LEARNING FROM THE TRANSITION TO DIGITAL AND VIRTUAL DELIVERY DURING THE COVID 19 PANDEMIC

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1. BACKGROUND

As a result of the Covid-19 pandemic and government “Stay at Home” advice, many services were required to either pause their work or to develop new ways of working with families, utilising digital or virtual platforms.

Small Steps Big Changes (SSBC) committed to gathering and synthesising any key learning from services from the transition to virtual delivery. The purpose of gathering the key learning was to ensure that good practice could be shared and it would support operational decisions moving forward. It would also provide a summary of information to consider as part of evaluations of services.

Method

Services were invited via the SSBC Executive Implementation Group (EIG) in June and July 2021 to be involved.

Those who expressed an interest met with the SSBC Research and Learning Officer between August and October 2021, to complete together the 'What Works for Wellbeing' case study* template (see Appendix 1), detailing their experiences of transitioning to virtual delivery. The case studies were synthesised between November and December 2021 and a report finalised in February 2022.

Services also provided in addition to the case study, any numerical data they had collected separately and SSBC also reviewed any internal data held to support the analysis and learning.

In total, five case studies were completed by Community and Voluntary Sector partners.

Framework Housing – Small Steps at Home
Framework Housing – Family Mentor Groups
Literacy Volunteers -Learning to Love Books
Framework Housing - Pregnancy Yoga
Homestart- Small Steps at Home and Groups

2. KEY FINDINGS FROM THE SYNTHESISED CASE STUDIES

Amongst the case studies synthesised, there was a large degree of variability, with some offering telephone delivery, one offering some live online content to supplement other activities and others offering a modified service online (see Appendix 2). To an extent the variability of the case studies has limited the ability to draw conclusions that may be generalisable. However, some key learnings from across the five case studies are presented below.

Transitioning to digital or virtual delivery

The transition to digital was not planned but a response to the Covid 19 pandemic and the government advice for all to stay at home. This advice related to families but also workforce. There was a perception amongst services of increased support needs for some families, which combined with a strong commitment from services to continue to deliver services to families.

Digital and virtual delivery involved for many staff a new and differing skill set, which needed to be built up over time. Different skills were required to use technology, build and maintain rapport via online or telephone settings.

Delivering virtually required additional IT equipment to be able to record relevant service information for some services.

Programme adaptation

The programmes offered via virtual or telephone delivery were all previously designed to be run face to face. Programmes which adapted more easily to virtual or online delivery were those programmes that

required less physical resources, such as baby massage and pregnancy yoga. These were also predominantly adult-focused activities. For those programmes that were more heavily reliant on physical resources, the transition was more challenging, although not impossible. Staff demonstrated commitment and ingenuity in ensuring families had resources at home to enable them to continue to access groups and programmes. Some reported these efforts built trust between families and providers. There was both a time and monetary cost to this, and suggests a significant need for resources to be provided in the home to support the home learning environment. Alternatively, future adaptation may wish to consider utilising existing resources in the home. Groups that supported physical activity in children were those that did not transition over to virtual delivery.

Where virtual delivery was possible and offered, some groups involved significant adaptation from the previously delivered face to face model. A number of factors necessitated changes in the model, including: copyright issues; filming and delivery on a virtual platform; and time families would engage virtually. Although the Small Steps at Home programme schedule was delivered as close to what is outlined, concerns were raised, particularly during the earlier "visits", of the impact of the lack of role modelling, and only some families being able to access video calls. Wellbeing calls introduced to the Small Steps at Home programme were well received. In terms of early child development outcomes, it is possible that the impact of these, and the support provided to families, may have been particularly beneficial in terms of supporting parent wellbeing.

Benefits to virtual delivery

During the pandemic, offering services virtually supported families, some of which, because of the pandemic, had increased needs and some who were particularly isolated, especially those who did not have family support in the UK. Some services reported greater involvement with Dads.

Online delivery enabled in-ward and out-of-ward attendees to attend, increasing the overall reach of the SSBC activities. Activities delivered online were also able to cater for more than one ward at a time, which reduced staffing requirements.

There were no restrictions on numbers, as would be likely in a venue.

The recording of the pregnancy yoga offer enabled greater, flexible access for those that were involved in the course, but unable to attend at a particular time. These participants were able to watch the recorded session and catch up.

Online delivery also enabled people to access services within the comfort of their own home, which was noted as being particularly valuable for pregnancy yoga. This also reduced the cost of running the service as venue hire was not needed.

Barriers or downsides to digital delivery

Some services found it more challenging and time-consuming to build trust over virtual delivery.

Role modelling as a behaviour change technique was a key component of some of the face to face programme offers, and it was not possible in the same way with telephone delivery or recorded delivery.

Online delivery was a barrier to building social connections and social interaction. Many people were reported to not have their cameras on during group sessions. Despite some attempts by providers to get discussion going, this was generally considered more challenging. Some children did, however, enjoy seeing others on a screen. Previous learning suggests that that building of social connections is a key element of why people attend groups and regular group attendance may support child development outcomes.

Concerns around digital poverty were explored as part of the case studies. Little concern existed that the lack of devices was a potential barrier.

Some families in fact had greater access to devices as schools had provided some laptops. Concerns did exist, however, around slow WiFi connections, particularly if a family was trying to link more than one device at a time. For one pregnant woman, a downloaded version of pregnancy yoga was more accessible than live streaming due to the cost.

It is possible, particularly for those groups that ran outside of the Family Mentor Service, that an assessment of digital barriers to access was not possible as those that were engaged, were less likely to have barriers. The uptake of online groups was initially good, but was not maintained; and when given the choice the vast majority of parents advised they wanted services to go back to face-to-face.

Roma groups were not reported to engage with online activities.

Moving on from Covid

At the time of collecting the case studies together, the services spoken to were transitioning back to working face-to-face. This also required some adaptations. There remained anxiety amongst families and staff about Covid. All efforts were made to ensure that government guidelines were followed to reduce any risk of transmission.

Key learnings from the transition to digital

The required virtual delivery of services had enabled some services to reconsider their service offers going forward : " it accelerated our thinking" around delivery. For some services, elements of virtual delivery were maintained, as they supported service delivery - i.e. doing a telephone call as opposed to a face-to-face visit service offer. This was viewed as enhancing the offer.

Some services felt, moving forward, that elements of virtual delivery may promote engagement. Some family mentors used short videos to introduce themselves and the service, which was felt to work well. Potential opportunities exist to use technology and short videos to promote services, enabling families a virtual taster or a short summary of the service provided. Online booking systems proved useful for services and would be maintained.

3. SUMMARY OF THE LEARNING & KEY CONSIDERATIONS WHEN CONSIDERING VIRTUAL DELIVERY

1. Programmes which aim to support the home learning environment need to be designed to accommodate a variety of home environments and be aware of likely resources that are available.

2. Virtual sessions which are designed to give information, particularly to pregnant women and families with younger babies, may be those best suited to online delivery.

3. This provides a potential opportunity for services who are balancing resources to work outside of traditional ward and city boundaries to work collaboratively to offer services.

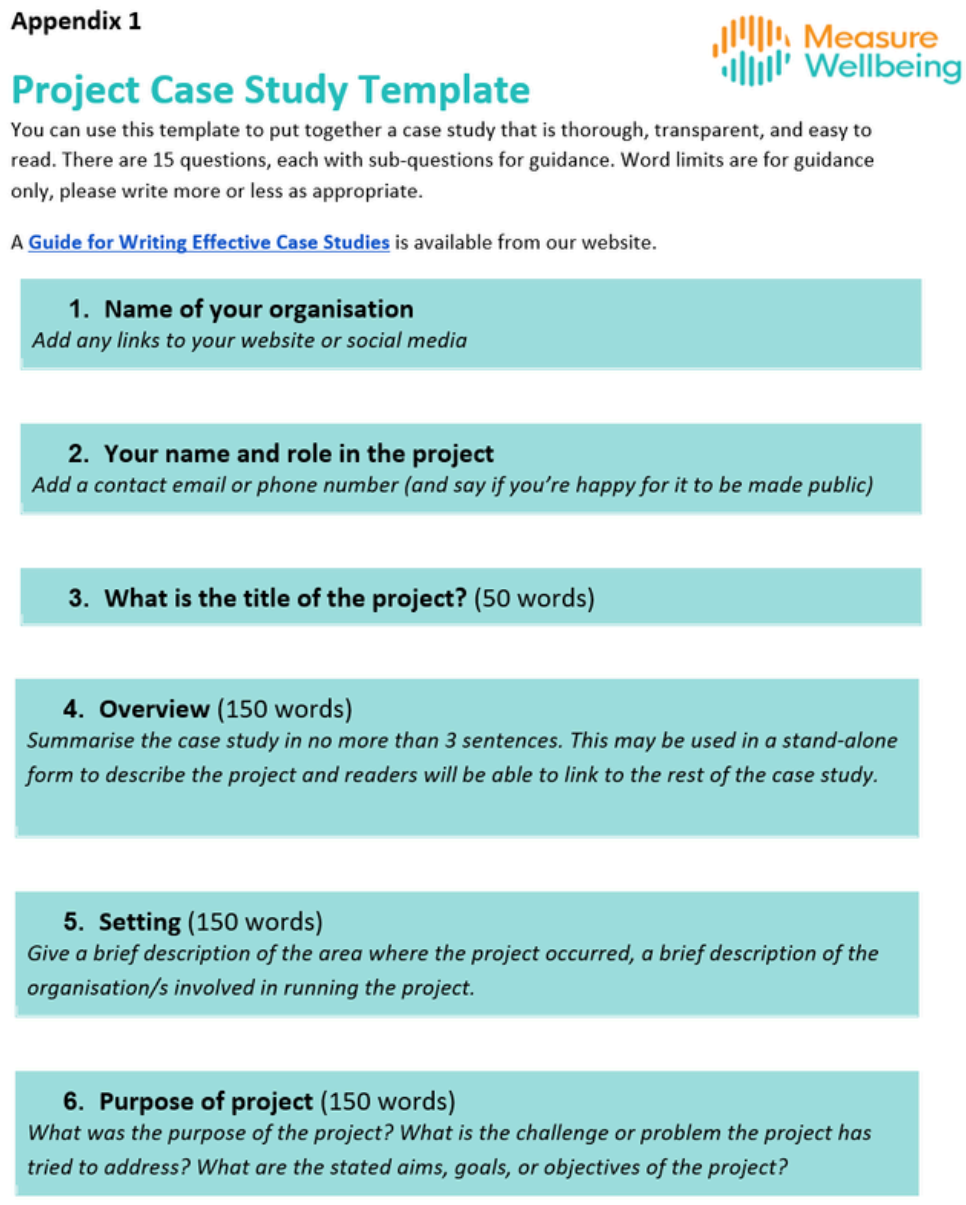
4. Workforce that deliver online should be appropriately skilled and confident working online.

5. Groups which are aimed to support community cohesion and social connections appear less suited to virtual delivery.

6. In adapting a programme designed for face-to-face delivery to a virtual model, consideration should be given to the core components of the programme, which contribute to how the programme might bring about change; and assess whether the core components can be effectively delivered virtually.

APPENDIX

Appendix 1



Appendix 1

Measure Wellbeing

Project Case Study Template

You can use this template to put together a case study that is thorough, transparent, and easy to read. There are 15 questions, each with sub-questions for guidance. Word limits are for guidance only, please write more or less as appropriate.

A Guide for Writing Effective Case Studies is available from our website.

1. Name of your organisation
Add any links to your website or social media

2. Your name and role in the project
Add a contact email or phone number (and say if you're happy for it to be made public)

3. What is the title of the project? (50 words)

4. Overview (150 words)
Summarise the case study in no more than 3 sentences. This may be used in a stand-alone form to describe the project and readers will be able to link to the rest of the case study.

5. Setting (150 words)
Give a brief description of the area where the project occurred, a brief description of the organisation/s involved in running the project.

6. Purpose of project (150 words)
What was the purpose of the project? What is the challenge or problem the project has tried to address? What are the stated aims, goals, or objectives of the project?

7. Description of the project (200 words)

Briefly describe what the project is and/or what it does.
When did the project begin and when did/will it end? Where did it take place? Who was involved in the project (staff, volunteers, partners)?
What funding has the project received? Does the project rely on any other resources, such as staff from other organisations or premises owned/managed by other organisations?

8. Why was this approach taken? (100 words)

Why was the project set up this way? Did you draw on any evidence or theory-of-change when setting up the project? What other reasons did you have for designing and running the project in the way you did?

9. Who took part? (150 words)

Indicate the number of people who took part in the project and any demographic information on participants (i.e. gender, ethnicity, age, disability). Describe how they came to join the project (referrals, word-of-mouth, existing relationship with them), and what you know about their motives for taking part. Are you aware of any groups that were unable to access...for what reason were they unable to access.

10. How was data collected for this case study? (100 words)

Has the project been evaluated? If so, how? What data was collected and by whom (i.e. by you/your organisation, external consultants, academics)?

11. Project impact and outcomes (300 words)

Has anything changed as a result of the project? What impact has the project had on participants, the wider community, and your organisation? Have you produced anything as a result of the project (i.e. reports, guidance, etc)? Were there any unexpected outcomes? Were there any negative outcomes?

12. Enablers and barriers (300 words)

What factors have supported the project and any positive outcomes? What factors prevented the project from being more successful? Examples might be amount and length of funding, staff skills, availability of volunteers, enthusiasm of participants, weather, or scheduling.

13. Key learning (100 words)

What is the most important thing you learned from this project? What key advice can you give to others starting a similar project?

14. Next steps and sustainability (100 words)

How sustainable is the project? Could the project continue? What are the plans for the project in the future and what is needed for this to happen?

15. Further information (100 words)

Include any titles/links to further supporting material about the project (i.e. website, evaluation report). Include contact details of anyone who would be willing to share learning from the project with others starting similar projects.

Appendix 2

Name	Programme	Principal Changes	Reasons for change	Key themes/learning
Framework Small Steps at Home Programme	A manualised programme delivered by peer Family Mentors from pregnancy to age 4 to support child development outcomes	Delivery moved from face-to-face delivery, predominantly to telephone delivery between March 2019 and August 2020, with occasional video call Wellbeing calls introduced to parents	All families had phones Some families faced additional pressures due to pandemic	A strong team environment and good support from leaders supported the transition Different skills needed to deliver on the phone, which needed to be developed for some Reach of SSAH during pandemic may have changed, more Dads involved, less drop offs and more sign ups Some families more isolated Role modelling to support behaviour change a key component of SSAH not possible in the same way Some aspects of telephone delivery support reach and service delivery and will be retained
Framework Groups	A series of family facing groups designed to support improving child development	Where possible groups transitioned over to virtual delivery by Zoom. Not all groups suitable for transfer over	Government advice to stay at home Wanted to continue to support children's development	Online group delivery required adaptation to programmes, different planning, skills, and equipment need to deliver. Confidence in delivery took time. Online delivery less resource intensive with fewer staff and families engaged for less time Some ethnic groups were more likely to access online groups during lockdown,

				perhaps due to isolation. Roma communities did not engage online. Online access enabled out of ward attendees. Wifi issues biggest digital access issue Engagement with groups dropped off when some lockdown restrictions eased and families reported wanting face to face Beyond baby massage, online groups may not have supported outcomes Online groups did not result in much parent-to-parent interaction
Literacy Volunteers	"Learning to Love Books" A community based programme supporting children with communication and reading for pleasure	Previously delivered via Face to Face groups in libraries Story boxes developed for families supplemented with online story telling	Venues closed Unable to access library resources in the same way	The addition of the story boxes to the programme was a welcome addition, it built trust with service, supported relationships. Higher engagement with the programme overall, promoted through word of mouth. Was more resource intensive Role modelling and anticipation key elements of effective story telling, did not translate well to pre-recorded delivery Story boxes well received, much lower uptake, particularly in ward of online story telling sessions Most families had tablets etc to be able to access sessions, ie not a barrier, limited engagement with Roma communities Face to face preferred to online groups

Framework Housing	Pregnancy Yoga	Moved to virtual online delivery		Transition to digital delivery relatively smooth, instructor experienced at online delivery, no additional resources needed by participants at home, less resources needed by project to deliver. Delivery in own home supported privacy and comfort Recorded online delivery could be accessed after the event Less social interaction online, increased out of SSBC ward attendances.
Homestart Small Steps at Home and Groups	A manualised programme delivered by peer Family Mentors from pregnancy to age 4 to support child development outcomes A series of family facing groups designed to support improving child development	Face to Face delivery of SSAH replaced with telephone and occasional video delivery Additional wellbeing calls introduced for families Some groups offered via virtual video platform Some groups not able to transition to digital delivery	Government advice to stay at home	**SSAH** There were increased support needs for families during the pandemic and wellbeing calls were well received Where an established relationship was built the transition to telephone delivery was easier It was harder to build up a relationship and trust virtually, although wellbeing calls helped Telephone delivery was quicker, less resource intensive, but questions about impact Some concerns that not all families would be able to access Wifi and video calling

				approx. 25% of families accessed video calls Resources provided to support Home Learning Environment – Resource Packs 300 activity packs to over 200 families **Groups** Not all groups transitioned well to virtual delivery Baby massage transitioned well, less resource intensive and easy to film Story and Rhyme time – took significant resourcing and changes to deliver online When presented with options parents wanted to go back to face to face groups **Social Media** Social media presence grown and to be utilised going forward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