorities were and are the virus and not the individual." Children's Centre parent support worker (survey respondent)

4.3 Long-term national policy context

In addition to the immediate pressures of lockdown and the national response, aspects of longer-term national policy challenges came to the fore throughout the coronavirus crisis and contributed to the local challenge.

Through our fieldwork we observed that initiatives such as the Healthy Child Programme, School Readiness guidance and Best Start helped to provide common reference points for local services and systems. Those we spoke to shared similar long-term goals, had the same minimum expectations of services in 'normal' times and all acknowledged the value of integrated approaches. Yet despite the many new initiatives and programmes that have sought to encourage more integrated approaches, fault lines remain between different agencies and frameworks.

This meant that when the call came to focus on the essentials, it was not always obvious which lens or forum should provide the guiding light. Most areas have multiple governance or programme delivery arrangements supporting 0-2s services from different perspectives. These are led from within the local authority, within the health service or a combination of the two – and it can be quite opaque as to where the balance of control and decision making really lies. As one interviewee commented:

"Government should think about join up between health and children's services... Healthy Child Programme, School Readiness guidance, Best Start all sit separately – should be one document –"there is something about the integration of that and recognising we can step into each others spaces." Director of Children's Services (interviewee)

The complex accountability picture in health visiting appears to have led to inconsistencies of approach and priorities. The shift of health visitor commissioning to local authorities in England in 2015 created the potential to align community health support for 0-2s further with wider local authority support. The coronavirus crisis seems to have tested this, arguably demonstrating that the reality of this alignment varies depending on the nature of the employer. Several professionals we spoke to observed that where the health visiting employer organisation was part of a wider NHS Trust running acute wards, they were perceived to be more prone to re-assign staff rapidly away from community health without any local authority input on the decision.

"There were vastly different issues with health visiting organisations and it seemed to depend on the nature of the employing organisation. So if you are a community trust with very little linkage to any significant bed-based unit or you are an employer that had bed-based but weren't in an area with high requirement to keep bed flow going through non-acute beds you were largely able to keep your staff and keep as close to a normal health visiting service as possible." Head of health visiting service (workshop participant)

There is also evidence that historically inadequate or insecure funding, and a rising tide of need, has inhibited the ability of some services and areas to respond to the coronavirus crisis. There was a sense among some professionals that this had put services at a disadvantageous starting point.

Over a third (38%) of respondents to our survey told us that the growing demand their service had experienced as lockdown measures eased was 'due to factors pre-dating March' as well as the direct impacts of lockdown. Some services and sectors are worthy of a particular mention in relation to this point:

In **childcare**, even before the pandemic, 11% of private-sector providers childminders were estimated to have been operating at a significant deficit pre-crisis[67]. These are amongst the groups most likely to serve 0-2s. Combined with the fact that many providers serving younger children tend to draw more on parent fees than direct government subsidy (as free entitlement places only start at age two, and then only for targeted groups – and the main financial support offered was via the maintenance of subsidised places), this is likely to have left many particularly vulnerable.

Health visiting in England is still dealing with long-term financial challenges. Cuts to public health funding and the removal of ring-fenced budgets for health visitors since the move of commissioning to local authorities have led to well documented decreases in numbers, especially relative to other parts of the UK. Low funding and de-professionalisation did not come up as major themes in any of our conversations but one larger study of the impact of the pandemic on targeted services in England concludes that the "pre-pandemic erosion of services as a result of austerity [...] has influenced the ability of frontline practitioners to respond to the pandemic". Drawing largely on input from health visitors the research finds that this undermined the efforts of services due to: "i) an erosion and devaluation of practice; ii) the move to a 'tick-box' culture; iii) unacceptably high caseloads; iv) inadequate performance indicators for health visitors; and v) the impact of a significant reduction in funding on service provision"[68].

A number of previous studies have also shown that when faced with budgetary pressures local authorities often make the unpalatable decision to cut those which are not statutory. This has meant that **early help and children's centres** have been vulnerable to the impact of austerity. The national picture on these services is now highly varied with gaps in provision in many areas. The coronavirus crisis has created additional challenges in this context[69].

5. Baby-positive local responses

In this section we illustrate what the most baby-positive local responses looked like during Spring 2020 lockdown, and what helped them come about. We do this by first summarising the key activities commonly practised in the areas where we observed, in our judgment, services were most successful in meeting babies' needs during the crisis. We contrast these with weaker responses to the needs of babies. In the rest of the section we set out the prior factors and attributes we have identified as crucially helping enable baby-positive responses. Ten key 'enabling factors' are identified across four dimensions. This section mostly draws on insights from our interviews and workshops.

5.1 What did good look like?

As described in section 3.3, the nature of actions and activities put in place during the national lockdown varied considerably by area. How did areas rise to the challenges outlined and what did 'good' look like in this exceptional time?

Figures 8 and 9 draw on the range of practices we heard about that illustrate both strong (baby-positive) and weak responses in relation to meeting the three primary aims of local systems and system leaders during the lockdown, as identified on page 25. To recap, these were:

a. To understand quickly which families with babies needed help and what was required, including ensuring no baby was 'invisible'

b. To provide good access to and engagement with effective essential support via maintained and adapted services

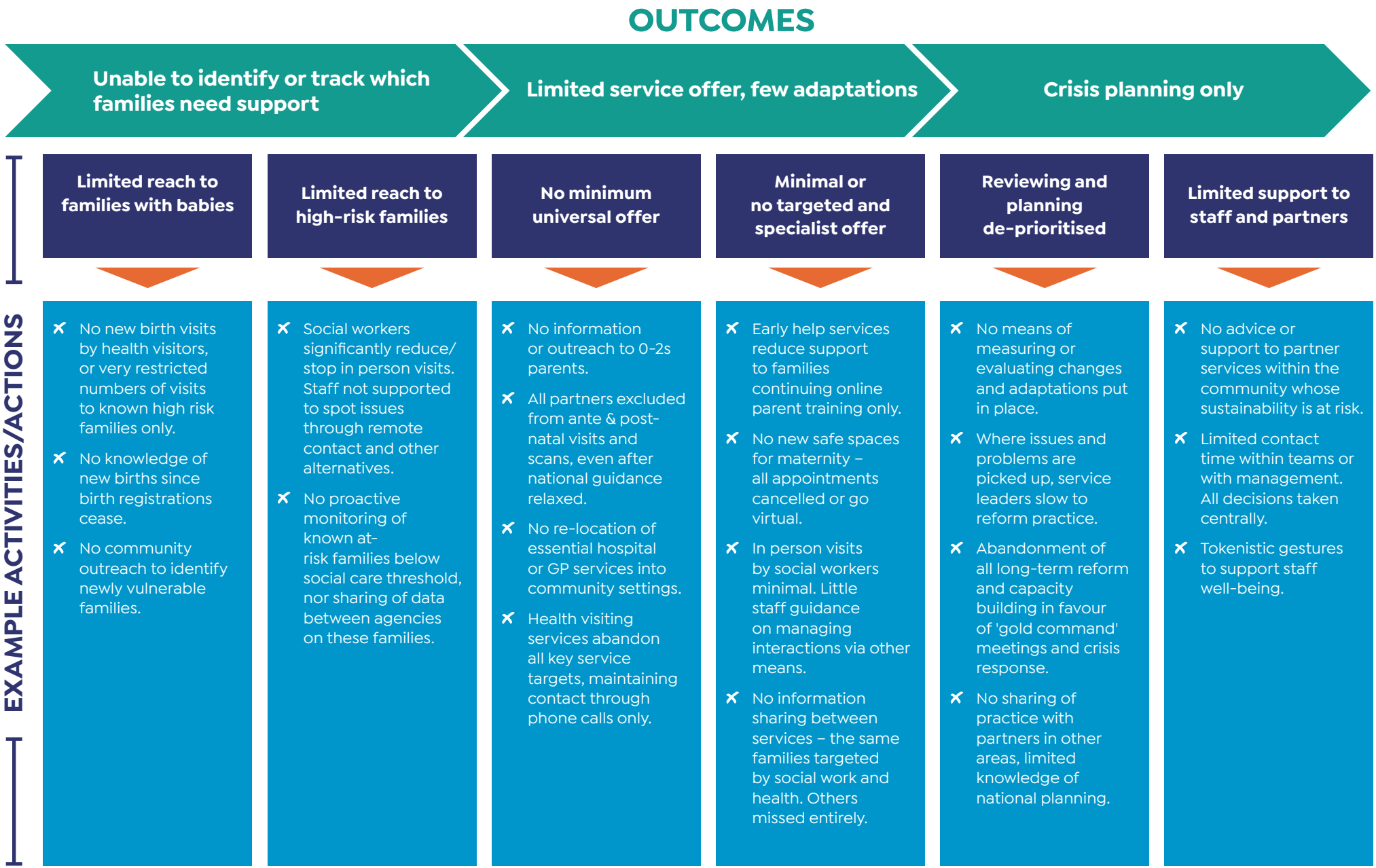
c. To continue to ensure local capacity to meet the future needs of 0-2s.

These diagrams draw on what we learnt from the research participants about the extent to which these aims were realised within their locality and what actions were involved (see the points in the blue boxes). The term 'baby-positive responses' hence refers to a set of actions and services within an area which most effectively met the needs of 0-2s.

The diagrams represent the polarised examples. Most areas we came across had at least some baby-positive actions and some aspects of a weak response, although we came across two areas which appeared to have achieved a largely baby-positive response overall.

Figure 8: Baby-positive local responses

Figure 9: Weak local responses



5.2 Enablers of baby-positive local responses

Reviewing all our primary evidence, we have found reasonably good consistency in the pre-existing factors which made it more likely that an area would demonstrate the strong response described above. Drawing on this, we identified 10 key enablers of 'baby-positive' responses during the crisis, which fit within four overarching dimensions (see **Figure 10**).

These are represented graphically below and then described in some detail. Each 'enabler' could be considered a pre-requisite for success – and none alone a guarantee. The strongest responses we observed incorporated all of these factors.

Strong, committed leadership

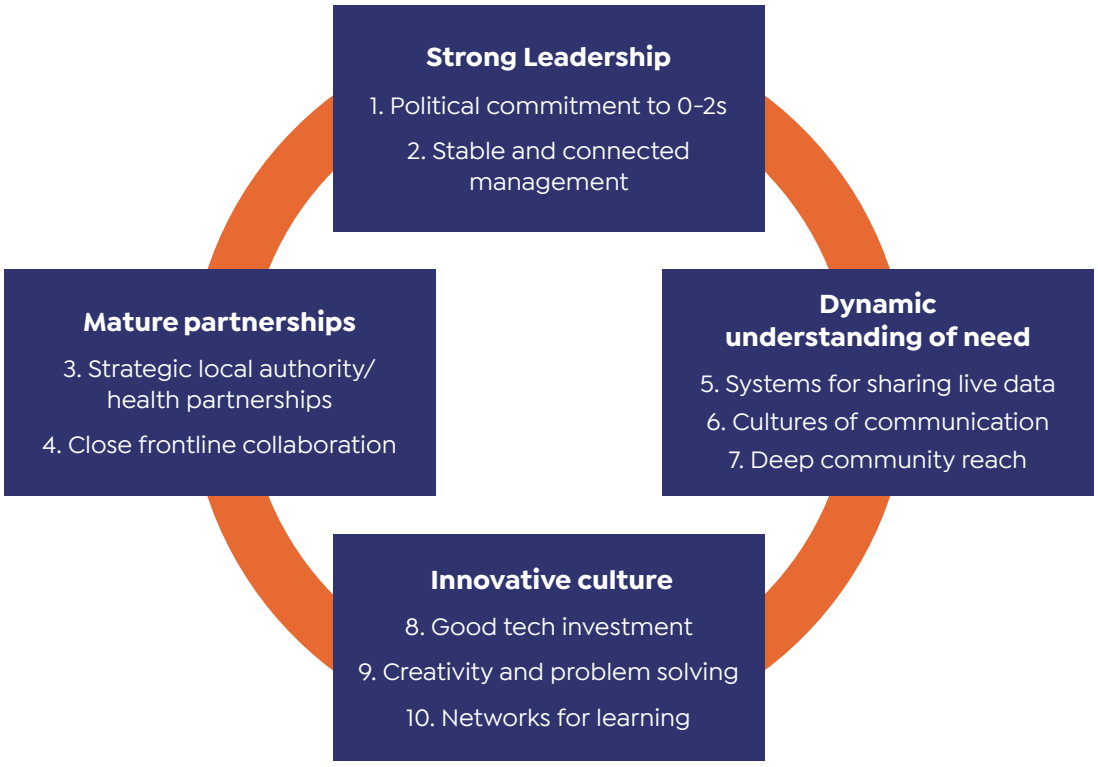
Strong, committed leadership emerged as a powerful enabler both at the political and strategic/ operational management levels. Local political commitment to the 0-2s agenda could pay dividends in terms of direct pressure to maintain services.

More often, it delivered benefits through the articulation of a clear commitment to babies, a clear vision of the offer and good investment in services and infrastructure. This in turn, supported good capacity to respond in the crisis, with prioritisation of services and trust in operational leaders to act decisively to make necessary changes. But for this to have effect, management also had to be clear-sighted, stable and well connected to staff at the frontline.

1. Local political commitment to 0-2s

Where political leaders were dedicated to improving outcomes for 0-2s, and the articulation of the 0-2s offer was clear, it could have a powerful effect in setting expectations around the need to continue to support all babies and setting service priorities. In one area, we heard an example of how this sense of political expectation and pressure had directly led to the protection of community health services. In another, we heard about how the explicit and widely understood set of expectations around early years inspired an almost 'war effort' approach to reaching out to all families with babies and making every contact count.

Figure 10: Enablers of baby-positive local responses



"We were able to protect our community health services to the extent that the guidance allowed us to. We made a real conscious effort to protect our HVs [health visitors] and community service because it's [this city]... There's a general acknowledgment here of the focus that we need to have on this age group and the need to continue to provide those mandated visits which then of course lead to the additional pathways and the additional contacts. That's well-rehearsed on our side but it's also well understood on the [city council] and the commissioner side." Assistant Director Public Health (interviewee)

"When it first hit I shut our children's centres and the pressure that came from elected members... they were like 'when can you get them back open? What are you offering' – even if we hadn't thought of it they were absolutely on our case. We were getting ongoing questions about what we could do with this group of children. They really see they matter." Children's Centre Leader (workshop participant)

Historical strong local political commitment to 0-2s was also associated with the development of robust and devolved service delivery models which stood the test of the crisis. Amongst our interviewees we heard two particularly striking instances of this – both were health/local authority strategic level partnerships with locality-based approaches to delivery set around well invested children's centres. Strategic leaders in these areas commented on the significant knowledge and capacity they were able to lever from the system, as well as the level of trust they felt from senior management and political leaders to make decisions rapidly and adapt services. It was clear they felt empowered.

"The result of longstanding commitment here is that we have a service that is robust enough and structured in such a way that we have enough leadership and management and practitioners to be able to respond in a situation like this. It has that very specific impact and then because of that you then have the capacity to respond... That commitment is a tangible thing." Head of Early Years (interviewee)

"There was a trust and faith that came from the members of the council that this is a service that would do the right thing." Head of Early Years (interviewee)

"If you asked some of the councillors what they would go to the wall for they would say early years and as a result of that things have been put in place such as the localities model and there is an enormous amount of trust in that structure, an enormous amount of trust in the vision that's been stated and working towards... For me that political buy-in is of immense value and in the crisis has been vital." Director of Early Prevention (Interviewee)

Political commitment to 0-2s may also have led to better investment in services prior to the pandemic, so they started in a stronger position. We heard, for example, from one Welsh locality where despite 38% of health visitors being suddenly redeployed, they were able to maintain new birth visits to *all* families, whilst also maintaining phone contacts for all other required visits, providing a safe physical space for families to come in when needed and continuing safeguarding visits. Whilst the challenge they faced still felt tough, the larger health visiting workforce they had to start off with had put them in a stronger position than those we spoke to in England, none of whom had been able to provide this level of service with similar levels of redeployment. In other areas of high investment, people proudly told us about how, despite all the restrictions, the system had the personnel and resources to meet new needs. One council worker reflected:

"We encouraged [Private, voluntary sector and independent (PVI)] nursery workers to call in when a family had a need and there wasn't a single thing we couldn't answer or couldn't sign-post, not just to the website but particular people who could help them." Local Authority PVI Lead (workshop participant)

2. Stable and connected management

The benefits of strong political leadership on 0-2s were most likely to be realised where high quality management was present. And where it was not, strong political leadership did not always translate to clear benefits.

This was very apparent in one council with a good high-level political commitment to the early years who were amid a service restructure when lockdown arrived. This council had a number of interim leaders in post and no permanent directors. In the workshop in this locality, there was a broad consensus that the lack of stable management had led to a more distant and centralised approach, undermining the ability and confidence of service leaders to make the necessary decisions and adaptations.

Some service leaders felt they knew what needed to be done in order to meet service objectives but did not have authority to do it. Others said that the absence of any strategic level joined-up assessment had left them feeling confused about priorities and somewhat isolated in their actions. From their perspective it had led to some very crude and blanket interpretations of national guidance which put COVID-19 related risks at the fore and obscured the wider risks to babies.

"The leadership has been phenomenal in terms of the service frontline leadership but the leadership the next bit up missed opportunities to jointly collaborate and be really discerning about what it was that was needed jointly." Health Service Manager (workshop participant)

"It's left us in a tricky situation. On a local and frontline level we know our jobs but in a wider situation we are in a state of interim change which has been unfortunate timing... Senior management levels should have allowed and trusted local communities and be able to be more responsive and flexible." Perinatal Support Service manager (workshop participant)

In contrast, strong management was aligned to an informed and knowledgeable approach, calm in the face of crisis, and a sense of collaborative decision-making with frontline managers and staff. It was not uncommon for senior managers to become more present at local level forums during the crisis. For example, a council Head of Early Years stepped in to chair the regular sure start children's centre locality leadership meetings which had always taken place without her involvement prior to the crisis. She already had good relationships with them and being more present enabled her to understand the rapidly evolving issues as they arose. It made it easier for decisions to be taken at those meetings, empowering frontline service leaders to use their close understanding to effectively drive necessary changes.

"A number of our senior leaders in health and the council's early years team and the Director of Health, they've been around for a while so they were well established and well versed on what the issues were." Children's Centre Manager (workshop participant)

"It was such an intense time but it felt very, very much that we were trusted and able to come together as a service. We would all come together at least weekly, and [we had] really good collective decision making." Locality Lead (workshop participant)

"We were able to retain enough staff with enough experience to be able to do things differently and try different ways of managing the service." Health Visiting Service Manager (workshop participant)

"It was almost like everyone immediately connected and pulled together across the maternity service and midwifery teams. Processes were put in place very quickly to allow everyone to help decide how to take things forward, exchange worries and for information sharing." Maternity Service Manager (workshop participant)

Strong management cultures were also correlated with a greater emphasis on supporting staff during the lockdown. This meant a general awareness of the pressures staff were facing and actions that went beyond set-piece corporate wellbeing gestures, for example keeping in very regular touch, creating forums for support and continually seeking out small changes and adaptations which could reduce the unique pressures frontline professionals were facing.

"One thing that was really apparent is that in April/ May the government guidance was coming out all the time and staff were shielding so we had to think about what that meant in terms of capacity, resource, risk management. A number of my staff are BAME. There were a lot of headlines about groups being disproportionately affected. You're managing also the wellbeing and anxieties and keeping the workforce well." Head of Early Years (interviewee)

"Within our team since we went into lockdown we have every morning a zoom meeting so we can catch up not only about the patients but how everyone is coping and what is going on. If someone felt distressed about a patient we had someone to speak to. We all felt more supported. Sometimes it just takes a quick meeting and it's nicer. So we still do that. It's working very well for us." Perinatal mental health worker (workshop participant)

"There was tonnes and tonnes in terms of online support but actually it was the simple stuff – Friday coffee catchups online. In some ways managers and staff felt more connected because they had more contact than previously." Head of Early Help (workshop participant)

It was very apparent that good and calm management was aligned to a continued emphasis on thinking and planning ahead.

"One of the things that we were able to do was plan ahead. It was really hard but we were still able to think of the new pathway and making changes to the service and I know that in some other boroughs in August that was very far from people's minds. I think it's a sign that we were able to work very calmly." Head of Early Years Operations (workshop participant)

Mature partnerships

Where genuinely mature partnerships existed already, we found these endured during the crisis and often came into their own. Where health/ local authority partnership arrangements did not extend meaningfully beyond frontline working relationships, or where partnership structures were not fully embedded and driving decisions and accountability, there could be a tendency toward retrenchment to silos during the crisis.

The strongest strategic partnerships provided a basis for key decisions and mitigation plans to be informed by a balance of perspectives. Across operational delivery and at the frontline, a strong history of close working and collaboration laid the ground for good crisis communication, swift and creative adaptions of services and effective use of resources.

3. Strategic local authority/health partnerships

In many cases the pace of NHS re-prioritisation made it hard for local authorities to have any explicit input to the initial decisions about resources. However, across our conversations we found that the maturity and depth of strategic level local partnerships between local authorities and health, impacted the extent to which babies' needs were effectively prioritised and planned for.

Where partnership arrangements did not extend meaningfully beyond frontline working relationships (as good as those might be), or where partnership structures were not genuinely embedded and driving decisions and accountability, we found examples of senior leaders retreating to silos during the crisis. Strategic partnership boards overseeing cross-agency strategies and programmes in these instances seemed to be de-prioritised as 'nice to haves' as organisations focused on their own emergency plans and systems.

The consequence of this was no forum for local authority leadership to have a voice in the decisions around the shape and length of community health redeployment, and limited possibilities for them to bring to the table their wider view of the balance of risks. Where there was not an effective working relationship or culture of communication between senior health and local authority partners, it could even prove hard for local authorities to keep abreast of what was going on with community health staff, and hence difficult to mitigate the effects through planning family support and targeted services accordingly. We heard some frustration at service duplication and gaps in these instances.

"Despite having integrated delivery boards through our family hubs, the LA went into it's own service prioritisation plan and health went into theirs... I've probably reverted much more into 'what we can do as a LA?' than I thought 'what can we do as a partnership'... I've been much more engaged with the schools system, been very, very closely working with early years settings, I've had conversations with health about what they are or aren't doing but it hasn't been as tight." Director of Children's Services (interviewee)

"Prioritisation in health was practitioners being taken out of the children's service and put somewhere else... I have expressed my concerns [about health visitors not doing birth visits] to our health provider and their system is so fragmented it goes all over the place and you never know who the decision maker is... They get hung up on the vulnerable but social services are supporting them, we know who they are, it's the other children." Director of Children's Services (interviewee)

Conversely, we saw evidence of established and influential strategic partnerships around early years and the first 1001 days taking on increased importance during the crisis. They did this partly by helping to secure expectations that key 0-2 services would be protected from the start and continually voicing the need to prioritise babies as an at-risk group in the context of lockdown.

"The School Readiness Board was very influential with the Health Board throughout the pandemic." Assistant Director, Early Years and Early Help (interviewee)

"[The Early Years Delivery Partnership has] shared the research and comms that have come out since May/June within our organisation but we've also shared them upwards. There've been some quite scary headlines that have come out which I think have helped us protect our services." Assistant Director, Public Health (interviewee)

Strong strategic groups also enabled effective sharing of understanding of new needs and risks associated with reduced and adapted services. For example, one very well-established city-wide delivery steering group, co-chaired by Assistant Directors from both local authority and health, continued to meet regularly throughout the crisis and became a vital space for sharing knowledge and joint planning about how to address the many new challenges that were arising across different services.

"We've continued these meetings over the last six months so our Health Lead has an understanding of the issues in children's centres and our local authority early years lead has understanding of issues on health visitors, speech and language etc – we've maintained that focus." Strategic Head of Early Help (interviewee)

The established and trusting relationships which had been formulated within that group, and past experience of working together, also meant that when key services could no longer continue in the normal way, senior service leaders contacted each other quickly and directly and were able to resolve barriers through new ways of working.

"We'd always had community drop-ins but the head of community midwifery came to us and said 'could you support us transferring our provision out of the hospital settings and into the communities." Assistant Director, Early Years and Early Help (interviewee)

Figure 11 summarises four partnership models we came across and what happened in relation to health visiting during the crisis. It illustrates the correlation between the depth of partnership arrangements and how pressures on health visiting were managed during lockdown.

Figure 11: Health visiting and local authority/health partnerships

Lockdown stories drawn from our interviews and workshops in different locations illustrate the correlation between partnership arrangements and how pressures on health visiting were managed during lockdown.

No Partnership	Early Stage/ Aspiring Partnership	Substantial Partnership	Mature Partnership
Some health/family support services were co-located and people had good relationships but there were no formal partnership or joint governance arrangements, service level integration or data sharing.	The First 1001 days is a clear shared priority. Some good service level collaboration via family hubs, "Everyone's talking about the aspiration of better join up, it hasn't yet materialised".	New but active strategic partnership between the local authority and health. Strong working level partnerships at locality level with community health visitors located in children's centres and mechanisms for regular data sharing.	An influential and effective local authority/health partnership group actively owns the maternity and early years strategy and oversees delivery. Strong working level partnerships at locality level across a range of health and support.
What happened 50% of health visitors were redeployed immediately. No face-to-face visits until August, other than in the most pressing safeguarding cases. Technology was limited so all other visits were conducted by telephone. Regular contact between the lead health visitor (employed by the Foundation Trust) and the local authority Early Years Lead.	**What happened** Some health visitors were redeployed. Those retained were told to prioritise face-to-face visits for known at risk families. The universal offer went online and no face-to-face new birth visits occurred unless there was a particular pre-known risk. This was still the case in September 2020.	**What happened** Some health visitors were re-deployed but senior health visitors were retained. New birth visits were a mix of virtual and physical visits based on risk and parent preference. The health visitor duty desk was retained in children's centres. All health visitors returned in June/July 2020.	**What happened** A very small proportion of health visitors were redeployed. Most birth and antenatal visits were done by phone initially, then online, but targeted visits and bookable clinic visits continued based on need. The health visitor duty desk was retained in children's centres. Health visitors promoted public messages on COVID-19, helping to alleviate parental anxiety.
How key decisions were made NHS health provider took the decision to redeploy alone. No sharing of service escalation plan, strategic discussion or joint planning with the local authority.	**How key decisions were made** NHS health provider alone took the decision to redeploy and cease new birth visits. Service escalation plan with children's services. No wider discussion or joint planning held with local authority.	**How key decisions were made** Initial redeployment happened without local authority input but ongoing communication was effective. Partners worked closely together to maximise effectiveness of the remaining health visitors and address gaps, including via input from early help and early years practitioners.	**How key decisions were made** The strategic partnership was considered to have directly influenced the decision to minimise initial redeployment. There were ongoing conversations between local authority/health about how to adapt and address service gaps.

4. Close frontline collaboration

A history of close collaboration between all 0-2s services at the operational management and delivery level appeared in many cases to lay the foundations for new and creative solutions to be generated and rapidly implemented. In some examples, previous relationships and collaborations were resurrected for these purposes.

Locality-based delivery models[ii] centred on well-funded and networked children's centres and family hubs hosting a range of services stood areas in good stead in this sense. Where these still existed, interviewees and workshop participants seemed particularly likely to have felt they could 'pick up the phone' and agree ways to adapt services and maintain their reach. We heard a number of examples of maternity services being moved out of hospitals and into children's centres, and GP based immunisation services similarly. The fact that many health visitors already had an element of their service based in such centres also paved the way for the set-up or expansion of health visitor duty desks, booked appointments and hotlines, all of which played a vital role.

"We struggled to access some of our estates quite early on and were able to work quite flexibly with our SureStart friends to access estates to see families and that really helped. Because we've got those relationships already established it was possible. Our partnership in early years delivery model is designed to be supportive of one another. We had the relationships." Assistant Director for Children's Community Health Services (interviewee)

"Having that strength of leadership based in the communities was so powerful. We had senior managers based out in the communities, running services, bringing partners together in a way that we would have struggled with without that." Head of Early Years (interviewee)

"We have a very well-developed relationship with the local authority, even at a practitioner level... I don't know if there was a good deal of agency-to-agency communication but we've always had our open front doors for health visitors through our children's centre duty desk and such like. During lockdown were even more vital." Health Visiting Service Manager (Interviewee)

A history of frontline collaboration with the voluntary sector was also an asset during the crisis and there are various examples of service co-delivery. Voluntary sector partners were commonly invited to host foodbanks in children's centres and family hubs, sometimes bringing with them families not previously known to services. Where the private, voluntary and independent childcare sector were already well known to the local authority they were able to quickly establish communication and offer them guidance on navigating the government's financial support and rules around opening, and use of PPE.

"Each PVI already has an [council early years] adviser. They provided daily updates to settings notifying of changing government advice but also interpreting that for them. It was a really tangible offer that made our nurseries feel safer [and gave them] a feeling of not being on their own." Head of Early Years (interviewee)

ii. The term 'locality based models' refers here to models where some or all children's services are organised at a sub-local authority or community level with a local structure in place providing oversight to a range of services in the area.

Dynamic understanding of need

Areas able to keep abreast of new births and identify and respond to new needs as they arose were better placed during the crisis. In practice, this was helped by having systems for sharing live data about vulnerable and potentially vulnerable families with babies, as well as a culture of sharing information between staff across and within agencies. Those areas with a history of service co-production with the voluntary sector and parents found these connections facilitated reach into the community which enabled better information about families in need or those becoming vulnerable but not previously on any agency's radar.

5. Systems for sharing live data

The use of live data sharing systems from pregnancy onward was effective for tracking babies and identifying families' needs. Where common processes were already in place for the routine sharing of personal maternity data for example, local authority services were at an advantage in being able to keep account of new births when birth registrations temporarily ceased. Where these systems were lacking, new births were potentially invisible, or senior leaders needed to negotiate new data sharing protocols.

"The electronic health record was a god-send in Covid..." Assistant Director, Public Health (interviewee)

Most early help teams held important information about potentially vulnerable families who could be targeted for additional 'checking in'. There were limitations however where data held was neither in-depth or 'live'. In these cases contact with families beyond those already known to be vulnerable or high risk was difficult. This risked missing families newly vulnerable as a result of factors such as financial hardship, domestic conflict or mental distress. One service leader articulated how the best prepared systems would have used live data dashboards.

"...Early help knows who we know and we've done really granular work looking at wards and super output areas to understand outcomes for under 5s. However, we have dynamic populations so that's useful for general targeting but when you're in a crisis and you want to specifically target the most vulnerable people in society you need actual real-time data. We simply didn't have that. I'm not just talking about health visiting data, I think midwifery data, possibly benefits data. We really needed a live data dashboard to think very specifically and quickly about who we should proactively reach out to." Head of Children's Centres (workshop participant)

6. Cultures of communication

Examples of best practice in tracking family vulnerabilities worked beyond formal management systems. Additionally staff connected on a day-to-day basis, referred to each others services and exchanged information and contacts to raise awareness of new families in need. Again, this seemed most evident in areas with strong children's centres or family hubs and multi-agency approaches where the partnerships and relationships already existed across a clearly defined and manageable locality. In areas with these partnerships, there were several examples of new forums that had been established very quickly to enable the real-time exchange of data across sectors.

"The protective factor for us locally was the fact that we're so integrated with health visiting. The fact that our health visiting and early years service work together from the Children's Centre and I think some of the strength behind that is the data sharing, so we have access to all of each other's systems so we know who all the new births are within the local authority." Children's Centre Lead (workshop participant)

"All the services from welfare rights, employability and family support pulled together on communication and keeping in touch. Sharing that information gave an overarching view on what was happening and that felt very key in keeping people safe. As a manager having an oversight of all those contacts by those individual services and pulling that together was a good bit of safeguarding practice that we brought in quickly." Locality Manager (workshop participant)

7. Deep community reach

In tandem with data sharing, some of the most baby-positive local responses utilised their relationships in the wider community to continuously gather information about families not previously known to them. Those with a history of co-delivery with local charities seemed poised to do this particularly well, although others were also able to establish fruitful partnerships over the course of the crisis. Children's centre based foodbanks proved a particularly valuable resource in this respect.

"Because of our longstanding relationship with the local community we were able to flag up areas of need and make changes quickly, particularly with our voluntary sector partners." Family Hub Manger (workshop participant)

"We made every opportunity count to check in with families. For example, when families were picking up food parcels we used that as an opportunity to check in with parents. We were thinking very flexibly about where we were seeing those families and taking opportunities to see what their needs were at that time." Children's Centre Manager (workshop participant)

"One of our community partners were giving out food parcels but through our partnership meetings we came together and shared a list. From this we could see that there was a particular parent going to a lot of different services for food parcels ... So together we were able to piece together that there was something bigger happening for this mum, she had lost her job and we were able to support her with mental health services." Locality lead (workshop participant)

"One children's centre became a foodbank with delivery service for families with children 0-5, run by a voluntary sector organisation...the interesting thing was we got referrals for families we hadn't worked with before through health and central referrals, including quite a lot of families with no recourse to public funds." Head of Early Years (Interviewee)

Well-established prior relationships with the private, voluntary and independent childcare providers and childminders were also harnessed to provide essential real-time insight about families. In one area with named council 'PVI advisors' assigned to all nurseries, playgroups and childminders a large proportion of settings remained active during lockdown, signposting families to help and flagging concerns about particular families to the council.

"When it came to trying to ensure that we knew what was happening with our vulnerable children, we were able to get that information from PVI providers as well. That meant we were able to key in those children into our network calls so we were really aware and in touch with all vulnerable children throughout this period." Head of Early Years (interviewee)

"...[Private, voluntary and independent early years settings] have become much more attuned to the local offer because they had to use it to get support for families. They would phone their advisers and say 'I've got a particular family and they are struggling with X or Y' and when they realised the opportunities for additional of support a few of them said 'wow, I never realised this was there'." PVI adviser (workshop participant)

Areas with a history of systematically engaging parents directly in peer support and co-production were also able to utilise their community contacts to reach deep into communities, including parents who may have been reluctant to come forward.

"Our Parent Champion Volunteers remained active. They did a really good job on the phone spreading the word about what was available and letting us know if someone was in trouble. They had their own children to look after but also did a lot of calling, provided feedback about support." Head of Early Years (interviewee)

Innovative culture

Prior investment, or not, in technology was a critical factor that enabled or hindered local baby-positive responses. More broadly, a culture of creativity and problem-solving that extended to the frontline, enabled professionals in some areas to feel more confident about developing and implementing adaptations to their services. Those areas which were part of active peer networks were well placed to learn from others and effectively reflect on their own practice during the crisis.

8. Priority to tech investment

Prior investment in technology was overwhelmingly identified as a service 'enabler' during lockdown. No-one we spoke to felt that the technology available locally had been sufficient at the start of lockdown to see them through the crisis. However, there was significant range in the capability of established networks, IT software and hardware, IT protocols and policies and general usage. Those who started off the crisis in a stronger position in all these respects were more easily and quickly able to move support and outreach onto digital platforms and adapt to effective home working.

"We went into lockdown and we realised we were going to have to keep in contact with families using digital platforms so we made sure all of the families connected to social care and early help had a device within the first two weeks." Director of Children's Services (interviewee)

"Over time we campaigned for IT and we managed to get i-phones and then laptops but the council didn't have sufficient capacity on the network so some of the staff that weren't key workers had to log on before 9 or after 5. We absolutely didn't have the IT." Head of Early Years (interviewee)

"We've got good IT but it needed to be better. And all staff needed to get laptops. That took time." Assistant Director Early Years (interviewee)

9. Creativity and problem-solving

Where there was an established culture of creativity and problem-solving, professionals felt less daunted and more empowered to make changes. To some extent this was down to having more practical experience in continually reviewing services, pinpointing problems or barriers, and developing new solutions. A number of people emphasised that the most effective adaptations had come about where individuals with the closest knowledge of delivery and of communities had the confidence to go beyond their job description and design and implement change. Where frontline leaders and professionals felt they had the backing of senior managers to do this they often relished the chance to come up with and operationalise new solutions.

"A theme here was devolvement. You know your communities, you know the partnerships, what do you need to do? And by permission, get on and do it." Head of Early Help Lead (interviewee)

"People taking initiatives and feeling they could do something outside their job description was really crucial." GP (workshop participant)

"I think we felt confident and empowered to make those decisions, to adapt practice, to make the buildings safe, that practitioners felt able to adapt that practice. It creates a culture where we all felt we were able to make choices and make decisions and adapt to the situation." Early Help (workshop participant)

"We relied on people to make adaptations and manage services and develop offers within the limitations that we're working to." Head of Early Years (interviewee)

Conversely, where their new ideas were blocked at a more senior level this felt limiting and demoralising. This is strongly tied to the points around good management set out above.

"Even though NHS England said what it said and there is cohort of staff that are quite innovative in their thinking so we would discuss that in the division and come up with ways forward but the division then had to go to Gold Command in the [Health] Trust and a lot of that was no you can't, not yet, not now. So even that creative license of could we, shall we could we make it happen – we were restricted." Senior Community Health worker (workshop participant)

10. Networks for learning

Those areas which were part of wider regional or national networks, found that the opportunity to think through problems with peers usefully informed their policy and practice during the crisis. This helped them feel more confident about making decisions and changes and, to some extent, less burdened by sometimes confusing top-down guidance.

"Every week up until July the Heads of health visiting and National Head of health visiting and National Chief Nursing Officer met. We had many common concerns initially with the mixed messages etc so it was decided we'd have these weekly Wales wide meetings... We were trying to be consistent with the service throughout Wales. The solutions remained really different based on geography and populations and practice varied a lot. But the challenges were similar and it was very useful to work through common problems. They'd go through a standard agenda: redeployment, PPE, IT equipment, student HVs, comms etc but it was really important to talk to everyone else and see what they were doing." Senior Nurse for Health Visiting (interviewee)

We also heard how in several areas the existence of regional level groups provided a forum to reflect on their learning as lockdown measures eased, providing a clearer perspective on the positives as well as the challenges. This provided a good foundation for future learning. Conversely the limitations of reflection and review within one area or service were also noted.

"We've got together [in the regional network] and looked at recovery plans... We have since looked at lessons learnt, positives, changes we'd like to keep... The School Readiness Board was a fantastic resource for collaboration and sharing ideas and that network was very influential with the health board throughout the pandemic." Assistant Director, Early Years and Early Help (interviewee)

"We tried to pull together the learning from the first lockdown. But we have kept it as local authority learning. We have the pre-birth to 5 Board and have had some discussions around HVs but I'm not sure we've been really open about sharing the whole picture. We've not shared what our learning has been and then mapped on their learning." Director of Children's Services (interviewee)

6. The future for 0-2s services

In this final section we reflect on the future prospects for services supporting 0-2s. We identify the key post-crisis pressures and new risks but also the new opportunities to build on momentum and learn from the experience. To do this we draw on insights from across our research bringing these together with our own broader knowledge of the policy landscape.

6.1 Growing pressures

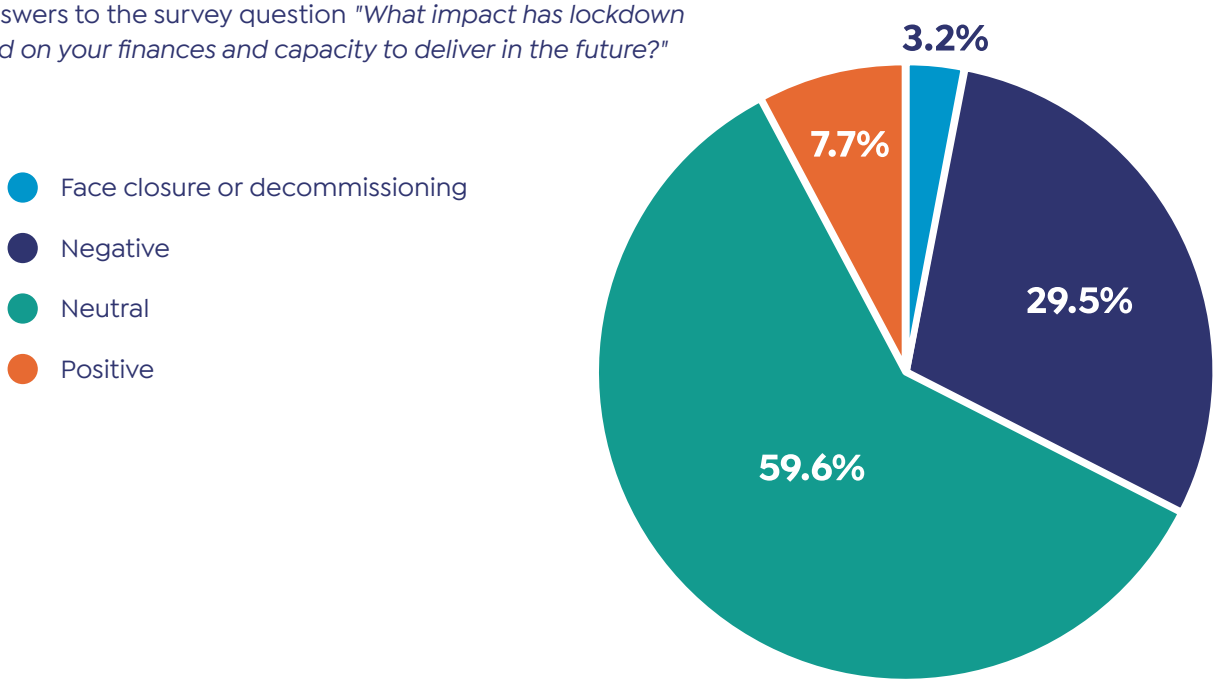
At the point of writing, the coronavirus crisis is ongoing and the full picture of future support needs of families with the youngest children is not yet apparent. Yet taking together what we already know about lockdown harms to babies and projections of increasing financial hardship to many families in the wake of the crisis[70], it seems inevitable that the need for early support and help to families will continue to grow in the short to medium term. Our survey gave a glimpse of this. When we asked about how demand for services increased as the lockdown eased (June to September 2020), respondents gave a wide variety of answers but on average reported an increase of 47%.

Over three quarters (77%) put this down to 'growing need due to the impacts of lockdown', with those providing parent or infant perinatal mental health services most likely to say this was the case. Nearly half (47%) also cited 'short-term demand as services catch up'.

At the same time, many services supporting 0-2s face being financially squeezed. The present crisis is likely to further exacerbate long term funding challenges. The full extent and impact of this is hard to grasp at this stage but our survey suggests in the wake of the Spring 2020 lockdown a significant minority (30%) have been negatively impacted, including a small number facing closure (see **Figure 12**).

Figure 12: Future finances

Answers to the survey question *"What impact has lockdown had on your finances and capacity to deliver in the future?"*



Private and charity sector providers were most likely to report a shortfall. The childcare sector appears to be in a particularly precarious position with many private sector providers and childminders in particular having run significant deficits during the 2020 lockdown (two groups likely to look after the youngest children)[71]. Government concern about the sustainability of these services is likely to have influenced the decision to try to keep early years settings open during the January 2021 lockdown.

Yet while services might feel they need extra support, the post-crisis outlook for public spending is bleak. The 2020 Spending Review left little room for doubt on this, introducing a public sector pay freeze and, for example, maintaining the public health grant at its current, relatively low levels. The Chancellor made explicit the plans to spend much less on public services when normal times return.

6.2 New threats

Services for 0-2s will have to meet the above pressures whilst also fending off new threats of workforce burn-out and low morale. 'Frontline fatigue' in 2020 has been well documented[72]. Our research echoed this with many participants articulating that the crisis response has taken its emotional toll on the mental health and wellbeing of many staff – despite many employers doing much to offer additional support. Several senior leaders and professionals described a feeling that, by Autumn 2020, the adrenalin and sense of public duty that had seen many staff through the early phase of the crisis was already wearing thin and staff were feeling exhausted. Others said that their morale had been impacted during the crisis by the cancelling or demoting of duties, or the low visibility of their efforts. This was a theme amongst some health visitors. There is a question about whether the public sector pay freeze, which will apply to many working to support 0-2s outside the NHS, will impact morale further. More work is needed to unpick how different aspects of the workforce have been impacted, and to put local and national strategies in place to address this.

"As a manager myself I'm seeing workers now really struggling. They are tired they are worried, they are exhausted. I've got social workers who are going off sick at the moment because of the intensity of the work – they're having to work from home and home is no longer that safe space." Assistant Director, Early Help and Early Years (interviewee)

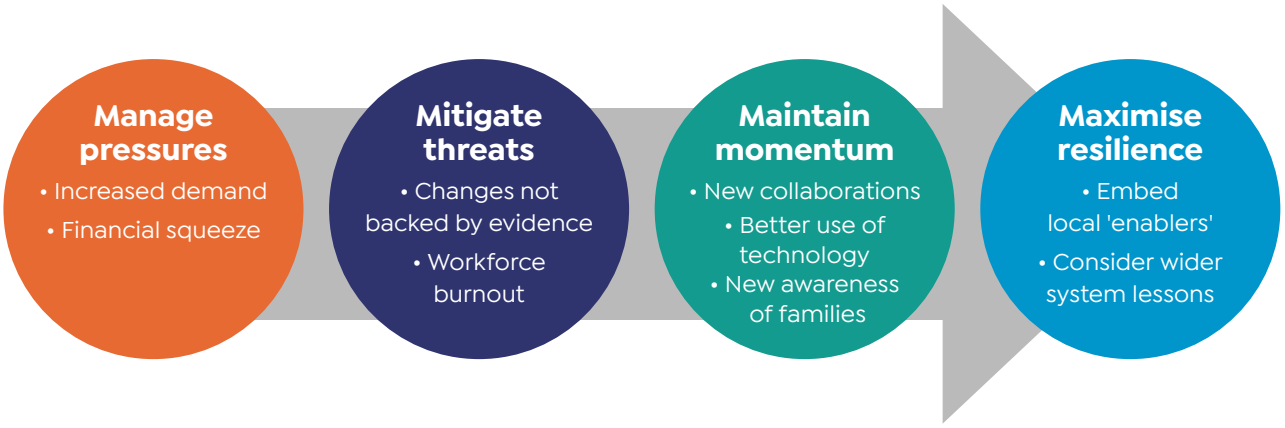
"Redeployment happened too quickly, without enough thought, staff felt health visiting was undervalued and it will take time to rebuild staff wellbeing and trust and respect. Staff also feared if health visiting can be redeployed so easily and quickly what does that mean for the future of the profession?" Senior Health Visitor (interviewee)

"Our service had no acknowledgement of the work we continued to offer families during lockdown. Our referrals increased massively but we had no support. We covered postnatal wards when we are usually community based. The pressure has been extremely hard. We had little time off and had no hardware to work from home. We were also made to go into offices against government guidelines putting many of us at risk. We have felt really unsupported as a service." Community Health Service Leader (survey respondent)

Another significant threat to 0-2 services is that of compromising quality through making permanent changes which are not sufficiently evidenced or thought out. The pull to do this may be particularly acute given the potential of some changes to deliver services at lower cost.

The vital importance of learning lessons from the rapid innovations and adaptations which have taken place – in particular the shift to virtual services – and understanding their impact before changes are permanently adopted, has already been flagged by the Early Intervention Foundation[73]. Where this can be done effectively there are huge opportunities to push services forward (more on this below). But it is not clear that all service leaders have had much opportunity to reflect deeply and learn lessons from the evidence. In our survey, just over a quarter (29%) of those who had adapted their service said they had put in place new monitoring systems or processes for evaluation. And of the many who told us a decision has been taken to maintain a lockdown change to their service in the long-term, 60% said this was driven by "an observation that it has had a positive impact – but not formal evaluation" – only 12% said it had been driven by a formal evaluation.

Figure 13: A summary of the challenge for 0-2s services in 2021



6.3 New strengths

"The learning is immense and comes across in all the service areas." Head of Early Years (interviewee)

Despite the incredible challenges of 2020 there are many signs that services and systems supporting 0-2s are emerging from this phase of the crisis with significant new strengths. A clear message from our research is that the changes forced by the crisis have brought about new ways of working and solutions to old problems. Numerous people referred to the crisis as having 'unblocked' aspects of the system, enabling rapid development of new policies and practice standards which in some cases had prevented service development for a long time. Examples of this are scattered throughout this report, but we identify three areas where significant momentum has been created across many local areas.

The first is a new and **enhanced understanding of families who may need support**, and new ways of thinking about how to reach them. Through the experience of the crisis many professionals are now thinking in more lateral ways about where those families who don't come forward are and how they get their information and support. As one Head of Early Years put it: *"We already have the focus on 0-2s but what the coronavirus pandemic has done is absolutely sharpen the focus on those families. It's not just the children who were on our radar, it's brought whole new families who need support beyond standard advice and guidance. We're asking much better questions now about how to reach them".*

Second, is that **huge strides have been made toward optimising the use of technology**. The workforce in general have accrued levels of learning about how to use digital tools that they would never have ordinarily achieved. Whilst there is still work needed to properly develop and evaluate new ways of working, the pathway has been laid for more effective blended services where this is desirable. As one survey respondent summarised it: *"Across the piste some of the challenges and blocks in the system that were previously in place were alleviated. Particularly in relation to the digital and virtual – for example permission to use zoom, using online tools, ensuring staff have laptops and connectivity, quickly working out data sharing requirements, what do safe online conversations look like, what's the conversation you were going to have with the parent sitting there with a toddler or at risk of domestic violence."*

Third, there are **numerous instances of improvement in collaboration and multi-agency working over lockdown**. This was demonstrated in examples scattered throughout our fieldwork and is echoed by other studies[74] which also suggest that across the country in 2020 many professionals and organisations working with children broke out of historic silos and forged more integrated approaches within and across services, including with community and voluntary sector partners.

6.4 New opportunities

As this report demonstrates, the coronavirus crisis has also provided a unique opportunity to test the strengths of our system and understand better how we might nurture these.

We hope the enablers identified in this report will provide a starting point for this. In many ways all ten sound uncontroversially desirable: strong political commitment, stable and connected management, strategic partnerships, close frontline collaboration, systems for sharing data, cultures of communication, deep community reach, good technology investment, creativity and problem solving and networks for learning. None of these are new. All build on and add to a significant and established body of thinking about the features of good local systems, effective support for children and good leadership.

The clarity of perspective the coronavirus crisis has provided should reinvigorate local and national leaders to continue to strive to build systems with such traits firmly embedded. The message is to double-down and sharpen the focus on these areas.

If there is one additional message that cuts across the findings it is the **value of human connection** across a system. The loss of connection brought by lockdown posed not only a significant challenge to babies and their families, but also to the services and systems that support them. And those that were best able to rise to the challenge presented did so by maintaining those connections using whatever means they could. **Those with a history of strong connection across agencies, between areas, across staff working at different levels and with communities seemed best placed of all.**

Drawing on the learning that has emerged from the enablers and more broadly the system leaders and professionals throughout this report, we end by posing the following high-level questions to support and focus future thinking...

1. How can we create the conditions for strategic leaders to forge stronger connections across agencies? Where do fault-lines remain across agencies, frameworks and accountability systems and what can be done to reduce this?

2. What can be done to support operational leaders to maintain connectedness with frontline staff and ensure they always include their knowledge in managing and adapting services?

3. How can frontline staff be supported to work closely with each other across services and with communities? In particular, how can the uniquely strong local systems of support set around well-funded children's centres and family hubs be replicated more widely? Where has the fragmentation of services left geographical gaps and what can be done to address these?

4. How can babies' current and long-term needs be better built into the thinking about risk and risk assessment?

5. How can local leaders be encouraged and supported to learn from and capitalise on new innovations, whilst being 'evidence based'? And specifically, how can they be helped to manage the shift toward delivering services through virtual technology in a way that optimises services and manages risks?

6. What, if any, further infrastructure is needed to maximise opportunities for peer learning between local leaders across regions and localities?

7. In the event of a future pandemic or crisis, how will the government communicate with local decision makers? What systems and principles can be adhered to that will make that interaction optimal?

Annex 1: Details of the survey

Survey respondents

The survey was promoted online by the First 1001 Days Movement to senior leaders of key pregnancy-to-age two services over the last three weeks of September 2020. They were asked to answer on behalf of their organisation, rather than as individuals. In that time 235 people participated, 65% (153) of whom completed it to the end. Of the 235:

- 33% (78) worked for health visiting services
- 33% (78) worked in perinatal and child mental health support services
- 28% (66) worked in parenting or child behaviour support services
- 21% (52) worked for organisations providing breastfeeding support
- 19% (45) worked for organisations providing home visiting services
- 7% (16) worked for maternity services

Amongst "other" organisations represented were leaders of children's centres or similar multi-agency community support (at least 10), professionals from neonatal services (6), Family Nurse Partnerships (5), local authority early help services (5), and in smaller numbers leaders of parent and peer support groups, baby banks, national charities, education psychologists, speech and language therapists and specialist support services for children with particular health conditions and disabilities.

A significant minority of respondents described their organisation as providing 2-3 services, meaning there was some overlap in respondent categories. For example, amongst health visiting services 17 respondents also described themselves as providers of perinatal and child mental health support and 22 said they also provided breastfeeding support (suggesting 61 of those providing perinatal mental health support were not health visitors and 29 of those providing breastfeeding support were not health visitors).

Nearly half of all respondents (48%) worked for local authority commissioned services. 28% said they were commissioned by the NHS and 23% were funded via charitable grants and donations. 57% considered their organisations to be 'public sector', 30% 'charity sector' and 12% 'private sector' or 'other' with a number of these specifying that they were either social enterprises or cross-sector partnerships.

75% worked for organisations principally operating in England. The other 25% worked for organisations with some reach across the other UK nations – this included 38 operating UK wide (half of whom classified their organisation as a charity), and 9, 8 and 3 in organisations operating in Scotland, Wales and Northern Ireland respectively.

Survey questions

About your organisation

1. Which of the following best describes the service your organisation provides? (multiple choice, tick up to three that apply)
2. Who commissions your service? (multiple choice)
3. What sector are you? (multiple choice)
4. Which nation do you operate in principally? (multiple choice)

How has lockdown impacted 0-2s?

5. To what extent were the babies you work with negatively impacted by any of the following during lockdown – please answer to the best of your knowledge based on direct observations within your service? (list of options with multiple choice)
6. How much did demand for your services supporting pregnancy and babies increase during lockdown, i.e. March-June (irrespective of whether you were able to fulfil that demand)? (sliding scale)
7. How much did demand for your services supporting pregnancy and babies increase as lockdown eased, i.e. June-September (irrespective of whether you were able to fulfil that demand)? (sliding scale)
8. Where you have seen a significant rise in demand as lockdown eased, what do you think is the main reason behind this? (multiple choice, tick all that apply)
9. If you observed any positive impacts of lockdown on babies, please tell us here. (free text)

Impact on services during lockdown

10. Tell us about how your service continued to support the parents/babies who you usually work with in person during the height of lockdown (March to June). (list of options with multiple choice)
11. Where your organisation adapted or re-designed it's service, which of the following steps were involved? (multiple choice, tick all that apply)
12. Where you adapted your service, did it deliver broadly the same benefits as your usual service in your view? (multiple choice)
13. Please briefly list any new risks/issues from the adapted service that concerned you (free text)
14. Please briefly list any new benefits from the adapted service that you noticed (free text)
15. If your organisation provided any new services and/or engaged with clients you would not have normally seen during the lockdown please tell us about these. (free text)

Long-term effects on services

16. How quickly has your service offer returned to normal? (multiple choice)
17. Please tell us about any successful adaptations/innovations/collaborations introduced during lockdown which your organisation are planning to maintain longer-term? (free text)
18. What impact has lockdown had on your finances and capacity to deliver in the future? (multiple choice)

Decision-making during lockdown and as restrictions eased

19. Where your organisation adapted all or part of its service to maintain contact with families during lockdown, which factor/s significantly influenced your decision to make this change? (multiple choice, tick all that apply)
20. Do you believe that managers in your organisation took necessary action to ensure that families with babies under 2 received the support they needed during lockdown? (multiple choice)
21. Do you believe that local commissioners and public service managers (in the local authority or CCG) took necessary action to ensure that families with babies under 2 received the support they needed during lockdown? (multiple choice)
22. Do you believe the Government in your nation took action to ensure that families with babies under 2 received the support they needed during lockdown? (multiple choice)
23. Did any key national decisions/bits of guidance/government oversights unnecessarily undermine the ability of your service to support 0-2s during lockdown and as lockdown eased? Please specify. (free text)
24. Where a decision has been taken to maintain a lockdown change to your service in the long-term, what influenced this decision? (multiple choice, tick all that apply
25. Please share any further comments or reflections about decision-making during and after lockdown in the box below. (free text)

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