Better Start Bradford Innovation Hub

Findings from the Implementation Evaluation of the Maternal Early Childhood Sustained Home visiting (MECSH) Pilot

End of Contract Report
July 2023

This is a report provided by the Better Start Bradford Innovation Hub (BSBIH) for the Better Start Bradford (BSB) and the MECSH team. The document provides an overview of the MECSH project, its performance and findings from the implementation evaluation for the project's pilot. The design of this evaluation is described in more detail in the Evaluation Plan Summary, which was approved by key stakeholders from the BSBIH and BSB.

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Version:

Approved by:

Produced for Better Start Bradford

Executive Summary

Project Overview

Good quality parenting and a suitable home learning environment have the strongest influence on a child's early development and their later behaviour, academic achievement and self-worth.

The Maternal Early Childhood Sustained Home visiting (MECSH) programme is a structured program of intensive home visiting, embedded within usual health visiting services. MECSH targets families at risk of poor maternal and child health and development outcomes. By supporting and empowering families, the project aims to improve parenting and the home learning environment for their children.

MECSH is an evidence -based programme which has been shown to improve parent responsivity and warmth and the child's home learning environment.

In Bradford, MECSH was commissioned by Better Start Bradford and delivered by the Bradford District Care Foundation Trust (BDCFT) in their Bradford East team. At the time (2019) BDCFT used a tiered model of health visiting, wherein a health visitor saw families in a single tier of need (universal, early help or children in need) and there were capacity concerns within the team. As a result, a new logic model was developed for a Bradford version of MECSH. This means that the theory of change and evidence base behind MECSH in Bradford might not be valid.

Aims of the Evaluation

MECSH has received an implementation evaluation over the 24 months of delivery from April 2021 to March 2023. This evaluation aimed to understand how well the project has been implemented, including whether the model components (training and supervision for the health visiting team and the series of visits and structured content for the families) were delivered as they are designed to be, and whether families were engaged and satisfied with the service.

MECSH also received an in-depth qualitative evaluation to explore the barriers and facilitators of implementation in the first year of delivery from the perspectives of the Bradford East health visiting team and service managers. Interviews and focus groups took place in January and February 2022.

Learning from the evaluation and implementation have been identified and summarised in this report to support the wider roll out of MECSH.

Executive Summary

Key Findings

Data

Codes used for MECSH families were frequently incorrectly used by health visitors outside the Bradford East team, and possibly not used correctly to capture all actibvity by HVs delivering MECSH. This made accurate interpretation of the data impossible. **If MECSH is to continue delivery, better data solutions need to be identified and implemented.**

Training and Supervision

The training and supervision components of MECSH were not able to be successfully implemented within the Bradford tiered model of HV

43% Only 43% of eligible health visitors were fully MECSH trained in year 1

50% Of all eligible health visitors in Bradford East, 15 of 30 (50%) delivered MECSH to at least one family.

0% No trained health visitors received the recommended number of supervisions to support their practice in year 1.

More than half (8 of 15, 53%) of those Health Visitors taking on MECSH families appeared to sit within Tier 3 of the service, meaning they are working with more vulnerable families, and hold smaller caseloads and have more frequent contacts with families. This is likely to provide more opportunity to engage families with the programme and more capacity to deliver the necessary visits and content to families. However, given that a key aim of MECSH is **prevention**, it is important that Health Visitors in the Universal tiers also have the capacity to screen, identify, recruit and deliver MECSH to families.

The barriers to implementation that were identified in the interviews included: The Covid-19 pandemic; Lack of staff capacity; Limitations within the tiered health visiting model.

Delivery to Families

The delivery of MECSH to families did achieve an average of one MECSH visit per family per month as would be anticipated and data suggests a good level of continuity in the care they received.

Those Health Visitors that had a MECSH caseload engaged with more MECSH supervision on average than those that didn't. Staff nurses and Nursery nurses were able to engage with both the appropriate training and supervision.

Whilst Health Visitors reported some apprehension about delivering MECSH, once they had started, the programme was highly valued by Health Visitors who saw it as an opportunity to provide Health Visiting "as it should be" delivered.

"...it's the bread and butter of health visiting, we're looking forward to delivering this, so those were my initial thoughts..."

"...it just gave us the opportunity with permission to really develop them relationships with the parents in a more structured way..."

Executive Summary

Conclusions

MECSH is designed to work within the proportionate universalism approach to health visiting, which is evidenced as the best way to prevent poor outcomes in early childhood. MECSH has been shown to improve parenting quality and the home learning environment.

Challenges in staff capacity, Covid-19 restrictions and the tiered model of health visiting (which is counter-intuitive to proportionate universalism) meant that the MECSH model had to be adapted in Bradford, this means that the theory and the evidence base behind MECSH might no longer be valid.

The training and supervision of MECSH was not able to be successfully implemented within the tiered model of HV. Key lessons have been learnt and solutions have been developed to address these issues which will ensure successful implementation of the roll out of MECSH.

Those families that were recruited to MECSH during the pilot appeared to receive the intervention as designed, and health visitors were very positive about the programme.

Recommendations

Now that the BDCFT health visiting has implemented a non- tiered model based on proportionate universalism, it will be possible to implement MECSH successfully within the system.

The lessons learnt and solutions developed from the MECSH pilot are presented on the following page. These will be important to adopt in the roll out of MECSH to ensure successful implementation.

In brief, these recommendations include:

- adapted and extended training which is a part of the role specific HV training.
- embedding of MECSH supervision within the HV supervision policy
- continuation of the MECSH Champion and MECSH specialist HV roles.
- promoting Bradford as a service that delivers MECSH, and the benefits of this programme for health visitors, might attract workforce into the city.

It will be extremely important to undertake close monitoring and evaluation of the implementation to continue to learn lessons, make adaptations as needed, and to evaluate the impact on children during the critical early years.

Executive Summary

Solutions to ensure successful implementation

The MECSH champion has revised the delivery of training and supervision to ensure that it is more successfully implemented in the roll out. This includes:

1. The addition of an "introduction to MECSH" session ahead of the foundation training within which staff complete the e-learning modules 1&2
2. Extension of the foundation training from 2 to 3 days to enable practitioners to a) look in more depth at the practicalities of actually delivering the module content and b) receive training on how to use and navigate the data capture processes and system.
3. Addition of the e-learning modules 3-6 as mandated role specific training for the HV team.
4. Embedding of the MECSH supervision model within the HV supervision policy and making sure that staff are aware of this.

Other key elements that have been identified as important to successful MECSH roll out are:

5. Raising awareness that MECSH needs to be delivered within a proportionate universalism model of health visiting
6. Having a MECSH Champion and a MECSH Specialist HV to support the roll out within the wider service by:

a) driving the agenda for MECSH with the staff and within the early years systems

b) ensure that the learning gained during the pilot can be implemented and the transition be as smooth as possible

c) provide impromptu and drop-in sessions for HVs after training / home visits to help increase confidence in the delivery of the programme.

Other key messages identified in this evaluation are that:

7. Once health visitors have had the training and support, they are able to deliver MECSH successfully, and this appears to add value and satisfaction to their work.
8. Promoting Bradford as a service that delivers MECSH, and the benefits of this programme for health visitors, might attract workforce into the city.

Project Background

Background to the Project

What is MECSH?

There is strong evidence that good quality parenting and a suitable home learning environment will have the greatest influence on a child's early development and their later behaviour, academic achievement and self-worth [1,2].

The Maternal Early Childhood Sustained Home visiting (MECSH) programme is designed to support and empower families to improve their parenting and the home learning environment for their children. This in turn will prevent poor outcomes in early child development.

The service is designed to embed within existing universal health visiting. It uses strengths based approaches and gives anticipatory guidance to support and enhance the skills and capacities of vulnerable families. MECSH has an emphasis on integrated working and enabling parents to engage with local services. It also has emphasis on increasing parents' ability to adapt and self manage. Core components of the model include the following requirements:

1. Health Visitors complete a training programme and have regular supervision from a trained member of the team

2. Trained health visitors screen all families in their caseload and offer MECSH to those who they perceive are in need.

3. MECSH families are provided with a more intensive series of visits which include structured content and focused modules (see Box 1).

4. Health Visitors provide continuous care to MECSH families to build a strong therapeutic relationship.

BOX 1: The Bradford MECSH modules:

1. **Promoting First Relationships**
Enhanced information and help for families to develop a strong attachment and positive relationship with their child

2. **Healthy Beginnings**
Promotion of a healthy lifestyle including infant feeding, nutrition, physical activity and social support.

3. **Learning to Communicate**
To enhance the ability of parents to provide stimulation for their babies, which will facilitate baby's communication development.

4. **HABIT (Oral health)**
To improve parents knowledge and behaviour of oral hygiene

What is the evidence for MECSH?

Findings from a randomised controlled trial demonstrated positive outcomes for participating mothers who were:
1. More responsive to their child [3],
2. Had fewer safety risks in the home,
3. More likely to engage in warm parenting practices,
4. Less likely to engage in hostile parenting
5. More likely to facilitate their child's learning [4].

Implementation evaluations have also demonstrated good acceptability of the programme with high levels of recruitment and retention [5].

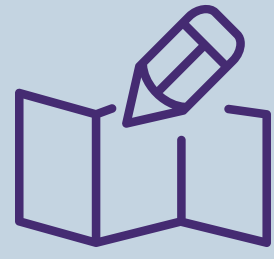
Using the Early Intervention Foundation (EIF) evidence rating scale as a framework, the Better Start Bradford Innovation Hub would suggest a rating of 3 for this project (that is, it has good evidence of impact from at least one robust trial).

Project Background

Adaptations to Bradford MECSH

In Bradford, MECSH was commissioned by the Better Start Bradford programme in 2019, and delivered by the Bradford District Care Foundation Trust (BDCFT), as part of an enhanced Health Visiting service delivered by their Bradford East team. Changes to the Health Visiting model as a part of the 0-19 Public Health Children's service recommission in 2020 posed challenges to the delivery of MECSH. The new model included a tiered model of Health Visiting wherein health visitors were assigned to work with families at one tier of need (Tiers 1-2 (Universal); Tier 3 (Early Help) or Tier 4 (Child protection and Child in need). This puts at risk the continuity of the therapeutic relationship (if a family move between tiers, their health visitor changes), and the ability to screen all families. In addition, challenges in recruitment and retention of health visitors meant that there were concerns that there was insufficient capacity to deliver MECSH to all families who need it.

As a result of these uncertainties, a new logic model was developed for Bradford MECSH, and it was agreed to deliver a pilot to explore the feasibility of delivery within the tiered health visiting model. This also suggests that the existing Theory of Change and evidence base for the programme may no longer reflect delivery in Bradford.



MECSH was delivered over a 24 month period with training and recruitment into the programme taking place from April 2021 to 31st March 2022, with continued support to recruited families continuing until March 2023.

Impact of Covid-19

Covid-19 caused delays to the planned start dates of training and implementation of the programme. Post pandemic, more health visiting was delivered online than face-to-face, which has an unknown impact on the therapeutic relationship between the practitioner and the family.

Aims of the Evaluation

MECSH received an implementation evaluation over the 24 months of delivery from April 2021 to March 2023. This evaluation aimed to understand how well the project has been implemented, including whether the model (featuring training and supervision for the health visiting team, and the series of visits and structured content for the families) were delivered as they are designed to be, and whether families were engaged and satisfied with the service.

MECSH also received an in-depth qualitative evaluation to explore the barriers and facilitators of implementation in the first year of delivery (April 2021-March 2022) from the perspectives of the health visiting team and service managers.

Learning from the evaluation and implementation have been identified and summarised in this report to support the wider roll out of MECSH.

Evaluation Findings

MECSH Training

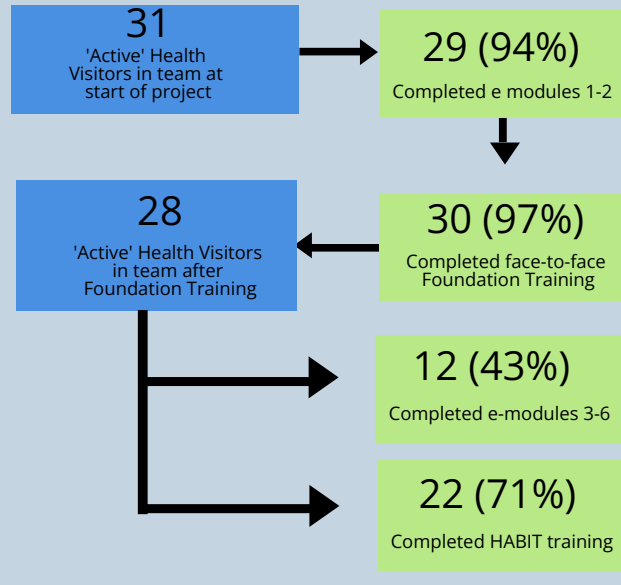
Health Visitors

Core MECSH training consists of 3 days of face-to-face Foundation training and 6 e-learning modules (1-2 ahead of Foundation training; 3-6 completed within 6 months of starting to deliver MECSH). It was anticipated that all Bradford East health visitors would complete the training, and that all health visitors who were trained would carry a caseload of at least one family. The performance target set for training was the proportion of MECSH trained health visitors who went on to recruit at least 1 family into the programme.

15 (50%) of the health visitor that received the Foundation training were recorded as having delivered MECSH activity to a family, placing the project in RED for this criteria.

Of 31 'active' health visitors, 30 (97%) completed the face-to-face Foundation training. 29 (94%) completed e-learning modules 1&2, with 24 (82%) completing them ahead of the face-to-face Foundation training.

28 health visitors remained active in the team after training, and so had the opportunity to complete e-learning modules 3-6. However, just 12 (43%) completed these, with 11 completing them within the required 6 months. In addition to core training, 22 (71%) also undertook the HABIT oral health module training.



Solutions for successful implementation

1. Undertake an "introduction to MECSH" session ahead of training to complete e-learning modules 1&2

2. Extend the foundation training from 2 to 3 days to enable practitioners to look in more depth at the practicalities of actually delivering the module content

3. Add the e-learning modules 3-6 to mandated role specific training for the HV team.

Evaluation Findings

MECSH Training continued...

Nurses and Nursery Nurses

Staff nurses and nursery nurses were also eligible to receive relevant training. 9 staff nurses, 15 nursery nurses and 4 other staff members were on the training log.
7 staff nurses were active and all 7 (100%) completed the e-modules. 6 were logged as eligible for the Foundation training and 6 (100%) completed it, and 5 (83%) completed the HABIT training.
All 15 (100%) of nursery nurses completed the Foundation training. All 14 who remained actve (100%) completed the HABIT training. There was no expectation that nursery nurses would complete the e-learning modules.

Staff nurses and Nursery nurses completed Foundation training

Staff nurses and Nursery nurses completed HABIT training

Staff nurses were fully MECSH qualified

Train the Trainer
It was anticipated that 1 Health Visitor would be trained to deliver MECSH training during the pilot period (this was in addition to the MECSH Implementation Champion). This was achieved.

Supervisor Training
One new Health Visitor received supervisor training in this period, in addition to the 6 who had received this in the pilot/first contract period; this Health Visitor did not go on to deliver any supervisions.
It was anticipated that 6 Health Visitors (identified as MECSH supervisors) would receive 1 full day of Supervisor training. This was based on 1 supervisor for every 8-10 staff. A total of 6 Health Visitors were recorded as having received Supervisor training (including the MECSH Implementation Champion).
Of these 6 only 2 went on to deliver supervision.

Supervision

The performance criteria set for supervision was that all MECSH Health Visitors would receive 8 supervisions per year. None of the Health Visitors on the supervision log received 8 supervisions. Of the 31 Health Visitors appearing on the supervision log, 27 had opportunity for 8 supervisions. The other 4 were recorded as having been on Maternity or Sick leave.

0 Health Visitors accessed 8 supervisions
29 Health Visitors (94%) were recorded as having accessed any supervision in the preceding 12 months
16 Health Visitors (52%) were recorded as having accessed supervision in the last 3 months of the pilot
On average Health Visitors had accessed 4 supervision sessions across the year

Evaluation Findings

Supervision continued...

94%

Health Visitors accessed supervision sessions during the 12 month pilot

29 Health Visitors had accessed at least one 1:1 session, with 18 (58%) accessing a minimum of 2. The average number of 1:1 sessions accessed was 2 with a minimum of 1 and maximum of 5. 23 Health Visitors had accessed at least 1 group session with the average number attended being 2 (minimum 1 and maximum 3). It should be noted that group supervision sessions were much more difficult for Health Visitors to attend as they could not be tailored to individual diaries.

It is worth noting that those Health Visitors who were recorded as delivering MECSH to families (n=15) had, on average, accessed more supervision sessions that those who weren't. MECSH delivering Health Visitors accessed an average of 5 supervision sessions across the year vs 2 accessed by those who had not delivered MECSH.

100%

Staff nurses and Nursery nurses accessed 2 or more supervision sessions

There were no specified number of supervision sessions for Staff nurses and Nursery nurses but it was considered good practice for them to access supervision twice across the year. 5 Staff nurses and 14 Nursery nurses appeared on the supervision log. All 19 had accessed at least 1 supervision session, and all those with opportunity to access 2 or more sessions (18) had done so. The average number of of sessions accessed was 4 with a minimum of 3 and a maximum of 5.

Data

The project have worked closely with BSBIH to support data capture for the project. Staff activity had to be recorded using spreadsheets, and family activities were logged on the BDCFT SystmOne system. However, codes used for MECSH families were frequently incorrectly used by health visitors outside the Bradford East team, making accurate interpretation of the data impossible. This makes the data difficult to interpret and assumptions have been made throughout this report, making the findings here heavily caveated.

Solutions for successful implementation

4. Embed the MECSH Supervision model within the HV supervision policy and make sure staff are aware of this.

6. Extend the foundation training from 2 to 3 days to enable practitioners to receive training on how to use and navigate the data capture processes and system.

Evaluation Findings

Delivery of MECSH

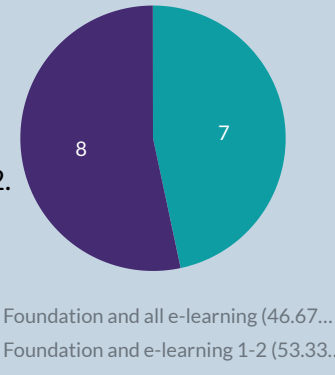
It was set out in the project Logic Model that every trained and active Health Visitor would recruit at least 1 family to MECSH. It is difficult to determine from the project data how many of the Health Visitors recruited a family into the MECSH programme because of the way recruitment onto the project is recorded .

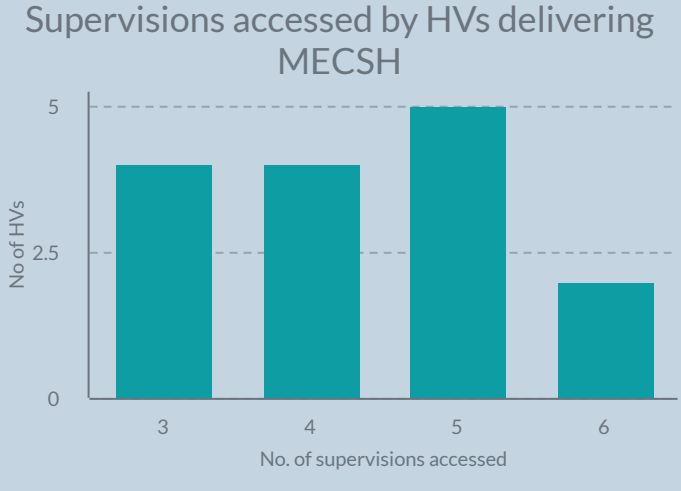
28 families were recorded as having any mention of MECSH within their records. 18 Health Visitors were originally recorded for this group. Of these, 16 Health Visitors were identified as active. MECSH activity data recorded 15 trained and active Health Visitors as delivering MECSH activity to families. A further 1 Health Visitor had delivered MECSH but had since retired. This related to 23 individual families.

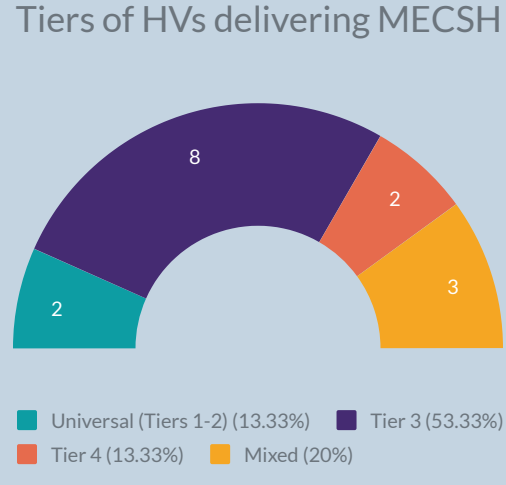
1 Health Visitor was recorded as having delivered MECSH activity to 4 families
2 Health Visitors were recorded as delivering MECSH to 2 families
The remaining 12 had delivered MECSH to 1 family each

Of the 15 Health Visitors that were recorded as having delivered MECSH:

- 8 (53%) had completed all MECSH training and so were considered fully MECSH
- qualified. All others had completed Foundation training and e-learning modules 1&2.
- 2 worked within the Universal tiers only, 8 worked within Tier 3, 2 worked within
- Tier 4, and 3 were categorised as having a mixed caseload working across at least
- *two different tiers.*
- 5 Health Visitors (33%) accessed 5 supervisions, 4 accessed 3 supervisions, 4 accessed 4 supervisions, and 2 accessed 6 supervisions across the pilot period.







It was anticipated the Staff nurses and Nursery nurses would deliver MECSH content to MECSH families and non-MECSH families (considered 'spill-over). However, it was not possible to determine how many Staff nurses and Nursery nurses had delivered MECSH.

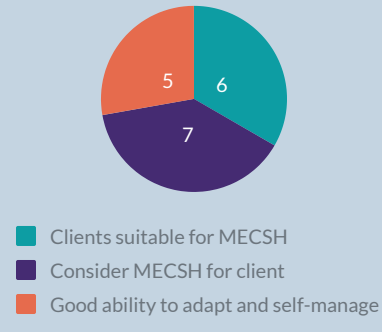
Evaluation Findings

How many families were recruited to MECSH?

The original MECSH model specifies universal screening of families for eligibility for the programme. However, it was acknowledged during Service Design of the project that this was unlikely to be possible in Bradford given capacity within the team.
It was agreed that eligibility screening of families would involve Health Visitors using their personal knowledge of a family, in combination with information contained within their health records and the use of the Adapt and Self Manage (ASM) tool - a 17-item client survey which assesses clients' ability to adapt and self-manage. Completion of the tool results in one of three recommendations; 'Client is suitable for MECSH', 'Consider MECSH for this client', and 'Good ability to Adapt and self-manage'.
Limitations of data capture means it is impossible to determine how many families overall were screened for eligibility to MECSH. This is because it is likely that where families were screened and felt not to be eligible, this was not recorded.

22 families were recorded as having been offered MECSH although only 8 were recorded as having been identified as eligible for MECSH suggesting issues with how screening outcomes are being recorded.
18 families were recorded as having completed the ASM measure at the point of enrolment according to the ZOHO MECSH data dashboard. However, only 13 ASM questionnaires were recorded within SystmOne, which again suggests issues with data capture.
23 families had MECSH activity recorded on SystmOne. Of these:
2 were not registered with the Bradford East team, suggesting that other teams have incorrectly been recorded MECSH visits.
A further 4 were recorded as non-MECSH families which may reflect some level of 'spill-over' delivery - meaning they are families who have been identified as likely to benefit from MECSH content but who do not need to be enrolled onto the programme. However, it is not currently possible to determine with any certainty if this is 'spill-over' or if this actually reflects a data capture issue.

ASM outcomes recorded at enrolment



Who were the families that were offered MECSH?

Of 22 families recorded as having been offered MECSH, ethnicity data was available for 21 mothers. Given small numbers a detailed breakdown of ethnicity cannot be provided. However, it is worth noting that these mothers were under representative of Asian/Asian British: Pakistani mothers (who made up 23% of the group). Representation across other ethnic groups was in line with what would be expected with the exception of those categorised as Mixed/Mixed British who accounted for 32% of the group. This may point to an issue with how ethnicity is currently being recorded in SystmOne.

Recruitment

What did families receive?

The core MECSH model is based on families receiving 25 visits over 2 years (averaging around 1 visit each month). Given that this evaluation covers a 12 month pilot it is reasonable to assume that those families recruited at the start of the pilot would receive at least 12 visits with the number of visits reducing in line with the month families were recruited into the project. It was therefore anticipated that families would still receive an average of one MECSH visit per month.

All MECSH families were receiving an average of 1 MECSH visit a month (with some receiving substantially more).

Month of first visit	No. of families	Average no. of visits	Average visits/month
April 2021	4	10	1
May 2021	3	11	1
June 2021	0		
July 2021	0		
August 2021	2	1	1
September 2021	1	18	1
October 2021	3	5	1
November 2021	1	8	1
December 2021	1	6	1
January 2022	0		
February 2022	1	2	1
March 2022	1	1	1

Delivery

What did MECSH families receive?

The core MECSH visit structure of 25 visits is intended to facilitate the delivery of 4 key components:

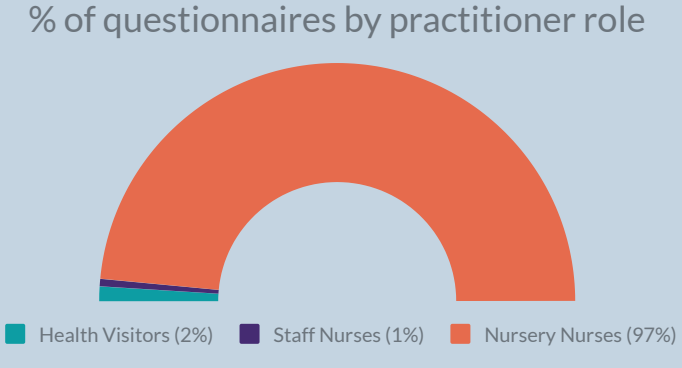
- Learning to Communicate
- Promoting First Relationships
- Healthy Beginnings
- HABIT (an oral health intervention)

As previously reported, project data suggests more than the 17 'recruited' MECSH families received MECSH modules. It is unclear if all families who received MECSH content were MECSH families or represent 'spillover' delivery. The numbers of families receiving each module are presented above.

A key element of MECSH is the development of a therapeutic relationship between Health Visitor and family. Of all those with MECSH activity recorded, MECSH visits appeared to have all been delivered by a single practitioner with the exception of instances where Health Visitors had left the service during the pilot.

Where 'spillover' delivery was possible to detect in the data was delivery of the HABIT oral health module . As part of the delivery, a HABIT questionnaire is completed by families and entered onto SystmOne. There were 290 HABIT questionnaires within the data. It is not possible to determine whether these questionnaires relate to 290 individual families. However, only 9 were marked as relating to a MECSH family, suggesting all of the other related to spillover delivery.

The HABIT questionnaire data included a record of who had supported families to complete it. Of the 281 that were non-MECSH related these had been completed alongside 14 members of the team; 2 Health Visitors, 10 Nursery nurses, and 1 Staff nurse.



It is worth noting that:

1 individual Nursery nurse was responsible for 35% of all the completed 'spillover' HABIT questionnaires

3 individual Nursery nurses were responsible for 76% of the 'spillover' HABIT questionnaires

6 individual Nursery nurses were responsible for 92% of the 'spillover' HABIT questionnaires

Qualitative findings

What did the Bradford East team say about MECSH?

19 qualitative interviews and focus groups were conducted with the project delivery team in January and February of 2022.
The interviews provided an opportunity for the team to share their perceptions of the programme and its implementation as well as to highlight barriers and facilitators of delivery.
Below are some of the key themes identified during analysis of the qualitative data. A more detailed report can be made available on request.

Perceptions of MECSH

"What Health Visiting should be"

Perceptions of the project were positive with a number of practitioners referring to MECSH as "proper Health Visiting", what Health Visiting "used to be" when they first started practicing, or being "what Health Visiting should be". This seemed to relate to the focus on the relationship between Health Visitor and family, and the number and quality of contacts. Several Health Visitors described feeling happy or excited about the project and their opportunity to deliver it.

"...it's the bread and butter of health visiting, we're looking forward to delivering this, so those were my initial thoughts..."

"...it just gave us the opportunity with permission to really develop them relationships with the parents in a more structured way..."

Apprehension

While overall perceptions of the programme were positive, some participants did report some level of apprehension when the programme was introduced because of concerns about their capacity to deliver or a lack of clarity about how implementation would really work in practice.

"...it was just quite hard to kind of get your head around how you were going to fit it in..."

Challenging context

COVID-19

Participants suggested that the timing of implementation of MECSH created a challenging context for delivering the programme. The start of the COVID-19 pandemic coincided with the start of initial MECSH training which was then paused delaying implementation of the programme. Refresher training was held in early 2021 and programme delivery finally began in April 2021.

"The next big challenge was obviously Covid, that came as soon as we'd done the training and that was a massive challenge because everything got put on hold..."

Qualitative findings

What did the Bradford East team say about MECSH?

Challenging context continued...

Team capacity

Staffing issues within the team were a challenge to programme delivery as the team were not working at capacity at any point through the pilot. High levels of sickness absence, exacerbated by COVID-19, as well as maternity leave meant caseloads were increased throughout the pilot. As well as creating a challenge to delivering MECSH, this led to an "intense" work environment for Health Visitors who reported covering caseloads for sick colleagues. It was also reported that for some families who were enrolled onto MECSH, having a change to Health Visitor due to long term absence meant that they decided to withdraw from the programme or had a new Health Visitor unable to pick up the programme delivery.

> "...we'd lost quite a lot of, we've lost quite a lot of the team for lots of reasons, so actually the caseload sizes have increased a lot for those people, so I think it's that conflict with time."

> "...you're just constantly picking up for shortage of staff, and then staff, massive sickness in the organisation, that hasn't let up over the last couple of years..."

The 'fit' of the programme and the Tiered Health Visiting Model in Bradford

Health Visitors felt MECSH was incompatible with the tiered model of delivery in Bradford. Health Visitors working within the Universal tier faced particular challenges in delivering the programme. It was felt the core aim of prevention and the foundation of therapeutic relationships were being missed. High caseloads within the Universal tier made it extremely difficult to deliver anything beyond the core five mandated Health Visitor contacts. The additional twenty contacts prescribed by the MECSH has implications for staff capacity and could be seen as an unrealistic ask. Where families move from one tier to another, particularly moving from Tier 3 into the Universal tier, they move onto the caseload of a new Health Visitor. This was felt to 'break' the continuity in care for a family, but it was noted that the caseload of the new Universal Health Visitor was also likely prevent continuation of the MECSH support because of a lack of capacity to deliver.

Conclusions

- MECSH is highly valued by Health Visitors who see the opportunity to provide Health Visiting "as it should be" delivered
- The team were apprehensive about delivery because of an awareness of existing challenges within Health Visiting
- The context in which the programme has been piloted has been extremely challenging:
  the team have not been working at capacity
  the current tiered model of Health Visiting appears to be incompatible with delivery of MECSH

Qualitative findings

Solutions for successful implementation

5. Raising awareness across the system, and having a commitment from commisioners that MECSH is delivered within a proportionate universalism model of health visiting.

6. Having a MECSH Champion and a MECSH Specialist HV to support the roll out within the wider service by:
a) driving the agenda for MECSH with the staff and within the early years systems
b) ensure that the learning gained during the pilot can be implemented and the transition be as smooth as possible
c) provide impromptu and drop-in sessions for HVs after training / home visits to help increase confidence in the delivery of the programme.

7. Once health visitors have had the training and support, they are able to deliver MECSH successfully, and this appears to add value and satisfaction to their work.

8. Promoting Bradford as a service that delivers MECSH, and the benefits of this programme for health visitors, might attract workforce into the city.

Conclusions and Recommendations

Conclusions

MECSH delivery from 2020-2022 within the Bradford health visiting service was challenging. Barriers included Covid-19, a lack of staffing within the service and a tiered model of delivery which is counter-intuitive to the proportionate universalism approach of Health Visiting and hence some core components of MECSH.

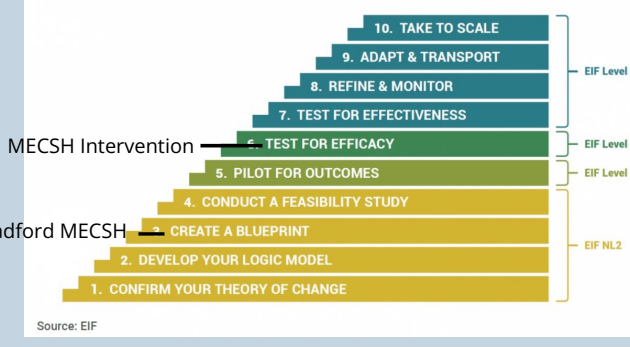
As a consequence the training and supervision elements of the Bradford MECSH model were not implemented successfully. The majority of Health Visitors taking on MECSH families were within Tier 3 of the service, however, a key aim of MECSH is prevention so it is important that Health Visitors are able to deliver MECSH to all families at risk. Once recruited, MECSH families receive the intensive support as designed, and had a caa good level of continuity in the care they received.
The qualitative findings highlighted the value that HVs placed in MECSH, but also reaffirmed that the context in which the programme was piloted was extremely challenging with the team not working at capacity and the tiered model of Health Visiting being incompatible with delivery of MECSH.
Based on this learning, solutions have been developed to address the lessons learnt. These will support successful implementation of the intervention moving forwards.

Conclusions and Recommendations

Review of the Evidence

MECSH is an evidence based intervention which supports usual health visiting, using EIF evidence levels of a framework, MECSH has level 3 evidence. There is strong evidence that a universal proportionate service, which offers care to all with increased intensity of care as and where needed is the best way to support families in the early years. MECSH as delivered in Bradford within the tiered model of delivery was not aligned with the key components of MECSH or the universal proportionalism approach. Bradford MECSH would be classed within the EIF evidence levels as NL2.

Other evidence-based intensive models similar to MECSH include the Family Nurse Partnership (FNP. This has strong evidence of effectiveness from RCTs undertaken in USA which has a very different model of care. A UK based RCT showed limited evidence of impact within the existing health visiting system.



FNP was also implemented and evaluated in Better Start Bradford from 2017-2019. There was a lack of evidence that this programme addressed the needs of the population, and as a consequence it was de-commissioned.

Recommendations

Now that the BDCFT health visiting has implemented a non- tiered model based on proportionate universalism, it will be possible to implement MECSH successfully within the system.

The lessons learnt and solutions developed from the MECSH pilot are presented on the following page. These will be important to adopt in the roll out of MECSH to ensure successful implementation.

In brief, these recommendations include:

- adapted and extended training which is a part of the role specific HV training.
- embedding of MECSH supervision within the HV supervision policy
- continuation of the MECSH Champion and MECSH specialist HV roles.
- promoting Bradford as a service that delivers MECSH, and the benefits of this programme for health visitors, might attract workforce into the city.

It will be extremely important to undertake close monitoring and evaluation of the implementation to continue to learn lessons, make adaptations as needed, and to evaluate the impact on children during the critical early years.

References

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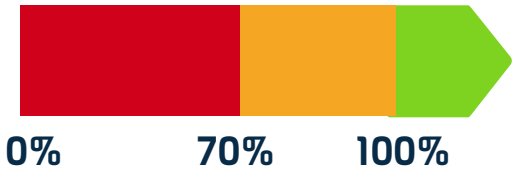
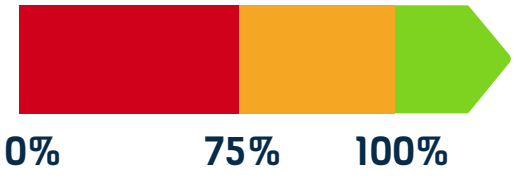
Appendix - Progression Criteria Cutoffs

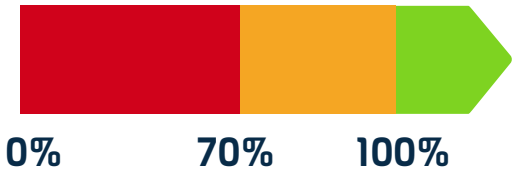
Recruitment



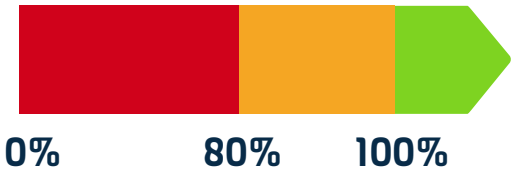
Completion



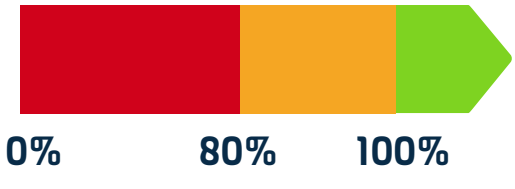
Reach



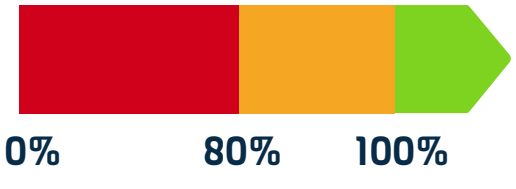
Fidelity



Implementation



Satisfaction



For more information on how progression criteria and associated cut-offs have been developed please see Bryant, et al., 2019 Use of progression criteria to support monitoring and commissioning decision making of public health services: lessons from Better Start Bradford. BMC Public Health