



The Independent Evaluation of 'Starting Well': Final Report

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The Independent Evaluation of 'Starting Well'
Final Report
June 2004

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Executive summary

Introduction

In 1999 the Scottish Public Health White Paper sought bids from health partnerships in Scotland to develop good practice in the areas of child health, coronary heart disease, sexual health and colorectal cancer. Through the Glasgow Healthy City Partnership, a multi-agency child health bid was developed and awarded funding. A key part of the rationale for this investment was the widespread belief that 'early years' interventions can help to break the cycle of poverty that limits the opportunities available to children born into the most disadvantaged circumstances. The project, 'Starting Well', was granted £3 million over a three-year period and was launched in November 2000.

The project drew extensively on the US literature on home visiting. The essence of this evidence-base is that, compared with standard health care provision, intensive home visiting had significant impacts on a range of child and family health related outcomes. The key elements of the US programmes on which Starting Well focused were: intensive visiting of families within the home; the development of supportive relationships between families and their visitors; and, an emphasis on health promotion approaches. However, the complex nature of home and health visiting makes this an evidence base that is not straightforward to implement and there were a number of ways in which Starting Well departed from the model associated with David Olds. These included:

- The targeting of deprived *communities* rather than vulnerable *individuals*;
- The inclusion of *all new* babies as opposed to only *first* babies;
- A lesser focus on the antenatal period than recommended by Olds, due to the availability of Community Midwifery services in Scotland, and to caseload issues within the project;
- The use of *paraprofessionals* as part of the home-visiting delivery mechanism in addition to professional health visitors;
- The vastly different primary care context within which the evidence was derived (for example, the absence of a universal health visiting service; and related to this,
- The requirement to integrate aspects of project delivery with existing professional and organisational structures as opposed to an entirely standalone intervention.

Notwithstanding these important modifications, the overall aim of Starting Well was originally set out as to 'demonstrate that child health can be improved by a programme of activities to support families, coupled with access to enhanced community-based resources for parents and their children'. This aim was addressed in three principal ways:

- the introduction of an augmented programme of home visiting to all families of new babies born within two geographical areas within the City of Glasgow, selected due to their relative socio-economic disadvantage (Greater Easterhouse¹ and Gorbals/Govanhill/ North Toryglen, known respectively as the East and the South);
- the development of enhanced local community supports and structures within these areas; and,
- the development of integrated organisational services to respond to the needs of children and their families both within the local areas and across Glasgow as a whole.

Evaluation

Following the decision to award funding to the Glasgow Healthy City Partnership, the Scottish Executive commissioned a multi-method independent evaluation led by the Department of Public Health, University of Glasgow. The main aims of the independent evaluation were as follows:

1. To measure the impact of the project on children and families;
2. To understand the theory, processes and context of the Starting Well intervention; and,
3. To analyse the policy implications of the project.

The independent evaluation of Starting Well was designed to be both formative and summative. To this end, the research team has produced several reports during the course of the evaluation, and two journal articles are currently in press. The final report provides an assessment of Starting Well's impact on a range of outcomes and processes and is organised around the main aims of the evaluation.

- An assessment of the health related outcomes for children and families as assessed through a quasi-experimental survey. This was supplemented by a relatively simple contextual description of study areas that is summarised in Appendix IV.
- A summary of the rationale lying behind the Starting Well demonstration project, as expressed by key stakeholders in the first year of the project, helps to introduce a number of key processes underpinning its implementation. These are:
 - the nature of the relationships developed between families and their health visitors;
 - the development of an augmented model of home visiting;
 - and, the development of mechanisms to support strategic change.

¹ Greater Easterhouse is used here as a shorthand for the following areas since the project did not cover Greater Easterhouse in its entirety: Cranhill, Ruchazie, Craigend, Garthamlock, Easterhouse and Gartloch.

This part of the report concludes with a discussion of strategic stakeholders' retrospective reflections on the initial rationale for Starting Well.

- Key findings, policy implications and recommendations are drawn together in the Conclusion.

Assessing Impact: the Quasi-Experimental Study

The most resource intensive component of the evaluation involved a quasi-experimental comparison of the two intervention areas with a socio-demographically similar area in the north of the city. This cohort study compared the health and development of intervention children over the first eighteen months of life with a group of families receiving statutory health visiting. Key health related outcomes included: quality of the home environment; maternal depressive symptoms; child dental registration; and measures of maternal service satisfaction. A designated health visitor approached all families with newborn children for consent between 01/06/01 and 31/06/02, yielding a total of 627 participants, or around 50% of all births².

Participating children were assessed on a maximum of three occasions (immediately after birth, then at six and eighteen months) using a combination of mother-report questionnaires, observation in the home and structured interviews with the mother. Questionnaires covered: background maternal, household and area characteristics; maternal mental health and health behaviour; and attitudes towards parenting and current health-visiting service. Each participant that could be contacted at six and eighteen months received a home visit from a trained research nurse who administered the HOME Inventory, a standardised interview-and-observation tool that assesses the quantity and quality of stimulation available to a child in its home environment (Bradley & Caldwell, 1979³). Interpreters were made available to assist participants with no or limited English. Finally, individual-level data such as the number of home visits were collected from routine sources including health visitor records.

There are a large number of complex findings but the most important are summarised below.

- 627/1321 (47.5%) eligible families were recruited over a 13-month period; 367 from intervention areas and 260 from comparison areas receiving the generic service.
- Cross-sectional analyses concentrated on 359 participants completing both baseline and 6-month assessments and 294 completing all three assessments to 18-months⁴. These sub-samples represent 57.3% and 46.9% of opt-ins, respectively.

² Health visitors stated that postnatal tiredness and a lack of time were very common reasons for not opting into the study.

³ See also the website <http://www.ualr.edu/~crtldept/home4.htm>.

⁴ At the time of writing, 73 participants had either voluntarily withdrawn from the study (N=26) or moved without leaving a forwarding address (N=47). Opt-ins who could not be contacted for at least one assessment were not included in analyses in order to maximise the number of predictor variables available for modelling.

- Comparisons of aggregate-level routine data on opt-ins and opt-outs suggest no obvious bias associated with recruitment or persistence in the study.
- Multivariate regression analysis revealed: lower rates of depressive symptoms amongst intervention mothers at 6 but not 18-months; no improvement in the quality of the home environment at 6-months but a small positive effect at 18-months ($p=0.088$); higher levels of client-satisfaction with levels of health visitor support; and higher levels of dental registration at both assessments.
- Minority ethnic mothers achieved lower HOME scores and were more likely to suffer from high levels of depressive symptoms. These findings are interpreted as indicating real need amongst this group but should be treated with some caution due to the fact that key instruments (the HOME Inventory and the Edinburgh Postnatal Depression Scale) have not yet been validated in a British Asian cohort.
- These modest findings provide some evidence of a positive Starting Well effect although the policy relevance associated with some findings such as those related to dental registration is open to question. More longitudinal data and analysis are necessary to determine the longer-term clinical and social significance of these intermediate outcomes and to assess the degree to which a 'step-change' in child health has been achieved.
- Despite doubts as to the transferability of the North American evidence-base to the British context and a number of evaluation limitations, findings relating to maternal depressive symptoms and HOME score are supportive of shorter-term benefits to the psychological health of study mothers and potentially longer-term cognitive and emotional developmental benefits for study children.
- Simple comparisons of area-level context (described in appendix IV) suggested a basic similarity between the intervention and control areas that did not help interpret the above findings. Lower-level comparisons, however, (for example at the level of postcode sector) revealed the potential for more sophisticated multi-level analyses that may help tease out the relative contribution of individual and area-level factors to these outcomes. More extended individual-level regression analyses remain our immediate priority, however, if future opportunities can be found to explore these possibilities, we may not only explain more of the variance in outcomes but also gain a more informed sense of the kinds of emergent community-level factors that constrain and facilitate both the operation and effectiveness of Starting Well.

In the future it would be valuable to determine whether or not Starting Well has had a direct influence on more child-centred outcomes such as readiness for school in general or cognitive development in particular. Whether or not this will be possible with the existing cohort remains to be seen, but we are optimistic. We have made strenuous efforts to put in place mechanisms for retaining contact with existing respondents and to maximise the availability of essential baseline information. Extrapolating from response rates thus far, our current assumption is that by the beginning of 2005, when the first of the study children will be

42 months old, we might reasonably expect to be able to contact approximately 500 families and that about 70 per cent of these (N=350) would respond positively to a further round of data collection. On this basis there is a strong case to be made for further follow-up that we propose to make in due course.

Theory, Processes And Context

Theory of change

A theory of change approach (Connell and Kubisch, 1998) was used to map stakeholders' views of how and why the intervention was being implemented and to capture expectations of change within a 3-year programme of activity. This was undertaken through interviews and focus groups with key strategic players, observation at steering group meetings and documentary review.

As with similar complex community initiatives, the strategic stakeholders within Starting Well struggled to articulate a Theory of Change that was wholly testable but developed a relatively robust internal monitoring system to capture the implementation of its plans, and, as with the independent evaluation, adopted a strong focus on process learning. The key assumptions underlying the initial Starting Well Theory of Change were:

- families in deprived areas would engage in the project;
- through the development of trusting relationships with home visitors (health visitors, support workers and community nursery nurses), families would engage in health promoting activities with the home and in the wider community;
- health visitors working more intensively with a smaller caseload and supported by evidence-based practice guidelines, would be able to take a broader view of a family's health;
- the employment of health support workers, predominantly from within the intervention areas would enhance the support provided by health visitors;
- through intensive work with individual families, health visitors would be able to develop a greater understanding of child and family health needs at a community level;
- new area infrastructures for child health would result in more responsive local statutory and community supports for families;
- a senior level project steering group would provide the driver for strategic change; and
- this whole system and individual family level intervention would result in a step change in child and family health in the longer term.

Processes

A substantial part of the evaluation investigated three key issues that were an integral part of Starting Well's Theory of Change:

- the extent to which intensive home visiting led to the development of therapeutic relationships between families and their home visitors;
- the implementation issues involved in developing a skill mix approach to home visiting; and
- the degree to which intensive home visiting at an individual family level led to improved community and strategic responses to child and family health problems.

1. Family Case Studies

A primary aim of this evaluation component was to examine the formation and the operation of the relationship between the child's key-care giver and their health. A second broader aim was to describe the developing views of both sets of participants on key aspects of the service. Key findings include:

- Analysis of fifty-nine individual interviews with a diverse group of 'Starting Well' mothers and their health visitors attempted to understand the interpersonal processes that underpinned the project's operation at the level of individual families.
- A process model was identified that linked demonstrably intensive home visiting input to a diffuse set of benefits summarised as 'enhanced support' (comprising: increased confidence; reduced anxiety; reduced isolation; the opportunity to confide; and experience of advocacy).
- The process model describes how intensive visiting equated to **more time** and direct contact with mothers during a period of universal need which encouraged the rapid formation of a **trusting relationship**, an **individualised care** package and the provision of **more and better quality information** on needs and life circumstances. This in turn, was associated with the identification of a **broad range of problems** and problem-solving activity and an **enduring two-way (functional) dialogue** between mother and health visitor. In sum, these processes promoted perceptions of enhanced support. Lack of maternal receptivity to the service and health visitor caseload pressures explained variation in process and outcomes.
- Intensive visiting can be an effective way of delivering a more patient-centred, 'holistic' model of care. Precipitating factors include: the convenience of the home setting; the shift in power relations inherent in the mother's control of access to the setting; and a concomitant need for the health visitor to maintain access by a) providing a flexible service and b) establishing a positive, non-directive relationship.

- Project health visitors praised teamwork, training and aspects of the approach (intensive support, skill mix) as strengths but had experienced resistance, scrutiny, and larger, more demanding caseloads than initially anticipated. These latter factors may, at times, have impeded their capacity to deliver the service as intended.
- Support was voiced for a universal intensive service in the first postnatal months, provided that it had the capacity to target sub-groups of women with higher levels of identified needs, for example, primiparous, isolated or depressed women.

2. Skill Mix

The process of developing and implementing an augmented model of home visiting was investigated in a report accepted by the Scottish Executive in June 2002, which was based on qualitative interviews with both strategic and operational staff at two time points. The final report builds on the findings of that fieldwork, where relevant, but focuses primarily on two specific issues: the extent to which Starting Well's model of home visiting was perceived to have acted as a vehicle for changing health visiting practice, and, the degree to which the project's health support worker model worked in practice.

The key findings related to these issues are set out below:

- In a relatively short space of time Starting Well developed two project teams incorporating a new type of worker (the health support worker) alongside a professional group of long-standing (health visitors) in order to implement its home visiting model.
- The project attempted to develop a standardised approach to health visiting but the degree of consistency achieved within practice was variable due to caseload size and some professional resistance to the notion of standardisation. This has wider implications for the use of standardised family health plans.
- Pressure of caseload size limited some of the project's aspirations and led, for example, to the need to rethink the ability of the model to be applied universally even within a deprived community.
- The project teams developed very differently in the two intervention areas. These differences were due to levels of individual, professional and organisational buy-in/resistance to the Starting Well model.
- The two emerging 'models' differed in the degree to which they advocated integration within GP practices and in the dilution of the Starting Well approach.
- The lessons that can be learned from these two manifestations of the project need to take account of the central role of organisational context in defining and supporting practice.

- In relation to skill mix, whilst much good practice was identified in bringing together health visitors and nursery nurses, issues of role clarity remained problematic throughout the life of the project. This has implications for the wider development of skill mix approaches, especially where new professional groupings such as community nursery nurses are introduced as single individuals to an existing primary care team. Time, training and supervision are all necessary at both local and strategic levels.
- Health visitors did not, in the main, develop their practice in relation to community development⁵ and this has implications for the implementation of Hall Four, the most recent recommendations from the Joint Working Party on Child Health Surveillance, (Hall and Elliman, 2003).
- The role of the health support worker developed into a diffuse and flexible one. It was a role that was, generally speaking, viewed positively by team members but one that required careful supervision.
- The employment of the support workers through a voluntary sector organisation allowed a supportive model of engaging individuals with a knowledge of the local area who might not previously have been engaged in the labour market. This was a model that was perceived to have been beyond the current capacity of the NHS.
- The dual management structure, however, led to operational difficulties around the day-to-day deployment and supervision of health support workers, some of which had their roots in a lack of professional ownership of the social inclusion aims of the health support worker approach. This may become an important policy issue in the future as public sector organisations develop ways of expanding their workforces.

3. Community and Strategic Change

Starting Well was conceived as a project that would impact not only at the level of an individual child and family health but also at the level of community and organisational capacity to respond to the health needs of local families. In assessing its impact at these levels the final report considers two sets of issues: the degree to which community infrastructures and supports have been strengthened through Starting Well activity; and the extent to which the project is perceived to have impacted on the strategic planning and provision of child and family health services. The key findings are summarised below in relation to 5 key questions:

1. *To what extent did the process of intervening intensively with individual families result in an understanding within project teams of key community health needs?*
 - More intensive contact with families helped health visitors to understand health needs at a community level. This understanding was also shaped by

⁵ The contested nature of community development (Pople, 2001) is discussed more fully within the body of the report.

communication within the project teams, working with other agencies and pre-existing knowledge of the local communities. A wide range of needs was identified but none were believed to be 'new' issues.

2. *Did a shared understanding of needs feed into local implementation groups?*
 - The process of sharing perceptions of community level need was rather haphazard within the two project teams and its success appeared to be a function of the level of collaborative working, with one team in particular demonstrating a significant lack of cohesion.
 - The increasing burden on health visitor caseloads and the early lack of clarity in the role of the community support facilitator (as perceived by other members of the project teams) led to a lesser emphasis on advocating for community change within the health visitor role, which questions the assumption that health visitors, and the changing systems with which they work, are ready for the challenges posed by Nursing for Health (Scottish Executive, 2001).
3. *Did local implementation groups develop and support local, community solutions?*
 - The local implementation groups were perceived to have been successful in disbursing monies from their development funds to local organisations but less effective in securing representation from both key statutory agencies and local parents.
 - The role of the community support facilitators and the bilingual worker became key in bringing about more sustainable changes at a local level in response to identified needs and in liaising with other relevant child health fora. Whilst there is evidence of much good practice at a local level, the implementation groups suffered from the poor level of representation from community and wider statutory groups that plagues health and social care projects more generally.
4. *To what extent were difficult issues referred to the project steering group?*
 - During the course of Phase I of Starting Well, only a small number of issues were passed from the local implementation groups to the project steering group (for example, the lack of breast feeding facilities within a local shopping centre and the high level of maternal mental health problems within the communities). None of these resulted in significant change at a strategic level and the members of the local implementation groups showed little knowledge of the role of the steering group. As with many complex interventions, a lack of connection between the city-wide and the local, and between the strategic and the operational, served to limit the effectiveness of organisational structures that the project established.

5. *Did the steering group advocate for more strategic, Glasgow-wide solutions?*
- The project steering group did not succeed as a mechanism for strong partnership working around the child and family health problems experienced in poor communities. A lack of ownership of the project beyond the health partners, and a lack of commitment to tackling broader strategic questions, were discussed by strategic stakeholders. On the other hand, there was some evidence provided of more constructive strategic work occurring 'behind the scenes' (for example, joint working around Sure Start and the development of additional money advice supports to vulnerable families). Given that partnership working lies at the heart of current public policy, it is imperative that further development in this area is taken seriously.

Theory of Change Revisited

Towards the end of the evaluation, the same group of individuals who articulated the project's initial Theory of Change, were asked whether they viewed the project as having been successful (in other words, was the Theory of Change **doable** in retrospect?). They were also asked for reflections on the **meaningfulness** of the original project plans. The key findings were that:

- Those involved at the most strategic level within Starting Well were largely optimistic that the project had met its objectives in relation to the home visiting and community support components of the project. Most were much less positive about the objectives set around partnership working, and the extent to which these had been realistic, given levels of commitment and shared ownership, was questioned.
- There were mixed views as to whether the types of short-term objectives set by the project were meaningful in leading to a longer term step-change in child and family health.

Whether or not the initial aims were appropriate it is clear that Starting Well did not, for example, demonstrate the step change that it aspired to as measured by the most important health related outcome that we investigated, and nor did the process of service development and delivery run as smoothly as predicted. Despite this, however, the complexity of the Starting Well experience should be recognised. It was highly valued by many of the staff and individuals involved, and there are valuable lessons to be learnt from it about the implementation of future initiatives. It may even be that further analysis of the quasi-experimental data will show stronger intervention effects. There is also a possibility that such effects only emerge as the Starting Well children get a little older, provided that attempts are made to look for them. The case for doing so will be made in due course. For now we conclude with a consideration of some of the reasons why Starting Well has not met all of the expectations of those who commissioned and designed it.

Wider Policy Implications

The most important implications for policy and practice that arise directly from the findings of the evaluation have been summarised above. Here we draw together a number of conclusions and reflections on the process of designing, implementing and learning from a Demonstration Project such as Starting Well. In particular we highlight four key issues: project planning; the meaning of 'demonstration'; the use of the existing evidence-base; and, achieving professional and organisational change.

- Project planning has to strike a balance between constriction and chaos. Planning and monitoring change in complex systems require time and capacity development; these were in short supply at the point of commissioning the Demonstration Projects. It is a positive sign that this has been recognised at a national level in commissioning Phase II although the meshing of independent evaluation findings with the development of this second phase has been less than ideal since the time for such findings to shape future plans is extremely limited.
- Far greater clarity and consensus is required for future projects and for Phase II of Starting Well if the project is to avoid being pulled in two opposing directions. This is particularly salient in relation to the debate around the most appropriate 'model' of Starting Well where there are stakeholder concerns that current policy thinking about 'integration' will force the project down a particular road regardless of its initial aims and underlying principles.
- In assessing the degree to which demonstration projects have or have not applied evidence-based practice, the complexity of the application of evidence needs to be considered. For a range of contextual, methodological, practical and philosophical reasons it may not be appropriate to transpose evidence from one setting to another.
- Implementing new ways of working within and across professional boundaries, and establishing meaningful community and partnership approaches, should not be viewed as straightforward, uniformly supported or inevitable outcomes of delivering a project. Greater realism will be required to turn around well-established ways of working.

Notwithstanding the very real issues of design and implementation highlighted above, there is much to learn from the Starting Well experience. Although the commitment to improving the early years experience of the poorest children is not in doubt, the evidence base to guide effective action is less secure than once was thought. This is particularly true of home visiting programmes in the UK. In these circumstances, the renewed emphasis on promoting social justice by reducing child poverty in all its forms, and the growing recognition of the importance of evaluating promising public health interventions exemplified by the second Wanless report (2004), suggest that the lessons to be learnt from Starting Well are important ones that should not be neglected.

Part 1. Background to Starting Well and its Evaluation

1.1 Introduction

1.1.1 Commissioning Starting Well and its Evaluation

In 1999 the Scottish Public Health White Paper, (Towards a Healthier Scotland, Scottish Office, 1999), sought bids from health partnerships in Scotland to develop good practice in the areas of child health, coronary heart disease, sexual health and colorectal cancer. Through the Glasgow Healthy City Partnership, a multi-agency child health bid (Glasgow Healthy City Partnership Proposal, 1999) was developed and awarded funding. The project, 'Starting Well' was granted £3 million over a three-year period and was launched in November 2000. Following the decision to award funding to the Glasgow Healthy City Partnership, the Scottish Executive commissioned a multi-method independent evaluation led by the Department of Public Health at the University of Glasgow (see Appendix I for details of the evaluation team).

The initial phase of funding for Starting Well would have ended in December 2003, however, it has been granted an additional year of funding until September 2004; subject to the Scottish Executive's agreement of a further programme plan, the project will be provided with funding for a Phase II from October 2004.

1.1.2 The Starting Well Demonstration Project

Starting Well is one of a family of 'early years' initiatives being developed across the UK, which are part of a concerted attempt to break the cycle of poverty and inequality by providing support to children in Britain's most deprived areas. The overall aim of the project is to 'demonstrate that child health can be improved by a programme of activities to support families, coupled with access to enhanced community-based resources for parents and their children' (Glasgow Healthy City Partnership Proposal, 1999). As described in the proposal document, the project drew extensively on the US literature on home visiting and, in particular, was shaped by the work of Olds and Kitzman (1993, 1997, 1998). The essence of this evidence-base is that, compared with standard health care provision, intensive home visiting had significant impacts on a range of child and family health related outcomes. The key elements of the US programmes on which Starting Well focused were: intensive visiting of families within the home; the development of supportive relationships between families and their visitors; and, an emphasis on health promotion approaches. However, the complex nature of home and health visiting (Gomby et al, 1993; Elkan et al, 2000) makes this an evidence base that is not straightforward to implement and there were a number of ways in which Starting Well departed from the Olds model. These included:

- The targeting of deprived *communities* rather than vulnerable *individuals*;
- The inclusion of *all new* babies as opposed to only *first* babies;
- A lesser focus on the antenatal period than recommended by Olds due to the availability of Community Midwifery services in Scotland and specific caseload issues within the project;
- The use of *paraprofessionals* as part of the home-visiting delivery mechanism in addition to professional health visitors;
- The vastly different primary care context within which the evidence was derived (for example, the absence of a universal health visiting and community midwifery service; and related to this,
- The requirement to integrate aspects of project delivery with existing professional and organisational structures as opposed to an entirely standalone intervention.

Within Starting Well the overall project aim was addressed in three principal ways:

- the introduction of an augmented programme of home visiting to all families of new babies born within two geographical areas within the City of Glasgow, selected due to their relative socio-economic disadvantage (Greater Easterhouse⁶ and Gorbals/ Govanhill/ North Toryglen, known respectively as the East and the South). Engagement with the project has been very high and at the time of writing, 1271 families have received input from the project.
- the development of enhanced local community supports and structures within these areas; and,
- the development of integrated organisational services that respond to the needs of children and their families both within the local areas and across Glasgow as a whole.

There are significant overlaps between these three strands of the intervention but the main mechanism and structures that underlie them are as follows.

1.1.2.1 The Model Of Home Visiting

The home visiting model aimed to provide intensive support to families during the first five years of the child's life. It incorporated a number of recommendations arising from Nursing for Health (Scottish Executive, 2001), including the implementation of best practice around health promoting activities and child health surveillance and an augmented public health role within nursing. A project team was initially established in each intervention area with a health visitor

⁶ Greater Easterhouse is used here as a shorthand for the following areas since the project did not cover Greater Easterhouse in its entirety: Cranhill, Ruchazie, Craigend, Garthamlock, Easterhouse and Gartloch.

coordinator, Starting Well health visitors and health support workers (the latter are employed through One Plus, a voluntary organisation) and a bilingual worker in the South. As the project has developed, these have been augmented with the employment of two community nursery nurses and a community support facilitator per team.

Health visitors used a number of standardised tools to structure their visits with families. These include:

- a core visiting schedule that provided guidance on the number of visits and age-related health topics that are appropriate at different points in the child's development;
- a family health plan that stimulated the discussion of, and recorded, jointly agreed health needs; and,
- a family support scale that required staff to make judgements about the vulnerability of families at different stages.

Project team members received intensive training on a wide range of issues including child development and protection, domestic violence, speech and language, and accreditation on a Triple P Programme (an Australian parenting programme that has been adopted by the project). They were encouraged to engage in reflective practice and provide each other with peer support. The project managed to engage almost all eligible families in this overall home visiting approach

1.1.2.2 Enhanced Community Supports

To develop a mechanism by which the needs of children and families could be supported at a local community level, local implementation groups were established. It was anticipated that these groups would include representation from the statutory and voluntary sectors and from the local community. Their remit included the identification and addressing of community level issues pertaining to child and family health. They each had a development fund, with an annual budget of £20,000, which they used to support the activities of local organisations that have joined a Starting Well Affiliation Scheme. An initial ceiling of £500 was placed on individual grants.

Part of the role of the community support facilitator was to act as a bridge between the home visiting teams and the local implementation groups and to manage the use of the development fund.

1.1.2.3 Organisational Responsiveness

The mechanisms that were put in place to encourage statutory organisations to work together to develop and deliver more responsive and strategic services for children and families included the local implementation groups within the two intervention areas and the project steering group which operated with representation from senior agency staff who had a role in strategy development at a Glasgow-wide level.

1.1.3 Aims of the final report

The independent evaluation of Starting Well was designed to be both formative and summative (specific methods employed are detailed in Part 2 of the report). A number of interim reports have been produced by the research team and two journal articles are currently in press. Full details of presentations and publications are provided in Appendix II. This final project report provides an assessment of Starting Well's impact on a range of outcomes and processes and is structured in the following way:

- Part 2 focuses on the health related outcomes for children and families as assessed through a quasi-experimental survey (Part 2)
- Part 3 describes the rationale lying behind the Starting Well demonstration project as expressed by key stakeholders in the first year of the project before going on to focus on a number of key processes underpinning its implementation. These are –
 - the nature of relationships developed between families and their health visitors
 - the development of an augmented model of home visiting
 - the development of mechanisms to support strategic change

This part of the report concludes with a discussion of strategic stakeholders' retrospective reflections on the initial project rationale.

- Key findings, policy implications and recommendations are drawn together in the conclusions.

1.2 Methods

1.2.1 Introduction

In this section we provide an overview of the main aims of the Starting Well Independent Evaluation as commissioned in September 2000. We then outline the methods used to address them⁷. In addition we highlight the ways in which the evaluation developed over time in response to the project itself. Ethical approval for the original research proposal and its subsequent amendments was sought and obtained from the Greater Glasgow Primary Care Trust Local Research Ethics Committee in 2001.

1.2.2 Overview Of The Independent Evaluation Of Starting Well: Aims And Methods

The main aims of the independent evaluation were as follows:

1. To measure the impact of the project on children and families;
2. To understand the theory, processes and context of the Starting Well intervention; and,
3. To analyse the policy implications of the project.

1.2.2.1 Assessing Impact

The most resource intensive component of the evaluation involved a quasi-experimental comparison of the two intervention areas with a socio-demographically similar area in the North of the city. This cohort study compared the health and development of intervention children over the first 18 months of life with a group of families receiving statutory health visiting in a demographically similar part of the city⁸. All families with newborn were approached for consent by their health visitor between 01/06/01 and 31/06/02, yielding a total of 627 participants, or around 50% of all births^{9,10}. The characteristics of participants are described more fully in section 2.2.3. Participating children were assessed on a maximum of three occasions (immediately after birth, then at six and 18 months) using a combination of mother-report questionnaires, observation in the home and structured interviews with the

⁷ Because of the wide range of the evaluation and the methods that it utilises, the description of methods that is provided within this section is relatively brief. Where more detailed technical descriptions of particular aspects of the evaluation exist elsewhere they are referenced rather than replicated in full.

⁸ predominantly the North Glasgow LHCC, including Springburn and Possil. Lower than expected recruitment rates here necessitated extension of the comparison area to encompass two further LHCCs in the west of Glasgow (Drumchapel and Clydebank)

⁹ 40% of which were comparison area births, 60% intervention births.

¹⁰ Health visitors stated that postnatal tiredness and a lack of time were very common reasons for not opting into the study.

mother. Questionnaires covered: background maternal, household and area characteristics; maternal mental health and health behaviour; and attitudes towards parenting and current health-visiting service. Each participant that could be contacted at six and 18 months received a home visit from a trained research nurse who administered the HOME Inventory (see <http://www.ualr.edu/~crtldept/home4.htm>; Bradley and Caldwell, 1979), a standardised interview-and-observation tool that assesses the quantity and quality of stimulation available to a child in its home environment. Interpreters were made available to assist participants with no or limited English. Finally, individual-level data on e.g., number of home visits were collected from routine sources including health visitor records.

Analysis of outcomes at six and eighteen months concentrated on the 'rich' datasets composed of those families that completed all assessments up to that point (n=346 and 294 respectively)¹¹. Key outcomes included: the total HOME score; extent of maternal depressive symptoms¹² and dichotomised survey measures of child dental registration, and maternal satisfaction with the service. After checking for opt-in bias, multivariate analysis was carried out in order to test for intervention effects whilst controlling for a range of other predictor variables. A detailed description of methods for this component can be found in Shute and Judge (forthcoming) and in Part 2 of this report.

1.2.2.2 Theory, Processes And Context

Aim 2.1 To understand stakeholders' theoretical rationale for the Starting Well intervention

A theory of change approach (Connell and Kubisch, 1998) was used to map stakeholders' views of how and why the intervention was being implemented and to capture expectations of change within a 3 year programme of activity. This was undertaken through interviews and focus groups with key strategic players, observation at steering group meetings and documentary review.

Data were collected in the first year of the project to produce a summary of the project's underlying theory of change that fed into the process of sharpening project planning (Mackenzie, 2002)¹³; stakeholders' perceptions of the robustness of this initial theory were reassessed in 2003.

¹¹ At the time of writing, 73 participants had either voluntarily withdrawn from the study (N=26) or moved without leaving a forwarding address (N=47). Opt-ins who could not be contacted for at least one assessment were not included in the analysis in order to maximise the number of predictor variables available for modelling.

¹² as assessed by the Edinburgh Postnatal Depression Scale, Cox, Holden and Sagovsky, 1987 (Appendix III)

¹³ Analysis for all qualitative data was analysed as follows. All interviews and focus groups were tape-recorded, transcribed in full and analysed using either ATLAS -ti or N5 (Computer Assisted Qualitative Data Analysis Software packages). Transcripts were coded for both a priori themes outlined in the interview schedules and themes emerging from the data. Data were analysed thematically using constant comparative techniques.

Quotations have been selected to illustrate the range of views on a given theme. The participant codes have been removed from quotations since these may render respondents identifiable. Where the names of persons or place appear in the data these have been replaced with the word "Person" or "Place" to preserve anonymity. Where views

Aim 2.2 To understand the key processes predicted to impact on Starting Well's success

Three separate studies were undertaken to address this aim:

- A primary aim of this evaluation component was to examine the formation and operation of the relationship between the child's key care-giver and their health. A second broader aim was to elicit the developing views of both sets of participants (mothers and their health visitors) on key aspects of the service. A total of 20 women (mean age 27 yrs, range 20-40 yrs) were recruited and interviewed when their child was around four months old with follow-up interviews conducted with 13 of those women at around eleven months¹⁴. Respondents were purposively sampled across both project areas to provide instances of the following categories: first-time and experienced mothers; black and ethnic minority mothers; families with a range of emotional, physical and material needs. Each family's current health visitor was interviewed separately in advance of the mother interview¹⁵. In order to capture ongoing service development, respondents were recruited in two cohorts and received their first interview approximately eight months apart. A total of 59 interviews were held, 56 of them tape-recorded.
- Through the initial theory of change approach two additional processes underlying stakeholders' beliefs about the mechanisms through which Starting Well might positively impact on child and family health were identified. The independent evaluation approach was amended to incorporate the exploration of these within its approach. The first of these was the process of developing and implementing an augmented model of home visiting. Qualitative interviews with both strategic and operational staff at two time points were used to explore this process. This part of the evaluation aimed to be both formative and summative (Weiss, 1998). That is, it aimed to provide feedback to the project (and the wider policy audience) of lessons learned within the early days of implementation and, to provide an assessment of how the model was perceived to have worked as the initial period of funding came to a close.

Strategic level respondents were selected to provide a range of experience from the project's senior management team, the steering group, the Scottish Executive (group interview), the wider Greater Glasgow Primary Care Trust and the employing bodies for members of the project team.

Project team respondents were selected to give coverage of the following staff groupings: community support facilitators (both facilitators participated); bilingual worker (of which

are believed by the researcher to be extreme or unique, this is signalled in the text. Some quotations are shortened (this is indicated by the presence of the following punctuation within the quoted text: ...); this shortening indicates that aspects of the quotation are either irrelevant to the issue that is being discussed, repetitive or unintelligible.

¹⁴ Of the seven women not interviewed a second time, three were contacted but failed to attend successive appointments and four could not be contacted.

¹⁵ 14 health-visitors took part in at least one interview, some providing more than one case.

there is only one); community nursery nurses (three of the four participated); health visitors (12 out of a total 21); health support workers (seven out of 16). Further detail of the methods used is provided in the interim evaluation of the home visiting model (Mackenzie, 2003).

- The second adaptation to the independent evaluation approach was to include a focus on the process by which individual family health needs were aggregated to a community level and responded to at a strategic level. This process was studied through a mapping of child and family health needs emerging through the project, an assessment of the extent to which the identification of local need impacted on the agenda and decision-making processes of relevant groups, and, of the degree to which Starting Well had impacted on strategic planning. A range of techniques including a local community survey, semi-structured interviews and focus groups were used to investigate these issues (Starting Well Evaluation Proposal, amended 2002). More detail on the local community survey can be found in Starting Well and Community Support: Exploring Relationships with Community Agencies in the Demonstration Project Areas, Berzins et al (draft, 2004).

Aim 2.3 To describe the broader material and social contexts of study areas

This evaluation component aims to describe dimensions of area context that might be hypothesised to influence health-related outcomes over-and-above the important individual-level characteristics identified in the quasi-experimental study. Defining study areas as aggregates of whole postcode sectors, the dimensions considered (derived from 2001 Census, routine medical and cohort survey data) include: basic demography; material and built environment; health; and social context. By making descriptive contextual comparison between intervention and comparison-areas, we aim to complement the impact study findings and to explore the potential for separating out individual- and area-level effects more formally using multi-level analyses.

Given that findings do not comment directly on the operation or effectiveness of the intervention, we have opted not to include them in the main body of the report but include them as Appendix IV.

1.2.2.3 The Policy Implications

The aim of analysing the policy implications of Starting Well cut across the other aims of the independent evaluation and signalled intent on the part of the evaluation team to contribute to the wider policy debate that surrounds the Health Demonstration Projects. In this respect it did not have a methodology in its own right.

Part 2. Outcomes from Starting Well

2. Assessing Impact: the Quasi-Experimental Study

Key findings:

- Almost 50% (627/1321) of eligible families were recruited between 01/06/01 and 30/06/02; 367 from intervention areas and 260 from comparison areas receiving the generic service.
- Cross-sectional analyses concentrated on 359 participants completing both baseline and 6-month assessments and 294 completing all three assessments to 18-months.
- Comparisons of aggregate-level routine data on opt-ins and opt-outs suggest no obvious bias associated with recruitment or persistence in the study.
- Multivariate regression analysis revealed: significantly lower rates of **depressive symptoms** amongst intervention mothers at 6 but not 18-months; no improvement in the **quality of the home environment** at 6-months but a small positive effect of the intervention at 18-months ($p=0.088$); higher levels of client-satisfaction with **levels of health visitor support** and higher levels of **dental registration** at both assessments.
- Despite doubts as to the transferability of the north American evidence-base to the British context, and a number of evaluation limitations, findings relating to maternal depressive symptoms and HOME score are supportive of shorter-term psychological benefits for study mothers and potentially longer-term cognitive and emotional developmental benefits for study children.

2.1 Introduction

An established literature suggests that home-based interventions delivered by trained health professionals can improve a range of outcomes for vulnerable pre-school children (Olds and Kitzman 1993; Brooks-Gunn et al 2000; Elkan et al, 2000; Bull et al, 2004). Most studies do not have sufficient numbers of participants to detect direct improvements in child health (e.g. lower morbidity and/or mortality rates) but show improvements in related factors, for example, quality of the home environment (Davis and Spurr, 1998), detection and management of postnatal depression (Holden et al, 1989) and improved rates of breastfeeding (Kitzman et al, 1997). In addition, long-term cohort studies show the benefits of home-visiting to be diverse and enduring for both mother and child (Olds et al, 1997; 1998).

One acknowledged limitation of this largely American-based literature is its lack of direct applicability to the British context¹⁶, specifically, its focus on specialist programmes that exist in the absence of a universal health-visiting service. The purpose of this evaluation component is not to establish the impact of a service relative to its absence but to explore the

¹⁶ For an exception, see Elkan et al (2000) which contains a selective review of the British literature

impact of an enhanced service ('Starting Well') on a group of families over the first eighteen months of the child's life relative to a group receiving the established (generic) service.

In this section, we first describe key features of the study design and characteristics of the recruited sample. This section (2.2) includes an exploration of sample representativeness using aggregate-level routine data on opt-ins and opt-outs. In section 2.3, we present the results of multivariate analysis of three health-related outcomes (quality of the home environment, extent of maternal depressive symptoms, child dental registration rates) and one measure of user-satisfaction (with levels of health visitor support) at both six and eighteen month assessments. In section 2.4 we discuss the implications of these findings.

2.2 Methods

2.2.1 Target populations

The intervention population was defined as all births visited by Starting Well health visitors between 01/06/01 and 31/06/02 within the project's strict geographical boundaries¹⁷. Statistics on the total number of births were generated by the project team's interrogation of the study database. The comparison population was defined as all births¹⁸ assigned to health-visiting teams working in the Northern Local Health Care Co-operative over the same time period. Comparison 'area' health visitors are attached to particular GP practices and, as they only visit families that are registered at that surgery, there is a strong but not defining geographic focus to their work¹⁹. Consent to evaluation was lower than expected in the comparison area and consequently recruitment was extended to a further two health visiting teams in the west of Glasgow (Drumchapel and Clydebank) between 01/04/02 and 31/06/02. The total numbers of comparison area births was calculated by the NHS data provider²⁰ from the interrogation of routine data sources. Table 2.1 shows the total number of births and opt-ins by group²¹.

Table 2.1: Total number of births and opt-ins.

	Comparison	Intervention	All
Opt-ins	260	367	627
Opt-outs	415	279	694
Total births	675	646	1321
Sample as % of population	38.5	56.8	47.5

¹⁷ as defined by whole or part postcode sectors. See appendix IV for a comparative contextual description.

¹⁸ As part of the UK's immigration and asylum policy, several hundred families of asylum-seekers were 'dispersed' (temporarily settled) to the area covered by the Northern LHCC during the study recruitment period. Births to these families could not be included due to variations in the developing health visiting service and to lack of interpreting support.

¹⁹ Appendix IV describes an approximation of the main comparison area comprised of whole postcode sectors.

²⁰ Here, and in the rest of the section, this refers to Greater Glasgow NHS Board Child Health Information Team

²¹ Note these figures include births to families who transferred out of the area before they could be approached for consent and therefore differ slightly to those published in previous outputs that did not consider these to be 'eligible' births.

Just under 50% of eligible families opted into the evaluation, proportionally more so from the intervention area(s). This is perhaps unsurprising given the implicit incentive of receiving the enhanced service.

2.2.2 Procedure

Each opt-in parent/family received a baseline postal survey. This was sent out as soon as the consent form was received from the attending health visitor, in most cases, within two months of the child's birth. The survey covered: background maternal, household and area characteristics; maternal mental health and health behaviour; and attitudes towards parenting and current health-visiting service. Interpreters were made available to assist participants with no or limited English (n=21) and completed surveys were returned using a pre-paid envelope. Participants with overdue surveys were followed up by letter and phone. Further surveys were sent out to each participant when their child was six and then eighteen months old. Content focussed on mother-reported child outcomes and updates of maternal health, support and attitudes to the health visiting service.

In addition, each participant that could be contacted at six and eighteen months received a home visit from one of three trained research nurses who administered the HOME Inventory. The average interview lasted around one hour. At the end of the interview, the nurse administered several additional survey instruments (e.g. the Edinburgh Postnatal Depression Scale) and retrieved any incomplete or unsent postal surveys. Again, interpreters were available for non-English speakers.

Table 2.2: Returns per assessment by group

	N			Totals as % of....	
	COMP	INT	Total	Sample (n=627)	Population (n=1321)
Baseline survey	180	267	447	71.3	33.8
6-month survey	198	292	490	78.2	37.1
18-month survey	185	252	437	69.7	33.1
6-month HOME	192	301	493	78.6	37.3
18-month HOME	196	252	431	68.7	32.6

Note: COMP = comparison group; INT = intervention group

Table 2.2 shows the number of returns by assessment and group with totals expressed as percentages of sample and population. In data not shown, similar fieldwork completion rates were observed at both assessments across cohorts. Contact by research nurses at six

months produced a better survey return rate than baseline postal methods, although this advantage was offset at eighteen months by attrition of subjects. The populations from which the cohorts are drawn are residentially mobile and at the time of writing, 73 (11.6%) of the original sample had either voluntarily withdrawn from the study (n=26) or moved house without leaving a forwarding address (n=47).

Table 2.3: 'Rich' six and eighteen months datasets as a proportion of sample and population

	N			Totals as % of....	
	COMP	INT	Total	Sample (n=627)	Population (n=1321)
Baseline & 6-month assessments	146	213	359	57.3	27.1
Baseline, 6 & 18-month assessments	122	172	294	46.9	22.3

All data were collated and stored securely at the study offices, before being coded and entered. Table 2.3 shows the percentage of participants who completed all instruments at six months (n=359) and eighteen months (n=294). A further 93 participants were not seen at baseline but completed a brief retrospective survey at six months, covering basic child, maternal and household characteristics. For the purposes of this report, richness of data is considered to be more important than maximising the number of subjects; analysis therefore concentrates on the two smaller datasets²².

2.2.3 Sample characteristics and representativeness

The preceding section showed that not all eligible families opted into the study and, of those who did, not all could be contacted at all assessments. This introduces two potential sources of bias, both of which must be understood in order to be able to generalise confidently from results. The first source of bias relates to *recruitment* and the possibility that there are systematic outcome-related differences between those who opted into the study and those who opted out. By definition, little or no information is available on opt-outs, however, by gaining ethical permission and signed consent to collect individual-level routine data on opt-ins (e.g. from the Child Health Surveillance system), the NHS data provider was able to 'subtract' these children from the known population of eligible births and generate limited aggregate-level comparative statistics on the remainder (i.e. the opt-outs). Tables 2.4a and b show the results of these comparisons, together with p values for associated comparisons of proportions and means respectively. Note that variable (and occasionally substantial) numbers of missing values are a feature of the data.

²² In practice, missing values for some predictor variables further restricted the number of cases available for analysis. This explains the reduction in N in some regression tables below.

Table 2.4a: Characteristics of opt-outs and opt-ins (frequencies)

Variable	OPT-OUTS		OPT-INS		p
	n/total n	valid %	n/total n	valid %	
minority ethnic mothers	85/606	14	60/559	10.8	.087
first-time mothers	311/644	48.3	272/578	47.1	.687
smoked in pregnancy	231/604	38.2	249/592	42.1	.178
male child	360/669	53.8	284/578	49.1	.099
low birthweight (<2500g)	67/572	10.7	76/532	13.1	.204
Breastfeeding at first health visitor visit	171/624	27.4	162/598	27.1	.902
Breastfeeding at 6-week check up	130/572	22.7	115/565	20.4	.330
maximum n	694		627		

Table 2.4b: Characteristics of opt-outs and opt-ins (means)

Variable	OPT-OUTS (max n = 694)			OPT-INS (max n = 627)			p
	mean (s.d.)	range	n	mean (s.d.)	range	n	
mother's age	27.3 (6.3)	14-43	581	27.2 (6.5)	15-44	566	.79
father's age	29.8 (6.7)	15-51	530	29.6 (7.2)	16-62	525	.64
gestation (weeks)	39.1 (2)	27-43	619	39 (2)	26-43	573	.39
birth weight (grams)	3233.9 (612.5)	880-5260	568	3186.8 (588.3)	1180-4740	532	.19

The tables show that compared to opt-outs, opt-in mothers were less likely to be from minority ethnic backgrounds and more likely to have smoked during pregnancy and to have lower birthweight children. However, comparison of proportions and means suggested no statistically significant differences at the 95% level on any of the above measures. Hence, there is no obvious evidence of bias associated with recruitment.

A second potential source of bias relates to *attrition and/or participation in assessment*; the possibility that participants included in analysis (i.e. the 'rich' datasets of people completing all assessments) are systematically different from opt-ins as a whole. In analyses not shown, we have compared all opt-ins and sub-groups on a number of measures using both routine and survey data and find that persistence in the study is very moderately associated with greater relative affluence and maternal age. Whilst some differences approach significance at the $p=0.05$ level, the large numbers of comparisons involved greatly increases the risk of a type one (false positive) error and we cannot confidently conclude that there is any bias associated with persistence in the study.

Finally, in this sub-section, we shift the comparative focus away from opt-ins and opt-outs to describe some salient characteristics of the groups of participants included in analysis. Table 2.5 shows a series of survey items relating to both ethnicity and disadvantage for participants included in the six-month analysis (n=359). Similar figures are obtained for the eighteen month dataset (see above). The table makes two principal points: first, that all minority ethnic participants are in the intervention group²³; and second, that on a number of measures, the comparison group are relatively more affluent in what may be regarded as a generally socio-economically disadvantaged cohort²⁴.

Table 2.5: Comparison of selected baseline characteristics by group (n=359 dataset)

variable	Comparison		Intervention		p
	n	%	n	%	
minority ethnic mother	0	0	34	16	<.001
mother has no qualifications	26	17.8	52	24.4	.13
no car in household	55	37.7	92	43.2	.30
not homeowner	75	51.4	134	62.9	.03
workless households	39	26.7	77	36.2	.06
higher income households (>£1000/month after tax)	72	49.3	59	27.7	<.001

2.2.4 Measures

Outcome variables

Three measures relating to child health and one measuring user-satisfaction were chosen as outcomes at six and eighteen months. The first two health-related measures - quality of the home environment and extent of maternal depressive symptoms – are chosen firstly, because of their proven association with later child cognitive and emotional development (Bradley, 1993; Murray and Cooper, 1997) and secondly, because well-validated instruments exist to measure them (Bradley and Caldwell, 1988; Cox, Holden and Sagovsky, 1987). The third outcome – the child’s dental registration status as reported by the mother – was chosen as an indicator of oral health, an area in which the programme is trying to promote positive change. The final outcome – satisfaction with the levels of health visitor support – is chosen as a key comparative indicator of user-satisfaction²⁵.

²³ In fact, all minority participants live in the *southern* project area, in a well-established Scottish Asian community largely composed of first, second and third generation Pakistani Muslims. Disclosure concerns prevent release of 2001 Census ethnicity data at small-areas levels (e.g. postcode sector), however, just over two (2.2) percent of all households in the city are headed by people of this ethnicity (General Register Office (Scotland), 2003).

²⁴ This is confirmed by contextual comparisons of area-level material resources (see Appendix IV).

²⁵ Note that additional outcomes (e.g. maternal self-esteem, functional support, parenting confidence) are not included here both for reasons of parsimony and the fact that they tap similar dimensions to the chosen measures (e.g. EPDS and self-esteem; HOME score and parenting confidence).

Turning to each outcome in detail, the first is derived from the Infant/Toddler version of the HOME Inventory (Bradley and Caldwell, 1979b; Caldwell and Bradley, 1984). The HOME (Home Observation and Measurement of the Environment) is a standardised interview-and-observation tool that assesses the quantity and quality of stimulation available to a child in its home environment. Administered by trained researchers (usually health professionals), the assessment takes the form of a home interview with the caregiver and index child present. The interviewer asks a set of questions about the child's 'typical' day and in conjunction with more general observation, scores the mother-child dyad on the presence versus absence of 45 key responses and behaviours (for example, 'mother responds to child's vocalisations with a verbal response'). Six sub-scale scores are produced: verbal and emotional responsiveness; acceptance of sub-optimal behaviour; degree of organisation of the child's temporal and physical environment; provision of learning materials; active involvement in learning; and inclusion of variety in the child's life. A higher score indicates a 'better' environment, i.e. one that is richer in terms of quality and/or quantity of stimulation. In keeping with many studies, we use the overall total score, i.e. the sum of all sub-scales, as our principal outcome.

The second outcome measure derives from another standardised, validated instrument - the Edinburgh Postnatal Depression Scale (EPDS; Cox, Holden and Sagovsky, 1987. See Appendix III for full instrument). This instrument is widely used as a screening tool for suspected postpartum depression. Participants indicate their strength of agreement with ten mood-related statements (for example, 'I have looked forward with enjoyment to things') and receive a total score ranging from 0-30, where a higher score means 'more depressive symptoms'. In this study, we used a dichotomised measure based on the advisory threshold score for clinical action: a score of 13 or greater was coded as '1'. It is to be stressed that the EPDS is a screening tool and scores exceeding this threshold do not equate to a formal diagnosis of depression. However, validation studies suggest that a threshold set at this value correctly identifies around two-thirds of depressed women (Murray and Carothers, 1990).

The third outcome used here is a dichotomised mother-report measure derived from a survey item. *Dental registration* indicates whether the child is registered with a community dentist at the time of assessment ('yes' = 1; 'no' or 'don't know' = 0). As this is a mother-reported measure, it awaits validation from routine data sources.

Finally, responses to the item 'how satisfied are you with the general level of support you have been receiving from your health visitor?' ('very satisfied'; 'fairly satisfied'; 'not very satisfied'; 'not satisfied at all') were dichotomised so that 'very satisfied' was coded as '1'.

Baseline predictor variables

A general aim of the quasi-experimental study is to explore the effects of the intervention on child health whilst controlling for the many individual- and household-level confounding factors. Accordingly, many such variables were included in the baseline survey, a sub-sample of which with *a priori* associations to outcomes were used in exploratory multivariate analysis. A full list of measures are available on request but the main sets of baseline predictors include: survey items relating to basic maternal and child data (child's gender, gestation, birth weight, feeding and behaviour, parity, mother's age, etc); items covering maternal health and health behaviour adapted from the 1998 Scottish Health Survey (Scottish Executive, 1998); self-control and alienation sub-scales from the Multidimensional Personality Questionnaire (MPQ: Tellegen et al, 1982); the Rosenberg Self-Esteem Scale (Rosenberg, 1965); the DUKE-UNC Functional Support Scale (Broadhead, 1988); questions on attitudes to parenting and health-visiting; and items taken from the 2001 UK Decennial Census, for example highest maternal qualification, household employment, tenure and car ownership.

Baseline socio-economic status was constructed from employment-related survey items using the reduced 2001 National Statistics Socio-Economic Classification system (NS-SEC; The Stationery Office, 2002). Some analytic classes were merged due to low counts, resulting in the following four dichotomised variables: NS-SEC class 1 and 2 (professional, managerial and higher technical occupations); NS-SEC classes 3, 4 and 5 (intermediate, lower supervisory and technical occupations); NS-SEC 6 and 7 (routine and semi-routine occupations); NS-SEC class 8 (never worked and long-term unemployed).

Material circumstances were indexed via a self-report measure of household income (after tax). This ordinal measure (participants ticked one of nine income bands, e.g. '£200-299') was recoded into three dichotomised variables: lower income (<£400/month); medium income (£400 - £999/month) and higher income (>£1000/month).

Service input was measured by collecting individual-level routine data on the number and type of contacts (including failed contacts) with health visitors and associated professionals. These data were collated from an operational database in the intervention area and from health visitor notes in the comparison area. Whilst a number of measures could be constructed, problems of comparability across cohorts meant that only two – the total number of recorded home visits by health visitors between 0-6 and 6-18 months respectively – were used in analysis²⁶. These measures are likely to be reliable as health visitors are more likely to recall and record face-to-face contact in the client's home than brief phone contacts or opportunistic encounters at a clinic or in the street.

²⁶ Due to differing skills, emphases, training, etc, it is not easy to confidently state that one health visitor home contact has the same therapeutic significance as one health support worker or one nursery nurse contact. For these reasons, visits by these health professionals were not included in analyses.

Table 2.6 shows the mean number of visits of this type at six and eighteen months, for both n=359 and n=294 datasets. All between-group comparisons were highly significant (t-values and dfs available on request). Although these figures confirm and emphasise the more intensive and home-based nature of the intervention, reference to both standard deviations and the range suggests considerable variation in the number of visits; evidently both types of service have the capacity to be flexible.

Table 2.6: Description of health visitor home visits at each assessment

Dataset (n)	Visits from...	COMPARISON		INTERVENTION		p
		mean (s.d.)	range	mean (s.d.)	range	
6 month (359)	0-6 months	3.5 (2.3)	0-16	9.1 (4.2)	0-24	<0.001
18 month (294)	0-6 months	3.3 (2.2)	1-16	9.2 (4.2)	0-24	<0.001
	6-18 months	0.8 (1.4)	0-9	4.6 (3.9)	0-26	<0.001

Finally, in order to test for intervention effects, intervention status was entered into analysis as a property of each individual family (i.e., intervention family coded as '1', comparison family as '0').

2.2.5 Statistical approach.

Stepwise ordinary least squares (OLS) regression was performed on the HOME total score and logistic regression on the three dichotomous outcomes. Our general approach was iterative and cumulative and involved initial stepwise experimentation with reduced models containing similar variables (e.g. relating to material circumstances) whilst always retaining five key control variables: mother's age; parity; ethnicity; child's gender and group (intervention vs. comparison). We entered the strongest predictors in the reduced models into a full model whilst again retaining key variables. Overall, we have tried to produce robust models that satisfy three modelling criteria: *a priori* reasoning; statistical significance; and parsimony in the number of variables retained in the final equation.

2.3 Outcomes at six and eighteen months

2.3.1 Notes on the interpretation of statistics in this section

The meaning of ‘significance’ in descriptive and inferential statistics sub-sections:

If we had adopted an ‘experimental’ (e.g. randomised control trial) design with *random* allocation of births to different treatment conditions, we would not expect there to be any meaningful differences between groups apart from the treatment/service they received. In these circumstances, ‘simple’ comparisons of proportions and means like those in the descriptive statistics sub-sections of this chapter would be sufficient to demonstrate the presence/absence of ‘real’ (i.e. unbiased and statistically significant) group differences. However, the area-based nature of ‘Starting Well’ necessitated the adoption of a quasi-experimental design where births were non-randomly assigned to groups based on where their parents lived. This means that comparisons of the intervention and control groups may be biased by differences other than the service they receive. The regression analyses enable us to adjust for these differences to provide a less biased estimate of the intervention effect. However, it can only be used to adjust for observed differences between the groups, and unobserved differences may still bias the comparison in either direction.

Regression statistics:

Regression statistics express the size and direction of an association between a predictor variable and an outcome, whilst statistically controlling for the influence of other predictor variables in the model. In OLS regression (the analysis carried out on the HOME score), attention should be directed to the ‘standardised beta coefficient’ where a positive value indicates a positive independent association between that predictor and the outcome, whilst a negative value indicates a negative association. Within any given model, a higher standardised beta indicates a stronger relative effect²⁷. Similarly, the key statistic in logistic regression is the odds-ratio (OR). An OR of less than 1 indicates a negative independent relationship between that predictor variable and the outcome whilst an OR of greater than 1 indicates a positive relationship. All predictor variables retained in models have an associated probability statistic. We use the conventional statistical significance criterion of $p < 0.05$.

2.3.2 Health-related outcomes

Descriptive statistics

Table 2.7 shows between-group descriptive statistics for three health-related outcomes at six and eighteen months. The comparison area cohort has a non-significantly higher total HOME

²⁷ This is only true for comparisons *across* models (e.g. 6- and 18-month assessments), to the extent that the same predictors are entered with similar sample sizes.

score at both assessments although the magnitude of the difference is less at eighteen months. HOME scores tend to increase over time. In contrast, identical proportions of women score above EPDS threshold at six months but there are significantly fewer comparison area women in this group at the later assessment ($\chi^2=3.89$, $dfs=1$). Finally, the intervention group had higher rates of dental registration at both assessments, although this is only statistically significant at six months ($\chi^2=13.43$, $dfs=1$).

Table 2.7 descriptive statistics for three health-related outcomes at six- and eighteen months

	GROUP			
	comparison	intervention	difference	p
HOME score: mean (s.d.)				
At 6-months	35.4 (4.1)	34.5 (5.1)	-.94	.07
At 18-months	38.2 (4.7)	37.4 (5.3)	-.78	.20
EPDS: % scoring 13+				
At 6-months	16.4	16.4	0	-
At 18-months	10.0	18.2	+ 8.2	.05
Dental registration: % registered				
At 6-months	26.0	45.1	+19.1	<0.001
At 18-months	73.8	82.5	+ 8.7	.07
N at 6 months	146	213		
N at 18 months	122	172		

Inferential statistics

Table 2.8 shows the final models obtained at six and eighteen months for OLS regression of the total HOME score. Five variables were significantly and independently associated with outcome at both assessments, indicating the basic similarity of the models. Other predictors appear only once, either because they did not fit the model or were novel variables entered at eighteen months (e.g. mother's self-control). No statistically significant intervention effect was found at the $p=0.05$ level although the association was positive at both assessments and at eighteen months was significant at the $p=0.10$ level. Elsewhere, mother's age and ethnicity were strongly associated with the total HOME score (although in opposite directions) whilst first-time mothers scored more highly at the first assessment but did not show this advantage at eighteen months. Other maternal characteristics, indexing dimensions of personality and (perhaps) levels of personal resources, also predicted outcome: mothers with high self-esteem scored more highly at six months, but impulsive mothers, single mothers and those with more resident children tended to achieve lower scores. Finally, there is a negative association between household income and HOME score at both assessments.

Table 2.8 OLS regression of HOME total score at six-months and eighteen months

	6-MONTHS				18-MONTHS			
	beta	s.e. (beta)	standardised beta	sig	beta	s.e. (beta)	standardised beta	sig
Group (intervention)	.315	.442	.032	.477	.823	.480	.079	.088
Child's age at assessment (years)	-7.260	5.182	-0.061	.162	-0.368	4.75	-.035	.438
Gender (male)	-0.986	0.416	-0.104	.018	-0.484	.470	-.047	.304
Mother's age (years)	0.156	0.037	0.217	<.001	0.222	.039	.287	<.001
Ethnicity (minority ethnic)	-5.876	0.810	-0.362	<.001	-6.203	.842	-.361	<.001
Parity (first time mother)	1.183	0.552	0.124	.033	0.455	.605	.044	.452
No partner	-	-	-	-	-2.153	.709	-.140	.003
No maternal qualifications	-	-	-	-	-1.189	.584	-.095	.043
Number of resident children	-0.573	0.236	-0.134	.016	-1.075	.263	-.233	<.001
Birthweight (ounces)	0.040	0.011	0.168	<.001	0.040	.011	.162	.001
Baseline self-esteem	0.104	0.049	0.097	.033	-	-	-	-
Mother's self-control score	-	-	-	-	-0.162	.063	-.118	.011
Higher income household	1.485	0.510	0.150	.004	-	-	-	-
Lower income household	-1.163	0.539	-0.108	.032	-1.405	.590	-.118	.018
NS-SEC class 6 or 7	-	-	-	-	-1.344	.544	-.110	.014
Research nurse A	1.298	0.458	0.132	.005	-	-	-	-
(Constant)	27.97	3.322	-	<.001	36.52	7.48	-	<.001
N	315				274			
Adjusted R-squared	.42				.47			

This association was supported by the retention in the model of number of cognate variables that express either personal-disadvantage (no maternal qualifications) or household-level material advantage/disadvantage (birthweight and 'lower class' respectively). The models predict, respectively, 42% and 47% of the total variation in HOME scores.

Table 2.9 Logistic regression of EPDS 'caseness' (score is 13 or greater) at 6 and 18 months.

Predictor	6 MONTHS		18 MONTHS	
	odds ratio	p	odds ratio	p
Group (intervention)	0.258	.004	1.718	.220
Gender (male)	1.231	.571	1.272	.548
Mother's age (years)	1.033	.293	1.080	.025
Ethnicity (minority ethnic)	6.127	.003	3.278	.030
Parity (first time mother)	0.723	.416	1.540	.338
Child spent time in SCBU	4.058	.003	-	-
Difficulty of child's behaviour	2.388	.024	-	-
Baseline self-esteem	0.845	<.001	0.907	.045
Mother's self-control score	-		1.162	.005
Previous mental health problems	7.135	<.001	-	-
Significant life-events in past year	-	-	1.592	<.001
Higher household income	0.331	.018	-	-
Number of home visits to 6 months	1.116	.022	-	-
Constant	0.520	.585	0.006	.001
N =	359		276	

Table 2.9 shows the results of logistic regression modelling with EPDS 'caseness' (the outcome expressing the proportion of women scoring above the potentially clinically significant threshold of 12/13). Minority ethnic women were more likely to post high EPDS scores at both assessments as were women with low levels of self-esteem. These variables, however, are the only real instances of similarity in what are plausible but quite distinct models. In contrast to the preceding section, a substantial intervention effect emerged at six months: after controlling for other relevant variables, mothers receiving the 'Starting Well' service were less likely to report high levels of depressive symptoms than those receiving the generic service. This advantage was not repeated at eighteen months however, and even showed signs of reversal with intervention women now *more* likely to score above threshold. At six months, mothers whose newborn had either spent time in intensive care or who presented with difficult behaviour were more likely to show depressive symptoms, as were women with a history of mental health problems. This latter association with vulnerability may also underlie the significant positive association between caseness and number of home

visits; health visitors adjusted to a high score at routine assessment by increasing the amount of contact. At eighteen months, a more parsimonious model emerged with maternal age, low self-control and the experience of significant life-events (bereavement, pregnancy, job-loss, etc) predicting caseness.

Finally in this section, table 2.10 shows the results for logistic regression with mother-reported dental registration status. A statistically significant intervention effect was observed at both six and eighteen months: more 'Starting Well' mothers reported that they had registered their baby than those receiving the generic service. This advantage was particularly marked at six months. Few other similarities existed across models, although indices of unemployment²⁸ predicted lower levels of registration at both assessments.

Table 2.10 Logistic regression of dental registration status ('yes') at six and eighteen months.

Predictor	6 MONTHS		18 MONTHS	
	odds ratio	p	odds ratio	p
Group (intervention)	2.742	<.001	2.218	.013
Gender (male)	0.963	.871	1.719	.073
Mother's age (years)	1.001	.949	1.061	.023
Ethnicity (minority ethnic)	0.474	.069	0.504	.164
Parity (first-time mother)	0.989	.966	1.275	.472
Child spend time in SCBU	2.210	.017	-	-
NS-SEC class 8	0.441	.003	-	-
Workless household	-	-	0.475	.018
Constant	0.379	.141	0.447	.353
N =	359		294	

²⁸ 'NS-SEC class 8' classifies respondents as never having worked or being long-term unemployed

2.3.3 User-satisfaction

The proportion of 'very satisfied' responses in each group is shown in table 2.11. The table displays two additional statistics: the proportion of all women at eighteen months who reported the service was 'better than expected'; and the proportion of multiparous mothers who reported their current experience of health visiting was 'better than before'.

Table 2.11: descriptive statistics for measures of user-satisfaction

	GROUP			p ²⁹
	comparison	intervention	difference	
% very satisfied with HV support				
At 6-months	53.4	68.2	14.8	.005
At 18-months	37.3	56.4	19.1	.002
% all women (n=294) reporting service was 'better than expected' at 18-months				
	20.2	46.9	26.7	<0.001
% multiparous mothers (n=174) reporting service was 'better than before' at 18-months				
	19.4	49	29.6	<0.001

On the strength of these unadjusted comparisons, receiving 'Starting Well' is associated with higher perceived levels of health-visitor support than generic health visiting and the service exceeds expectations for a large proportion of women. This intervention advantage is particularly strong for multiparous women comparing current experiences of the service to their last.

Table 2.12 confirms the finding for satisfaction with health visitor support using logistic regression³⁰: a statistically significant intervention effect was observed at six months which became more significant at eighteen months. Considerable stability in levels of satisfaction was shown by the fact the baseline measure (collected at around 2-3 months postpartum) was a significant predictor of later satisfaction. Positive attitudes towards health visitors at baseline also predicted satisfaction at six months, though whether these attitudes were pre-existing or had already been changed by the time of the baseline assessment is not clear. Finally, smoking during pregnancy positively predicted satisfaction at both assessments although there is no obvious *a priori* reason for this to be the case.

²⁹ Actual χ^2 statistics and degrees of freedom available on request.

³⁰ Significant positive intervention effects are also observed with the other two measures described in table 2.11 but are not reported for reasons of space.

Table 2.12 Logistic regression of satisfaction with health visiting service ('very satisfied')

Predictor	SIX MONTHS		EIGHTEEN MONTHS	
	odds ratio	p	odds ratio	p
Group (intervention)	1.882	.024	2.861	.000
Gender (male)	0.829	.490	0.657	.111
Mother's age (years)	0.993	.744	1.032	.170
Ethnicity (minority ethnic)	1.347	.587	0.566	.204
Parity (first time mother)	0.655	.176	0.904	.734
Smoked in pregnancy (yes)	1.974	.021	2.280	.006
Baseline satisfaction with HV	5.425	<0.001	2.447	.002
Positive baseline attitudes to HVs	1.190	<0.001	-	-
Number of community facilities used	0.607	.003	-	-
Not car-owner	-	-	0.559	.042
Constant	0.013	<0.001	0.145	.025
N =	341		273	

2.4 Discussion and conclusions

2.4.1 Evidence for intervention effects

After first establishing the basic representativeness of the recruited sample and confirming the more intensive, home-based nature of 'Starting Well', we assessed the evidence for intervention effects on a range of health indicators over the first eighteen months of the child's life. By standard scientific criteria, the project was not successful in improving the quality of the home environment relative to generic health visiting, although the association was positive at both assessments and approached levels of statistical significance at eighteen months. A number of clearer intervention effects were observed: more 'Starting Well' children were registered with a dentist at six and eighteen months; their mothers were more satisfied with levels of health visitor support at both assessments and were also less likely to be at risk of postnatal depression at six months. At face value, these findings are undoubtedly encouraging and suggest that diverse outcomes relating to the home environment, psychological functioning, health-related behaviour and service-related attitudes can be modified by an enhanced home-visiting service over a relatively short period of time. We will now briefly discuss each set of findings in turn.

HOME score

A recent and authoritative systematic review (including a meta-analysis of twelve studies) concluded that there was strong evidence for the positive effects of home visitation on the quality of the home environment as indexed by the HOME and related measures (Elkan et al, 2000; Bull et al, 2004). Given this evidence-base, why did we not observe more clear intervention effects? Three sets of points are relevant: basic problems of comparability with other studies; the possible dilution of effects due to service heterogeneity; and statistical power considerations. Taking the comparability point first, Elkan and colleagues' work is unquestionably rigorous but their conclusions are based largely on North American randomised control trials of diverse interventions delivered to particular high-risk groups, often in the absence of routine health visiting. Variation also exists in the timing of HOME assessments and the exact measure used. Moreover, only seven out of seventeen studies reviewed provided positive and statistically verifiable evidence of intervention effects³¹. Given these basic problems of comparability and the equivocacy of the literature in general, it may be concluded that expectations of very marked intervention effects were unrealistic. Secondly, the intervention itself developed rapidly over time and introduced new components (e.g. the 'skill mix' of auxiliary health professionals and paraprofessionals) more than halfway through its initial phase. Given that participants were recruited over a thirteen month period, it may well be that later recruits were receiving a qualitatively different service to earlier recruits. If true, but not well-captured in analysis, this service variation may serve to dilute intervention effects. Finally, our ability to detect group effects may have been further compromised by the decision to use smaller, 'richer' datasets for regression analysis which may have unfavourably traded power (in terms of number of cases) for comprehensiveness (in terms of the range of available predictors).

Given the above limitations, it is perhaps all the more notable that we observed a 'borderline' intervention effect ($p=0.088$) at eighteen months. Whilst we do not suggest a shifting of the 'statistical goalposts' to accommodate this finding, borderline results are a feature of the HOME literature³². Given both the complexity of the project and the limitations of evaluation, it is probably wise to avoid a simple success/failure conclusion based solely on significance level (Sterne and Davey-Smith, 2001) and tentatively explore the possibility that our findings point to a cumulative and/or delayed impact of the intervention on home environment. If this is true, and the small relative advantage continues to grow beyond eighteen months, the well-described associations of quality of early stimulation to later cognitive and behavioural development (Bradley, 1993; Shonkoff and Phillips, 2000) might suggest real future advantages for 'Starting Well' children.

³¹ Interestingly, given the prominence of Olds' work in the initial design of the project, only three studies (Olds et al 1986; 1994; Kitzman et al, 1997) use the HOME as an outcome. Only one (Kitzman et al) shows significant intervention effects but in relation to a highly selective sample of disadvantaged African-American primiparous mothers who had given birth to very premature infants (<29 weeks gestation).

³² A number of studies in the HTA review (e.g. Larson, 1980; Black et al, 1995) report findings that are only just significant at the $p=0.05$ level, whilst others (e.g. Black et al, 1994) just fail to reach this level.

Postnatal depression

Results at six-months postpartum support a number of studies showing the positive impact of home-based interventions delivered by trained health visitors (Holden, Sagovsky and Cox, 1989; Gerrard, Holden, Elliot, et al, 1993; Seeley, Murray and Cooper, 1996; Cooper and Murray, 1997). In this study, the fact that an intervention effect emerged despite the cohorts having an apparently identical proportion of 'at-risk' women underlines the importance of including relevant statistical controls in analysis; there were fewer 'at risk' women in the intervention group than would be predicted from their background characteristics. Findings at eighteen months are harder to interpret. Original work by the primary developer of the EPDS (Cox, 1986) suggested that postnatal depression either occurred in the first few months after birth or not at all. At eighteen months then, it is doubtful whether one can talk meaningfully of women having postnatal depression but the instrument may still have some validity as an indicator of depressive symptoms. If this is true, it is clear that the early mental health benefits afforded to 'Starting Well' mothers fade over time, with prevalence 'returning' to levels predicted by other key sample characteristics (e.g. deprivation) at eighteen months.

Taking the six-month finding in isolation, the evidence-base linking postnatal mood disorders to impaired child cognitive and emotional development (Murray, 1992; Murray, Fiori-Cowley, Hooper and Cooper, 1996) strongly suggest that 'Starting Well' could deliver immediate benefits to the depressed mother and more enduring benefits to the child. This may be particularly salient for this socio-economically disadvantaged cohort as children of poor depressed mothers are at substantially greater risk of impaired development (Murray & Cooper, 1997). Two qualifying points may be made, however. First, developmental impairment is more strongly predicted by disturbed maternal interactional style than by simple exposure to depressed mood; at this stage, however, we have only demonstrated an intervention effect in relation to reduced exposure. A pertinent question might then be 'was there an intervention effect on the interactional style (indexed for example by HOME Inventory sub-items) of depressed mothers?' Unfortunately, both the relatively small absolute numbers of EPDS high-scorers and the fact that only cross-sectional analyses are possible on six-month data³³ mean that we are poorly equipped to test this hypothesis. Second, the practical, service-development implications of the positive six-month result are not straightforward as it is not clear what aspect(s) of the intervention produced the observed effect. Most intervention studies focus exclusively on postnatal depression and involve dedicated training in non-directive counselling techniques whereas 'Starting Well' has a much broader health focus and improved maternal mood without comparable training. At this stage then, findings are only supportive of a 'whole package' effect of the intervention on depressive symptoms but one candidate for the 'active' ingredient may be the quality of the mother-health visitor contacts

³³ As both HOME and EPDS were collected at the same assessment, it is difficult to make causal statements regarding their inter-relationship.

(Korfmacher, Kitzman and Olds, 1998; Elkan et al, 2000). This point will be pursued in later sections.

Finally, it is clear from our longitudinal findings that women who have previously scored below threshold at six months, can go on to score highly at eighteen months. These families may constitute an important vulnerable group who would not ordinarily be identified as 'at risk' from earlier assessments³⁴.

Satisfaction with health visitor support

Very few evaluations of health-visiting interventions make explicit efforts to assess client-satisfaction and those that do use methods that are notably inconsistent (Elkan et al, 2000; Bull et al, 2004). This may be due to a widespread perception that survey responses are meaningless when the overwhelming majority of respondents express general satisfaction with all health services due to the desire to give a socially-acceptable response (Avis, Bond and Arthur, 1995). Whilst it is true that the vast majority of participants in this study were either 'very' or 'fairly' satisfied with levels of health visitor support, responses were submitted via a confidential postal questionnaire and to a researcher as opposed to a health practitioner. In these perhaps less-biased circumstances, the distinction between the two terms (the former emphatic, the latter 'lukewarm') may be more valid and when the size of the group differences are considered, alongside those for the other measures expressed in table 2.11, it may be concluded that a clear preference is being expressed for the enhanced service. It is notable too, that contrary to other studies that show client satisfaction diminishing over time (Graham, 1979), our findings show that it actually *strengthened* from six to eighteen months.

Dental registration

Scottish child dental health statistics are stark: only one-third of children aged 0-2 are registered with a dentist (Information and Statistics Division, NHS Scotland, 2003) and by age five, 55% of children have dental disease (Scottish Executive, 2003). Marked social gradients are observed for both registration and outcomes (Davies, 1999). Against this backdrop, we have demonstrated strong evidence of project impact on dental registration rates over the first eighteen months of life. It is clear, however, that the substantive implications of this finding depend crucially on the extent to which registration is translated into actual attendance and/or better dental health (for example, fewer dental caries or tooth loss). Whilst positive cross-sectional associations between children's' dental registration status and dental health have been demonstrated (Pitts, 1995), the causal nature of this relationship remains unclear.

³⁴ A similar conclusion was reached in a recent British study by Davies, Howells and Jenkins (2003) which involved repeated EPDS screenings over the first postnatal year. Here 'new' cases were often women who had moved into the practice area and had not been screened previously. This could not be a factor in our study but the finding that the number of significant life-events predicted high scores at eighteen months could point to the aetiology of depressed mood amongst this 'late-onset' group.

Conclusions from this study should, therefore, be guarded until comparative practice data can be collected³⁵.

2.4.2 Associations between outcomes and other predictors

Two sets of variables especially merit further comment: material (dis)advantage and ethnicity.

Material (dis)advantage

The last two decades have witnessed an explosion of multi-disciplinary research into health inequalities and their relationship to income and social status. Our findings support this literature in two ways. Firstly, both cohorts are disadvantaged in terms of their *absolute* material resources and display correspondingly high levels of adverse health and other behaviour (e.g. maternal smoking). Secondly, families' *relative* position within this cohort, in terms of available material resources, is robustly and consistently associated with each outcome. These findings, whilst unsurprising, point to the relatively limited potential of health services to impact on the health of deprived populations when unaccompanied by improved material circumstances and firmly point to the need to link vulnerable low-income families to both local and national poverty-reduction initiatives.

Ethnicity

Minority ethnic status was strongly associated with lower HOME scores, higher EPDS scores and lower rates of dental registration and, at face value, these findings offer a comparatively poor prognosis for these children. It is likely, however, that systematic measurement error is responsible for at least some of this apparent difference in outcome. The HOME, though used internationally in a variety of cultural settings, has never been validated on a *British* Asian cohort and the authors of the instrument admit that additional work is necessary in order to establish its wider validity (Bradley, 1993). Similarly, there are well-recognised problems with the translation of concepts relating to depression (Launguni, 1997; 2000) and with the EPDS in particular (Elliott, 1996; Gerrard, 2000). Measurement error is, perhaps, a less convincing explanation of lower dental registration rates; not only is this item a much simpler concept constructed from a response to a single survey item, the finding also supports other studies of infant feeding and dental health amongst British Asian populations (see Watt, 2000).

In summary, the findings most probably reflect both measurement issues and real health-relevant cultural differences and illustrate the need for culturally sensitive assessment tools and culturally-competent health workers of the type being piloted in 'Starting Well'.

³⁵ As a corollary, a recent qualitative study of parents of pre-school children in three Scottish NHS Boards (including Greater Glasgow) described the many perceived barriers to registration, including confusion as to the appropriate age to do so, parental fear, hostile attitudes to staff, accessibility issues and lack of information and incentives to attend (Morrison, Macpherson and Binnie, 2000). Future qualitative work might explore the extent to which the observed gains in intervention areas are attributable to challenging these attitudes.

2.4.3 Next steps

A number of points may be made regarding instrumentation and measures. Firstly, our use of the number of home visits by health visitors is a useful but limited measure of service input that tends to understate the amount of contact (e.g., from health support workers) in the intervention group. More sensitive and comparable indicators are required, including perhaps, contacts with health staff that are not recorded by the index health visitor. It would also be advantageous to develop an equivalised measure of input that ascribed different weightings to different types of contact. This would mean, for example, that a ninety-minute face-to-face home visit from a health visitor is accorded considerably more importance than a five-minute phone contact from a lay worker. Secondly, more work is required on research nurse inter-rater reliability in order to account for the observed investigator effect on HOME score. Thirdly, the cultural specificity of both the HOME and EPDS necessitates careful interpretation of results, and may benefit from separate analyses, although numbers are small. These and other points will be pursued in further analysis in due course.

Finally, we have, by necessity, focussed on a narrow range of indirect/intermediary outcomes. In order to demonstrate a 'step-change' in child health, we would need to show that Starting Well had a *direct* influence on *actual* child-centred outcomes such as school readiness or cognitive development. Whether or not this will be possible with the existing cohort remains to be seen, but we are optimistic. We have made strenuous efforts to put in place mechanisms for retaining contact with existing respondents and to maximise the availability of essential baseline information. Our current assumption is that by the beginning of 2005, when the first of the study children will be 42 months old, we might reasonably expect to be able to contact approximately 500 families and that about 70 per cent of these (N=350) would respond positively to a further round of data collection. On this basis there is a strong case to be made for further follow-up.

2.4.4 Conclusions

In conception, the project was influenced by both a general (review-based) and specific (Olds and colleagues) evidence-base that suggested a home-visiting service with key characteristics could result in demonstrable improvements in child-health-relevant outcomes. The exact correspondence of the project plan to this evidence-base and the fidelity with which it was carried out are important empirical questions. Basic problems in transferring findings from the north American to British contexts, however, cast doubt on the extent to which marked *expectations* of impact were realistic. In addition, methodological problems associated variously with project-area size, short recruitment and assessment timescales, imperfect participation, and attrition, have limited both the range of outcomes used and the number of participants available for analysis. All of these factors have limited the capacity of this evaluation component to *detect* impact.

Despite these impediments, we have recruited a not-obviously biased sample of families and uncovered evidence that is suggestive of project impact on earlier maternal psychological health and later quality of the home environment. When considered alongside findings relating to client-satisfaction, we can begin to build a picture of a service that is delivering generally higher levels of support than generic health visiting. In doing so, it may have the potential to impact on families in ways that are not only beneficial to the mother in the short-term but may also have more enduring benefits for the child.

Part 3. The Process Evaluation of Starting Well

3.1 Starting Well's Initial Theory of Change

3.1.1 Introduction

Having summarised the degree to which Starting Well brought about measurable changes to health related outcomes for children and families, we turn now to more processual change arising from the project. In order to set the scene for the various components of the process evaluation undertaken by the research team it is important to understand the theoretical and programme logic that lay behind the Starting Well intervention. One approach that helps evaluators to do this is the Theories of Change (Connell and Kubisch, 1998). This section of the report briefly summarises:

- the background to a Theories of Change approach to evaluation; and
- the key elements of the Starting Well Theory of Change articulated in the first year of the project.

3.1.2 The Background to a Theories of Change Approach

The complexity of initiatives such as Starting Well, poses a challenging set of issues for evaluators (Judge and Mackenzie, 2002). These include the following:

- initiatives such as Starting Well have multiple and broad goals and are therefore not well suited to evaluation methods that rely on a small number of key outcomes;
- objectives are defined and strategies are chosen to achieve goals that often change over time - for example, interventions which aim to be locally driven require to respond to both community needs and these are not necessarily defined at the outset. Likewise, initiatives such as Starting Well frequently find themselves in the position of responding to changing policy requirements at a national level and this can militate against an approach that is consistent over the life time of a project;
- many activities and intended outcomes are difficult to measure since units of action are complex, open systems in which it is virtually impossible to control all the variables that may influence the conduct and outcome of evaluation;
- the saturation of a given community with a particular intervention limits further the potential for traditional experimental designs since the option of randomising individuals to treatment and control is not a viable one. In addition, the usefulness of identifying control *areas* is severely curtailed where an initiative such as Starting Well is seen as a initiative with a politically high profile and where some processes that are being

introduced through the project are anticipated to be rolled out across some parts of Scotland before any formal evaluation has taken place; and,

- finally, improving child and family health outcomes that are socially determined takes longer than the lifespan of an initiative and its evaluation.

A range of theory-based approaches have been developed to partially address these challenges, with the two most common being Theories of Change (Connell and Kubisch, 1998) and Realistic Evaluation (Pawson and Tilley, 1997)

The Theory of Change approach, developed by the Aspen Institute from their evaluation of community initiatives in the US, is defined as 'a systematic and cumulative study of the links between activities, outcomes and contexts of the initiative' (Connell and Kubisch, 1998). The approach aims to gain clarity around the overall vision or theory of change of the initiative. In generating this theory, steps are taken to link the original problem or context within which the programme is located, with the activities planned to address the problem and the medium and longer-term outcomes that are predicted to follow.

The starting point is for the initiative (with the help of the evaluator) to reflect on the key aspects of the context within which it is operating. The next stage is to specify a rationale for intervening in relation to priority issues (for example, in response to a local needs assessment). This rationale should then translate into clearly defined change mechanisms each with specified targets that should form part of a logical pathway that leads in the direction of prospectively expressed, strategic goals.

The logic of the Theory of Change approach is that where such pathways are articulated in a way that is **plausible** (derived from an existing evidence base), **doable** (practically feasible given the time, financial and personnel constraints), **meaningful** (leading to worthwhile outcomes), and **testable** (are able to be shown to have taken place as anticipated) then the following benefits will accrue:

- project planning and implementation will be sharpened;
- the Theory of Change will help to identify *what* data need to be collected *when* and using what *methods*;
- Where prospectively specified outcomes are achieved at the predicted time and following prescribed activities then the question of causality can be partly allayed. (The argument here is that if the constituency of stakeholders are able to agree from the outset the outcomes that will constitute success then the achievement of these

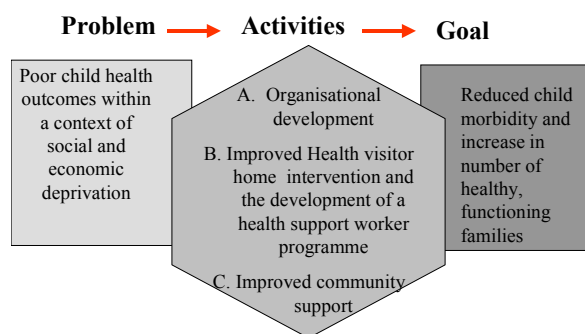
outcomes will be seen as a plausible means of attributing change to the intervention)³⁶.

3.1.3 Starting Well's Theory of Change

The process of generating and articulating Starting Well's Theory of Change was an iterative one with the evaluator working with those at a strategic level over a one-year period. Participants were members of either the project steering group (a strategic management group) or the senior management team (an operational management group). Inevitably stakeholders' theories are evolving concepts and even at this early stage in the project may have moved on from the original proposal accepted by the Scottish Executive in the autumn of 2000.

As illustrated in diagram 3.1.1, the *theory of change* for the project, at its most general level, was that a 'step change' in the health and well being of vulnerable young children and their families could be achieved by a combination of intensive, individualised support from home visitors, a well developed community infrastructure and strong partnership working between statutory, community and voluntary services (A detailed version of this that sets out the project's targets within a three-year period is presented in Mackenzie, 2002).

Diagram 3.1.1. A simple representation of the Starting Well Theory of Change



Underlying this were a set of beliefs concerning key mechanisms. These assumptions are set out in table 3.1.1

³⁶ The practice of articulating a project's Theory of Change, however, throws up a serious of further practical and conceptual challenges for the evaluator (Barnes et al, 2003; Mackenzie and Blamey, in press; Mackenzie and Benzeval, in preparation).

Table 3.1.1: Key assumptions underlying the initial Starting Well Theory of Change

- families in deprived areas would engage in the project;
- through the development of trusting relationships with home visitors, families would engage in health promoting activities with the home and in the wider community;
- health visitors working more intensively with a smaller caseload and supported by evidence-based practice guidelines, would be able to take a broader view of a family's health;
- the employment of health support workers, predominantly from within the intervention areas would enhance the support provided by health visitors;
- through intensive work with individual families, health visitors would be able to develop a greater understanding of child and family health needs at a community level;
- new area infrastructures for child health would result in more responsive local statutory and community supports for families;
- a senior level project steering group would provide the driver for strategic change; and,
- that this whole system and individual family level intervention would result in a step change in child and family health in the longer term.

During the time that the project's Theory of Change was being refined, the Scottish Executive provided the Health Demonstration Projects with short-term resources to assist them in project planning and performance indicator setting. These processes resulted in the production of a revised project plan in March 2002. This is summarised in table 3.1.2

The evaluation report, based on developing project plans until January 2002, raised a number of issues concerning the Theory of Change articulated by the project, including its limited **testability** largely due to a lack of baseline information. This issue is just as evident in the March 2002 plans and is shared by complex initiatives across the UK (Mackenzie and Blamey, in press; Judge and Bauld, 2001). On the other hand, unlike many such initiatives, Starting Well invested in the development of a project specific monitoring database and in conducting/commissioning small pieces of evaluation that, in combination with the independent evaluation allowed many, although by no means all, of its key demonstration questions to be addressed (for a summary of these see table 3.1.3.

Table 3.1.2: A summary of Starting Well's Key Outcomes as extracted from 2002 Project Grids presented to the Scottish Executive (outcome measure)

Health Outcomes	Improved oral health in children (<i>Decayed, Filling and Missing Teeth</i>)	Improved child nutrition (<i>healthy weaning practices</i>)	Enhanced uptake of services for incomplete immunisation/child surveillance	Enhanced home safety	Enhanced parenting skills	Impact on young people's behaviour and educational attainment
Risk Factors	Childhood registrations with community dentist in infant's first year (<i>40% registered by 8 months</i>)	Good weaning practices (<i>Identification of breastfeeding support for mothers; significant improvement in weaning practice</i>)	Knowledge of barriers to uptake of preventative services (<i>evidence of intervention with families with incomplete immunisation/child surveillance</i>)	Safe home environments (<i>75% of families registered with RoSPA project; reduced level of self reported child accidents in the home</i>)	Parental access to evidence based positive parental training (<i>100% of families provided with basic parenting information post-natally</i>)	Uptake of pre 5 nursery places
Underlying Determinants	Parental involvement in family health (<i>family goal setting levels</i>)	Parental awareness of community pre 5 resources (<i>level of use of community pre 5 resources</i>)	Access to community pre 5 resources by ethnic minority families (<i>level of use by minority ethnic families</i>)	Parental involvement in development of local pre 5 services (<i>level of involvement in local implementation groups</i>)		
Service Development	Innovative models for family/professional health collaboration – the Family Health Plan (<i>100% of families have completed plans and have agreed goals</i>)	Transferable models of innovative health visiting (<i>visiting schedule applied with 100% of families; routine use of Triple P and Practice Guidelines</i>)	Effective child health teams in primary care, flexibly using available skill mix (<i>description of skill mix in primary care child health teams</i>)	Innovative use of lay workers in primary care child health (<i>description of lay worker role/development</i>)	Innovative management collaboration between the NHS and voluntary sector (<i>description of management structure for lay workers</i>)	Routine assessment of post-natal depression (<i>utilisation of EPDS with 100% of mothers</i>)

Table 3.1.3: Starting Well's Key Priorities for Learning as extracted from the project grids submitted to the Scottish Executive in 2002

Effective strategies to improve child health	Supporting, involving and working in partnership with communities to improve child health	Effective interventions to improve child health	Organisational development and partnership working
How can child health be improved by multi-sectoral collaboration	Are families enabled to make better use of community support	Is this new model acceptable to families (and specifically, minority ethnic families)	What can we learn from the organisational model for intensive support to vulnerable families
	What referrals are made and do families attend	How is this model perceived to differ from routine health visiting	What is the influence of new partnerships and how can we maximise success through commitment from key agencies and their policies over the long term
	Does the community become more effective in supporting families with young children	What training is required to implement this model of home visiting and how is it best delivered	How can we improve the voluntary sector's involvement to ensure the sustainability of its work
		Is this model transferable as a whole or in part? What are the funding and training implications	How do we facilitate change/make flexible use of the primary care team/consult with and engage primary care professionals
		What is the role of lay workers and is it perceived to be effective	Lessons about joint assessment processes
		Does Triple P work in a Scottish Context	
		What are the benefits of the family health plan and home visiting guidelines	
		What do families identify as needs	
	How can families work in partnership with professionals to address these needs		

3.1.4 Conclusions

As with similar complex community initiatives, the strategic stakeholders within Starting Well struggled to articulate a Theory of Change that was wholly testable (Mackenzie, 2002; Mackenzie and Blamey, in press) but developed a relatively robust internal monitoring system to capture the implementation of its plans, and, as with the independent evaluation, adopted a strong focus on process learning.

The following sections of this part of the report now consider the more detailed findings in relation to some of the questions underlying Starting Well's Theory of Change:

- the extent to which intensive home visiting led to the development of therapeutic relationships between families and their home visitors (section 3.2);
- the implementation issues involved in developing a skill mix approach to home visiting (section 3.3); and
- the degree to which intensive home visiting at an individual family level led to improved community and strategic responses to child and family health problems (section 3.4).
- Finally, this section finishes with a discussion of strategic stakeholders' retrospective reflections of the project's initial Theory of Change.

3.2 Case Studies: Project Families and Health-Visitors

Key findings:

- Analysis of 59 individual interviews with a diverse group of 'Starting Well' mothers and their health visitors attempted to understand the interpersonal processes that underpinned the project's operation at the level of individual families.
- A process model was identified that linked intensive health visiting input to a diffuse set of benefits summarised as 'enhanced support' (comprising: increased confidence; reduced anxiety; reduced isolation; the opportunity to confide; and experience of advocacy).
- The process model describes how intensive visiting equated to **more time** and direct contact with mothers during a period of universal need which encouraged the rapid formation of a **trusting relationship**, an **individualised care** package and the provision of **more and better quality information** on needs and life circumstances. This in turn, was associated with the identification of a **broad range of problems** and problem-solving activity and an **enduring two-way (functional) dialogue** between mother and health visitor. In sum, these processes promoted perceptions of enhanced support. Lack of maternal receptivity to the service and health visitor caseload pressures explained variation in process and outcomes.
- Intensive visiting can be an effective way of delivering a more **person-centred**, 'holistic' model of care. Key factors include: the convenience of the home setting; the shift in power relations inherent in the mother's control of access to the setting; and a concomitant need for the health visitor to maintain access by a) providing a flexible service and b) establishing a positive, non-directive relationship.
- Project health visitors praised teamwork, training and aspects of the approach (intensive support, skill mix) as strengths but had experienced resistance, scrutiny, and larger, more demanding caseloads than initially anticipated. These latter factors may, at times, have impeded their capacity to deliver the service as intended.
- Support was voiced for a universal intensive service in the first postnatal months, but that had the capacity to target sub-groups of women with higher levels of identified need, for example, primiparous, isolated or depressed women.

3.2.1 Introduction

The general aims of this chapter are to allow the views and voices of service-users and their health visitors to emerge in such a way that we begin to understand:

- the inter-personal processes that link inputs (intensive home-visiting) to outcomes (perceptions of benefit)
- their general perceptions of project strengths and weaknesses

In this way, we aim to move beyond more mechanistic account of impact (chapter 2) to consider whether and how the project ‘works’ at the level of individual families.

We begin in section 3.2.2 by providing a brief methodological context to the interviews including more detail on the characteristics of participants, the timing of interviews and a description of actual health visiting input for some of the case study families. Proceeding from a detailed analysis of fifty-nine interviews, section 3.2.3 goes on to present a process model linking intensive home visiting to a key set of perceived benefits summarised as ‘enhanced support’. Section 3.2.4 describes perceptions of project strengths and weaknesses, and conclusions are drawn in 3.2.5.

3.2.2 Methodological context

Characteristics of participants

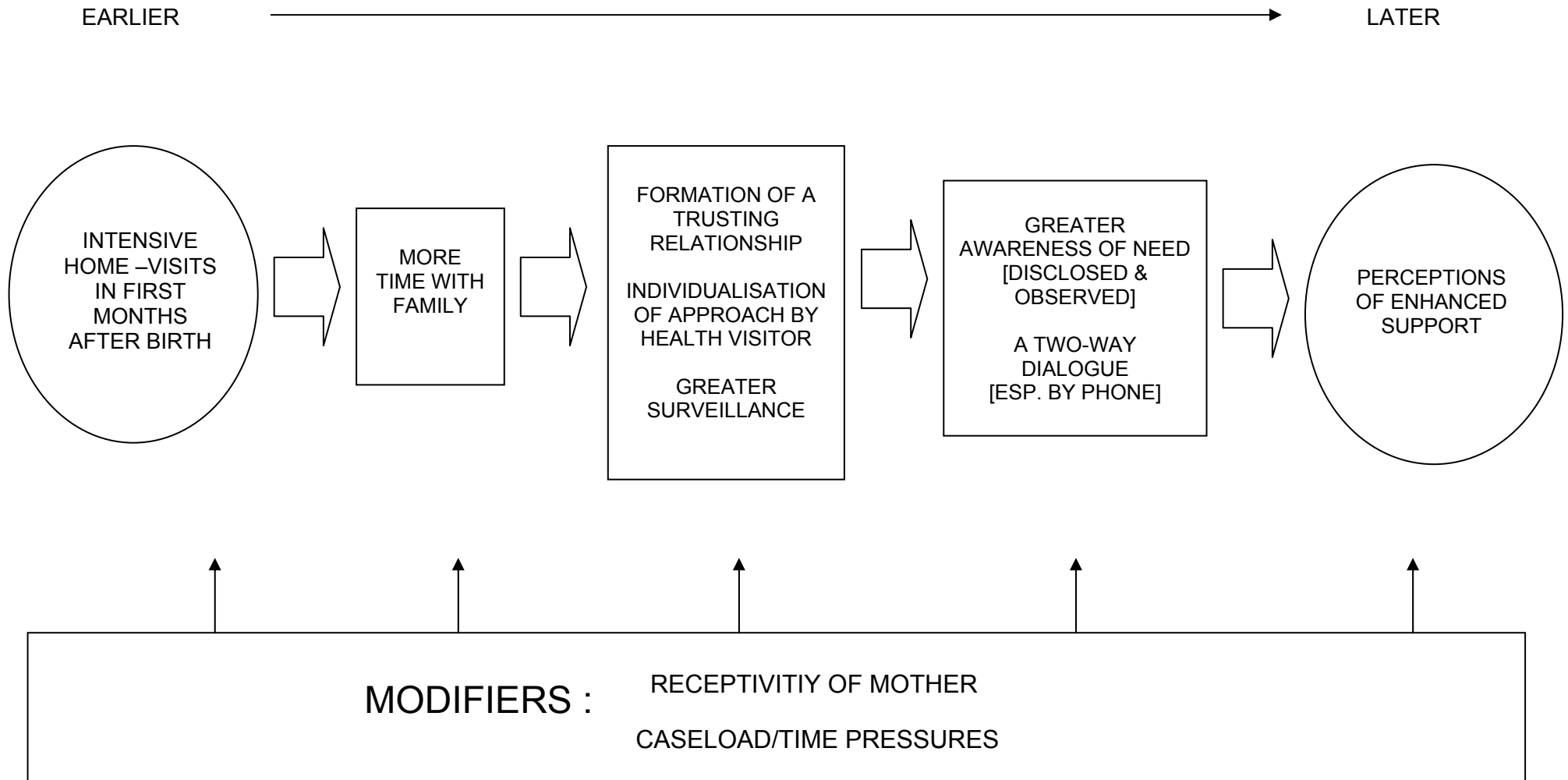
With regard to parity, age and number of children, half of the 20 mothers purposively recruited were primiparous with multiparous mothers generally having either one toddler or a number of older children. The median mother age was 29.5 (range 18-40) with around three-quarters of women having a resident partner. Around one third of households were workless. Six minority ethnic women from predominantly Scottish Asian (Pakistani) backgrounds were interviewed, two of whom required an interpreter to complete the interview. While participants were drawn equally from the two project areas, all minority ethnic women lived in the southern project area. Of the seven women not interviewed a second time, several were contacted but were either not at home or failed to attend more than one scheduled interview, whilst others could not be contacted on a reliable phone number and did not respond to a postal approach. Index health visitors had also experienced access difficulties with some non-responders although they did not obviously share other characteristics. One mother was not contacted on the advice of her health visitor due to a deteriorating home situation. All interviews were carried out in the family home apart from two which took place at the local health centre.

Around half of the health visitors interviewed were experienced workers, whilst for the other half (predominantly in the eastern project area) working on the project was their first post-qualification post, although several had experienced other forms of nursing. A mixture of part- and full-time staff were interviewed. Finally, two male health visitors were interviewed although reference to gender has been removed from quotes in order to respect confidentiality.

Timing of interviews in relation to project development

Fig. 3.2.1 shows the timing of each round of interviews which took place between early February 2002 and mid-June 2003. It is important to note that the ‘skill mix’ of health support-

Fig. 3.2.2. A PROCESS MODEL OF INTENSIVE HEALTH VISITING



3.2.3.1 Key perceived benefits/'outcomes'

Benefits as 'outcomes'

Both sets of actors were asked questions that were designed to elicit perceptions of benefit relating to the case, for example (to mothers) 'how do you feel the project has helped you?' and (to health visitors) 'what success do you feel you have had with this family?'. In general, health visitors found these questions easier to answer and, to the extent that they felt there had been benefit, were more likely to attribute causal significance to their work or to the project in general. Mothers' statements tended to be more circumspect and tentative and gave the impression that they were unused to reflecting on the impact of services in a cause-effect way. Moreover, whilst some causal attributions were made in response to direct questioning, many statements of benefit from mothers were indirect and implicit in either positive reactions to service components or in reflections on the project's 'good' points. It is clear then, both from the style of comments and, as we shall see, their substance, that the types of 'outcome' seen as important to mothers were quite different from those traditionally associated with quantitative research; often focussing on 'softer', more interpersonal achievements that are frequently treated as mediating factors in impact studies. This was also true of an important subset of health visitor statements. We use the term 'outcomes' therefore, to refer loosely to broad sets of identified benefits that had either psychological (mothers) or more professional (health visitors) validity for participants.

Health visitor accounts

The top half of figure 3.2.3 illustrates in their own words, the range of benefits identified by health visitors. These accounts of progress are generally consistent within-case and across time and mostly refer to the immediate and more enduring effects of an intensive period of input in the first few postnatal months. Two distinct sets of outcome emerged in addition to general **preventative work**, which by definition was a professional but subjective assessment of harm avoided. The first set of identified outcomes was the **achievement of health-related targets**, such as maintaining breastfeeding, appropriate weaning, dental registration, the delivery and use of safety equipment, and referral uptake. Active health promotion work was illustrated by at least three participants' description of how their advice had positively affected breastfeeding intention, weaning practices and opportunities for child-environment interaction. The second main set of outcomes refers to a diverse set of activities that may be summarised as the **provision of general support**. At its most basic, this support consisted of frequent and clear communication and the establishment and maintenance of a good relationship, however, high levels of postnatal depression amongst study mothers highlighted the specific focus of this support. The main vehicles of support here were firstly, the 'listening' visit which provides the opportunity for women to talk about their problems and secondly, referral to the GP. Finally, support was provided in the attempt to alleviate families' financial and material concerns, for example referral to debt advice, the provision of non-safety equipment (e.g. nappies, cots, toys) and writing support letters to housing associations and nurseries.

FIG 3.2.3: EXAMPLES OF PERCEIVED BENEFITS TO CASE FAMILIES

HV ACCOUNTS

'I think we have prevented quite a lot ... which has probably prevented catastrophic results with these families...probably with this single-mum has probably made a big, big difference in her whole parenting style and kept – he (child) could have well gone into care otherwise...So there's a lot of **prevention** and avoidance going on which is unseen because you've prevented it you know?'

...'she was 30 weeks pregnant when I met her and...was saying, she was saying that she was not going to **breast feed**...[lengthy description of persuasive dialogue]...and she was kind of laughing "well maybe I will think about it" and I was like "okay maybe you will think about it" and she is still to this day breast feeding' [at 4 months postpartum]

'they are **accessing services** - [toddler] is attending audiology and speech therapy, the wee one has been attending [hospital] and is being followed up so that is a positive thing...I made sure that **safety equipment** arrived so [toddler] didn't fall into the two bar fire'

'we got [case mother] to go back to the GP, she went back and got anti-depressants and her **mood** is much, much better now; she is feeling good at the moment actually - the best I've seen her...The other big issue is [complying with older child's specialist **diet**] ... the health support workers are involved, they go in now three times and help her collect food off the supermarket shelves; there is so much small writing and small print, she was finding that really difficult...that seemed to be really good for her'.

[replying to question on what the project offers case families] '**support** with their parenting and their childcare and access to other services in the community, and for things to be more pleasant, and for them to enjoy better health because of having an informed choice'

'they are both isolated girls and I still feel that listening visits are very important to them. Well whatever benefit they got out of it is just **extra support** for them and helped them work through a difficult period you know when they have a young baby and they have got a lot of other issues going on in their life, to have that extra support I think benefited them both'

MOTHER ACCOUNTS

'I think he would have still been quite good but I think a lot of his development, a lot of the key stages in his development might no' have been picked up on by me because I'm no' trained in **child development**...now if I hadnae had that help, I don't think I would have done as good a job'

'my Health Visitor did talk to me about like that she said to me 'you are doing brilliantly', even although I knew that she was saying it to me so that I could feel confident, it did make me feel confident, it did give me the **confidence**'

'when he is getting weighed it kinda **reassures** you, that you are feeding him enough and you are looking after him enough and all that stuff...but, I think aye, I have benefited from it and the fact that there's been somebody there to give me advice when I've needed advice. And when I've been going spare about something I've just been able to ask and get it answered straight away, know what I mean?'

'Aye, it's the advice and the information and things like that and the **support**, you know, that's basically em where it's been useful you know so. Aye especially when I was feeling really low you know em that was beneficial for me...I mean the last couple of months have been em a whole lot better you know, and I kind of see life a wee bit different em from right at the beginning you know? And I'm like 'well get up and do something' and I do feel as if [HV] has had a lot to do with that you know?'

'when it comes to like personal matters, I would rather have kept them in ...but with [HV] I feel that I have been able to **express personal matters** as well...that's something that takes the burden away better than it is talking to somebody that you know'

'well you do feel as if you have got more support. Its **good to have somebody to talk to**, because my partner works long hours so I am usually round about the kids all day, so its good to have a wee bit of adult conversation'

[referring to HVs work in support of **re-housing**] 'she phoned them up you know made an appointment... she will say 'I'll do this and I'll do that for you, you know, if you would like me to do it?' you know and I think well 'that will be lovely you know?' It takes it off my hands, it takes the worry off...and its nice to know that somebody is there to help you as well you know? Like I'm not all alone, I haven't got any help at all kind of thing, and it is very nice to have that support off her'

Mothers' perception of outcome

There is a strong correspondence within-case between health visitor and mother accounts of benefit, which again tend to relate to work done in the early postnatal months. Three women spoke of perceived **developmental gains** (either cognitive or motor) for their children as a result of taking part in the project; this was attributed to advice on parenting and interaction from health visitors and nursery nurses. Overwhelmingly, however (see fig. 3.2.3), the most dominant and clear message emerging from the mother interviews was the perception that the service offered **enhanced levels of support**. Statements to this effect were made in detail by virtually every participant regardless of need and background, across both cohorts and at both first and second interviews. The main source of this support at interview one was the health visitor but at interview two also included other project workers and resources. Favourable comparisons were made with previous experience of health visiting and also with friends/relatives receiving the generic service elsewhere in the city. Five dimensions of enhanced support associated with intensive health visiting could be identified:

- i. *Increased confidence*: either in general or in connection with a specific parenting practice (e.g. breastfeeding, play).
- ii. *Reduced anxiety*: in relation to help with common infant issues such as feeding, elimination and sleep/wake cycles and to a range of maternal physical and mental health problems.
- iii. *Reduced isolation*: for a number of women for whom simple contact with an interested adult relieved loneliness and provided structure and variety to the day.
- iv. *The opportunity to confide*: either chatting generally or unburdening at length about specific problems.
- v. *Experience of advocacy*: for families experiencing childcare and/or housing problems, letters of support sent to nurseries and local housing associations gave a sense of someone 'fighting their corner' despite more mixed views as to the ultimate efficacy of such letters.

3.2.3.2 From input to outcomes

The previous section highlighted the extent to which perceptions of enhanced support were identified as key benefits for families. This was particularly the case for mothers but also for health visitors who valued support as an end in itself as well as a means to longer-term health-related goals. This section describes the processes that intervene between intensive input and perceptions of enhanced support.

The functional importance of time and direct contact

Figure 3.2.4 contains illustrative quotes for this section. Both mothers and health visitors identified an **increased amount of time and direct contact** as important features of the intensive visiting pattern. Whilst this may seem obvious, both factors were important enablers of mother-health visitor interactions in three important ways. Firstly, they promoted the rapid formation of an informal but **functional relationship** that was often characterised as 'trusting', 'relaxed' and 'more like a friend'. At least four health visitors spoke of the establishment of this type of relationship as a key indicator of success, whereas several mothers went further and described it as a basic pre-requisite for getting any benefit from the service. The absence of a good relationship was felt to cause tensions, discourage women from asking questions and even prompt the foreclosing of access to the family. This relationship was generally accorded greater significance for depressed/isolated women with a manifest lack of other support. Secondly, increased time and contact led health visitors to believe that they would be able to 'follow through' particular courses of action and allowed them to tailor their approach to the particular characteristics of the mother, including needs, life circumstances and temperament. This **individualisation of care** was evidenced by increased visits for vulnerable families, visiting at atypical times to fit in with shift patterns and adopting a non-directive approach in response to 'strong-willed' mothers. Thirdly, more time and contact simply permitted **greater surveillance**; the increased opportunity to see mothers interact with their children in the home environment and to discuss/assess needs. Whilst some mothers displayed initial attitudes to health visitors as being 'nosy' and/or allied to social work, several also saw the surveillance aspect of intensive visiting as positive, either in relation to the monitoring of their own child's health, or in relation to the prevention of child abuse.

FIG 3.2.4: TIME, FLEXIBILITY & THE IMPORTANCE OF RELATIONSHIPS

HV ACCOUNTS

'I think probably first of all, going into visit more regularly I had built up quite a **good relationship** with both of them, which for both these girls for their individual reasons was very valuable...I think we get **more information** because we go to the home and we are a contact for them, we are building up a relationship and then over time it's easier for them to ... broach different subjects with us, their different needs.. going in to visit more regularly gives them that opportunity.

'I feel that there has been a relationship established, and I think going in for the first sort of eight weeks it seems a lot, but I think that's when you really get the relationship going and the **trust** gets going...I think intensive visiting does create that'

'Relationships are key, and particularly because we're visiting so frequently, I mean you can't but help build a relationship with them because you're there all the time!...there's never been another incidence in health visiting where the health visitors can build up such a good relationship ... with their client purely because they haven't got the **time** to go out and see them so frequently as we've been doing'.

'I definitely feel that I have made progress with her. I think that I wouldn't have had as much time [in generic visiting] to be able to do...the housing referrals and things as well, I mean you are completely stretched with a caseload of 300 or up to 500 or whatever and I feel as if I have had the time...as if I am **following things through** an awful lot better because I always know when I am going to see her again. Its not about 'there's your immunisation I will see you again at some point'...We have already built up a really good relationship quite quickly because I am visiting every single week'

'we see the same problems probably as a generic health visitor...its just maybe we get to **find out** about them a bit **sooner** because we are going in more often...the value of home visits is you can tell a lot from a home visit than just a clinic contact, somebody can come on in with a fur coat ...and say everything is hunky dory and when you go to their home its not.'

'she is working full time now, she is **not available during normal working hours**, so...every visit is at quarter past eight in the morning and [M07] leaves for her work at 9 o' clock and that is working well'

seeing people more frequently...it does break down the barriers... its just a familiarity factor I think...I felt that she didn't seem the kind of person that would have responded to me saying 'well lets try and work it out together'; she might have felt that I was trying to take over and 'who was I to tell her what to do?'. So having gotten to know her I felt that the **best approach** would have been to suggest to her in a round about manner

MOTHER ACCOUNTS

'I do feel like you are getting the information and like if there is any concerns, they have the **time** to sit there and listen to you, whether it be about yourself or about the baby or you know?'

'with the first, like the first from one month to three months, I felt that it was good support, 'cos you felt ...you knew if there was any queries, you were going to get it sorted pretty soon anyway 'cos you're gonnae get a **visit soon**'

'I didnae like my first Health Visitor at all, I never paid any attention to what she said either, I didnae like her...if you don't like the health visitor or anything I mean you're no gonnae want to let them in your house and then the weans urnae getting the benefits do you know what I mean? ...if you don't **get on well** with your Health Visitor, weans can sense tension right and ...so they're no gonnae want to go to them cause your Mammy doesnae like them do you know what I mean? So it would be harder for their job as well let alone harder for me, do you know what I mean? If you don't get on well with them then there's no point in having them'

'you've got to **feel comfortable** with your health visitor, if you don't feel comfortable it just doesn't work. I know a few mothers have asked their health visitor not to go back because they didn't feel comfortable'

'I think I would say personally it is very important to have a good relationship with your health visitor. Because obviously I mean like I've had the help off her and ...if I wasn't comfortable, if I wasn't getting on with her, then I wouldn't be able to **ask for that help**'

'I think it's a good thing them coming out because they can actually get to see the baby and if there had been any child abuse they would be able to see it. It's more personal when she can actually see the surroundings'.

Communication and awareness of need

As illustrated by quotes in figure 3.2.5, the effect of these facilitative dynamics was to co-create two phenomena that contributed to both the delivery and perception of enhanced support. The first of these was a **greater and broader awareness of need** as revealed by more and better quality information. Both sets of actors stated that trusting relationships encouraged disclosure³⁸, which combined with greater surveillance, and also perhaps the multi-domain family assessment tools, resulted in the identification of a wide range of physical, psychological, environmental and material problems (see table 3.2.1).

Table 3.2.1 Type of maternal and infant problems and frequency of identification

Maternal problems (frequency)		Infant problems (frequency)	
Tiredness/exhaustion	(5)	Colic	(7)
Anaemia	(1)	Feeding irregularity	(6)
Retained placenta	(1)	Weaning difficulties	(2)
Stress / anxiety	(3)	Sleep irregularity	(2)
Depression	(7)	Elimination problem	(6)
Constipation	(1)	Urinary tract infection	(2)
Breast problems e.g. mastitis	(1)	Nappy rash/ skin problems	(8)
Lack of confidence in feeding child	(2)	Allergy	(1)
Employment	(1)	Eye infection	(2)
Financial issues	(2)	Teething	(2)
Partner problems/domestic violence	(3)	Cough/wheeze/cold	(5)
Social isolation/single mum	(2)	Jaundice	(2)
Harassment	(2)	Eczema	(2)
Housing problem	(3)	Developmental delay infant	(2)
Chronic illness e.g. diabetes	(2)	Premature baby	(3)
Substance misuse	(1)	Toddler disability/serious illness	(2)
		Toddler tantrums	(1)
		Toddler developmental problem	(2)

Secondly, the processes identified in the previous section lead to the establishment of an **enduring two-way dialogue** between mother and health visitor. In the early days of the relationship, this was more likely to be based on face-to-face contact where health visitors gave assurances that no question or anxiety was too trivial to raise and reinforced this by handing out office or even mobile phone numbers so that contact could be maintained between visits. Even if not available, several mothers described how they had been able to obtain advice from other health visitors in the project office and this potential availability of help and advice seemed to constitute a very important psychological 'safety net'. Even at interview two, when mothers displayed increased parenting confidence and the desire to disengage from the project, frequent references were made to the likelihood of getting in touch with the health visitor should anxieties arise.

³⁸ Several health visitors noted that this often meant that input *increased* over time, meaning that the scheduled decrease in visit frequency did not always occur. This exacerbated already-heavy workloads (see next section).

FIG 3.2.5: AWARENESS AND DIALOGUE

'people **tell you more** in Starting Well because they get to know you a bit better' [HV]

I'm now realising that what comes with intensive home visiting comes much **more disclosure** from the parents from you know different events and things as well that you are in there much more frequently.' [HV]

'I think we do have a good relationship...she can phone and I think that is closer because of the early intensive visiting'. [HV]

[at interview 1] 'she used to always tell me "Ask any question and ask anything you need to ask because don't hold it back the question, don't think it a silly question, just ask the questions. **You can phone and ask anytime**, any the Health Visitors are available", [at interview 2] she comes less I mean it doesn't bother me. Because I don't feel like I need her there ...and if I do I would normally phone her up or I know that I can, I know that I can phone her up. I feel confident that I can phone her up. [mother]

'I knew that if I ever **needed to speak** to her if she could come out and see me that I could phone her and she would come out or she would speak to me over the phone or somebody else in the office would do it'. [mother]

'I think we certainly got a really good relationship going. She would **phone for anything** at all that she was concerned about'. [HV]

'It [visiting] actually tails off ... like in [index mother]'s case if I'm not seeing her that frequently because its three monthly after that. So you, you know, if there is a bit of dependency built up it does tend to tail away a wee bit then, but hopefully you've built that good relationship that they feel they can then phone up if there is something that's worrying them.' [HV]

3.2.3.3 Explaining variation in process and outcomes: modifiers

In the last two sections, we have shown how increased levels of time and direct contact lead to a series of intermediate interpersonal achievements that are, in turn, associated with perceptions of enhanced support. However, not every interviewee benefited from the service and, of those who did, there was variation in the breadth and strength of opinions. How do we explain these variations in outcome? One major source of variation (see fig. 3.2.6 for illustrative quotes) relates to a number maternal characteristics and resources which might be summarised as **receptivity to the service**. Many women displayed initially negative attitudes towards health visitors relating to their perceived surveillance and/or quasi-social work (i.e. child protection) role and, whilst these attitudes were overcome for most, complaints of 'nosiness' or the inappropriateness of certain lines of questioning persisted for some and may have impeded the development of the relationship. Secondly, some women seemed less able to accept help, either because to do so would admit fallibility or because they did not agree that there was a problem to resolve. This latter point became particularly relevant when an identified problem threatened child health or safety. Thirdly, at least two experienced mothers with more negative views of the service seemed to perceive routine advice to be either patronising or a challenge to their established identities as mothers.

FIG 3.2.6: MODIFIERS [MATERNAL RECIPTIVITY, HV WORKLOAD]

MOTHERS

[interview one] 'So [HV] offered me services like where people can come in let them speak like just to unload things basically and because I am - okay I am outspoken but I like to keep things privately as well - and I felt that I didnae want that because I would seem a failure to people like myself. Like me, I will speak for myself ...because I've got a large family and I'm **strong minded** ...and they are all strong people, I thought 'no I don't want that, that's making me look as if I cannae cope basically'. [interview two]see at the beginning when I said I feel that Starting Well should have been given to somebody else that needs it more.... but like it just totally turned on me after saying that because once as I said I got to six months, that's when I felt I needed more support. Because at six months that's when I think that the whole depression bit that comes from babies hit me and I thought and that's when I felt 'oh here we go'...it was me that cut my visits down to longer periods of time in between them - obviously I **made a mistake** by doing that'.

'well that's the way I took her to be, like she's too stuck in her ways, 'like don't do this because we've found the information that its no good for the wean's kidneys', the salt and whatever, ... she's like that 'no, you shouldnae be doing it this way' and I thought 'no I'm going to do it my way, **its my way or no way**'.

Well [first HV] was a bit **pushy** in getting me to do things where [current HV] is no', ...like 'you have to go to the dentist and make an appointment' well 'sorry [first HV] but its no that easy, I'll go when I've got time', eh and would come back next month like 'did you go and make that appointment?' that was the first words ...[current HV] is no' pushy....and just mentioned the dentist once and I went away and got an appointment because [current HV] didnae seem pushy about it! So I went away and I got an appointment and that was it done.'

'Well I don't know. When [HV] was coming out ... telling me not to feed her until she was four months right, but with all them - [refers to older children] was a different case - they all got I think, they were about two and half months but [HV] said its all different now they are trying to do it - waiting - until they are about four to six months because their kidneys need developed right? When [HV] was saying to me I was saying 'I have got another three and that **I know myself**' ...and sometimes I felt like - 'I am not saying I am brilliant - at it but I know a wee bit more than you do' you know what I mean?

Interviewer: Have you learned anything new from it in terms of weaning the baby?

No I have not learned anything new because I know that'.

HEALTH VISITORS

'The strengths are the team that I am working with. The weaknesses are the **time-frames** that are expected to work from and still do our work as well...Like we had the opportunity to do [best practice] guidelines for various things this year but let me tell you that that was done at home, it was not done at work'

'even with the best of intentions working with **vulnerable, isolated families** in a deprived area generated **huge amount of work** and I don't think that was you know even if it was anticipated but I think it has even generated more work than what maybe people thought in the beginning when they were planning this'

'we are running with the caseloads that are double the size of what they should have been. And the expectations ... there are **pressures from the project** as a whole, like ...attending training courses, attending seminars and things and promoting the project which is all part of the marketing, you do get involved in all that stuff. They do want to have focus groups and they do want to have interviews and all these things because it's a demonstration project but that all takes time over and above what you are trying to do in a working day'.

'You have to **prioritise** more and I think we are becoming like generic health visitors because our caseloads rocket -'cos that's what they're doing. Some of the generic health visits here have got caseloads of a hundred because we've taken the babies, so some of them have got a similar size caseload to us. So now, I mean I see a small amount of my clients a lot and there is a huge amount in my drawer I've not opened up and I think 'god I haven't seen that one for four months, I haven't seen that one for six months, lets try and squeeze in some phone contacts just so that some of them have had some contact'. And then you've got say about ten families that are going through a terrible crisis and you have to visit these more often. Some of them are weekly sometimes twice a week you're going out and it creates a lot more work in terms of sort of social work, making phone calls, you are still getting the 'B' forms coming through. So it's become impossible to really give folk the service that they set out to do'.

Finally, in at least two cases, these factors combined with very high levels of need (related to depression and substance-abuse respectively) to produce a large number of broken appointments and very limited health visitor contact.

Health visitor characteristics too could contribute to receptivity: in one case, an already less-receptive mother cited a brusque and unfriendly manner as problematic, however, the clear majority of mothers' statements suggested workers were generally adept at presenting themselves as approachable and friendly. A more important set of modifying factors related to **time pressure** and its effect on the work capacity of the health visitor. Consistent with the already-established perception that more time and contact lead to benefit for families, factors that impinge on that time were perceived to reduce effectiveness. The amount of time pressure felt by health visitors varied between workers, across time and project site, but when identified, was due to a combination of: transiently low staffing levels; the extent of social and health problems in project areas; the extra training and promotional work associated with the demonstration project; and the wider range of problems disclosed as a result of more confiding relationships. These factors tended to produce caseloads that were bigger and more demanding than initially anticipated, an inevitable prioritisation according to need, and an increasing resemblance to the generic service. These very strong and consistent views must be considered to have general relevance to our understanding of process as lack of time was not identified as a problem with (or by) these specific case study families.

3.2.3.4 Summary

We noted that, although participants occasionally referred to 'harder' indicators of family-level success (e.g. recovery from postnatal depression, prolonged breastfeeding), many of their statements of benefit referred to a range of activities they felt had produced a diffuse sense of enhanced support. Participants gave a clear sense of how intensive home visiting increased the amount of time and direct contact available which enabled greater surveillance, the rapid development of a trusting relationship and the creation of an individualised care package. These factors in turn, permitted a greater awareness of disclosed and observed needs and set up an enduring two-way dialogue which were associated with perceptions of enhanced support. Occasional comparative statements from multiparous mothers suggested that their recent experience of support had been an improvement on the generic service. Finally, both the general receptivity of the mother to the service and the capacity of the health visitor to deliver intensive visiting were likely modifiers of process and hence, outcome.

This model, like all models, contains inherent oversimplifications. Analysis of participants' statements suggest the functional relationship *develops* over time, from the mutual ignorance of the first visit through to working and disengagement phases, and as such, temporal linearity *is* a valid feature. However, there will be considerable variation in the rapidity and extent to which this relationship develops (the temporal 'distance' between input and

outcome), some stages may occur nearly simultaneously as opposed to sequentially (e.g. enhanced surveillance and awareness of need), and the 'end point' of enhanced support may occur at an earlier stage (e.g. early anxiety-reducing advice) and have mutually reinforcing effects on relationship quality.

3.2.4 Perceived project strengths and weaknesses

3.2.4.1 Person-centredness

Over the last ten to fifteen years, a great deal of interest has been shown in moving beyond a 'medical model' of health care to more person-centred models that re-evaluate traditional roles and relationships and incorporate information on the wider determinants of health (Evans and Stoddart, 1994; Mead and Bower, 2000). Analysis of mother and health visitor statements suggests that intensive home visiting can be a particularly effective way of delivering person-centred care in two respects. Firstly, as can be seen from the quotes in figure 3.2.7, the fact that visits take place in the **home setting** is perceived to be convenient, reassuring and conducive to making the mother feel less 'processed' than in a health centre setting, where most routine interaction with the health visitor takes place. Convenience is particularly important for mothers who might, for a variety of reasons, have difficulties attending clinic appointments. Importantly, the fact that the mother controls access to the setting fundamentally shifts the power balance in the client-worker relationship in her favour and actively encourages both flexibility and approachability on the part of the health visitor; if one or both of these things are absent, access is more likely to be denied. The second set of factors illustrating the person-centredness of Starting Well relate to aspects of the **general approach**. The range of physical, mental and material concerns identified in table 3.2.1 suggest that a more social/psychosocial (as opposed to medical) model of health care was being employed in the project. In addition, it is clear that the nursing approach most often delivered by health visitors and most preferred by mothers is a non-directive, non-judgmental one that may include a clear evidence-based 'steer' but leaves final decisions on most matters unambiguously to the mother. Whilst this approach may be empowering, it is also likely to be necessary in order for the health visitor to maintain access. Finally, as we saw in the previous section, intensive visiting is associated with the rapid formation of a trusting and functional relationship.

FIG 3.2.7 EVIDENCE FOR AND LIMITS OF PERSON-CENTREDNESS

'I think that's the biggest difference - they are **coming to you**. So that makes a lot of difference because you can arrange an appointment, you can sit and relax when there is a good time for you and you can talk to your Health Visitor about whatever you need to know about, about whatever your problems are. So it does make a big difference'. [mother]

'I mean its good, the fact that [HV] did come in to the house do you know what I mean? Because the way that I was feeling [referring to depression], **I couldnae go out**, I couldnae go to the clinic'. [mother]

'I feel as if you've got more attention sorta thing on the baby. You feel as if when you're up the health centre you're getting shipped in and shipped back out sorta thing; **you're just a number**. When she [HV] was coming out here she was, you know, listening and that, actually paying attention to what [index child] was doing and his behaviour and that'. [mother]

'it is good to know that its not just the baby they care about, its you as well; they are there to **see how you are as well**'. [mother]

'I haven't actually spoke to [HV] for a month, I mean I think it was about it was all through the time my mum passed away - it could be about four or five months possibly...I was quite surprised... She probably told me that obviously we will be **reducing** [visit intensity] but I wasn't under the impression that it was only the health support worker to come in you know?' [mother]

[on hearing HV was moving] 'afterwards I felt a wee bit **upset**, because I thought to myself, she's been there since [index child] was born, she's seen a lot of development... And I just kinda felt as if I can't confide in her anymore... I felt really, really comfortable with [HV] because she never she never **judged** or she never erm, she never forced you into doing something, she never said 'right you have to do something this week', she always gave you that option' [mother]

'she will tell you 'I can only advise you I am **not telling you what to do** and this is the guidelines and that the recommended stuff you know...whether you use to follow that then at the end of the day she's your baby' you know so it is better you know?' [mother]

I can be quite intimidated with doctors and professionals but with [HV] it's a different relationship, which I was quite happy about, its an **equal relationship**, its no' her coming in telling me how to be a parent, its her coming in and seeing if there's anything I want to know. So its more voluntary, getting information rather than being force-fed it. [mother]

'I hate people being fussy its as if they are trying to get information out you and that's what I thought [first HV] was doing to me - **trying to get information that wisnae there**, as where [current HV] will concentrate on [baby] and then that makes me feel more at ease because you think 'you're here for him you are not here for me', although they say they are here for the full family they have to be but I'd rather they just concentrated on the wean. [mother]

'Aye I felt as if, aye I felt as if some of them [questions about relationship with child's father] were just a wee bit **unnecessary** sorta thing, like some of the things she was saying I felt uncomfortable with, trying to answer them like I was put in a position sorta thing'. [mother]

'you treat everybody as an individual and you treat them with respect because you have got to remember that you are a **guest in their home**, and the thing is if you go in there with all guns blazing they are not going to let you in again, you've got to work with these parents and be open and honest and have a rationale ready and evidence based practice'. [HV]

'over the weeks I began to kind of build up a rapport and a trust with her and realised that - as much as possible I tried to appreciate the fact that when you go into somebody's home you're their guest - the need not to lecture to somebody but to kind of treat them, like adults, as you would want to be treated yourself, and so that whenever you try and do raise a point with them, you are trying to phrase it in a way that sounds like I'm **respecting their feelings and their current experience**, so that I'm not going in saying 'well you do this, you do that, you do the next thing'. [HV]

How I work generally is eh I do have a **line that I draw** that I class as things I can't let go and that's obviously your kind of em child protection issues...that's when I would kinda have a more direct approach and, I hate to use the word, but 'authoritarian' approach with a family (laughs)... But the approach I take eh with probably all my families other than that is, the ideal is, 'and the current recommendations are and ...you might like to eh think about doing it this way, this is what's currently recommended. However you are the parent and you know you can make up your own mind, all I am trying to do is keep you up to date with the latest research information so you can make your own informed choices' [HV]

All of these factors are consonant with a high-degree of person-centredness, however a number of statements and cases illustrate important caveats to this positive conclusion. Whilst the gradual reduction of visiting was generally understood and appreciated, at least two mothers, who had previously coped well, experienced problems later on in the postnatal year (later-onset depression and bereavement respectively) and felt they required more health visitor input than they received. An allied point relates to continuity of care: several women who had had their health visitor changed at the second interview found this upsetting. Taken together, these points suggest the process of (especially abrupt) health-visitor **disengagement** needs to be handled carefully in order to maintain perceptions of effective support. Some statements also point to the **limits** of, respectively, exploring the wider determinants of health and offering a non-directive nursing approach: some women found questions relating to finance or relationships to be inappropriate and prying; whilst more directive approaches are clearly needed if child health/safety is at risk. Finally, the principle of jointly-defining health goals in the form of '**goal-setting**' was not conspicuously successful: health visitors found this conceptually and practically difficult to realise with mothers, and where it was reported to occur it was not always clear whether mothers were simply following health visitor advice (e.g. the goal of 'visiting the GP' for a depressed mother).

3.2.4.2 Teamwork, training and approach (health visitors)

Moving away from the case families and concentrating on more general views of the project, three sets of strengths were identified by health visitors (see fig. 3.2.8). The first of these related to the quality of project **teamwork**, particularly amongst the health visitors themselves. Whilst a number of references were made to early difficulties experienced in both sites due to staff turnover and shortages, many later interviews praise the high levels of peer support available. This was particularly appreciated by newly or recently qualified staff, many of whom cited support as one of the reasons for applying for the post. Secondly, the general levels and quality of available **training** were praised although courses were generally taken at the expense of caseload time. Finally, specific aspects of the **approach** were highlighted as satisfying or useful, for example, intensive home support and community work.

3.2.4.3 Constraints on delivery (health visitors)

We have already highlighted how staffing issues, the general scale and complexity of needs and increased disclosure combined to produce larger, more demanding caseloads than anticipated and commensurate chronic time/work pressure. A number of health visitors stated that this may have affected the capacity of the teams to deliver the project as intended for all families. A number of other pressures were highlighted (see fig. 3.2.8), including: the **burden of scrutiny and expectation** that resulted from working on an evaluated and high profile project; the widespread **resistance and scepticism** of generic health-visitors and other staff,

especially in the southern project area; and problems of **inter-agency working**, specifically the difficulty of getting hold of appropriate social work staff in crisis situations.

FIG 3.2.8: PERCEIVED STRENGTHS AND CONSTRAINTS (HVs)

STRENGTHS

'I was driving to work thinking "what would I do without the Starting Well **team**,? I don't know if I want to be a Health visitor...on my own in a wee practice" because ..as a new health visitor, to be around other health visitors has been so supportive because I am able to say "what would you have done, would you have said that, I said this do you think that's alright?" ...they are there at hand'.

'There was public speaking as well I really don't think I would have got that as a generic health visitor and I find that really, really valuable, I am absolutely terrified of public speaking! So em the community development one its coming up ... breast feeding **training** again all these things have been really useful...the goal setting one as well and I found that helpful as you know kind of professionally and personally as well'.

'Probably I think the **ethos** behind it: this notion that you're working alongside the families in Starting Well. I think there's a recognition that you're not so prescriptive in the way you approach things, that you work in collaboration with the families...coupled with the sort of collaborative working with ... Nursery Nurses and Health Support Workers - and incorporating them into sort of a team.. different disciplines working together to have a greater sort of cohesion'

'being able to see what **resources** are lacking in the **community**, do something actively about it rather than sit frustrated and just not having the time to do anything about it. Since I last saw you we've now successfully run, ...a stress management course. And that, that has been good and it has turned round these women to rather than them just thinking stress was there and that was it, you had to react, they are turning round and realising that you know, they can anticipate, they can take time out they don't have to react to this trigger, they understand'.

CONSTRAINTS

'I think the nature of these demonstration projects, ...the extra contacts first of all, the extra training involved, extra meetings and the necessity to do community development as well, actually makes what I am doing now in a lot of respects, busier than what I was doing previously [as a generic HV] even though I had a huge caseload...In my x health visiting jobs, I can honestly say I've never seen a team so stressed. It's a combination of internal and external **pressures**; you're working on a new project that you want to succeed, so you put pressure on yourself, plus there's all the paperwork, the fact that the goalposts keep changing and the constant scrutiny and expectation. Several times the co-ordinator had to say 'look, no new births for you for a while', because they're under too much pressure – and I've never seen that before'.

'combining practices is really quite difficult and I am also finding that the link with the generic health visitors in particular in [area] has been really, really strained. There has been a lot of **resentment** towards Starting Well em health visitors and I think its because of the small em caseload sizes, em again been asking to cover a lot of immunisations clinics and developmental clinics. Em its so hard when people are not receptive or not willing to be receptive to the aims of the project but they are not understanding that its not about not being helpful its simply the fact that the project is being evaluated - and the effectiveness of home visiting - and not the effectiveness of doing all these clinics. I think that is one of the major limitations of the project ...There has been huge resentment there and really, really difficult working relationships em you know to the point that you are just wondering why you are here you know? Its been really stressful.'

'we have got such a limited **number of senior social workers** for the childcare department ...we've got good inter agency child protection guidelines that we follow ...we have got a child protection liaison health visitor here and the child protection advisor for Glasgow that we can phone up at any time and ask her opinion on whether its an appropriate referral. We go through all of that discuss it with the family and the GP and make a written referral but we phone up and an awful lot of the time we are asking to speak to the social worker and find out that its not even a social worker, it's the social work assistant. We're getting conflicting advice from them because they're so short staffed, they are not taking referrals on board and its there staring you in the face especially because you are doing intensive home visiting you can see issues emerging and getting more and more dangerous by the minute, and when you make a referral which is really in some ways like a last resort, its not even taken on. So so much of my time is made phoning continually phoning social workers [and] never getting your return call... there is only so much as a health visitor from Starting Well that you can offer despite health support workers being in there or nursery nurses but when it comes to child protection issues, we have to have somebody that is going to have the appropriate authority...So it's a hugely stressful part of the job and it consumes everything, I mean, I've had to cancel visits for families before because I've had one family that have iust soiralled out of control'.

3.2.4.4 Barriers to the use of community facilities (mothers)

Several health visitors described how their intended community development work had been a substantive 'victim' of increased caseload pressure. However, mothers' statements (fig. 3.2.9) suggested a number of barriers would need to be overcome in order for them to take advantage of existing, let alone enhanced, services. Women who had not considered using facilities tended to fall into two categories: those who were either **intimidated** by the prospect of attending on their own; and those who **harboured negative views** about their area or people working within it. It is notable that none of the former group had taken up the services of health support workers who may have provided the opportunity for accompanied attendance; this may point to a generalised lack of confidence with novel social situations.

The positive testimony of two women who had not considered using community facilities at interview one but were attending groups at interview two (see figure) illustrates the potential benefits of overcoming these barriers.

FIG 3.2.9: BARRIERS AND BENEFITS TO USING COMMUNITY FACILITIES (MOTHERS)

BARRIERS

'There is one place that has just opened in at [school] and that is meant to be like a crèche for babies as well, but me I never use anything round about here. I always **keep myself to myself** and to me that is the best way about here because there are too many junkies and whatever'.

'I haven't really got any friends to support nearby at the moment you know? My health visitor, she has given me like different like places like mother & toddler Groups to go and places but deep down, I feel like quite a **shy** person; I don't know how I'd like, how to make that first step, to go there you know?'

[answering question on likely future use of facilities] 'yes,, once I have got myself back on my feet then I can. A wee bit more **confidence** about myself as well you know? Then I can feel like going and socialising with strangers'.

BENEFITS

[at interview one] 'Well I have not really tried anywhere, do you know what I mean? Because other people do take him for me which is great. [at interview two] I have been there [mother & toddler group] a couple of times, its good, at first it wisnae so busy but then as more people got to know about it they had done put like flyers and all that out, it got really busy which was a good thing for [index child] and all the other kids there...[it's] really, for me to **get on with other and meet different people** and for [index child] to know how to share toys and things like that with other kids, so that he doesn't get very jealous with his own toys when people are up visiting...he just sits and laughs at them now'.

'I've just started, it was actually started with the baby massage, we went to the baby massage and then [HV] had started up this course. And its one of those places, every time they've got a new course, they phone you up – 'right we want you here!' sort of thing, so most days of the week we're up there for something sort of thing. But she loves it because she's into the crèche as well and like yesterday they done like a mini assault course and today we were at the park and its gets her out as well so she enjoys it as well...It has [helped] because actually we're supposed to be there for like anti-stress and getting massages, but you all share your different stories and that as well and it helps to know that **you're not on your own**, do what I mean there is other folk going through the exact same thing, and like that they all share their different tips and hear they work or whatever'.

3.2.4.5 Prioritisation and targeting

As illustrated by the quotes in figure 3.2.10, mothers consistently expressed the view that the most important time for service input was in the **first few months after birth**, this being a time characterised by overall readjustment, physical recovery and/or postnatal depression. Intensive visiting was seen as less appropriate after this time (i.e., by interview two at 10-11 months) due to the resolution of early postnatal anxieties, greater parenting confidence and the desire for independence. Support for early intensive visiting was perhaps especially true for **first-time mothers** who experienced greater levels of anxiety associated with the novelty and extent of the child's demands. Support for a **universal service** was voiced by mothers who saw the difficulties experienced in the first postnatal months to be universal and not predicted easily by factors such as wealth or age. However, they accepted that there would always be a need within a basic universal service to prioritise to those with the most problems. In general, these views were reinforced by health visitors who supported universal provision in principle but pointed to the practical impossibility of delivering an intensive service to all given current staffing levels.

FIG 3.2.10 PRIORITISATION AND TARGETTING

MOTHERS

[service was most important] 'when my two were wee tiny babies ... They were always up during the night and I mean always up. I was up about six times during the night, feeding them, its dead tiring as well know what I mean? ...So I think you need to see them more when the weans are **just first born**'

'I think **first time mothers** would really appreciate it, because I think with you second baby, you know, what to expect, you roughly know what you are in for sort of thing'.

'I think it would be a nice idea if it was **offered to everybody**. I think just now it is just to the areas that are maybe needy of it, that where it is actually offered just now, like...say a very posh area, it isn't actually offered there but in saying that those mothers might need it as well 'cos they're just like us as well really aren't they?'

'I think to say that **some groups would benefit more than others would be wrong**, it would be individuals because there could be a professional couple in their forties havnae had a wean 'til their forty five because they've had their career and they're that bit older and they maybe need a bit of information because their pals have had their weans and all that and they've had their weans ten/twenty years before do you know what I mean?'

HEALTH VISITORS

'for the first six, eight weeks I think I mean I just think home-visiting should help **any mother** it doesn't matter whether you know where she's coming from because there are so many stresses. Those that are not so vulnerable, they will be the ones to access the groups'.

'but I mean they are all targeting and to a certain extent that's what the generics are doing as well, a file full of who we hardly ever see and then you've got this bundle of really vulnerable families that you make sure that you see all the time. So we're not doing it universally, but I don't think it's a bad thing .. because the person that you're visiting that doesn't really want you there, it can ruin your relationship. Because you're constantly appearing and there's not many issues and you're becoming a nuisance so I think it is better to **prioritise**. But there's still ones in my caseload that I should be seeing that I'm not and that's the frustrating thing'.

'I think Starting Well would work best if its targeted. I know that there has to be a universal service and there is obviously targeting because of **limited resources**'.

3.2.5 Summary and conclusions

In our attempt to describe the interpersonal processes that putatively underpin the intervention, a number of substantive points have emerged. First, perceived benefits were more likely to be couched in terms of diffuse interpersonal achievements (e.g. better relationship, more confidence) than in terms of 'concrete' health indicators. Undoubtedly some participants (and especially mothers) had difficulty or were unused to reflecting on benefit or change in concrete terms, but the number and diversity of statements describing enhanced support point to it being a valid and valued commodity for both sets of actors.

Secondly, it was possible to describe some of the processes that linked intensive visiting to these outcomes. More visits during the first postnatal months generally equated to more time and direct contact with mothers during a period of universal need, which encouraged the rapid formation of a trusting relationship, an individualised care package and the provision of more and better quality information on needs and life circumstances. This in turn was associated with the identification of a broad range of problems and problem-solving activity and an enduring two-way (functional) dialogue between mother and health visitor. Lack of maternal receptivity to the service and health visitor caseload pressures explained variation in process and outcomes. This process model, whilst limited, draws attention to the functional importance of establishing an informal, trusting relationship. Given the mother's control of access to the home, this is probably a pre-requisite for a service to be delivered at all (McNaughton, 2000), but is also likely to be both of therapeutic value to isolated and/or depressed mothers for whom the health visitor may be the main or only support (Holden et al, 1989). The model, in combination with other statements relating to caseload pressure, also draws attention to the importance of time: for delivering basic levels of service; establishing relationships; and following through therapeutic advice.

In sum, despite resistance from associated staff, the intense scrutiny of working on a demonstration project, heavier-than-expected caseloads and variable mother receptivity, health visitors succeeded in forming generally good client relationships, identifying a wide range of problems and producing perceptions of enhanced support amongst case study families. To the extent that workload and staffing levels permit, intensive health visiting is a potentially very effective way of delivering a more person-centred, 'social' model of health that may be of particular benefit to sub-groups of women (primiparous, depressed or isolated mothers) but is generally perceived to be both acceptable and helpful.

3.3 The implementation of the home-visiting model

Key Findings from Section 3.3

- In a relatively short space of time Starting Well developed two project teams incorporating a new type of worker (the health support worker) to a professional group of long-standing (health visitors) in order to implement its home visiting model.
- The project attempted to develop a standardised approach to health visiting but the degree of consistency achieved within practice was variable due to caseload size and some professional resistance to the notion of standardisation.
- Pressure of caseload size limited some of the project's aspirations and led to the need to rethink the ability of the model to be applied universally even within a deprived community.
- The project teams developed very differently in the two intervention areas. These differences were due to levels of individual, professional and organisational buy-in/resistance to the Starting Well model.
- The two emerging 'models' differed in the degree to which they advocated integration within GP practices and in the dilution of the Starting Well approach – the lessons that can be learned from these two manifestations of the project need to take account of the central role of organisational context in defining and supporting practice.
- In relation to skill mix, whilst much good practice was identified in bringing together health visitors and nursery nurses, issues of role clarity remained problematic throughout the life of the project.
- Health visitors did not, in the main, develop their practice in relation to community development and this has implications for the implementation of Hall Four.
- The role of the health support worker developed into a diffuse and flexible one. It was a role that was, generally speaking, viewed positively by team members but one requiring careful supervision.
- The employment of the support workers through a voluntary sector organisation allowed a supportive model of engaging individuals with a knowledge of the local area who might not previously have been engaged in the labour market. This was a model that was perceived to have been beyond the current capacity of the NHS.
- The dual management structure, however, led to operational difficulties some of which had their roots in a lack of professional ownership of the social inclusion aims of the health support worker approach. This may become an important policy issue in the future as public sector organisations develop ways of expanding their workforces.

3.3.1 Introduction

A substantive interim report based on interviews with a purposive sample of project team and strategic level stakeholders was accepted by the Scottish Executive in June 2002 (Mackenzie, 2003). This section builds on the findings of that fieldwork, where relevant, but focuses primarily on the following two issues:

- The extent to which Starting Well model of home visiting is perceived to have acted as a vehicle for changing health visiting practice; and
- The degree to which the project's health support worker model has worked in practice.

3.3.2 Health-visiting practice

In this section of the report we consider the evidence for Starting Well as a means of changing health visiting practice in two related areas: the implementation of a standardised approach; and, progress toward skill mix. In addition we consider the implications of two distinct 'models' of Starting Well that developed in the two interventionl areas.

3.3.2.1 Standardisation

Both the interim report and the views of strategic stakeholders as summarised later in Section 3.5, highlight the difficulties in implementing a standardised approach to practice within a group of health care professionals who have traditionally identified themselves as autonomous practitioners. The means by which standardisation was encouraged were: the development of a series of evidence-based guidelines; the use of a family health plan where goals jointly identified by families and home visitors could be systematically recorded; the introduction of a core-visiting schedule that indicated when visits should take place and what information should be imparted within them;³⁹ and, a family support scale that health visitors could use to identify families requiring more or less support than indicated within the core visiting schedule⁴⁰.

An unpublished evaluation of the use of the evidence-based guidelines by Gilhooly echoes the findings of the first stage of fieldwork and suggests that health visitors did not use guidelines in a systematic way but, instead, that their knowledge about, and use of best-practice was more tacit and implicit. Similarly, the implementation of a goal-setting approach

³⁹ Copies of the Family Health Plan available on request.

⁴⁰ This evaluation was not commissioned to look in detail at the effectiveness of these individual tools in changing practice; rather it aimed to focus on *general* lessons concerning changing practice. Various pieces of evaluation commissioned internally by the Starting Well team focus on specific tools of practice.

proved to be more complex than initially anticipated. The reasons for this (as illustrated below) were three-fold. First, health visitors did not feel comfortable with the language of goal-setting:

'...it doesn't happen because, if you're having a conversation and then you say 'oh hang on' it's really hard to do that, to break the kinda, especially because you're going in and you you are trying to encourage them to kinda communicate with you verbally ... I don't think any of the girls actually sit with the family and sit and say 'right I'm gonna write this, what would you like me to write? ... every health visitor has done that down the line.'

Secondly, the *negotiation* with individual families was thought to be more important than picking off what might seem like obvious goals to health care professionals:

'...smoking, for instance, that's very often something that I feel that I'm perhaps addressing now with families, a year down the line. That you would go in and there's maybe four or five people sitting [smoking], a brand new baby and they'd all be sitting without windows open and that was something I had to ignore initially. Sometimes I would say 'could you open a window' but ... it was really important to build up that relationship to do that because they could really take offence to that. ... it was really things that were staring you in the face that were difficult to address.'

Finally, the traditional culture of the health service was perceived to have constrained families' expectations about raising their own health needs with home visitors:

'... it's like, how a whole community perhaps perceive the roles of professionals, if you perceive that professionals are going to come in and sort me out or we'll go to the doctor and get a script or whatever. Then actually saying we're going to negotiate, empower you, to have you feel you're in charge of setting goals in your own health and so on, that's not like throwing a switch.'

These findings are reflected in the health visiting literature that stresses the need for intuitive approaches to goal setting (Robinson, 1995, cited in Elkan, 2000)

In response to the realisation that goal-setting was not a straightforward process to implement, the project management team invested in staff training and in commissioning a small piece of evaluation to identify how and where joint goal-setting was operating (this work will be completed by early summer 2004). In addition those at a management level identified that, notwithstanding the difficulties identified above, change in practice was evident:

'Whereas I think a much more traditional model would have been you go in and health visitor does or directs and I think that has changed. I think the fact that they are very much more geared and attuned to the actual requirements of the family and what they need and letting them direct – the needs of the family directing actually the interventions that they give. They also challenge a lot more about why are we actually doing this.'

As identified in the interim report, the use of the core-visiting schedule was also problematic as caseloads started to rise and health visitors felt pressurised to follow the schedule to the letter. Whilst those at a strategic level discussed the implicit flexibility of the schedule, this was questioned by the health visitors themselves:

'I'm not sure how much it was put across as being flexible ... I don't know that we really interpreted it as being as flexible but then when I think everybody was under a lot of stress and strain, you know, management were then saying 'well, you know, this is not set in stone, it is flexible' and maybe that was to suit them a wee bit.

'...there's still a push to follow the visiting schedule.

The flexibility of the core-visiting schedule is key to the debate about targeting. Starting Well was initially conceived as a universal service targeted at vulnerable communities; yet as time went by and the realities of the financial constraints on potential roll-out became more salient, the need for some degree of targeting became accepted as a necessity. Whilst purists might be critical of this significant deviation from the original plans, some of those at a strategic level were critical of the project's failure to grasp this nettle at an earlier stage:

'I think we should have thought earlier on about was it not just a bit glib to say we won't stigmatise vulnerable families or a vulnerable community. What would that mean in practice... We don't have resources to universalise the project so clearly we are going to have to think more clearly about that. I think we should have realised that earlier on. And planned for it. And I think that we have been somewhat playing footsie under the table around that at times.'

On the other hand, the universal approach of the project allowed the development of a more preventative approach to child and family health issues:

'...there is a risk I suppose that we move to targeting the most vulnerable whereas actually what we thought we would do was targeting the less vulnerable and preventing crisis and preventing them becoming the most vulnerable.'

The home visitors themselves continued to express both a need to target to alleviate caseload pressure (this was particularly salient for one health visitor whose job remit was split over a Starting Well and a vulnerable non Starting Well caseload) and to provide the kind of support to families in the early days that would facilitate the future accessibility of the project teams:

'...it can actually frustrate me when I'm seeing that I've got to go and see this person in starting well who has lesser needs. I've got to see them weekly or fortnightly at the moment, but I'm not able to carry that out for a family who are going through horrific things.'

'...they might appear to be fine in the first couple of months and you know you might have, if you were having to make a decision at the beginning of the first couple of months, you might

have said 'that family are fine, they really don't need the intensive support from me' you know, two parents, good support from the family blah, blah, blah and no concerns. But then the other side of that is that there is also a lot of families in that situation where the more contact you have with them you will build up your relationship if things do come out about other social problems within the family, like depression... I think I personally would find that very difficult to then suddenly say to somebody that you haven't seen for a year, you know, 'oh god, this is a disaster and everything is going haywire.'

What became increasingly apparent over the life of the project was that there was no simple means of assessing vulnerability since it might be chronic or acute and may or may not be predicted by a range of traditional risk factors:

'...it's not a straight sort of mathematical equation.'

'...do we identify those and there isn't a good way to do that at the moment. The best way seems to be on the basis of health visitor perceptions – that's as reliable as anything else.'

The way in which complex professional judgement came into play in determining need and labelling vulnerability is illustrated by a health visitor who talked about the relationship between a family's support scale assessment and the intensity of visiting:

'...only times it doesn't really correlate with the support scale is if you've not updated the support scale because you've just kinda said 'oh this is a wee blip, we'll just kind of work through it'. And sometimes after a few weeks you can go back, you can build yourself back up to monthly visits.'

A more targeted approach to health visiting is recommended by Hall Four (Hall, 2003) and by the Scottish Executive's response to it (Scottish Executive, 2004). Once again, the health visiting literature on assessing vulnerability as the basis for targeting highlights the importance of non-reductionist approaches (Barker, 1996; Appleton, 1994) and supports the need to view risk-factors as inherently unstable (Elkan, 2000).

3.3.2.2 Providing a skill mixed approach to home visiting – the broader project team

For many strategic level stakeholders a key outcome for Starting Well was as much to pilot a model of skill mix as to impact on child and family health. Both Hall (2003) and the Scottish Executive (2004) assume the need to base future workforce planning on a skill mix model. In this section we consider the extent to which the project teams were viewed to have worked effectively in developing a skill mix approach⁴¹ and discuss the learning that can be gleaned

⁴¹ The joint working between health visitors and health support workers is discussed in section 5.3.

from the extent to which this approach leads to empowerment or encourages dependency in families with young babies.

The initial planned make-up of the project teams was health visitors and health support workers with a bi-lingual worker in the south team. Concerns over health visitor shortages and the delay in recruiting the support workers, however, led to the development of new roles within the teams; specifically, two community nursery nurses and a community support facilitator in each area. The interim report (Mackenzie, 2003) describes the early development of these teams where, not surprisingly, a lack of role clarity was an issue for those working on the ground.

One year later there was more evidence of effective team working but issues of role clarity remained. Health visitors described and valued a range of tasks performed by nursery nurses such as undertaking routine visits, providing dental health promotion information, using Triple P, and delivering play/developmental interventions. However, despite efforts to clarify their role and, in particular, to distinguish what they did from the tasks of the health support worker, nursery nurses themselves were still concerned that duplication occurred and that they didn't feel supported as team members:

' think it's just a bit of insecurity for everybody and a role hasn't been designed. What's come down from the top is, that they don't want a defined role, that they think that that doesn't help and there's nobody prepared to say ' no that's not your role, that's your role', there's nobody prepared to take that on.'

'...you just feel like, we're here and they're there and you don't really work together, there's no real crossover.'

Much of the disquiet expressed by nursery nurses (unlike the health support workers) appeared to stem from a feeling of isolation in their new role due to their small numbers in comparison to the other professional groupings. This is an important issue for the wider NHS in light of the increasing employment of individual community nursery nurses across Glasgow that has been taking place since the beginning of Starting Well.

Given the pressure on health visitor caseloads it is perhaps surprising that there appeared to a relatively small number of families that were utilising the additional support provided by other team members other than on an ad hoc basis. Most health support workers and nursery nurses talked about seeing only a handful of families (between two and eight) on a regular basis and this tied in with health visitors' views on how many of their families used the additional support. One health support worker summarised this across one of the intervention areas as follows:

'I think we're only getting more families because there's more and more families taken on board. I think the ratio, or the amount of families that are actually getting help, hasnae went up very much - 40 or 50 out of about 400 families.'

The interim report discusses the role of health visitors in taking a community development approach to tackling ill-health in children and families and concludes that, whilst the project initially offered health visitors the opportunity to develop this aspect of their work, it was not an approach that was uniformly well-understood by staff; nor did they perceive that their caseloads allowed them to take this role (Mackenzie, 2003). One year later whilst some health visitors still expressed disappointment that this side of their role was not being developed, at least half no longer believed that this was an area in which they had expertise.

'I think I may have misread into what the project would be expected to achieve community side of things at the start because I thought it was gonnae be a lot more hands-on community development.'

'... community development, it's not really my thing as it's turned out and I thought I would be really keen.'

The devolvement of the community development role to the community support facilitators and to the bilingual worker appeared to be viewed more positively in the later fieldwork but this certainly raises questions about mainstreaming the project in the future. If health visitors in their role as public health nurses are not motivated, skilled and resourced to take a community development approach then the role of community support facilitator for child and family health needs to be build in to child primary health teams. Hall (2003) clearly states the requirement for such approaches to be embedded within health visiting practice specifically and the Scottish Executive (2004) argues for community development to form a major role of the new Community Health Partnerships.

The skill mix approach that evolved within the reduced caseloads of Starting Well allowed the provision of a range of intensive supports to be delivered to families over prolonged periods of time. A question raised at the beginning of the project was the extent to which Starting Well would enable families to become empowered or whether it would act to develop dependencies within vulnerable groups. The answer, not surprisingly, given the real life complexity of family circumstances was that it did both of these things.

The following example from a health visitor described the way in which a particular family was able to use the project as a positive support:

'... there was a mum of three who on paper doesn't appear to be a vulnerable mum, but as it turns out, as thing progressed, she was depressed, her husband was depressed. Now that we've sat down and we've spoken about it ... she was able to access help for herself and her

husband. She's also involved with the breast feeding initiative now whereas she felt she didn't have the confidence before ... she's now looking at what employment that could lead on to ... she's a volunteer now with the initiative, and she's now considering midwifery as a career. ... when you've invested time with a family and the family have also invested time themselves and done all the hard work themselves and you can see it paying off. Because now she can leave her children in childcare whereas before she couldn't, she's now got the confidence to access things and there is less of a role for me now as her confidence grows, which has been great to see.'

This perception of real change is shared by the majority of health support workers:

'I havenae really had a family that hasnae sort of progressed that I've had a long time with.'

On the other hand some project team members provide examples of families who prove to be very resource intensive yet are not perceived to have changed in any long term way (predominantly because of their difficult life circumstances):

'I have a school age mum, her parents who she's living with are both on methadone scripts and she has a young baby and we've had all members of the team going in, you know, the nursery nurse going in and trying to motivate her with how to play with your child and how to stimulate her to bring on her development. We've had the health support worker, who's helping her with basic parenting skills, healthy eating, healthy cooking, trying to get her out and about to different places. Myself sorta over-seeing everything and discussing issues such as like furthering her education ... social work is also going in there and basically this again is a difficult to engage family. Basically when you're going in and talking to this mum or going in and trying to do practical things with her, she's giving absolutely no response at all. She's not wanting to go down on the floor and play games with the baby, you know, with the nursery nurse and her needs are absolutely crying out at you. So, even with all this regular visiting and building up a relationship with her for about 14 or 15 months, she's had a visit at least once a fortnight from someone in the team for that length of time. And I would say that we are no further forward, we've maybe done the odd thing like physically force her down to the dentist to get her registered, get the baby registered but I mean, how's that progress. You know, you can register a baby at the dentist and they'll never go back and their teeth are still rotten because the diet's awful anyway.'

However, many health visitors viewed the question of empowerment and dependency as rather more complex than simply labelling individual families. Thus empowerment might have emerged from a period of dependency and/or the health care professionals themselves might be responsible for creating the circumstances in which dependency thrives:

'...it's maybe not the right time for them to develop because to make any changes they have to be at that level, sometimes they just want the sticking plaster that you can provide to get through the day, rather than, they don't want to look any further than today because that's the way their lifestyle is. And if you're at least supporting them in that aspect then hopefully in the future other things will fall into place.'

'you get the joke story about the girl that will not change the nappy without the health visitor. That's a sad reflection on the health visitor not the mum ... I think it's the skill of the health visitor who doesn't encourage dependency and who encourages empowerment.'

In addition most staff members were positive about the process of reviewing work with families and of withdrawing specific forms of support (such as taking older children to nursery) if they were not seen to be leading to positive change.

3.3.2.3 The development of two 'models' of Starting Well

In considering the extent to which Starting Well has afforded an opportunity to change health visiting practice, it is necessary to consider the way in which the project has evolved within the context of its two Local Health Care Co-operatives (LHCC). This section summarises the differences between the intervention teams in the east and south and discusses the implications of this for future mainstreaming decisions.

From the outset the two teams have approached Starting Well differently. In the east, LHCC management accepted the view of the demonstration project as a stand-alone entity and a team was developed around a group of enthusiastic and largely inexperienced health visitors. In the south, meanwhile, the LHCC management was keen to push for integration from the outset and the health visiting team consisted of a more experienced but more antagonistic group of health visitors (a large proportion of these moved back to generic posts during the course of the project). In both teams relationships with 'generic' health visiting staff was poor. Over the course of the last three years, these individual, group and organisational differences served to crystallise into two very different 'models' of Starting Well. In the south, as a means of salvaging the project, the management team within the Health Board negotiated a contract with the LHCC to manage Starting Well locally as an intervention integrated within GP practices. This required all staff to work to a corporate caseload with considerably larger caseloads and a much more targeted approach to delivering the core-visiting schedule. An attempt to encourage the east down a similar route failed and there the project team continues to exist and operate an approach that broadly reflects the original Starting Well approach.

At the point of interviewing staff in the south, the move to integration within practices was starting to happen and health visitors who had previously not viewed themselves as 'part of a Starting Well team' (Mackenzie, 2003) were largely positive about the direction of travel. Some who were still operating a more 'traditional' Starting Well model were cautious about what the realities of increased caseloads would mean to the service they were providing:

'...if they think that ... one health visitor, a health support worker and a nursery nurse then 450 families is quite acceptable , it's not and you haven't listened to anything that the people around you have been saying.'

In the east too, there was a cynical and fearful reaction to the prospect of integration using the south's model:

'... there is no way on earth with caseloads of 300 that they are doing anything like a starting well model so then you argue – what was the point in that? They've got a nursery nurse and a health support worker, they could of given everybody a nursery nurse and health support worker two years ago and saved themselves three million pounds.'

'...if we take away the kind of the framework of starting well there is a danger that things will just, you know, go to jelly and wobble away into corners and never be seen again. ... I think there would need to be some still kinda central driving force to maintain it, because otherwise the GP focus or the LHCC priorities or just whatever other things would take over again, yes, I think we would be lost in the maze.'

In essence the tension that developed within the project was between a model in the south that encouraged the development of Starting Well skills and practice across the LHCC but that risked considerable dilution of the original approach and a model in the east that concentrated on maintaining the core principles of the Starting Well principles that then risked a degree of isolation from the rest of primary care practice. This is a classic tension between the implementation of a project and mainstreaming *elements* of good practice.

At a strategic level, those most closely involved in management within primary care were most closely aligned with the position that mainstreaming skill-mix approaches and the diffusion of good practice were the key objectives for the future. This is illustrated as follows:

'I don't want to have this 'fix it' team or elitist team and I would be more comfortable if we spread the skills around.'

On the other hand, those at a strategic level most closely associated with the project itself had concerns about good practice spreading so thin as to be unrecognisable:

'I have real concerns about dilution'

'I think by integrating it, it becomes a different beast. Whereas the work that's happening in the east is still to an extent the starting well idea but the more you integrate I guess, and I'm not an expert on David Olds' idea, but it becomes more and more diluted.'

Within this debate it is important to reiterate that the models themselves were artificial constructs and the two Starting Well project teams have always been 'different beasts'.

This was recognised by the project management team:

'...things have moved in the east and south differently based on different histories and the way in which things are beginning to move anyway. So we have kind of, rather than fighting against that, we've gone with that and it was really, the process really began in the south because it was a way of moving the project forward in a way that was kind of, people were making noises toward.'

However, because there are now perceived to be two different 'models' there is a danger that integration within GP practices is now viewed as the ultimate aim of the project rather than one possible means of achieving a more creative and intensive approach to addressing the health needs of children and families. This momentum is illustrated below:

'...so it was not 'the south is better than the east' it was the other way round, however, when it got to the Scottish Executive, because of their own need and value that they are placing on this integration they are saying 'ah ha, it's working much better in the south' which is very ironic because that's not where we started from at all. What we were doing in the south was saying this is not a great situation but if we are going to turn around we are going to have to move in a certain direction.'

A broader view of integration might also be considered where a skilled team delivers targeted care as per the original model but that over a much longer time period helps to generate these skills over a wider group of staff, for example:

'I suppose it depends what you mean by integration. I think integration doesn't mean well 'its adding more resources to the primary care teams and people share caseloads and are able to target within that to those with most need'. It might be that you would still have a team of people that people referred into.'

In addition, viewing the diverging approaches as 'models' masks the contextual factors underpinning the differences that have emerged and leads to implicit questions about 'which is best'. The variation in home visiting programmes is a constant theme in the evaluation of their effectiveness (Gomby et al, 1993; Powell, 1993). The reality for Starting Well was that there was little likelihood that the approach could be uniformly applied in two very different areas and furthermore, given the decentralising agenda of Community Health Partnerships, that a 'model' would emerge that could be easily delivered elsewhere:

'...you go to Govan and Pollok and it's a rip-up, you just don't impose products on them that have been working elsewhere then miles across the city. So I think the first point is why not let different models flourish if it turns out that they work in an ad hoc way for local circumstances then that's precisely to the good ... what ever happens, if particular staff sites or professions are worried about their future, pissed off with it being disengaged for years and all the rest of it you're going to have problems whether you put them in the same staff room or put a note on their door saying by the way, starting well is going on, there are going to be fights in the corridor and I think one thing both models show is that you get fights. ... we need to be careful that we don't turn models out of what happens to be convenient.'

This reality applies not only to the mainstreaming of Starting Well but more widely to policy roll-out. The interim report (Mackenzie, 2003) discussed the difficulties in implementing a broad public health approach within primary care. These included a lack of consistency to what the approach entails and variable commitment to its implementation. The degree to which Starting Well provided the potential for sustainable changes in health visiting practice will depend on the consistency and commitment of the organisations within which change is now located. The variation in these primary care organisations is recognised at a strategic level:

'... leadership is a key aspect of replicating either model ... some are avoiding it and hiding from it and others are up confronting it and you know all sorts of variations are going on their right now. I think when we come to the next phase we will see, some settings will be at different stages of change caused by the public health roll-out. Some will be stuck in the same spot they were and so it will be even harder to them to learn these lessons but others will be so far ahead in their implementation of those that they may not see it as that difficult a thing to incorporate these ideas into their future direction.'

3.3.3 The health support worker model

The interim evaluation report produced in 2003, discussed early findings in relation to the implementation of the health support worker model. In this section we reiterate the key elements of this model and discuss stakeholders' perceptions of its success during the final year of Phase I.

For a range of practical, philosophical and economic reasons a key tenet of Starting Well was the employment of a group of lay or health support workers to augment the work of health visitors. These workers were recruited predominantly from the local areas covered by the intervention. In the first year of the project it was agreed that the health support workers should be employed directly through a voluntary sector organisation (One Plus) rather than through the NHS and that they would receive support, intensive training and direct management from a health support worker coordinator based within One Plus. Within the intervention areas, health support workers would work closely with health visitors who would retain management and legal responsibility for their individual caseloads.

Strategic stakeholders expressed a view, at the beginning of the project, that central to the successful working of the model would be: good communication between the two employing organisations at a strategic and operational level; role clarity for all team members; and, mutual respect between the health visitors and health support workers. The early perceptions of staff working on the ground indicated that, whilst good progress had been made in a

relatively short space of time, there remained teething problems in each of these inter-linked areas.

We turn now to views on how these areas had progressed by 2003.

3.3.3.1 Establishing a clear role for health support workers

The interim report discussed a range of activities in which health support workers engaged. These included a range of practical tasks including child-care (within the home and in escorting children to school) and domestic tasks (such as light cleaning or shopping). Social and emotional supports to mothers were also viewed as a substantial part of the support worker's role with mothers taken to a variety of community activities or encouraged to re/engage with training and employment opportunities. A small number of health support workers spent considerable amount of time advocating on behalf of families to a range of agencies such as housing or money advice. Some had become engaged in developing community activities such as a sports club for young children in Gorbals and a men's group for fathers in Easterhouse.

One year later a very similar picture emerged with workers undertaking a wide range of tasks that might vary between families and between workers themselves; in addition, some support workers were undertaking routine visits in place of the health visitor in charge. This wide scope is encapsulated by the description of a the post by One Plus and by the summary provided by a health support worker:

'...[a support worker] is a person who is multi-skilled, able to relate quickly and easily with local people and has a knowledge of the local area. The role is holistic, it's not task-oriented, it is a person who is able to go in and identify issues, relate these back to health professionals and be an asset to the health professionals and that's how I would describe a health support worker.'

'...what I see my role as is basically providing support for the families, be that emotional support, social support, practical support and just helping them reaching a goal ... if they have any problems, target that, sort that out in terms of financial advice, or housing, childcare.'

The typical way in which these roles develop within a single family are illustrated as follows:

'I think the biggest progression I had was one family where you just went in with a ROSPA pack and she was sitting and looked like she maybe needed a wee bit of help and I don't think she'd went out the house other than to do the shopping for three months. Basically we took her to one of the mother and toddler groups, a month later she was doing it herself and then the next month she was at college.'

The appropriateness of undertaking practical help within families continued to be justified as a vehicle to tackle wider health issues such as postnatal depression and there were no instances of health support workers being required by health visitors to perform tasks that they felt were inappropriate. Where they felt abused by individual families (as with the example below), the process of case review undertaken jointly with health visitors (as discussed in section 3.3.2.2) served as a means of tackling families' expectations:

'... there was a particular family that I was going into, again to help with their shopping, help her to get her money and stuff for the kids, for nine weeks. I was just going in, it's what I felt like, while she slept. I was basically going sitting with her two weans while she went to bed and I was like 'no, I'm no having this'. I just felt that she's pure abusing the system because I used to go in at nine o'clock to 11 and she was like 'gonnae no' come at nine cos I'm still in my bed, I don't get out my bed till ten.' So I was going in at ten, wakening her up out her bed and then she's like 'I'm dead knackered, I need to go back to bed again' and you're like 'no, I don't think so.'

The interim findings suggested that judgements about the appropriateness of different roles were made in the same way as within familial or friendship relationships. This was endorsed by the second round of fieldwork; one health visitor reflected:

'...you then hear whispers about people laying carpets for people and things like that and then I'm thinking 'oh, that wasn't an agreed goal' but I think that's just because the health support workers are there and they want to help out so, if the family is needing that done and they feel capable, they'll just get stuck in ... I think it's very difficult to differentiate between befriending and becoming a friend, because if you were in your friend's house and they needed help with something that you could help them with, you would just automatically do it and I think that's where things like laying carpets and plumbing in washing machine come in.'

The success of employing local workers was partly premised on their being better able to form bonds with families than those perceived as professionals but this was perceived by health visitors to bring an added pressure to bear:

'...the health support workers, because they're from the local community, aren't getting any peace when out with their own children or out there in the shopping centre at the weekend. People are coming up to them and saying 'oh, you got so-and-so a cooker and what are you going to do for me?'

Some health support workers described the need to separate out friendship from their working relationship with families (This concurs with the distinction made by Cox between friend and befriender, Cox, 1986). In some cases this happened where workers were already known to families and where they had to operate strict codes of confidentiality in relation to disclosed information; it also occurred where families crossed the lines⁴²:

⁴² The issues that arise where these boundaries are not maintained are discussed further in 3.3.3.3

'...you've got to keep that professional boundary in your mind, you know, when you go into the family ... there's even been cases where we've walked in and there's been like alcohol kind of sitting in the premises and the mum's there, she's had a glass poured out and went to take a drink. And you know, it's like, 'well I'm really sorry, I can't stay if you're gonnae drink so I'll come back and make another appointment to come back and see you.'

The role of health support worker then developed into a complex one that required a wide range of skills including flexibility and the ability to negotiate. Whilst many support workers were happy to encompass this wide range, a small number of project team members believed that two sets of skills had developed requiring two different types of individual. These are summarised below:

'...there's scope for two types of health support worker. Some people are very comfortable being like the mother type, going into a family and, moving them along for that short period ... other people ... just wouldn't be suited to that, it would be a whole waste of resource ...initially families need the support but then they'll get to the stage where they need somebody ... to pick that up and then move them forward and it's not a case of just getting by, ticking by, functioning, it's a case of getting people to believe in themselves and have the confidence to go out there and get a job.'

Whilst it may be that some health support workers were more comfortable with one or other of these sets of skills there would appear to be no a priori reason for believing that the two sets of skills cannot co-exist. Rather it would seem to be important that development of both remains central to the role of health support worker and to recognise that some of the variations in the role played by workers were perceived to stem from individual differences between health visitors as well as the support workers themselves:

'...we're quite wide in the sorta stuff we're doing, we're not sorta everybody doing exactly the same thing, it all depends on what the health visitor's asking, some of us do this, some of us do that.'

'... so it's about accepting that ... jimmy will let you weigh babies, but jeanie doesnae like you to do that.'

'... the health visitors feel, you know, everybody has got their own wee niche and their different kind of strength. And they find like certain families will be suited to different health support workers.'

3.3.3.2 Implementing a dual management structure for health support workers

The rationale for employing health support workers through a voluntary organisation rather than through the NHS was that the voluntary sector in general, and One Plus in particular, had an expertise in employing, supporting and training those who have traditionally been excluded from the labour market. In addition, this management structure would allow the opportunity for a genuine partnership between statutory health organisations and the voluntary sector that might encourage a broader perspective on health issues (Mackenzie, 2003)

The interim report presented largely positive perceptions of the training provided by One Plus. Since the first round of fieldwork support workers had received accreditation in Triple P (the parenting programme implemented through Starting Well) and their on-going, modular training had been endorsed by the Scottish Qualifications Authority. The Starting Well health support workers represent the first cohort of workers to have received this health and social care qualifications and all who participated in this fieldwork expressed career aspirations in a similar field.

However, perceptions of the difficulties of implementing a dual management structure documented in the interim report were echoed, and in some instances heightened, in the final year of Phase I. Whilst for the majority of health support workers this was not a major issue (except in so far as individuals had to go through additional hoops to seek decisions), for health visitors the problems of maintaining responsibility for a caseload without direct management for the support workers had not been alleviated over the course of the project.

These problems were multi-faceted and included: a perception that communication breakdown was inevitable where there was more than one line of management; a belief that the support workers were managed by an organisation lacking in a day-to-day understanding of the work of health visitors; a sense of professional dissatisfaction over the lack of control over another group of workers' time; and a view that split management was antithetical to team working:

'...it's like Chinese whispers, 'my coordinator told me this' and that's the information you're getting from the health support workers. So then you act on that information, then it turns out that's not the information and it's just people have picked it up differently and then it's gone round like wildfire.'

'...if the health support worker came into work late continually or phoned in sick and change visits without negotiating with you, you actually have to phone somebody who has, in my opinion, no real idea of what you're doing out there.'

'...if they say they are busy you are like 'right okay' so you go and look for somebody else and you can be three health support workers down the line before you actually get somebody. Sometimes you have your doubts about just how busy is busy, kind of thing ...you're not really, you're not their boss, you're not their manager so is it up to me to actually question that or do you just have to take it that they're busy?'

'...they don't know who their boss is...and I think that's been wrong ... it's been 'could you do such and such' 'we don't do that' 'so, you're like ok – we're not really working as a team.'

It is disappointing that despite attempts to alleviate these types of problem that the perceptions of most health visitors had become more negative in relation to the model of employing the support workers. Only one expressed the view that the benefits of the system outweighed its costs:

'I still keep coming back to the fact that I don't think we'd have done it if we hadn't had one plus employing and managing them. I think it would have been a complete disaster ... I think we need one plus's experience of supporting people, you know, from kinda like this labour market that haven't got the skills and the experience, the kinda professional qualifications, I think we would have just kind of made a complete hash of it.'

Views of those at a strategic level remained largely optimistic and supportive of the add-on value of utilising an organisation such as One Plus. This was largely related to a view that the NHS is not suited to the support of vulnerable employees:

'I think philosophically I remain entirely in favour of it and I like that link between the traditional statutory provider and the kind of the Goliath and the David out there who has particular expertise in a particular area who can feed into this process and provide a particular kind of support and a particular kind of understanding for the kind of people that we are dealing with in that employment programme. ... I think the danger [if lay workers were employed within the NHS] is that we just replicate our own hierarchical structures. We replicate our own way of kind of looking at people and working with people and I am not sure that our health support workers, some of our health support workers and some of our very good ones would have survived the kind of system we had in the NHS.'

'...if there had been a problem that a health support worker had, you know, in the NHS, there would be a risk that you would just think 'oh well, we need to discipline you and sack you.'

The role that One Plus played in providing supported employment to the lay workers is highlighted as follows:

'...the stresses and strains that come with recruiting local people are without question much greater than if you were employing maybe a middle class woman who's looking for extra money to go her holidays. Now I don't mean that in a snobbish way, I just mean that's a fact of life ...we've actually gone to the complete grassroots, we've given people the chance who may otherwise no' have had that chance. ... I could give you a million examples, there's the girl I

was talking about, having absolutely no money to get to her work, the long-term sick, you know, people who have been physically abused by partners who have alcohol problems and drug problems, you know, marriage breakdowns with husbands taking houses off people and all that kind of thing and we have actually worked through that and maintained these people in employment.'

The negative views of health visitors were explained by a lack of ownership of the aspirations of the health support model and by difficulties in communicating new systems of practice. First, the overwhelming desire of health visitors to have pressures lifted by the support workers that were sold to them as a means of reducing their work load, led to disillusionment around the support required by these new workers:

'...the aim about that, at a strategic level was, you recruit people from the local area who have experienced exclusion, give them support, they can become health support workers, there's a connection between them and the families and they can bring something to it. The way it happened and the way the project was recruited, I don't think that the health visitors necessarily bought into that part of the argument. They were looking for a pair of hands. And when that pair of hands sometimes came with a little baggage on it, it wasn't something [that was viewed positively]'

'...they've never alleviated workload for the health visitors as was originally envisaged they would do. Just never have done and I don't think they ever will do ... they are always gonnae need supervising, monitoring and feeding back and all those things that really take quite a bit of time.'

Secondly, project management messages about the way in which health visitors were to manage their caseload and the day-to-day work of their project teams were not perceived to have been effective:

'...we can't get the message through. Now that says something about the way in which we need to prepare G grade nurses and I don't think we do prepare them very well and I don't think we can move their models and experience from hospitals out into the community.'

'...it should be reiterated that it is supposed to be a nonstigmatised team working approach and we don't have this hierarchy. I think the health visitors need to be reassured that they are the caseload holders, they are the managers of their families, you know, they're legally responsible. But I'm quite sure the health support workers are blue in the face hearing this because I've told them a million times.'

The move from autonomous, GP attached practitioner to caseload manager has therefore required considerably more time and energy than initially anticipated by the project.

Whilst the majority of those at a strategic level viewed the involvement of One Plus as important in the future employment of support workers (and indeed the organisation is now

involved in providing a variation of the Starting Well model in other Local Authority areas), there was a view expressed that, in the longer term, it will not be acceptable for statutory organisations to delegate the employment of vulnerable individuals to voluntary sector organisations and that the capacity to support these workers will require to be developed in-house:

'I do think one plus was a good solid partner but I think the partner relationship should henceforth lie elsewhere ... I think that the NHS does need to consider the issues because if it is going to get anywhere around its current labour force shortages, it is going to have to dig much further beyond the sort of jobseeker allowance into people who are long-term unemployed, on incapacity and invalidity with addictions and all sorts of other problems ... it comes from a more general perspective that the NHS with thousands of vacancies in Glasgow in the next few years and not all of which are consultant level but form lab techs and porters and sorts of entry level jobs, has to sort this thinking through anyway, about how we can get a labour force of any sort, because they're not coming from Bearsden to do those jobs and how we can maximise the social inclusion aspects of what it does for the mass of Glaswegians who don't have work.'

3.3.3.3 Health support workers and health visitors: a relationship based on respect?

The third requirement for the health support model as expressed by strategic stakeholders at the outset of the project was that health visitors and support workers should treat each other with respect. The first round of fieldwork found that, whilst relationships were largely positive in one of the project teams, there was some evidence of hostility in the other that centred on a lack of respect (Mackenzie, 2003).

The recent fieldwork found that most health visitors in both areas were enthusiastic about the role played by support workers:

'God if I was in a generic post or another post I would actually miss having, knowing that they're there'. Alright, I might not use them all the time but it's just knowing that they're there and knowing that there is somebody else that you can refer the family onto for these practical things. And I'm sure I'd be kicking myself in another post and think 'god, I wish I had a health support worker now.'

'...please don't take them away, you couldn't do it, I mean you couldn't it would be really unfortunate if you had to move away to a caseload with no skill mix now, you know, because they're just, they're a godsend, you know. They're able to get in, they're able to follow up stuff, they're able to kinda keep an eye on people that you kinda think, that would be great if there was three of me. And, in a way, although there's not, there's still three sets of eyes ... I'm their number one fan.'

Likewise, health support workers were positive about the way in which they were treated by health visitors:

'I think they've put their trust in us right away because, at the end of the day, it's like anything you put your trust in and if it goes, it's downhill. The trust has got stronger and stronger and stronger ... there's not a single health visitor that I've had any issues with, not one'

'...we have got absolutely no problems between health visitors and health support workers. I'm treated with respect'

However, an issue raised with some frequency particularly within one project team was the extent to which particular individuals with personal problems were providing inappropriate support to families, crossing the boundaries between a professional and non-professional relationship, providing families with their home numbers, and, inappropriately liaising with social services without communicating with the relevant health visitor. The following quotation expresses the concern stated by a number of health visitors that vulnerability within employees may be problematic when dealing with similarly vulnerable families:

'I would be looking for somebody who's had life experience, somebody who has been able to deal with their life experiences ... not somebody who's carrying baggage around with them ... I mean, everybody carries baggage but that shouldn't be their agenda and why they're doing the work.'

Interestingly, this perception was shared by one health support worker who felt alienated from her co-workers:

'...the majority of the people I work with have more problems than the families they visit ... I think we've got to remember we're dealing with real families and real people and I think if you scratch the surface you've got to be there for that open wound ... if you're not solving your own problems, how can you detach yourself and say to somebody else 'well this is what I would do? ... I'm not saying that people that don't work shouldn't have a chance but I ...don't think people with major, major problems are right to go into other families.'

This view highlights again the question of whether the social inclusion aims of the health support model were fully endorsed by hard-pushed health visitors working on the ground. (In addition, it does not take cognisance of the existence of vulnerability within other professional groupings. Domestic abuse, for example, is as prevalent within middle class women as it is for those living in deprived areas.)

Some health visitors reflected upon individual differences between health support workers in an attempt to learn lessons for future recruitment:

'...certainly some of the health support workers have very much fitted more than others and part of that is around, I mean we've been trying to analyse what it is about the ones that are

busy that makes them different to the other ones and it kind of boils down to very simple things like their time-keeping is good, they will do what's asked of them and come back and tell you it's done. They are reliable in that they will always do what they say they're going to do or, if not, they will make sure you know they haven't done it and why. They are conscientious, you know, they're very kind of just, personality things almost, you know, kind of characteristics of personality that make them fit into the system. Whereas some of the other ones are a little more laissez-faire about things and 'och, what's time?'

Others offered judgments that did not appear to have been based on personal experience, for example:

'...you will get ones that will look for work to do and you've got other ones you probably put Richard and Judy on in the corner while the baby is sleeping. And I'm not saying that I think that happens with any of the ones we work with, but I think it's just human nature, you just get people who think 'anything for an easy life.'

It is perhaps inevitable that a new group of workers is open to greater scrutiny than an established professional grouping and, that instances of negative working practice unfairly generalise to the wider group:

'... there is a couple of characters who, for whatever reason, things don't work as well as they do with the majority of them. And I think although there are only two of them particularly, it kind of colours the view of everybody else ... I think it's that kind of little bit of, you know, a little bit of black ink in with the white and it just makes everything a bit grey.'

'...every health visitor you speak to says 'well I've got a really good relationship' so you think, 'where are these stories coming from.'

This should not detract from the huge progress that has been made in introducing and supporting a potentially vulnerable group of workers to a profession under some considerable change.

3.3.4 Conclusions

In a relatively short space of time Starting Well developed two project teams to implement its home visiting model. These teams travelled a long distance in this time in which they encountered and negotiated a number of barriers.

The health visitors within the teams were encouraged to adopt an evidence-based and standardised approach to their practice. In reality whilst many developed a broader understanding of the health and social issues affecting the families that they were dealing with, the extent to which a consistent approach to the quantity and quality of visiting that was undertaken is less clear. Health visitors continued to argue for the need to practise in an

unstandardised, intuitive manner that cannot be entirely reconciled with a more managerial perspective (Robinson, 1995). This has wider implications for the use of standardised family health plans as recommended by Hall (2003).

Over time the project acted as an advance demonstration of the kind of targeted intensive support within the context of universal provision that is recommended by Hall (2003). Once again, the need for flexible approaches to identify vulnerability was recognised over the course of the project.

In considering the success of the two project teams in influencing their wider LHCCs, context is everything. The projects developed in very different ways as a result of their individual team members, the dynamics between them and the organisational culture within which they were located. Those charged with mainstreaming Starting Well practice require to be alert to the potency of context. In addition, the degree to which the Starting Well model will be 'diluted' through integration with GP practices will be dependent on the project team members, the GP practices and the wider LHCC. These same factors will impact on whether a more discrete team of skilled workers manages to broaden the practice of other staff within an LHCC.

In relation to skill mix with nursery nurses and community support facilitators, the project illustrated some of the possible ways in which different professionals can work together to tackle need. However, a lack of role clarity remained within the project teams by the final year of Phase I. More explicit support mechanisms for nursery nurses were required. Health visitors believed that they had done far less of a community support nature that they had originally anticipated but many were not concerned by this and had come to the view that this was not an area of practice that they had a particular wish to develop. This has implications for ensuring that community development approaches to child and family health become part of routine primary care (Hall, 2003).

A key element of the Starting Well home visiting model was the employment of health support workers from the local communities. These workers developed very diffuse and flexible roles that varied between the individuals; different health visitors also deployed them in different ways. The lack of role clarity did not appear to be problematic for the support workers themselves although some health visitors found these variations difficult to manage. A specific concern arose about the extent to which some health support workers were able to maintain professional boundaries in their relationships with service users as a result of their access to the real life complexity of families' lives. Reflective practice and supervision should perhaps be an explicit and continuous part of the support that such workers receive.

In general health visitors were positive about the role played by these additional workers and, in particular, the part played by those support workers that they worked most closely with.

Nonetheless, stories of negative experiences with health support workers were told. It is important that, whilst lessons are learned from critical analysis of incidents that go wrong, individual stories are not generalised to a wider group of workers.

A further layer of innovation in the health support worker model was that the staff were employed, trained and managed by One Plus, a voluntary sector organisation. This offered the workers support from an organisation with expertise in employing those re/entering the labour market and was part of the project's strategy for tackling social inclusion.

Perhaps inevitably this dual management structure led to some difficulties at an operational level with staff perceiving there to be a distinct lack of clarity over the day-to-day management of caseloads. This became a major stressor for many of the health visitors and senior managers attempted throughout the project to resolve this issue. However, those at a strategic level acknowledged that the close involvement of a voluntary sector organisation allowed a supportive work culture for the local workers that would have been inconceivable within the NHS. The problem remained however that health visitors had viewed the support workers as a means of alleviating their caseloads and instead found themselves with a significant supervisory role. More work at the beginning and throughout the project in ensuring health visitor ownership of the social inclusion aims of the support worker model may have been valuable. This issue will become increasingly salient for public sector organisations as they devise ways of expanding the natural constituency of their workforces.

3.4 Delivering change at community and strategic levels

Key Findings from Section 3.5

Step 1:

- More intensive contact with families helped health visitors to understand health needs at a community level. This understanding was also shaped by communication within the project teams, working with other agencies and pre-existing knowledge of the local communities. A wide range of needs was identified but none were believed to be 'new' issues.

Step 2:

- The process of sharing perceptions of community level need was rather haphazard within the two project teams and its success appeared to be a function of the level of collaborative working, with one team in particular demonstrating a significant lack of cohesion.
- The increasing burden on health visitor caseloads and the early lack of clarity in the role of the community support facilitator (as perceived by other members of the project teams) led to a lesser emphasis on advocating for community change within the health visitor role.

Step 3:

- The local implementation groups were perceived to have been successful in disbursing monies from their development funds to local organisations but less effective in securing representation from both key statutory agencies and local parents.
- The role of the community support facilitators and the bilingual worker became key in bringing about more sustainable changes at a local level and in liaising with other relevant child health fora.

Step 4:

- During the course of Phase I of Starting Well, only a small number of issues were passed from the local implementation groups to the project steering group. None of these resulted in significant change at a strategic level and the members of the local implementation groups showed little knowledge of the role of the steering group.

Step 5:

- The project steering group did not succeed as a mechanism for strong partnership working around the child and family health problems experienced in poor communities. A lack of ownership of the project beyond the health partners, and a lack of commitment to tackling broader strategic questions were discussed by strategic level stakeholders. On the other hand, there was some evidence of more constructive strategic work occurring 'behind the scenes' (such as the joint working around Sure Start and the development of money advice support for vulnerable families).

3.4.1 Introduction

Starting Well was conceived as a project that would impact not only at the level of individual child and family health but also at the level of community and organisational capacity to respond to the health needs of local families. In assessing its impact at these levels this section of the report considers two sets of issues: the degree to which community infrastructures and supports have been strengthened through Starting Well activity; and the extent to which the project is perceived to have impacted on the strategic planning and provision of child and family health services.

As outlined in Sections 1.1 and 3.1, a rational model of change was assumed whereby:

- Step 1 - the process of intervening intensively with individual families would result in an understanding within project teams of key community health needs;
- Step 2 - a shared understanding of these needs would feed into local implementation groups; which
- Step 3 - would develop and support local, community solutions; that,
- Step 4 - if unable to be resolved locally would be referred to the project steering group; which
- Step 5 - would act as an advocate for more strategic, Glasgow-wide solutions.

The various elements of this model of change are considered in turn.

3.4.2 Community Support

3.4.2.1 Introduction

In this section we look at the processes that were established to encourage the identification of community level health needs and describe the types of action that were taken to address these.

The project teams were able to describe a range of health issues that they believed to be salient at a community as well as an individual family level, a full list of which is provided below in Table 3.4.1.

Table 3.4.1. Identified community health needs

East	South	Both areas
Addictions	Activities for older children	Breast feeding support
Baby friendly facilities	Ante natal services	Childcare
	Book Start	Cooking skills
Head lice	Child and family development worker	Housing
Improved policing	Culturally sensitive services	Men's health
Lack of training	Domestic abuse	Mental health
Public transport	English classes - minority ethnic women	Money advice
Respite	Exercise classes	Play at Home
Shopping facilities	Family friendly GP facilities	Safe play
Suitable location for services	Lack of community	Territorial issues
	Oral health	Toddler groups
	Post natal depression - minority ethnic women	Triple P parenting
	Social isolation - minority ethnic women	Weaning support
	Toy library	

Two of these, head lice and domestic abuse, are used as illustration throughout this section. These two issues were selected to provide examples across a spectrum from a time limited local level initiative to a more endemic social determinant of health and well-being. Tables 3.4.2a and 3.4.2b below provide a background to these two very different issues.

Table 3.4.2: The background to the selected health issues

3.4.2a Head Lice	3.4.2b Domestic Abuse
<p>Head lice are becoming an increasing public health problem with 80% of cases affecting children aged between four and 16 (Community Hygiene Concern, 2003). Repeated infestations of head lice affect the whole family and cause frustration and stress; effects can include missing work, taking children out of school and nursery. There is an additional social stigma in having a child with head lice therefore parents may be reluctant to report an episode (Gordon, 1999). It was acknowledged by the Starting Well Home Visiting Team that head lice were a problem across the whole of children's services in Greater Easterhouse.</p>	<p>Estimates of the prevalence of domestic abuse in Britain, range from between one in four and one in ten women (Abbott and Williamson, 1999). The current figure used in Scotland at a policy level is taken from the recent Scottish Crime Survey (Scottish Executive, 2002) where it is found to affect one in five women over their life course. Some research suggests that domestic abuse can start during pregnancy (Casey, 1989), with one estimate of one in six pregnant women experiencing it (Elliott, 1993), making it a particular issue for health care professionals who come into contact with women in the ante and post natal periods. Domestic abuse has serious consequences for both physical mental health (Stark and Flintcraft, 1996). Health Visitors are believed to be one of the most effectively placed groups of professionals to identify and support women since they claim to use a more social approach to health (Abbott and Wallace, 1990). Within the Starting Well project teams, however, the extent of the problem came as a surprise to some and was acknowledged as a key concern. In the south team this was perceived to be an issue particularly (but not exclusively) within the minority ethnic community.</p>

3.4.2.2 The Process of identifying community health needs

Members of the home visiting teams described four distinct ways by which needs were identified:

- Through home visiting individual families;
- By communication (both formal and informal) within the team;
- In collaboration with other agencies; and
- Through a pre-existing broader knowledge of community needs.

The home visiting teams identified community health needs through their *engagement with individual families* and the recognition that problems experienced were not unique:

'As a team we acknowledged ... it wasn't just one individual.'

The subsequent communication of these needs within the teams was then important as it was through this that issues from an individual's caseload were shared with other team members. Neither of the home visiting teams used a formal written system to report needs and communication appeared to be largely oral. A pro forma had been designed but had been utilised so infrequently that its use had fallen away:

'I think that system only lasted a month or two and was used two or three times. I think what actually that enabled us to do was to kind of bypass having to write it on a piece of paper. And it's now happening verbally that the staff, instead of writing it on a piece of paper, give to me or [the Community Support Facilitator] or just come and say to me or [the Community Support Facilitator].'

Members of one home visiting team discussed their caseload informally with colleagues and realised that the needs they encountered were also present in their colleague's caseloads. They raised issues with the health visitor co-ordinator as part of their regular clinical supervision and during Starting Well and home visiting team meetings:

'So we've tried to kind of do it so that once a month there is a whole team [meeting] and then the other point in the month, it's just kind of health visiting business.'

In the other team the situation was different, with regular meetings having been disbanded:

'We used to have team meetings every two weeks, which was fantastic, and I was able to tell what's going on, because there was always new stuff on the agenda and so forth. They've stopped unfortunately.'

The ensuing lack of communication within the team was described by one health visitor who gave an example of not knowing that a particular group had been set up:

Health Visitor 1: 'I mean there was an Asian Woman's group started up...I was one of the Health Visitors in the project and didn't even know anything about it starting up. Even as a team there is people taking their own wee chunk and not saying, 'Well I am doing this, what does everybody think of it?' because then they want to buy into it.'

Health Visitor 2: 'But that has always been a problem. We have all been doing wee bits of work...'

Health Visitor 1: 'People get very protective of their bit.'

This protectionism of roles was reaffirmed when a health visitor spoke of how she did not want to pass things to the Community Support Facilitator (CSF) for fear of losing her input into them:

'I was just like saying that weaning is one of the things that I can do and I don't want anybody else to take that away.'

This protectionism was symptomatic of an early lack of team cohesion in one of the teams.

In addition to those family health needs identified through their own case-work, some community needs were communicated to the Home Visiting Teams through their liaisons with other agencies:

'...it was not just within the health visiting team, it was through networking with other agencies and everything.'

This contact was either through attending multi-agency fora, such as the Easterhouse Family Forum or the South East Glasgow Domestic Abuse Forum, through multi-disciplinary working on specific projects with agencies such as nurseries, LHCC personnel, and other community groups concerned with child and family health issues. One CSF, in fact, felt that most of the needs she was working to address had come to her through other agencies:

'When I was working with those three or four agencies, we had a development day in Toryglen and one of the priorities that came through from that was that we had to have a Children and Families Development Worker... we put together a bid to the Toryglen SIP and we were successful in getting £37,500. So as of today we now have a Children and Families Development Worker working in Toryglen which is great.'

In addition, the CSFs appeared to have made good links with other agencies in the community as well as within the LHCC, for example, the Public Health Practitioner.

Those home visiting team staff that had either previously worked in the project areas or were resident there drew on this experience to inform them in identifying community health needs. Health support workers in particular felt that, as many of them lived locally, this enabled them to have specific knowledge of the issues facing the community. This supports the view that a key strength of the health support worker model was the local knowledge of the employees. One health visitor had over two decades experience working in the area and commented on the long standing health needs she was aware of:

'The issues that we have spoke about in Easterhouse are the same issues that were here 20 year ago when I worked in the community, so there hasnae been a lot of changes, the only changes I can see are in the housing.'

Once individual level needs had been aggregated into community health needs the communication of these by the home visiting teams differed across the two areas. This appeared largely to be influenced by the communication structures in place and the relationship between the CSF and the home visiting team members.

The first port of call for the south home visiting team members was either the health visitor co-ordinator or their local LHCC based Public Health Practitioner. They were aware of the latter's plans for community support work and wished to avoid duplication of work. In the east their first point of contact was generally the CSF or health visitor co-ordinator, unless they felt it was an issue they could deal with independently, for example, setting up a mother and toddler group. The nature of the need influenced the person to whom it was communicated. It appeared to both health visitor co-ordinators that if a need was perceived by the health visitor or home support worker to fall into a more medical definition of health it may be more likely to be passed to them, for example mental health, whereas more social health needs would be passed to the CSF or Public Health Practitioner. Viewing mental health as a medical issue, however, runs counter to the social model of health that Starting Well was seeking to promote.

One home visiting team did not appear to have as much communication with their CSF. The team, for example, spoke of not having been consulted on community health needs:

Health Visitor 1: *'Health Visitors have got local knowledge, we should know and we've got good links but I don't think she's ever spoken to us.'*

Health Visitor 2: *'She goes on about the LIG and 'Come to that' but it's a cop out.'*

Here the CSF felt that the home visiting team was too busy with the demands of their caseloads to pass on community needs:

'I'm not bombarded with needs because they are too busy just getting on with their caseloads and just doing the health visiting.'

The problem of communication between the CSF and the home visiting team was a two way problem, the CSF felt that few needs were passed to her and thus successfully focussed her work on developing wider community involvement.

In the other area the situation was different with team members saying that most people had communicated a need to the CSF:

'Well [the CSF] chairs the LIG ... I think we have all given her topics to raise at the LIG, that they can then discuss among themselves and decide if there's something, from their point of view, that they can take forward.'

3.4.2.3 Local implementation group

In this section we look at the views of the home visiting teams, local implementation group (LIG) members and strategic stakeholders on the impact of these groups in addressing local child and family health issues.

The focus of the community capacity building element of Starting Well was the LIG. This was a group with membership drawn from local community agencies and its role was to discuss community issues, support the development of community infrastructure and had a ring-fenced budget to provide small amounts of funding to applicants from affiliated local community organisations. The LIGs were initially intended to have input from statutory agencies such as the Social Work and Housing departments although there was no representation provided. All local community agencies providing services to children and families were invited to apply for affiliated status and encouraged to apply for funding. They had a role in influencing strategic change, passing information about aggregated community needs on to other higher-level groups such as the Starting Well Steering Group or other more specific strategic agencies such as the Greater Easterhouse Community Mental Health Forum.

The community support element of Starting Well had the aim of strengthening community links and capacity building through both local and strategic level development. Whilst the area of community development is a long contested area with many differing opinions on what its aims are and what activities can be considered meaningful community development, it is generally accepted that the key aspect is the involvement of community members in the planning, development and delivery of services. Using the models of community work as defined by Popple (2001) the closest definition to the Starting Well approach is that of 'community organisation'. This entails improving co-ordination predominantly between service providers with the aim of avoiding duplication and tends to be service and project orientated. In contrast Popple's (2001) definition of a 'Community Development' approach centres around assisting groups to acquire skills to enhance members' quality of life and to aid their participation. Sullivan and Skelcher (2002) describe the requirement of full involvement of service users as an essential ingredient of community collaboration and capacity building. The element of citizen or even service user involvement in this aspect of Starting Well had not met initial expectations with participants talking of the dwindling interest of parents in the strategic structures put in place. Only one of the LIGs had a parent representative; it was felt that meetings were not appealing to parents who had fallen away as the groups had progressed. The members were confident in their own abilities to identify family and community health needs and bring them to the table for discussion without the presence of parents.

As the LIG was seen as being the focus for tackling community health needs, the perceptions of the home visiting teams and how they communicated with it was an important factor. The home visiting teams appeared to have a good understanding of the function and purpose of the LIG, particularly in one area where they were positive about it as a forum to which community needs might be taken:

'I think probably having the LIG we are probably in quite a good position in that there is actually somewhere that you can take things like that to. Because if it wasn't for that you would probably be a bit of a lone voice.'

Despite this the health visitor co-ordinator in this area was less positive about the group, seeming unsure of its role:

'I've never been particularly clear myself exactly what should go there and what to expect from that group, so it's kind of difficult to say how I feel it's gone.'

The LIG was most closely aligned with the CSFs in both areas. Both had chaired the group at some point and were responsible for feeding back identified needs from the home visiting teams to the group. The CSFs both saw the LIG as developing more in the direction of an awareness raising and campaigning role as opposed to merely a funding body:

'I do think it's fulfilled its potential, but I think we can still do more ...We are not quite sure, are we a funding body just to identify funding? I think it should be a cocktail actually, to be looking at wee bits of funding, to be campaigning or raising awareness around issues that don't get [raised] anywhere else.'

The other CSF had a similar view but saw greater links with the Steering Group:

'We are there to integrate the home visiting element into the project, we are also there to integrate the agencies that are out there into Starting Well. We are also there as a lobbying body, if you like, for the Steering Group, we are also there to fund local projects.'

The health visitor co-ordinator in this area felt that continuity within the LIG had been difficult to establish due to changing personnel:

'I think it's probably a group that does need to continue and evolve and to attract new members to be affiliated with it... initially we did consult with all the pre-five agencies and pre-five type services. But as they change or as personnel change, it's quite difficult to kind of maintain that.'

It was a different situation in the other area where a core group had emerged:

'...In terms of working relationships within the group, it's a good group and there is a fairly steady kind of core membership that attend it and I think that's been good.' (Health visitor co-ordinator)

The views of LIG members were also explored and the issue of funding and community links raised. One member felt that the group was serving a useful purpose by having a budget to distribute to local agencies:

'I've not gone to every meeting, but the meetings that I've gone to, I thought have been reasonably effective in terms of passing out the money and the funds to needy organisations, local organisations.'

The fact that people felt unable to attend all the meetings was commonly described by members of the LIG who felt that they had many commitments attending other fora, often as well as casework:

'I've been a member of the LIG but I actually have seldom attended and that's just been due to other priorities and other commitments.'

The difficulties health visitors had attending was also remarked upon by several participants, echoing the comments of the home visiting team:

'When I first started the first two meetings the first two Child and family sub groups there were health visitors and health support workers at them but there has not been any attendance since then. So they were reporting from their end but I don't know whether they've been too busy to attend.'

LIG members generally agreed that they would bring community needs to the group but not exclusively, as they often sat on other fora and would communicate needs to whatever forum they attended, as did the CSFs who had linked in with other structures in the communities, for example, the SIPs. LIG members seemed largely unaware of where needs from the LIG would be passed on to, seeing themselves as predominantly an operational group who could initiate and fund pieces of work or use their membership of the group for information sharing.

'See it's quite operational this group but I don't know... I mean I would imagine it [a need] would be passed on.'

'I think groups tend to work in partnership with one another and I feel if there's something that you want to bring forward you can bring it to the group and if there's anybody there can help out or bring in some other information, well that's kind of the way that I've been using it.'

The membership from local community organisations had led to a perception of strengthened links horizontally across the community organisations:

'Because they've met more often and at least know who each other are, sitting across the table.'

A survey of community agencies found that over half of the respondents across both areas felt that Starting Well had helped develop multi-disciplinary working and increased liaison and networking which is reinforced by the opinions of the LIG members. Despite these successful local links, there was little vertical communication with minimal awareness of the connection with the Starting Well Steering Group among the LIG members not employed by the project.

The perceptions held by more strategic level stakeholders were also explored and the following issues raised: the extent to which the LIG had linked in with other stakeholders; and, its operational rather than strategic focus. The intended role of the LIGs was described by one participant who had a strategic role both within the Local Authority and Starting Well:

'...With the LIGs the hope was they might be the reformative base for some general linkage in children's services planning terms between the local community, parents and local workers and the broader picture. That theoretically has happened but I don't think it's right, I think in the way issues immediately come to mind when you raise that question.'

As with the LIG members' views of the group, the strategic level participants also saw the LIG as having a more operational than strategic focus:

*'I think the implementation group was a forum that was started by Starting Well and **** in particular has taken it forward. And that has in itself become a strong forum, [it] has developed and taken forward a number of issues and made links. So it's been a bit of both, it's been about yes Starting Well linking in, but also being able to do stuff itself.'*

The LIG was seen by the strategic level personnel at the highest strategic level, the Scottish Executive, as being a forum for communication and capacity building between local agencies and not primarily as a funding body:

'My understanding is that it's not a huge budget which is quite good. Because I think often things that affect communications do not take a lot of money is more about this perception that money is needed... it's generally about the will the will to make things work and often that comes from the very fact of bringing people together. I think the money side of it, if there is money, it can take away from it. The positive side of it is that it means people don't feel they have to come with a pot of money, they can come and look at the best way of achieving something, the negative side of it that can be the only incentive for people to participate.'

Not having partnerships over-reliant on funding is described by Stewart et al (2003) as fostering a 'can do' spirit, with additional resources being seen as encouraging complacency. Strategically the gathering of individual members of organisations together was seen as the most important factor in generating capacity for agency involvement.

3.5.2.4. Actions taken to tackle community health needs

Overall it appears that, notwithstanding the issues raised earlier, the LIGs made their mark within the local community with regard to membership and providing funding and support to member agencies. The strategic work that had been carried out had been very much on a local level with the examples of lobbying which mainstream services in the east and entering into partnership and collaborative working with wider agencies and professionals, for example, the Public Health Practitioner in the south. In the east, action was taken to influence a public transport provider when this had emerged as a problem for families in accessing healthcare at hospitals and travelling on buses with pushchairs. Additionally the CSF had approached the developers of a new shopping centre to raise the issue of family friendly facilities being included in the plans. In the south the CSF and bilingual worker had liaised with personnel within the LHCCs on initiatives such as postnatal depression screening for minority ethnic women and promoting breastfeeding. The survey of community organisations (Berzins et al, 2004) found that 70% of respondents felt that Starting Well had had a positive impact on the community.

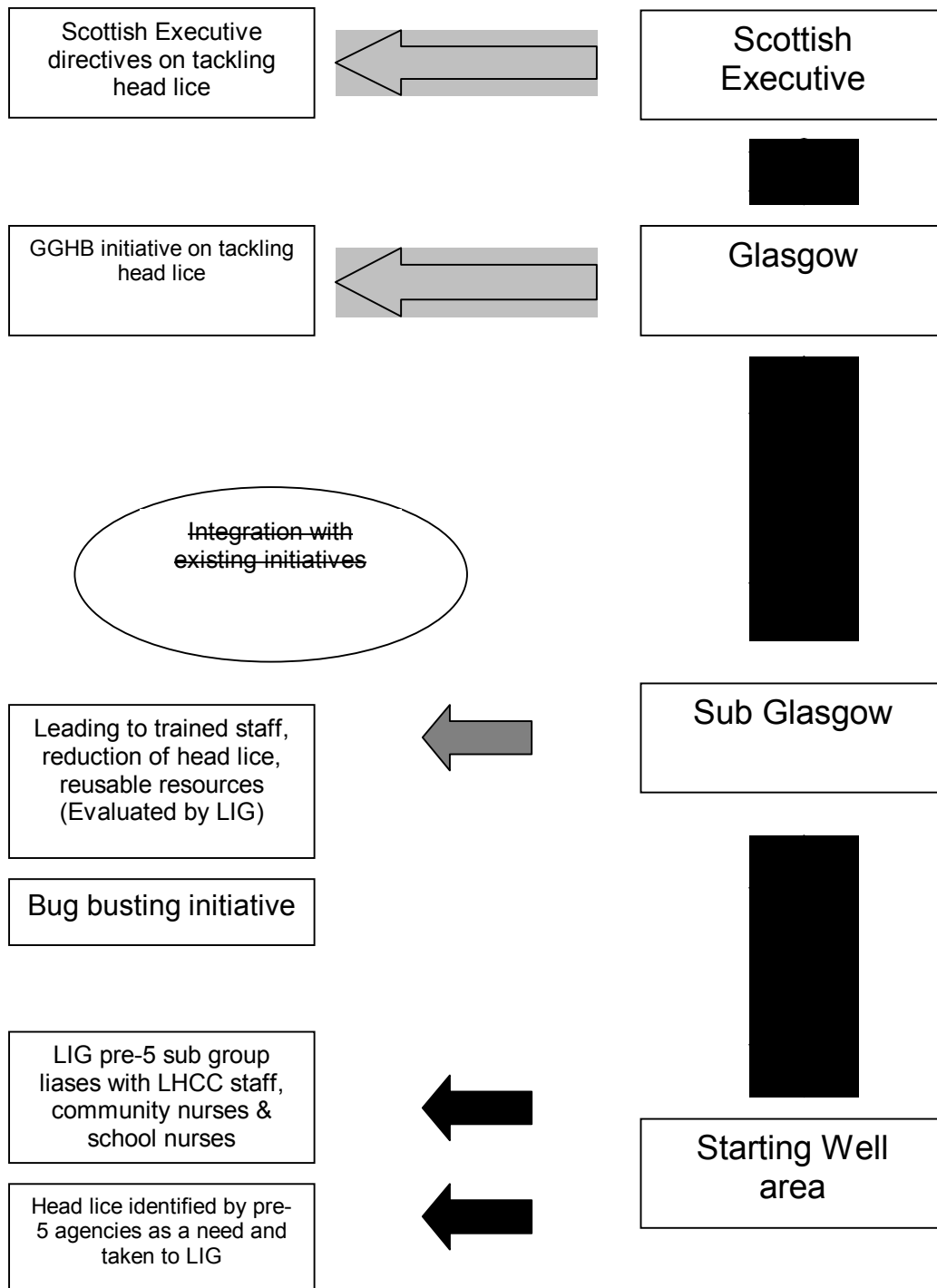
The impact of the project within the community was seen a wide range of stakeholders as having achieved three aims: taking health needs from parents to the LIG; providing resources and support for existing community organisations; and entering into partnership with them to take forward new initiatives:

'Yes I mean certainly what Starting Well has brought is an addition in terms of resources, in terms of input it's a more intensive approach to working. It's one of its great strengths I think is the way that it's been able to engage with and involve the local community, involve local parents both through the home support workers but also by from being based within the Ruchazie Family Centre and that whole development, I think that the community feels a sense of ownership around that.'

There was a sense that collaboration and successful partnership working had been achieved in some instances at a local level within the community organisations.

Taking the example of head lice, see Diagram 3.5.1, the LIG had passed the issue on to their pre-five sub group, which takes forward short term working and which co-ordinated the 'Bug busting' programme (this method aims for a systematic removal of head lice by combing hair to remove lice). The initiative was funded by the LIG in partnership with nurseries, to take the information into the nursery schools and groups where parents were already meeting and provide training for community nurses and other personnel. It provided information leaflets, posters, an educational video and distributed fine-tooth combs for the identification and removal of head lice. The aim was to make to the delivery of information non-threatening so that parents did not feel they were being judged or lectured.

Figure 3.4.3 Bug busting initiative pathway



It aimed to encourage collaboration across agencies and disciplines. The CSF felt that this was an issue that only Starting Well would have raised:

'We are raising issues that nobody else is, nobody, no other groups are interested in head lice.'

The sustainability of the initiative was described by a nursery head viewed the initial resources from Starting Well as pump-priming:

'I feel that Starting Well gave us the impetus to go and do it and we will just carry it on, so we've got the basis there, all we need to do is top up with the combs.'

The nursery felt that the education they had provided to parents would stay with them and they would continue to use the resources with the new intake.

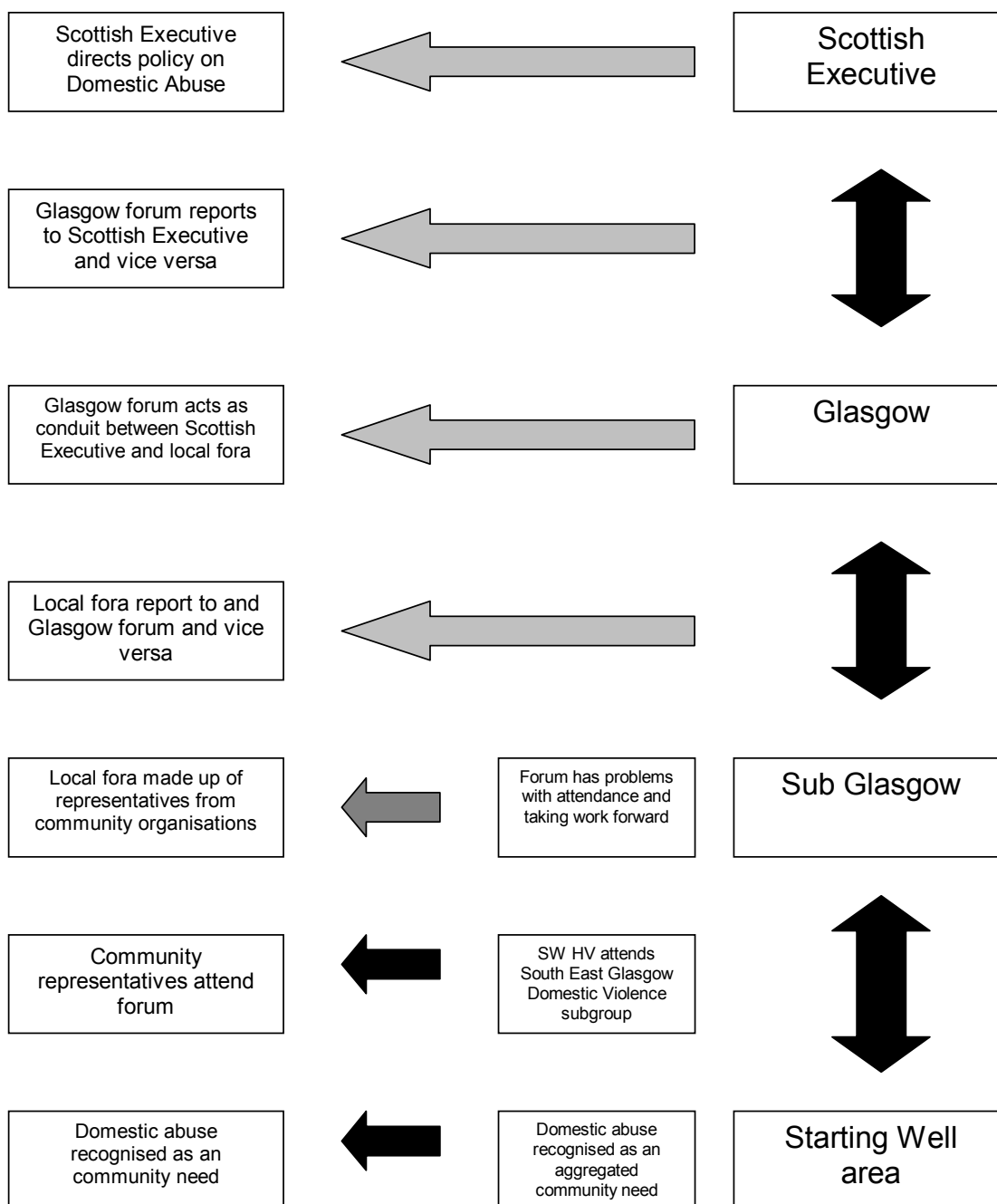
Providing a co-ordinated campaign across all agencies was perceived by some to have had the effect of changing the practice of mainstream agencies. However, as a professional with responsibility for joining up services and providing an integrated approach, one strategic level participant had concerns about the fact that the 'Bug busting' was a time limited initiative and as can be seen in Diagram 1 did not 'join-up' with existing initiatives:

'...it needed to be sustained and in terms of where does it link with the community pharmacy head lice initiative that's happened... how do we kind of tie up all that kind of stuff really? It was a January thing and that's it finished....'

A further Glasgow-wide initiative originated by the Health Board is to follow this later in the year providing access to medicated shampoos and lotions for children and families. This is a different approach to 'Bug busting' and it remains to be seen whether this conflicting advice about how to deal with the problem causes confusion with parents' understanding of how to tackle it. It seems that although the initiative was deemed a success by those most closely involved, there was more scepticism from those within the wider service community concerning integration within mainstream provision.

From the other end of the unmet need spectrum, figure 3.4.4 illustrates the approaches taken and barriers encountered in tackling domestic abuse within the project.

Figure 3.4.4 Domestic abuse strategic pathway



Despite recognising the issue as a problem and, despite training in recognising and dealing with domestic abuse, Health visitors often felt unable to cope with it within their caseloads. Instead they felt that they should refer women to Social Work but perceived that this did not meet women’s needs:

‘It’s strange though because you feel because if you go to Social Work about domestic violence then they haven’t got the capacity to take that now. So all they are doing is handing a leaflet that we have already handed this girl and saying ‘Well there is counselling services there is you can access them but they have got a waiting list of about six months, so it’s really frustrating...’

The home visiting team, therefore, did not all feel confident to deal with women that were experiencing domestic abuse and some did not feel that training that they had received was an adequate response to the problems they were encountering. Many felt that they would benefit from further training and, in particular, multi-agency training (Womens' Health Team, unpublished Starting Well Domestic Violence Study). Some health visitors believed that there should be specialist services that they could refer on to. This challenges the conclusions of Abbott and Wallace (1990) concerning the current readiness of this group of professionals to recognise and address domestic abuse.

On the other hand there was a specific response at project level to the needs of women from the minority ethnic communities experiencing abuse. The bilingual worker arranged an ad hoc counselling and support service from a specialist agency for these women and made close links with a Muslim-faith based agency that provided support for Muslim women as well as joint training for agency staff.

For issues of abuse within non-minority ethnic women the home visiting teams relied on a strategic network already in place and were represented on the local domestic abuse fora.

[there is] 'A domestic violence forum that we go to with that.'

Members of the home visiting team were, however, dissatisfied with the information coming back from these fora:

'What was the outcome of domestic violence forum? There is NO communication about it as well because you don't know what's going on, there might be something going on but we don't know about it.'

I feel, I don't know, I feel it's quite often that there are a lot of groups working on these things and then there is no end to it.'

The forum was one of a number that covered the city of Glasgow. The chair of each forum attended a citywide group which in turn fed into a Scottish Executive forum hypothetically providing a link from the local community to the Scottish Executive. The local fora themselves had proved problematic; one forum co-ordinator described the lack of consistent attendance by members due to the priority service users were given over attending meetings or the high turn over of staff within the member organisations. This lack of attendance of forum members meant that the co-ordinator felt this could be off-putting to those who did attend due to the repetitive nature of the meetings. The actual activities of the Domestic Abuse fora were perceived to be limited:

'It's been more of a talking shop really.'

The groups had carried out information sharing exercises about local services and produced leaflets about what was available for women locally but was not perceived to have influenced strategic decisions. The co-ordinator of the forum at Glasgow South East level was asked how much influence she felt it had had over policy either at city level or Scottish Executive level and whether its members knew of the strategic pathway the forum provided:

'Yes they have been informed about the link in fact ... I think there was a wee chart that the Violence Against Women Partnership did and I gave out to everybody.'

In this case the actual structures were in place for ground level professionals to pass needs in their communities upwards as far as the Scottish Executive. Diagram 3.5.2, however, shows how this process had become fractured at the first level due to the problems in the attendance and membership of the fora with the result that community needs were not effectively communicated. Hague (1998) found that nationally multi-agency fora for domestic abuse were at risk at becoming a smokescreen for any meaningful activity and their usefulness in information sharing and providing directories of services were time limited; there is some support for this analysis within the Glasgow example.

In general, apart from those directly involved in Starting Well strategic stakeholders struggled to identify what the project had achieved at a community level and what, if any, community health needs had been communicated. Often saying that they were *'too far away'* or that they could not remember. Only one strategic level participant could talk about something new she had learned from the project. She felt she had gained some insight into provisions for minority ethnic groups:

'What people had thought was 'provide a clinic or a centre for them to come to and it will be fine, they can come to the centre and get everything'. But actually the centres weren't getting used, that wasn't working.'

In general when strategic level personnel were asked about what information they had gained from the project it was vague and focussed very much on the home visiting element and the 'hard' outcomes such as the six-month findings. The community element was seen as something that they knew was going on and that there had been problems with implementation due to the early imbalance between home visiting and community development.

For those working at a local level but not within the project itself, the general consensus was that the project had not raised any issues that were not already known about:

'To be honest with you I don't think Starting Well from where I sit has uncovered anything that you wouldn't have known through common sense anyway. That some of the vulnerable families have huge problems with parenting and childcare, and if we did something about it it's probably a good idea.'

This feeling was echoed by a participant and LIG member from a local voluntary organisation:

'I mean in some ways I don't think that Starting Well has done anything radically new to be honest, I think what they've done is good. I don't think that they've invented something that didn't exist before, I think they've taken good ideas from a number of different areas and they've put into practice within one project.'

It was, however, seen as having the potential to provide evidence to reinforce these 'common sense' opinions:

'I think something like Starting Well does kind of cement that approach, particularly if it proves to be effective, then it enables us to defend the social model which people challenge all the time.'

3.4.3 Strategic Change Beyond the Local Level

3.4.3.1 Introduction

Having considered the types of community health needs identified through Starting Well and the processes adopted to tackle them at a local level, this section now turns to the role of the steering group as a driver for strategic change and considers the future potential of the project to influence planning for child and family health.

3.4.3.2 The role and effectiveness of the project steering group

As we discuss later in Section 3.5, which discusses stakeholders' views of the extent to which Starting Well met its original aspirations, partnership working at the steering group level was identified as the most disappointing aspect of the project. The steering group was perceived to lack role clarity, ownership and the will to exercise its strategic muscle:

'... we were never very clear what we wanted that group to do.'

'...you see the same people sitting round the table there with actually key responsibilities somewhere else. They should have been able to align these, you know, very powerfully around the starting well table and they didn't. It was a committee meeting that they attended.'

'...now I feel that the steering group might have had a little bit more muscle and I was disappointed that they didn't, ... I feel that the people that are there or should be there at the table, are the people who can flex muscles and get things done.'

During its lifespan it discussed the transport issues and lack of baby-friendly feeding facilities raised by the east LIG (neither of which could be satisfactorily progressed due to the lack of statutory accountability of the transport company or the Easterhouse Shopping Centre). Furthermore, although a short-term solution to the issue of women's mental health services

raised by the project teams at the beginning of the project was put in place, this was not sustained (Mackenzie, 2003). The literature on strategic change emphasises the importance of vertical connections between levels of planning and implementation (Wilkinson and Applebee, 1999; Chapman, 2002); there was little evidence of this within the structures that evolved.

At the same time the number of issues that came to the group from the LIGs was scant and some stakeholders reflected that the predicted model of issues filtering through the various structures was perhaps unrealistic and suggested that changes were happening locally in ways that did not touch either the steering group or high level individuals within its represented organisations:

'...that aspiration is not being met at all about kind of aggregating need and feeding all that back in, at least it wasn't manifest for us but I'm not sure that it isn't happening at all, in kind of divergent ways out there in the community. But it didn't come through a system that we set up – that's a classic – setting up a system and expecting life to work according to our system ...sometimes I'm not sure ... throwing a stone into a pond, what do the ripples look like somewhere further down ... and we don't always know what those are so we might have had impacts that I'm not particularly aware of.'

3.4.3.3 Working behind the scenes

This notion of progress occurring opportunistically outside the structures established by the project is evidenced by the work undertaken to develop a money advice project in both the east and the south and to expand the full employment initiative already operating in part of Greater Easterhouse to cover the geographical boundaries of the project in the east. The first of these, emerging from the work of the CSFs in conjunction with Glasgow Healthy Cities, resulted in the securing of Scottish Executive monies for welfare rights advice to be delivered within the home as referred by members of the project team. This represents a good example of a community health need addressed within the local areas within the life-span of the project.

The second example on the other hand, the Full Employment Initiative, emerged through a more circuitous route that encountered barriers at the local level, did not come to the steering group for discussion but which, nonetheless, developed into a project that demonstrates the kinds of synergies that can happen when links are made between initiatives. Its genesis is described below:

'...we've always had some extra money floating about ... well, I was at a meeting and heard people talk about the full employment programme – it was on the border of where we are in the east but it wasn't in our area ... and I simply thought 'wait a minute this is really interesting' ... I took it to [csf] and said 'take this [to the local implementation group] because I don't want to

make that decision. It isn't my money, I want the community to make that decision' ... well, she took it to the group of all professionals who said 'no, not a good idea, we really need to spend this money in this area on mental health' so, I had to go back to [csf] and say 'this money is for this or nothing. It cannot be used for anything else. It's not a pot of money that we are trying to find a home for. It's a specific pot of money and this is what we can do with it. Well, then there was a big hue and cry because it was felt as if I, me, the project was centrally pushing through something that the community didn't want. But it wasn't the community, it was the professionals sitting around'

On the other hand, whilst strategic links were made across projects, a concern is raised by some that the project did not make the kinds of links with mainstream services that would have been required to lead to long-term change. For example:

'...with the women's health team and the children's health team being just across the corridor you might have expected some cross fertilisation about the project ... that approach has only been one way and that has been from us to starting well in relation to the piece of work that we have been doing, looking at the response to domestic violence ...not enough work has been done to think about, what is the strategic landscape look like and how does starting well fit into it.'

In the last months of Phase I, the project started to move toward a different type of planning whereby Starting Well and Sure Start would develop an integrated approach to tackling the health of vulnerable families. A group entitled Ensuring a Good Start, chaired by Starting Well's existing project manager would be established and linked more explicitly into children's planning services at a Glasgow level. Some, closely involved with this process, believed that this approach would be productive since partnership working around children's planning was viewed to be effective:

'...we've had to work together and agree joint priorities, the children's services planning process has been I think very positive in Glasgow city.'

Others, also closely involved in children's planning were much more sceptical about the degree of drive and partnership working associated with this strategic level planning and viewed Glasgow as illustrative of the crisis in tackling childhood vulnerability identified by For Scotland's Children (Scottish Executive, 2001):

'...the general state of children's services, ... as assessed by the Scottish executive through an action committee, is close to crisis ... the picture is one of lack of integration, lack of co-ordination and a lack of ownership ... so, I think we're not exempt from that in Glasgow ... so that's the first thing. The second is then that in the absence of top-level strategic drive 'let's get this right, let's take an integrated approach, let's make Sure Start really help families with hardship, let's break the cycle', in the absence of that, then you have the blockages which is that people only

know the boundaries in their organisations and the limits in their thinking that goes along with that.'

3.4.3.4 Starting Well and the Community Health Partnership agenda

As discussed, some of the difficulty for Starting Well in influencing change was the disjuncture between the LIGs and the project steering group. The advent of Community Health Partnerships (CHP) provides a potential opportunity for projects such as Starting Well to bridge this gap and to influence strategic planning at a local level. Their development was seen by stakeholders as an opportunity to impact on the breadth of responses to community health needs and to shift the focus of local health care management away from a narrow GP model:

'CHPs for me are the once in a generation opportunity for the NHS to create structures that are much more directly linked to communities and much more socially orientated and deal[ing] with causes as well as effects. So I'm terribly optimistic about CHPs...'

'LHCCs were never owned by their local communities because they were imposed by the NHS because basically GPs decided how they wanted to group together. So for me CHPs are about more than just LHCCs and health promotion, they're about a real step change in the influence that communities have on the NHS. And actually organising and structuring that in a way that really influences resource and local decision making...So you look at something like child health I would expect each CHP to have a major focus on child health as a kind of core issue.'

The potential for Starting Well to influence this agenda was stated by one Health Board participant as follows:

'I think Starting Well should be influencing these big major strategy things in future, what practices look like and I suppose as part of our child health team we should be looking at that... if the whole planning for that community's health including its children's and families health is at that community health partnership level and they are working hand in glove with local authorities with education with social work, there is a real potential and I think it would be daft if Starting Well is not part of that.'

However, one strategic stakeholder was not aware of the project currently capitalising on the opportunities to influence this process:

'I think then Starting Well does have a future across the city but to the best of my knowledge currently Starting Well is not at the forefront of any thinking around development of CHPs.'

3.4.4 Conclusions

There is some evidence that the process of working more intensively with families generated within health visitors a greater understanding of complex health needs that needed to be addressed at a community as well as an individual level. The greater awareness of domestic abuse is a good example of this. Health visitors also developed their picture of community health needs through their own experience of the areas they worked in, through their collaboration with other team members, and through their links with other organisations.

At the same time, it is not surprising that the kinds of health issues that were uncovered were not 'new' in the sense that they were generally issues that were already recognised within the community and the agencies working in the areas.

The processes of discussing shared perceptions of community level need were relatively haphazard within the two intervention areas and their success appeared to be less the function of the existence of formal systems of communication and more about levels of collaborative working within the project teams. The burden on health visiting caseloads, the subsequent delay in establishing the community support arm of the project, and the lack of early clarity in the role of the CSF (Mackenzie, 2003) also served to push this further down the agenda for health visitors.

However, through both the work of the LIGs and of the CSFs in conjunction with other multi-agency fora, there is evidence that Starting Well made an impact on local organisations. The survey of community organisations undertaken jointly by the independent and internal evaluation teams, for example, demonstrated a relatively high level of awareness of Starting Well and its activities.

In addition, the development funds were used to support small scale and short-term activity within a variety of settings (such as nursery schools and play groups). More significantly, in terms of sustainable work, the community support facilitators were instrumental in securing funding from the Scottish Executive for the Money Advice Project in each area whilst the bilingual worker made significant advances in developing support for minority ethnic women suffering from domestic abuse and raised this issue within the LHCC⁴³.

However, there is little evidence that the project steering group acted as advocates for Starting Well. Whilst it was probably naïve, in retrospect, to expect the LIGs to fully find their feet, identify needs and filter those that needed to be dealt with more strategically through to

⁴³ This is a small number of examples of good practice undertaken at a local level and is not an exhaustive list.

the steering group, those needs that were identified in this way were not progressed significantly.

Key stakeholders and members of the steering group acknowledged that the group suffered from a lack of clarity as to its role, a lack of ownership and a luke-warm approach to partnership working. These features seriously compromise the potential for mainstream developments (Stewart et al, 1999; Sullivan and Skelcher, 2002; Rummery and Coleman, 2003)). Where strategic change began to take place this was behind the scenes rather than around the steering group table.

These issues remain salient if Starting Well is to influence the policy and practice of child and family health within the new CHPs.

3.5 Revisiting the Theory of Change - Strategic Level Stakeholders' Perceptions of Success

3.5.1 Introduction

Having discussed the extent to which Starting Well made an impact on a number of key processes, this section now turns to the question of whether the same group of individuals who articulated the project's initial Theory of Change, viewed the project as having been successful within Phase I (in other words, was the Theory of Change **doable** in retrospect?). We then consider their reflections on the **meaningfulness** of the original project plans.

Key Findings from Section 3.5

- Those involved at the most strategic level within Starting Well were largely optimistic that the project had met its objectives in relation to the home visiting and community support components of the project. Most were much less positive about the objectives set around partnership working and the extent to which these had been realistic was questioned.
- There were mixed views as to whether the types of short-term objectives set by the project were meaningful in leading to a longer term step-change in child and family health

3.5.2 Retrospective Reflections on the **doability** of Starting Well's Theory of Change

Stakeholders were asked to consider, at the most general level, the objectives set by the project in 2002. Most perceived these to have been met.

'...I'd be surprised if they haven't achieved most of [them]. I know that the community development side was not as quick off the mark as it ought to have been but that was a question of resources and, when the resources were brought to speed, then I think they picked up in that.'

'...if I speak in general terms, I don't think the actual remit and objectives is in jeopardy.'

'...I don't think there is any in the territory of really, you know, ... falling off the rails'

The ways in which participants supported their views of the project's success varied depending on their proximity to Starting Well. For those most intimately involved, success was evidenced with performance monitoring data on specific objectives such as dental registrations or direct experience of managing particular components of the project:

'...Well if you look at these for example forty percentage registered with community dentists - we've done all that. In fact we're well in advance of that.'

'...it's been fascinating for me seeing a bunch of paper and outlined plans turn into real people and real initiatives and so on. So my overall assessment is that many of the things we hoped might come to fruition have done so in terms of staffing, teams, relationships, interactions.'

Others at greater distance from the project provided more impressionistic and qualified responses:

'...Um. Well my sense of it is, and there are limits to this because of how close I am to it, my sense of it is that it's met its promise - my sense of it is that in large part it's done what it set out to do. Its reach is evidenced by the fact that people refer to it a lot. So people are aware of it within health and beyond health as being a different way of doing things. So I think on that basis, that's an indicator [but] it's like a half life - once it's radiated so far from the core of experience, you don't know what the value of that visibility is, but from where I sit and what I pick up from social worker colleagues ... it has positioned that service differently from what happens elsewhere.'

'I ought to be able to answer that question fairly easily. And yet I continue to find that with the exception of your interim independent evaluation, I find it very difficult to get to grips with the areas in which the project has been more or less successful and therefore for that very reason I find it very difficult to answer your question. ... (I have) concerns that some of what we are hearing is the policy rhetoric that the project feels is appropriate to feedback to more external stakeholders.'

Stakeholders were then asked to discuss the extent to which the project had met its objectives in the areas of home visiting, community support and partnership working. These are discussed in turn.

Echoing the data reported in section 3.2, the home visiting model employed by the project was believed to have been largely successful at engaging families, developing productive, therapeutic relationships with families and in changing professional practice:

'I see some of the huge difficulties that is attached to actually getting people to change their kind of frames of reference and the way they have always done things, so they have managed to put together a project that does deliver different things and challenges a lot of people's assumptions about the way things have been done in the past and the way that they need to be done in the future and I think it has also managed to engage parents very successfully in

that process so I think that the recruitments rates are, you know very, very good and most families have taken part in it.'

'When you go to Starting Well events of any sort and you talk to parents and talk to health visitors you get an amazing, real depth and richness of the anecdotal evidence of what you might call case studies, but which I simply call narrative of people's lives almost transformed by that relationship and the transformative aspects may be little more than the health visitor saying 'go on hen and I'll accompany you to the debt advice centre or the alcoholics anonymous or anything'. I think it might not be major stuff but it has transformative effects because someone took an interest, someone had the information, someone maybe geed them up a little bit to go along, arranged the childcare, arranged the meeting, gave them the confidence, made sure they bloody well kept their appointment and went through with it. The next thing you know they're on their own, they don't need the health visitor any more.'

'I think that as a starter for ten, it's quite useful that the team has produced documents as recommended by Nursing for Health.'

Two issues were highlighted by those most closely involved in the project's development in relation to operationalising the project's plan. These were: the difficulties in establishing a structured and standardised model of health visiting practice; and, the vast underestimation of the time and effort required to integrate a new workforce into an existing professional grouping (again, these confirm the findings discussed in section 3.3):

'I think the biggest frustration in health visiting (and I'm generalising) is they are not really that interested - or there is a distrust of evidence based practice or of evidence. The biggest evidence for them is their experience. And whenever we try and look at standardising or guidelines or protocols, the discussions comes back to, 'but we have to respond to the individual family's needs and that's our professional skill and that's what we think is right'. Particularly we're seeing it, looking at the parenting programme where we have said 'well the evidence is very strong elsewhere for triple P, we want to see that programme used more widely' and they will say 'well that's only relevant for some families - some families prefer another programme or I'm more used to another programme'. And there maybe is, um I suppose but there will be rights and wrongs in both of these. But the sort of cultural move in health visiting to evidence based practice is behind where probably it is in medicine for example.'

'...we have done some interesting things in terms of bring in the health support workers and if we consider the original proposal that was actually a couple of sentences. And it was a much more complicated process to try and do, in terms of beginning and simply trying to get a contract in place. You may recall it took a long time because of going back and forth and legal departments etc but it eventually got there. I think that that programme is beginning now to reach what potentially it could offer ... and again it was a huge cultural change to bring people who are non-professionals into a professionally oriented culture very hierarchical culture em and into the middle of a project where people who were supposed to be leading them, the

health visitors, were trying to find their own feet at the same time. So it was a big bang approach to try to change services and I think that it is beginning to pay off.'

In relation to the community support aims of the project stakeholders were generally happy that these had been met despite the project's early concentration on home visiting:

'Community support. I think that again through the community support facilitator we have moved a long direction in that ... you know, the right road of travel and there are all kinds of things going in the local communities and all kind of local community organisations being brought together and I think this whole use, or this whole development of a local implementation group has been very useful and a specific group that looks at pre five services in a local community - there are other groups, there might have been other ways to do that, when I look back on it but I think that was useful for our purposes. ...having someone with a specific focus on the pre five agenda has proved really valuable.'

Securing of funding for a money advice project through the Scottish Executive was cited as an example of good practice as was the development of a Full Employment Initiative in Easterhouse. On the other hand, for one stakeholder based at a local level, the implementation group, established to tackle child and family health needs, was not believed to have integrated with existing primary care structures:

'If I am being honest I don't think it has been terribly successful. ...I don't think there is any issues that they have ... brought into my table. But I think that is one of the difficulties with the way project is run - it is seen as separate.'

As discussed earlier in section 3.4, the element of the project that was viewed almost uniformly as having missed the mark in terms of the project's aims was partnership working. The project steering group, which was initially viewed as the means through which child and family health issues that could not be tackled at a local level would be addressed, was disbanded in 2003 and a new structure incorporating Starting Well and SureStart ('Ensuring a Better Start in Life') developed. The critiques offered by stakeholders cover the general utility of steering groups as a model of governance and the engagement of key partners. These are key themes in the literature of partnership working (Sullivan & Skelcher, 2003):

'The partnership stuff, I think that's the area that still requires the most development. And I think we moved down a certain road but ...I think we have to question ourselves, not just this project, I think projects generally, the health service generally, social services, we create these steering groups and I'm not sure that - are they good value? I haven't got another model in my head, may I say - I don't know how else we do that. But what ... we have here is exactly what we didn't want to have, where we have a range of people, duplication from agencies, not always the right people, people without investment or real ownership of the project. And we have to take responsibility for that as well. People weren't asked often to make very important decisions around the project or if they were, the direction of travel and that decision was so clear that really it did become kind of rubber stamping in some way. So, that didn't really work

and evidence of that is that eventually it kind of wound down although what we want to do now is to pick it up under a new banner under the Ensuring a Good Start in Life Group and link it into SureStart.'

'I think coming from a local authority background, my feeling is that the local authority's involvement has been disappointing as well. On two fronts - first of all by its own lights at times I think it has just stood away and said 'ah well loads of Executive money going to an NHS project - that's fine, good luck to you. We haven't got that money to invest how could we? You're lucky - good on you'. I think there has been that, which is a form of institutional miserabilism and which is questionable anyway because the local authority is the housing for a lot of new Executive money anyway under Changing Children's Services and pre-fives and all the rest of it. Secondly, I do feel ... because of the concentration of the project particularly in work force issues around a particular area i.e. health visitors, that broader perspective was lost earlier on and my colleagues in the local authority were not as engaged as they should have been earlier on. And I think we have probably lost opportunities to integrate better with children's services planning which we are only now beginning to address.

A further issue raised in relation to both the partnership working and community support aspects of the project concern the extent to which the objectives around these processes were realistic or thought about carefully enough in the planning stages:

'The only bit where it was unrealistic because it was going into uncharted territories was ... it was a quite vague on the aim of partnership and collaboration and community development because that begs that bigger question of what is the framework for community development and integrated service delivery. So that is like how far you can actually change the world from looking at one corner of it. That's unrealistic.'

3.5.3 Retrospective Reflections on the **meaningfulness** of Starting Well's Theory of Change

Having explored the extent to which strategic stakeholders believe Starting Well to have met its original objectives for Phase I, we now turn to a discussion of their views on the role of different types of evidence in supporting their perceptions of success (**testability**), and the extent to which they were **meaningful** in relation to the long-term goal of achieving a 'step change' in child and family health.

Despite the fact that the project was encouraged to set itself objectives that included processes as well as harder indicators and outcomes, and that both the independent and external evaluation employed a multi-method approach, a number of stakeholders expressed a concern that, the dominant paradigm for judging success would be that of the medical model:

'I think it's one of my areas of regret that a lot of people have come to perceive Starting Well as an evaluation that is a ... clinical trial rather than as a demonstration project. ...you still hear the phrase in and around Starting Well, of people observing and then commenting on it 'when does the evaluation come in'. As if there is a single one and that is a dominant deception I would say in classic public health, that all the rest is essentially window dressing. ... we could end up, and I use the phrase intendedly I guess, throwing the baby out of the bath water, that's my biggest concern.'

In addition, (confused) expectations from project commissioners were perceived to feed into a skewed implementation focus on the objectives that were more readily measurable:

'...in terms of what the Scottish Executive has been expecting um, at times ... you've got messages from the CMO ... 'you have got to be clear, you've got to stick to these, you've got to get really hard evidence about this, that and the other' and then it's 'no, more process stuff'. Aye well ok - I think again [the project management team] must have been thinking 'I really have got to look at oral health, dental care, and all that kind of stuff. As for community development, well it's airy fairy, it's hard to just sort of explain, ... while folk are bursting for the hard stuff.'

Early evidence from the quasi-experimental arm of the independent evaluation (section 2) that indicated a difference between the intervention and control areas on only a small number of variables (including maternal mental health and dental registration) was discussed by stakeholders. For some the lack of effect size was neither surprising nor disappointing given long-term nature of inequalities and poor health outcomes.

'...you might actually help stabilise a family through intensive input but, in terms of any outcome measures, there may be none. They might not become drug free or you might not help get the kids off the child protection register, or whatever.'

'I think it takes generations to change outcomes and I think that you understand that you only get funding for certain things, so you put outcomes in to get the funding. I don't know if that is realistic given the ambition of what it is trying to change ... I think that's more to do with the framework of how we actually develop initiatives.'

One stakeholder expressed an uncertainty about what it would mean for the project's underlying Theory of Change if there were no evidence of the project's impact as demonstrated by quasi-experimental data.

'I don't think we know yet what that means. Does that mean it's [the 6 month data] too early? Or does that mean, it could be a number of other things. I don't think we know. I don't - maybe I don't have a huge sense of optimism that we are going to see big differences even in the 18 month outcomes.... I think there will be a number of reasons for that. I think that there are a lot of initiatives going on anyway in terms of the control area. I think it has taken us time to get the project up and running well. And we still haven't got everything perfect but certainly in that first year much of when the cohort was recruited from things were still at a very early stage. Um

some of it will be, these are the most vulnerable families that will need a lot of help over and above what we are able to offer here. Maybe some of it is we have got the wrong measurements. I suppose there is a lot unknown here that we need to discuss when we see the results. ...So I guess the answer is I'm not absolutely sure yet. But I don't think we are going to see such amazingly fantastic results that everybody says well we've got to put lots more money into following a Starting Well model which is what we need to think about when we look at the next phase'.

The supremacy of experimental evidence in convincing future funders and planners of comprehensive, child health services can, however, be contested. One planner, for example, indicated that the evidence required might be less rigorous than anticipated:

'What I'm relying on is a sell from this project.'

Another stakeholder reflected on the power of 'human narrative' over performance monitoring data in persuading policymakers of impact:

'...it is the sort of stuff where I know it doesn't necessarily evaluate always rigorously well, it is the sort of stuff if you were to say to the minister 'in a nutshell this is what it has done' – 'oh, what have you done' – 'turn lives around'. 'Brilliant. What more do you want? Would you rather have reduced dental caries?'

This leads then to the discussion of how **meaningful** the project's plans were believed to have been in retrospect. Whilst some stakeholders believed the plans to have been appropriately ambitious statements of intent, some were less convinced that they represented significant inroads into the task of producing a 'step change' in child and family health. One, for example, discussed the lack of early planning around the way in which the project would tackle major issues impacting on population health:

' think some of those, some things I think we could have anticipated and because we could have anticipated, hadn't done as much as I'd liked and I'm disappointed we haven't. And that's I think around what I will call the iceberg effect of finding out much more about women's mental health and domestic abuse issues that has come through the health visitors. Now we damn well should have known that. Could have guessed it and if we hadn't guessed it - there were enough reports out there from Glasgow and elsewhere to have thought this is what we are going to find ... we should have maybe just sat and taken some time and thought our way through the implications of what happens if all of a sudden people turn round and say um there is an awful problem about mental health issues and black and ethnic minorities, domestic abuse or whatever.... we should have somehow got culturally into the mind set at the beginning where there will be a certain fix set of stuff that this will be based on ... but a lot of it should have been left open ... It doesn't have to have a structure plan or Venn diagrams either, you just need to say, as a matter of culture and openness, this is what we will try and do.'

Part of this difference in viewpoint was due to differing perspectives of the scope of the Starting Well project (as one stakeholder noted 'I go back to basic principles ...and again, you'll know everybody in the team will have slightly different or a dramatically different take on what they are'). Another component of the disagreement about the meaningfulness of the project's plan is the tension around whether performance targets and objectives are liberating or constraining to projects that seek to adapt to complex policy and organisational contexts (Blalock, 2000). Whilst some stakeholders believed that reaching targets was less important than setting out bold aspirations, others viewed targets as a statement of 'can-do's':

'...some of the stuff around oral health and weaning they are all well and good, but it's a bit flat. ... I think that there are other areas where I would have wanted maybe to have set, well what I would regard as more meaningful indicators or challenges, we may have met only half of them or none them and then have had an argument about it but I would rather we did that ...I would much rather you kind of aimed for stars and got as far as the moon as opposed to just jumped up and down on the spot. I think there are aspects there where we haven't developed as far as we could have done because we weren't spurring ourselves with that particular perspective.'

'...we [had to] try to be very careful about the size of this stick we were building. ...So what we try to do is find something that is achievable, a little bit difficult but achievable that we can work towards ... but it's not going to rebound in a way that would be just unhelpful.'

This latter stakeholder then goes on to describe how the relatively unambitious targets within the project plan, whilst not perceived as meaningful in relation to the project's ultimate goals, can become prompts to implementers for activity that would not otherwise have happened:

'I think we could go back to a project and ask what use is it having a three year project plan written - I would say very little because things are going to emerge all the time and having this written down in this kind of concrete way is not probably that helpful. There is another approach however. So I think it is a painful process, probably worth using but not reifying into something other than what it is. It is a kind of guide. But then lets not get carried away with this. It is going to suggest a direction of travel but we might move, based on our experience. We have to be alive to the possibility that a million things are going to emerge here. In the same way, if we don't have these kinds of targets we can go in all kinds of direction so as a means of kind of concentrating thinking, they are probably quite useful. As a means of ensuring some kind of outcome in long term health I am not sure they are particularly useful but what they give if we have to think about ensuring that people get to the dentist we have to think about this whole infrastructure of activity and we have to make links with all kinds of people we wouldn't have made if we didn't have to think about that target. So the value is probably not the value for which it is intended.'

For others the energy that was expended on the more easily measurable inevitably detracted from other more difficult objectives:

'...what does a step change actually look like, which criteria do you use, again you're constrained by what you can actually measure and what is considered to be a robust instrument rather than what other things you'd ideally like to measure.'

3.5.4 Conclusions

In relation to the retrospective **doability** of the project's programme plan, strategic stakeholders were relatively confident that success could be evidenced for much of the home visiting model and, to a lesser degree, the community support element of the project that had experienced delays in its implementation. The achievement (and indeed realism) of the partnership working objectives of the project was much less evident to stakeholders. These findings echo those discussed throughout Part 2 of this report. On the other hand, the findings from the quasi-experimental study of the project suggest that a more tentative view of success is warranted.

The extent to which the achievement of the stated objectives could be viewed as **meaningful** in producing a longer term 'step change' in child and family health was contested by stakeholders. Short-term health indicators, for example, were viewed as both constraining and useful to project development. This tension is found in many complex initiatives (Mackenzie et al, forthcoming) and signals the need for clearer ownership of and commitment to a model of project planning that acknowledges the need for both monitoring and more creative evolution.

Part 4. Conclusions

Conclusions and Policy Implications

4.1 Introduction

In this final section of the report we discuss the main conclusions from the various elements of the independent evaluation and summarise the policy implications arising from these. In addition, we consider the more general learning associated with designing and implementing a Demonstration Project.

Before doing this we summarise some of the key assumptions lying behind the Starting Well model that emerged from the process of articulating the strategic stakeholders' implicit Theory of Change.

- families in deprived areas would engage with the project;
- through the development of trusting relationships with home visitors, families would take part in health promoting activities within the home and in the wider community;
- health visitors working more intensively with a smaller caseload and supported by evidence-based practice guidelines, would be able to take a broader view of a family's health;
- the employment of health support workers, predominantly from within the intervention areas would enhance the support provided by health visitors;
- through intensive work with individual families, health visitors would be able to develop a greater understanding of child and family health needs at a community level;
- new area infrastructures for child health would result in more responsive local statutory and community supports for families;
- a senior level project steering group would provide the driver for strategic change; and,
- that this whole system and individual family level intervention would result in a step change in child and family health in the longer term.

4.2 Impact on child and family health related outcomes

The original Starting Well proposal was based largely on an attempt to replicate a model of home visiting tested within the US (Olds et al, 1998). Despite doubts as to the transferability of the North American evidence-base to the British context and a number of limitations within the quantitative evaluation of Starting Well, findings relating to maternal depressive symptoms and HOME score are supportive of shorter-term psychological benefits for study mothers and potentially longer-term cognitive and emotional developmental benefits for study children.

More specifically, multivariate regression analysis of the quasi-experimental survey data that compared families in the intervention areas with those in a broadly similar control area in Glasgow found:

- lower rates of **depressive symptoms** amongst intervention mothers at 6 but not 18-months;
- no significant improvement in the **quality of the home environment** at 6-months but a small positive intervention effect at 18-months ($p=0.088$);
- higher levels of client-satisfaction with levels of health visitor support within intervention families;
- and, higher levels of **dental registration** at both assessments for such families.

These modest findings provide some evidence of a positive Starting Well effect although the weight of importance that might be carried by an outcome such as dental registration is open to question. More child-focused and longitudinal analysis is necessary to determine the longer-term clinical and social significance of these intermediate outcomes and to assess the degree to which a 'step-change' in child health has been effected. In retrospect it is unfortunate that the evaluation was not designed to address questions concerning the economic impact of the project; it may be that a future extension to the quasi-experimental study could usefully consider weighing the costs and benefits of this approach to child and family health promotion.

Simple comparisons of area-level context (described in appendix IV) suggested a basic similarity between the intervention and control areas that did not help interpret the above findings. Lower-level comparisons, however, (for example at the level of postcode sector) revealed the potential for more sophisticated multi-level analyses that may help tease out the relative contribution of individual and area-level factors to these outcomes. More extended individual-level regression analyses remain our immediate priority, however, if future opportunities can be found to explore these possibilities, we may not only explain more of the variance in outcomes but also gain a more informed sense of the kinds of emergent community-level factors that constrain and facilitate the operation and effectiveness of Starting Well.

4.2.1 The case study families

The impact of Starting Well was also assessed qualitatively by exploring the views of a purposive sample of case-study families and their health visitors. Through this fieldwork a process model was identified that linked intensive health visiting input to a diffuse set of benefits that might be summarised as 'enhanced support'. These included: increased

confidence; reduced anxiety and isolation; the opportunity to confide; and, experience of advocacy.

The process model describes how intensive visiting equated to more time and direct contact with mothers during a period of universal need which encouraged the rapid formation of a trusting relationship, an individualised care package and the provision of more and better quality information on needs and life circumstances. This in turn, was associated with the identification of a broad range of problems and problem-solving activity and an enduring two-way (functional) dialogue between mother and health visitor. In sum, these processes promoted perceptions of enhanced support. Lack of maternal receptivity to the service and health visitor caseload pressures explained variation in process and outcomes.

Intensive visiting was found to be an effective way of delivering a more patient-centred, 'holistic' model of care. Precipitating factors include: the convenience of the home setting; the shift in power relations inherent in the mother's control of access to the setting; and a concomitant need for the health visitor to maintain access by a) providing a flexible service and b) establishing a positive, non-directive relationship.

Project health visitors praised teamwork, training and aspects of the approach (intensive support, skill mix) as strengths but had experienced resistance, scrutiny, and larger, more demanding caseloads than initially anticipated. These latter factors may, at times, have impeded their capacity to deliver the service as intended.

Support was voiced for a universal intensive service in the first postnatal months, but that had the capacity to target sub-groups of women with higher levels of identified need.

The project demonstrated that an individual family level, more intensive home visiting could provide a more supportive and family-centred approach within which health promotion could be effectively embedded. The challenges of maintaining this approach within the constraints imposed by growing caseloads and within a mainstreaming agenda are significant.

4.3 Implementing a new model of home visiting

Starting Well set itself the challenge of not only delivering an intensive home-visiting service but of implementing this through delivery mechanisms that provided a potential challenge to existing professional remits and structures. In a relatively short space of time Starting Well developed two project teams that incorporated a new type of worker (the health support worker) alongside a professional group of long-standing (health visitors).

This delivery mechanism threw up a series of challenges and variable progress was made in response to these. Here we draw out the key findings in relation to two main issues: the degree to which Starting Well was able to change health-visiting practice; and, the extent to which the project's health support worker model has worked.

4.3.1 Changing health visiting practice

The health visitors within the teams were encouraged to adopt an evidence-based and standardised approach to their practice. In reality, whilst many developed a broader understanding of the health and social issues affecting the families that they were dealing with, the extent to which a consistent approach to the quantity and quality of visiting that was undertaken is less clear. Health visitors continued to argue for the need to practice in a less standardised and more intuitive manner that cannot be entirely reconciled with a more managerial perspective (Robinson, 1995) and many demonstrated a degree of hostility to the Starting Well approach that they were being asked to implement. **This has wider implications for the use of standardised family health plans as recommended by Hall (2003) and more generally for the implementation of Nursing for Health (Scottish Executive, 1999).**

Over time the project acted as an advance demonstration of the kind of targeted intensive support within the context of universal provision that is recommended by Hall (2003). Assumptions about the ease of identifying the most vulnerable families were challenged over the course of the project and a need for flexible and ongoing approaches to identify vulnerability eventually recognised. **A high level of interaction with all families over the first six months of a baby's life was viewed as key in developing the kind of trusting relationship that would facilitate future disclosure of vulnerability – this is a major challenge within generic caseloads.**

In considering the success of the two project teams in influencing their wider LHCCs, context is everything. The projects developed in very different ways as a result of their individual team members, the dynamics between them and the organisational culture within which they were located. **Those charged with mainstreaming Starting Well practice should be alert to the potency of context. In addition, the degree to which the Starting Well model will be 'diluted' through integration with GP practices will be dependent on the project team members, the GP practices and the wider LHCC. These same factors will impact on whether a more discrete team of skilled workers manages to broaden the practice of other staff within an LHCC.**

In relation to skill mix with nursery nurses and community support facilitators, the project illustrated some of the possible ways in which different professionals can work together to tackle need. However, a lack of role clarity remained within the project teams by the final year of Phase I. More explicit support mechanisms for nursery nurses were required. **The addition of a professional group in small numbers to existing primary care staff requires time, training and support at a local as well as at a more strategic level. Without these individuals can flounder and integration stall.**

By the end of the project, health visitors believed that they had done far less of a community support nature than they had originally anticipated but many were not concerned by this and had come to the view that this was not an area of practice that they had a particular wish to develop. **This has implications for ensuring that community development approaches to child and family health become part of routine primary care (Hall, 2003). Community development is unlikely to happen if left to chance and should be planned at the strategic level rather than left to the personal preferences of individual members of staff.**

The process of implementing the project's home visiting model raises some important questions about a number of assumptions with Nursing for Health and Hall Four. At the very least it highlights the hugely resource intensive effort required to change practice *effectively*. Particularly where members of a professional group are not wholly supportive of change, then introducing the tools of standardisation and skill mix approaches, much less changing approaches to interacting with families and communities, cannot be tackled lightly.

4.3.2 The Health Support Worker Model

A key element of the Starting Well home visiting model was the employment of health support workers from the local communities. These workers developed very diffuse and flexible roles that varied between the individuals; different health visitors also deployed them in different ways. The lack of role clarity did not appear to be problematic for the support workers themselves although some health visitors found these variations difficult to manage. A specific concern arose about the extent to which some health support workers were able to maintain professional boundaries in their relationships with service users as a result of their access to the real life complexity of families' lives. Reflective practice and supervision should be an explicit and continuous part of the support that such workers receive in this and similar interventions.

In general health visitors were positive about the role played by these additional workers and, in particular, the part played by those support workers that they worked most closely with.

Nonetheless, stories of negative experiences with health support workers were told. It is important that, whilst lessons are learned from critical analysis of incidents that go wrong, individual stories are not generalised to a wider group of workers.

A further layer of innovation in the health support worker model was that the staff were employed, trained and managed by One Plus, a voluntary sector organisation. This offered the workers support from an organisation with expertise in employing those re/entering the labour market and was part of the project's strategy for tackling social inclusion.

Perhaps inevitably this dual management structure led to some difficulties at an operational level with staff perceiving there to be a distinct lack of clarity over the day-to-day management of caseloads. This became a major stressor for many of the health visitors and senior managers attempted throughout the project to resolve this issue. However, those at a strategic level acknowledged that the close involvement of a voluntary sector organisation allowed a supportive work culture for the local workers that would have been inconceivable within the NHS. The problem remained however that health visitors had viewed the support workers as a means of alleviating their caseloads and instead found themselves with a significant supervisory role without always seeing their own work-load reduce. **More work at the beginning and throughout the project in ensuring health visitor ownership of the social inclusion aims of the support worker model may have been valuable. This issue will become increasingly salient for public sector organisations as they devise ways of expanding their workforces to those outside the current labour market. Health care organisations that plan to complement their existing professional workforces in the future will need to be clear about the purpose, management and support of paraprofessional staff. Existing staff who are expected to share in operational management roles would benefit from early and ongoing consultation and more realistic assessments of the impact of change on existing workload.**

4.4 Delivering community and strategic change

To help conceptualise the progress made in delivering both community level and wider strategic change we represented the direction of travel from identifying to tackling community health needs in 5 stages. These were:

Step 1 – that the process of intervening intensively with individual families would result in an understanding within project teams of key community health needs;

Step 2 – that a shared understanding of these needs would feed into local implementation groups; which

Step 3 - would develop and support local, community solutions; that,

Step 4 - if unable to be resolved locally would be referred to the project steering group; which

Step 5 - would act as an advocate for more strategic, Glasgow-wide solutions.

Our findings in relation to these stages are summarised below.

Step 1

Despite the limited degree to which health visitors were able to engage with the community support aims of the project, more intensive contact with families appeared to help them understand health needs at a community level. This understanding was also shaped by communication within the project teams, working with other agencies and pre-existing knowledge of the local communities. A wide range of needs was identified but none were believed to be 'new' issues.

Step 2

The process of sharing perceptions of community level need was rather haphazard within the two project teams and its success appeared to be a function of the level of collaborative working, with one team in particular demonstrating a significant lack of cohesion.

The increasing burden on health visitor caseloads and the early lack of clarity in the role of the community support facilitator (as perceived by other members of the project teams) led to a lesser emphasis on advocating for community change within the health visitor role. **Once again, this questions the assumption that health visitors and the changing systems with which they work, are ready for the challenges posed by key policy documents such as Nursing for Health.**

Step 3

The local implementation groups were perceived to have been successful in disbursing monies from their development funds to local organisations but less effective in securing representation from both key statutory agencies and local parents.

The role of the community support facilitators and the bilingual worker became key in bringing about more sustainable changes at a local level and in liaising with other relevant child health fora. **Whilst there is evidence of much good practice at a local level, the implementation groups suffered from the poor community and statutory representation that plagues health and social care projects more generally. More strategic influence is required to build the capacity of local planning groups.**

Step 4

During the course of Phase I of Starting Well, only a small number of issues were passed from the local implementation groups to the project steering group. None of these resulted in significant change at a strategic level and the members of the local implementation groups showed little knowledge of the role of the steering group. **As with many complex interventions a lack of connection between the city-wide and the local; and between the strategic and the operational, served to limit the effectiveness of organisational structures that were established. These connections should be planned, supported and resourced more explicitly.**

Step 5

The project steering group did not succeed as a mechanism for strong partnership working around the child and family health problems experienced in poor communities. A lack of ownership of the project beyond the health partners, and a lack of commitment to tackling broader strategic questions were evident. On the other hand, there was some evidence of more constructive strategic work occurring 'behind the scenes'. **The evaluation of a range of policy interventions across the UK, and beyond, supports the view that partnership working is not the natural modus operandi but is a long hard process requiring commitment at a number of levels. Given that partnership working lies at the heart of current public policy (Barnes et al, in press), this requires to be taken seriously. More time at the beginning of the project in establishing aims around partnership working and of developing specific partnership approaches to issues arising through the project might have been useful. In addition, the steering group suffered from a lack of opportunity to work together to resolve practical issues and this fostered a serious dip in enthusiasm for the project. Partnership is not simply established through the convening of a group but requires ongoing engagement, training and cultivation.**

Whether or not the initial aims were appropriate it is clear that Starting Well did not, for example, demonstrate the step change that it aspired to as measured by the most important health related outcome that we investigated, and nor did the process of service development and delivery run as smoothly as predicted. Despite this, however, the complexity of the Starting Well experience should be recognised. It was highly valued by many of the staff and individuals involved, and there are valuable lessons to be learnt from it about the implementation of future initiatives. It may even be that further analysis of the quasi-experimental data will show stronger intervention effects. There is also a possibility that such effects only emerge as the Starting Well children get a little older, provided that attempts are made to look for them. The case for doing so will be made in due course. For now we conclude with a consideration of some of the reasons why Starting Well has not met all of the expectations of those who commissioned and designed it.

4.5 Demonstration Projects – Final Considerations

In this concluding section we draw together a number of conclusions and reflections on the process of designing, implementing and learning from a Demonstration Project such as Starting Well. In particular we look at the following issues: project planning; the meaning of ‘demonstration’; the use of the existing evidence-base; and, achieving professional and organisational change.

4.5.1 Project Planning

As with almost all projects operating in a complex setting, Starting Well struggled to develop detailed programme plans that were wholly testable and many of the targets that they set were felt, by some stakeholders, to be unhelpful in terms of unleashing creative approaches to tackling inequalities in child health. On the other hand, unlike many such initiatives, the project placed a relatively strong focus on monitoring systems that would allow their plans to be verified. **Project planning requires to strike a balance between constriction and chaos. Planning and monitoring change in complex systems require time and capacity development; these were in short supply at the point of commissioning the Demonstration Projects. It is positive that this has been recognised at a national level in commissioning Phase II although the meshing of independent evaluation findings with the development of this second phase has been rather clumsy with very little time allowed for evaluation findings (both external and internal) to feed into the planning process. The precise model of project planning utilised within a future phase of the project is probably much less important than that planning is both systematic and flexible so that learning continues to be captured about what is working well. Careful planning should therefore be viewed as a help rather than a hindrance to strategic management.**

4.5.2 What is Meant by ‘Demonstration’

Project commissioners, planners, implementers and evaluators have grappled with the meaning of the term ‘demonstration’ and the tension that it contains between the application of an existing evidence base and the encouragement of innovative approaches to intractable problems. Once again, this phenomenon is not new to the Scottish Health Demonstration Projects (Judge et al, 2004) and nor is it a purely academic point. Demonstration Projects find themselves criticised for responding to their policy circumstances by those who believe that an intervention should be evidence-based and static; and, for implementing irrelevant interventions by those who believe that projects have a primary duty in providing lessons about the here and now. **Far greater clarity and consensus is required for future projects**

and for Phase II of Starting Well if the project is to avoid being pulled in two opposing directions. This is particularly salient in relation to the debate around the most appropriate 'model' of Starting Well where stakeholder expressed concerns that current policy thinking about 'integration' as a primary goal, will force the project down a particular road regardless of its initial aims and underlying principles.

4.5.3 The Use of the Evidence-Base

Related to the discussion of what is meant by 'demonstration' is the question of the robustness and contextual applicability of the existing evidence base. As described earlier, Starting Well drew extensively on the US literature on home visiting and, in particular, was shaped by the work of Olds and Kitzman (1993, 1997, 1998). The essence of this evidence-base is that, compared with standard health care provision, intensive home visiting had significant impacts on a range of child and family health related outcomes. However, recent reviews (Elkan et al, 1999; Bull et al, 2004) suggest that this evidence base is far from conclusive and that much further work is required before our knowledge of the impact of home-visiting can be described as robust. In addition, the complex nature of home and health visiting (Gomby date; Elkan et al, 1999) makes this an evidence base that is not straightforward to implement and there were a number of ways in which Starting Well departed from the Olds model. These included:

- The targeting of deprived *communities* rather than vulnerable *individuals*;
- The inclusion of *all new* babies as opposed to only *first* babies;
- A lesser focus on the antenatal period due to caseload issues than recommended by Olds;
- The use of *paraprofessionals* as part of the home-visiting delivery mechanism in addition to professional health visitors;
- The vastly different primary care context within which the evidence was derived (for example, the absence of a universal health visiting service; and related to this,
- The requirement to integrate aspects of project delivery with *existing professional and organisational structures* as opposed to an *entirely standalone intervention*.

In assessing the degree to which demonstration projects have or have not applied evidence-based practice, the complexity of the application of evidence needs to be considered. For a range of contextual, methodological, practical and philosophical reasons it may not be appropriate to transpose evidence from one setting to another.

4.5.4 Achieving Professional and Organisational Change

A final reflection emerging from our evaluation and supported by experience across a range of similar projects is that there is a chronic lack of realism expressed in the commissioning and planning of projects when it comes to goals around professional and organisational

change. **Implementing new ways of working within and across professional boundaries; and, establishing meaningful community and partnership approaches should not be viewed as straightforward, uniformly supported or inevitable outcomes of delivering a project. Greater realism will be required to turn around well-established ways of working.**

Notwithstanding the very real issues of design and implementation highlighted above, there is much to learn from the Starting Well experience. Although the commitment to improving the early years experience of the poorest children is not in doubt, the evidence base to guide effective action is less secure than once was thought (Elkan et al, 1999; Bull et al, 2004). This is particularly true of home visiting programmes in the UK. In these circumstances, the renewed emphasis on promoting social justice by reducing child poverty in all its forms, and the growing recognition of the importance of evaluating promising public health interventions exemplified by the second Wanless report (Wanless, 2004), suggest that the lessons to be learnt from Starting Well are important ones that should not be neglected.

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Appendix I: The Starting Well Independent Evaluation Grant holders and Research Team

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Appendix II: Presentations and Publications

Conference Presentations:

Blamey A, Coppel D, **Judge K, and Mackenzie M** (2000) UK Evaluation Society, London, 'Eliciting Theories of Changes – The Theory and the Practice in English Health Action Zones and Scottish Health Demonstration Projects'

Blamey A and **Mackenzie M** (2001), UKPHA, Bournemouth, 'Using Theories of Change to evaluate complex interventions: proposed evaluations of two Scottish Health Demonstration Projects'

Blamey A and **Mackenzie M** (2001), UK Evaluation Society, Belfast, 'The Practice of a Theory-Based Approach'

Blamey A and **Mackenzie M** (2002), UKPHA, Glasgow, 'The Theory of Change: A useful approach or the emperor's new clothes'

Blamey A and **Mackenzie M** (2001), Scottish Social Research Association, Edinburgh, 'The practice of a Theory Based Approach'

Blamey A and **Mackenzie M** (2002), European Evaluation Society, Seville, 'The Practice of a Theory-Based Approach'.

Blamey A and **Mackenzie M** (2002), Belfast Healthy Cities, Belfast, 'Using a Theories of Change Approach: examples from the Scottish Health Demonstration Projects'

Blamey A and **Mackenzie M** (2003), UKPHA, Cardiff, 'The implementation of an intensive model of home visiting: early lessons from Starting Well'

Blamey A and **Mackenzie M** (2003), UK Evaluation Society, Cardiff,

Blamey A and **Mackenzie M** (2004), Seminar - Research Unit in Health and Behavioural Change, Edinburgh

Gray R (2001) 'Starting Well', the Scottish Child Health Demonstration Project: Project description and plans for evaluation'. Delivered at UK Faculty of Public Health Medicine, Annual Scientific Meeting, Glasgow.

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Mackenzie M and Blamey A (in press) The Practice of a Theory-based Approach: Lessons from the Application of a Theory of Change Approach, *Evaluation*

Shute J and **Judge K** (in press) Evaluating 'Starting Well', the Scottish National Demonstration Project for Child Health: Outcomes at six-months. *Journal of Primary Prevention*.

Appendix III: Key outcome instruments

a) the Infant-Toddler HOME Inventory (Bradley & Caldwell, 1979)

Please note that we cannot include the HOME interview booklet for reasons of copyright. The interested reader can, however, obtain further details on instrumentation and key references from the dedicated site: <http://www.ualr.edu/~crtldept/home4.htm>

b) the Edinburgh Postnatal Depression Scale (Cox, Holden & Sagovsky, 1987)

Prompt: 'Please read the following statements and then tick ONE box after each one'

1. I have been able to laugh and see the funny side of things

- as much as I always could
- not quite so much now
- definitely not so much now
- not at all

2. I have looked forward with enjoyment to things

- as much as I ever did
- rather less than I used to
- definitely less than I used to
- hardly at all

3. I have blamed myself unnecessarily when things went wrong

- yes, most of the time
- yes, some of the time
- not very often
- no, never

4. I have been anxious or worried for no good reason

- no, not at all
- hardly ever
- yes, sometimes
- yes, very often

5. I have felt scared or panicky for no good reason

- yes, quite a lot
- yes, sometimes
- no, not much
- no, not at all

6. Things have been getting on top of me

- yes, most of the time I haven't been able to cope at all
- yes, sometimes I haven't been coping as well as usual

- no, most of the time I have coped quite well
- no, I have been coping as well as ever

7. I have been so unhappy that I have had difficulty sleeping

- yes, most of the time
- yes, sometimes
- not very often
- no, not at all

8. I have felt sad and miserable

- yes, most of the time
- yes, quite often
- not very often
- no, not at all

9. I have been so unhappy that I have been crying

- yes, most of the time
- yes, quite often
- only occasionally
- no, never

10. The thought of harming myself has occurred to me

- yes, quite often
- sometimes
- hardly ever
- never

Scoring: each item is scored from 0 ('least depressed' response) to 3 ('most depressed' response) and a summary score with possible range of 0-30 constructed.

Appendix IV: Contextual comparisons of study areas

IV.1 Introduction

This chapter, as part of Aim 2.3c, does not comment directly on the operation or effectiveness of the intervention, but aims to describe dimensions of area context that might be hypothesised to influence health-related outcomes over-and-above the important individual-level characteristics identified in section 2 of this report. The dimensions considered (derived from census, routine and cohort data) are not intended to be exhaustive but illustrative and include: basic demography; material and built environment; health; and social context. By making descriptive contextual comparison between intervention and comparison-areas, we aim to complement the impact study findings and to explore the potential for separating out individual- and area-level effects more formally using multi-level analyses. More broadly, we aim to illustrate the kinds of area-level factors that may indirectly influence the effectiveness of the intervention.

IV.2 Methods

This section describes the process of defining study areas and the various measures used.

IV.2.1 Area definitions

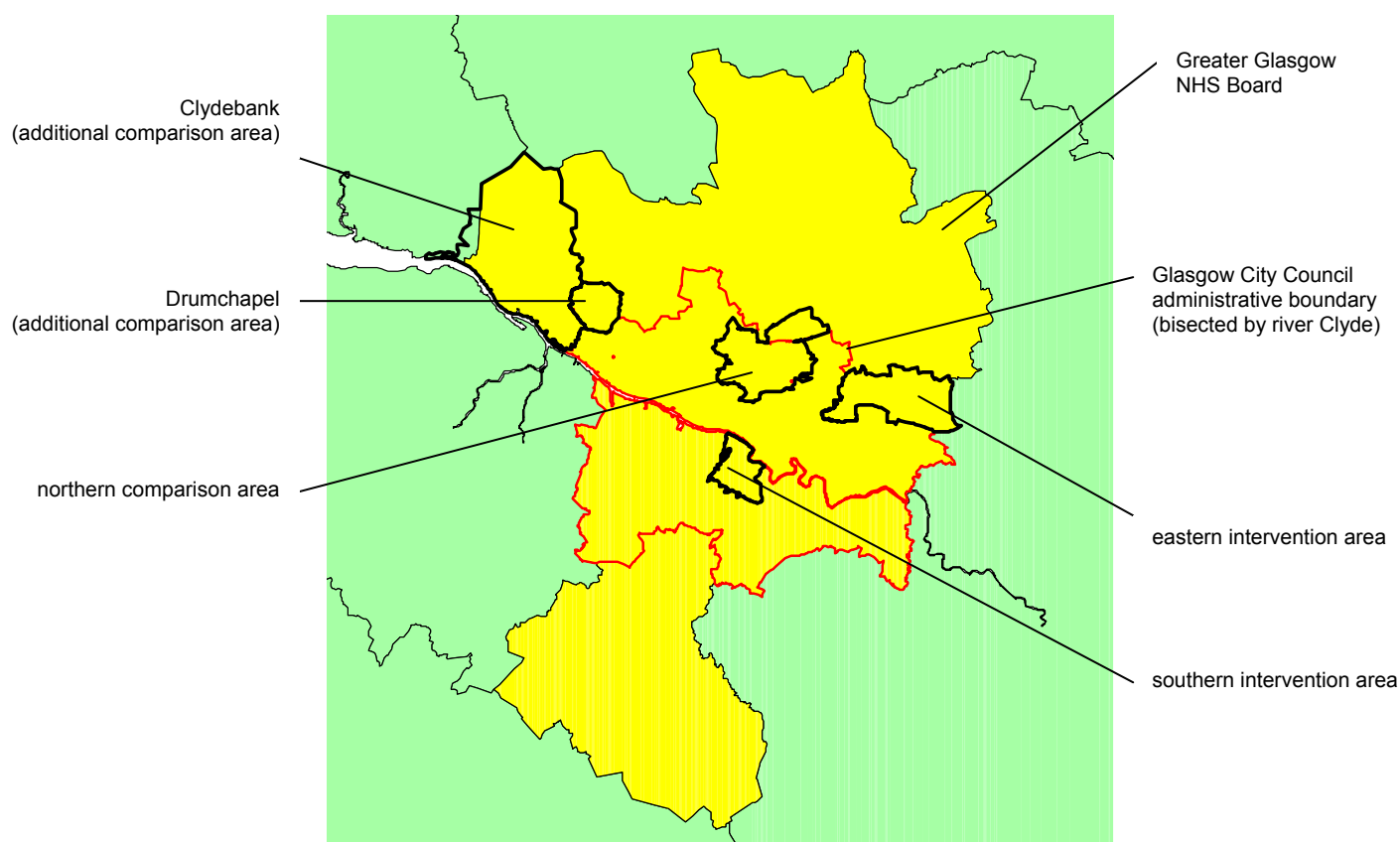
Problems of definition: Any attempt to describe area context must first define 'area'. This is far from straightforward as the operational definitions of service-providers rarely match the administrative boundaries at which contextual data are available (e.g. council wards, postcode sectors, census units). The task is further complicated by the fact that administrative boundaries change over time. This section describes a functional definition of 'area' based on combinations of whole postcode sectors, the boundaries of which were fixed in 2001⁴⁴. The use of postcode sectors to define area fulfils two important criteria: first, it permits the collection and comparison of aggregated (e.g. 2001 Census) data; and second, approximates to the geographies in which services were offered.

General orientation: figure IV.1 (below) shows approximations of study areas relative to the administrative boundaries of Greater Glasgow NHS Board and Glasgow City Council. Note that the geographic size of each area is not proportional to its resident population (see table IV.1), however, the 'northern' comparison is roughly as populous as the 'eastern' and 'southern' intervention areas combined.

⁴⁴ Digitised boundary data obtained from the UKBORDERS service: <http://www.ukborders.ac.uk>

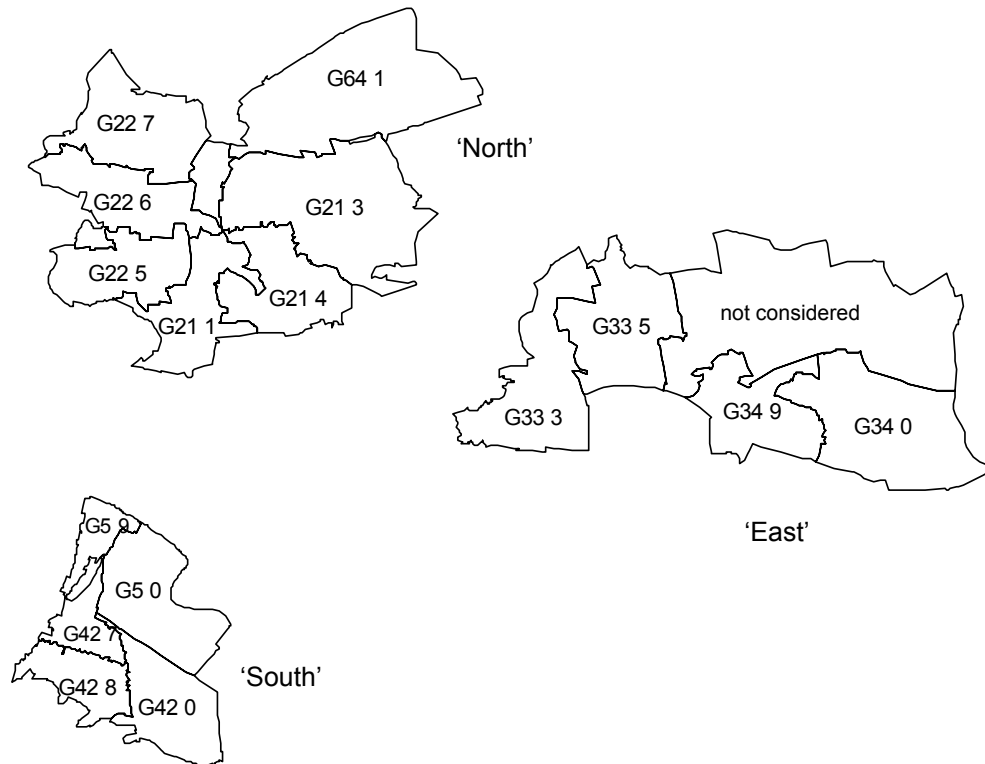
Intervention areas: At the outset of the project, the ‘eastern’ intervention area was defined to consist of four postcode sectors (G33 3 and 5; G34 0 and 9, see figure IV.2) covering the ‘communities’ of Cranhill, Ruchazie, Craigend, Garthamlock, Easterhouse and Gartloch. Since the initial proposal, the boundaries of these postcode sectors have changed and now include G69 8. This postcode sector is included in figures IV.1-IV.3 in order to reflect both geographic contiguity with G34 0 and 9 and the fact that the intervention was offered here, however, its very low population count means that fewer census and routine statistics are available and it is therefore not included in the analyses below. The ‘southern’ project area was also operationally defined by geography but not in terms of whole postcode sectors. We define it here to consist of the postcode sectors G5 9 and 0; G42 0, 7 and 8 (the ‘communities’ of Gorbals/Hutchesontown, Oatlands, Polmadie, Govanhill and north Toryglen), although the service was not offered to all residents in G42 8 (Govanhill) or G42 0 (Oatlands)⁴⁵.

Figure IV.1: Study areas in relation to local administrative units



⁴⁵ Further details can be obtained from the project team.

Figure IV.2: Postcode sectors of areas analysed in this section



Comparison areas: in contrast to the above, comparison ‘areas’ were defined as part of the independent evaluation impact study and related to a population of births visited over a specified period by GP-attached health visiting teams⁴⁶. The teams visited families registered at specific surgeries and consequently there was a strong but not defining geographic focus to the caseload. In order to permit comparative analysis of census and routine data *and* summarised cohort data (e.g. on social context - see below), we have defined the comparison area as contiguous postcode sectors in which the clear majority of survey respondents lived at the eighteen-month assessment. Eight-one percent (99/122) of respondents lived in the following postcode sectors: G21 1, 3 and 4; G22 5, 6 and 7; G64 1⁴⁷. Other postcode sectors with large populations but that provided few survey respondents⁴⁸ were not included in analysis due to the possibility that they would skew comparisons of census data whilst having relatively little impact on cohort measures. Figure IV.2 shows each postcode sector used in analysis, key properties of which are described below in table IV.1.

⁴⁶ see definitions in section 2.2.1, page 14.

⁴⁷ in analyses not shown, this sub-sample of comparison families were found to be non-significantly less affluent than the ‘full’ cohort

⁴⁸ for example, those composing the ‘additional’ recruitment areas of Drumchapel and Clydebank

Table IV.1: Persons and households by postcode sector and study area (2001 Census data); resident cohort members at 18-months by study area (cohort data).

Area	Postcode sector	Persons	Households	Cohort n
North	G64 1	495	210	
	G22 5	10491	2795	
	G22 6	6004	3127	
	G22 7	7165	3166	
	G21 1	7698	4023	
	G21 3	10491	4459	
	G21 4	8050	4181	
TOTALS (comparison)		45161	21961	99
South	G5 0	5753	3190	
	G 5 9	2415	1503	
	G42 0	5365	2632	
	G42 7	4683	2551	
	G42 8	10034	5136	
		28250	15012	81
East	G33 3	6964	3009	
	G33 5	5376	2398	
	G34 0	5713	2488	
	G34 9	4567	1999	
		22620	9864	104
TOTALS (intervention)		50870	24906	185

The table demonstrates that whilst the total number of persons and households in intervention and comparison areas are roughly comparable, around twice as many intervention cohort members were available for analysis. This latter fact reflects the selection of a sub-set of comparison postcode sectors and the lower opt-in rates described in section 2.

IV.2.2 Dimensions of context and associated data

In selecting relevant dimensions of context, our general approach was to gather data that was available at the appropriate level (postcode sector or smaller) and that either illustrated basic and relevant aspects of demography and population health, or that could be hypothesised to influence child health and well-being directly or indirectly (e.g. by impacting on caregivers). The following domains were of interest:

Aspects of general demography: One simple contextual difference may be the proportion of pre-school children (aged 0-4) in the local populations; this was established at the postcode sector level from 2001 Census table UV04⁴⁹. In addition, information on population mobility was collected as indexed by the proportion of people not resident at their current address one year previous to April 2001 (table UV52). Whilst this has no direct effect on child health, it

⁴⁹ All 2001 Census data was downloaded from the General Register of Scotland's 'Scottish Census Results On-Line' (SCROL), accessed at <http://www.scrol.gov.uk>.

may affect parental 'stake' in the area and the ability to maintain the kind of effective social networks that could predict better health (see below). Census data on ethnic group was not available at postcode sector level due to disclosure concerns. Finally information on household tenure (specifically the proportion of social rented housing) was derived from CAS table UV64.

Material and built environment: Low socio-economic position and associated poverty has the potential to impact on child health and development by adversely affecting family processes and the resources available to caregivers. We indexed this at the postcode sector level from CAS tables UV76 (the proportion of adults classified as National Statistics Socio-Economic Class 8: never worked and unemployed) and CAS031 (% workless parents aged 16-74 and with dependent children). Adverse living conditions relating to the built environment also have the potential to affect health. We gathered data on two relevant domains: overcrowding, as indexed by the proportion of households with more than one person per room (CAS052); and high-rise living (the percentage of residents living on the 5th floor of a building or higher: CAS020).

Health: Two postcode sector level child-relevant datasets (both relating to 2001) were obtained from Scottish Neighbourhood Statistics (<http://www.sns.gov.uk>). The first indexed the rate/1000 births of low birthweight children (<2500g); the second the rate/100000 population of children (aged 0-14) admitted to hospital due to accidental injury. Finally, an indication of the self-reported health of resident women of childbearing age (16-49) was derived from CAS table 025.

Social context: In contrast to the above variables which were all derived from either the 2001 Census or routinely available medical data, social context variables were constructed from the aggregated responses of impact study participants. Proceeding from reviews relating area-level social dynamics to a number of dimensions of child health and well-being (see e.g. Sampson, Morenoff & Gannon-Rowley, 2002), a range of measures were included in the 18-month survey:

- 'Global' social capital. The sum of four scored items derived from the ONS Social Capital Question Bank (ONS, 2002): 'generally speaking, most people can be trusted'; 'generally speaking, people help each other out'; 'by working together, people here can influence decisions that affect the area'; and 'this area has a good reputation'. Each item was scored 0-4 on a five-point Likert-type strength of agreement response set ('strongly disagree' = 0 to 'strongly agree' = 4, with 'not sure' scored as '2'), resulting in a measure with a possible range of 0-16.
- Perceptions of child-relevant area safety. A measure developed 'in-house' and derived from four items relating to: the general safety of the area for play; safety for play after dark; safety of local playgrounds and parks; and local roads. Respondents rated each

item on a four-point scale ranging from 'very unsafe' (scoring 0) to 'very safe' (scoring 3). An overall score was constructed by summing responses (possible scoring range 0-12).

- Informal social control. From Sampson, Raudenbush & Earls (1997), the perceived likelihood of neighbours intervening in three situations involving children's anti-social behaviour (truanting and 'hanging around'; spraying graffiti; showing disrespect to an adult). An overall score (range 0-12) was constructed from combining responses to a five-point likelihood rating ('very unlikely' = 0 to 'very likely' agree' = 4, with 'not sure' scored as '2').
- Parenting-relevant reciprocity. Another 'in-house' measure expressing the sum of six items rating the frequency with which: respondents look after neighbours' children; have neighbour's children round to play; both these favours are returned by neighbours (two separate items); respondents talk to neighbours about their children; and exchange information or advice about parenting. All items were rated on a four point scale ('not at all' = 0 to 'very often' = 3), and an overall score with a possible range 0-18 constructed.
- The extent to which supporting parents is a local priority (measure developed 'in-house'). Using the same response set as for the social capital items, the extent to which respondents agreed with the six statements: 'people around here look out for each other's children'; 'this is a good area to bring children up in'; 'most people around here can be trusted with children'; 'if a parent with a young child was standing on a bus, people would give up their seats'; 'people around here hold shop doors open for parents with pushchairs; and 'bringing up kids well is a priority for people in this area'. An overall score (possible range 0-24) was constructed.

IV.3 Comparisons

IV.3.1 Highest level of aggregation: intervention and comparison areas

Table IV.2 compares aggregated census and routine data measures across intervention and comparison areas. Beginning with basic demography, the two areas are very similar in terms of the proportions of children aged 0-5 but the combined intervention areas have significantly more mobile populations and significantly fewer social rented properties. This latter statistic is likely to reflect a high percentage of private rented properties in the southern sub-area of Govanhill. In absolute terms, however, the proportion of social rented housing is high.

Table IV.2: comparisons of intervention and comparison areas on selected 2001 Census and routine data

Dimension	Measure ^a	INTERVENTION	range ^b	COMPARISON	range	z ^c	sig.
Demography							
Age structure	% children aged 0-5 (p)	7.27	4.4-9.4	7.0	5.0-8.7	1.62	.105
Population mobility	% moved in last year (h)	13.35	7.0-19.4	12.21	9.1-16.2	3.67	<.001
Tenure	% social rented (h)	51.6	16.6-76.2	59.22	14.8-80.3	-16.6	<.001
Material/built context							
Socio-economic group	% NS-SEC Class 8 (p)	12.35	10.7-17.1	11.94	4.3-15.7	1.67	0.09
Worklessness	% parents workless (p)	44.7	33.5-67.3	46.6	23.3-59.4	-2.54	.011
High-rise living	% 0-4 yr olds living on 5 th floor + (p)	0.43	0- 1.66	0.73	0.15-1.84	-5.98	<.001
Overcrowding	% >1 person/room (h)	3.78	1.8-6.1	3.53	2.8-4.2	1.41	.159
Health							
Low birthweight (<2500g)	rate/1000 births	92.9	60.9-168.7	70.2	30.5-94.1	-	- ^d
Self-reported health	% women 16-49 'not good' (p)	14.2	9.1-19.9	15.2	8.0-18.0	-2.21	.027
Accidental injury	rate/100,000 (children 0-14)	2087	1.5-2.8K	1896	1.2-3.1K	-	- ^d

Notes:

^a in this column, (p) refers to 'persons' and (h) refers to 'households'

^b in terms of values for constituent postcode sectors

^c statistic for comparison of proportions

^d significance tests were not possible due to the unavailability of numerator and denominator information

Moving onto material and built context, the intervention area has a non-significantly higher proportion of people classified as NS-SEC Class 8 (never worked and unemployed) and contains a higher proportion of overcrowded households high-rise housing and a non-significantly higher proportion of workless parents⁵⁰.

Finally, regarding health indicators, the intervention areas have higher rates of low birthweight children and hospital admissions due to accidents. In contrast, the self-reported health of intervention women was significantly better than in comparison areas.

Data relating to area-level social context is displayed in table IV.3. Comparison area families score slightly more highly on every measure, although only significantly so in relation to levels of informal social control.

Table IV.3: comparison of social context variables by main study area

Measure (minima & maxima)	INTERVENTION		COMPARISON		p ^a
	mean (s.d.)	n	mean (s.d.)	n	
'global' social capital (0-16)	8.45 (2.99)	172	8.77 (3.16)	98	.41
perceived area safety (0-12)	4.41 (2.81)	172	4.94 (2.77)	95	.14
informal social control (0-12)	6.31 (3.24)	174	7.59 (3.08)	96	.002
reciprocity (0-18)	5.23 (4.54)	172	5.41 (4.00)	96	.75
prioritising parenting (0-18)	13.54 (4.64)	171	13.88 (4.85)	96	.58

Note: ^a in all cases, the p-value relates to an independent t-test (details available on request)

It is important to note, with all the comparisons made in tables IV.2. and IV.3, that even very statistically significant group differences are not the product of very marked or obvious differences in means and proportions. The nature and meaningfulness of these results are discussed in the final sub-section below.

IV.3.2 Lower levels of aggregation: 'east' and 'south'; postcode sector

As with the impact study, the primary comparative focus of this section has so far been at the level of intervention versus comparison area(s). We now turn briefly to an illustration of the kinds of variation observed at lower levels of aggregation.

a) 'East', 'south' and 'north': one obvious source of comparison is within-intervention, that is between eastern and southern areas. Tables IV.4a and IV.4b, respectively, compare the east, south and north (comparison) areas on two dimensions of social context and two census-derived variables. It can be seen that the aggregated intervention measures described above

⁵⁰ This latter statistic seems at odds with the impact study finding that the intervention cohort are more disadvantaged than the comparison cohort. This may be due, however, to the fact that the census data refers to parents with dependent children of *all* ages; parents of the youngest children may compose a more disadvantaged sub-group.

mask variation at this lower area level. Specifically, with regard to levels of informal social control (table IV.4a), analysis of variance confirmed a significant group effect, but post-hoc (Bonferroni) tests revealed no significant difference between eastern and northern area means; significant differences existed between southern and eastern and between southern and northern means only. Similarly, a significant group effect was obtained for the 'prioritising parenting' measure but the only significant difference in group means was between eastern and southern project areas.

Essentially the same point can be made regarding variation in census data (table IV.4b): the higher level of residential mobility observed in the intervention area (see table IV.2) is largely the product of high mobility in the southern area; the eastern figure is actually lower than that for the comparison area. Similarly, overcrowded households are substantially more common in the eastern as opposed to the southern project areas.

Table IV.4a. Comparing selected social context measures: east vs. south vs. north

Measure (minima & maxima)	SOUTH		EAST		NORTH		p ^a
	mean (s.d.)	n	mean (s.d.)	n	mean (s.d.)	n	
informal social control (0-12)	5.65 (3.14)	79	6.87 (3.23)	94	7.59 (3.08)	95	<.001
prioritising parenting (0-18)	12.52 (4.65)	75	14.34 (4.50)	96	13.88 (4.85)	96	.036

Note: ^a p-values relate to one-way analysis of variance (ANOVA).

Table IV.4b. Comparing selected census-derived measures: east vs. south vs. north

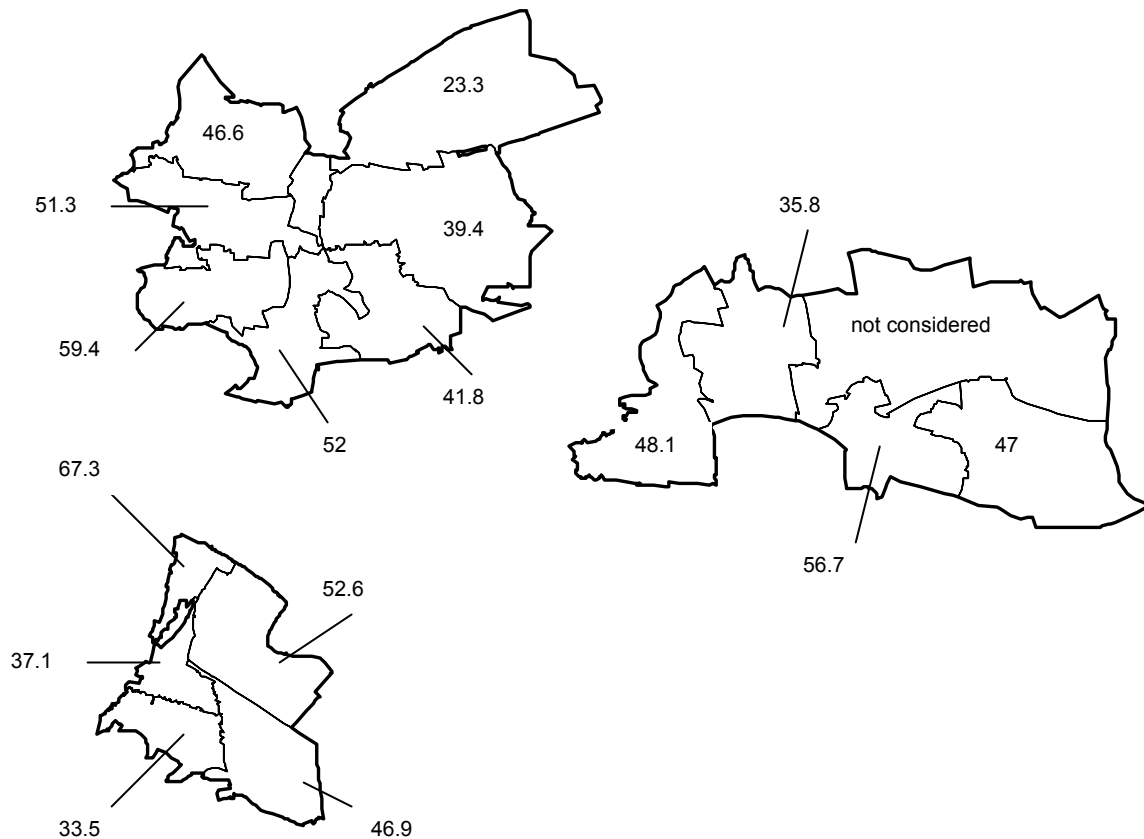
Measure	SOUTH	range	EAST	range	NORTH	range
% households moved in last year	15.1	10.9-19.4	10.7	7-14.2	12.2	9.1-16.2
% households with >1person/room	2.8	1.8-3.8	5.3	4.8-6.1	3.5	2.8-4.2

It might be reasonable to expect that a further 'community'-level analysis of the comparison area would yield similar variation.

b) Postcode sector level: Even more variation exists at smaller area levels and whilst postcode sector boundaries do not generally map well onto residents' definitions of 'community/neighbourhood', they serve to illustrate this point. Figure IV.3 depicts the variation across study postcode sectors of the percentage of resident parents (aged 16-74 and with dependent children) who are workless. This statistic is sensitive, amongst other things, to the proportion of economically inactive lone-parent families, however, two points can be made. First, as described at the highest levels of aggregation (see table 4.2), the figures are

generally high⁵¹ confirming the disadvantaged nature of the study communities. Second, there is at least twenty percentage points of variation within a particular study area and an overall range of forty-four percent (23.3 – 67.3%). The extent of this variation points to real micro-level differences in the nature of the communities served in this study.

Figure IV.3. Comparison of % workless parents by postcode sector



IV.4 Discussion and conclusions

The purpose of this section was to describe and compare the evaluation areas on dimensions of context that are potentially relevant to child health and development. Naturally, the most pertinent contextual difference between intervention and comparison areas was the *service* context and the fact that an enhanced home-visiting service was being offered in one set of areas and not the other. However, we have attempted to comment on other contextual domains including measures that reflect aspects of the material and social environment.

⁵¹ compared to a Glasgow City figure of 31.5% and a Scottish figure of 14.7% (GRO(Scotland), 2004)

Despite the various approximations involved in defining 'area' and the manifestly limited datasets available, at least three key observations may be made.

Firstly, statistics relating to material resources (e.g. parental worklessness) are stark and confirm that the areas under study are highly disadvantaged regardless of level of aggregation. The scale of this disadvantage combined with the well-described relationships between poverty and ill-health illustrate the magnitude of the task faced by 'Starting Well' and other service-providers in promoting positive changes in population health.

Secondly, whilst at the highest level of aggregation/comparison, (intervention versus comparison area), a number of highly statistically significant group differences in *census-derived* measures were found, the precise meaning of these differences remains obscure. Partly this is due to the fact that related findings are not always in the same direction⁵² but a more technical reason relates to statistical power; comparisons of census variables at area level involve very large populations of people and households which means that modest group differences translate easily into very significant statistical differences. Whilst this means that the observed differences are very unlikely to have occurred by chance, it does not mean that they are *meaningful* differences with respect to their impact on the health and well-being of residents. Given these problems of interpretation, it is difficult to reach firm conclusions about the pertinence of differences observed at this level aggregation. Additionally, whilst findings relating to *cohort-derived* social context variables are at least consistent (intervention areas seem less well-endowed than comparison areas), differences in absolute means are again typically very small. Taken together, therefore, these findings of 'no reliable area differences' have very little capacity to shed light on the conclusions of the impact study.

Thirdly, considerable variation is found for most variables at lower levels of aggregation. To an extent, this is to be expected (an aggregated statistic, by definition, averages out variation in constituent units), however, these smaller areas may be intrinsically more appropriate for considering the operation of some dimensions of context, for example, social dynamics that are the product of localised face-to-face interactions. Additionally, the amount of variation, both between intervention areas and individual postcode sectors points to the utility of carrying out at least two further sets of analyses. At its most simple, the first might involve repeating the individual-level regression analyses in section 2 but with area of residence ('east' or 'south' with 'north' as a reference category) as an additional predictor. This would help detect substantive differences in outcome between intervention areas after controlling for individual-level factors. Secondly, it may be possible to assess more formally the relative contribution of people and place to health outcomes using multi-level analysis. Candidates for appropriate 'levels' may be postcode sectors or (better) an attempt to define 'natural

⁵² for example a higher proportion of NS-SEC Class 8 residents in the intervention area but better women's self-reported health in the comparison area

communities' that, for example, respected existing community identities but could be described as aggregates of smaller data-rich units (e.g. census output areas, Scottish Neighbourhood Statistics 'data zones').

In sum, this section has shown both the difficulties of describing context meaningfully at high levels of aggregation but also the potential perhaps for more sophisticated lower-level analyses that may help tease out the relative contribution of individual and area-level factors to health-related outcomes. More extended individual-level regression analyses remain our immediate priority, however, if future opportunities can be found to explore these possibilities, we may not only explain more of the variance in outcomes but also gain a more informed sense of the kinds of emergent community-level factors that constrain and facilitate the operation and effectiveness of Starting Well.