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The Provision of 0–5 Specialist Public Health Nursing Service Evaluation in the London Borough of Tower Hamlets

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RESEARCHTHATMATTERS

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BAME – Black, Asian and minority ethnic
BMI – Body Mass Index
FGM – Female Genital Mutilation
FNP – Family Nurse Partnership
HCP – Healthy Child Programme
HSE – Health Survey for England
HV – Health Visitor
IDACI – Income Deprivation Affecting Children Index
KPI – Key Performance Indicator
MASH – Multi-Agency Safeguarding Hub
MECSH – Maternal Early Childhood Sustained Home-visiting
NEET – Not in Education, Employment or Training
NHS – National Health Service
ONS – Office for National Statistics
SEND – Special Educational Needs and Disabilities
SOP – Standard Operating Procedures
SUDI – Sudden Unexpected Death in Infancy
WHO – World Health Organization

1. Executive summary

1.1 Background

The Healthy Child Programme (HCP) for the early life stages focuses on a universal preventative service, providing families with a programme of screening, immunisation, health and development reviews, supplemented by advice around health, wellbeing and parenting. The HCP includes a Health Visiting Service for children aged 0 to 5 years, and a School Health Service for ages 5 to 19, alongside the Family Nurse Partnership, which aids first-time young mothers from pregnancy to 2 years. Acting as an early intervention and prevention public health programme, the HCP is the cornerstone of our universal service for children and families. Particularly crucial during this stage of life, its widespread reach presents a vital opportunity to identify families needing extra support and children at risk of poor outcomes.

The Tower Hamlets Health Visiting Service provides comprehensive support to families with children from birth to age 5. All children born or living in Tower Hamlets can have several check-ups with the Health Visiting Service, starting before birth and continuing until they turn 5. As part of the free National Health Service (NHS), it includes home visits, health checks, immunisation, and parenting advice from trained health visitors. Health visitors are nurses or midwives with specialised training in child development and public health, who help families keep their children healthy by identifying early signs of problems, and who offer guidance on topics such as nutrition and breastfeeding. The service also includes the Family Nurse Partnership (FNP) for young, first-time parents, offering intensive home visits to improve health and social outcomes. Additionally, the Maternal Early Childhood Sustained Home-visiting (MECSH) programme provides extra support in Tower Hamlets through structured home visits to promote the wellbeing of mothers and children, with interpreters available for non-English speakers. This voluntary programme includes at least 25 visits from pregnancy until the child is 2 years old, covering topics such as feeding, sleeping and child development. Families can contact the 0–19 Single Point of Access for more information or to participate in the programme.

Tower Hamlets presents a unique landscape, with its high population density and the lowest median age among all local authority areas. Notably, a significant proportion of its population comprises young children, with almost half of all children in the borough living in poverty. In Tower Hamlets, vulnerable children face multiple health challenges spanning mortality, morbidity and behaviours. While infant mortality rates have improved, investigations into sudden unexpected death in infancy (SUDI) reveal concerning risk factors, such as exposure to tobacco smoke. Children aged 1–4 exhibit mortality rates second only to older teens, with disparities across ethnic and socioeconomic groups. Morbidity data show higher hospital admission rates for newborns and under-5s, mainly for respiratory issues and injuries. Additionally, reception-aged children face elevated obesity rates, poor oral health and potential mental health issues. Despite high breastfeeding rates, exclusive breastfeeding falls short of targets, and vaccination coverage is inadequate. A significant proportion of children also experience poverty, linked to adverse health outcomes and disparities in health-promoting behaviours.

The aim of the evaluation was to gain a clearer understanding of the delivery processes and the outcomes/impacts of the Tower Hamlets Health Visiting Service, Family Nurse Partnership and MECSH programme. This understanding would help better comprehend the needs of families and children aged 0–5 residing in the London Borough of Tower Hamlets. The feedback received would then be used to enhance the service design for the Tower Hamlets 0–5 Specialist Community Public Health Nursing Service.

Between January and April 2024, the Institute for Connected Communities conducted a comprehensive evaluation. This included in-depth qualitative interviews with service users and service staff, discussions

with families, surveys of stakeholders and service staff, analysis of service activity data, and benchmarking of key performance indicators (KPIs), both within London and nationally.

1.2 Key findings

In Tower Hamlets, the performance of the Health Visiting Service has varied across different programmes. For the Universal Health Visiting Service, patient satisfaction was mixed, with many finding the service unpredictable. Changes in delivery modes due to the pandemic have led to a combination of in-person and remote services. There is some inconsistency in how the workforce and leadership describe the current delivery mode, with parents generally dissatisfied with the frequent changes in health visitors but still receiving the stated services. Parents and children without specific issues interacted with health visitors at set intervals, and they did not expect more. However, some community members were reportedly not being reached due to communication barriers. Support structures for refugee families are in place, but language barriers frustrate parents, who often rely on older children or male relatives for translation. Staff shortages have made it challenging to maintain continuity of care, with higher grade staff particularly overworked. While leadership is responsive to training needs, higher grade staff have limited time for training. While the team is predominantly from non-paediatric nursing backgrounds, it would benefit from a broader range of expertise. While the borough warmly welcomes vulnerable families, such as the homeless and asylum seekers, the workforce grapples with a turbulent and ever-changing system, constrained by limited resources to adequately meet the needs of both established and transient communities.

Overall, the Tower Hamlets Health Visiting Service performs well regionally and nationally, particularly in early engagement, proactive support and meeting KPIs. However, there is room for improvement in community engagement through workshops and in reducing service delivery challenges. By learning from the practices of other London boroughs, Tower Hamlets can continue to enhance its Health Visiting Service and better support its diverse community. The current service provider should be asked to provide an input during the development of the new service specification on: (1) what improvements need to be made to address issues of national health visitor shortages; (2) timescales for service improvement and innovation; and (3) how to respond to changing birth rates across the new life of the contract. This process should consider the monitoring and reporting needs of the commissioner, the national shortage of health visitors, the provider's ability, a timeline to innovate the service, and the changing birth rates in the area.

The MECSH service suffers from a lack of primary and service data. Commissioners believe that the service lacks quality data and proper monitoring, leading to underperformance against KPIs. There is a disconnect between the expected outcomes based on the Australian model and current commissioning specifications, causing confusion among the workforce about their delivery expectations. Parents receiving MECSH services are often unaware if they are participating in MECSH or Universal services, with the focus remaining on parent and child interactions. The current programme model has proven inadequate in addressing the evolving needs of vulnerable families within the borough. It demands a significant level of engagement from these families to derive substantial benefits, a requirement that is rarely met with enthusiasm.

The FNP programme has received very good patient satisfaction due to its personalised approach. Consistent health visitors are assigned before birth, and they adopt a hands-on approach that goes beyond routine checklists. The service employs highly qualified family nurses, and the workforce feels confident in their practice, particularly in attachment theory. The programme targets first-time young parents and works with various family structures, adopting a sensitive and relational approach. The FNP workforce is small but high performing, with good communication and supervision, and shared office space. They deliver in-person services fortnightly with additional support as needed, and they are always available by phone. Occasionally, FNP staff support the Universal service with routine visits. Transitioning families from FNP to Universal services is challenging due to the shift from intensive, personalised care to less frequent interactions.

Parents with complex needs, including mental health issues, refugees and asylum seekers, receive substantial support, resulting in high satisfaction. Dedicated and knowledgeable health visitors provide tailored support, boosting parental confidence and working around parents' schedules. However, parents needing minimal support often experience frequent changes in health visitors, leading to dissatisfaction and the perception of the service as a tick-box exercise. Overall, the service helps with developmental milestones for all groups, with basic support acknowledged universally.

1.3 Recommendations

Based on the information provided, here are some key points and recommendations for improving the Health Visiting Programme:

1. **Clarify and Narrow Focus**: The programme should concentrate on priority outcomes, such as promoting childhood immunisations, breastfeeding, child development and school readiness. This focus will streamline efforts and improve accountability. The priority outcomes need to be very explicit in the new service specification, with KPIs attached to each area of focus, which encompass more than the 5 mandated reviews.

2. **Co-develop and/or Review Key Performance Indicators (KPIs)**: Establish clear KPIs to track performance and ensure accountability. This will help measure the programme's effectiveness and identify areas needing improvement.

3. **Enhance Health Promotion**: Shift from solely meeting KPIs to prioritising health promotion initiatives. This may require additional resources, and a change in organisational culture to emphasise the importance of health promotion.

4. **Address Workforce Shortages**: Implement strategies to address the national shortage of midwives and nurses transitioning to health visiting roles. Consider initiatives to attract and retain qualified health visitors, such as investing in training and development opportunities with overseas HE partners, which reflect the ethnicities/cultures of the borough. Implement a system that is prepared to address nurse workforce shortages in the periods when nurses transition into health visiting roles; for example, start recruitment earlier to replace staff nurses who move on to health visiting roles.

5. **Improve Accessibility**: Tackle challenges related to appointment scheduling and accessibility for parents with multiple toddlers. Explore options for providing appointments closer to clients' homes, and improving facilities to accommodate parent–child treatments as highlighted in the commissioning guidance (1).

6. **Enhance Training and Practice Implementation**: Develop strategies to integrate training, such as newborn observational training for mothers with mental health problems, into daily practice. This may involve ongoing support, mentoring and opportunities for reflective practice.

7. **Strengthen Administrative Capacity**: Allocate resources to improve administrative processes, appointment booking, and monitoring of mothers and babies. This may require investing in technology and training staff to streamline administrative tasks.

8. **Enhance Data Utilisation**: Improve data use (i.e. data sets that speak to each other) to inform and shape practice. Develop systems for collecting, analysing and utilising data to evaluate programme effectiveness and identify areas for improvement, and to mitigate risk and the vulnerabilities in the

system. A tool such as The Institute of Health Visiting Outcomes and Evaluation enables providers to measure and evaluate the impact of their work.

9. **Improve Engagement with Communities**: Address barriers to engagement, particularly with settled white East End populations and Bangladeshi brides. Explore culturally sensitive approaches to build trust and facilitate communication, such as engaging community leaders and providing culturally relevant resources.

10. **Ensure Clinical Leadership**: Consider appointing a programme lead with a clinical qualification to provide leadership and guidance. This individual can ensure a focus on evidence-based practice and quality improvement initiatives. Someone with public health backgrounds is needed to connect systems at the corporate level, beyond one organisation and one service. It is essential that the service improvements are viewed through a public health lens, and new KPIs are only to be implemented if they focus on improving public health outcomes.

11. **Group-centred Support**: To combat understaffing, supplement one-on-one health visitor sessions with group-centred support.

12. **Clear Communication of Appointments**: Clearly communicate appointment times in advance to address issues of forgetting, losing, and not memorising dates, as well as last-minute appointments.

13. **Expand Reach to Marginalised Parents**: The service's reach is generally good, but it is less effective with marginalised parents, due to using traditional methods of communication. Explore new ways to make these individuals aware of the service.

14. **Improve Data Sharing**: The full range of primary data collected by the service is not being shared evenly across all levels. Improve data sharing, both vertically and horizontally, implement agreed data-sharing protocols with partners and other providers to improve co-ordination and communication.

15. **Transition Period for FNP and MECSH**: Introduce a transition period for parents moving from the Family Nurse Partnership (FNP) and Maternal Early Childhood Sustained Home-visiting (MECSH) programmes. This will help parents adjust to the new service regime, manage expectations, reduce dependence, and ensure that they are adequately signposted to community-based services to fill any gaps.

By addressing these key areas, the Health Visiting Programme can better achieve its goals of supporting families to better support their children, and can improve overall programme effectiveness.

2. Introduction

Health visiting plays a crucial role in supporting the health and wellbeing of children and families through relationship-based care and delivery of the 0–5 years Healthy Child Programme (HCP) (2). The HCP provides an evidence-based framework for universal interventions from the antenatal stage up to school entry. Whilst health visitors lead the delivery of the HCP and use their clinical judgement to identify health needs, the need for a skill-mixed workforce to meet changing needs was acknowledged 15 years ago (3).

The implementation of the '4-5-6' health visiting service delivery model (4) coincided with the government's deadline to increase the number of health visitors by 2015 (5). Health visitor retention and attrition remain a challenge (6, 7, 8), and the COVID-19 pandemic further impacted service delivery and accessibility, particularly for vulnerable children and families (9). A review of the HCP and 4-5-6 model aimed to address its limitations with an updated evidence base (10).

A personalised place-based approach, that is, 'Universal in Reach – Personalised in Response' supersedes the 4-5-6 model and supports the government's 'No child left behind' (11) ambition. The new service delivery model has four levels of Health Visiting Service – community, universal, targeted and specialist – delivered by a skill mix of registered specialist public health nurses (health visitors), registered community staff nurses, community nursery nurses and support workers. Mandated reviews at key contact points (12) are opportunities to identify where additional contact and support are needed for early intervention.

Strategic goals of the service

In addition to mandated services are voluntary evidence-based interventions delivered by health visitors for the most vulnerable families. Interventions include the home-visiting Family Nurse Partnership (FNP) Programme (13) for teenage and young parents, and the MECSH programme (14) for vulnerable and at-risk mothers. The programmes provide relationship-centred care within a support system to reduce vulnerabilities and improve health inequalities. Targeted home-visiting programmes have demonstrated positive longer term outcomes on early child development (15), and have highlighted the importance of home-visiting for developing trusting relationships between health visitors and parents (16, 17, 18).

Commissioning guidance acknowledges health visitor expertise as leaders of the HCP, and the health visiting skill mix works in partnership with providers for continuity of care. The updated HCP and service model aims to mitigate barriers in service delivery and accessibility with a personalised response. A place-based approach is a driver for identifying and assessing local needs, where communities contribute to positive health and wellbeing, and local assets provide opportunities for developing local solutions for improving outcomes for the 0–5 population (19). The current HCP outlines a suggested timetable for all families, including specific contact points from pregnancy through early childhood. These are detailed as follows:

- Pregnancy
- Birth to one week
- One to six weeks
- Six weeks to six months
- Six months to one year
- One to three years
- Three to five years

The HCP is designed to support the wellbeing of children and families through various measures. It identifies and addresses needs and risks early, conducts health checks, and provides screenings and vaccinations. It also supports social and emotional development, offers parenting support, and adopts a family-centred approach. Furthermore, it emphasises promoting healthy behaviours and adjustments based on family assessments.

This evaluation is part of the Maternity and Early Years team's efforts within the Healthy Children and Families team of the Public Health Division. The 0–5 Specialist Public Health Nursing contract delivers components of the Healthy Child Programme to children aged 0–5, supporting families from pregnancy to school entry. Tower Hamlets also commissions the Family Nurse Partnership, offering intensive home visits to teenage and young parents, and the MECSH programme, providing intensive nurse home visits to vulnerable mothers.

Why this review was needed

The historical challenges faced by the borough include a broadly defined specification for the health visiting service and the absence of KPIs to ensure accountability. Despite service improvement being a contractual obligation, there has been a lack of capability to implement these improvements. Contract management is handled by a part-time individual with a business background, rather than a healthcare background, resulting in a narrow focus on meeting KPIs rather than promoting overall health. Additionally, the national shortage of midwives and nurses transitioning to health visitor roles has further impacted the service delivery.

The Tower Hamlets Council Children and Families strategy for 2024–29 aims to create a child-friendly borough where all children and young people thrive, achieve their best, have opportunities, and are heard. Developed with input from children, families and partners, this strategy is built on six key ambitions:

1. Ensuring every child has a great start in life.
2. Promoting the best possible health during childhood.
3. Providing timely support for mental health and wellbeing.
4. Offering appropriate support for children with special educational needs or disabilities.
5. Ensuring children feel safe and secure.
6. Helping children achieve their best in education and career development.

The strategy also addresses broader societal barriers, focusing on:

7. Supporting families facing cost of living and child poverty challenges.
8. Advocating for co-production, equality and anti-racism.

The strategy is guided by values such as being child-focused, collaborating with families, adopting a strengths-based and trauma-informed approach, and actively combating discrimination and racism. These values align with the principles of the wider Tower Hamlets Partnership Plan and the United Nations Convention on the Rights of the Child.

3. Aim

The aim of the evaluation was to gain a clearer understanding of the delivery processes and the outcomes/impacts of the Tower Hamlets Health Visiting Service, Family Nurse Partnership, and Maternal Early Childhood Sustained Home-visiting programme. This understanding would help better comprehend the needs of families and children aged 0–5 residing in the London Borough of Tower Hamlets. The feedback received would then be used to enhance the service design for the Tower Hamlets 0–5 Specialist Community Public Health Nursing Service.

4. Objectives

The objective of the evaluation is to help us to answer the following questions:

- Should the service remain with the current provider?
- What improvements could be made to the service to ensure accessibility, effectiveness and patient satisfaction?
- Does the population need, and evidence of effectiveness indicate, the continued commissioning of the additional elements for vulnerable families (Family Nurse Partnership, MECSH programme)?

5. Methodology

The evaluation was shaped by Pawson and Tilley's (20) realist evaluation approach to investigate what worked for whom, in what circumstances, in what respects, and how. This approach stresses the need to evaluate programmes within their context, and to assess the mechanisms and processes that produced specific outcomes. The development of the interview guides was informed by Normalisation Process Theory (May and Finch, 2009), a conceptual framework for explaining what people do to implement a new practice. The study adopted a multi-method approach, with data collection, collation and analysis consisting of interviews, practitioner logs and surveys with a range of stakeholders, including residents, programme partners, trainees and wider stakeholders. These primary data were supplemented with the analysis of administrative data captured by the programme partners and shared with Tower Hamlets Council. Furthermore, the effectiveness of the London Borough of Tower Hamlets Health Visiting Service was evaluated against local, regional and national indicators using secondary quantitative data.

The aim of this approach was to rapidly gather insights into the planning and delivery of the intervention, and to gain an understanding of the workforce and participants' experiences of the Health Visiting Service. By using a combination of approaches, the evaluation aimed to provide a comprehensive picture of the programme and its effectiveness, and to identify areas for improvement.

The quantitative data accessed and utilised for the evaluation assessment include:

1. Monitoring returns for the Tower Hamlets MECSH programme, covering service delivery data from March 2019 to the present.
2. Monitoring returns for the Tower Hamlets FNP programme, encompassing service delivery data from March 2019 to the present.
3. Service delivery data for the FNP programme in Hackney and Newham, sought for the period from March 2019 to the present, pending assistance in obtaining access.
4. If available, equivalent service delivery data for the MECSH programme in Newham and Hackney, from March 2019 to the present.
5. A report detailing the skill mix within the Health Visiting Service.
6. Delivery metrics for the Health Visiting Service for the years 2021–22 and 2022–23.

Population data were sourced from the Office for National Statistics (ONS) website (https://www.ons.gov.uk). Public health data were collected using the Fingertips Public Health Data API (https://fingertips.phe.org.uk/api), and from the Public Health Research and Statistics provided through the UK Government website (https://www.gov.uk/health-and-social-care/health-improvement). Quantitative data were processed and visualised with use of the diverse packages within the R programming environment. Indicators for FNP targets, service delivery, client engagement and drop-out, as well as MESCH service delivery and uptake were not available for the years 2019–21. In part, this was due to a

change in KPIs from 2022 onwards. Public data had missing data; the reasons provided for this were for data quality incompleteness of source data. This includes indicators for: breastfeeding prevalence at 6–8 weeks (missing 2019 and 2021), premature births and infant mortality (missing 2021–23), drinking and drug misuse during pregnancy, and the number of teenage mothers were completely missing.

In the qualitative stage, the team conducted interviews with residents, health visitors and stakeholders to gain both top-down and bottom-up perspectives on the impact and outcomes of the Health Visiting Service initiative. These interviews were digitally recorded with consent, and analysed using an analytical framework that incorporated the central research questions:

1. Should the service remain with the current provider?
2. What improvements could be made to the service to ensure accessibility, effectiveness and patient satisfaction?
3. Does the population need, and evidence of effectiveness indicate, the continued commissioning of the additional elements for vulnerable families?

The team triangulated both primary and secondary data to ensure a comprehensive analysis, leading to robust evaluative evidence and insights to help inform and shape the recommissioning of the Health Visiting Service. Tower Hamlets stands out as the most densely populated local authority in England, experiencing the largest population increase between 2011 and 2021 at 22.1%, compared to London's overall increase of 7.7%. With over 19,000 children under 4 years old, and more than a quarter of households having dependent children, it has a youthful demographic. Tower Hamlets has the lowest median age in England at 30 years old, significantly younger than the national average of 40. The borough's population is ethnically diverse, with Asian ethnicity representing the largest proportion at 44.4%, followed by white at 39.4%, black at 7.3% and mixed ethnicity at 5%. Notably, approximately 47% of children under 5 in Tower Hamlets are estimated to have Bangladeshi ethnicity, according to data from Barts Health NHS trust.

Sample population

A total of 50 participants[1] took part in the data collection. The details of participant groups in each type of data collection method are summarised below (Tables 5.1–5.4).

A total of 16 participants responded to the Practitioner Reflection Sheet (see Appendix 1/d), out of which 10 (62.5%) represented the Universal Health Visiting Service, 5 (31.25%) represented the Family Nurse Partnership and 1 (6.25%) represented the MECSH programme (Table 5.1).

Table 5.1 Practitioner Reflection Sheet participant characteristics

Role	Number of participants	Percentage of participants
Universal Health Visiting Service	**10**	**62.50%**
0–19 Clinical Director	1	6.25%
Locality Clinical Manager – Band 7	2	12.50%
Health Visitor – Band 6	3	18.75%
Community Nursery Nurse – Band 4	3	18.75%
Clinical Support Worker – Band 3	1	6.25%

[1] Please see Limitations section regarding potential duplication of data collection from participants.

MECSH Programme	**1**	**6.25%**
Health Visitor	1	6.25%
Family Nurse Partnership	**5**	**31.25%**
Family Nurse – Band 7	4	25%
Family Nurse Partnership Supervisor – Band 8a	1	6.25%
Total Practitioner Reflection Sheet Participants	**16**	**100%**

A total of 3 stakeholders responded to the Stakeholder Survey (see Appendix 1/e), representing three organisations (Table 5.2).

Table 5.2 Stakeholder Surveys – participant characteristics

Organisation	**Number of participants**	**Percentage of participants**
Look Ahead Campbell Rd YP services	1	33.33%
Tower Hamlets GP Care Group	1	33.33%
Unknown	1	33.33%
Total Stakeholder Survey Participants	**3**	**100%**

A total of 31 participants took part in qualitative in-depth interviews. The practitioner qualitative interviews (see Appendix 1/a and 1/b) were conducted with 13 participants, including 2 commissioners, 2 GPs, 7 staff members from the Universal Health Visiting Service and 2 staff members from FNP (Table 5.3).

Table 5.3 Practitioner Qualitative interviews – participant characteristics

Role	**Number of participants**	**Percentage of participants**
Commissioner – Tower Hamlets Public Health	2	15.38%
General Practitioner	2	15.38%
Universal Health Visiting Service	**7**	**53.85%**
0–19 Clinical Director	1	7.69%
Operations director 0–19 services	1	7.69%
Health Visiting Service Clinical Lead	1	7.69%
Health Visitor – Band 6	1	7.69%
Staff Nurse – Band 5	1	7.69%
Community Nursery Nurse – Band 4	1	7.69%
Clinical Support Worker – Band 3	1	7.69%
Family Nurse Partnership	**2**	**15.38%**
Family Nurse – Band 7	1	7.69%
Family Nurse Partnership Supervisor – Band 8a	1	7.69%

Total Practitioner Qualitative Interview Participants	**13**	**100%**

We conducted 17 parent qualitative interviews (see Appendix 1/c) with a total of 18 parents. Two parents took part in a paired interview. Half of the sample (9 parents) required interpretation during the interview. Most parents were engaged with the Universal Health Visiting Service (12 parents, 66.67% of the parent interview sample), while 5 parents (27.78%) were engaged with FNP, and 1 (5.56%) with the MECSH programme (Table 5.4)

Table 5.4 Qualitative interviews with parents – participant characteristics

Participants	Number of participants	Percentage of participants
Universal Health Visiting Service	**12**	**66.67%**
Mothers – without Interpretation	4	22.22%
Mothers – required interpretation	8	44.44%
MECSH programme	**1**	**5.56%**
Mothers – without Interpretation	1	5.56%
Family Nurse Partnership	**5**	**27.78%**
Mothers – without interpretation	3	16.67%
Mothers – required interpretation	1	5.56%
Fathers – without interpretation	1	5.56%
Total Parent Qualitative Interview Participants	**18**	**100%**

Protecting the identities of participants is extremely important. Although we have taken steps to anonymise the data, the way the commissioning structure and team roles are set up unintentionally makes it possible to guess who some participants might be. To maintain integrity, we have kept team names unchanged and have paraphrased direct quotations. Each participant is assigned a unique ID to ensure anonymity. This method ensures that the research respects confidentiality while accurately presenting its findings.

The prevention of ill health and the promotion of good health

Deprivation Index Score

In Tower Hamlets, poverty rates exceed those of other London boroughs and regions across England, leading to adverse effects on the wellbeing of both residents and their children. Astonishingly, 43% of families with children aged 0 to 4 live in relative poverty, encompassing 3,680 children, with 7% experiencing food poverty and 52% facing fuel poverty. Additionally, 44% are eligible for the national Healthy Start scheme. Alarmingly, even after housing costs are considered, 47.5% of children in Tower Hamlets live in poverty, the highest rate in the UK. Moreover, a significant 78% of children under 5 reside in areas classified within the most deprived 40% of households according to the Index of Multiple Deprivation. This highlights the pervasive impact of poverty within the borough, necessitating urgent attention and support.

Vulnerable children

Birth rates in Tower Hamlets (see Table 5.5) remained relatively stable through 2019–21, with a slight decrease in 2022.

Table 5.5 Total number of live births per year in Tower Hamlets

Year	2019	2020	2021	2022
No. of births	4,307	4,291	4,381	4,127

Source: ONS

This section provides an overview of the needs of children and young people in North East London, with a specific focus on Tower Hamlets Council. We examine various factors affecting children and young people, including the proportion of children and young people aged 0–25, those impacted by knife crime (aged 1–24), unaccompanied asylum-seeking children looked after (aged 0–21), children referred to social services (aged 0–17), and those not in education, employment or training (NEET), or with unknown status (aged 16–17). Additionally, we explore the proportion of young people with Special Educational Needs (SEN) in secondary schools (aged 11–16), as well as those suspended or permanently excluded from state secondary schools. Data for this analysis were sourced from publicly available data sets.

To restate, vulnerable children in Tower Hamlets face several health and wellbeing challenges. While infant mortality rates have improved, issues such as sudden unexpected death in infancy (SUDI) persist due to modifiable risk factors such as tobacco smoke exposure. Children aged 1–4 have high mortality rates, especially among different ethnic and socioeconomic groups. Hospital admissions for newborns and young children are high, primarily for respiratory conditions and injuries. Reception-aged children experience elevated obesity rates, poor oral health and mental health challenges. Although breastfeeding rates are high, exclusive breastfeeding and vaccination coverage are below targets. Poverty, affecting nearly half of children, exacerbates these health issues and disparities.

Maternal and child health in Tower Hamlets

According to data from 2011 provided by the NHS to Tower Hamlets Council, the two ethnic groups with the highest percentage of births are Asian – Bangladeshi, with 48.86% of births within the London Borough of Tower Hamlets, representing 2,030 newborns, and white British, with 13.8% of births within the London Borough of Tower Hamlets, representing 578 newborns.

Asian – Bangladeshi women have the highest percentage of maternity in the 26 to 29 age range, with 54.91% of births occurring within this age range, while white British women have the highest percentage of births under 18 years old, with 30.43% of births occurring under 18.

In 2009, 66% (87) of conceptions under the age of 18 led to an abortion. This is higher than the average for England (49%) and for London (61%). Although the number and rate of 15–17-year-olds conceiving decreased from the 2003–05 period to the 2006–08 period, the percentage of under-18 conceptions leading to abortion has increased slightly.

Between 2011 and 2012, the midwifery Gateway Team at the Royal London Hospital saw an increase of referrals from domestic violence of 23.8%. Female genital mutilation (FGM) has been observed to be prevalent within the Somali community, with 13 out of 29 women of Somali origin delivering in this period documented as victims of FGM. No evidence of FGM was found in other BAME background women delivering during the period (out of a total of 34 patients).

An audit was extended to retrieve information about the effects of FGM in pregnancy, and to establish adequate procedures to ensure good practice and quality delivering: 74 maternity notes were retrieved, with 47 of these notes being for Somali women; 44 of these women had experienced FGM, 15 had previous repair (reversal), 10 had FGM recorded in the birth register and 19 had FGM recorded in their

maternity notes. No women were documented as having Type 3 FGM, which was unexpected, as according to World Health Organization (WHO) figures, Type 3 was the most prevalent type of FGM amongst Somali women.

Smoking during pregnancy was relatively low in Tower Hamlets, with improvements during the 2010–11 period. The prevalence of smoking at time of delivery was particularly low in pregnant women from the Bangladeshi community: 0.84% of all maternities, compared to 2.2% of white women. Within the group of women smoking at the time of delivery, 61.2% were white and 23.0% were Bangladeshi.

Of pregnant women in Tower Hamlets, 12.3% were found to have a BMI > 30 at booking between 2012 and 2013. Statistics on the prevalence of maternal obesity are not collected routinely in the UK. Trend data from the Health Survey for England (HSE) for the period 1993 to 2010 show an increase in the prevalence of obesity (BMI at least 30 kg/m2) amongst women of childbearing age between 16 and 44 years.

Data from Public Health England/United Kingdom Health Services Agency lists Tower Hamlets infant mortality rate as 3.3, lower than the rate for England (3.9) in the period between 2018 and 2020. However, child mortality is slightly higher, with a rate of 11.1 in Tower Hamlets and a rate of 10.3 for the whole of England.

For this period, child vaccination rates have worsened in Tower Hamlets, with values below the English average.

School readiness, or percentage of children achieving a good level of development at the end of reception, has improved, and is above the national average, with a percentage of 69.9% for Tower Hamlets in comparison to the English average (63.2%).

While below the English average, the number of children in low-income families has increased in Tower Hamlets, in both relative (28%) and absolute (22.1%) terms.

Violence against women

The Violence Against Women and Girls Strategy 2016–19 that the London Borough of Tower Hamlets envisioned acknowledges that violence against women and girls is a significant problem in the borough. In this document, Tower Hamlets is listed as being the local authority with the sixth highest number of recorded sexual offences in England. Furthermore, between 2014 and 2015, Tower Hamlets had the ninth highest prevalence in London for rape, and the sixteenth for sexual offences.

Tower Hamlets consistently has one of the highest rates of reported domestic abuse across London. Between November 2014 and November 2015, there were 2,773 domestic crimes reported, which is a 13.3% increase on the previous year, meaning that Tower Hamlets had the third highest rates of reporting in London, after Croydon and Greenwich.

Moreover, the document expresses concern about a significant number of conditions that make women within the borough particularly vulnerable, such as mental health, substance issues, language barriers or disabilities. Such support needs are known to make women affected by violence less likely to seek help or assistance from authorities and health providers.

According to this document, similar levels of violence affect LGBT individuals, and it acknowledges that both men and women can be victims and perpetrators. However, approximately 97% of all known victims of interpersonal violence in Tower Hamlets were female.

Furthermore, recent reports from PHE/UKHSA reiterate risk factors identified in the 2012 report by Tower Hamlets, specifically an association existing between domestic violence and antenatal depression, postnatal depression, post-traumatic depression, anxiety and PTSD. However, the report states that it is unclear whether domestic violence increases the risk of mental health decline or whether, conversely, mental health problems might result in vulnerability to domestic violence. In any case, the relationship between all the conditions is solid, even if a causal relationship has not been established. The report also

reiterates substance abuse, homelessness and teenage pregnancy as risk factors that might negatively impact mental health during pregnancy.

6. Findings/outcomes

This section summarises the key findings from the evaluation. To demonstrate the impact of the national Healthy Child Programme on communities in Tower Hamlets, we used a mix of qualitative and quantitative data, community feedback and comparative studies.

Universal Health Visiting Service

The Universal Health Visiting Service in the UK is a nationwide programme that offers support and guidance to families with children from birth to age 5. It is a key part of the National Health Service, and it is completely free. Health visitors, who are trained nurses or midwives with additional training in child development and public health, provide these services along with staff nurses, nursery nurses and clinical support workers. They aim to help families to keep their children healthy and happy by spotting any early signs of problems, giving advice on parenting, nutrition and child development, and referring families to other services, if needed. The service includes home visits, health checks, vaccinations and help with parenting skills. Health visitors also offer information on topics such as breastfeeding and creating a safe home. Overall, the Universal Health Visiting Service is vital for giving families the support they need to ensure that their children grow up healthy and well.

Service access and coordination

In Tower Hamlets, the process begins as soon as a woman is booked for pregnancy. She sees a midwife, and a referral is made to the Health Visiting Service, which typically engages with the expectant mother around the 28- to 30-week mark of her pregnancy. This early engagement ensures that the mother is aware of the service and what to expect once the baby is born. The handover from midwifery to health visiting happens about 14 days post-birth, with proactive follow-up appointments scheduled. This seamless transition aims to provide consistent and accessible care.

Research insight: Overview of Health Visiting Services in Tower Hamlets, Hackney and Newham

The Healthy Child Programme is a national initiative aimed at improving child health outcomes through a structured Health Visiting Service. This service operates across three levels: Universal, Universal Plus (Targeted) and Universal Partnership Plus (Specialist). The Universal level includes standard visits for all families, while Universal Plus provides additional support for those needing it. Universal Partnership Plus offers extra visits and specialised help for families with significant needs. The Family Nurse Partnership, supporting young first-time mothers from pregnancy until their child turns 2, is a key component available in both Newham and Tower Hamlets. Tower Hamlets also offers the MECSH service for families with complex needs, likely covered under Newham's Universal Partnership Plus and FNP reporting.

Hackney's Health Visiting Service distinguishes five levels of engagement: Community, Universal, Targeted, Specialist (based on individual and family needs), and an Intensive Home Visiting Service, also known as the Family Nurse Partnership.

Service delivery and public health data show that Tower Hamlets and Hackney achieve better public health outcomes compared to Newham. Despite this, Newham showed greater resilience in maintaining service delivery during the COVID-19 pandemic. All three boroughs exceeded targets for New Birth Visits within 30 days, although Tower Hamlets consistently met subsequent review targets (6–8 weeks, 12 months, 2–2.5 years), except during the pandemic.

In terms of developmental outcomes in 2023, the percentage of 2–2.5-year-olds achieving a good level of development was 87% in Hackney, 85% in Tower Hamlets and 79% in Newham. However, these gains did not consistently translate into school readiness, with the percentage of children achieving a good level of development by the end of reception being 70% in Newham, 69% in Hackney and 65% in Tower Hamlets.

The demand for Health Visiting Services varies across the boroughs. As of mid-2022, Newham had the highest number of children aged 0–4, with 24,354, compared to 18,876 in Tower Hamlets and 16,177 in Hackney. Economic deprivation levels,

measured by the Income Deprivation Affecting Children Index (IDACI) Decile, are similar across the boroughs, averaging 2.7 in Tower Hamlets, 3.7 in Newham and 2.9 in Hackney.

Ethnic diversity is a significant characteristic in all three boroughs, each having substantial non-white populations and large Bangladeshi communities. Hackney is also notable for its large Charedi Orthodox Jewish community. Newham reported that 90% of Specialist role visits were to families in the Universal Partnership Plus category, indicating focused support for families with higher needs.

Overall, this case study highlights the structured approach and varying levels of support provided by Health Visiting Services in Tower Hamlets, Newham and Hackney, showcasing strengths and resilience, particularly evident during the pandemic.

National, regional and local picture

Performance against local, regional and national standards

Tower Hamlets has a unique demographic profile, with about one third of the general population coming from the Bangladeshi community, and similarly, a significant proportion of babies born in the borough belong to this community. This multicultural aspect is a crucial factor when comparing the Tower Hamlets health visiting service with those in Newham and Hackney.

The Tower Hamlets Health Visiting Service compares well locally (against Newham and Hackney) regionally (London) and nationally (England), meeting KPIs at levels that are competitive with both London and England averages (see Figures 6.1–6.4 and 6.6–6.7). Tower Hamlets generally showed a greater number of completed new birth visits and developmental reviews than England and London, and particularly the neighbouring borough of Newham.

Tower Hamlets has been diligent in monitoring performance through KPIs, using these data to identify areas for improvement. This focus on KPIs helps ensure that service delivery meets expected standards and outcomes. In comparison, Newham and Hackney also use KPIs to monitor performance, but the specific indicators and their outcomes might differ based on local priorities and challenges.

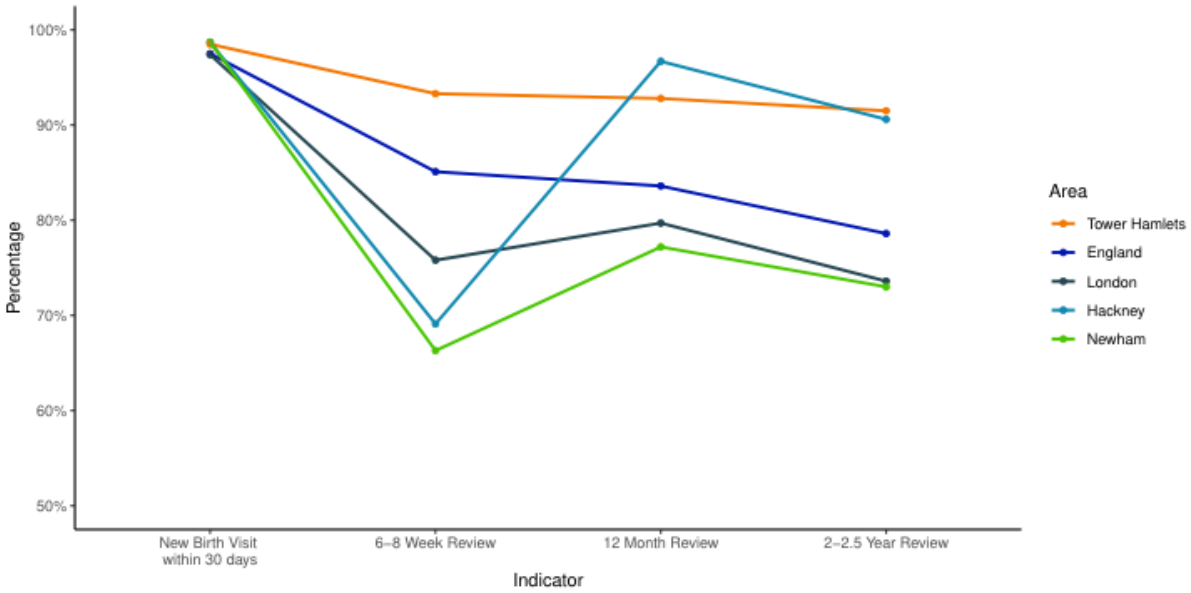
The Tower Hamlets service has shown strong results in areas such as early engagement with expectant mothers, timely follow-ups post-birth, and proactive support for child development and parental guidance.

Effectiveness of service pre-, mid- and post-pandemic

Pre-pandemic (2019–20)

Before the pandemic, some parents felt that their interactions with the Tower Hamlets Health Visiting Service were limited and did not provide in-depth support. Many did not feel that the service helped boost their confidence in parenting. The strategic aim of the service was to ensure that children met developmental milestones and were ready for school. It provided essential support for immunisations, breastfeeding and overall child development. Additionally, the service effectively directed parents to necessary services, such as speech and language therapists, and offered useful advice on child safety and developmental milestones.

Figure 6.1 Pre-pandemic: Percentages of completed new birth visits and reviews 2019–20



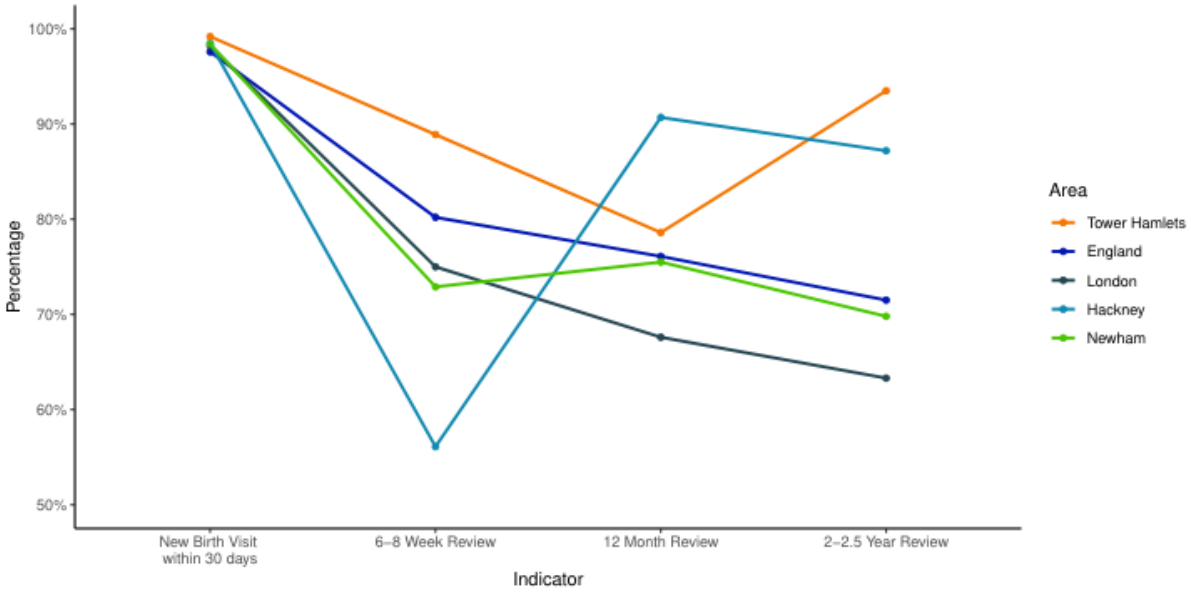
Source: Health Visitor Service Delivery Metrics: 2019–20

During the pandemic (2020–21)

During the pandemic, the Tower Hamlets Health Visiting Service adapted by conducting antenatal programmes and follow-up appointments virtually, which increased the workload for staff. There was a decrease in 6–8-week and 12-month reviews (see Figures 6.2 and 6.3). This pattern reversed in the 2022–23 period, but not to pre-pandemic levels (see Figure 6.4).

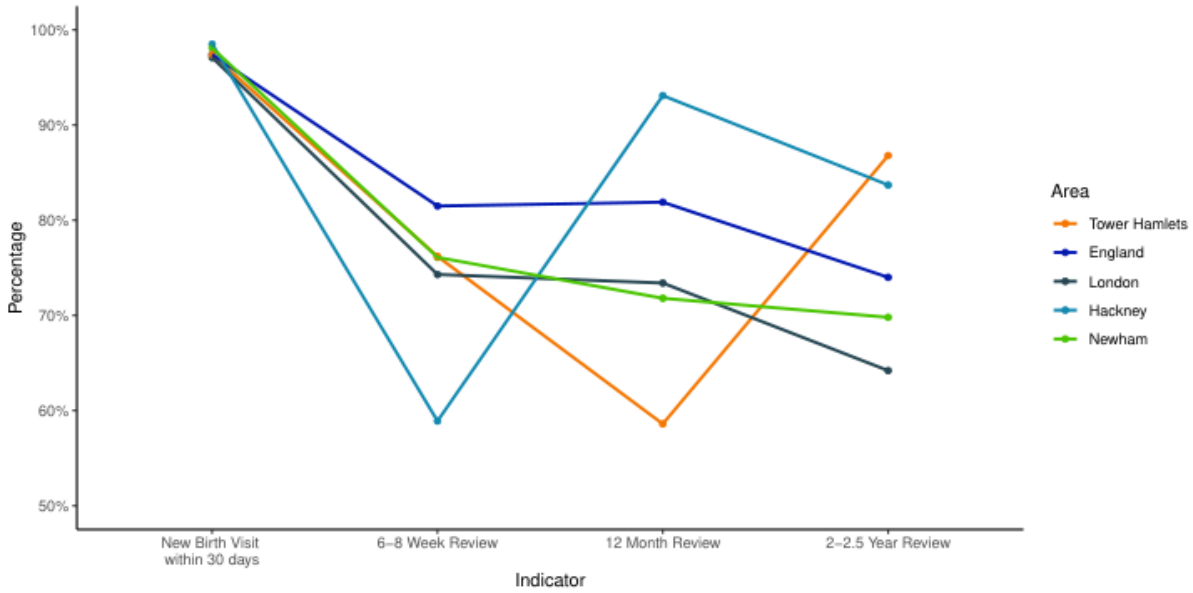
Parents experienced longer waiting times for phone appointments, but they generally found that their issues were resolved satisfactorily. Feedback from parents was mixed: some appreciated the support and found it valuable, while others felt that the visits were routine and lacked detailed advice. There were also communication and structural issues within the team that affected morale and effectiveness. Despite these challenges, the service remained proactive in following up with parents and addressing health concerns.

Figure 6.2 Mid-pandemic: Percentages of completed new birth visits and reviews 2020–21



Source: Health Visitor Service Delivery Metrics: 2020–21

Figure 6.3 Mid-pandemic: Percentages of completed new birth visits and reviews 2021–22

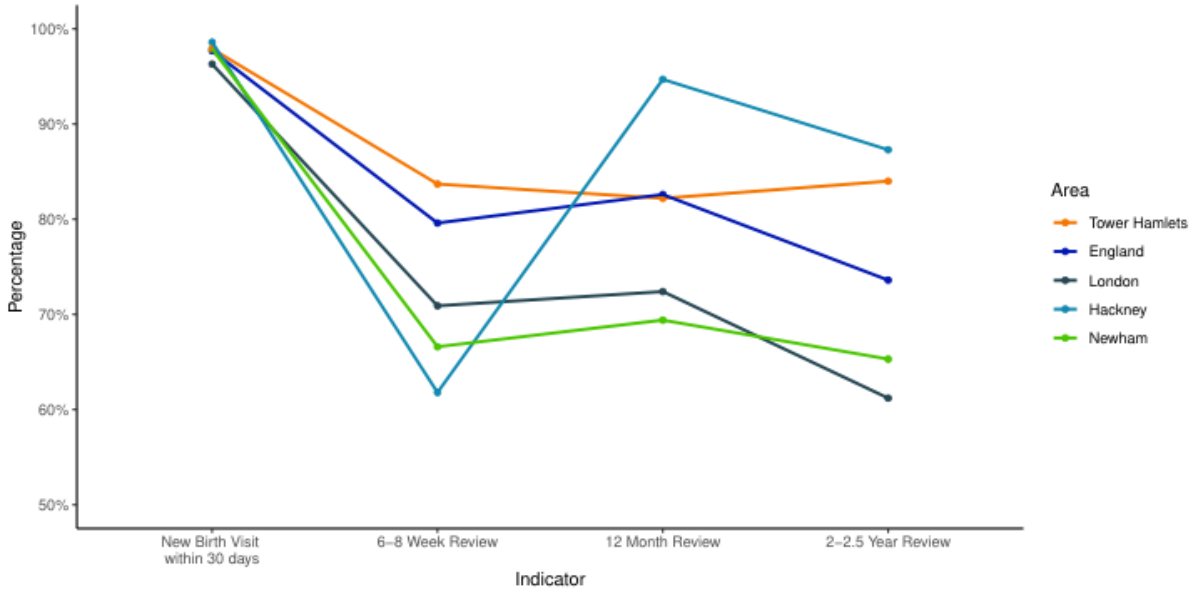


Source: Health Visitor Service Delivery Metrics: 2021–22

Post-pandemic (recovery phase, 2022–23)

In the post-pandemic recovery phase, the service saw an increase in new birth visits, and it began closely monitoring performance through KPIs to identify areas for improvement. Efforts were made to recruit local health visitors and support newly qualified nurses and midwives through training. In a diverse community, translation services were crucial, but some parents faced challenges due to the lack of translators. The implementation of a central rota system aimed to meet the borough's needs effectively, but it created a sense of instability and affected team cohesion.

Figure 6.4 Post-pandemic: Percentages of completed new birth visits and reviews 2022–23



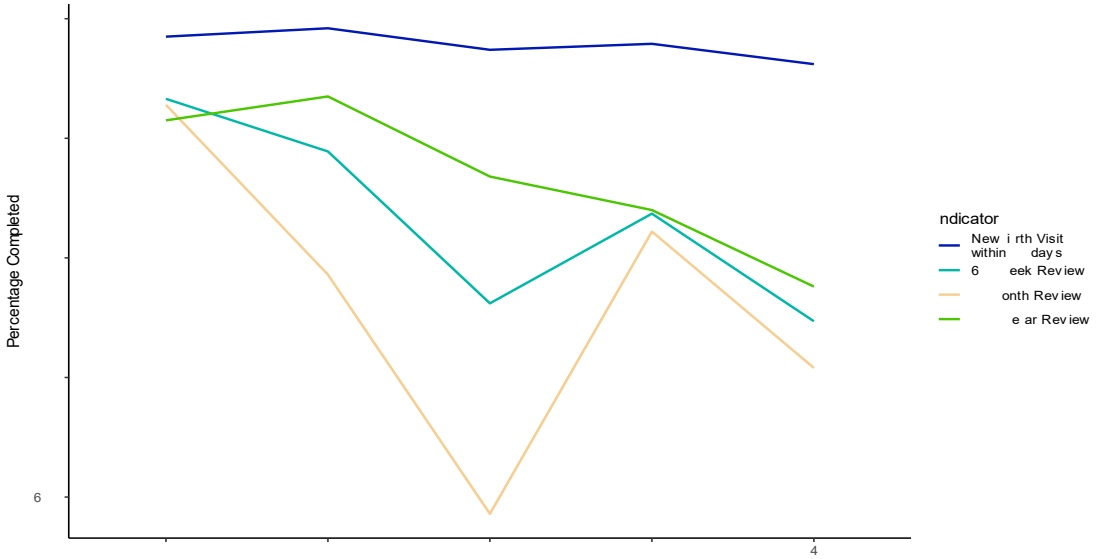
Source: Health Visitor Service Delivery Metrics: 2022–23

Although the Health Visitor Service Metrics were shared for 2023–24 by the Tower Hamlets service, the national, regional and local authority data are not yet available for comparison.

Figure 6.5 shows the yearly percentage of completed reviews for new births in Tower Hamlets from the start of 2020 to the start of 2024. New Birth Visits (within 30 days) have consistently remained high over the

years. However, other reviews have been declining since 2020, especially the 6–8-week reviews and 2–2.5-year reviews, which were significantly impacted during the pandemic, including the lockdowns from early 2021 to early 2022. This trend did not recover, and it continued to decline through 2023 to 2024.

Figure 6.5 Yearly percentages of new birth visits: 6–8-week, 12-month and 2–2.5-year reviews in Tower Hamlets, 2020–24

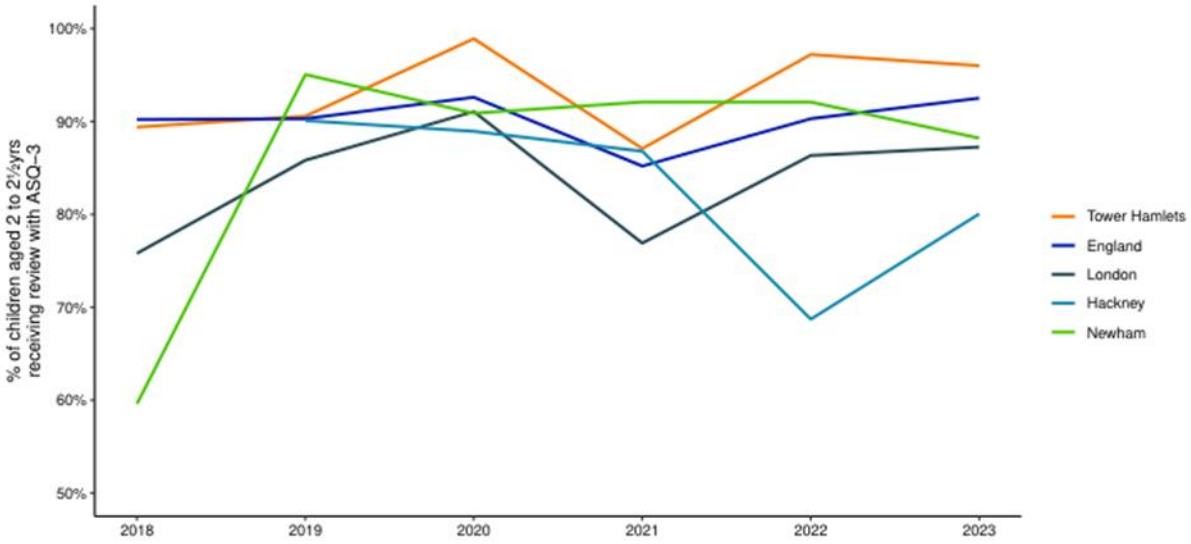


Source: Health Visitor Service Delivery Metrics: 2020–23 and Tower Hamlets Health Visiting Service data: 2023-24

Key indicators relating to child development compared across boroughs, London average and nationally are depicted in Figure 6.6 (Percentage of children aged 2–2.5 receiving review with ASQ-3) and Figure 6.7 (Percentage of children achieving a good level of development by age 2–2.5).

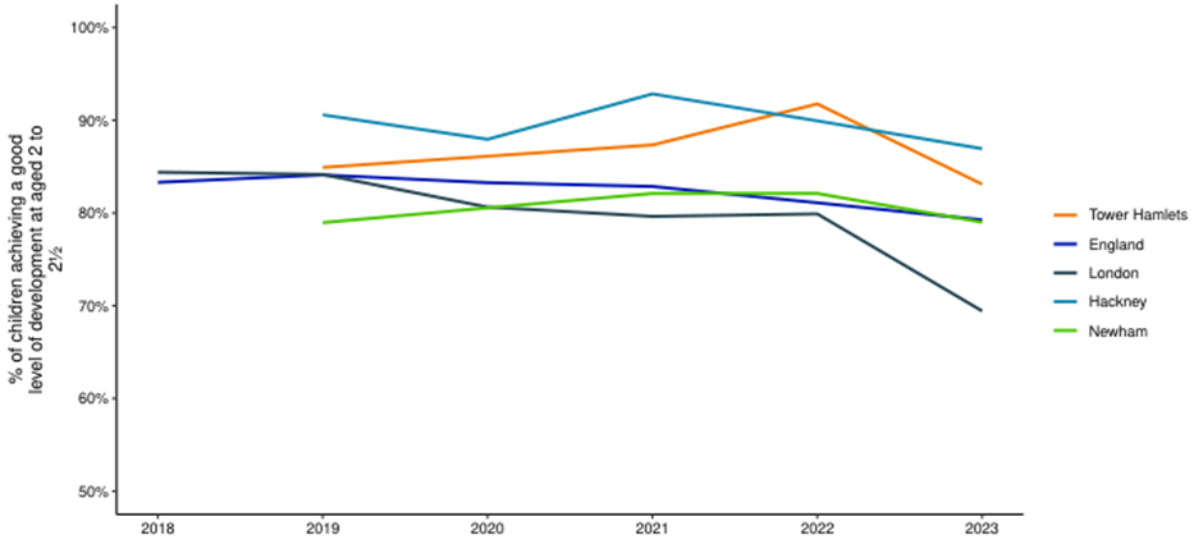
Across both these indicators, Tower Hamlets outperformed both London and national averages, and was comparable or better than neighbouring boroughs.

Figure 6.6 Percentage of children aged 2–2.5 receiving review with ASQ-3



Source: Fingertips Public Health Data

Figure 6.7 Percentage of children achieving a good level of development by age 2–2.5



Source: Fingertips Public Health Data, Service Data

Service user positive experience

A stay-at-home mother shared her experiences with a universal service, emphasising various aspects of her interactions and support received. She appreciated being directed to necessary services, recounting how the service arranged an appointment for her son with a speech and language therapist. This was particularly valuable as she was concerned about her son's speech development. The advice on child safety and nutrition was also beneficial. For instance, she learned about the availability of free vitamins for her child through the health visitor, information she had not known before. In terms of practical support, she found the guidance on breastfeeding and bottle-feeding extremely helpful. As a first-time mother, she experienced significant pain while breastfeeding, and she was grateful for the advice on managing it. Additionally, she learned about the importance of preschool for children after the age of 2, which was new information for her. However, she noted the extended waiting times for phone appointments, sometimes as long as 20 to 25 minutes. Despite this, she appreciated that her issues were eventually addressed during these calls. The service also played a role in addressing her overall wellbeing. The health visitors asked her various questions about her happiness and family life, providing a space to discuss her concerns, and offering answers and support. She encountered a diverse range of health visitors, meeting professionals of different ethnicities due to having three children. This variety in health visitors offered her multiple perspectives and support styles. The flexibility in appointment types was another positive aspect. She could choose between phone consultations, home visits or office appointments depending on her needs, making the service accessible and adaptable to her circumstances. Overall, the universal service provided essential support and information, despite some challenges with waiting times. The mother found the service beneficial for her and her children's wellbeing.

Service user mixed experience

A white first-time mother returning to work had varied experiences with her health visitor (HV). Initially, receiving dedicated support for postnatal complications was appreciated. However, subsequent appointments felt routine and lacked personalised advice, focusing on administrative tasks. The HV's limited knowledge about child illnesses left her feeling unsupported in managing her son's health. She noted disparities in services between boroughs, mentioning workshops in other areas that Tower Hamlets lacked, such as on teething or weaning. Despite these gaps, she valued the one-on-one support from her consistent HV, Jane, who provided reassurance and advice by phone, boosting her confidence. The mother

preferred continuity with a single HV, finding it beneficial, despite not being standard. There was confusion over the HV's role and when to seek medical versus HV advice for issues such as persistent nappy rash. Reflecting on her experience, she suggested clearer communication on HV roles and service expectations from the start. She also recommended proactive measures, such as group classes between HV visits to support new parents. Despite challenges in consistency and service offerings, the personal support from a dedicated HV was crucial in her early parenting journey, underscoring the need for accessible and knowledgeable healthcare professionals for effective support.

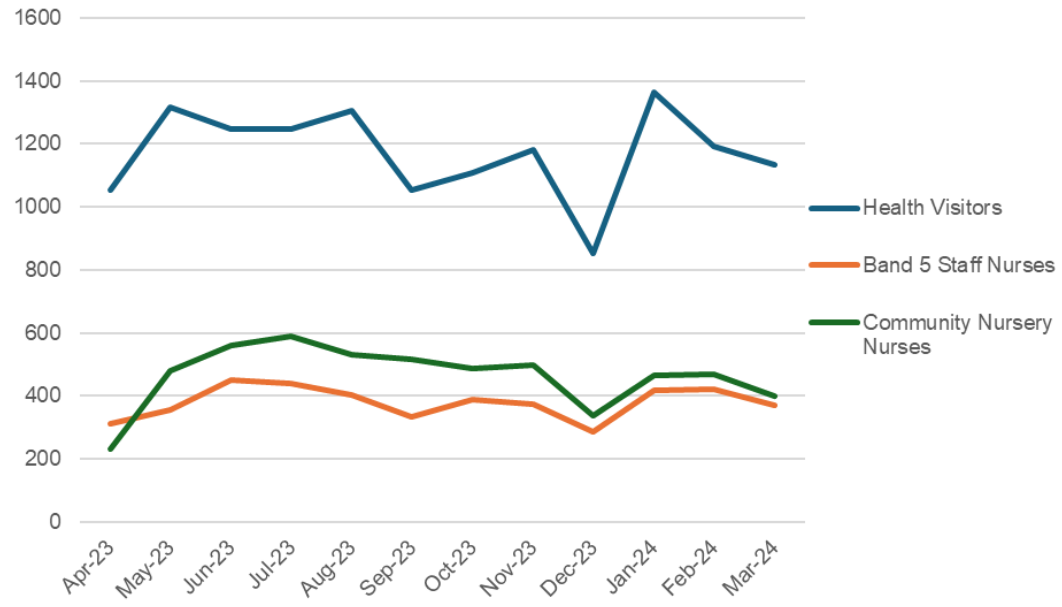
Service user negative experience

A stay-at-home Asian first-time mother shared her mixed experience with a universal service. She had minimal, non-in-depth interactions with the service, feeling that the advice given did not boost her confidence in parenting. Frequent changes in health professionals led to inconsistent care, and smooth transitions were lacking, making her question whether new visitors were adequately informed. On the positive side, she found the leaflets provided during sessions useful, especially for weaning and other practical tips. She also received helpful advice on developmental milestones for her child. However, she felt that her family routines were sometimes not respected, particularly regarding her child's sleep schedule Despite some positive aspects, the issues with interaction, advice, service continuity and respect for family routines affected her overall confidence and satisfaction.

Workforce effectiveness

In Tower Hamlets, in the period April 2023 to March 2024, a total of 24,175 Health Visiting Service contacts were carried out across Health Visitors, Band 5 Staff Nurses, and Community Nursery Nurses (see Figure 6.8 for a monthly breakdown of number of visits).

Figure 6.8 Number of monthly Health Visiting Service contacts per role 2023–24 in Tower Hamlets



Source: Service data

These contacts included antenatal visits (thirty-minute appointment with a Band 5 Staff Nurse), New Birth Visits and 6–8 Week Review (both are two-hour appointments with a Health Visitor), 3–4 Month Review (forty-five minute appointment with a Band 5 Staff Nurse), 8–12 Month Review and 2.5 Year Review (both are forty-five minute appointments with a Community Nursery Nurse), Healthy Child Clinics (thirty-minute appointment with a Health Visitor) and Multidisciplinary Meetings, which are completed by a Health Visitor (see Table 6.1 for a breakdown of number of visits).

Table 6.1 Number of contact visits

	Antenatal Visit	New Birth Visit	6–8 Week Review	3–4 Month Review	8–12 Month Review	2.5 Year Review	Healthy Child Clinics	Multidisciplinary Meetings
n	1,893	4,140	3,164	2,663	2,980	2,582	5,914	839

Source: Service data

Research insight: A comparison of Health Visiting Services in Newham and Tower Hamlets

In Newham, the Health Visiting Service operates with a well-funded team of around 200 clinical workers, including health visitors and school nurses. They cater to various family needs, such as through the Family Nurse Partnership. However, the service protocol has not been updated since the pandemic, and much of the support is still provided over the phone rather than through in-person visits. There are concerns about financial mismanagement, particularly excessive spending on agency staff that has contributed to Newham Council's budget deficit. Permanent staff feel that the service is underfunded, suggesting that funding could be better allocated, for example, to Community Nurse Staffing supervised by specialist staff. Increasing the productivity of permanent staff while addressing their dissatisfaction could enhance service effectiveness and reduce reliance on agency staff.

In contrast, Tower Hamlets utilises community staff nurses and nursery nurses who are trained to conduct specific developmental reviews. Community staff nurses handle antenatal and some early visits, while nursery nurses conduct developmental reviews at one year and two to two-and-a-half years. This allocation allows health visitors to focus on critical visits requiring higher qualifications, such as new birth and six to eight-week visits, and increases capacity for safeguarding cases such as UP, UPP and MECSH. The supervision structure in Tower Hamlets involves clinical leads overseeing all levels of staff (health visitors, staff nurses, nursery nurses) in specific bands and localities, indicating a well-considered allocation of responsibilities compared to Newham.

Tower Hamlets primarily conducts in-person appointments, except for antenatal visits, which are remote. New birth visits occur at home, while other appointments under the universal pathway take place in Children's Centres or Health Centres, demonstrating strong partnerships with these facilities hile Newham could enhance its use of Children's Centres, Tower Hamlets' service is integrated into these centres' operations

Both evaluations in Newham and Tower Hamlets identified a need for more drop-in clinics and improved community awareness about them to enhance local access. Both services also face administrative challenges that impact staff capacity, such as redundant data entry and inadequate IT systems for client administration and reporting. Health visitors in Tower Hamlets managing heavy caseloads, particularly safeguarding cases, are burdened with significant administrative tasks. Improved administrative support and IT infrastructure were identified as critical needs in both boroughs to streamline operations and support staff effectively.

Non-patient-facing aspects of the service

Workshops and community engagement

Unlike some other boroughs, Tower Hamlets does not currently offer health visitor-led workshops on topics such as teething, weaning, toilet training or sleep management. In contrast, other London boroughs have successfully implemented these workshops, providing additional support and community engagement opportunities for parents. Tower Hamlets could potentially improve its services by adopting these regional practices. A nursery nurse noted that group-centred support would also help with staff capacity and workload:

> *"I believe it's important to enhance our capacity to handle additional tasks. We could collaborate with a children's centre to promote group sessions on topics like healthy eating, toilet training, and effective child play. This approach could complement one-on-one sessions and benefit families by speeding up learning processes." (Nursery Nurse, Band 4, Health Visiting Service)*

The study examined how staffing affects service effectiveness, particularly in light of national issues such as understaffing and low capacity. It identified several critical findings.

The service faces significant staffing challenges, including high turnover, retirements and difficulty in recruiting health visitors. These issues lead to frequent changes in health visitor assignments and inconsistency in patient care. External contracts, such as the one in Waltham Forest, did not enhance senior leadership or staffing levels in other areas. This has strained existing resources and created a perception of neglect toward local needs.

While some training opportunities are available, senior staff often lack the specific training needed for their roles, so they have to train themselves. The heavy workload is a major barrier, affecting the service's ability to meet expectations and to allocate time for essential training. Although the service offers regular meetings and pastoral support, there is limited interaction between frontline health visitors and service commissioners. This hampers information flow and decision making. For example, a staff nurse mentioned that meeting work outcomes and completing training is difficult to achieve:

> *"I believe workload is a significant barrier. Meeting workload expectations while ensuring completion of training can be challenging." (Staff Nurse, Band 5)*

Insufficient staffing directly impacts service delivery, leading to cancelled appointments, backlogs in KPIs, and difficulties in maintaining quality care across all service areas. Efforts are being made to train staff to meet changing demands through regular training and clinical audits. However, remote working reduces team cohesion, making collaboration less effective. As a nursery nurse pointed out, it also limits learning opportunities:

> *"We don't have as many opportunities to meet our colleagues now because we are spread across different locations, and fewer people come to the office. Many prefer working from home. This has probably led to something missing because you learn a lot when you work alongside others. Peer support is essential, not just for venting, which can be helpful, but also because you learn from each other." (Nursery Nurse, Band 4)*

Strategically, the service aims to increase the number of staff nurses and expand training opportunities. However, transitioning staff to higher roles, such as health visitors, strains current operational capacities. In summary, despite ongoing efforts in training and recruitment, the service continues to grapple with staffing shortages that impact service delivery and staff morale. Improved communication between management and frontline staff is crucial to enhancing overall service effectiveness, and to addressing current staffing and support deficiencies.

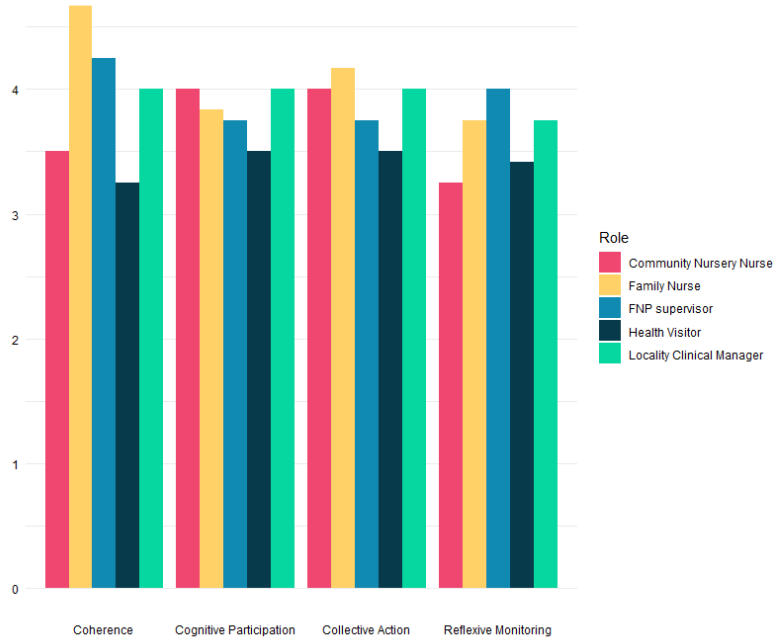
Team morale and structure

One notable issue in Tower Hamlets is the central rota system, which has created instability and affected team cohesion. Staff have to work with new practitioners daily. Although this change aimed to meet the borough's needs effectively, it has lowered team morale, as highlighted by a clinical support worker:

> *"Now we're all on a central rota. It affects band fives, fours, and threes more than health visitors. We're spread thin, assigned wherever needed. It's necessary but challenging because there's no team cohesion anymore. You just fulfil your role, see some kids, and go home. While its effective, morale suffers. A happy team is crucial for achieving overall KPIs." (Clinical Support Worker, Band 3)*

In comparison, Newham and Hackney might have different structural approaches that impact team morale and effectiveness in varying ways.

Figure 6.9 Practitioners self-ratings of project engagement with the Tower Hamlets Health Visiting Service per role



Source: Survey data

Practitioners gave self-ratings across questions which assessed their project engagement on four elements: Coherence, Cognitive participation, Collective action and Reflexive monitoring. The participants responded on a scale from 1 (Strongly disagree) to 5 (Strongly agree), with high numbers indicating stronger project engagement. Figure 6.9 indicates their mean self-ratings for each element, averaged across each role.

The self-ratings reveal relatively strong project engagement. No-one reported disagreement with any of the questions, and the most common response was ‘Agree’ (corresponding to a score of 4) Overall, the mean score was 3.8.

However, health visitors fell behind this, with some indicating a lack of agreement, ‘Neither agree nor disagree’, and a mean score of 4. Community nursery nurses showed some lower scores than the average, with a mean score of 3.7. Family nurses showed the strongest project engagement, with a mean score of 4.1. Health visitors expressed in their feedback that they are unclear about how they should be working. There are no clear guidelines on which families should receive different levels of support within the Universal service, excluding MESCH or FNP.

Clinical support worker – Band 3

The clinical support worker plays a pivotal role in supporting parents by ensuring that their children are developmentally on track and promoting healthy stimulation. This role is particularly crucial for Tower Hamlets' diverse immigrant families, who often face language barriers and social isolation upon arriving in the country. However, the service's effectiveness is hampered by limited staffing, leading to cancelled appointments and backlogs across KPIs. Despite these challenges, the service provides essential one-on-one support for vulnerable families, and it facilitates community building among parents and children. Additional benefits include the provision of free necessities such as toothbrushes and toothpaste, although language barriers persist, with resources such as the Ages and Stages Questionnaires not always being translated, potentially causing confusion for parents.

Community nursery nurse – Band 4

The service provides comprehensive training opportunities covering various competencies beyond mandatory courses. However, staff consistency suffers due to shortages, leading to fluctuating roles and responsibilities across different locations.

There is a need for clearer roles and standardised practices within the service to ensure consistent quality. Reviews of children's and families' needs are irregularly conducted, highlighting a lack of systematic documentation and accountability.

Efforts are underway to address these issues, although progress is slow. Concerns also exist about health visitors lacking relevant backgrounds, such as adult nursing, which may not adequately prepare them for child development and mental health contexts.

Staff nurses at Band 5

Staff nurses at Band 5 have adapted their roles post-pandemic, now offering virtual antenatal programmes and care for younger children, adding to their workload. However, there is inconsistency in care due to no designated health visitor for all clients. Staff receive adequate training, but they struggle with workload management. The service prioritises families with greater needs, including vulnerable groups. Language barriers hinder access for some, and better outreach is needed. Antenatal contact is valued for educating parents. Regular meetings ensure staff alignment, but more direct outreach events are desired. There is a push for educational sessions, especially for safeguarding families, aiming to enhance service effectiveness.

FNP supervision – Band 8a

FNP supervisors oversee a caseload averaging 25 clients per family nurse, totalling around 100 clients for the service. They address cultural stigma around mental health, particularly prevalent among clients from Bangladeshi and African backgrounds, comprising about 65% and others. The recent influx of Bangladeshi new brides, due to changing immigration laws, complicates eligibility criteria and requires cultural sensitivity during initial assessments with interpreters.

Shared office space fosters team cohesion and supports formal and informal supervision, which is crucial for managing emotionally demanding cases. Weekly team meetings enhance skills, learning and business discussions. The FNP benefits from guidance, frameworks and evidence-based training materials provided by the national unit.

However, there is a need for broader understanding within the 0–19 service regarding FNP's role and operations, highlighting a gap in integration and awareness at the wider service level.

Clinical Lead

Clinical Leads oversee support and development within the service through regular meetings that address pastoral care, training gaps and process improvements. They provide supervision to ensure effective programme delivery, although senior staff often have to self-train due to limited training opportunities.

The focus is on tailoring care to diverse communities, understanding their values and perspectives to build social capital and address health inequalities. The service shifted from a local, GP-based model to a corporate approach, serving families across various locations.

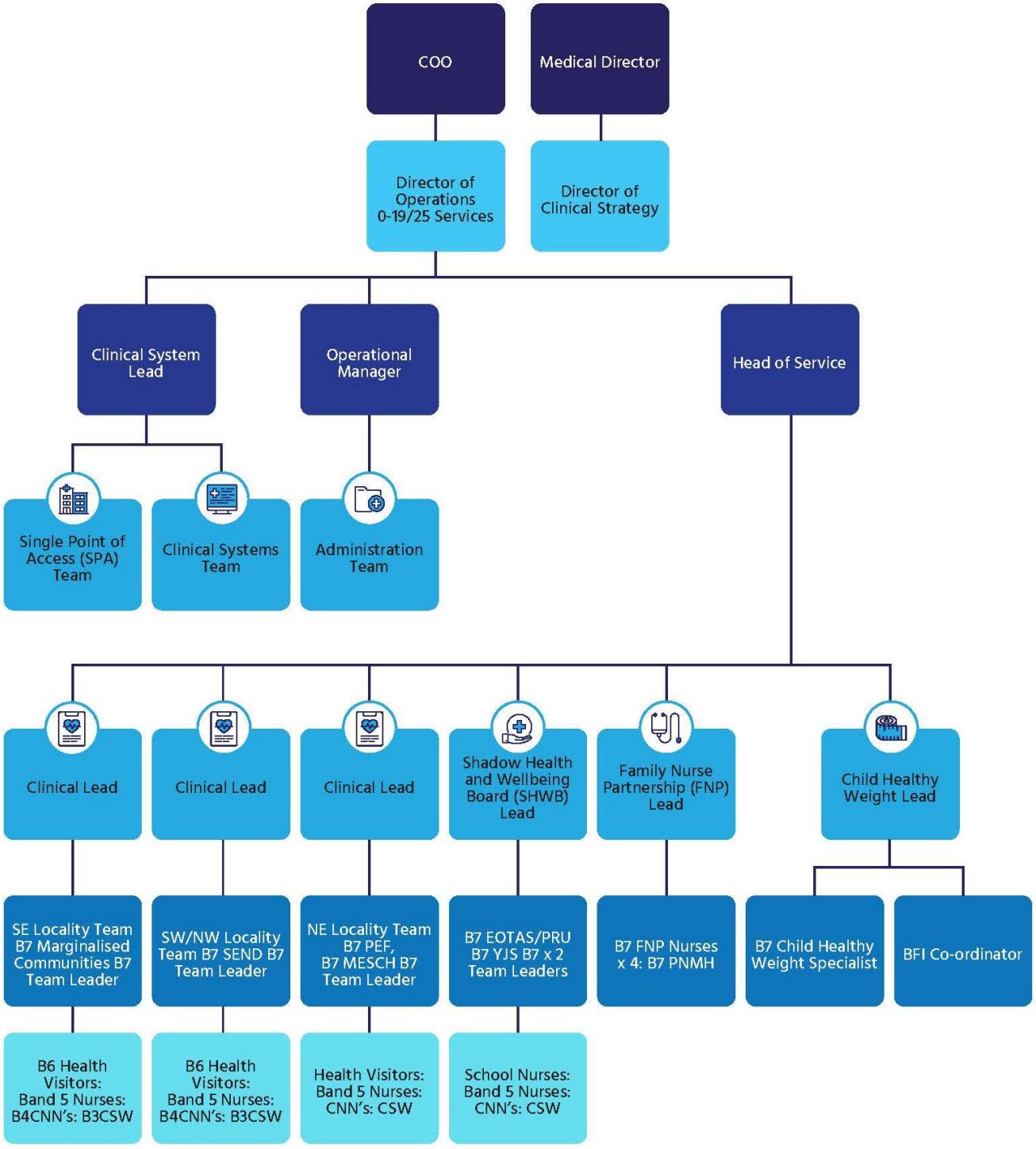
However, there is a lack of coherence in understanding audit processes beyond the strategic level, leading to uncertainty about accountability and shared understanding among staff. Audit results are communicated both upwards and downwards, but there is a need to better connect business-oriented goals with staff and patient experiences.

Adapting the MECSH programme to Tower Hamlets presents challenges, particularly in adjusting recruitment age limits to better serve the community's needs and contexts.

Workforce structure

This section examines the workforce, particularly in terms of training, teamwork, morale, capabilities and capacity, focusing on both strengths and weaknesses within the service.

Figure 6.10 Health Visiting Service workforce structure – organisational chart



Source: Adapted from the Tower Hamlets Health Visiting Service organisational chart

Research Insight: Description of Health Visiting Service Staff roles and responsibilities

Operational Director: Manages the service contract deliverables, including contract monitoring, review, liaising with commissioners, budgeting and finance, performance analysis, reporting, and managing both back-office and front-office functions, systems and processes (including estates and IT systems).

Clinical Director: Provides evidence-based clinical direction, ensures overall safety, oversees clinical audits, leads clinical modelling transformation and workforce models (including staff training), and manages partnerships with the NHS and other clinical settings.

Head of Service: Leads strategically and operationally for the Health Visiting Service in Tower Hamlets and Waltham Forest. Oversees portfolios such as safeguarding/early help, SEND, SPCHN students and apprenticeships, maternity liaison, EMIS

(clinical system: bookings, feedback), and clinical SOPs.

Clinical Leads: Manage specific portfolios and staff levels across the service. They prepare audit reports, oversee staff competencies, training, and supervision models, and manage all staff within their locality. There are four localities, but only three clinical leads, as one was promoted to Head of Service without a replacement.

Health Visitors (Band 6): Conduct various visits and reviews, including New Birth Visits at home and 6–8-week reviews at clinics. They handle safeguarding cases and some also manage MECSH clients. They perform all six mandated contacts for safeguarding cases. Specialist Health Visitors focus on areas like asylum seekers and refugees.

Community Staff Nurses (Band 5): Conduct virtual antenatal contacts and developmental reviews at 3–4 months and 8–12 months in family and children centres. They also handle A&E follow-ups and other follow-ups after referrals.

Nursery Nurses (Band 4): Conduct 1-year and 2–2.5-year developmental reviews in clinics or children and family centres.

Clinical Support Workers (Band 3): Assist Health Visitors, Staff Nurses and Nursery Nurses during reviews (3–4 months, 1 year, 2–2.5 years, and occasionally 6–8 weeks). They handle tasks such as height and weight measurements and blood spot screening.

Stakeholder and staff perceptions of service delivery approaches

The research highlighted several challenges in delivering healthcare services, particularly due to staffing shortages. There is a national deficit of qualified health visitors, who play a crucial role in providing comprehensive support to families, including refugees. Health visitors are appreciated for their holistic approach, offering not just medical advice but also emotional and practical support:

> *“Good parts are the wraparound support, and having access to the knowledge and advice that can be gained from the team.”* (Stakeholder – Look Ahead Campbell Rd YP services – supported housing for YP)

However, there are issues with service coherence and staff understanding of service goals. Different programmes, such as MECSH and listening visits, lack a unified understanding among staff. For instance, some health visitors continue conducting listening visits despite changes in leadership discouraging it:

> *"When I started, listening visits were more common, especially for mothers facing emotional health challenges, even without formal mental health support. A director briefly halted them, citing lack of training, but this changed after six months. Experienced health visitors persisted with these visits, but now I'm unable to offer them due to capacity constraints." (Health Visitor, Band 6)*

Communication barriers, especially with non-English speaking communities, hinder effective service delivery. The use of interpreters sometimes results in misunderstandings, impacting the quality of care provided. One-on-one appointments are seen as most effective in addressing parental concerns and providing crucial information:

> *"We have issues with interpreters provided by the GP Care Group. They often don't meet our service standards. Many are older women who tend to chat with family members or offer personal advice instead of strictly following our programme's guidelines. This complicates our efforts to communicate effectively and work with non-English speaking clients." (Family Nurse – Band 7, FNP)*

There is also a shift in service delivery models from local GP-based care to a corporate model, affecting how services are accessed and delivered to families. This change has implications for service integration and coordination:

> *"Before GP Care Group took over the contract, my caseload was tied to a specific GP practice. I conducted clinics and saw children only from that practice's area, partnering closely with the GPs for checks and meetings. When GP Care Group took over in 2016, the model shifted to a corporate approach. Now, regardless of which GP a baby is registered with, we visit and support all families who come our way." (Clinical Lead – Band 8a, Health Visiting Service)*

Stakeholders (GPs) also noted that changes in staffing negatively impacted their practice's work and care. Having a named health visitor as a consistent contact helps maintain a coordinated approach:

> *"What works well is having a named health visitor and point of contact. Due to staff turnover and other issues, this isn't always possible. There had been a lot of turnovers at my practice, and meetings with health visitors had lapsed. The GP*

didn't know how to engage with health visitors or discuss cases. It was hard to find the right contact. This was a struggle, but now that we have a specific contact person, care for families is more coordinated and efficient." (GP-Stakeholder)

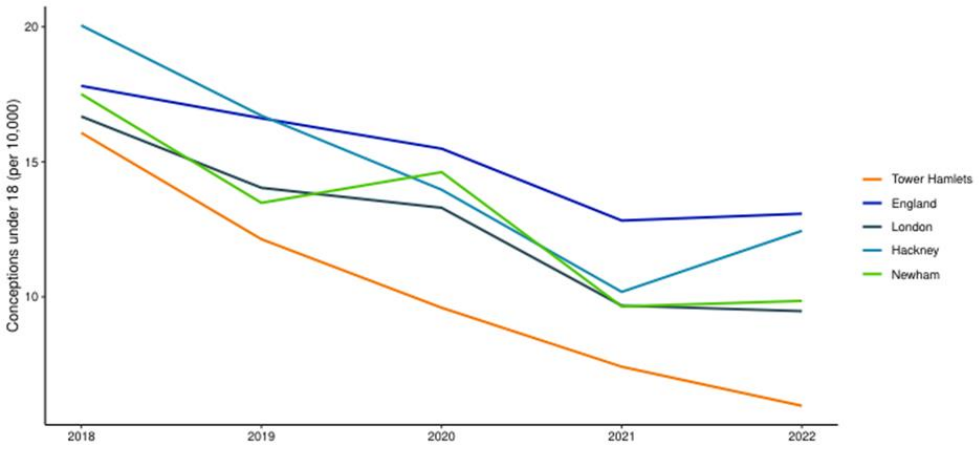
Training opportunities within the service are valued, covering various competencies from breastfeeding support to mental health training. However, there are concerns about the clarity and effectiveness of communication regarding these opportunities.

Overall, while there is appreciation for the service's potential impact, stakeholders highlight the need for clearer communication, better staff training and improved accessibility to ensure consistent and effective healthcare delivery.

Meeting the needs of vulnerable families

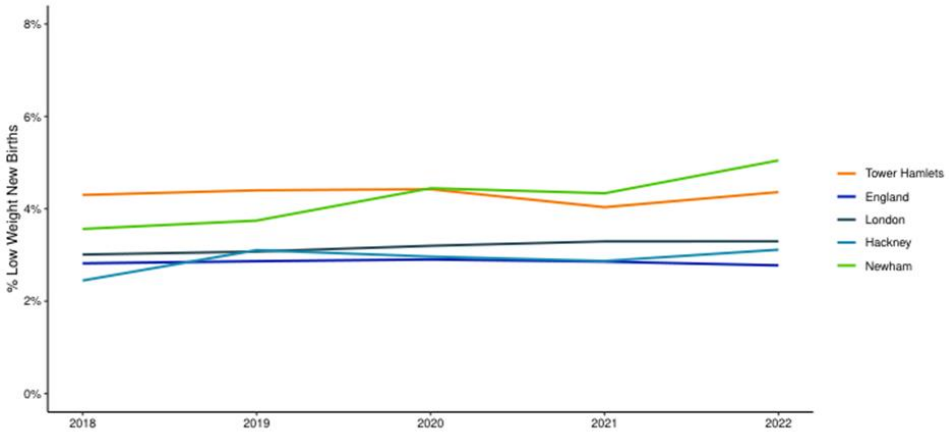
Key indicators related to complex families are shown in Figures 6.11 and 6.12. Tower Hamlets had lower conceptions under 18 than national and London averages, and compared to neighbouring boroughs. Moreover, this has been declining significantly over the last five years (Figure 6.11). Tower Hamlets has a lower percentage of mothers who are smoking at time of delivery than the national average, and it is comparable with the London average and neighbouring boroughs. The figures have been mostly level, with a modest increase over the last two years (Figure 6.13). However, Tower Hamlets showed a greater percentage of babies with low birth weight than national and London averages, as well as Hackney. The figures were comparable to Newham, and they have stayed level over the last five years (Figure 6.12).

Figure 6.11 Conceptions under 18 per 10,000



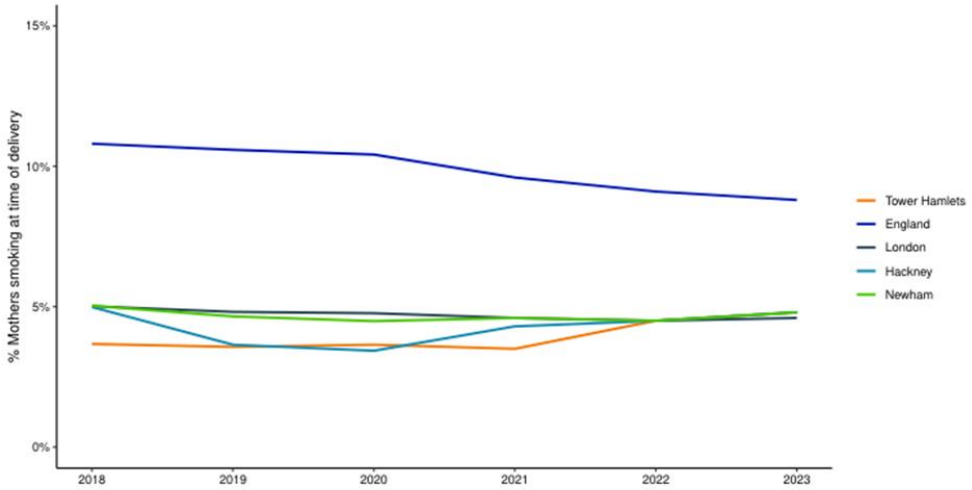
Source: Fingertips Public Health Data

Figure 6.12 Percentage of babies with low birth weight



Source: Fingertips Public Health Data

Figure 6.13 Percentage of mothers smoking at time of delivery



Source: Fingertips Public Health Data

The London Borough of Tower Hamlets Health Visiting Service aims to provide equitable and accessible support to diverse families, particularly those with protected characteristics. Programmes such as the Family Nurse Partnership (FNP) and MECSH cater to high-risk families, including young first-time parents and those with increased care needs.

FNP supports parents under 21 during pregnancy until the child turns 2, focusing on maternal and child health, parenting skills, emotional wellbeing and future planning. This initiative empowers parents to make informed decisions, and it emphasises life skills and independence.

MECSH complements FNP by addressing complex family situations involving mental health and troubled relationships, fostering healthy parent–child relationships through sustained interventions. Variability exists in how families are assigned to different service levels, which highlights potential inconsistencies in service delivery.

To overcome barriers, the service provides language support through interpreters and culturally sensitive approaches. Home visits and drop-in sessions enhance accessibility, acknowledging that tailored care and building trust are crucial for effective engagement, especially with vulnerable populations such as refugees and asylum seekers.

Efforts include reducing mental health stigma within diverse communities, and accommodating specific needs, such as developmental reviews adapted for language difficulties. Collaboration with community organisations and children's centres addresses broader health inequalities and social determinants affecting family wellbeing.

Despite these efforts, challenges persist in engaging younger parents and those from settled white East End or newly arrived Bangladeshi backgrounds. Enhancing communication and clarifying service expectations remains a priority to ensure equitable access and effective support delivery across all demographics in Tower Hamlets:

> *"The white indigenous population of Tower Hamlets has high smoking rates and low breastfeeding rates, with potentially high involvement in social care. This could be a reason why their daughters are becoming pregnant at a young age. Some of these families are very challenging to work with." (FNP Supervisor)*

The service has implemented several strategies to support vulnerable families effectively:

- **Consistent Communication:** Health visitors maintain regular communication with families, keeping them informed even when they are away, ensuring continuity of support.

- **Useful Health Information:** Families receive valuable health advice and information, contributing to improved health outcomes for children. This support includes practical tips and guidance that parents find helpful.

- **Wellbeing Support:** Health visitors provide emotional support to parents, helping them navigate challenges, and referring them to specialist services such as the Perinatal team when needed.

- **Flexibility with Appointments:** The service accommodates families' schedules by offering flexible appointment times, making it easier for parents to attend consultations without disrupting their daily routines.

- **Additional One-on-One Support:** Vulnerable families receive personalised support with more frequent one-on-one contacts. This approach ensures families receive dedicated attention tailored to their specific needs, including developmental reviews conducted by a named health visitor.

- **Population Needs Assessment:** The service assesses the specific needs of vulnerable families, utilising data from various NHS data systems. This helps to identify gaps and tailor services to better meet the needs of high-risk populations, including children with medical needs.

- **Service Improvement and Health Outcomes:** There is a focus on improving service delivery to enhance health outcomes. Emphasising data sharing and a data-driven approach aims to create a more integrated and effective service for vulnerable families.

In summary, the service is committed to providing comprehensive support to vulnerable families through consistent communication, valuable health information, personalised wellbeing support, flexible appointment scheduling, and targeted one-on-one assistance. By leveraging data-driven insights, the service aims to continuously improve and better meet the needs of the communities it serves.

P25 – A special case experience with Health Visiting Service

P25, a white first-time mother, initially received heightened support from a health visitor due to a misdiagnosis of postpartum high blood pressure as postpartum depression. This resulted in frequent visits for a month post-delivery, exceeding the usual frequency.

Despite the unusual circumstances, P25 found the support provided to be invaluable, encompassing both baby's needs and her own wellbeing. However, after the misdiagnosis was corrected, her experience with the service became lacklustre.

Subsequent visits at 6 and 12 months felt routine and lacked engagement, with the health visitor seeming ill-prepared to address P25's concerns.

P25 suggested improvements, including group classes and workshops for mothers, especially considering NHS staffing crises. She also stressed the need for clearer appointment timelines and more frequent check-ins between appointments for better support.

Family Nurse Partnership (FNP)

The Family Nurse Partnership (FNP) was introduced in England in 2007 to support young, first-time parents. It involves specially trained nurses, called family nurses, who provide intensive home visits to eligible pregnant women and new parents. The programme aims to improve health and social outcomes for mothers and their children by offering guidance on parenting, health and personal development. Carefully implemented across over 130 local authority areas, FNP uses clear guidelines, a national database and a

high-quality learning programme for family nurses to ensure its effectiveness. The focus is on building trusting relationships to empower parents to make positive choices for themselves and their children.

Comparing FNP across Tower Hamlets, Newham and Hackney

The Family Nurse Partnership (FNP) programme supports young first-time parents across Tower Hamlets, Newham and Hackney. However, detailed information about the FNP programmes in Newham and Hackney is insufficient for a thorough comparison with Tower Hamlets.

In Tower Hamlets, the FNP operates as a semi-independent branch of the Health Visiting Service. It has its own strategic leads and office, and it employs four family nurses who serve about 100 families. Conversely, in Newham and Hackney, the FNP is integrated as a specific tier of the Health Visiting Service, with Hackney referring to it as the Intensive Home Visiting Service.

Data on the number of families enrolled in the FNP in Newham and Hackney is unclear. Newham reported 49 visits by FNP nurses but also noted poor record-keeping, with 2,339 visits recorded where the staff position was unknown, suggesting some may have been by family nurses. Hackney's FNP programme shows that parents from black backgrounds are over-represented, comprising 56% of participants compared to around 24% of the general young population. In contrast, the 2023–4 statistics for Tower Hamlets' FNP reveal that 63% of enrolled families identify as Asian or Asian British (primarily Bangladeshi), 22.2% as White, 11.1% as Mixed or Multiple Ethnic groups, and 3.7% as Black African, Black Caribbean, or Black British.

o th Tower Hamlets' FNP service and Hackney's ntensive Home Visiting Service follow a similar approach The frequency and number of visits are adjusted based on need, in line with national FNP guidelines. This adaptable approach ensures that families receive the necessary support tailored to their individual circumstances.

FNP supports parents under 21 during pregnancy until the child turns 2, focusing on maternal and child health, parenting skills, emotional wellbeing and future planning. This initiative empowers parents to make informed decisions, and emphasises life skills and independence.

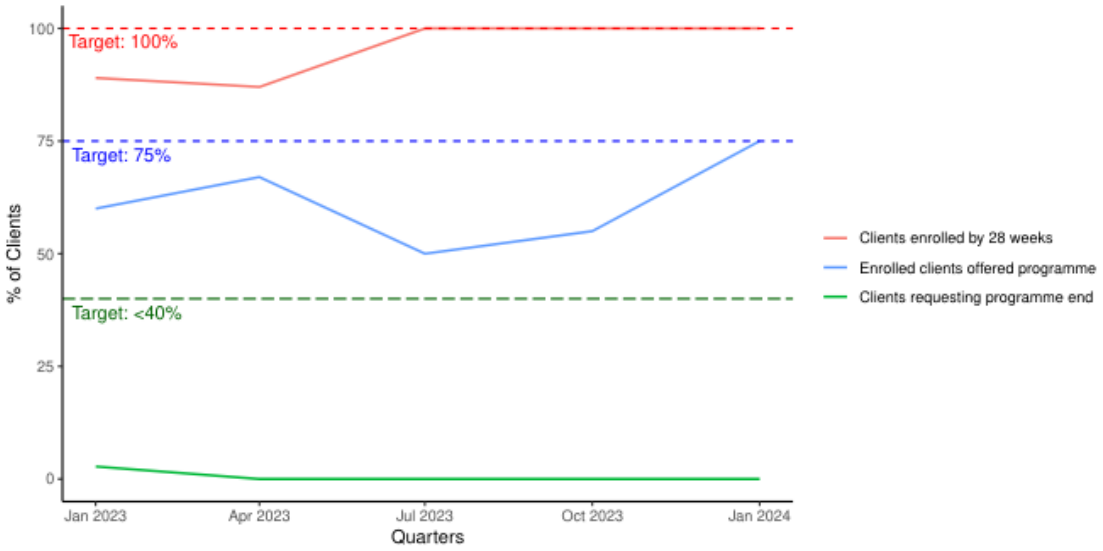
However, challenges arise with certain communities, such as Bengali families, due to language barriers and cultural differences. For example, FNP staff stress that some families agree to services without full comprehension, seeking help for issues such as housing, which are unrelated to the programme's scope:

> "*One of our current struggles is assessing non-English speaking families, especially Bengali families. They often agree to everything due to unfamiliarity with services in the UK and a reluctance to seem impolite. This has led to challenges in providing effective support, despite their supportive family networks. It's like fitting a square peg into a round hole – we're not always the right fit for their needs." (Family Nurse, Band 7)*

The available FNP data from the year quarters from the end of 2022 to the start of 2024 are depicted in Figure 6.14. It shows the percentages of clients enrolled on the FNP service by 28 weeks, the percentage of those enrolled clients engaging with the service, and the percentages of those enrolled who declined further service involvement. For each of these, the associated targets are also presented with the dashed lines.

Well ahead of target is those declining further service involvement. Enrolment and client engagement fell just below target, before meeting the target in the latter quarters of 2023–24.

Figure 6.14 FNP targets, service delivery, client engagement and drop-out



Source: Service data

The FNP has shown positive outcomes in its approach to supporting families, focusing beyond traditional health visiting services. Families report frequent contact with nurses every two weeks, supplemented by phone calls and event attendance, fostering ongoing support and accessibility. This consistent engagement is crucial for maintaining rapport and addressing evolving needs effectively.

The programme's holistic approach, encompassing the entire family dynamic, rather than solely focusing on the child, has been well-received. It extends support to include education and employment guidance, aiding parents in securing stability and enhancing child development outcomes, which are particularly crucial post-pandemic.

However, enrolling families, especially those ambivalent or guarded due to past social care involvement, can be challenging. FNP staff highlighted that overcoming resistance from family gatekeepers often necessitates extended efforts, sometimes involving multiple visits before acceptance into the programme:

> *"The mum [of the client] didn't want another professional in my life. 'I've had children's social care involved with all my children all my life. I do not want another professional', so really she was the gatekeeper."* (FNP Supervisor – Band 8a)

Expectations for regular engagement are clear, typically fortnightly, although some flexibility is negotiated based on family circumstances. Clear communication regarding appointment attendance is stressed, although adolescent clients may find this commitment challenging.

The pandemic temporarily reduced pregnancy rates, allowing FNP to extend its services to older youths up to age 21, and up to 25 for those with Special Educational Needs and Disabilities (SEND), expanding their reach and impact.

Data collection and benchmarking against national indicators inform FNP's practices and annual reviews. An FNP supervisor emphasised that despite challenges in reaching engagement targets, especially in recruiting clients early in pregnancy, their performance compares favourably to national averages. This reflects the programme's effectiveness within a complex client demographic:

> *"For example, we aim to recruit 60% of clients by 16 weeks of pregnancy. Given our challenging and sometimes chaotic client group, we currently achieve around 33–34%. Nationally, the average is about 36%, so we're fairly close." (FNP Supervisor – Band 8a)*

Concerns remain about data quality and utilisation across services, highlighting opportunities for enhanced evidence-based decision making. FNP demonstrates better data management practices, contributing to ongoing service improvement efforts.

In summary, while FNP faces challenges in enrolment and data management, its tailored approach and commitment to holistic family support have yielded positive outcomes. Continued refinement of

engagement strategies and data utilisation will be key to sustaining and enhancing its impact on vulnerable families.

FNP young parents

A first-time teenage mother in the FNP programme shared her positive experiences. When concerned about her baby's rash and weight loss, the team promptly referred her to a GP, and scheduled follow-up appointments. The health visitor maintained consistent communication, providing alternative contact information when on leave, and offered useful health advice that improved the baby's condition.

The health visitor also supported the mother's wellbeing, referring her to the perinatal team and being a good listener. Flexibility in scheduling appointments was helpful, accommodating the baby's sleep patterns. However, the mother felt overwhelmed by the amount of paperwork, and she suggested using a single laminated book for reference instead.

She appreciated the ongoing support, and wished for the health visitor to continue visits after her second child is born, valuing the established relationship and familiarity with her family.

P8 – A young first-time black mother's experience with Health Visiting Services (FNP)

P8 is a young first-time black mother under 21 years old, with a 2-year-old toddler. She expressed overall satisfaction with the Health Visiting Service, noting that it effectively met her emotional and well-being needs.

P8 was particularly grateful for the emotional support she received from her Family Nurse Practitioner (FNP) during what began as a traumatic pregnancy and birth. Although there was a temporary discontinuity in the service, it was quickly resolved, and P8 did not experience any negative consequences as a result.

According to P8, the FNP service became an integral part of her family life, providing essential emotional and pastoral care throughout her pregnancy and beyond.

P11 and P12 – A young South Asian parent dyad's experience with Health Visiting Services (FNP)

P11 and P12 are a young South Asian couple with twin boys under 2 years old. The mother speaks limited English, but she is able to understand the information communicated to her.

The mother reported consistent care from their Family Nurse Practitioner (FNP), with visits initially every two weeks, now reduced to monthly. Both parents described their FNP as "very helpful and kind". Initially, appointments were held at a clinic in Poplar, but they have since shifted to home visits to better suit their needs.

When asked about career support, both parents mentioned that the FNP helped them enrol in college-level English classes (ESOL) and provided advice on finding classes to fit around their childcare responsibilities. The mother mentioned that she did not have any emotional concerns needing additional support, but that she valued the wealth of information the FNP provided during visits and through pamphlets left behind.

The parents praised the service for its flexibility and tailored approach, which helped expand the mother's social network through various baby groups. The information provided by the FNP was specific to their needs, including feeding newborns, baby health and developmental stages. The mother understood this information well. Both parents were satisfied with the service, and they did not suggest any areas for improvement.

MECSH performance comparison: Local, regional and national

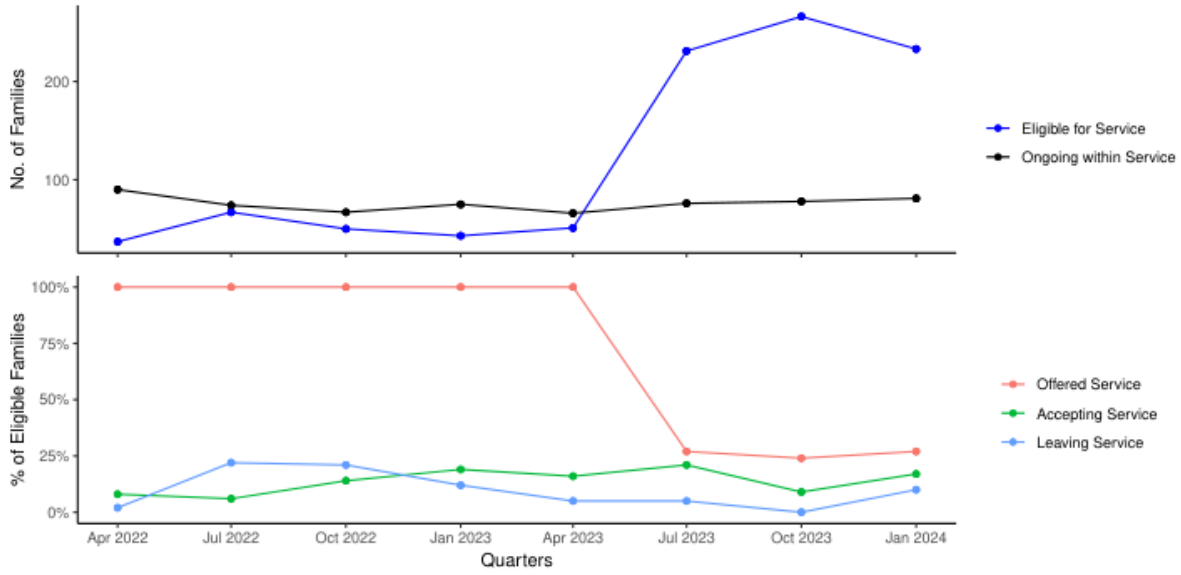
The MECSH programme is designed to offer extra support to families in Tower Hamlets. It involves structured home visits by a health visitor to mothers and their babies, aiming to promote emotional and social wellbeing for both mother and child, and to assist parents in supporting their child's development. The programme is voluntary and free, and interpreters can be arranged for non-English-speaking mothers. Home visits may start during pregnancy and continue until the child is 2 years old, with at least 25 visits scheduled at specific intervals. During these visits, parents can discuss various topics with the health visitor, including feeding, sleeping, managing crying, and promoting the baby's health and development. Families can opt out of the programme at any time, if they wish. For more information about MECSH,

families can contact the 0–19 Single Point of Access, which serves as the central hub for health visiting services in Tower Hamlets.

Available data from the quarters starting in 2022 to the start of 2024 are depicted in Figure 6.15. The top panel shows the number of families that are eligible for the MESCH service, and the number of families currently enrolled on the MESCH service. The bottom panel shows the percentage of eligible families being offered the MESCH service, the percentage of those families being offered who accept the MESCH service, and the percentage of those currently enrolled who leave the MESCH service.

Eligible families increased roughly three-fold in the last three quarters of 2023–24. This need could not be met, as seen in the drop of those being offered the MESCH service. The number of families fluctuates but remains relatively stable; this pattern is reflected in the percentage of families accepting and leaving the MESCH service.

Figure 6.15 MESCH service delivery and uptake



Source: Service data

The MECSH programme in Tower Hamlets has encountered several challenges in meeting its intended goals and specifications. Originally designed to offer targeted support for families with additional needs who do not qualify for the Family Nurse Partnership (FNP), MECSH has struggled to deliver according to its defined model. Parents often lack understanding of what the programme entails, resulting in low engagement and misaligned expectations about the support they will receive.

Despite being commissioned some time ago, MECSH has not been fully rolled out due to various administrative challenges and changes in staffing. These issues have hindered consistent delivery and adherence to the programme's Australian model, which was imported without sufficient adaptation to local needs and resources. Health visitors report difficulties in allocating enough time for each visit, which impacts the quality of interaction needed for effective support:

> *"Essentially, the content from Australia is just copied over with a different logo, and then sent out. Your health visitor is supposed to see you weekly for the first six weeks after birth, and then every two weeks after, but that's not always feasible. A barrier to delivering the MECSH programme is the lack of time to engage fully with families, like they did in Australia where they had more staff and time to spend. With current staff limitations and workload, there's little time to spend hours with families, letting things happen naturally." (Health Visitor, Band 6)*

Communication gaps between commissioning teams and delivery partners have further complicated MECSH implementation. There is a perceived lack of openness and collaboration from the delivery partner, making it difficult for the commissioning team to understand and address operational challenges effectively. This disconnect has also affected data monitoring and reporting, which are crucial for assessing programme outcomes and making informed improvements.

Parents' feedback suggests that the MECSH programme's structured approach, which includes following prescribed guidelines and reading through materials, often feels artificial and scripted during visits. This rigidity can discourage participation, especially from families seeking more informal support or feeling stigmatised by the programme's emphasis on vulnerability. Health visitors have observed that families may not show interest or may resist engaging with the programme as intended, due to these concerns:

> *"MECSH is challenging because I haven't found any parent who has fully engaged with it as intended. They often prefer to just talk rather than follow the structured programme. The extensive materials and preparations required each week are often neglected or ignored. The focus ends up being on discussing the child's progress and the family's wellbeing, which takes up all the time." (Health Visitor, Band 6)*

Moreover, there is a mismatch between the programme's recruitment timing and the developmental needs of children. MECSH recruits early, but it lacks provision between ages 2 and 5, impacting school readiness and continuity of support during critical developmental stages. Strategic leads of the service stressed that families identified later who could benefit from MECSH principles are unable to join the programme, highlighting a gap in service flexibility:

> *“The research in Australia indicates it only works with early enrolment, but Tower Hamlets is not Australia. We have a different population, community, and access to resources. I believe the programme should be more flexible, accommodating any age. However, since we're following an Australian model, our options for delivery are restricted." (Clinical Lead)*

In summary, while MECSH aims to support families with complex needs, its implementation in Tower Hamlets faces significant operational, communication and engagement challenges. Addressing these issues will be crucial for aligning the programme with local realities, enhancing parental understanding and participation, and ultimately improving outcomes for vulnerable families.

Research Insights: Comparison of MECSH and Enhanced Safeguarding Support: Tower Hamlets, Newham, and Hackney

In Tower Hamlets, the MECSH (Maternal Early Childhood Sustained Home-visiting) programme offers intensive support for families with enhanced needs. This programme, originally from Australia, has been implemented without adaptation to the local context of Tower Hamlets or the UK. It is resource-intensive, demanding significant time and cognitive involvement from participating families. Despite these demands, MECSH provides families and children with enhanced safeguarding needs one-to-one, frequent and targeted support, tailored to their specific situations.

Hackney and Newham, on the other hand, do not have an equivalent of the MECSH programme. Instead, they operate a Multi-Agency Safeguarding Hub (MASH). This hub coordinates collaboration across various services to support families where safeguarding concerns have been identified.

In Hackney, the MASH serves as a single point of contact for the public and professionals seeking support for a child or young person with specialist needs or in need of protection. The core functions of Hackney's MASH include:

1. Acting as the "front door" for statutory social work intervention.
2. Providing an early help hub where children and families not requiring statutory support are given advice, guidance, signposting and referrals.
3. Serving as an information-sharing and advice hub, allowing multi-agency partners to access guidance and advice regarding potential contacts with the Multi-Agency Safeguarding Partnership.

Overall, while Tower Hamlets focuses on intensive, individualised support through the MECSH programme, Hackney and Newham utilise the collaborative and coordinated approach of the MASH to address and manage safeguarding concerns.

Families' access to and experiences with the Health Visiting Service

Research case study: Comparison of resident service satisfaction in Newham and Tower Hamlets

Access:

In Newham, access to the Health Visiting Service was a significant concern, according to the evaluation. About 67% of participants found it challenging to schedule visits, expressing dissatisfaction with access. While some had positive experiences with individual health visitors who were responsive and facilitated access to services, reaching health visitors and securing in-person appointments remained persistently difficult.

On the other hand, opinions on access to the Tower Hamlets Health Visiting Service were generally more positive. Clients needing additional support received personalised attention, including link workers for appointments and translation services. However, those on the universal pathway reported less engagement, long wait times even for phone appointments, and a lack

of translation support. They emphasised the need for clearer appointment scheduling and more frequent check-ins between appointments. Service providers were noted to be overwhelmed, with limited capacity, which impacted service delivery.

Effectiveness:

In Newham, families were largely dissatisfied with the service, with only 20% rating it as "Good". Many felt unsupported due to insufficient appointments, brief and unhelpful interactions with health visitors, and the need to seek solutions independently. There was also a lack of awareness about available services for families.

Tower Hamlets received more positive feedback on service effectiveness. Participants appreciated the support provided during visits, including addressing cultural differences in parenting practices and prioritising parents' health and wellbeing alongside their parenting role. However, concerns were raised about inconsistency in care providers for families on the universal pathway, and the absence of certain workshops offered in other boroughs.

Client experience:

Client experiences in Newham varied widely. Some felt well cared for and listened to by health visitors, while others described the service as impersonal and lacking meaningful engagement or solutions. Overall, many felt the support received did not significantly impact their situation.

In Tower Hamlets, positive experiences were noted for the attention given to mental health and wellbeing, improving confidence, and engaging in meaningful conversations during appointments. However, criticisms included routine appointments lacking engagement, perceived pressure on mothers without considering their perspectives on parenting, and insufficient support for confidence building.

Overall, participants with additional support needs (UP, UPP, FNP, MECSH) in Tower Hamlets reported more positive experiences compared to those on the universal pathway, highlighting greater engagement, attention and care received during appointments.

The Tower Hamlets Health Visiting Service has been beneficial for many families, offering valuable support and advice on various parenting challenges. Families appreciate the practical help provided through informative leaflets and guidance on developmental milestones, such as transitioning from bottle to cup. However, there have been instances where the programme's recommendations did not align with family routines, leading to some dissatisfaction:

> *"For example, when my daughter doesn't sleep at 7:00 p.m. as suggested, it doesn't fit our lifestyle and routine. They insist she must stick to 7:00 p.m., but it doesn't work for us. Despite this, most of the time they do respect our choices." (P23, Stay-at-home Asian mum)*

Feedback indicates that the service addresses wellbeing concerns effectively by providing opportunities for mothers to discuss personal issues and receive relevant advice. Families value the diverse pool of health visitors available, reflecting different ethnic backgrounds, which contributes to a supportive and inclusive environment. The flexibility of appointment types – whether by phone, face-to-face at home, or in-office – ensures accessibility for families with varying needs and preferences.

Parents find general parenting advice useful, especially safety tips and developmental guidance tailored to their child's age. They appreciate that the visits fit into their routines seamlessly, enhancing convenience. Overall, the service is positively reviewed for its thoroughness and personalised approach, with families emphasising the importance of consistent, one-on-one support from a familiar health visitor.

Despite these positives, there are areas needing improvement. Some families report confusion over the service's scope and boundaries, such as whether health visitors can address specific health issues or if medical professionals should be consulted instead. The shift to online appointments during the pandemic has presented challenges, with families preferring face-to-face interactions for better engagement and support:

> *"Yeah, there's a lack of clarity on what the health visiting service is meant for and what they can do, where the boundaries lie. For issues like persistent nappy rash or diarrhoea, I'm not sure if I should consult a doctor or the health visitor. Could the health visitor have advised me on my baby's persistent nappy rash, or is that solely the doctor's role?" (P25, Caucasian working mother)*

There are also concerns about workload pressures impacting service quality and training consistency for staff. Families recognise the service's efforts, but they feel that there's room for enhancement in organisational aspects such as appointment scheduling and clinic accessibility.

In summary, while the service generally receives positive feedback for its supportive and informative role in parenting, addressing issues such as clarity of service offerings, preference for face-to-face interactions, and organisational improvements will be crucial to better serve the diverse needs of families in Tower Hamlets.

Protected characteristics – Service accessibility and equity

The multicultural population in Tower Hamlets presents both challenges and opportunities for the Health Visiting Service. Effective use of translation services is crucial, and while the service strives to meet these needs, there are instances where language barriers have caused issues. Newham and Hackney face similar multicultural challenges, but specific community needs can vary. For example, Newham has a significant South Asian population, while Hackney is known for its diverse ethnic mix, including a substantial African and Caribbean community.

Multicultural Service Delivery: Serving a diverse population, Tower Hamlets has effectively utilised translation services to cater to non-English-speaking families. This is particularly important given the significant Bangladeshi community in the borough. While similar challenges exist in other London boroughs, specific community needs vary, and Tower Hamlets' tailored approach has helped it maintain strong service delivery standards.

P37 – Health visiting support for a Bengali-speaking mother

P37 is a stay-at-home mother with two children, a 2-year-old and a 5-year-old. Before living in Tower Hamlets, she lived in Bangladesh, and she speaks only Bengali (Sylheti).

Her youngest child was born in England and did not require any specialist care due to good health. P37 found the aftercare from the health visiting team very beneficial, particularly appreciating the home visit by the health visitor after she returned home with her newborn. Although she did not have any emotional needs, she was impressed that the health visitor enquired about her emotions and mental health.

The health visiting team provided general advice on keeping her child safe at home. P37's husband is the sole earner, and she has never worked or taken any classes. Overall, P37 reported being happy with the service provided by the health visiting team. However, she did express concerns about the language barrier, as it was difficult for her husband to take time off work for every appointment and there was no translator available for her.

P36 – Health visiting support for a Bengali-speaking mother

P36 has been living in Tower Hamlets for five years, having previously lived in Bangladesh, her home country. She is sociable, with a strong support network of friends, family and neighbours. Before the birth of her second son, she took English classes.

P36 expressed overall satisfaction with the service she received, especially appreciating the time the health visiting team spent with her during home visits after the birth of her most recent child. She primarily visited the children's centre for health visits, and she was pleased to find Bengali-speaking staff available, which benefited her greatly. Whenever she had concerns, she found the health visiting team to be supportive and resourceful, referring her to appropriate services when needed.

The health visiting team provided valuable information on child safety, particularly helpful as her older son was not born in England, making parenting practices different. She continues to attend regular appointments due to concerns about her baby's weight, receiving appropriate advice during each visit. Overall, P36 feels that the service has boosted her confidence in parenting, particularly given the differences in child-rearing practices between Bangladesh and England.

P31 – Health visiting experience for a Bengali-speaking mother

P31 is a mother of three sons, aged 2, 10 and 12. Originally from Bangladesh, she initially lived in Manchester for six months, before settling in Tower Hamlets, where she has resided for the past four years. She has no family in England beyond her husband, and she lacks a social network in London. While her husband is employed full-time, she is a stay-at-home mother.

P31 reported that, having already raised two older children, she did not find the services provided by the health visiting team particularly useful, as the information presented was not new to her. Although the health visiting team expressed concern about her emotional and mental wellbeing, she assured them that she was content and did not require any support in that regard. Overall, she felt that the health visiting appointments were inconvenient, and she would prefer if they were optional, as she did not perceive much benefit from attending them.

Service users matched with a health visitor of the same ethnicity

A Bengali-speaking mother found the health visiting service beneficial. Matching her with an ethnically similar health visitor made her feel more comfortable and understood. The health visitor offered reassurance on developmental milestones, and suggested talking therapies at the Children's Centre, boosting her confidence. However, she received no guidance on returning to work beyond mentioning that her husband worked, and she was unsure of the health visitor's full role, believing that it focused solely on child health and mental wellbeing. Nonetheless, she received valuable parenting advice, including child safety tips, such as securing reachable windows. The visits were convenient and integrated well into her family's routine. Overall, she found the service supportive, and she appreciated the advice on child concerns.

Service users seeking asylum

Health visitors play a vital role in supporting refugee families by providing comprehensive care and information. They offer not just nutritional advice, but also address maternal mental health, financial concerns and other family needs. This holistic support is crucial because refugee families often find the NHS system confusing and fragmented, and they are unsure where to seek help. Health visitors act as a consistent source of support, capable of addressing various family needs comprehensively.

Specific outreach efforts by health visitors to asylum seeker families have been effective. In settings such as asylum seeker hostels or hotels, health visitors from local boroughs provide targeted support, even though this support is not always formally commissioned. Despite this, it has integrated well into existing services, and it has proven beneficial for supporting these families in challenging circumstances.

Health visitors often conduct clinics in local children's centres, which are preferred over GP surgeries due to their suitable space and child-friendly environment. Although they sometimes use GP practices when necessary, children's centres offer a more conducive setting for health visits, especially for young children. This preference highlights the importance of accessible and well-equipped spaces in delivering effective health visiting services.

These findings underscore the adaptable and essential role that health visitors play in delivering tailored healthcare support to refugee and asylum seeker families. They utilise a variety of settings and approaches to meet diverse healthcare needs effectively within these vulnerable communities.

Research insights: Case study: Humera – Health visiting support for an asylum seeker

Humera is an asylum seeker who has been in England for just over three years. She has a 4-year-old child with serious health challenges, including the need for a stoma, and a 10-year-old from whom she is estranged. The interview was conducted with the help of an Urdu translator and her link worker. Humera was assigned a single health visitor, who handled all her follow-ups and appointments.

Humera reported an overall positive experience with the Health Visiting Service. Due to her language barriers, she often relied on her link worker to facilitate appointments, which she described as working effectively. Her appointments typically required a translator. Given her daughter's health needs, Humera had more contact with the service than usual until her daughter started school.

According to Humera, the Health Visiting Service was crucial for both her emotional wellbeing and her child's health, which required substantial support. She repeatedly described the Health Visiting Service as very good when asked about her experience or if anything needed improvement. Humera expressed feeling fortunate, and she emphasised how much easier her life had been because of her dedicated health visitor.

Research insights: Fikert – Health visiting support for an asylum seeker

Fikert is an asylum seeker from Israel who has been living in England for the past three years. She is a first-time mother with a 16-month-old boy, and she is unable to work due to visa restrictions. Through participating in community integration activities, she has learned to speak and understand English well.

Fikert was assigned a single health visitor (HV) who handled all her appointments and follow-ups. She described her HV as exceptionally helpful, both during her pregnancy and afterward. The HV assisted her in obtaining food vouchers, connected her with charities for baby clothes, and ensured her overall wellbeing.

The HV took the time to engage in meaningful conversations with Fikert, and even arranged for an Arabic translator when discussing complex topics. Fikert found her HV to be respectful and understanding, always making sure that everything related to the baby's and her own health, as well as the home environment, was in good order.

Fikert did not feel that any improvements were needed in the service. She expressed immense gratitude for the support she received, and she felt fortunate to have had such assistance when she needed it most.

In Tower Hamlets, parents have reported both positive and negative experiences. The service is appreciated for its proactive approach, and for the support it provides, especially in a multicultural context. However, there are areas needing improvement, such as reducing waiting times for phone appointments and ensuring that health visitors provide detailed and knowledgeable support consistently. Feedback from Newham and Hackney indicates similar challenges, but the specific issues can vary depending on the local demographics and administrative practices.

7. Discussion

About managing the existing contract

The research identifies several key factors influencing the decision to maintain or change the current service provider. One significant advantage noted is the alignment of the GP Care group with the same IT system used by GP surgeries (EMIS). This integration allows them to access GP records efficiently, providing a comprehensive view of family health histories, which is seen as beneficial for delivering coordinated care.

However, concerns have been raised about resource allocation and operational capacity. The current provider manages a substantial workload, overseeing services for approximately 4,000 babies annually across Tower Hamlets and Waltham Forest. Despite this dual responsibility, there is uncertainty about the adequacy of their management team, which operates centrally for both boroughs. Stakeholders suggest a need for dedicated full-time positions, such as an Operations Director, Clinical Director and Data Analyst, to ensure effective service delivery without overextension.

Additionally, stakeholders emphasise the importance of clarifying and possibly renegotiating KPIs and deliverables in any new contract. This reflects a collaborative effort between Commissioners and stakeholders to ensure that expectations are clearly defined and achievable. Discussions have also highlighted the need for improved administrative support and coordination resources, which were perhaps underestimated in the initial contract specifications.

In conclusion, while there are benefits to the current provider's technological alignment and historical familiarity with the service area, there are valid concerns regarding operational capacity and resource management. The decision to continue with the current provider will likely hinge on addressing these concerns through revised contractual terms that prioritise adequate staffing and operational support to meet the demands of the service effectively.

Service improvements

To improve healthcare services for better access, effectiveness and patient satisfaction, several changes can be made. Initially, a challenge was the lack of clear guidelines for service providers, which made it hard to hold them accountable. Redefining these guidelines to be stricter yet adaptable will ensure better service delivery and accountability, even with limited funds.

A successful example is the dedicated health visitor for asylum seeker families, which has effectively supported 50–60 children in such situations. Formalising and expanding this service could maintain its effectiveness. Health visitors prefer conducting clinics in local children's centres due to better facilities, making these centres more suitable for health visits.

Structured support benefits new mothers greatly. Providing a visit schedule at the start and organising proactive group classes can manage expectations and offer valuable advice and community support. Enhancing the skills mix within health visiting teams by introducing new roles and securing funding for recruitment and career development can improve service quality.

Collaborating with community organisations is crucial for understanding and addressing community needs. Producing resources that enhance health visitors' understanding of their communities ensures more personalised care. Reducing post-visit paperwork in favour of interactive information sessions can enhance patient satisfaction.

Improving staff consistency is vital. Addressing short-staffing and standardising procedures can prevent service delivery inconsistencies. Regular team meetings and shared office spaces for peer support are essential for team cohesion and managing complex cases.

Engaging families through community events and educational sessions at family centres improves service accessibility. Ensuring vulnerable clients have a trusted named health visitor is essential, and this needs formalisation and better resources. Clear pathways for escalating concerns and referrals to safeguarding services should be maintained.

Offering optional services for patients who find mandatory appointments inconvenient can enhance satisfaction by respecting their preferences and autonomy.

Research findings highlight critical areas for improving healthcare, such as setting clear performance goals for accountability, quarterly meetings between GPs and health visitors for better collaboration and encouraging consistent engagement across services. Implementing structured feedback from health visitors ensures ongoing improvements. Smoothing transitions between services and addressing capacity issues are crucial. Enhancing awareness of service roles and tailoring care plans to individual needs improves effectiveness. Relocating health visitors to community settings enhances connectivity, despite reduced GP interactions. Building partnerships and improving communication between healthcare sectors integrate care and enhance quality. Establishing dedicated mental health teams and refining communication systems reduce staff stress and improve service delivery. These efforts collectively aim to significantly enhance healthcare delivery, making it more responsive to patient needs.

Addressing the known and emerging needs of vulnerable families

In Tower Hamlets, there are challenges in reaching and engaging certain families, such as those who do not register with GPs or children's centres, or who are transient. Strengthening systems to ensure that every GP practice has a designated practitioner for children aged 0–19 facilitates information sharing. There is a shared child health information system for Northwest and Southwest London, managed by NEFT, but gaps in communication persist when GPs fail to update their records.

The borough faces significant vulnerabilities due to the impact of social isolation on child development, evidenced by increased referrals for speech and language delays and school readiness issues. Economic challenges exacerbate these issues, affecting families' ability to provide nutritious meals and support their children adequately.

School readiness remains a concern in Tower Hamlets, with initiatives exploring whether bilingualism affects developmental assessments. The MECSH programme, initially intended for enhanced midwifery cases, faces misuse by other disciplines, such as social care, prompting calls for clearer programme justification and adaptation to local needs. There is a need to broaden MECSH eligibility beyond its current restrictions, to better suit Tower Hamlets' diverse population.

Despite challenges, the Family Nurse Partnership (FNP) in Tower Hamlets remains vital, appreciated for its community integration and strong support from stakeholders and commissioners. Post-COVID, safeguarding concerns have dominated health visitor agendas, reducing time for other family support activities. Leadership and system teams collaborate on contract reviews and performance analysis, emphasising localities with higher safeguarding and perinatal mental health needs.

Assessments of vulnerable families focus on identifying and addressing needs through robust templates, informing case studies and performance reports. Tower Hamlets continues to refine its approach to enhance family health and support, aiming for more inclusive and effective service delivery.

Limitations

This study was a rapid evaluation of health visiting services conducted with limited funding and incomplete data, which presented several challenges. The primary issue was that missing and inconsistent data made it difficult to accurately assess the effectiveness of the services. Limited funding meant that the evaluation was not heavily resourced, affecting the time and scope of the investigation and potentially impacting the quality of the findings. The short timeline required for rapid evaluations often prevented deep analysis and limited the involvement of key stakeholders who could provide valuable insights. Variations in service delivery across different areas complicated the comparison of results and hindered the drawing of reliable conclusions. Additionally, participant numbers did not account for any duplicated participants who might have completed the Practitioner Reflection Sheet or participated in qualitative in-depth interviews.

The ethical integrity of the research was considered from the design stage to ensure that data sets would not reveal the identities of participants. Despite these efforts, the limitations made it difficult to fully understand the impact of health visiting services under these constraints, especially among parents who opted out of the service.

8. Conclusion

The Associate Director of Public Health for Children and Families outlined several challenges facing the Health Visiting Service, including high staff turnover due to sickness, retirements and difficulty in recruiting trained health visitors. These staffing issues often leave the service understaffed, affecting its effectiveness. Concerns were also raised about the Waltham Forest contract, which did not bring additional senior leadership and diverted attention away from Tower Hamlets' needs.

There is frustration among stakeholders due to perceived neglect of Tower Hamlets' priorities following the Waltham Forest contract win. Inadequate feedback mechanisms with frontline staff further hinder communication and strategic planning. However, the Family Nurse Partnership (FNP) received praise for effectively serving families and expanding its age range up to 25 years old, showing promise in addressing community needs.

Conversely, the MECSH programme in Tower Hamlets has faced criticism for not meeting its intended specifications. MECSH aims to provide targeted support similar to FNP, but it has struggled to deliver in

practice. Both MECSH and FNP play vital roles in supporting high-risk families dealing with poverty and overcrowding, which are prevalent in the area.

There is a recognised lack of coherence in the goals and language used within the Health Visiting Service, impacting overall effectiveness. Efforts are underway to enhance the skills mix among staff through a pilot programme funded by the Department of Health and Social Care. This initiative aims to introduce new roles and career pathways within health visiting to improve recruitment and retention.

Looking ahead, plans should include collaborating with community organisations to better understand local priorities and challenges. This collaborative approach aims to develop resources that will enable health visiting staff to better engage with and support their communities. Additionally, efforts are being made to address low school readiness levels in Tower Hamlets, examining whether bilingualism affects children's development and educational outcomes.

9. Recommendations

Based on the information provided, here are some key points and recommendations for improving the Health Visiting Programme:

4. **Clarify and Narrow Focus**: The programme should concentrate on priority outcomes, such as promoting childhood immunisations, breastfeeding, child development and school readiness. This focus will streamline efforts and improve accountability. The priority outcomes need to be very explicit in the new service specification, with KPIs attached to each area of focus, which encompass more than the 5 mandated reviews.

5. **Co-develop and/or Review Key Performance Indicators (KPIs)**: Establish clear KPIs to track performance and ensure accountability. This will help measure the programme's effectiveness and identify areas needing improvement.

6. **Enhance Health Promotion**: Shift from solely meeting KPIs to prioritising health promotion initiatives. This may require additional resources, and a change in organisational culture to emphasise the importance of health promotion.

7. **Address Workforce Shortages**: Implement strategies to address the national shortage of midwives and nurses transitioning to health visiting roles. Consider initiatives to attract and retain qualified health visitors, such as investing in training and development opportunities with overseas HE partners, which reflect the ethnicities/cultures of the borough. Implement a system that is prepared to address nurse workforce shortages in the periods when nurses transition into health visiting roles; for example, start recruitment earlier to replace staff nurses who move on to health visiting roles.

8. **Improve Accessibility**: Tackle challenges related to appointment scheduling and accessibility for parents with multiple toddlers. Explore options for providing appointments closer to clients' homes, and improving facilities to accommodate parent–child treatments as highlighted in the commissioning guidance (1).

9. **Enhance Training and Practice Implementation**: Develop strategies to integrate training, such as newborn observational training for mothers with mental health problems, into daily practice. This may involve ongoing support, mentoring and opportunities for reflective practice.

10. **Strengthen Administrative Capacity**: Allocate resources to improve administrative processes, appointment booking, and monitoring of mothers and babies. This may require investing in technology and training staff to streamline administrative tasks.

11. **Enhance Data Utilisation**: Improve data use (i.e. data sets that speak to each other) to inform and shape practice. Develop systems for collecting, analysing and utilising data to evaluate programme effectiveness and identify areas for improvement, and to mitigate risk and the vulnerabilities in the system. A tool such as The Institute of Health Visiting Outcomes and Evaluation enables providers to measure and evaluate the impact of their work.

12. **Improve Engagement with Communities**: Address barriers to engagement, particularly with settled white East End populations and Bangladeshi brides. Explore culturally sensitive approaches to build trust and facilitate communication, such as engaging community leaders and providing culturally relevant resources.

13. **Ensure Clinical Leadership**: Consider appointing a programme lead with a clinical qualification to provide leadership and guidance. This individual can ensure a focus on evidence-based practice and quality improvement initiatives. Someone with public health backgrounds is needed to connect systems at the corporate level, beyond one organisation and one service. It is essential that the service improvements are viewed through a public health lens, and new KPIs are only to be implemented if they focus on improving public health outcomes.

14. **Group-centred Support**: To combat understaffing, supplement one-on-one health visitor sessions with group-centred support.

15. **Clear Communication of Appointments**: Clearly communicate appointment times in advance to address issues of forgetting, losing, and not memorising dates, as well as last-minute appointments.

16. **Expand Reach to Marginalised Parents**: The service's reach is generally good, but it is less effective with marginalised parents, due to using traditional methods of communication. Explore new ways to make these individuals aware of the service.

17. **Improve Data Sharing**: The full range of primary data collected by the service is not being shared evenly across all levels. Improve data sharing, both vertically and horizontally, implement agreed data-sharing protocols with partners and other providers to improve co-ordination and communication.

18. **Transition Period for FNP and MECSH**: Introduce a transition period for parents moving from the Family Nurse Partnership (FNP) and Maternal Early Childhood Sustained Home-visiting (MECSH) programmes. This will help parents adjust to the new service regime, manage expectations, reduce dependence, and ensure that they are adequately signposted to community-based services to fill any gaps.

By addressing these key areas, the Health Visiting Programme can better achieve its goals of supporting families to better support their children and can improve overall programme effectiveness.

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Appendix 1: Research tools

Appendix 1/a: Interview Guide for Healthcare Practitioners – Frontline staff (Health visitors, nurses)

INTRODUCTION

The interview should take about 30-45 minutes. We will ask you questions about your views on the Health Visiting Service(s) in Tower Hamlets. We will feedback the results of this evaluation to Tower Hamlets Public Health Healthy Children and Families Team.

No individual staff member will be identifiable in our report, however because the sample size is small, we cannot guarantee that information provided is not traceable back to your service. If you do not want to answer a particular question, you don't have to, and if you feel uncomfortable, we can stop the interview at any point

Do you agree to take part? <u>We need you to fill in and sign a consent form. Is that OK?</u> Have you got any questions before we start?

Interviewer to complete
Researcher's initials:
Date/time:
Research participant's name:
Organisation name:
Have you gained informed consent Yes/No

BACKGROUND INFORMATION

1. **What is your role at the organisation?**

2. **When did you start working at this service?**

3. **What are the goals of the Health Visiting Service/FNP/MECSH?**

Prompts:
- *In what ways the goals of the three services are interrelated.*
- *What strategic needs in Tower Hamlets the services respond to, and what outcomes they aspire to achieve at borough level?*

4. **In your opinion, why is the Health Visiting Service/FNP/MECSH service is needed in the borough? What types of physical, mental or social care needs were identified historically that required support systems to be implemented/ required the service to respond to?**

Interviewer probe:
- *Supporting vulnerable families in accessing health visiting/child support/family support services and increasing the uptake of services*
- *Building trusting relationships with vulnerable people/communities*
- *Pressure on healthcare staff/health visitors*
- *Supporting healthcare staff/health visitors*

DELIVERY OF THE SERVICE

5. **Can you tell me about who uses, and how they access your service?**

Prompts:
- *How is the service being promoted to the target population?*
- *What have been some of the challenges so far in reaching these groups?*
- *What strategies have been put in place to overcome some of these challenges and how well are they working?*
- *Which staff are responsible? (Some/all?)*
- *What's the process for referring clients to other services?*

COHERENCE

6. **Are there any factors that facilitate or hinder achieving the goals of the service? What changes have you experienced over your time of working at this service?**

Prompts:
- *Change in workforce deployment?*
- *Change in health visit numbers or lengths?*
- *Change in the way service users are booking/getting health visits?*
- *Changes to your tasks on health visits?*
- *Changes in the goals of the service?*

7. **What types of training have you and other staff at the service accessed and how frequently? Did it support staff's work at the service?**

Prompt:
- *What type(s) of training you/or staff attended that specifically aimed to contribute to the successful delivery of the service? (e.g. types of training and number of sessions)*
- *How did the training contribute to your understanding of the goals and visions of the service?*
- *What additional training needs did you identify?*

COGNITIVE PARTICIPATION

8. Do you think other staff members see the benefits of the service and support the short-term and long-term and wider strategic goals of the service in the right way?

Prompt:

- *Do you think that the service is set-up in a way that key staff members, strategic leads and stakeholders are involved in the right positions to help achieve the strategic goals?*
- *What are those characteristics of the staffing of the service that help achieving the services' goals?*
- *Are key workforce members involved in the service in the right position?*
- *If no, what key staff members or partners are missing that would optimize the operation of the service?*
- *Do staff members involved in the service believe the potential benefits of the service?*
- *Do you think there is a collective (rather than individual) support from staff for the service?*
- *If they don't see the benefits, why?*
- *Do you feel that staff's voices have been heard if/when defining actions and procedure for the service?*

COLLECTIVE ACTION

9. How would you describe your experience working with your colleagues and your experience of working with outside organisations?

Prompt:

- *Do you feel there is a good partnership work environment with colleagues?*
- *If not, what have been the main barriers?*
- *If yes, what have been the main facilitators?*
- *Are there any issues around staffing: capacity, staff turnover, differences between individual practices?*
- *What partnerships have been developed? What has been the value of these partnerships?*
- *How do you find the collaborative working with School nurses, clinical leads, GPs, mental health support workers (stakeholders)?*
- *How do your partners and local stakeholders view the value of the service?*

10. What resources do you think are needed to continue to provide effective health visiting/family support service for your target communities?

Probes:

- *What do co-workers view as the best aspects of the service?*
- *What do co-workers/ think could be improved?*
- *What have been the significant barriers and drivers from your perspective?*
- *What additional resources the service needs to sustain or improve the effective delivery of health visiting service for your target communities?*

11. What skills do you think you or staff at the organisation need to continue to provide effective service?

Prompts

- *What was the impact of the training provided on the delivery of the service?*
- *What additional training needs have you identified?*
- *What skills staff at the service should improve to ensure effective delivery?*
- *To what extent, if any, do you use trauma-informed approaches?*

REFLEXIVE MONITORING

12. Which groups of clients/families have been the most responsive in engaging with the service?

Prompt:

- *Why and how?*
- *Has the service been successful in encouraging the uptake among those families/clients who have historically not been engaged?*
- *What have been the barriers for each client/family groups?*

13. What have been the best aspects of designing and delivering the Health Visiting Service/FNP/MECSH programme?

Prompt:
- *Improved uptake among target communities, improved reach of target communities.*
- *Better public health outcomes (transition to parenthood, breastfeeding, healthy weight and physical activity, improved health literacy, reduced illness, children improved skill levels and school readiness)*
- *Service user satisfaction*
- *Quality care*
- *Staff workload*

14. What aspect have been the most challenging aspect of the service?

Prompt:
- *Lack of knowledge/understanding of the services*
- *Access problems (e.g. digital problems, getting health visiting appointments)*
- *Lack of knowledge of local support groups, etc.*
- *Lack of individualised support prior to engaging with the service?*
- *Lack of time on health visiting appointments?*
- *Staff workload? Continuity (i.e. a health visitor assigned for the family for the full eligibility period)*

15. Is there anything else that you would like to tell that we have not covered already?

Prompt:
- *What would be the key message to consider for improving the service and potentially scaling-up?*

Appendix 1/b: Interview guide for Healthcare Practitioners – Backoffice strategic leads (Programme coordinators, service leads, commissioners)

INTRODUCTION

The interview should take about 30-45 minutes. We will ask you questions about your views on the Health Visiting Service(s) in Tower Hamlets. We will feedback the results of this evaluation to Tower Hamlets Public Health Healthy Children and Families Team.

No individual staff member will be identifiable in our report, however because the sample size is small, we cannot guarantee that information provided is not traceable back to your service. If you do not want to answer a particular question, you don't have to, and if you feel uncomfortable, we can stop the interview at any point.

Do you agree to take part? <u>We need you to fill in and sign a consent form. Is that OK?</u> Have you got any questions before we start?

Interviewer to complete.
Researcher's initials:
Date/time:
Research participant's name:
Organisation name:
Have you gained informed consent Yes/No

BACKGROUND INFORMATION

What is your role at the organisation?

When did you start working at this service?

What are the immediate and wider strategic goals of the Health Visiting Service/FNP/MECSH?

Prompts:
- *In what ways the goals of the three services are interrelated.*
- *What strategic needs in Tower Hamlets the services respond to and what outcomes they aspire to achieve at borough level?*

In your opinion, what historical needs has the Health Visiting Service/FNP/MECSH responded to? What types of physical, mental or social care needs were identified historically that required support systems to be implemented/ required the service to respond to?

Interviewer probe:
- *Supporting vulnerable families in accessing health visiting/child support/family support services and increasing the uptake of services*
- *Building trusting relationships with vulnerable people/communities*
- *Pressure on healthcare staff/ health visitors*
- *Supporting healthcare staff/health visitors*
- *Better public health outcomes for children*

DELIVERY OF THE SERVICE

1. **Can you tell me about who uses, and how they access the service(s)?**

Prompts:
- *How is the service being promoted to the target population?*
- *What have been some of the challenges so far in reaching these groups?*
- *What strategies have been put in place to overcome some of these challenges and how well are they working?*
- *Which staff are responsible? (Some/all?)*
- *What's the process for referring clients to other services?*

COHERENCE

2. **Are there any factors that facilitate or hinder achieving the goals of the service? What changes have you experienced over your time of working at this service?**

Prompts:
- *Change in workforce deployment?*
- *Change in health visit numbers or lengths?*
- *Change in the way service users are booking/getting health visits?*
- *Changes to your tasks on health visits?*
- *Changes in the goals of the service?*

3. **What types of training have you and other staff at the service accessed and how frequently? Did it support staff's work at the service?**

Prompt:
- *What type(s) of training you/or staff attended that specifically aimed to contribute to the successful delivery of the service? (e.g. types of training and number of sessions)*
- *How did the training contribute to your understanding of the goals and visions of the service?*

- *What additional training needs did you identify?*

COGNITIVE PARTICIPATION

4. **Do you think other staff members see the benefits of the service and support the short-term and long-term and wider strategic goals of the service in the right way?**

Prompt:
- *Do you think that the service is set-up in a way that key staff members, strategic leads and stakeholders are involved in the right positions to help achieve the strategic goals?*
- *What are those characteristics of the staffing of the service that help achieving the services' goals?*
- *Are key workforce members involved in the service in the right position?*
- *If no, in what key staff members or partners are missing that would optimize the operation of the service?*
- *Do staff members involved in the service believe the potential benefits of the service?*
- *Do you think there is a collective (rather than individual) support from staff for the service?*
- *If they don't see the benefits, why?*
- *Do you feel that staff's voices have been heard if/when defining actions and procedure for the service?*

COLLECTIVE ACTION

5. **How would you describe your experience working with your colleagues and your experience of working with outside organisations?**

Prompt:
- *Do you feel there is a good partnership work environment with colleagues?*
- *If not, what have been the main barriers?*
- *If yes, what have been the main facilitators?*
- *Are there any issues around staffing: capacity, staff turnover, differences between individual practices?*
- *What partnerships have been developed? What has been the value of these partnerships?*
- *How do you find the collaborative working with School nurses, clinical leads, GPs, mental health support workers (stakeholders)?*
- *How do your partners and local stakeholders view the value of the service?*

6. **What resources do you think are needed to continue to provide effective health visiting/family support service for your target communities?**

Probes:
- *What do co-workers view as the best aspects of the service?*
- *What do co-workers/ think could be improved?*
- *What have been the significant barriers and drivers from your perspective?*
- *What additional resources the service needs to sustain or improve the effective delivery of health visiting service for your target communities?*

7. **What skills do you think you or staff at the organisation need to continue to provide effective service?**

Prompts
- *What was the impact of the training provided on the delivery of the service?*
- *What additional training needs have you identified?*
- *What skills staff at the service should improve to ensure effective delivery?*
- *To what extent, if any, do you use trauma-informed approaches?*

REFLEXIVE MONITORING

8. **Which groups of clients/families have been the most responsive in engaging with the service?**

Prompt:
- *Why and how?*
- *Has the service been successful in encouraging the uptake among those families/clients who have historically not been engaged?*
- *What have been the barriers for each client/family groups?*

9. What have been the best aspects of designing and delivering the Health Visiting Service/FNP/MECSH programme?

Prompt:
- *Improved uptake among target communities, improved reach of target communities.*
- *Better public health outcomes (transition to parenthood, breastfeeding, healthy weight and physical activity, improved health literacy, reduced illness, children improved skill levels and school readiness)*
- *Good partnership working with outside organisations positively impacting on the engagement of target communities*
- *Service user satisfaction*
- *Quality care*
- *Staff workload*

10. Do you or your team make full use of insights gathered (e.g. service data, surveys, polls and complaints) on the thoughts and feelings of service users and of those families that opted out of the service?

Prompts
- *If yes, in what ways did your service use feedback and what has changed?*
- *What type of data and insights have you gathered?*
- *What have been the main reasons for families to opt-out?*
- *What were the primary benefits for families/service users who have been engaged?*
- *Do you share insights with partner organisations and with strategic leads in the borough? If yes, how are the insights used on a strategic level?*

11. What aspects have been the most challenging aspects of the service?

Prompt:
- *Lack of knowledge/understanding of the services*
- *Access problems (e.g. digital problems, getting health visiting appointments)*
- *Lack of knowledge of local support groups, etc.*
- *Lack of individualised support prior to engaging with the service?*
- *Lack of time on health visiting appointments?*
- *Staff workload? Continuity (i.e. a health visitor assigned for the family for the full eligibility period)*
- *Lack of collaborations/partnerships with outside organisations*

12. Is there anything else that you would like to tell that we have not covered already?

Prompt:
- *What would be the key message to consider for improving the service and potentially scaling-up?*

Appendix 1/c: Parent/Guardian Interview schedule

Ho w well has the health visiting services (Family nurse service) addressed the child's physical health?

2. Please describe how the health visiting services addressed your sense of well-being?

3. How well has the health visiting service addressed your emotional needs?

4. How has the health visiting services helped you to keep your children safe?

5. Please describe your social networks?

6. What education and learning did you gain on parenting through the health visiting service?

7. Please describe the health visiting services boundaries and behaviour towards you/family?

8. Please explain how the health visiting services worked around your family routine?

9. How has the health visiting services impacted your home life?

10. How well has the health visiting services impacted your ability to continue/return to work?

11. What do you know about the Tower Hamlets Healthy Schools programme?

12. What are your expectations regarding the Tower Hamlets Healthy Schools programme in terms of your child's diet, activity, learning and well-being (mental health)? What do you expect your child to learn about health in the school?

Appendix 1/d: Practitioner Reflection Sheet – Tower Hamlets Health Visiting Service evaluation

The purpose of this Practitioner Reflection Sheet is to build evaluative evidence and insights into the Tower Hamlets Health Visiting Service (i.e. including the universal Health Visiting Service, FNP and MECSH programme) commissioned by the London Borough of Tower Hamlets. These services cover the Healthy Child Programme elements for children between 0–5 years of age and provides support to families during the antenatal period and until the child starts school.

This practitioner reflection sheet is made up of sixteen scale questions and six open-ended question and should take no longer than 15 minutes to complete.

The areas covered in the self-assessment form are framed around implementation science principles to help us better understand what worked well and what worked less well in the design and delivery of the health visiting services.

All the information provided will be fed directly into the evaluation being undertaken by the Institute for Connected Communities based at the University of East London.

Data governance

The information you provide on this self-assessment form will remain strictly confidential, in accordance with the Data Protection Act 1998 and GDPR 2018. The University will process your personal data for the purpose of the research outlined above. Research is a task that we perform in the public interest. Further information about your rights with respect to your personal data is available here.

If you have any further questions or enquiries, please contact Dr Darren Sharpe at d.sharpe@uel.ac.uk

1. I give my consent to participate in this project evaluation

- ○ Yes
- ○ No

2. Role within the service (including Band if relevant)

_____

3. How long have you worked at the service?

_____

4. Please indicate which service you are completing the practitioner sheet about?

- ○ Universal Health Visiting Service
- ○ Family Nurse Partnership
- ○ Maternal Early Childhood Sustained Home-visiting programme
- ○ Other _____

5. Please indicate how much do you agree with the following statements in regards to your role in the delivery of the health visiting services?

	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Not Applicable
I deliver a safe and effective service within the allocated resources	○	○	○	○	○	○
I communicate vision with enthusiasm and clarity	○	○	○	○	○	○
I provide others with clear purpose and direction, through a well stated vision	○	○	○	○	○	○
I take time to build critical support for the vision	○	○	○	○	○	○
I put forward ideas to improve the quality of services	○	○	○	○	○	○
I take responsibility for embedding new approaches into working practices	○	○	○	○	○	○
I consult with key people and groups when making decisions taking into account the values and priorities of the service	○	○	○	○	○	○
I take action when resources are not being used efficiently and effectively	○	○	○	○	○	○
I identify opportunities where working collaboratively with others will bring added value to client care	○	○	○	○	○	○
I share information and resources across networks when needed	○	○	○	○	○	○
I actively engage with others (including clients and public) to help shape the direction of the organisation	○	○	○	○	○	○
I actively seek contributions and views from others	○	○	○	○	○	○
I regularly use data and information to suggest improvements to services	○	○	○	○	○	○
I routinely use feedback from clients, residents and service users to contribute to improvements in service delivery	○	○	○	○	○	○
I work with others to constructively evaluate our services	○	○	○	○	○	○
I make sure I assess the available options in terms of benefits and risks, and use this information to decide an appropriate course of action when providing a service	○	○	○	○	○	○

6. Please describe the vision and goals of the service and what's worked well and less well in order to achieve these goals?

Please consider: What have been the facilitators and barriers of delivering an effective service?

_____

_____

_____

7. Which groups of families have been the most and least responsive to engage with the service? And why?

_____

_____

_____

8. Please explain any lessons learnt in your practice in delivering the service and any adjustments that has been made in the team to better reach and respond to the needs of the targeted families.

_____

_____

_____

9. Please, describe any training you and your colleagues attended in the last 12 months and the impact it had on delivering the service. Please consider any additional training needs you identified since working at the service.

_____

_____

_____

10. Please describe the barriers and enablers in collaborations/partnerships to support targeted families in engaging with the service.

_____

_____

_____

11. In your opinion what areas of improvements need to occur across the system to improve the efficiency of the health visiting services?

_____

_____

_____

Appendix 1/e: Stakeholder Survey for the Tower Hamlets Health Visiting Service evaluation

Introduction

We're doing this survey to gather information that will help us understand what works well and what works less well when it comes to working together with Tower Hamlets Health Visiting Services. These services include the Universal Service, Family Nurse Partnership, and Maternal Early Childhood Sustained Home-visiting programme, which are all commissioned by the London Borough of Tower Hamlets.

The evaluation is being done by the Institute for Connected Communities at the University of East London. We are looking at the information provided to give advice on how to make service improvements.
This survey should take no longer than 10 minutes to complete.

Data governance

The information you provide on this survey will remain strictly confidential, in accordance with the Data Protection Act 1998 and GDPR 2018. The University will process your personal data for the purpose of the research outlined above. Research is a task that we perform in the public interest. Further information about your rights with respect to your personal data is available here.

Contact

If you wish for your personal information to be withdrawn from the evaluation you can contact ***Dr Darren Sharpe (D.Sharpe@uel.ac.uk).***

1. I give my consent to participate in this service evaluation.

- ○ Yes
- ○ No

2. I am a stakeholder partnering/collaborating with Tower Hamlets Health Visiting Services.

- ○ Yes
- ○ No
- ○ Other _____

3. What is the name of your organisation/service?

_____

4. What is the nature of your organisation/service? (E.g. GP, Nursery, School, mental health support service, infant feeding support service, refugee support service etc.)

_____

5. How do the Tower Hamlets Health Visiting Services directly benefit your organisation/service goals? (E.g. widening access for families, improving families' experience, or achieving organisational goals in tackling health inequalities)

_____

_____

6. How would you rate the benefits of partnering/collaborating with Tower Hamlets Health Visiting Services for your organisation/service?

- ○ Exceeded expectations
- ○ Met expectations
- ○ Below Expectations

6/1. Please, explain why

_____

_____

_____

7. Has your organisation/service been sufficiently consulted in the design and delivery of the Tower Hamlets Health Visiting Services?

- ○ Yes, a great deal
- ○ Yes, a lot
- ○ Yes, a moderate amount
- ○ Yes, a little
- ○ No, none at all
- ○ Unsure

7/1. Please, provide an example

_____

_____

_____

8. In your opinion, what are the good parts, and the not-so-good parts in working with the Tower Hamlets Health Visiting Services?

_____

_____

_____

9. What have been the historical challenges for your own organisation/service in supporting clients to access Health Visiting Services in Tower Hamlets?

_____

_____

_____

10. What do you think other organisations – who also help the people you work with – feel about how useful the Tower Hamlets Health Visiting Services are?

- ○ Extremely valuable
- ○ Very valuable
- ○ Somewhat valuable
- ○ Not so valuable
- ○ Not at all valuable

10/1. Please, explain why

_____

_____

_____

11. What changes or improvements would you like to see in the Tower Hamlets Health Visiting Services over the next two years?

_____

_____

_____

12. In your opinion, what 'place-based' issues should the Health Visiting Services better address to tackle health inequalities amongst your client group?

_____

_____

_____