

A realist evaluation of the enhanced health visiting service in NHS Ayrshire and Arran



HEALTH AND SOCIAL CARE

A realist evaluation of the enhanced health visiting service in NHS Ayrshire and Arran

**Dr Lawrence Doi,
Dr Ruth Jepson
Samantha Hardie
Scottish Collaboration for Public Health Research and Policy,
University of Edinburgh**

Scottish Government Social Research
2015



THE UNIVERSITY *of* EDINBURGH



Acknowledgments

This Evaluation was funded by the Directorate for Chief Nursing Officer, Patients, Public and Health Professions, Scottish Government.

Our thanks to Donna McKee, Senior Manager, Universal Early Years and Family Nurse Partnership Lead at NHS Ayrshire and Arran for granting us the opportunity to undertake this evaluation. We thank Gillian Arnold, Implementation Manager, Family Nurse Partnership at NHS Ayrshire and Arran who helped to organise potential participants. Also, many thanks to the participants themselves for taking part in the evaluation.

SCPHRP core funding is from the Medical Research Council and the Scottish Chief Scientist Office.

Contents

Acknowledgments	2
Contents	3
Executive summary	5
1 Introduction	7
Background.....	7
Aim and objectives.....	8
Structure of the report.....	8
2 Methods	9
Evaluation design	9
Setting.....	10
Sample and recruitment for phases 1 and 2.....	10
Phase 1. Identifying the programme theory/logic model	10
Phase 2. Testing the programme theory	10
Data collection for phases 1 and 2	10
Analysis of phases 1, 2, and 3.....	10
Ethics approval	11
3 How is it expected to work?	12
Phase 1 Logic model	12
4 What did health visitors say?	13
Prevention and early identification.....	13
Home visiting versus drop-in clinics	14
Health visitor-parent relationship	15
Engaging families with wider services	16
Health visitors' perceptions of how families understand their role.....	16
Assessment and recording systems.....	17
Differences in service delivery across the three areas	18
Perceived impact of workload on timeline	18
5 What did parents say?	20
Support provided by health visitors	20
Home visiting versus drop-in clinics	20
Health visitor-parent relationship	21
Reflections on the universal timeline	22
Assessment and engaging with wider services	22
6 Bringing them all together	24
Context, mechanism and outcome configuration	24

Component 1: Families being supported	24
Component 2: Benefits of home visiting	25
Components 3: Trusting relationships	25
Components 4: Health visitors' role	26
Component 5: Systems and structures supporting implementation	27
Limitations of this evaluation	28
7 Conclusions	29
What worked well?.....	29
What may need further consideration?.....	30
Recommendations	30
For NHS Ayrshire and Arran.....	30
For the nationwide implementation.....	30
For nationwide evaluation.....	31
Final concluding statement.....	31
References	32
Appendices	33

Executive summary

In the middle of 2013, NHS Ayrshire and Arran transformed their health visiting service with more focus on pre-birth to 5 years. Also introduced was a universal assessment timeline that ensures that children and families receive at least ten home visits.

These service changes are set within the wider context of the recommendations of NHS Scotland Chief Executive Letter (CEL) 13 (2013), which aims to refocus health visiting and school nursing roles, to improve care delivery within the community and tackle health inequalities.

The primary aim of this evaluation was to understand how the enhanced health visiting service (including the universal assessment timeline) in NHS Ayrshire and Arran works for both parents and health visitors, with a view to inform the implementation and evaluation of CEL 13 (2013) and a structured, increased home visiting service in Scotland.

A realist evaluation design was considered to be the best approach to answer the research aim and objectives. Realist evaluation seeks to understand *how* a programme works rather than providing a verdict of whether the programme works or not. It has three distinct phases: phase 1 defines the programme theory; phase 2 tests the programme theory; and phase 3 provides an explanation and refinement of the programme theory. In phase 1, eight managerial staff who were involved in developing and implementing the programme provided data, which were used to construct a logic model (programme theory). In phase 2, the theories were tested using qualitative data from 25 health visitors who delivered the service and 22 parents who received the service. In phase 3, all the data were brought together and explanation of how the programme works was provided.

The evaluation identified the following key findings:

What worked well?

Parents' increasingly viewed health visitors as their first point of contact on wellbeing and developmental-related issues. This was primarily due to more trusting relationships they have developed with health visitors through the enhanced programme. They also felt comfortable contacting health visitors by phone. Although this was possible in the previous service, however, health visitors reported that the frequency of contacts had increased.

Both parents and health visitors reported that the service changes have improved early identification of concerns (about both parents and children) leading to early engagement with wider services, including nursery services, in ways that were not previously possible.

Health visitors felt that the changes have made their role much clearer and well defined. They perceived that this has enhanced their professional partnership working.

What may need further consideration?

Both parents and health visitors found the gaps between some assessment visits in the timeline too wide apart.

Some health visitors, were concerned about referral pathways. They felt they were cumbersome and presented significant challenges to the enhanced service.

Health visitors universally acknowledged that increased home visiting has been challenging and reported that they struggled to fulfil the entire timeline. This prompted some areas to involve staff nurses and skill mix to fulfil the timeline.

Some parents and health visitors missed the drop-in clinics, which were largely stopped when the enhanced service was introduced. For parents, the key reason why they still wanted the clinics was the opportunity to build social support networks.

The enhanced health visiting service in NHS Ayrshire and Arran is currently being delivered with limited resources, yet this evaluation demonstrates a number of positive findings in terms of the value it has added to health visiting practice and indicates promising improvements in outcomes for children and families. There are some findings which the nation-wide roll-out may wish to consider to ensure favourable outcomes, but overall this evaluation should be reassuring for the impending implementation of the programme across Scotland, which promises to offer more resources than are currently available in NHS Ayrshire and Arran.

1 Introduction

Background

1.1 The early years of life is an important time for children and families. It has been argued that the provision of universal access to healthcare in early years has the greatest potential to promote health and wellbeing and reduce health inequalities in later life (Marmot et al., 2008; Roberts, 2012). In the UK, one such provision is the universal child health programme, often but not solely provided by the Public Health Nursing Services. Recently, the Public Health Nursing Services – Future Focus (CEL 13: (2013) recommended a refocusing of the Public Health Nursing (PHN) roles, responsibilities and titles. Briefly, it specified that the existing Public Health Nursing role as defined in Nursing for Health 2001, should be refocused and the titles of health visitor and school nursing reintroduced. Further, it suggested that the role of the health visitor should focus on pre-birth to 5 years. This refocusing of the PHN role is intended to support the delivery of targeted interventions, delivered by a specialist workforce, who will be better equipped to address the specific needs of children and families.

1.2 The Scottish Government is currently supporting NHS boards to implement the recommendations of CEL 13. In line with this, and in recognition that families were receiving variable service experiences, the Nurse Director at NHS Ayrshire and Arran commissioned a nursing review to provide intelligence to support the development of the Community Nursing Service that allows the workforce to develop and puts children and families at the centre. The goal was to improve care delivery by improving access to services closer to home. As a result, significant organisational changes were introduced to the health visiting service in NHS Ayrshire and Arran from mid-2013. The key changes include an introduction of a universal assessment timeline that increases assessment contacts with children and families. Core families (families who do not usually require additional monitoring and support) now receive eleven visits from their health visitors, beginning from when children are 11-14 days old until the preschool handover assessment contact. Moreover, throughout the period, additional programmes of care can be offered to children and families if required. Moreover, health visitors are no longer required to immunise children or be involved in drop-in clinics. How these changes impact on health visiting practice and whether or not they make a difference in terms of outcomes for children and families need to be examined in order to inform the impending roll-out of the enhanced health visiting service across Scotland.

Aim and objectives

Aim:

1.3 To understand how the enhanced health visiting service in NHS Ayrshire and Arran works since its introduction in 2013, with a view to informing the implementation and evaluation of a structured, increased home visiting service in Scotland.

Objectives are to:

1. Describe the model of enhanced health visiting implemented; expected outcomes and how the service would achieve these (using a logic model)
2. Assess whether the service was delivered as expected and whether outcomes were achieved
3. Explore parent and nurse experiences of the service
4. Identify barriers/enablers to implementing the service
5. Assess the implications for wider adoption of an increased health visitor service
6. Identify the implications for future national evaluative activity of the roll-out of the health visiting model

Structure of the report

1.4 The first chapter outlines the background, aim and objectives of the evaluation. Chapter two provides an overview of the realist design adopted by this evaluation and also describes the methods used to generate data. In line with the stages of realist evaluation, the findings are presented in three chapters. Chapter three outlines the logic model of the enhanced visiting service (Phase 1). Health visitors and parents' findings are reported separately in chapter four and five (Phase 2). Chapter six provides further explanation and refinement of the findings (Phase 3). Chapter seven summarises the key conclusions of the evaluation and provides recommendations both for NHS Ayrshire and Arran and in the context of implications for national implementation and evaluation of the enhanced health visiting service.

2 Methods

Evaluation design

2.1 The evaluation was informed by realist framework. Briefly, realist evaluation is a theory-driven approach to evaluation of social and healthcare programmes, such as the refocussing of the health visiting service in NHS Ayrshire and Arran. It focuses on building, testing and refining programme theories (or logic model) by exploring the complex and dynamic interaction of the context (settings or conditions in which the programme was implemented), mechanisms (behaviours and decisions of practitioners delivering the programme) and outcomes (intended and unintended effects) (Pawson and Tilley, 1997; Pawson, 2006, Wand et al, 2010; Byng, 2011). Following the realist framework, this evaluation comprised three phases (Figure 1).

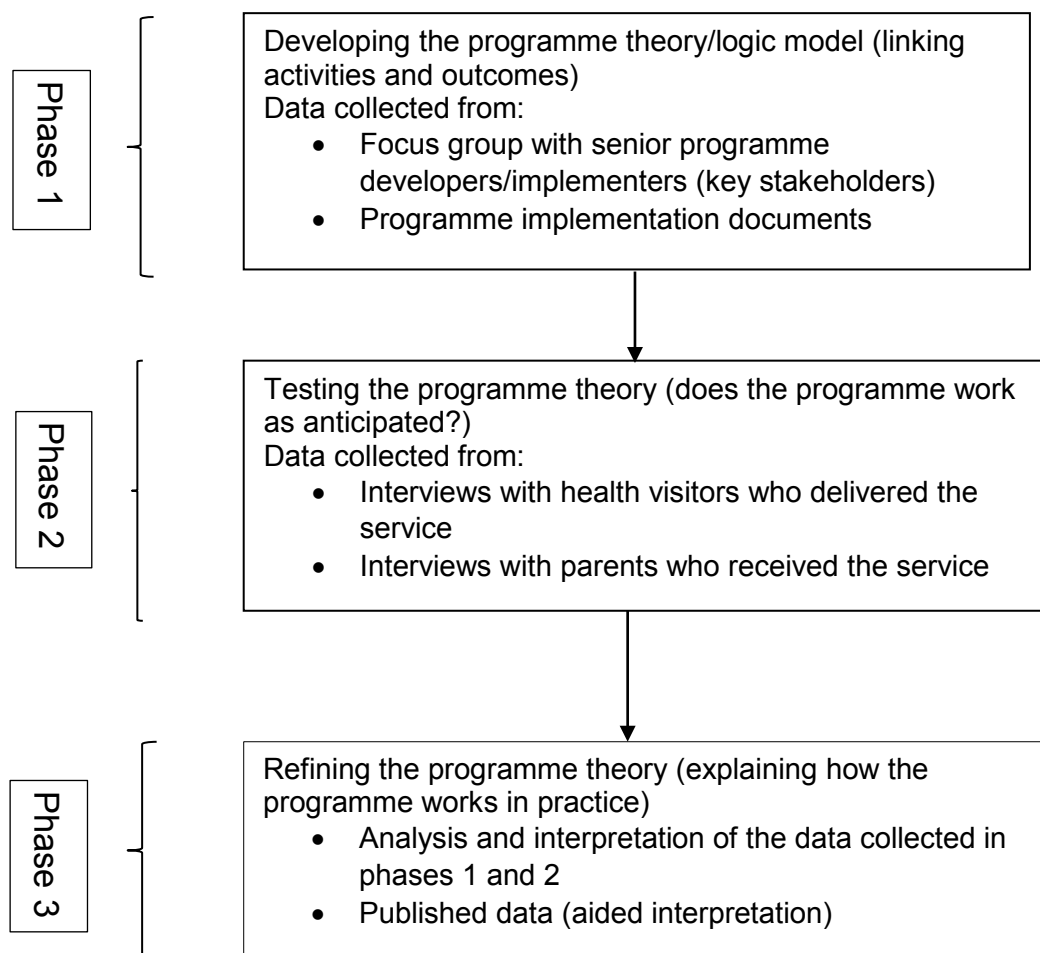


Figure 1. The realist evaluation process

Setting

2.2 NHS Ayrshire & Arran is in the mid-south west of Scotland and covers an area of 750,464 square hectares. It comprises a mix of rural and urban development. It has three local authority areas – North, South and East Ayrshire. In mid-2013, the estimated population was 372,210 (National Records of Scotland, 2015) and the total births in 2013 was 3,640 (ISD Scotland, 2014). NHS Ayrshire and Arran has about 80 health visitors and new health visitors are currently being trained.

Sample and recruitment for phases 1 and 2

2.3 Participants of this evaluation were recruited from all three local authority areas. The detail of the steps taken for sample and recruitment are provided in Appendix 1.

Phase 1. Identifying the programme theory/logic model

2.4 Eight key stakeholders (managerial staff) involved in either developing or implementing the structured, increased home visiting service in NHS Ayrshire and Arran participated in a focus group.

Phase 2. Testing the programme theory

2.5 Overall, 25 health visitors participated in Phase 2 of the evaluation. Of this, nine were from South Ayrshire, whilst eight were from North Ayrshire and East Ayrshire had six. The other two were based in Ayrshire central hospital and covered all three areas. All health visitors except six, had experience of delivering both previous and current service.

2.6 Twenty-two parents participated in the evaluation. North and East Ayrshire had eight participants each, whilst the remaining six were from South Ayrshire. All parents except five, had used both current and the previous service.

Data collection for phases 1 and 2

2.7 Details of how data were collected in phases 1 and 2 and all topic guides used are provided in appendices 2-5.

Analysis of phases 1, 2, and 3

2.8 In phase 1, the transcribed focus group data were synthesised together with programme implementation documents to develop a logic model (see figure 2) of the enhanced health visiting service in NHS Ayrshire and Arran. In phase 2, qualitative data were transcribed and then thematically analysed based on the logic model. Transcripts were coded, analysed by themes and presented in a narrative fashion. The analysis was facilitated by the software package QSR NVivo 10. In phase 3, the findings from phase 2, and the logic model from phase 1 were

disassembled, enabling the analysis to focus on explaining ways in which the programme mechanisms unfolded or did not unfold in practice. This analysis was presented as context, mechanism and outcome components, which further aided understanding of the enhanced health visiting programme.

2.9 Where necessary, published data were obtained to support the interpretation of the qualitative data. Published data covered before and after implementation of the programme and provided an indication of the impact of the programme on certain outcomes, even though cause and effect relationship cannot be assumed.

Ethics approval

2.10 Ethics approval for the evaluation was granted by the University of Edinburgh Centre for Population Health Sciences ethics committee and complied with research governance procedures in NHS Ayrshire and Arran.

3 How is it expected to work?

Phase 1 Logic model

3.1 This chapter outlines the logic model (Figure 2) of the enhanced visiting service using data from the focus group with eight key stakeholders and programme implementation documents.

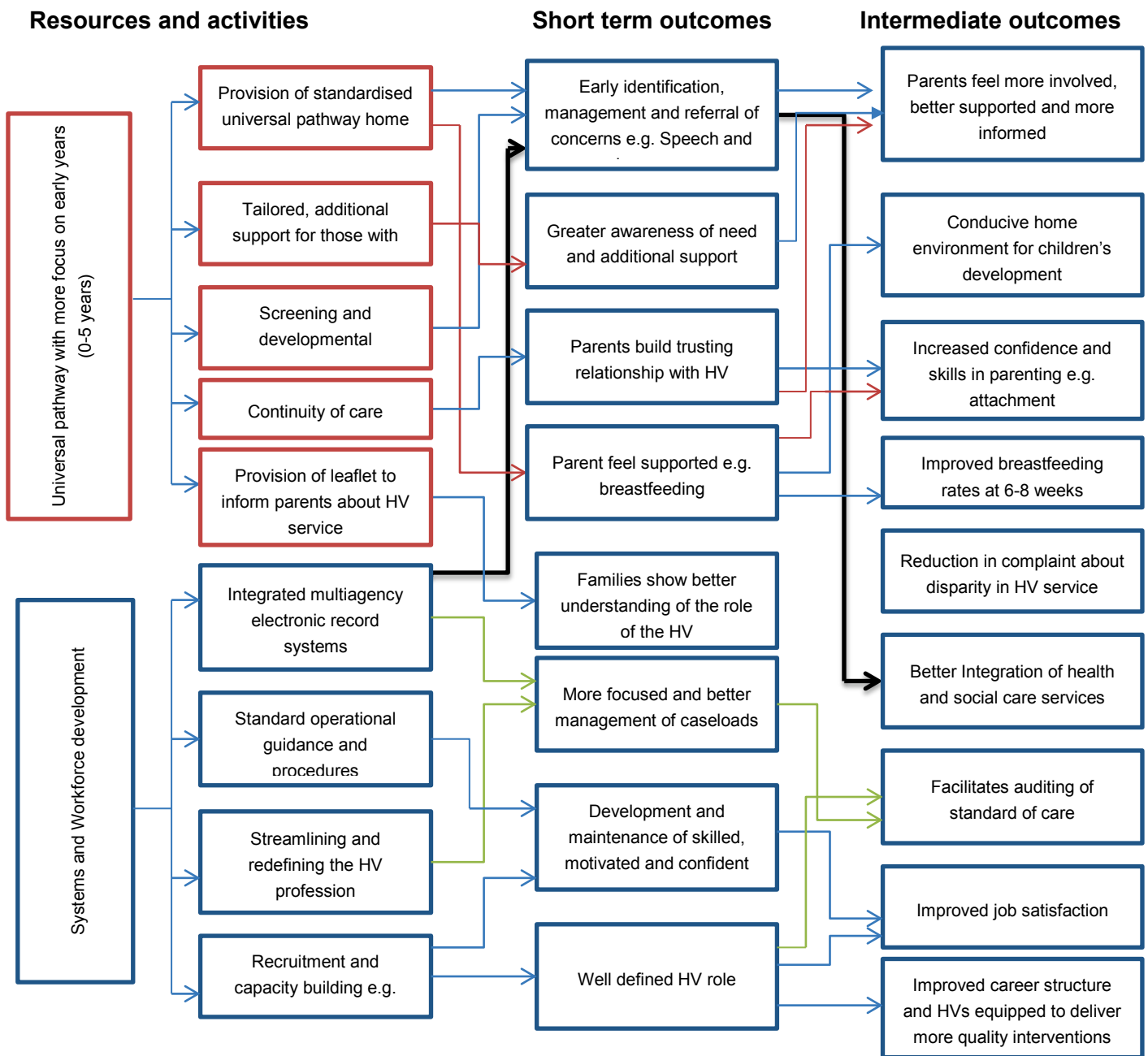


Figure 2 Logic model of the enhanced health visiting service

4 What did health visitors say?

4.1 This chapter presents the findings of how the programme works in practice from health visitors' perspective (phase 2), by examining the assumptions outlined in the logic model. Using the logic model, eight themes were identified.

Prevention and early identification

4.2 Almost all the health visitors acknowledged that they have found the structured, increased home visiting hugely beneficial. They particularly appreciated the focus it offers in terms of prevention and early identification of concerns.

I think it's made me far more aware of my families. I would have missed lots of things, and I would end up having lots of families in crisis. And it would be crisis intervention, rather than prevention, and that's not how to do it. A child should never get to the stage where their family is so chaotic that they have to be removed. So, for me, I wouldn't have been in the houses as often as I am now (H23).

4.3 The majority of health visitors were keen to add that with the previous service, concerns were often identified at advanced stages. They stressed that this was the case particularly for some core families as described by one health visitor below.

There are real benefits – I don't know whether it helps to say, previously we had examples of children – and not necessarily children who would come through on that vulnerable pathway, so not families that previously might have been monitored more closely by health visiting before the introduction of the timeline. Those kind of more affluent, professional families where you look at the family and think, oh mum knows what she's doing, everything's fine, but it happens with the second sibling, but actually when they've then come into their pre-school or ante-preschool setting, it's been a child that people have gone to see, Oh my Goodness, nobody has picked up that there is a significant issue with this child, because actually mum and dad haven't taken them anywhere, haven't engaged because there wasn't that routine visits (H15).

4.4 Some health visitors added that the changes have placed them at a better position to build a good understanding of children and families' concerns from the very beginning, and take action if necessary, or possibly observe over time whether those concerns would be confirmed or allayed.

And it gives you the chance to build up a better picture I suppose, because if you're seeing them right at the beginning then you can see if there's any deterioration, or any differences that would maybe raise concerns. Or it would reassure you that the family are doing okay, because there have not been any changes over the past maybe four or five months. So it just lets you see how...instead of them coming to a clinic, because when they're coming to a clinic

that can be completely different. When they're in their home environment you get to see exactly what they're like (H20).

Home visiting versus drop-in clinics

4.5 Health visitors felt that the benefits of the home visiting were far greater than the previous drop-in clinics. A number of them acknowledged that the home visiting put much more focus on families than the drop-in clinics.

Home visiting has given us much more control over, sort of, prioritising what we're doing for families, you know, whereas before when we, sort of, you were, kind of, it's clinic time and you had to work around that, you know, and it was more around fitting people in around that rather than, sort of, being led by the needs of families you were working with (H16).

4.6 They believed that the home visiting provides clear opportunities to identify more concerns. They explained that it was impossible to observe and identify such concerns in the previous service.

Well, I think I had a family that I visited quite frequently at home, and the pattern became that this child was probably left alone quite a lot in the mornings. The parents weren't very good at getting out of their beds. And I think that became more apparent because I was visiting at home, because when you go at home, you hear the child crying, and the parents aren't responding. They took a long time to answer the door, and when you go in, the home environment is not great, the child is maybe running about with a really wet nappy on. Whereas, I think if it was a clinic setting, they might not come on time, however, the child will probably be well presented, because they know they're coming (H18).

4.7 Some health visitors also felt that the home visits were hugely beneficial in terms of providing targeted support to children and their families.

One family I can think of off the top of my head, I've known that there's been issues going on, but the fact that I've been going in more proactively, I've been able to get different services in and even getting those services in within two weeks. I've seen huge differences to that child. So whereas maybe previously, all that might not have been as timeously (H22).

4.8 Interestingly, even those who initially thought that the structured, increased home visiting was unnecessary and would not be beneficial to parents as it was too intrusive, acknowledged how valuable they have found it.

I used to think that we should still have kept our clinic going, but actually, see now, I'm happier doing the home visits. I don't mind doing the home visits, I think it gives you a better picture, because as I say, they could come to a clinic and be all completely nicely dressed, but you don't know what's going on in the background. So I do like the fact that all our visits are done at home (H12).

4.9 However, some very few health visitors still believe that the drop-in clinics were more useful than the home visiting. They even suggested that some parent preferred them more than the home visits.

I've got mums who would probably prefer to go into the clinic but that's not an option for them now so probably you're taking choice away. I personally don't think there's a benefit (H3).

Health visitor-parent relationship

4.10 Professional and client relationship is integral to effective health visiting practice (McKee and Queen, 2004). Ongoing positive relationship between clients and health visitors can maximise outcomes for children and families (Cowley et al. 2013). In this study health visitors were asked to reflect on how the enhanced, structured home visiting service had influenced their relationships with children and families.

4.11 The majority of health visitors were positive that the increased home visiting offered a good opportunity to build trusting relationships with children and families.

I think, the biggest difference that I feel is that we've been able to establish really strong relationships with families because of the intensive visiting (H16).

4.12 However, only two health visitors felt that the changes have not had any influence on their relationships with families. For instance, one of them felt that drop-in clinics were equally useful in terms of establishing trusting relationship with families.

I think I've always had a good relationship with the families and I feel my relationships through clinics and immunisations as well enhanced that relationship. I wouldn't say just the home visits strengthen the relationship (H25).

4.13 Nevertheless, those who felt that the universal timeline had improved their relationships with children and families, also articulated some additional benefits. For instance, they felt that the enhanced service helped develop relationships and enhanced trust. This ensured that families were more open and confident to discuss sensitive issues with them. Families then saw them as first point of contact.

Another mother asked me to go and see her and I saw her this morning. And the pretext was she wanted the baby weighed. But, really and truly, what she wanted to talk about was her eight year old child who has a bowel problem. So, I was able to discuss that, his diet, the importance of developing a bowel habit. So, the mother knows you well enough, trusts you enough, doesn't think it's important enough to go to the GP, so it saves an expensive doctor appointment if she feels she can contact me and I can manage the situation (H17).

4.14 Some health visitors also added that, due to the trusting relationships they have developed with parents, parents now feel more confident to contact them by phone.

I think we get to build up a better relationship with the parents. I think that's quite important, that we do sort of, at the beginning, we do six weekly visits, which I think is really helpful to build up that relationship. And you find mums do phone quite frequently now, and I think they've got a sort of a bit of a trust in you (H18).

Engaging families with wider services

4.15 There is evidence that health visiting is instrumental to an uptake of services, especially for families who find services difficult to access (Cowley et al., 2013). It was clear in this evaluation that health visitors are now making more referrals to wider services. Nursery placements was a service that was particularly mentioned.

If you're visiting people on a more regular basis, you identify problems and you can anticipate difficulties, therefore, you can make appropriate referrals, perhaps, sooner than you might have done and that can only be a good thing. For example, I made six referrals this month to access an early nursery placement (H17).

4.16 Health visitors however, expressed the opinion that referring families for additional support has often been challenging. They felt that a more efficient system was required.

I think, there's still a lot of work needed around referral pathways (H16).

4.17 Role clarity and clear responsibilities enable staff to manage challenges around interagency or inter-professional team working (McKee and Queen, 2014). Families also benefit from professionals working together in an effective way (Barlow et al., 2008). As such, we asked health visitors to report on their experiences of professional partnership working. They felt that the enhanced service has improved their professional partnership working. They perceived that other practitioners and services are much clearer of their role.

So, if you are at say, for example, a child protection meeting and the team are drawing up a care plan, I think, we're much clearer about what our role is within that whereas before we were probably getting, sort of, a lot of blurring of roles between the agencies and, kind of, getting fitted into the care plan whereas, I suppose, now we're a bit clearer about what our role is (H16).

Health visitors' perceptions of how families understand their role

4.18 Health visitors felt that increased, structured home visiting offers the opportunity for families to know and understand their role much better. They

assumed that previously most people were unclear of their role. However, they believed that the changes have helped to clarify this.

I think, because they see more of you so they're much clearer about who their named health visitor is, how to contact you and what our role is (H16).

4.19 More so, health visitors felt that families are now more knowledgeable of the services they offer.

And, I think, families are much more aware now of what to expect from the timeline so often they'll phone us up and say, oh, my baby's coming up for six months and, you know, they know that that's what they're entitled to now so, no, it's good (H16).

At the early stages, they know what you're doing. They know when you're available, and I think it's a better understanding. Although before you would say when you would be visiting and whatever, I think because of the closeness at the beginning of the visits there's maybe less anxieties with families, sort of, thinking, right, well, when is the next time the health visitor's coming out? And they don't need to worry as much. They know they can maybe leave things until you come out (H20).

Assessment and recording systems

4.20 In NHS Ayrshire and Arran, there is currently a total of eleven visits in the universal assessment timeline for core families. The first visit starts from 11-14 days, then weekly until the fifth week. The next visit in the timeline is the 6-8 weeks, which is followed by visits at 12, 16 and 24 weeks. The next two visits occur at 12 months and 27-30 months. The last visit is the preschool handover assessment contact. However, some health visitors were concerned that some of the gaps between assessment visits in the timeline were too wide apart and that seems uncomfortable for parents.

But a lot of the parents find from a year to 27 months is too long not to be seeing anybody. And I think that is quite a gap as well (H12).

4.21 Although, the health visitors are no longer involved in drop-in clinics, they felt that it would be useful to get access to children's immunisation records in order to conduct a more complete assessment of children and their families.

In some ways, because that (immunisation) was always part of our role to check that, you know, part of your holistic assessment would be to check immunisations are up to date, but now they're not even going on FACE, our electronic system. So they're not really going in the notes. So it's been sort of, sort of taken away from us and put more on the GPs, which is fine, but then we don't know people who failed to attend (H5).

4.22 Almost all health visitors raised concerns about their current electronic recording system. They felt that a much more efficient and less laborious system will be helpful to compliment the timeline.

I am constantly aware of the numbers of visits you've got in one day and it's not just that, the electronic records take up quite a lot of time and, of course, it's very important. You have not completed your intervention with a client until you've got your electronic record complete. You've got to have contemporaneous records (H17).

Differences in service delivery across the three areas

4.23 There were small differences in service provision across areas of Ayrshire and Arran. It appeared that some very few areas were still offering women the opportunity to attend drop-in clinics (*supporting quotes withheld*).

4.24 There were also some indication that some health visitors were engaging the services of skill mix and staff nurses to fulfil some of the timeline.

At the moment, we're using, sort of, skill mix to do some of the visits, some of the staff nurses are carrying out a couple of visits in the timeline (H18).

4.25 However, others pointed out that involving skill mix in the timeline does not promote continuity and consistency across the service.

I think it (timeline) has brought continuity I think, like, and within Ayrshire and Arran, you know, I think...I would hope that it would. It brings a more consistent approach to all families. However, talking to colleagues in other areas, I think some people have pulled back a bit more and have put in more skill mix and, you know, the waters are getting muddied again (H13).

4.26 This assertion was also supported by another health visitor who felt that there was a need for clearer guidelines regarding how the timeline should be operationalised.

There needs to be clear guidelines as to who does the visits. Because it's not the same, it's not the same throughout. I think it needs to be endorsed in such a way that, you know, who should be doing the visits. Because it's all over the place (H23).

Perceived impact of workload on timeline

4.27 It was clear that outcomes of the enhanced, structured home visiting service cannot be looked at in isolation without considering how the health visitors who deliver the service are coping with the demands and challenges of their current

role. This also presented an opportunity to examine their belief and enthusiasm towards the programme.

4.28 A common theme amongst all health visitors was that their current caseloads limited their ability to fully fulfil the demands of their role.

I mean as I say, I do like the timeline and I do think it would work. I think you need smaller caseloads to be able to do it properly and do all the other things as well (H12).

4.29 They added that even though they are now identifying more concerns, their caseloads have made it nearly impossible to support families the way they would have expected. This appeared to have compelled some health visitors to refer more clients to wider services as explained by one participant below.

I mean, to be honest, we've not got a huge deal of time for targeted intervention work. We would tend to ask a support worker, or maybe another service, to do that, like Barnardo's, if there was maybe housing issues. It's like an ongoing assessment, so you're able to pick it up quicker, really. And that's what we're looking for with prevention, and early intervention. But actual pieces of work, probably I would need to refer to somebody else, because we can't do the timeline, and do specific pieces of work, within the size of the caseload (H21).

4.30 Considering plans to increase the number of health visitors in NHS Ayrshire and Arran by 50, health visitors were asked to comment on what they would be able to provide that they are currently unable to, due to workload constraints. They all agreed that the proposed increase in the number of health visitors will ensure that more opportunities will be available to support families.

I think we'll be able to fulfil the whole timeline, we'll be able to do all the visits. And I think our vulnerable families will have a much better service, because we'll have less of an overall caseload (H18).

5 What did parents say?

5.1 This chapter presents the findings of how the programme works in practice from parents' perspective (phase 2), based on the assumptions outlined in the logic model. Overall, five key themes were identified.

Support provided by health visitors

5.2 Parents highly appreciated the support provided by health visitors. They felt that the increased, structured home visiting made it possible for them to receive more support both for themselves and their children.

I think it's definitely improved since I've had my current child. This past year, I've had a lot of support because I went through postnatal depression with her and they (health visitors) were there supporting me as much as they could, type thing. In 2005 when I had my first one, I was just left. I mean, I had no support whatsoever (P16).

5.3 The enhanced, structured home visiting programme ensured that families who required additional support also received them. The few families that have required the service affirmed this.

I'm getting more visits just now for, like, medical reasons... (P21).

5.4 Parents found the option of contacting health visitors by phone in the absence of drop-in clinics quite positive and reassuring.

...they always say, well if you get any other problems, just give us a call. So it's quite nice (P16).

5.5 Thus, if parents needed further support the opportunity to gain access to health visitors by phone seemed important.

Home visiting versus drop-in clinics

5.6 Almost all the parents acknowledged that the home visiting was hugely beneficial. They felt that health visitors gave them more attention, which was important in terms of discussing issues in depth.

They don't just rush in, like, let's get the baby weighed. They don't do that anymore, because they did that when I had my first one. It was, kind of like, in to do what they need to do and then go. Whereas now, it's kind of, how are you doing? (P16).

5.7 This was even evident among parents who had previously experienced the drop-in clinics.

It's quite personal I suppose but if they come into your house you can open up a bit more whereas if you come to the clinic and there's a big queue of people behind you waiting, you always think right I'm just gonna go in and get them weighed and go, but actually you want to discuss other things with them (P12).

5.8 However, a third of the parents who had previously experienced the drop-in clinics also stated that they missed attending them.

He's had the amount of visits like he's meant to have with this new thing, but as I say, I do prefer if I could go down to the clinic (P13).

5.9 Amongst those who said they missed the drop-in clinics, aspects of the drop-in clinics which engendered such sentiments included opportunity of weighing the baby on a more regular basis, and meeting and receiving advice from other parents.

I loved it (drop-in clinics). See when my oldest son – he's 11 – when he was born it was great because you met other mums. I was young when I had him so I didn't really know anybody so it was great to try and get advice off other mums, and then with my youngest, when they were saying they were closing it I was kind of...because it was good to meet other folks when you were there (P4).

Health visitor-parent relationship

5.10 Continuity of care where care is provided by the same person for all or most, planned episodes of care has the potential to build trust between a practitioner and a client. With the enhanced, structured home visiting programme, a health visitor is expected to fulfil the entire timeline with a family. In this study, very few parents mentioned that they had visits from a single health visitor. Yet, they felt that this did not influence their relationships with the health visitors. A common reason given as to why they have had different health visitors was because the substantive health visitor was on annual leave.

5.11 All the parents, with the exception of two, felt that the timeline promotes continuity of care and yields better relationships with health visitors.

I would say the relationship has been probably better for my current child because it's been continuously the same person whereas with first child it was just whoever did the clinic that morning (P14).

5.12 Of the two who had not had a good relationship with health visitors, one had two different health visitors and was unable to establish a rapport with either of them. The other, although, has had the same health visitor, felt that the relationship had been poor after the health visitor failed to consider her views during assessment.

5.13 However, those parents who established trusting relationships with health visitors, also added that the health visitor will be their first point of contact if they were concerned about any developmental or weight related issues as described below.

If it was concerns about development or weight or things, I would phone them first (P14).

Reflections on the universal timeline

5.14 Many parents expressed a greater awareness of the service they now receive from health visitors. They commented that the timeline was a great deal better than the previous service. They were almost universally positive about the increased home visiting. For instance, comments akin to the one below were not unusual.

It's been great! I'd say more so, that they've been more involved with my third baby I've felt than with the last two. I felt that they were more wanting to come out and see you more than just going to the drop-in clinic (P4).

5.15 It also appeared that additional number of visits were offered to parents who required them.

He was two months early, so he was in the hospital for a month basically. When he first got home, we had quite a lot of visits (P22).

5.16 However, a few parents felt that gaps in between visits could be improved. One such case was a first time mother who felt that a six months gap between her previous visit and the coming one was a bit too wide.

Like I said, from six months to 12 months there seems to be a big gap there, because I think that although I've got an appointment with the doctor which is quite good I suppose, but it's not the health visitor service (P2).

5.17 As well as the six to 12 months gap, there is also another wide gap between the 12 to 27-30 months' assessment visits. It appeared that first time mothers were particularly concerned about these gaps.

Assessment and engaging with wider services

5.18 Generally, parents reported that their views were considered as part of their children's assessment. However, only one parent felt that a health visitor disregarded her opinion when assessing her child and this was repeated later when she had her own assessment.

5.19 Almost all the parents felt that the timeline has facilitated the process of engaging early with wider services. They indicated that health visitors were very helpful in terms of assisting them to access services both for themselves and their children.

The way that I've been feeling the past few month, you know, the way I've been feeling down and everything as well. You know, she's helped and got me that appointment at the doctor and everything and I've started feeling a lot better now (P20).

6 Bringing them all together

Context, mechanism and outcome configuration

6.1 This chapter forms phase 3 of the realist design. It uses the findings of phase 2 (health visitors and parents) to revise the initial assumptions of the programme outlined in the logic model (phase 1). The initial logic model has been disassembled into context, mechanism and outcome (CMO) configurations/components in order to understand how the programme works in practice. For instance, contexts entail the established conditions or opportunities offered by the programme but are not necessarily worded as in the logic model. For example, “immunisation and drop-in clinics no longer part of model of care” in figure 4, evolved from “streamlining and redefining the HV role in the logic model”. However, this has been made more explicit here to reflect a clearer understanding of the programme. Discussions in this chapter are based on overarching themes that emerged across health visitors and parents’ findings.

Component 1: Families being supported

6.2 It was clear from both health visitors and parents that the increased, structured home visiting improves early identification of concerns and assists in tailoring support (see figure 3). Health visitors mentioned that they are increasingly providing diverse kinds of supports to children and families, including feeding and attachment support. Although most of the parents who participated in this study indicated that they did not breastfeed their children, they were nevertheless appreciative of the feeding support they received from health visitors. It is therefore not surprising that breastfeeding rates in NHS Ayrshire and Arran had increased since the enhanced service was implemented (ISD Scotland, 2014) (see appendix 6). However, the data must be treated with caution as cause and effect cannot be assumed.

Context

- Provision of structured universal timeline
- More focus on children aged 0-5 years

Mechanism

- HVs anticipated and tailored support to families
- Early identification of concerns
- Additional support sought for families where necessary

Outcome

- Increased feeding and attachment support
- Improved satisfaction with service
- More families engaging with services

Figure 3 Refined CMOs for Components 1: families being supported

Component 2: Benefits of home visiting

6.3 Although parents liked the structured, increased home visiting, however a good number of those who had previously experienced the drop-in clinics also indicated that they missed attending them because of the social support opportunities they provided. This confirms what some of the health visitors mentioned. It is likely that because there are no more drop-in clinics, some health visitors and parents found gaps in between some assessments visits a little too wide apart. This might have resulted a higher demand for phone support.

6.4 Also, there were thoughts that since health visitors were no longer immunising children, immunisation uptake rates might perhaps decrease. However, the current figures show that they have either stayed the same or increased from 2013 to 2014 (ISD Scotland, 2015) (see appendix 7). Although definite conclusions cannot be made about the rates, they still provide some reassurance that the changes have not had negative impact on immunisation rates. Nevertheless, there was strong sentiments from health visitors that getting access to immunisation records of children would enhance holistic assessment of children and families (see figure 4).

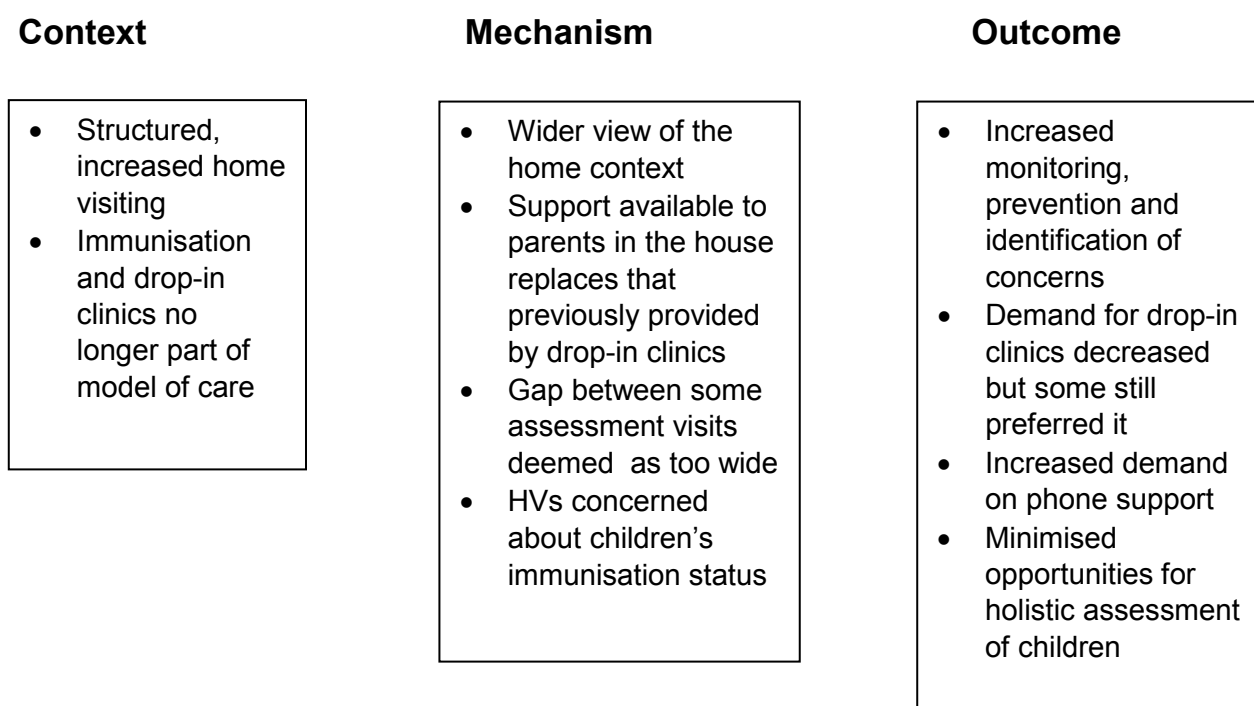


Figure 4 Refined CMOs for Components 2: Benefits of home visiting

Components 3: Trusting relationships

6.5 It was clear from both health visitors and parents that the timeline has hugely improved the rapport between them (see figure 5). Although most parents have had two or more health visitors, they felt that home visiting provided adequate time to establish new relationships. More so, it was reassuring to see more parents

recognising health visitors as first point of contact on a range of issues which they would have previously sought medical attention.

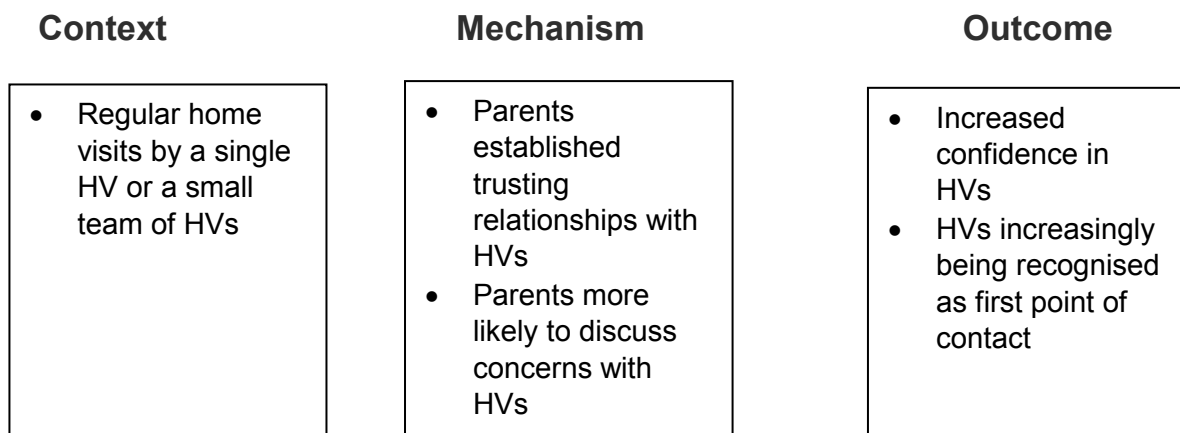


Figure 5 Refined CMOs for Components 3: trusting relationships

Components 4: Health visitors' role

6.6 There was evidence that the increased, structured home visiting service has clearly defined the role of health visitors. Parents showed greater understanding of what they feel the health visitors' role is. Health visitors also felt that they are receiving more recognition from other professionals regarding supporting the needs of children and families. They feel that they now work more efficiently with other agencies. This appeared to have raised health visitors' confidence and enhanced their morale (figure 6).

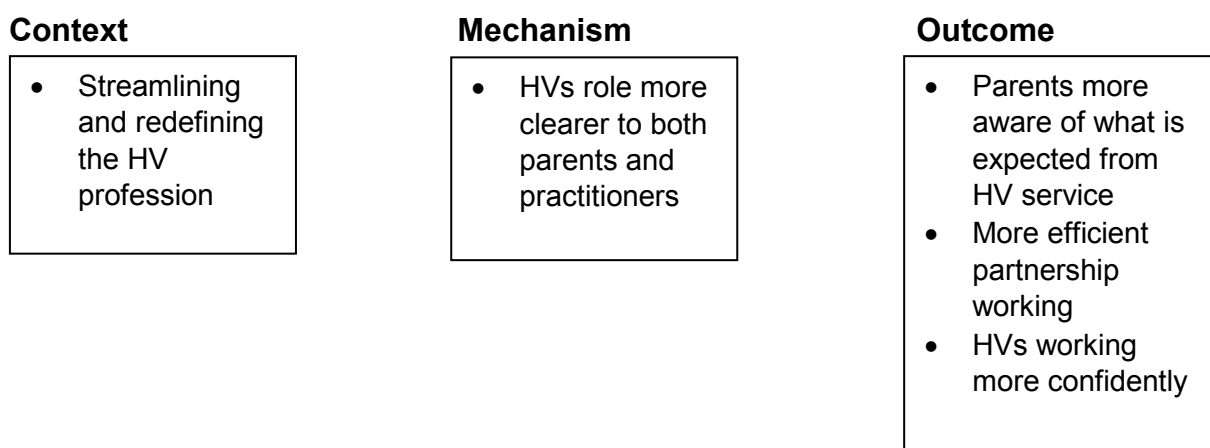


Figure 6 Refined CMOs for Components 4: health visitors' role

Component 5: Systems and structures supporting implementation

6.7 The increased, structured enhanced service has hugely standardised health visiting service in NHS Ayrshire and Arran. However, there appeared to be subtle differences in the service delivery. There were also indications that some health visitors were referring more children and families to wider services as they struggled to accommodate the timeline and caseloads. Yet, most health visitors found the referral pathways challenging and this contributed to the workload pressure. The situation was not helped by the perceived laborious electronic recording system. Some health visitors also felt frustrated by not being able to access children’s immunisation records from the current electronic system (see figure 7).

Context

Mechanism

Outcome

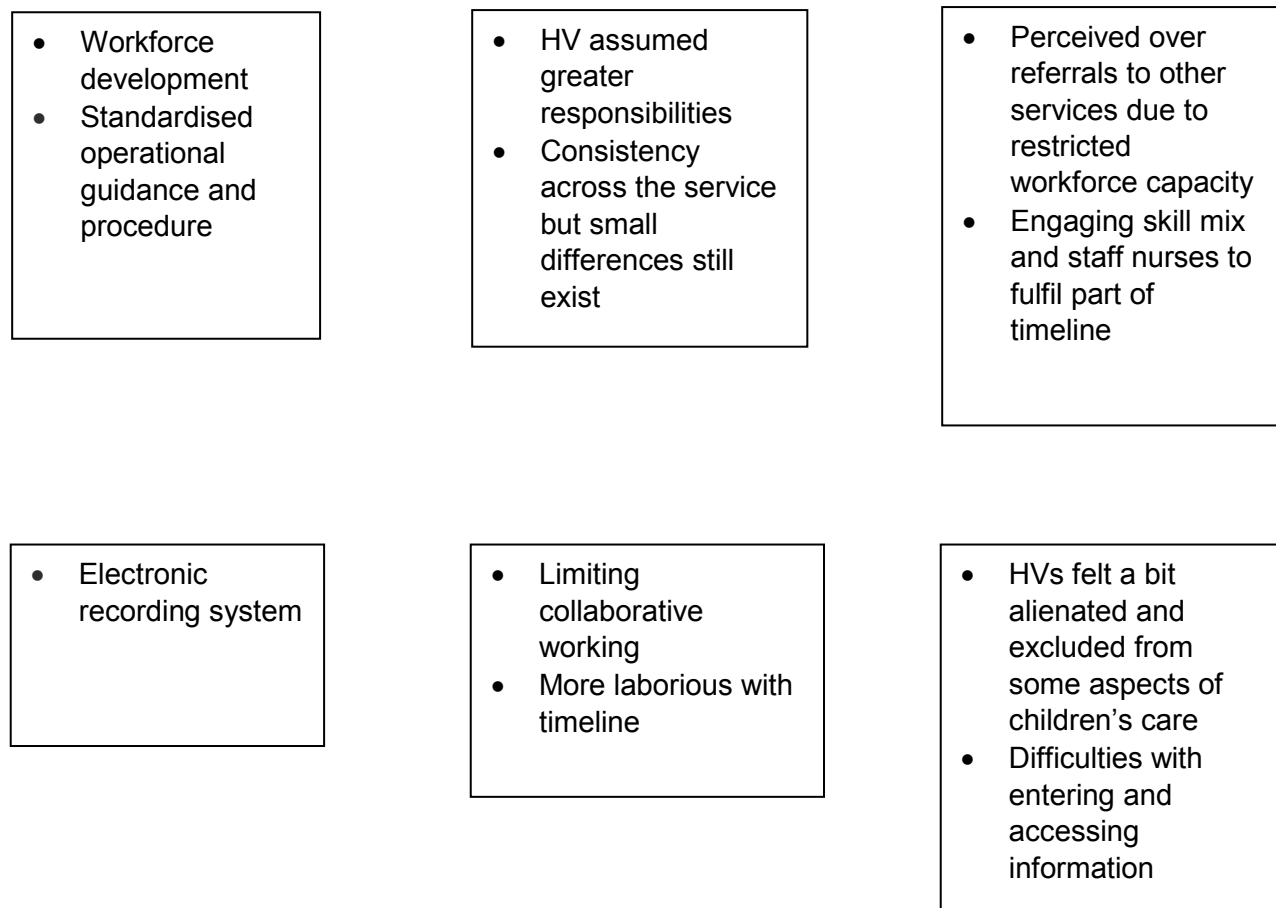


Figure 7 Refined CMOs for Components 5: systems and workforce development

Limitations of this evaluation

6.8 This study did not use experimental design and mainly used qualitative methods to collect data. As such, outcomes cannot be robustly linked to the activities offered by the programme.

6.9 It was practically challenging to obtain data to fully interrogate all the items identified in the initial logic model. For instance, there was no routine data available on reduction in complaint about disparity in service across areas, and it was also not feasible to ascertain this outcome qualitatively.

6.10 Nearing the later stages of the evaluation, recruitment stalled and a member of staff at the study site contacted potential participants directly and informed them about the study. It is likely that this approach led to selection bias, in that individuals with particular characteristics may be more likely to agree to participate.

7 Conclusions

What worked well?

7.1 This evaluation yielded insights into how the enhanced health visiting practice is influencing outcomes for children and families. It also illuminated the difference it is making to health visiting practice in NHS Ayrshire and Arran. Overall, health visitors were almost universally positive about the universal assessment timeline and acknowledged the value it has added to their practice. Parents recognised the change in service and were extremely positive about the current support they received from health visitors.

7.2 Parents reported that the universal timeline improves rapport and enhances trusting relationships with health visitors. A very good number of them indicated that they have contacted their health visitors for support by phone because of the good relationship they have developed with them. Although this does not appear to be different from what was available to parents in the previous service, but what is peculiar was the perceived frequency of phone contacts with the current service.

7.3 Parents reported that their health visitors have been instrumental in terms of assisting them to access wider services both for themselves and their children. Health visitors also reported the changes have improved early engagement with services for families. Engaging children and families with nursery services were particularly highlighted by both parents and health visitors.

7.4 Parents also reported that aside from the support health visitors provided to their children, the current service ensured that their own health and wellbeing also received more attention. Support to deal with postnatal depression was particularly mentioned.

7.5 Health visitors reported that their roles are now much more defined. They believed this has enhanced their professional partnership working and they emphasised that other agencies are much clearer about their role and the services they offer.

7.6 Health visitors reported that an increasing number of families recognised them as first point of contact in various aspects of their health, wellbeing and development. There were some evidence from parents to affirm this assertion.

7.7 Health visitors reported that the universal assessment timeline has empowered them in terms of early identification of concerns, even amongst some families who would previously been considered as core families.

What may need further consideration?

7.8 Both parents and health visitors indicated that gaps between some assessment visits in the timeline were too wide apart.

7.9 Health visitors however, were concerned about referral pathways. They felt they were cumbersome. More so, as they currently identify more concerns, they viewed this as a significant challenge of the enhanced service.

7.10 Almost all parents have had more than one health visitor. However, many reported that this had little or no bearing on the support they received.

7.11 Health visitors universally acknowledged that increased home visiting has been challenging and reported that they struggled to fulfil the entire timeline. It appeared that some areas involved staff nurses and skill mix to fulfil the timeline. Other areas also operated drop-in clinics albeit in a limited fashion.

7.12 Although parents liked the home visiting, a number of them also missed the drop-in clinics. This was also the case for health visitors. Parents valued the peer support that the drop-in clinics used to provide and emphasised the importance of social support from other parents.

Recommendations

For NHS Ayrshire and Arran

1. Provision of clear and less cumbersome guidance on referral pathways would be beneficial to health visitors.
2. Health visitors would benefit from clear guidance as to who does the visits at each stage in the universal timeline.
3. A robust electronic recording system, which is less time consuming but is accessible from the field, would be useful for health visitors.
4. It would be useful for health visitors to have access to children's immunisation records to enable a more holistic service to be provided to children and families.
5. It would be beneficial for the timeline to consider integrating weighing of babies on a more regular basis.

For the nationwide implementation

1. The number of health visitors should be adequate to ensure appropriate caseloads for a more effective delivery of the enhanced service across Scotland.
2. Clear referral pathways should be developed as health visitors are likely to identify more children or parents with additional support needs.

3. The availability of additional support services should be monitored in case more are required to deal with an increase in referrals.
4. Adequate and timely phone support should be built into the service provision. The demand for this might increase, especially as parents were concerned about wider gaps between assessment visits and were also unable to access drop-in clinics.
5. Training and refresher programmes should be made available to health visitors, possibly before the nationwide roll-out of the enhanced service, in subjects such as neurodevelopment, attachment and strength-based skills.

For nationwide evaluation

1. Collection of robust, standardised data is essential to any evaluation. A robust electronic recording system, which captures a range of outcome data and which is accessible from the field should be considered.
2. Collection of data on the following processes and outcomes should be considered:
 - a. parents' and health visitors' experiences of the service;
 - b. relationships and degree of trust between the parents and health visitors;
 - c. additional breastfeeding rates at 4 or 6 months at the health board level;
 - d. how the enhanced service impacts on other services (e.g. nurseries, primary care, social work, speech and language services);
 - e. number of parents and children with additional support needs identified;
 - f. demographics of parents and children (to see whether the programme is addressing health inequalities);
 - g. number of interactions (e.g. phone calls) outside the home visits;
 - h. self-management of common problems and conditions.

Final concluding statement

7.13 NHS Ayrshire and Arran's model of the enhanced health visiting service is currently being delivered with limited resources, yet this evaluation demonstrates a number of positive findings in terms of the value it has added to health visiting practice and indicates promising improvements in outcomes for children and families. There are some findings which the nation-wide roll-out may wish to consider to ensure favourable outcomes, but overall this evaluation should be reassuring for the impending implementation of the programme across Scotland, which promises to offer more resources than are currently available in NHS Ayrshire and Arran.

References

Byng R (2011) What makes a realist evaluation? *Family Medicine*, 43(2): 112-113.

Cowley S, Whittaker K, Grigulis A, Malone M, Donetto S, Wood H, Morrow E, and Maben J (2013) Why health visiting? A review of the literature about key health visitor interventions, processes and outcomes for children and families. National Research Unit, Kings College London. DOH Policy Research ref. 0160058.

ISD Scotland (2014). Maternity and births. Available at <http://www.isdscotland.org/Health-Topics/Maternity-and-Births/Publications/data-tables.asp> (Date accessed 06/06/2015)

ISD Scotland (2015) Childhood Immunisation Statistics - Quarter and year ending 31 December 2014. Available at <http://www.isdscotland.org/Health-Topics/Child-Health/publications/data-tables.asp?id=1164#1164> (Date accessed 06/06/2015)

Marmot M, Friel S, Bell R, and Houweling TA (2008) Closing the gap in a generation: health equity through action on the social determinants of health, 372: 1661-1669.

McKee D and Queen G (2014) Universal assessment group 0-5 years for health visitors in Scotland. A report from the universal assessment sub-group of the children, young people and families national advisory group.

National Records of Scotland (2015) Mid-2014 Population Estimates Scotland. Available at <http://www.nrscotland.gov.uk/files//statistics/population-estimates/midyear-2014/14mid-year-pe-cahb-publication-correction.pdf> (Date accessed 06/07/2015)

Pawson R: Evidence-based policy. A realist perspective. Sage Publications 2006.

Pawson R and Tilley N (1997). *Realistic evaluation*. London: Sage.

Public Health Nursing Services – Future Focus (CEL 13) available at http://www.sehd.scot.nhs.uk/mels/CEL2013_13.pdf (Date accessed 06/06/2015)

Roberts, H (2012) What works in reducing inequalities in child health? 2nd Ed. Chicago: The Policy Press.

Wand T, White K and Patching J (2010) Applying realist(ic) framework to the evaluation of a new model of emergency department based mental health nursing practice, *Nursing Inquiry*, 17: 231-239.

Appendices

Appendix 1. Sample and recruitment

Phase 1. Identifying the programme theory/logic model (linking activities and outcomes)

All eight key stakeholders were given information about the study. A member of the research team contacted them to arrange date and time for focus group. Signed consent form was obtained from each participant before the start of focus group.

Phase 2. Testing the programme theory (does the programme works as anticipated?)

Potential participants (health visitors and parents) were recruited via an administrator at Ayrshire central hospital who has no direct job responsibilities to either health visitors or parents. Participants were sent information pack containing an invitation letter, participant information sheet, expression of interest form and a stamped self-addressed envelope. Interested participants were asked to complete and return an expression of interest form to a member of the research team. All individuals who expressed interest to take part in the evaluation met the inclusion criteria and were contacted directly to arrange a convenient date, time and venue for interview, where a consent form was obtained before interview. Parents were also given an option to participate in a telephone interview. Verbal consent were obtained from those who took part in telephone interviews. Interviews were audio recorded. All parents received £15 high street store vouchers.

Appendix 2. Data collection for phases 1 and 2

Phase 1

The focus group explored key stakeholders accounts of the purpose and key aspects of the structured, increased home visiting programme, its implementation, how it was expected to work and its anticipated outcomes on families and health visiting practice (see appendix 3 for topic guide). Eight key stakeholders agreed to take part in focus group to discuss the activities involved in the enhanced programme and how they could be expected to link with outcomes for children, parents and health visitors. One member of the research team facilitated the focus group, whilst another member recorded the discussions according to key activities implemented and their outcomes expected on a whiteboard. This was done in addition to audio recording. After the focus group, participants reviewed and revised what was recorded on the whiteboard.

Phase 2

Interviews with health visitors focused on perceived changes in practice and their account of perceived outcomes of the programme for children and families (see appendix 4 for topic guide). Parents were asked about their perceptions and experiences of the service and how the changes have influenced them (see appendix 5 for topic guide).

Appendix 3. Topic guide - Stakeholders

1. What are the key changes that have been introduced to Health Visiting since April 2013?
2. What are the key contents that the service will provide over and above what was previously offered?
3. What do you think was the rationale for implementing these new changes?
4. What additional resources were needed to implement these changes?
5. How was it envisaged that the changes would make things better for:
Health visiting practice?
Children and families?
6. How do you think delivery of the revised universal pathway home visits by Health Visitors could improve outcomes for children and families?
7. How are the changes going to contribute in terms of keeping children safe and also promote their wellbeing?
8. What specific plans/structures have been put in place to ensure that Health Visitors improve their knowledge and awareness of community assets, care and referral pathways?
9. What strategies or activities were put in place before the changes were introduced?

(prompt to find out more about whether Health Visitors were trained and details about the training programme)
10. Could you tell me how these changes were implemented?
11. Were there any partners involved in planning or implementing these changes? If so, could you tell me how they were involved?
12. What do you think are the challenges to implementing and delivering this enhanced service?
13. What organisational structures do you think might act as barrier to these enhanced health visiting service?
14. How are you addressing them?
15. What do you think have been the key benefits of implementing these changes to the health visiting service in NHS Ayrshire and Arran?
16. What were you expecting to achieve in the short, medium and long term?
17. In your opinion, what would success look like?
18. What other ways do you think the service can further be improved?

Appendix 4. Topic guide - health visitor

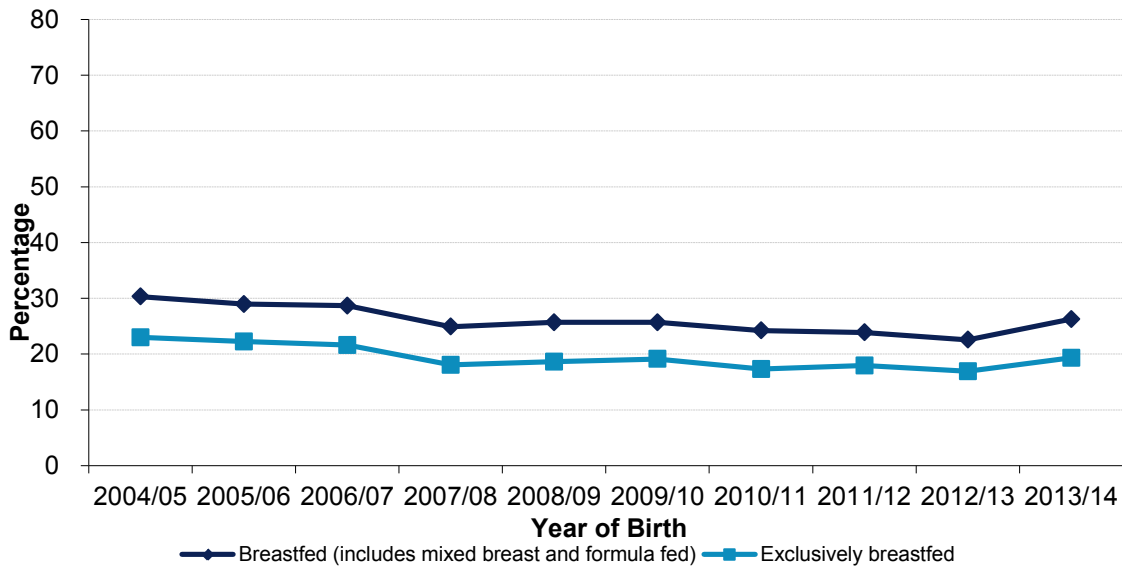
Introduction: A brief description of health visiting changes and explanation of information leaflet/consent process.

1. How is your service responding to the national drive for early intervention and prevention, to ensure that all children have the best start in life?
2. I understand that you are now delivering a structured, increased home visiting service for all families, apart from workload issues what difference has this made for:
 - a. Children
 - b. The families
 - c. Professional partnership working
 - d. You as the Health Visitor
3. What opportunities does a home visiting programme provide you with? Are there specific interventions that you are able to deliver? (prompt: in terms of assessing the child's needs and risks?)
4. Neuro-development, child development and attachment are of key importance to give children the best start in life.
 - a. How has your individual practice changed in response?
 - b. How has service delivery changed in response?
 - c. Do you have any other suggestions to enhance professional learning around Neuro-development, child development and attachment?
5. Has the service you provide enabled you to link to wider services such as nurseries and social work in ways that you had not previously done?
6. Can you give me some examples of interventions or supports that you have been able to access earlier for children and families due to the more frequent contacts?
7. Does the home visiting service and universal contacts allow you to:
 - a. Strengthen relationships with families?
 - b. Improve outcomes for children and families?
 - c. If so how?
8. Has the increased visit schedule affected other parts of your work? If so, in what ways?
9. We know that the introduction of an enhanced home visiting programme in Ayrshire has been challenging due to workload and high caseloads. However when Ayrshire has the additional 50 Health Visitors what will you be able to provide that you are currently unable to do, due to workload constraints?
10. What are the differences between assessing children in their home to a clinic setting?
11. I understand that Ayrshire Health Visitors promote a less advisory approach when working with families and moved to an individual asset and strength based way of working.
 - a. How do you understand the term strengths based working?
 - b. How has this influenced your practice?
 - c. What is your experience of working with families in this way?

Appendix 5. Topic guide - Parents

1. What age is your child/children?
2. How do you feel about the number of visits you have received from your HV so far?
3. Have these visits been carried out by the same Health Visitor? If not do you know why?
4. If you have other children, has your experience of having a Health Visitor changed?
5. How do you feel about the quality of visits you have received? Do you feel supported by your HV?
6. Can you tell me what support you received from your Health Visitor? (prompt: in terms of supporting you with knowledge and skills of being a parent?) Did the HV help you with issues/concerns that were important to you?
7. What support did you receive from your Health Visitor regarding feeding your child?
 - a. Was this enough?
 - b. If not, what else would have helped?
8. Do you feel that your views are always considered as part of your child's assessment?
9. Are you able to contact your Health Visitor with any concerns?
10. Has your Health Visitor helped in terms of engaging your family with other services or professionals? If so how?
11. What is the most important part of having a Health Visitor to you?

Appendix 6. Breastfeeding at the 6-8 Week in NHS Ayrshire and Arran



Appendix 7. Annual Primary Immunisation Uptake Rates in NHS Ayrshire and Arran

	2008	2009	2010	2011	2012	2013	2014
Diphtheria	97.0	98.4	97.6	..	..	..	..
Tetanus	97.0	98.4	97.6	..	..	..	..
Pertussis	96.9	98.4	97.6	..	..	..	..
Polio	97.0	98.3	97.6	..	..	..	..
Hib	96.9	98.3	97.6	..	..	..	..
DTP/Pol/Hib	..	..	..	98.0	98.3	98.6	98.3
MenC	97.2	98.2	97.6	97.8	98.2	97.6	99.0
PCV	97.2	98.4	97.9	98.1	98.4	98.6	98.5



© Crown copyright 2015

You may re-use this information (excluding logos and images) free of charge in any format or medium, under the terms of the Open Government Licence. To view this licence, visit <http://www.nationalarchives.gov.uk/doc/open-government-licence/> or e-mail: psi@nationalarchives.gsi.gov.uk.

Where we have identified any third party copyright information you will need to obtain permission from the copyright holders concerned.

The views expressed in this report are those of the researcher and do not necessarily represent those of the Scottish Government or Scottish Ministers.

This document is also available from our website at www.gov.scot.

ISBN: 978-1-78544-651-1

The Scottish Government
St Andrew's House
Edinburgh
EH1 3DG

Produced for
the Scottish Government
by APS Group Scotland
PPDAS56548 (10/15)
Published by
the Scottish Government,
October 2015



Social Research series
ISSN 2045 6964
ISBN 978-1-78544-651-1

Web and Print Publication
www.gov.scot/socialresearch

PPDAS56548 (10/15)