Access to community services and support through family and friends during the pandemic: *Families in Tower Hamlets* survey and panel findings

In spring 2020, access to child health services underwent a dramatic change in response to the Covid-19 emergency. Between April and July 2020, around one-quarter of paediatric staff were not available due to shielding, illness or remote working (RCPCH 2020). Others were redeployed to adult services and approaching half of community child health staff were redeployed within paediatrics, giving rise to concerns about risks to children's wellbeing in the community, to the health impacts of waiting longer for health procedures, and, in addition, concerns about additional stress on staff (ibid.). There were parallel substantial changes in the accessibility of maternity services: around 70% of maternity units reduced antenatal appointments and over half reduced postnatal appointments, replacing them with remote consultations. Many units also removed the option for home births (Jardine et al., 2021). Pregnant women and families with young children also utilise support from their wider family and the voluntary sector; these sources also underwent significant change in 2020. The voluntary sector pivoted to emergency responses in the light of falling incomes for families and increased demands, while at the same time the volunteering workforce was in flux and digital modes of delivery become common for the first time (King et al 2022). Simultaneously support for new families from wider kin was subject to social distancing and lockdown rules.

This was the context for families using child and maternal health services in Tower Hamlets in 2020; there were far-reaching restrictions on health services between March-September, with the potential to affect the care, support and connectedness parents and pregnant woman need On March 19th 2020 NHS England issued national guidance setting out how providers of community services can release capacity to support the COVID-19 preparedness and response (NHS England and NHS Improvement 2020). The Health Visiting service was categorised as a 'partial stop' service resulting in a stop to some of the mandated HV contacts, such as newborn blood spot test. In Tower Hamlets, antenatal contact and health visiting continued during lockdown. All health visitor mandated contacts –28 weeks in pregnancy, 10-14days after birth, 6-8 weeks, 9-12 months, 2-2.5 years - continued to be available as digital consultations using telephone and increasingly video (Gilmour,p.c). Initially, minimal or no face-to-face contacts were available. Some of the 6-8 week GP reviews [these were separate from the 6-8 weeks health visitor review] were stopped by GPs locally for a period and offered together with the first immunisations scheduled at 8 weeks. Early indications were that contact and child immunisations were maintained with around 90 % of mothers and pregnant women, with particular focus on those women considered vulnerable (Gilmour, p.c). For those women in 'compelling need', face to face appointments were offered in children's centres, under infection control regimes (ibid.).

Study data sources

This paper is one a series of five thematically organised short reports presenting results from the UKRI-ESRC funded Families in Tower Hamlets study (2020-2022). In this paper, we focus on access to services and

community support for families with young children, and pregnant women, living in Tower Hamlets during the Covid-19 pandemic. The study data drawn upon consists of a longitudinal community survey in two waves and a qualitative panel in two waves, alongside a community assets mapping exercise in the borough undertaken in summer 2020. The Wave 1 survey (July – November 2020) had 992 respondents of whom 620 took part in the Wave 2 survey (February – April 2021). In this Brief, all the data presented is cross-sectional. Because child age data is more specific in Wave 2, we draw on Wave 2 data to report service access. Participants were recruited via general local authority communications channels and specifically targeting low-income families through postcards sent to housing benefit recipients. The sample broadly matched the borough in terms of the major ethnic groups, with just over a third White British/Irish, and a similar proportion from a Bangladeshi background (Table 1). For ease of reference, and to manage low responses rates on some items, we have used three main ethnic groups: White British/Irish, South Asian (including Bangladeshi, Pakistani and Indian), and All in this brief.

Wave 1	**Male**		**Female**		**Prefer not to say**		**Total**	
	N	%	N	%	N	%	N	%
White British/Irish	109	11.2	231	23.7	0	0.0	340	34.8
Other White	12	1.2	73	7.5	0	0.0	85	8.7
Asian: Bangladeshi	77	7.9	259	26.5	12	1.2	348	35.7
Asian Other	16	1.6	80	8.2	4	0.4	100	10.2
Somali	1	0.1	25	2.6	2	0.2	28	2.9
Black: Black Other	7	0.7	28	2.9	1	0.1	36	3.7
Other ethnic group	2	0.2	36	3.7	1	0.1	39	4.0
Total	224	23.0	732	75.0	20	2.0	976	100

Table 1: Gender and ethnicity of survey respondents, Wave 1

By Wave 2, the 620 participants were more likely to be White British/Irish and there were fewer respondents from South Asian backgrounds. They were also more likely to be of higher income. To generate a longitudinal sample, participants in Wave 2 were 'matched' to their Wave 1 record. Survey items were about child and family health, parental quality of life, including financial security, housing, couple relationships, health and education, and community engagement. Survey questions on access to health services and community support were asked in both Wave 1 and Wave 2. Respondents were asked about access to antenatal health services [if pregnant] and routine health appointments for babies and young children (e.g. immunisations, health and development reviews) since the coronavirus lockdown began in March 2020. At Wave 1 there were 112 participants who were pregnant or whose partner was pregnant and these make up the sample included in the data on access to midwifery services.

The second data source is a qualitative household panel (QP) which consisted of interviews with 33 mothers and fathers in 22 households selected to represent a range of household structures, ethnicities and household income. Wave 1 QP interviews took place in January - March 2021; Wave 2 follow up interviews were conducted October-December 2021 with 27 mothers and fathers in 19 households.

The third data source is from mapping the assets or services (broadly defined) for Tower Hamlets' families with young children using Internet tools (websites, Facebook pages) and with help from key individuals during the summer 2020. The aim was to establish a list of all relevant services and support aimed at families and children in LBTH, including both statutory provision as well as support from the voluntary sector, and to closely map changes to support services available to families, including the emergence of new forms of support (e.g. mutual aid).

Survey families

At Wave 2, 36 percent of survey families had a youngest child aged 0-24 months and 64 percent had a child aged 2 and 5 years. There were few differences by the major ethnic groups: 34% of White British/Irish parents and 39% of South Asian parents had a child aged 0-24 months; 66% of White British/Irish parents and 61% of South Asian parents had a child aged 2-5 years (figure 1).

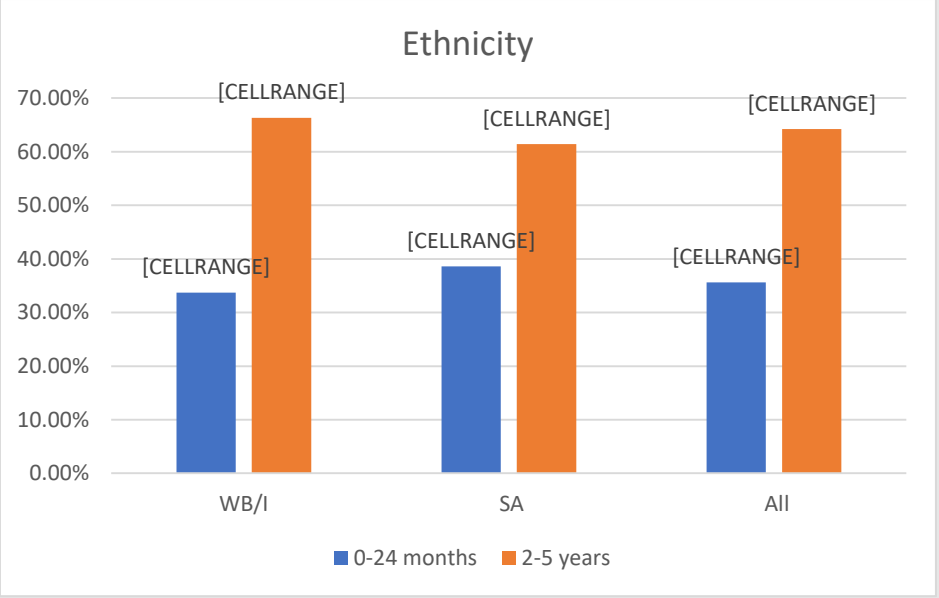

Figure 1 Age of youngest child by ethnicity wave 2 (n = 619)

Main findings

Access to Health Services

Routine pregnancy checks

At Wave 1, among pregnant survey respondents, most reported access to routine pregnancy checks [82%], access to scans [83%] and other checks such as chromosomal and neural tube defect screening [82%] since the start of the lockdown in March 2020. Slightly fewer [70%], reported access to whooping cough vaccine, this is higher than uptake generally (Bedford, p.c; Public Health England, 2021). There was a slight social and ethnic gradient, with more high income and White British/Irish (WB/I) households than low income and South Asian (SA) households reporting access to routine pregnancy checks (Figure 2).

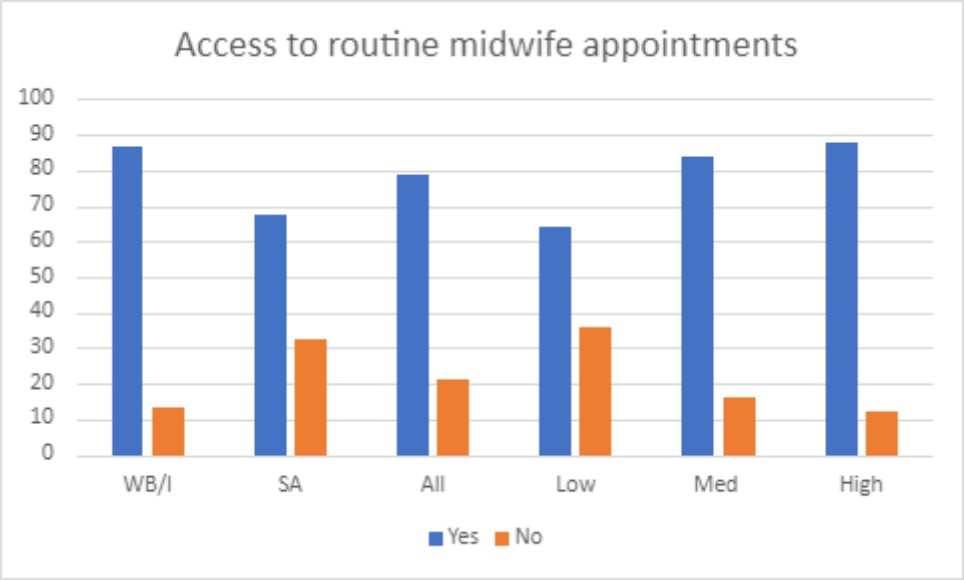

Figure 2 Access to routine midwife appointment in 2020 (n = 78)

Access to non-routine support

At Wave 1, 15% of pregnant participants said they needed to access a midwife for non-routine help and of these, 85% reported they were able to access help from a midwife. South Asian households were more likely to report no access to non-routine help from a midwife (18%) than White British/Irish households (3%). Middle income families were also less likely to access non-routine help from a midwife (16%) than low (9%) and higher-income families (0%). Overall, 97% of pregnant households that accessed non-routine help from a midwife reported receiving the support they needed.

In the qualitative panel there were four families that had accessed maternity services during the first lockdown and all reported some disruption to their routine antenatal care. Although these women reported having 'regular' check-ups and scans, the frequency had changed and was often reduced resulting in some women not having all planned routine antenatal checks. Half of the women reported a change in the mode of delivery of their routine checks post March 2020 from face-to face to on-line check-ups, and the other half reported no change and saw a midwife in person. All women reported having at least one face-to-face check-up appointment, usually just prior to their expected due date.

Newborn Checks

At Wave 2 (early 2021), during the third lockdown, survey families with newborn babies reported limited access to newborn baby checks. Twelve percent of survey parents reported no access to hearing screening; 23 % said their newborn did not have a blood spot test done by a midwife and 40% reported no access to newborn baby checks usually done at 10 days old. No access to the newborn hearing screening could be explained by the categorisation as a stop service, with screenings only taking place in maternity units. However, whilst newborn baby checks were instructed to continue, there is growing evidence of no access to newborn baby checks during the pandemic (Best Beginnings, Home-Start UK, and the Parent-Infant Foundation, 2020; IHV, 2020b). Access to a blood spot test is done face-to face and is usually carried out when babies are 5 days olds. However with the reduced face-to face contact during the pandemic this may have impacted on newborns having the test done. Although given the stringent fail safe system in screening programmes we cannot rule out the possibility that some respondents were not aware it was being done [possibly in maternity units] or that they misunderstood the question Taking the 6-8 week check as an

example (Figure 3), 30 per cent of parents with children of the right age reported no access. This was more likely among low-income parents compared to mid- and high-income households but similar across the ethnic groups; lower access ranged from 19% to 40% across the different newborn baby checks.

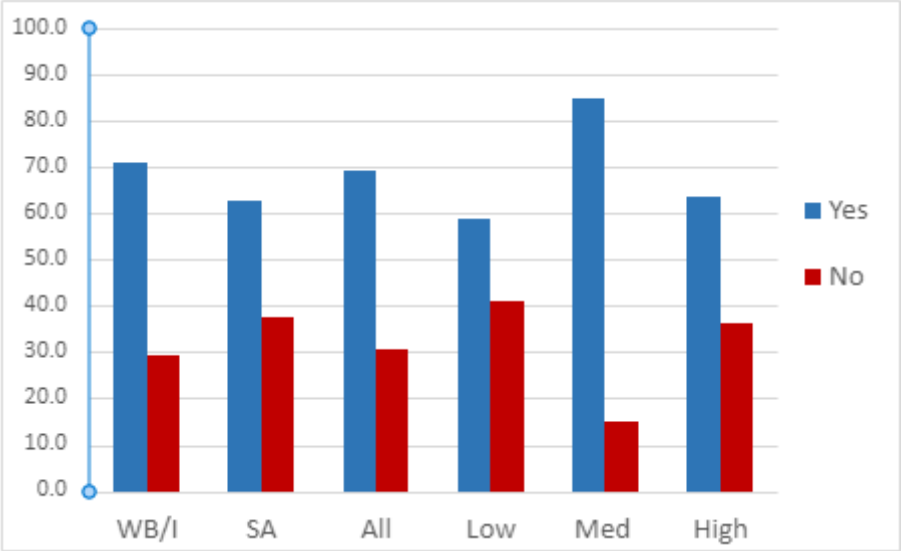

Figure 3: Access to six-eight week check wave 2 (n=59)

In the QP, the majority of mothers with a baby born since March 2020 or aged under 12 months at the time of the interview were happy with the level of access to Health Visiting Services after their child's birth. Mothers reported access to routine appointments with health visitors, either in person, by telephone or via video. They reported having stitches checked and removed; help with breastfeeding, and babies were weighed regularly in person at the GP or health centre.

So when [Child A, the youngest of two children] was initially first born we had a lot of midwife support because he was losing a lot of weight. I was determined to breastfeed because the first time round it didn't work with my daughter. … And actually considering I was in lockdown, the midwife support I had was really good. I was able to go … I had to go to them, which was fine. I was able to get him weighed regularly, and so that was really good. I never really saw the health visitor, a lot of them appointments was over the phone. But … it was regular and I still felt quite supported by them, like if I needed her I would text her and she would ring. [Middle income Mother]

In terms of the medical, I was able to see the midwife one week and then two weeks afterwards. I had stitches and I was able to get them checked. I was able to get the baby weighed and given a check over. The health visitor video called me twice. Personally, I think it was… For being in a lockdown, it was really good. [High income Mother]

Immunisations and Child health checks

At Wave 2 (early 2021), 16% of survey parents with a child of the relevant age reported no access to immunisations at 8, 12 and 16 weeks. Caution is needed as numbers are low but there was a social gradient to this, with more low-income families (35%) reporting no access (figure 4).

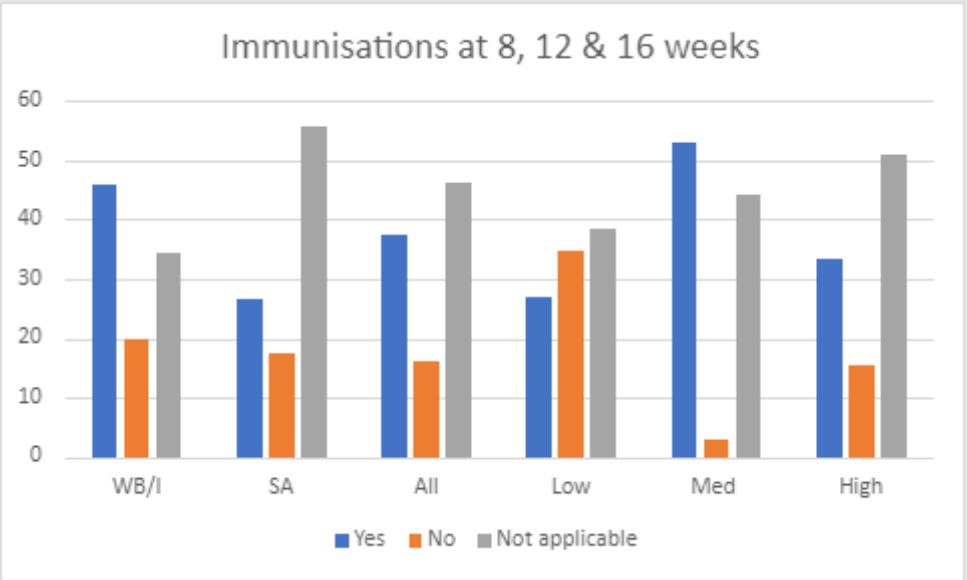

Figure 4 Immunisations at 8,12, and 16 weeks (n= 112)

Overall, almost three-quarters (73%) of survey families in Wave 2 with a child eligible for a child health review at age 2-2.5 years, reported that they had no access to this since the start of the third lockdown in January 2021. High levels of no access to child health reviews reflect data collected from HV which reports that only 17% of 1-year reviews and 10% of 2-year reviews were completed by a qualified HV (IHV, 2020b). As figure 5 (below) shows, having no access was more common among South Asian families [82%] and those from low-income [77%] and high-income households [78%].

In the QP Wave 1 (early 2021), parents with older babies (aged 12 months or more) reported no access to routine health visiting reviews, a finding supported by other research (Best Beginnings et al., 2020). Parents reported appointments being cancelled and not rearranged, leading to delays in routine reviews and difficulty getting their child weighed. Whilst some families reported access to missed or delayed routine health visitor reviews during periods when lockdown restrictions were lifted or relaxed, by Wave 2 interviews four families reported that routine appointments with health visitors were still outstanding as these two mothers document:

I rang up and they [GP] said that they were going to do a review over the phone, like a Zoom. Cos I said like … my [name of child B], she's 2, she's meant to have her check, and [name of child A] going to be 1, so she's got to have a check. They said that we'll do a Zoom, and they managed to do [name of child C], but didn't do [name of child B or name of child A]. [Low-income Mother]

I guess that's been a bit of a point of contention for us. We did get allocated, what are they called, a health visitor. She was supposed to come over and do a house visit and things like that, she cancelled last minute. Because we had a bit of a scare with him at the beginning about his weight, he was losing weight, we'd asked, "Could we be given access to one of the children's centre weigh-ins?" You know, we could get booked

in for weekly weigh-ins or anything like that. She had said she'd arrange it for us but she never did. Yes. We literally, I think, haven't had any contact from her in the last six months… not even for the 12-month checks. [High Income Mother]

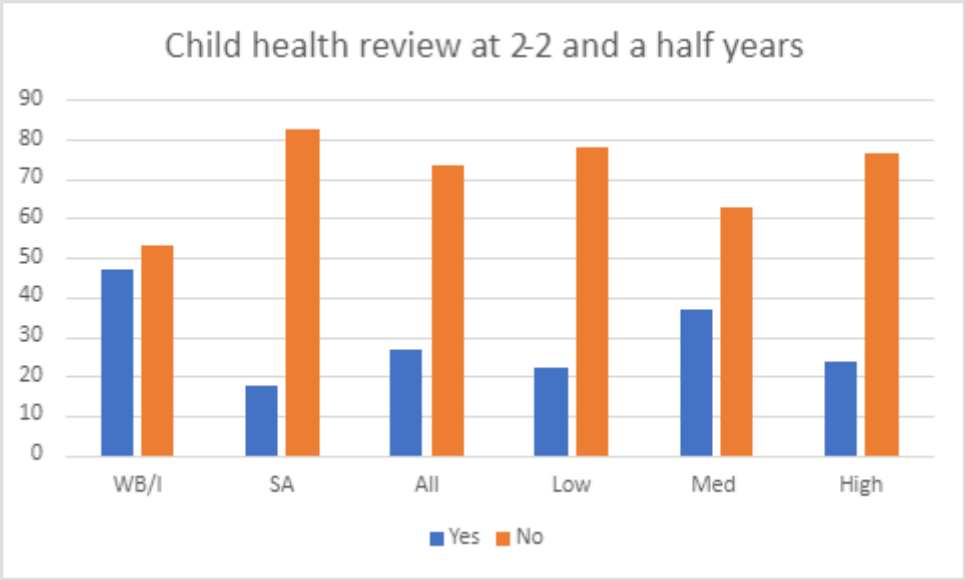

Figure 5 Access to child health review at 2- 2.5 years (n = 86)

Community Support and Social Networks

Receiving Support

At Wave 1, Survey families reported low levels of support received in the form of school food vouchers (27%), free food from local religious or voluntary organisations (16%) or other types of community support (20%). Sample numbers are small, but receipt of school food vouchers and free food from local organisations was lowest amongst low-income families (50%), but similar amongst White British (25% school food vouchers, 15% free food); and South Asian households (15%, 18% respectively). White British/Irish families reported higher access to support received from other types of community support (27%) compared to South Asian families (11%).

Survey respondents were asked at Wave 1 if they were receiving more or less support during the pandemic than before. Just under half (44%) reported no change in the level of support received, 33% reported receiving less support than pre-pandemic and 23% reported receiving more support. White British/Irish families and mid-income families were more likely to report receiving less support during the first lockdown compared to pre-pandemic levels of support, 42% and 41% respectively (we did not ask this question again at Wave 2).

Help and support received	White British/Irish	South Asian	All Groups	Low income	Mid income	High income
More support now than before pandemic	20%	27%	23%	28%	19%	21%
Less support now than before pandemic	42%	23%	33%	35%	41%	24%
No change in support	38%	50%	44%	37%	40%	55%

Table 2. Change in support received now (March 2020-Nov 2020) compared to pre pandemic Wave 1 (n=650)

Support from Family, Neighbours and Friends

At Wave 1, half of survey families (52%) reported receiving support from family, neighbours or friends not part of their household but by Wave 2 (early 2021) lower levels of support were reported, with 65% of families reporting receiving no support from non-household family, friends or neighbours. There was little difference between major ethnic groups in support received reported at Waves 1 & 2. At Wave 1 around 50% of White British/Irish and South Asian families reported access to support; this fell to 35% and 40% respectively at Wave 2. Mid-income families reported higher levels of no support (72%) than low- (57%) and high-income families [65%].

Parents or grandparents were the most common sources of support reported at Wave 1 (55%) followed by friends (43%), spouse or partner (41%) and siblings (39%). At Wave 2 households reported an increase in support from all non-household sources (Table 3).

Families received support from	Wave 1 %	Wave 2 %
Parents or grandparents inc in-laws	55	67
Siblings	39	54
Spouse or partner	41	62
Friends	43	61
Neighbours	34	46
Adult children inc. in laws	14	39
Former spouse or partner	7	14
Someone else	9	12

Table 3: Sources of support in 2020 (Wave 1) and 2021 (Wave 2)

At Wave 1 65% of respondents reported receiving the most help with shopping since the first lockdown began in March 2020, followed by help with food or cooked meals (46%) and looking after children (39%). At Wave 2 survey families received the most help with looking after children (69%); followed by help with food

or cooked meals (64%) and shopping (56%). Counterintuitively, despite survey families reporting lower levels of support received from family, neighbours or friends at Wave 2 than that reported at Wave 1, they reported increases in sources of support and support with day-day tasks at wave 2 (Table 3). Participants may have underestimated the level of support in their responses to the question about overall support.

Help or support received by families	**Wave 1 %**	**Wave 2 %**
Giving you lifts in your car	20	47
Shopping for you (including going to the shop or ordering an online delivery	65	56
Providing or cooking meals	46	64
Helping with basic personal needs like dressing, eating or bathing	13	29
Washing, ironing or cleaning	17	22
Dealing with personal affairs e.g. paying bills, writing letters	14	31
Assisting with online or internet access	10	22
Decorating, gardening or house repairs	10	26
Looking after children	39	69
Something else	17	17

Table 4: Support received in 2020 (Wave 1 n=787-992) and 2021 (Wave 2 n=178-199)

Giving Support

Half [55%] of survey respondents reported that they had provided help or support to family, friends or neighbours since the start of the lockdown in March 2020, with all ethnic and income groups providing similar levels of support. Most commonly, respondents provided help with looking after children (66%), shopping (65%) and providing or cooking meals (58%) for family, friends or neighbours.

Help or support provided to family, friends or neighbours	**Wave 1 %**	**Wave 2 %**
Giving them lifts in your car	10	45
Shopping for them (including going to the shop or ordering an online delivery	35	65
Providing or cooking meals	20	58
Helping with basic personal needs like dressing, eating or bathing	7	29
Washing, ironing or cleaning	7	22
Dealing with personal affairs e.g. paying bills, writing letters	10	31
Assisting with online or internet access	15	22
Decorating, gardening or house	6	26

repairs		
Looking after children	10	66
Something else	17	17

Table 1: Support provided in 2020 (Wave 1 n=992) and 2021 (Wave 2 n=178-199)

QP interviews showed there were many reports of acts of kindness amongst neighbours ranging from receiving small gifts, sharing of food, helping neighbours with small practical tasks, and giving advice. A few mothers living in private developments with communal areas talked about how they were able to form support networks with other parents and children living in the same development during lockdown, and how this was a lifeline for them and their children.

More broadly, some panel families felt that the general sense of community in their neighbourhoods had receded during the pandemic. They described their community as feeling more distant, and people keeping themselves to themselves.

Most panel families talked about the massive impact that the pandemic and restrictions had had on their social networks and relationships outside the household. Fathers and mothers reported being and/or feeling less supported by family and friends because of not being able to see them and spend time together. The social restrictions in place and having a vulnerable or shielding household member, meant that panel families lost the practical support they would usually rely on before the pandemic started, such as help with childcare, being provided with food/meals.

> *When I used to go to [the office to] work and my partner used to go to work my mother-in-law would look after my daughters when they were younger. She would be with the buggy going to different places – children's centres, libraries, parks…my younger son, he is not getting that same exposure … because you can't take the risk. I have an elderly mother who lives with us and we can't take that risk. Now it's a bit different because thank God she's had both of her vaccinations, but it still doesn't mean it's 100% safe. [Middle income father]*

> *My [neighbour] opposite and my next door [neighbour], they're quite good, when we saw each other it's like hi, hello ... we are not so close but we help each other, like suppose a delivery come, we exchange the food - something like that you know. But during the pandemic I rarely see their face. [Low income father]*

Mothers with new babies reported how hard they found it having to look after a newborn baby without the anticipated support from their own mothers or mothers -in laws' extended family, as had been the case with previous children. For some, this lack of support left mothers without any reassurance and help with caring for their newborn baby and in some cases led to a deterioration in mental health and feelings of loneliness and isolation.

> *So yeah it would have been nice to have family closer just for the support, also for … you know just to help out with the childcare occasionally, it just would have been more reassuring to have family close by [High income mother]*

> *Sometimes this situation you feel a bit lonely you know dealing with children and then having to be inside, indoors and alone basically indoors. I don't have much of family close…..we've got friends*

> *that I can call family as well you know – no way to share time with them or even to get a little bit of support. [Middle income mother]*

Community Assets Mapping

Community assets of help to families during the pandemic changed their mode of operation during 2020. Of the 54 different types of support noted in the database of community assets, 33 moved online, offering remote services, and 16 offered new services after 23 March 2020. Examples of new services include the following:

Tower Hamlets Talking Therapies moved all their appointments to be delivered by telephone or video call, and they also began offering Covid-specific webinars to help offer important life skills to manage problems better and overcome difficulties in the future.

The Bromley-by-Bow Centre introduced remote services via telephone and email advice. A new online platform was set up in early April, introducing family playrooms, an online activity group for families with children up to 11 years old. BBBC also started a 'Parents Corner' including a Facebook group and social prescribing highlighted by a community research team.

First Love Foundation continued with their feedback activities, offering delivery and online requests rather than face-to-face. They offered deliveries to vulnerable individuals who are self-isolating or experiencing income shock. Their requirements for this included filling out an advance referral form.

The Women's Inclusive Team who provide social welfare support in LBTH suspended their drop in services, but set up food banks in two locations in Poplar, and moved to Bethnal Green in July. They also set up a telephone befriending service to support disadvantaged female Tower Hamlets residents to become independent and socially included.

Several problems were noted in carrying out this mapping exercise which may have had implications for families using the services.

Not up-to-date websites - whilst many organisations may have a website detailing their services, these websites were frequently not updated with COVID-19 specific information, or how the changes in circumstance had affected the service provision. Much of the offer of support was provided via the social media platform Facebook, with easy-to-set-up Facebook pages, and in some instances, specific groups. For example, the NHS Baby Feeding support group in Tower Hamlets, has a Facebook page which is regularly updated with different types of supportive content, with a particular focus on baby feeding and breastfeeding.

Dynamic information – much of the information on support is dynamic, and frequently changing, meaning also that it regularly becomes old and out of date. Similarly, it was reported that some information in relation to support and access to services was circulated via word-of-mouth, or via WhatsApp messages and groups, as organisations sought to respond to the government announcements about lockdown as quickly as they could. This was particularly true for faith groups, whose websites were not updated, and who reported developing networks of support by word of mouth, or potentially over the phone.

Lack of access to physical spaces – prior to 23rd March 2020, another way to access support and find out about different offers was via appointment attendance and seeing information boards in GP/hospital

waiting rooms. However, in the move to online provision of support services, physical noticeboards became redundant, and information relayed this way became rapidly out of date.

Digital access – the importance of digital access increased in significance. In addition to developing confidence using a computer and the Internet, the skills required include literacy, especially understanding very specific digital vocabulary or how to access specific services such as internet banking or using comparison sites, which require a greater level of skill.

Solutions to the issue of information about community support available to families require investment. In a very diverse and cosmopolitan borough such as Tower Hamlets, keeping information up to date is a perennial difficulty. In order to maintain the dataset as a useful resource with the most up-to-date and valuable information, it needs to be maintained by local organisations and individuals working in this area. However, maintaining the dataset via an unfunded community group will not work. This also points to the crucial nature of the role of multi-functional organisations such as the Bromley-by-Bow Centre, and other children's centres that could have a more pivotal role in sharing and disseminating information. Digital tools have played a vital role during the pandemic and continued to do so during recovery: home-working, home-schooling, e-healthcare, online services (e.g., shopping) and peer-support groups (e.g., e-leisure/sports). Digital tools replaced physical places for play and social interaction in lockdown, when access to outdoor areas was limited, and many community centres and services remained closed for physical visits, and school children were intermittently needing to study remotely. The location of the home, and the quality of its indoor spaces was crucial; as was access to online resources for essential advice and support, communication and connection, and to continue day to day life.

Conclusion

The study found that there were relatively high levels of access to pregnancy services, although caution is needed because the sample size is small. But there were some concerning findings in relation to a social gradient to accessing universal health services. Families on low- and mid- incomes were more likely to report lower levels of access to routine pregnancy services and newborn checks, compared to families on higher incomes. This could partly be explained by changes to NHS services introduced at the onset on the pandemic, which included a reduction in face-to-face antenatal and postnatal contact with women (Royal College of Obstetricians and Gynaecologists 2020), a reduction in the number of pregnant outpatient clinics, giving priority to pregnant women at risk, cancellation/delay of appointments (Karavadra et al. 2020). There is no evidence to suggest that the pregnant women in the sample were high risk and the data suggests that most women received the support they needed. For families with children aged between 2- 2.5 years, there are high levels of no access to child review appointments, with South Asian families reporting less access than White British/Irish households.

Households reported low levels of support from community organisations and the majority of households did not report an increase in support over time. This finding stands in contrast to UK data on public behaviour which indicates a substantial rise in informal and voluntary action at the neighbourhood level (Felici, 2020; Tanner & Blagden, 2020). White British/Irish families and mid-income families were more likely to report receiving less support during the first lockdown. The study did find that levels of support from non-household sources increased as the pandemic continued and subsequent lockdowns were imposed. Families were receiving more support at Wave 2 than at Wave 1 from family, friends and neighbours. Households reported higher levels in both sources of support and support with specific day to day responsibilities and tasks.

Families across ethnic groups reported similar levels of support received from local networks at both Waves 1 and 2, with mid-income families reporting less or no support more frequently than families in other income bands; this may have to do with these families not having a local network of support living nearby as indicated by the qualitative data. Overall, the picture on community support is mixed: decreased overall support but increased specific local support as the pandemic progressed. Families generally felt they were less supported and connected to their social networks resulting in feelings of loneliness and isolation, and, meanwhile, community organisations were facing difficult issues around delivery. Other studies have suggested that local networks of support in response to the Covid-19 lockdown have predominated in areas of higher socio-economic status (e.g., Felici, 2020) and that respondents in areas of higher socio-economic deprivation were less likely to agree that they and their neighbours were supporting each other well (Jones 2020). Findings suggest that localised networks of support can constitute a notable form of informal social action during a pandemic.

References

Best Beginnings, Home-Start UK, and the Parent-Infant Foundation (2020) Babies in Lockdown: listening to parents to build back better. Available from https://babiesinlockdown.files.wordpress.com/2020/08/babies-in-lockdown-main-report-final-version.pdf

Felici, M. (2020) Social capital and the response to Covid-19. Bennett Institute for Public Policy Cambridge. https://www.bennettinstitute.cam.ac.uk/blog/social-capital-and-response-covid-19/ [Accessed 27th May 2022]

Institute of Health Visiting (2020). State of health visiting in England. https://ihv.org.uk/wp-content/uploads/2020/12/State-of-Health-Visiting-survey-2020-FINAL-VERSION-18.12.20.pdf

Jardine J, Relph S, Magee LA, von Dadelszen P, Morris E, Ross-Davie M, Draycott T, Khalil A. (2021) Maternity services in the UK during the coronavirus disease 2019 pandemic: a national survey of modifications to standard care. British Journal of Obstetrics and Gynaecology. 128(5):880-889. doi: 10.1111/1471-0528.16547.

Jones M, Beardmore A, Biddle M, Gibson A, Ismail SU, McClean S, White J. (2020) Apart but not Alone? A cross-sectional study of neighbour support in a major UK urban area during the COVID-19 lockdown. Emerald Open Research, 2, 37. doi: 10.35241/emeraldopenres.13731.1.

Karavadra, B., Stockl, A., Prosser-Snelling, E., Simpson, P. and Morris, E. (2020). Women's perceptions of COVID-19 and their healthcare experiences: a qualitative thematic analysis of a national survey of pregnant women in the United Kingdom. *BMC Pregnancy and Childbirth*, *20*(1), pp.1-8.

King, D, Chan, O, Coule, T, Dahill, D, Mainard-Sardon, J, Martin, A, Rossiter, W, Smith, S, Stuart, J, Vahidi, G and Ibokessien, N (2022) Respond, Recover, Reset: Two Years On, Nottingham Trent University, Centre for People, Work and Organisational Practice. Available at : https://www.ntu.ac.uk/__data/assets/pdf_file/0029/1673741/Respond-Recover-Reset-Two-Years-On-2022.pdf

Morton A, Adams C. (2022) Health visiting in England: The impact of the COVID-19 pandemic. Public Health Nursing. 39(4):820-830. doi: 10.1111/phn.13053. Epub 2022 Jan 31. PMID: 35099079.

NHS England and NHS Improvement (2020). COVID-19 prioritisation within Community Health Services. https://ihv.org.uk/wp-content/uploads/2021/08/COVID-19-prioritisation-within-community-health-services-19-March-2020-version-1.1.pdf

Public Health England, 2021. Pertussis vaccination programme for pregnant women update: Vaccine coverage in England, April to June 2021

RCPCH (Royal College of Paediatrics and Child Health (2020) Impact of COVID-19 on child health services between April and July 2020 – report. Available at: https://www.rcpch.ac.uk/resources/impact-covid-19-child-health-services-report-2020

Tanner W, Blagden J: Covid-19 and community. Onward Research Note, March 2020. 2020. https://www.ukonward.com/wp-content/uploads/2020/03/Report-Coronavirus-and-community-1.pdf

Appendix One

Research Design and Methodology

The study consisted of two waves of a **community survey** of parents of children under five or expecting a baby and two waves of a **qualitative household panel**. **Survey Wave 1** with 992 valid responses took place July-November 2020 and **Survey Wave 2** took place February – May 2021. Wave 2 respondents were matched to Wave 1 and there were 620 valid responses making a longitudinal sample with a response rate of 62.5 percent. See Tables 1 and 2 (below) for sample characteristics. Non responders to Wave 2 were more likely to be low income and non-White British/Irish. The community Survey used Qualitrics, an online and phone based multi-language survey tool, and was promoted through borough communications channels with support from specialist voluntary organisations to recruit members of under-represented groups. Data items were drawn from parallel studies (e.g., Born in Bradford, Dickerson et al., 2020; International Network of Leave Policies and Research, Yerkes et al., 2020; Understanding Society). After data cleaning, 'prefer not to say' and 'don't know' responses were excluded from analyses. In instances of multiple answers 'yes most of the time', 'yes all the time' data were collapsed. Using SPSS, descriptive tables, were used to inform this briefing for 1) the wave 1 sample and 2) the longitudinal samples (see tables below). Ethnicity is described in terms of 'White British/Irish', 'South Asian' (including Bangladeshi, India, Pakistani), and 'All' (total sample including all ethnic groups). We use 'N' to denote the number of responses to any one item; there is missing data in relation to some variables, particularly in relation to service use and access.

The **Qualitative Household Panel (QP)** members were drawn from the survey and selected to represent ethnic diversity, household structure and income diversity. Wave 1 Panel interviews with 1-3 adult household members in 22 households took place February-April 2021 and Wave 2 interviews October-November 2021. Panel interviews were fully transcribed and coded using Nvivo by team members with cross-referencing to moderate interpretation. The steps of thematic analysis were used to establish analytic themes. Miro boards were used to display coded data and create relationships between dimensions of the themes. In this report, 'few' refers to three or under cases, 'some' refers to four-seven cases, half refers to 11 cases and 'most' refers to more than half the cases.

In this briefing paper we refer to **survey** findings and Qualitative **Panel** (QP) findings to refer to the community survey and the qualitative household panel respectively.

HH Income	Parental status	WB/I		SA		All	
		N	%	N	%	N	%
Low (<£20,799)	Parent U5	60	84.5	169	91.4	304	91.3
	Pregnant	3	4.2	2	1.1	5	1.5
	Both	8	11.2	14	7.6	24	7.2
	Total	**71**	**100**	**185**	**100**	**333**	**100**
Mid (£20,800-£51,999)	Parent U5	124	86.7	63	85.1	234	87.6
	Pregnant	11	7.7	6	8.1	18	6.7
	Both	8	5.6	5	6.8	15	5.6
	Total	**143**	**100**	**74**	**100**	**267**	**100**
High (>£52,000)	Parent U5	76	72.4	20	80.0	142	76.3
	Pregnant	24	22.9	3	12.0	31	16.7
	Both	5	4.8	2	8.0	13	7.0
	Total	**105**	**100**	**25**	**100**	**186**	**100**
Total						786	79.2
Missing (ethnicity or income not stated)						206	20.8

Appendix Table 1 Wave 1 survey sample (n = 992) parental status, income bracket and ethnic group

HH Income	Parental status	WB/I		SA		All	
		N	%	N	%	N	%
Low (<£20,799)	Parent U5	45	86.5	96	90.6	175	90.2
	Pregnant	1	1.9	1	0.9	2	1.0
	Both	6	11.5	9	8.5	17	8.8
	Total	**52**	**100**	**106**	**100**	**194**	**100**

Mid (£20,800-£51,999)	Parent U5	104	87.4	44	86.3	179	88.2
	Pregnant	10	8.4	4	7.8	14	6.9
	Both	5	4.2	3	5.9	10	4.9
	Total	**119**	**100**	**51**	**100**	**203**	**100**
High (>£52,000)	Parent U5	56	68.3	11	78.6	102	75.0
	Pregnant	23	28.0	1	7.1	25	18.4
	Both	3	3.7	2	14.3	9	6.6
	Total	**82**	**100**	**14**	**100**	**136**	**100**
Total						533	86.0
Missing (ethnicity or income not stated)						87	14.0

Appendix Table 2 Longitudinal Sample Wave 2 (n=620), parental status, income bracket and ethnic group

Research team

Claire Cameron, Hanan Hauari, Katie Hollingworth, Margaret O'Brien, Lydia Whitaker, with Charlie Owen, Francisco Zamorano Figueroa and Sarah O'Toole. Thomas Coram Research Unit, UCL Social Research Institute, 27-28 Woburn Square, University College London.

Co-Is: Andrew Hayward (UCL), Marcella Ucci (UCL), Helen Bedford (UCL), Josie Dickerson (BIHR).

Study funder: UKRI-ESRC project ES/V004891/1

Families in Tower Hamlets was undertaken as part of UKPRP funded ActEarly: A City Collaboratory approach to early life changes to improve the health and opportunities for children living in areas with high levels of child poverty; Bradford, West Yorkshire and Tower Hamlets, London.

Ethical approval was granted by UCL IOE Research Ethics Committee (REC1366) and Camden NHS HRA (20/LO/1039). Data Protection registration number Z6364106/2020/05/151.