



Evaluation of the Universal Health Visiting Pathway in Scotland Phase 1 Report - Primary Research with Health Visitors and Parents and Case Note Review



CHILDREN, EDUCATION AND SKILLS

Evaluation of the Universal Health Visiting Pathway in Scotland

Phase 1 Main Report – Primary Research with Health Visitors and Parents and Case Note Review

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- **Additional Reports:**
 - Phase 1 Report – Routine Data Analysis – Workforce (published)
 - Phase 1 Report – Routine Data Analysis – Outcomes (due to publish 2022)
 - Phase 1 Report – Routine Data Analysis – Implementation and Delivery (due to publish 2022)

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Executive summary

Early years experiences and outcomes have long term impacts. Health and wellbeing pre-birth and during the first three years of life affect all aspects of health and wellbeing, social and emotional development and future learning and attainment. The early years (pre birth to age three) also provide the greatest opportunity to influence a child's development. Health visitors are uniquely positioned to improve outcomes for all children and families and drive sensitive, responsive, care giving.

Historically, the role of health visitors has varied across and even within Health Boards in Scotland. To ensure consistency and maximise the impact of the service, in 2013 the then Chief Nursing Officer for Scotland, directed all Health Boards to enhance the specialist role of health visitors towards the delivery of preventative and targeted interventions, delivered by a health visitor workforce, better equipped to address the specific needs of children and families, in the first five years of life. Following the directive, the service has now been enhanced to follow a routine pathway for delivery (Universal Health Visiting Pathway (UHVP) and includes:

- a more structured home visiting service and refocused role from 0-5
- an increased number of home visits of at least eleven visits before the child enters school, with eight in the first year of life, including three child health reviews
- adaptation of the relevant post graduate education Specialist Community Public Health Nursing (SCPHN) to support the refocused role
- additional training of existing health visitors to support the new educational components
- sustainable recruitment of new health visitors.

In order to facilitate such significant changes in the service, the Scottish Government made an investment of £40 million over four years to enable the number of health visitors in Scotland to increase by at least 500 whole time equivalent (WTE) staff by the end of 2018. The Scottish Government then set a timeline for ensuring all families received the pathway, this was set as 1 Jan 2020. These substantial changes in the service model and increased investment in health visiting have necessitated an evaluation to assess the impact of the UHVP on outcomes for children and families and to enable identification of areas for improvement in the future.

To address the goals of the evaluation, a logic model was developed with stakeholders to outline the processes and relevant outcomes of the UHVP delivery. Following this, four main evaluation components were identified to assess the implementation processes and outcomes achieved over a 4 year evaluation period, across two phases. This included qualitative evaluation with parents and health visitors, a case note review, surveys with parents and health visitors and routine data analysis (findings from the routine data analysis will be published in separate reports). This publication reports the main findings from the primary research for Phase 1, where data collection occurred between May 2019 and September 2020. A total of 55 parents and 50 health visitors took part in one-to-one interviews and a further 33 health visitors took part in focus groups. A case note review was also

undertaken which reviewed 73 health visitor records. In the survey, 554 health visitors and 550 parents responded.

This was a nation-wide evaluation across all Health Boards in Scotland. However, the qualitative evaluation and case note review were undertaken in five case study Health Boards (NHS Ayrshire and Arran, NHS Borders, NHS Grampian, NHS Lothian and NHS Tayside).

Below are the **key findings** of the primary research conducted as part of the evaluation are:

- All Health Boards in Scotland have adopted the UHVP, however the implementation of the pathway varied between Health Boards.
- By 1 January 2020 all Health Boards were delivering the pathway to new parents, and most were delivering all aspects of the pathway to their caseload.
- Almost all health visitors who responded to the survey said they were delivering the UHVP, with around half (47%) delivering it for one to three years.
- The majority of health visitors said they felt confident (90%) and skilled (91%) in their roles.
- As well as pathway visits, it was clear from the case note review that health visitors were providing a substantial number of additional visits to some families, often leading to increased paperwork and workload, which is concerning.
- Some additional visits seem to cluster at certain points between pathway visits, particularly, between the 3/4 month and 8 month home visits; and between 13-15 month and 27–30-month child health reviews, indicating a possible gap in the pathway between visits, which may need to be addressed.
- The majority of parents surveyed felt they developed a positive and trusting relationship with their health visitor. They found their health visitor to be approachable, non-judgmental, and professional and as a result, they felt very comfortable approaching health visitors with questions or concerns.
- The main aspects of the pathway attributed to building positive and trusting relationship with families are the frequency of visits (particularly within the first 6 months), the antenatal visit, and the continuity of care and carer model.
- In the survey, more than a third (36%) of health visitors said that the pathway they were delivering enabled them to identify concerns about a child at an early stage 'very well.' A further 57% felt the pathway did this 'fairly well' while 4% said it did not do this 'very' or 'at all' well.
- Eight in ten parents (81%) agreed that their health visitor listens to their concerns either 'very' (51%) or 'fairly' (30%) well. This is positive for the pathway.
- The survey examined the extent to which parents felt their health visitors had provided them with information about certain topics. A high proportion (77%) of parents felt well informed and knew 'a great deal' or 'a fair amount' about how to manage their own mental health and wellbeing.
- In the survey, half (50%) of the health visitors felt that the UHVP has had a positive impact on providing opportunities to work with other agencies, 43%

felt it had made no difference one way or the other while 5% felt the impact had been negative.

- Health visitors who were positive that the pathway created more opportunities to work with other agencies explained in the qualitative interviews and focus groups that the frequent visits embedded within the pathway promoted timely and appropriate referrals to relevant agencies.
- The frequency of the pathway visits facilitates timely referrals to relevant services. However, in some instances, services for onward referrals such as speech and language therapy may not be available or accessible to families, and this appears to be a challenge that the needs to be addressed.
- The COVID-19 pandemic (COVID-19 is a respiratory disease caused by SARS-CoV-2, a new coronavirus discovered in 2019) led to a series of national lockdowns in Scotland. The first lockdown started on 23rd March 2020 and relaxation of lockdown restrictions began on 29th May 2020. The survey of parents took place between 12 August to 17 September 2020. Positively, around two thirds of parents (69%) were satisfied with the health visiting service they had received before the onset of the COVID-19 pandemic, with 37% saying they were very satisfied and 32% fairly satisfied. Just over one in ten parents (12%) were dissatisfied with the service they had received (7% 'fairly' and 4% 'very') while 18% were neither satisfied or dissatisfied and 2% said they did not know.

The following areas may require further consideration:

- The antenatal visit should be prioritised in the pathway schedule, because of its role in building positive and trusting relationships between families and health visitors, as well as facilitating the earlier identification of concerns relating to maternal mental health.
- The pathway should be considered in terms of perceived gaps in the visit schedule. Additional visits could be introduced at 6 months and 18 months.
- The substantial number of additional visits health visitors provide to families outside the core visits should be adequately monitored and incorporated into their workload planning.
- At times services for onward referrals such as speech and language therapy may not be available or accessible to families. It might be helpful to develop robust referral strategies in conjunction with such services to ensure families receive timely support.
- More efficient ways of reducing or simplifying documentation and paperwork should be explored.

Introduction

The early years of life have a profound impact on an individual's long-term health and wellbeing. Children's emotional, cognitive, linguistic, social and physical development, including the bond they form with parents, can significantly affect their future health and wellbeing as adults^{1,2}. Investing in early years therefore creates opportunities for the future². In Scotland, health visitors are well placed to contribute to improving the health and wellbeing of children. However, while a universal health visiting service has been in place in Scotland for over a century, service delivery has varied substantially in terms of assessment, resources and visiting patterns across and even within Health Boards in Scotland.

The Universal Health Visiting Pathway (UHVP)

In 2013, the Chief Nursing Officer for Scotland³, directed all Health Boards to enhance the role of health visitors in line with the Nursing for Health Review⁴ and the national Getting it Right For Every Child (GIRFEC) approach⁵. This resulted in the development of, an evidence review⁶ to support the delivery of an enhanced health visiting service. The evidence review examined the direct impact of the health visiting role and resulted in a redefined focus for Health Visiting that would focus on children aged 0-5 years (pre-school). The review also highlighted a need for consistency and efficient and effective use of resources within the service⁶. The evidence review was also clear that all pregnant women should receive an antenatal contact, to ensure a smoother transition of care from the midwife to health visitor post birth.

The UHVP was developed and refocuses the specialist role of health visitors towards the delivery of preventative and targeted interventions. The pathway is designed to be delivered by a health visitor workforce who are better equipped to address the specific needs of children and families. In relation to workforce, a caseload weighting tool was developed. This uses formula to calculate the core numbers of health visitors required in a Health Board area to meet wider population need and uses the Scottish Index of Multiple Deprivation (SIMD) in its calculations. This tool was developed to facilitate the effective allocation of resources to areas of greatest need. The tool acknowledges the role and responsibilities of health visitors and takes into account the additional home visits that form part of the UHVP. The tool was designed to ensure that the right numbers of health visitors are available to respond to the needs of children and families in Scotland. It also provides guidance around caseload size related to deprivation and complexity. This tool, along with other workforce planning tools, supports Health Boards in their overall workforce planning, in managing vacancies, planning for retirements and to ensure that workforce numbers continue to reflect ongoing need.

As part of the implementation of the UHVP, a review of educational and continuous professional development (CPD) programmes for health visitors were undertaken.

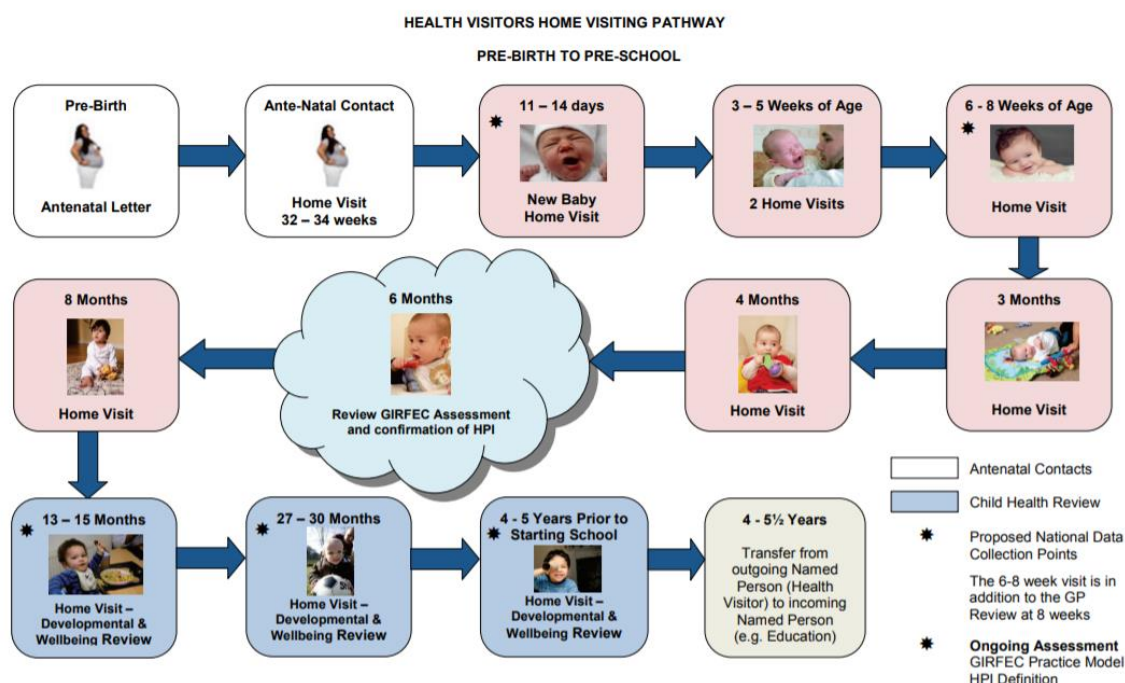
This led to two key changes. Firstly, relevant postgraduate education '*Specialist Community Public Health Nursing*' (SCPHN) was adapted to support the refocused role. Secondly, to ensure additional training of existing health visitors to support the new educational components of the pathway, the Scottish Government funded a national Health Visiting CPD Programme delivered by Higher Educational Institutions to upskill health visitors and build confidence in delivering a more focussed role. This consisted of four days of CPD on Named Person, Leadership, Strength Based/Asset Based Approaches, Child Development and Quality Improvement Tools. Health Boards were asked to identify which staff required this CPD.

The UHVP ensures that health visitors have a structured home visit programme for all families, which includes an increased number of visits from what was previously delivered from at least 8 routine visits over the first 5 years to at least 11 visits. All families are entitled to receive at least eleven routine visits from health visitors, eight within the first year of life and three child health reviews between 13 months and 4-5 years. Additional support is also provided according to the level of need in line with a proportionate universalism approach, where the service is provided to all families but more of the service is provided to those with more need. The home visits begin from pre-birth until the child is five years old (or enters school). Figure 1.1 shows the expected UHVP visits.

At the home visits, health visitors undertake a holistic assessment of a child's need for ongoing support and subsequently allocate the child to either 'core' or 'additional' using the Health Plan Indicator (HPI). An additional HPI (HPI-A) indicates that the child (and/or their carer) requires sustained (more than 3 months) additional input from professional services to help the child attain their health or development potential. Any services may be required such as additional health visitor support, parenting support, enhanced early learning and childcare, specialist medical input, etc. A child's HPI can be changed at any time by the health visitor. For instance, an HPI allocated at the 6-8 week home visit can be amended at the 8 month home visit to reflect changes in the level of need.

To support and maximise the role and impact of health visitors within early years, the Scottish Government made a significant investment of £40 million (including over £3.4 million in health visitor training) over four years to enable the number of health visitors in Scotland to increase by 500 by the end of 2018⁷. This target was achieved and reported through National Workforce statistics⁸. This substantial increase in investment in health visiting and the change in approach has necessitated an evaluation to assess the impact of the UHVP on outcomes for children and families and to identify further areas for improvement in the future.

Figure 1.1: UHVP visits⁹



Additional changes introduced to the service included most health visiting teams across Health Boards discontinuing the delivery of child immunisations. Group clinics were also largely discontinued. The focus of health visiting teams also changed, moving from mixed skills teams (health visitors, community staff nurses, nursery nurses), to one where health visitors prioritised undertaking core child health reviews and acting as a main contact for families.

Implementation of the Universal Health Visiting Pathway

NHS Boards were asked by Scottish Government to introduce the UHVP to all pregnant women who booked for a first trimester screening scan from October 2015. This meant that these women should have had an antenatal visit by a health visitor at 32 to 34 weeks of pregnancy in March 2016. However, implementation of the pathway has varied between Health Boards, with Health Boards rolling it out at different times. Appendix 1 shows information from a questionnaire completed by all Health Boards. The results of the survey show the stage of the UHVP implementation within each Health Board as of September 2018. The timeline for ensuring all families receive the pathway was set at 1 Jan 2020¹⁰, which took into account the incremental increase of health visitors to undertake the role through a national recruitment exercise and local reviews of how the current mix of staff would fit into the new model of delivery.

The Evaluation of Health Visiting in Scotland

This section covers the methodological approach and methods employed in the evaluation process. The methods have also been published in the British Medical Journal Open¹¹. The study adopted realist evaluation¹² principles, employing both qualitative and quantitative data in a mixed-methods approach, to address the aims of the evaluation.

Previous Research

In April 2013, implementation of the Universal Health Visiting Pathway was piloted in NHS Ayrshire and Arran. A process evaluation of the service¹³ was undertaken in 2015 to provide initial learning and guidance to support the national roll out of the UHVP.

In Spring 2016, an evaluability assessment¹⁴ was commissioned by Scottish Government. The aim was to assess the strengths and weaknesses of various options for evaluating the Universal Health Visiting Pathway and to provide recommendations on the methodology for the evaluation. The evaluability assessment was a collaborative, process including key stakeholders from policy, practice and research. The final recommendation of the evaluability group was a process evaluation and an outcomes evaluation based on natural experiment methodology.

Aims of the evaluation

Since every family will take about five years to go through the health visiting pathway (pre-birth to school entry or when child is 5 years), it is important to ensure the full cycle of the health visiting pathway can be evaluated. Phase 1 of the evaluation commenced in 2018 and provides baseline outcomes data and early learning about the health visiting pathway. Phase 2 of the evaluation will provide evidence regarding the medium to long term impact of the health visiting pathway and identify further areas for improvement.

The key aims of the evaluation are:

- 1) to examine what elements of the UHVP are being implemented in which areas, when and how.
- 2) to determine the extent to which the UHVP is implemented and delivered across Scotland and assess any associated impacts over the longer term.
- 3) to identify and explain to what extent recommendations to fill gaps in the UHVP are delivered and their impacts on services, staff and children and families.

Realist evaluation is well suited to understand the complexities of healthcare programmes and can provide useful insights into how programmes work, whilst

placing emphasis on identifying and explaining factors that can be improved in order to enhance the programme^{15,16,17}. The UHVP can be described as complex intervention and it is important to understand and explain how it works. Realist evaluation is concerned with understanding how contexts interact with underlying mechanisms of programmes to produce health and wellbeing outcomes for children and families. The implementation of the UHVP was not uniform across Health Boards and therefore the evaluation aims to contextualise findings based on the stage of roll-out across or between Health Boards.

Structure of the evaluation

In order to address the aims of the evaluation, the evaluation began with a comprehensive review of the existing logic model as described below.

Following this, four main research approaches or evaluation components were identified to assess outcomes. This included qualitative research with parents and health visitors, a case note review, surveys with parents and health visitors and routine data analysis (findings from the routine data analysis will be reported separately).

As stated above, the evaluation has been designed across two phases:

- Phase 1 – provides baseline outcomes data and early learning in regard to the process evaluation.
- Phase 2 – will provide evidence in regard to the outcomes that health visiting is contributing towards and provide further information for the development of the processes health visitors use.

Logic Model Review

A logic model supports evaluation by setting out the relationships and assumptions, between what a programme will do and what changes it expects to deliver. A logic model can be particularly valuable in drawing out gaps between the ingredients of a programme, the underlying assumptions, and the anticipated outcomes. As part of the evaluation and the realist approach it was important to understand the assumptions underpinning the UHVP from the perspectives of stakeholders involved in its design and implementation, as well as those with an interest in early years policies and programmes aimed at improving outcomes for children and families.

A range of stakeholders were identified and invited to take part in two separate workshops. Stakeholders included Scottish Government policy teams, researchers and professionals, senior nursing, and health visiting staff from Health Boards, third sector organisations, academic experts in Health Visiting and the members of the Evaluation Team.

The logic model review part of the evaluation was designed to revise the previous logic model produced in 2016 as part of the Evaluability Assessment. This review, which was carried out in October 2018, was necessary because it was agreed that a revised model was needed to reflect current practices and to incorporate new learning that might have ensued from the ongoing implementation of the pathway. The revised logic model was expected to drive the rest of the evaluation. It was carried out across two workshops and guided by co-production principles to enable a structured, participatory approach where participants were actively engaged to contribute.

Workshop one

As part of the activities for workshop one, stakeholders were divided into five groups and were asked to review the existing logic model and discuss whether the inputs and activities reflected current or expected practice in line with the pathway. Stakeholders were asked to review and discuss all of the outcomes within the logic model. Following the group discussions, all groups reconvened, and feedback was gathered and discussed by the wider group. Several changes were made to a number of outcomes. New outcomes were also introduced to ensure that the logic model captured appropriate outcomes for children and families as well as the health visitor workforce. Most importantly, stakeholders agreed that the logic model should carefully consider priorities relevant to the current role of health visitors and should be aligned with outcomes, which are realistic and achievable.

Following the first workshop, the evaluation team gathered all of the feedback and developed a revised first draft of the logic model. The draft logic model was then circulated to workshop participants (stakeholders) in advance of the second workshop.

Workshop two

During workshop two, stakeholders were asked to briefly review the draft logic model and provide any final comments. These final comments were used to refine the logic model further. The final logic model is shown in Appendix 2. The items in the logic model have been numbered for ease of reference. Overall, the final logic model sets out the short, medium and longer-term outcomes of the UHVP. As part of workshop two, stakeholders also outlined relevant data sources required to measure these outcomes.

Study setting and population

This is a national evaluation and covers all 14 Health Board areas in Scotland. However, some elements were carried out in five Health Boards or case study areas in order to provide a more in-depth understanding of the UHVP. A robust process informed the rationale for selecting Health Boards as case study areas. It included a

self-completion questionnaire sent to all Directors of Nursing in each of the 14 Health Boards to inquire about the stage of the UHVP implementation. Using the information received from the self-completion questionnaires alongside the geographical profile of each area, population data and the Scottish Index of Multiple Deprivation, the following case study areas were selected:

- NHS Ayrshire and Arran
- NHS Borders
- NHS Grampian
- NHS Lothian
- NHS Tayside

Table 1.1 shows the evaluation components and the Health Board areas they cover.

Table 1.1 evaluation components and Health Board areas of coverage

| Study Components | Health Board Areas |
|--|--|
| Survey of health visitors | All Health Boards |
| Survey of parents | |
| Routine secondary data analysis | |
| Qualitative interviews and focus groups with health visitors | Five Health Boards (case study areas) |
| Qualitative interviews with parents | |
| Case note review | |

Interviews and Focus Groups

Health visitors from each of the case study areas were invited to take part in an interview or focus group. Parents were also invited to take part in interviews. Around 90% of the interviews were face-to-face with about 10% conducted by telephone. Interviews and focus groups lasted between 30 minutes and an hour and a half. Interviews were conducted between May 2019 and January 2020.

Recruitment and data collection

Health visitors – Interviews and Focus Groups

Health visitors from each case study area were sent information about the evaluation and invited to participate in either a focus group or individual semi-structured interview. The topic guide (Appendix 3) explored adherence to implementation and

delivery of UHVP, barriers and facilitators to delivery, perceived impact of UHVP on outcomes for children and families, training and support structures, as well as engagement with other professionals.

Parents – Interviews

Parents were recruited through their health visitors, who informed them about the study and offered them a study information pack. The recruitment strategy was continually reviewed to ensure parents with a range of characteristics (e.g. age, first time parents) were included in the sample. The information pack included details of how to contact the researchers for those interested in participating in the study. Potential participants were contacted by a member of the evaluation team to arrange a suitable venue and time for interview. The topic guide (Appendix 4) included questions around experiences of parents as well as their perceived impact on how the service has influenced their families' health and well-being. Each participant received a high street store vouchers worth £20 in return for their time.

Information about the number of parents and health visitors who took part in the study is provided in Table 1.2.

Table 1.2: Number of participants that took part in the qualitative research

| Participants | Health Board 1 | Health Board 2 | Health Board 3 | Health Board 4 | Health Board 5 |
|--------------------------------|----------------|----------------|----------------|----------------|----------------|
| Health visitors – Interviews | 10 | 10 | 10 | 10 | 10 |
| Health visitors – Focus Groups | 10 | 5 | 5 | 6 | 7 |
| Parents – Interviews | 7 | 12 | 12 | 12 | 12 |
| Total (138) | 27 | 27 | 27 | 28 | 29 |

Analysis of interview and focus group data

All interviews and focus groups were audio recorded and transcribed verbatim. Transcribed data were coded and analysed by thematic analysis, using QSR NVivo V.11. Thematic analysis was used particularly because of its suitability in exploring qualitative data of this nature, as it is possible to examine both within-case and cross-case themes.

Case note review

A data collection tool was tested, and data was gathered from health visitor case notes between October and the end of December 2019, ensuring that no identifiable personal information was attached to any of the data.

Case note sample

The sampling criteria was finalised in discussion with Clinical Managers within the Boards.

Inclusion criteria

- 15 case notes from each area, evenly spread across Health and Social Care Partnerships (HSCPs) (HSCPs are the organisations formed as part of the integration of services provided by Health Boards and Councils in Scotland. Each partnership is jointly run by the NHS and local authority).
- Case notes of children that were at least 13 months old
- Randomly selected – but with Health Plan Indicator (HPI) of Core and Additional levels proportionate to the geographical area.

Exclusion criteria

- Transferred in from another area at any point
- Participation in Family Nurse Partnership (FNP) at any point (Families that have a family nurse receive FNP from pregnancy until their child is aged two. Families participating in FNP receive a more intensive and more regular service than is outlined in UHVP and their experiences are not likely to be typical of those receiving the UHVP - they were therefore excluded from this study).

Table 1.3. Case note review sample

| Health Board (HB) | HB1 | HB2 | HB3 | HB4 | HB5 |
|--|-----------------|-----------------|-----------------|-----------------|-----------------|
| Total number of case records used | 15 | 13 | 15 | 15 | 15 |
| Number of Core case records | 10 | 8 | 10 | 11 | 9 |
| Number of Additional case records | 5 | 5 | 5 | 4 | 6 |
| Youngest age born during week commencing | Week 39 In 2018 | Week 30 In 2018 | Week 39 in 2018 | Week 50 in 2018 | Week 20 in 2019 |
| Oldest age born during week commencing | Week 10 in 2015 | Week 21 In 2016 | Week 49 in 2016 | Week 51 in 2017 | Week 27 in 2015 |

Case Note Data collection

Although the main data collection tool was used consistently, the case notes were a mixture of electronic and paper records. Electronic case notes were supported using different platforms across the Boards. This variance across the case notes created some challenges in terms of consistently being able to locate similar information from within the records – as the same information was recorded differently across systems.

Case Note Data analysis

The anonymous data was transferred from the data collection tool onto an MS excel spreadsheet. Every case was assigned an identification code and there were no personal identifiable data linked to any identification code. Information relating to each case was kept together to ensure a level of understanding around health visitor contacts. Analysis of cases from each Health Board area were reported separately.

Health Visitors' Survey

The questionnaire (Appendix 5) for the health visitors' survey was designed by the evaluation team with advice from the Scottish Government and the Evaluation Advisory Group. It was also reviewed by a small number of health visitors, whose feedback was incorporated before it was converted to a script that could be completed online.

The survey was open from late November 2019 to early January 2020. Executive Directors of Nursing and Directors of Public Health in each Health Board were asked to nominate a staff member to forward an email invitation from the evaluation team to all health visitors and family nurses (and their managers) in their area and encourage them to take part in the survey. In total 554 health visitors and 37 family nurses took part in the workforce survey about their experiences and views of the UHVP.

The data were weighted to match the profile of health visitors across Scotland in terms of Health Board and the proportion of part-time and full-time staff.

Parents' Survey

The impact of the COVID-19 pandemic

The parents' survey was both delayed and redesigned due to the COVID-19 pandemic. As NHS Scotland was placed on an emergency footing in March 2020, it was agreed that it was no longer appropriate to pursue the original plan of asking Health Boards to undertake the sampling of parents on behalf of the evaluation team. Various options for alternative ways of approaching the Phase 1 parent survey were discussed. It was acknowledged that all the alternative options would result in a

much reduced sample size (from the original target of 6,000 online responses) and greatly reduced subgroup analysis, but it was also agreed that delaying the parent survey further was not desirable.

Of the options identified, it was agreed that conducting a survey using re-contact details for families with children under five who had taken part in existing Scottish Government surveys was the preferred route. The revised design involved:

- Approaching parents of children aged under five years old who consented to be recontacted in either the Scottish Household Survey or Scottish Health Survey in 2018 or 2019 (sample details provided by Scottish Government to the evaluation team)
- Inviting all of these parents to take part in the survey online initially, either by email invitation (where emails were available), or letter
- Boosting the online survey with telephone interviews.

The questionnaire for parents

The questionnaire aimed at parents was piloted with a small number of parents, whose feedback was incorporated before it was converted to a script that could be completed online and by Computer-Assisted-Telephone-Interviewing (CATI) (Appendix 6). As the fieldwork took place during the COVID-19 pandemic, and after Scotland had been in lockdown, the questionnaire was amended, prior to fieldwork, to take account of the potential impact of the lockdown on health visiting services. A small number of questions on engagement with wider health services and on parents' mental wellbeing were also added to the questionnaire in order to provide the Scottish Government with data on views and experiences of health services among parents of young children since the beginning of the COVID-19 pandemic. However, the parent survey mainly focused around key UHVP outcomes as experienced in the early roll-out / pre-roll out stage of UHVP in relation to key target outcomes.

Survey data collection

The survey was open from 12 August to 17 September 2020. All parents in the sample (2,317) were invited to take part in the survey online via an email or letter (if email addresses were unavailable). The invite requested that the parent who had had most contact with health visitors complete the survey. After the online survey had been live for a week, telephone fieldwork began and a proportion of those who had not yet taken part online were invited to take part in a telephone interview. Quotas were set on area deprivation (as measured by Scottish Index of Multiple Deprivation (SIMD) quintiles), with the telephone interviewing targeting (where possible given the available sample) those in the SIMD quintiles where response to the online survey was lowest. In total, 550 parents took part in the survey, with 250 taking part online and 300 taking part by telephone (24% of the total issued sample).

For parents with more than one child aged five or under, at the start of the survey, one of their children was selected randomly to be the focus of the survey, and parents were asked subsequently to answer about their experiences of health visiting only in relation to this child.

While the vast majority of families with children under five are seen by a health visitor, a small minority, where the parents are aged under 20 years, are seen by a family nurse from pregnancy until the child is two years old. Only one respondent in the survey reported seeing a family nurse so, for purposes of simplicity, the term health visitor is used throughout to refer to all respondents.

Survey analysis

The data from the parents' survey is unweighted. There is no definitive source of data on the profile of parents or carers of children under school-age in Scotland. However, analysis of the Scottish Household survey of the profile of highest income householders living in a household with a child aged 5 or under (the vast majority of whom will be their parents or carers) suggests that older parents are likely to be slightly over-represented in the sample (parents aged 35 years and above accounted for 62% of the UHVP parent sample, compared with 51% of highest income householders in the 2019 Scottish Household Survey). The sample is also somewhat skewed towards parents of children aged 3 or older, and has slightly fewer parents in the most deprived quintile of areas (as measured by SIMD) compared with other quintiles. Significant differences between these groups of parents are noted in the relevant sections of this report.

As the number of respondents was insufficient to allow analysis of differences between individual Boards, Health Boards were grouped into Health Board Regions for analysis as follows:

- East (Fife, Lothian and Borders)
- North (Western Isles, Grampian, Highland, Orkney, Shetland, Tayside)
- West (Ayrshire & Arran, Dumfries and Galloway, Forth Valley, Greater Glasgow & Clyde and Lanarkshire).

Survey sample

Table 1.4 below, shows key demographics for the achieved sample as a whole, and for each mode of data collection.

Table 1.4 Parent survey: sample profile

| | All | Online | Telephone |
|----------------------------------|-----|--------|-----------|
| Parent's age (at time of survey) | | | |
| 16-29 | 14% | 13% | 15% |

| | | | |
|---|-----|-----|-----|
| 30-34 | 24% | 22% | 26% |
| 35+ | 62% | 65% | 59% |
| Number of other children in the household | | | |
| None | 33% | 36% | 30% |
| 1 or more other children | 67% | 64% | 70% |
| Age of selected child (for whom they were asked to answer the survey questions) | | | |
| Under 1 | 6% | 6% | 6% |
| 1 year-old | 14% | 17% | 11% |
| 2 year-old | 18% | 20% | 17% |
| 3 year-old | 24% | 23% | 25% |
| 4 year-old | 24% | 20% | 27% |
| 5 year-old | 13% | 14% | 13% |
| Deprivation (SIMD) quintile (all who gave a postcode = 540) | | | |
| 1 (most deprived) | 16% | 16% | 15% |
| 2 | 20% | 17% | 22% |
| 3 | 21% | 18% | 23% |
| 4 | 22% | 26% | 19% |
| 5 (least deprived) | 22% | 23% | 21% |
| Urban-rural (all who gave a postcode = 540) | | | |
| Urban | 75% | 75% | 75% |
| Rural | 25% | 25% | 25% |
| Household income (all those who gave an income = 479) | | | |
| £15,599 or less | 8% | 7% | 8% |
| £15,600-£25,999 | 15% | 17% | 13% |
| £26,000-£36,399 | 19% | 18% | 19% |
| £36,400-£51,999 | 22% | 25% | 20% |
| £52,000+ | 37% | 32% | 40% |

It should be noted that the sample of parents is a small sample and the results should be interpreted with caution.

Routine Data Analysis

The methods adopted for the routine data analysis elements of the evaluation will be published within each of the relevant routine data reports.

Ethics approval

The evaluation received approval from the School of Health in Social Science Research Ethics Committee, University of Edinburgh, the case note review received approval from the Public Benefit and Privacy Panel for Health and Social Care in Scotland and the survey received approval from the Scottish Government Statistics Public Benefit and Privacy Panel.

Reports

The following four reports will be produced as part of the Phase 1 evaluation:

- Phase 1 Report – Primary Research with Health Visitors and Parents and Case Note Review (this report)
- Phase 1 Report – Routine Data Analysis – Workforce (published)
- Phase 1 Report – Routine Data Analysis – Outcomes (due to publish 2022)
- Phase 1 Report – Routine Data Analysis – Implementation and Delivery (due to publish 2022)

Impact of COVID-19

The first phase of the evaluation was almost complete prior to the COVID-19 pandemic, which resulted in a national lockdown in March 2020. The fieldwork in relation to the case note review, qualitative focus groups and interviews with health visitors and parents had all been completed prior to March 2020. The planning for the parents' survey was still in process in February and March 2020. The onset of the pandemic meant that the parents' survey methodology had to be substantially changed.

After redesigning the methodology for the parents' survey, an online and telephone survey of parents took place between 12 August to 17 September 2020. Due to the timing of the questionnaire, questions about the on-going COVID-19 pandemic were included in the survey alongside the original questions relating to health visiting services more generally. The results of this are reported in section 8 of this report.

The last year (2020) has been a period of great uncertainty across NHS Scotland, including health visiting, which continued throughout but was delivered in a completely new and untested way. The health visiting service had to immediately pivot to a digital or telephone-based service, with home-visits being restricted to a small number of priority areas such as the early days and weeks following birth and support for the most vulnerable families.

The full evaluation of the UHVP will be conducted in two phases, this report focuses on Phase 1. While Phase 1 of the evaluation does not fully capture the changes to the service during COVID-19, it will set the scene for some of the anticipated findings from Phase 2, which will explore the impact of the pandemic more fully.

Findings

The findings reported here were obtained from interviews with parents; focus groups and individual semi-structured interviews with health visitors; online and telephone surveys with parents; an online survey of health visitors; and a review of health visitors' case note records.

The findings are presented around the key themes identified in the logic model developed for the evaluation. Where possible the findings from the various elements of the evaluation will be interwoven to present a full picture of the theme under consideration. However, not all elements of the evaluation covered all the themes and the findings combine the national level data and the case study data.

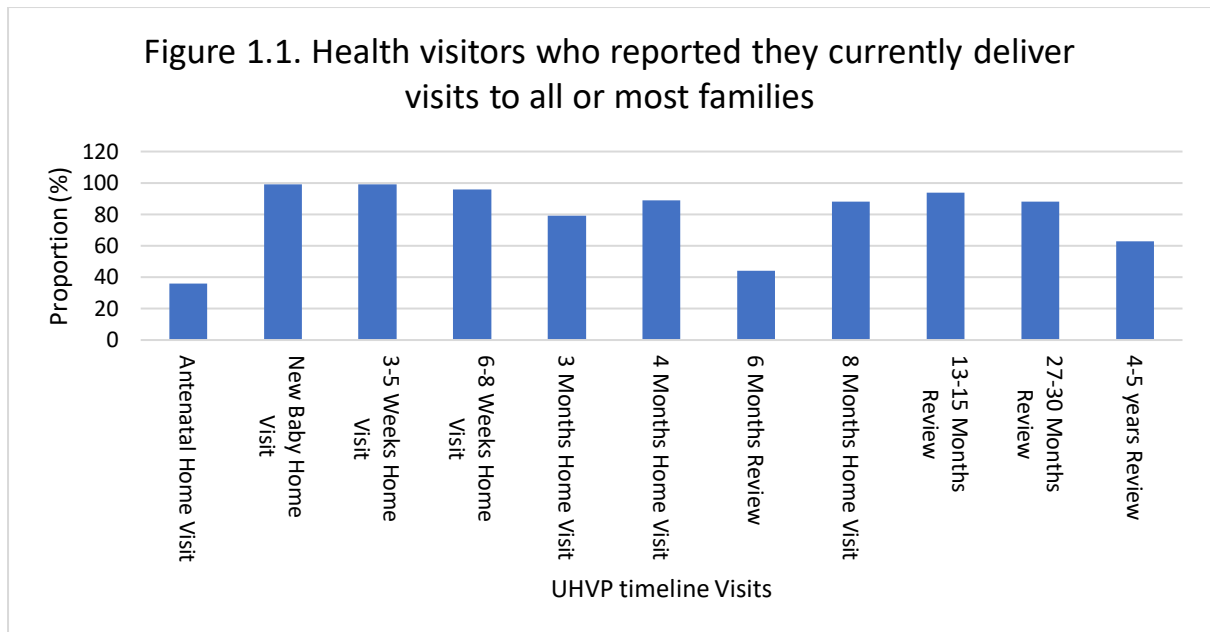
The eight major themes that will be covered are:

- Core and additional visits
- Trusting relationships
- Impact of the pathway
- Partnership working with other agencies
- The health visiting workforce
- Overall satisfaction with the health visiting service
- Suggested improvements
- Parents experiences during COVID-19 pandemic.

1. Core and additional pathway visits

In the survey, a third (34%) of health visitors reported they had been delivering the UHVP, either fully or in part, for more than three years, around half (47%) said they had been delivering it for between 1 and 3 years and 17% for under a year. Under 1% said they were not yet delivering the UHVP, and 2% were unsure how long they had been delivering it.

Figure 1.1 shows the distribution of UHVP visits amongst health visitors who reported that they delivered the UHVP to **all or most** families.



Overall, most visits were being delivered across health boards, however the antenatal home visit, 3 month visit, 6 month visit and 4-5 year review were the least likely to be rolled out at an earlier stage. However, by 1 January 2020 all Health Boards were delivering the pathway to new parents, and most were delivering all aspects of the pathway to their caseload. The pathway rollout across Scotland will be explored further in the routine data analysis implementation report.

In the qualitative research, almost all health visitors said that they had been delivering the core pathway fully or in part and that they felt that the pathway has enhanced the health visiting service. For many health visitors, the greatest value of the pathway lies in the structure and consistency it brings to the health visiting service with all families in Scotland receiving the same minimum number of visits. They believed this made the service equitable across Scotland and also made it possible to provide additional targeted support where required. This reflects the proportionate universalism concept of the pathway.

I think the timeline [or pathway] has been very good. I think it is, it has been more equitable. Do you know, people years ago, when I first started health visiting, people would sometimes see a health visitor, when the baby was born, you know at day ten, day eleven and then maybe again for a six-week check and then they would just be invited into a clinic and they might never be seen again by health visitors. So, how do you pick up concerns? So, I think it has been great from that point of view and everybody is getting the same thing. You know, so I think that is important. Some people are getting more than the timeline, because they need it but at least there is a minimum standard, so no, I think it is good. I am pro-timeline (Health visitor).

Through further exploration, it became apparent that health visitors particularly liked the frequent visits during the early weeks because they felt that parents mostly required their support during this period.

I think it's quite nice to have the focus in the early weeks. Because that's when most change is happening, and parents are most anxious (Health visitor).

However, a few health visitors were worried that the focus on providing support to all families meant it was sometimes challenging to support those who needed the service the most, such as children on an additional health plan indicator (HPI-A).

Core visits

There was national variation in the delivery of the various pathway visits. For instance, health visitors in the North (67%) and West (67%) Health Board Regions were more likely than those in the East (49%) to be delivering the 4-5 year review to all or most families. Those in the North were more likely to be delivering the 6 month review (53%, compared with 32% in the East). While those in the East (57%) and North (53%) regions more likely to be delivering the antenatal visit than those in the West (21%). Health visitors working full-time were more likely than those who were part-time to say they were delivering the 6-month review (52% vs 36%).

The survey further explored why some areas were not delivering some pathway visits. Personal caseload pressures (46%) and 'My Health Board is not yet delivering all elements' (41%) were the most common reasons provided by health visitors for not delivering all elements to all/most families. Staffing issues were reported by 12%, while 7% said they had insufficient training to deliver the pathway. It's important to highlight that almost half of health visitors in areas not delivering some pathway visits cited workload pressures, and this could be an indication that health visitors workload may require review.

Those in the East (76%) and North (71%) Health Board Regions were much more likely to report personal caseload pressures as a reason than those in the West (29%), while those in the West were more likely to report that their Health Board was not yet delivering all elements of the pathway (58% versus 18% of those in the North and 10% of those in the East).

Antenatal visit

The antenatal visit can be regarded as a unique visit in the pathway as it is the only visit in the UHVP timeline that takes place before birth. In consideration of this, we explored the importance of this visit with health visitors and parents.

Health visitors delivering the antenatal visit considered it a crucial visit because it facilitates relationship building with families. This was consistently reported by health visitors across all Health Boards in the qualitative research. Health visitors explained that the antenatal visit provides an opportunity to establish trusting relationships with families by getting to know families within the prenatal context and being able to ease parental concerns about what will happen following the birth of a child. Health visitors also indicated that undertaking the antenatal visit helps to save time during the primary home visit, because a lot of information had already been provided to parents.

I think even with the antenatal visit, obviously the ladies are getting to meet us before the baby's even born which I think is very beneficial because they know who's going to be coming out when the baby is born. Then obviously the primary visit and then the weekly visits up until six weeks really gives us a chance to get to know the families, not just the mum, but the dad if there is a dad, other children, again which allows...it lets us get to know the [mother], you know, her presentation so if we go into a visit and we think, mmm, she doesn't really seem herself today, allows us to quickly identify issues or potential mental health problems or anything (Health visitor).

Parents' views were similar to those of health visitors. Parents reported that the antenatal visit is an important first meeting as it provides an opportunity to meet the health visitor and know who they are before the birth of the baby. They explained that this was helpful and made subsequent visits after the birth of the baby less stressful.

Because I got to meet [HV] before it and she gave me some information, she gave me leaflets to read. She just introduced herself and it was nice to meet her beforehand, so you knew who was coming to your house when you had your newborn. It was less stressful knowing who it was coming rather than meeting someone for the first time with a baby (Parent, first time).

Another important benefit that some parents noted was that the antenatal visit offered health visitors the opportunity to observe the physical and psychological state of the mother during pregnancy, therefore any deterioration in their health or wellbeing after birth could be identified and appropriate support provided.

I think just getting to meet her before [the birth], I think it did impact on...because she'd seen us before so she knew...she was able to see if there were changes in us, if that makes sense. Like mental health wise, because obviously that is quite a big and important thing after you've had the baby, so it was nice to see like what I was like before having a child and she knew that I was just the same (Parent, first time).

Despite the outlined benefits of the antenatal visit, health visitors mentioned that in some areas it was often the visit to be removed from the pathway timeline if they needed to prioritise workloads (Figure 1.1 reflects this). Some health visitors also mentioned that parents do not often take up the offer of antenatal visit. This seemed to mainly be the case for health visitors working in one particular Health Board and it was noted that that the opt-in approach of the letter for this visit could be responsible. However, lack of uptake was also reported as being common amongst parents where this was not their first child, some of whom felt the antenatal visit would not be necessary. Health visitors believed there was a benefit here for maintaining engagement with families identified as requiring additional support. In some cases, health visitors coupled antenatal visit with scheduled visits to older siblings in families who were already in receipt of the pathway at this point.

When I contact people to say, “hi my name is...I’m your health visitor and we have our universal pathway and part of that is an antenatal contact, so would you want me to come to visit you?”. Some people think it’s a waste of time, quite a few people have declined that contact. I think it’s beneficial if people engage with you but obviously if they don’t want to, they think they’re seeing the midwife and that’s sufficient at this point in time. It can [also] be because they’ve had two or three children previously, so they know what it’s all about or the other side of that is it could be someone in their professional role who feels they can’t afford the time to allocate to see somebody else, they already make appointments with the midwife. So because of work commitments, they feel they don’t want to see somebody else, because it’s going to be another appointment that they have to attend (Health visitor).

It appeared from both individual interviews and focus groups with health visitors that in some areas within a Health Board, the uptake of antenatal visit was initially low, and this was attributed to the nature of the opt-in letter sent out to families. However, uptake seemed to have improved when an opt-out approach was adopted.

In a very deprived caseload...what we found is, when we were offering, sending out the letter: would you like us to offer an antenatal visit? There was probably ten per cent uptake. When we changed to using the letter saying, I will be your health visitor, I will visit you at home at ten o’clock on that day, should you not want this, and we are now up to probably about 89, 90 per cent of uptake (Health visitor, Focus Group).

In the case note review, it was evident in most Health Boards that the antenatal home visits were not being achieved as anticipated. This supports the qualitative findings above that it is one of the pathway visits most likely to be removed when Health Boards are struggling with capacity. Amongst the records reviewed, it was found that in HB1, five antenatal home visits (out of a possible fifteen) to five separate families were achieved and in addition there was one attempted home visit,

but the pregnant woman was not at home. The two home visits achieved in HB2 (out of a possible thirteen) were both related to referrals from another service. In HB4, three visits were recorded (out of a possible fifteen), one following a referral at 17 weeks gestation. In addition, one letter was recorded as being sent. In HB5, where three home visits were achieved (out of a possible fifteen), another visit was arranged but cancelled by the pregnant woman, although another contact was achieved through a telephone call.

In the survey of health visitors, those who had been delivering the UHVP for four years or more were also more likely than those that had been delivering the pathway for a shorter time period to be delivering the antenatal visit (55%, compared with 36% overall).

Additional visits

The UHVP presents a core home visiting programme to be offered to all families by health visitors as a minimum standard. However, additional visits from a health visitor may also be deemed beneficial following a 'Getting it right for every child assessment' which is undertaken as routine part of the UHVP. When asked to think about families in their personal caseload identified as requiring additional visits, 43% of health visitors said that those families received all of the required additional visits, 40% said most of them, 13% said some of them and 2% said none of them. Health visitors who had been practicing for under a year were the least likely to say that all/most of the families in their caseload received the required additional visits (71% versus 83% overall).

Analysis of the case note data revealed that aside from the core visits, some families received a large proportion of additional visits, and a closer observation of the data indicates that they seem to cluster at certain points between some pathway visits. Examination of Table 1.1 using the case note review data seemed to highlight an increased number of additional visits between 3/4 month and 8 months pathway visits. Table 1.1 also shows increased additional visits from some families between the 13-15 month and 27–30-month pathway visits, and between 27-30 month and 4-5 year visits.

Additional visits appear to have taken place for a wide range of reasons, including feeding support, maternal depression and domestic abuse as can be seen in Appendix 7. It was evident that additional visits taking place up to the age of 15 months were provided to children assigned to both HPI Core and Additional indicators, whereas beyond 15 months of age, additional visits were more often provided to those assigned HPI Additional. Table 1.1 identifies the distribution of extra home visits and includes the timeframe between Pathway visits.

Table 1.1. The number of families receiving extra visits, between pathway visits, as a proportion of the total number of case records reviewed

| Health Board | Extra visits between 6-8 week and 3-month visit | Between 3/4 month and 8-month visits | Between 8 month and 13–15-month visits | Between 13-15 month and 27–30-month visits | Between 27-30 month and 4–5-year visits |
|--------------|--|--|---|--|---|
| HB1 | 4/15 total cases (27%) (2 Core; 2 Additional) | 3/15 total cases (20%) (2 Core; 1 Additional) | 4/15 total cases (27%) (2 Core; 2 Additional) | 5/10 total cases (50%) (3 Core; 2 Additional) | 5/9 total cases (55%) (2 Core; 3 Additional) |
| HB2 | 5/13 total cases (38%) (2 Core; 3 Additional) | 4/13 total cases (31%) (1 Core; 3 Additional) | 4/13 total cases (31%) (1 Core; 3 Additional) | 4/10 total cases (40%) (1 Core; 3 Additional) | 1/2 total cases (50%) (1 Core; 0 Additional) |
| HB3 | 2/15 total cases (13%) (2 Core; 0 Additional) | 3/15 total cases (20%) (2 Core; 1 Additional) | 7/15 total cases (47%) (2 Core; 5 Additional*) | 7/9 total cases (78%) (2 Core; 5 Additional*) | No case records reviewed |
| HB4 | 2/15 total cases (13%) (1 Core; 1 Additional) | 3/15 total cases (20%) (2 Core; 1 Additional) | 4/15 total cases (27%) (2 Core; 2 Additional) | No case records reviewed | No case records reviewed |
| HB5 | 6/15 total cases (40%) (3 Core; 3 Additional) | 9/15 total cases (60%) (4 Core; 5 Additional) | 5/13 total cases (38%) (2 Core; 3 Additional) | 4/9 total cases (44%) (1 Core; 3 Additional) | 1/5 total cases (20%) (0 Core; 1 Additional) |

* due to the large number of extra visits undertaken every visit date was not collected

Pathway schedule

During the interviews and survey, it emerged that parents and health visitors both had concerns about some of the gaps in the pathway schedule. Health visitors universally highlighted two main gaps: the gap between the four to eight-month visits; and the gap between 13-15 month and 27-30 month visits.

After the pathway visit at four months, there is a six-month review, which is not conducted as a home visit but as a record update only, according to the pathway.

Both parents and health visitors felt that the gap between four and eight months was particularly important because it is during this period that weaning (introduction of complimentary foods) typically begins. The WHO, UNICEF and the UK Scientific Advisory Committee on Nutrition recommend that introduction of nutritionally-adequate complementary foods should begin after six months.

Weaning was noted to be one of the greatest sources of parental anxiety, especially for first time parents. There are challenges associated with introduction of solid foods and inappropriate foods can lead to longer term health implications, including malnutrition, unhealthy weight, obesity and tooth decay. Health visitors said they are expected to educate parents about weaning at the four-month visits, yet they are keen to avoid promoting weaning at this stage. Health visitors felt that providing weaning information to parents at four months and encouraging them to begin weaning at six months is challenging and creates confusion for some parents. This is discussed further below in the *Infant Weaning* section under *Impact on parental understanding, choices and behaviour [theme 3]*.

Health visitors also described a perceived gap between the 13-15 month and the 27–30 month visits. Both of these visits are when child health developmental reviews take place. They felt it was possible they were missing opportunities to identify important developmental concerns within the intervening time period.

At one year if they don't speak it doesn't mean anything, but if they are not speaking by 18 months it means a lot. And you don't see them at that time, you don't see them until they are 27 months, therefore yes, you are late, you are very late in making a referral (Health visitor).

Yeah, I definitely think rather than maybe like the thirteen to fifteen month [visit], I think a visit around eighteen months would be more appropriate because they likely would be walking and they would be reaching a lot more of their milestones like their kind of language development would be kind of you know, a lot better as well. But as I say we don't see them until they are twenty-seven months unless they are an additional family (Health visitor).

Health visitors explained that a child unable to meet a developmental target at 13-15 months could be a source of worry for parents. While it is possible that the child could attain that particular developmental goal within a few months, the next scheduled visit is not until the 27-30 months. However, parents can contact their health visitor at any time.

I think perhaps the 13-15-month [visit] could be delayed slightly to 18-months. Just I think a lot of the children when you visit at 13 months, on the ASQ forms, are not walking, are not getting from a sitting to a standing position. That puts a lot of parental anxiety into the interaction between us and the parents. So, I feel that if we waited to perhaps, even instead of 13-15 months, if we incorporate it at 15-18 months, that would be a better age group to deal with, rather than the earlier and putting that anxiety onto the client (Health visitor).

Data from the case note review (Table 1.1) supports the concept that there is gap in contact with health visitors around 6 months which is when health visitors advise children should be weaned onto solid foods. It is apparent in this data that there is an increased number of additional visits when children are around 6 months and this may be due to requests by parents for additional help or advice at this time. Similarly, Table 1.1 shows increased number of additional visits between the 13-15 month and 27–30-month visits, which may also reflect parents request for help or advice around during this time. It appears these identified gaps in the pathway are problematic and might require attention to enhance parents' experience of the UHVP. Addressing the issue of the gaps might also help address the increased additional visits health visitors provide out with the pathway schedule.

2. Trusting relationships

In order for health visiting to achieve the outcomes for families envisioned in the design of UHVP, families need to be able to form trusting relationships with their health visitors. This ensures families are better able to ask for and accept the support on offer. A majority of the parents felt they developed a positive and trusting relationships with their health visitor. They also found their health visitors to be approachable, non-judgemental and professional and as a result, parents felt very comfortable approaching health visitors with concerns.

I think it's more that she's really supportive and I'm really comfortable with her and I know I can speak to her. I'm not scared and think oh God, she might judge me for that, or this has happened, or whatever if you know what I mean. I'm not scared to ask her a question, I know that she'll just give me the right advice, and honest advice. She won't, even though obviously she's got the guidelines to stick by, but I don't feel like I can't approach her or anything, and that's been really important because you know, sometimes in the world of parenting you get a bit like overwhelmed and scared, so it's good to have someone you know you can go to (Parent, two children).

Very positive. She's very...you know, it's just a great relationship. She's very friendly, reassuring, encouraging, you know, she's just...I'd say she's definitely fitted for her job. I'd say we get on very well. Definitely positive is probably the main...you know, it's a positive relationship definitely (Parent, two children).

Health visitors also reported that the pathway has allowed them to strengthen and develop more trusting relationships with families.

Oh, definitely, yes, that's probably the biggest advantage of [the pathway] actually, because you're seeing that family from antenatal, you're seeing the mum and then you're going all the way through their journey with them, and [you are] able to build up relationships that way. You get to know your families a lot better. I would say that that is the biggest advantage of it (Health visitor).

The majority (92%) of health visitors reported having developed positive relationships with all or most of the families in their personal caseload (21% said 'all' and 71% 'most') – just 6% said they only had positive relationships with 'some' families and 1% 'only a few'. Health visitors who had been delivering the UHVP for four years or more were most likely to report having developed positive relationships with all or most of their families (99%, compared with 92% overall).

Health visitors believed that having a more trusting relationship with families offered many benefits, including being able to build a better picture of the family from their own observations, which leads to more confidence in their professional judgement.

I think the benefit of the pathway, though was, if you do know your family, I sometimes have arranged to go in and do a visit at 13 months, because I know the family, I know the child. And I'm pretty sure the child is going to be able to complete that development. Whereas, there are other children where I'll say, I'm going to leave that, I'm going to delay that to 14 months, for example, because I don't want them to not succeed. Because they're still within the range. So that's another benefit of having the pathway, and having that relationship with the family (Health visitor).

The main aspects of the pathway attributed to building trusting relationships were the frequency of visits or contacts (particularly within the first 6 months), the antenatal visit (already covered above) and the continuity of care and carer during this time.

Frequency of visits

The frequency of early visits was consistently reported as contributing to the development of positive relationships with families.

Particularly the visits, the early on ones where they are quite close together, definitely that's the best way I think, the ones where it's later and I'm going into them and they are much older, I find them much harder to build the relationship with families because I'm only seeing them occasionally (Health visitor).

Health visitors mentioned that they used a range of communication methods to keep in contact with parents in between home visits, including phone calls, text messaging, emails and formal letters. Health visitors reported encouraging parents to contact them outwith pathway visits if any concerns arise. There was agreement among health visitors that families are more likely to contact them outwith pathway visits when a strong relationship is formed.

The pathway enables us to have a lot of contact with the families in the early six months, so therefore you have pretty much established if you are going to have a relationship, that's where it's going to happen. And in fact, what we used to say for many years, if you don't do that first new birth visit you won't actually get that really connected relationship because it's such a crucial time. So, the pathway being there has encouraged us and our managers behind and beyond, to employ more health visitors to allow us to deliver the pathway, so therefore it enables the creation of that relationship. 'Cause once that relationship is there, if the parent has a question, they are going to lift the phone and say, can I see you, I've got a wee worry, it's probably nothing, can I talk to you? (Health visitor).

The above quote indicates the positive developments that can happen when a good health visitor-parent relationship is developed.

One of the ways to assess the quality of the relationships between parents and health visitors is to explore the extent to which arranged visits successfully took place. This was scrutinised within the case note data. Table 2.1 shows the number and proportion of cases in which at least one arranged visit did not take place (we describe this as “missed visit” because the health visitor made an attempt or actually visited the house of the family, but parents were not available). There were considerable variations between Health Boards, with 10 of the 15 cases in HB5 missing at least one arranged visit. Only two cases, out of a total of 15 cases missed at least one arranged visit in HB4. Overall, in the majority of cases (58%) there were no missed visits. However, in 42% of cases there was at least one arranged visit that did not take place.

Within families that were receiving the core pathway the number of visits that did not take place was (42%), while this was 44% of visits for families assigned HPI-Additional.

Table 2.1 Number of cases where at least one arranged home visit did not take place

| Health Board | Total cases (N=73) | Total number of cases where at least one arranged visit did not take place (N=31) | Proportion of cases where a visit did not take place for 'HPI - core' families (%) | Proportion of cases where a visit did not take place for 'HPI – Additional' families (%) |
|--------------|--------------------|---|--|--|
| HB1 | 15 | 7 | 4/10 (40%) | 3/5 (60%) |
| HB2 | 13 | 5 | 4/8 (50%) | 1/5 (20%) |
| HB3 | 15 | 7 | 4/10 (40%) | 3/5 (60%) |
| HB4 | 15 | 2 | 1/11 (9%) | 1/4 (25%) |
| HB5 | 15 | 10 | 7/9 (78%) | 3/6 (50%) |

Table 2.2 further examines the timepoint in the pathway when missed visits occurred. It appears that there were no clear patterns across the pathway for families assigned either HPI-Core or HPI-Additional. However, the data indicates most of the planned visits that did not take place occurred when children were less than eight months old.

Table 2.2 Age of child and HPI allocation in relation to missed visits

| Health Board | Antenatal and up to 8 weeks | 8 weeks to 4 months | 4 months to 8 months- | 8 months to 13-15 months | 13 – 15 to 27 – 30 months | Over 32 months |
|--------------|-----------------------------|-----------------------------|----------------------------|--------------------------|----------------------------|----------------|
| HB1 | 1 x Core | 1 x Core 3 x Additional | 0 | 1 x Additional | 2 x Core | 1 x Core |
| HB2 | 1 x Core | 4 x Additional | 0 | 2 x Additional | 3 x Core 1 x Additional | 0 |
| HB3 | 1 x Core 1 x Additional | 1 x Additional (4 times) | 0 | 0 | 0 | 0 |
| HB4 | 1 x Core | 0 | 0 | 1 x Additional | No case records reviewed | |
| HB5 | 3 x Core 1 x Additional | 2 x Core | 1 x Core 3 x Additional | 0 | 1 x Additional | 1 x Core |

The parents' survey also asked about how often parents saw their health visitor in the 12 months prior to the COVID-19 pandemic, which led to the onset of the national lockdown in March 2020. Any interpretation of these survey responses should take into account the actual number of contact health visitors should have with families at different age points according to the UHVP Guidance (All families are entitled to receive at least eleven routine visits from health visitors, eight within the first year of life and three child health reviews between 13 months and 4-5 years)

Given there are a greater number of visits in the early stages of the pathway, there was substantial variation in the number of contacts (by phone or in person) parents had with their health visitor in the 12 months prior to the March 2020 lockdown depending on the age of their child. As Table 2.3 shows, almost all parents of children aged one or under had seen or spoken to their health visitor (either by phone or in person) at least once in the 12 months prior to lockdown in March 2020, compared with around half of parents of 4 or 5 year olds (these contacts could have been as part of the main pathway visits or out with those visits). The average number of contacts was between 5 and 6 for parents of children aged one or under, and 4 for parents of 2 year olds, before falling to just under 2 for parents of 3 year olds and just over 1 visit for parents of 4 or 5 year olds. When comparing this to the expected minimum number of visits in the pathway for each of these stages, the minimum number of visits is 8 visits for children up to one year old, one visit at 13-15 months, another visit at 27-30 months and the remaining visit occurs when children are between 4 and 5 years. So, there was not much variation in terms of the actual and expected contacts. For parents of children aged one or under, an average between 5 and 6 seems less than expected, however, it is likely that these children are not up to one year and are likely to receive additional visits or contacts with the health visitor before their first birthday.

Table 2.3 Contact with health visitor(s) in the 12 months prior to lock down in March 2020

| | All | Child aged 1 or under | Child aged 2 years | Child aged 3 years | Child aged 4 or 5 years |
|--------------------------|-----|-----------------------|--------------------|--------------------|-------------------------|
| No contact at all | 27% | 2% | 6% | 28% | 47% |
| 1 contact | 29% | 8% | 32% | 43% | 27% |
| 2 contacts | 12% | 11% | 20% | 11% | 8% |
| 3 contacts | 9% | 11% | 11% | 9% | 7% |
| 4 contacts | 5% | 10% | 10% | 2% | 2% |
| 5-9 contacts | 12% | 41% | 11% | 5% | 3% |
| 10+ contacts | 5% | 9% | 6% | 2% | 2% |

| | | | | | |
|-------------|--|----|-----|-----|-----|
| Base | 537 (All parents with babies born prior to lockdown) | 96 | 100 | 133 | 207 |
|-------------|--|----|-----|-----|-----|

The average number of contacts for the 12-month period reported on was higher among parents aged under 30 years, who reported almost 5 visits on average, compared with just under 2 among parents aged 35 years and above. This is likely to reflect the fact that, in general, older parents in the sample had older children (who are scheduled to receive fewer regular visits under the pathway).

Continuity of care and carer

Improved continuity of care and carer is a key aim of the UHVP. An important feature of the UHVP is that the same health visitor or fewer different health visitors support individual families over time, increasing opportunities for building trusting relationships with families.

Across all case study areas, it was clear from the qualitative interviews that it was often the same health visitor that delivered the pathway visits to families in their caseload. In particular, the focus groups made clear that health visitors ensured that the same health visitor delivered all the visits to families requiring additional support.

I would agree with that, we would try and keep [HPI] additional families, wherever possible, the same health visitor (Health visitor).

The survey data of health visitors provides further information about continuity of care and carer. Most health visitors (59%) reported that they personally make all of the pathway visits to the families in their caseloads, a further 37% make them to most families and 3% to some of them. Those in the West Region were more likely to report making all of the visits (68%) than those in the North (56%) and East Regions (38%).

Examination of health visitors' case notes revealed that most parents had more than one health visitor delivering the pathway visits, as illustrated in Table 2.4. While a third were shown to have one health visitor, almost half had two or three health visitors contributing to the case notes. Where there were 5 or 6 health visitors involved with each family, closer scrutiny established that this was more likely for families that were HPI-Core rather than HPI-Additional.

Table 2.4 Total number of health visitors contributing to each case note

| Health Board | 1 HV | 2 HVs | 3 HVs | 4 HVs | 5 HVs | 6 HVs | Total cases where evidence of |
|--------------|------|-------|-------|-------|-------|-------|-------------------------------|
|--------------|------|-------|-------|-------|-------|-------|-------------------------------|

| | | | | | | | numbers of health visitors gathered |
|-----|---|---|---|---|-----------------|-----------------------|-------------------------------------|
| HB1 | 4 | 5 | 2 | 0 | 0 | 1 (HPI Additional) | 12/15 |
| HB2 | 3 | 4 | 3 | 3 | 0 | 0 | 13/13 |
| HB3 | 3 | 3 | 3 | 4 | 1 (HPI Core) | 0 | 14/15 |
| HB4 | 7 | 4 | 2 | 0 | 1 (HPI Core) | 0 | 14/15 |
| HB5 | 4 | 4 | 2 | 1 | 0 | 1 (HPI Core) | 12/15 |

The survey of parents explored the extent to which parents were experiencing continuity of care and carer for their child in the early roll-out or pre-UHVP phase, in terms of how frequently they saw the same health visitor.

Overall, two thirds of parents (67%) said that they had one main health visitor who they have seen for most of the time, while one third (31%) said they did not. This contrasts with the health visiting survey findings above. There were more parents of older children in the survey sample and it is less likely they see same health visitor over longer periods of time and during the implementation of the pathway, before it became fully embedded.

From the survey results, among the 31% of parents who had more than one main health visitor, 23% said they had seen two different health visitors, 42% had seen three, and 24% had seen four or more (11% were not sure how many different health visitors they had seen for their child). The average number of different health visitors that parents reported having contact with (among the minority for whom this was more than one) was three.

Furthermore, those with younger children were more likely to report that they had one main health visitor – 100% of the small number of parents (n = 33) answering for a child aged under one said they had one main health visitor, falling to 74% of parents of one-year olds, 73% of parents two year-olds, 65% of parents of three year-olds, and 59% of parents of children aged 4 or 5 years. This may reflect the way the UHVP has been rolled out across Scotland. Nevertheless, to maximise the impact of the pathway it is important to ensure that parents see the same health visitor throughout the entire pathway. There were no clear significant differences in whether or not parents reported having one main health visitor by parental age, working status, income, or deprivation.

The most common reasons reported by health visitors and parents for families receiving visits from multiple health visitors during the pathway were annual leave, sickness or emergency situations (e.g. when the safety of the family is at risk). These issues necessitated the need for alternative arrangements, where in most cases another health visitor covered the caseload of the substantive health visitor.

Among the pathway visits, health visitors mentioned that the visits most often prioritised when taking a planned absence from work were the birth visits and visits for families assigned HPI-Additional. Health visitors elaborated that the standardised nature of the pathway helped to facilitate any temporary caseload cover.

But if somebody is off sick or on holiday, you know exactly what point they're at. Because you know, right, it's that five week visit, therefore this is needing discussed. I know we all maybe tweak it slightly differently, but you pretty much know the information that, the health promotion information that needs to be delivered at those points (Health visitor, Focus Group).

It appeared that in some Health Board areas, health visitors still relied on additional skill-mix staff (community staff nurses and nursery nurses) to undertake certain pathway visits, especially for core families as one health visitor explained.

We always try for the first year that it will be the same health visitor that sees the family. If the family were an additional family, then we would do the 27-month review and the four-year check. If they were a core family, the 27-month review and the four year would be done by the nursery nurse (Health visitor).

In one of the focus groups, health visitors reported that there was fragmentation in the continuity of care for families transferring into the health visiting service after receiving support from the Family Nurse Partnership (FNP)¹. Health visitors discussed the way that building relationships with families who had previously been in receipt of the FNP programme was challenging due to the change of practitioner and the timeline of the pathway, which offers two visits to 'core' families at 27 and 48 months after the initial handover visit at 24 months. It was noted that forming relationships at this stage was challenging for both health visitors and families. Health visitors also felt that the lack of continuity of carer and decreased level of support in comparison to what was offered under the FNP programme impacted negatively on families.

We see them at two, for a handover visit, with very intensive support, up until two. We see them for the handover visit, we see them at 27 months, and if they're core children, we don't see them again until they're four. There's lots of scope to miss things, I feel, there's huge gaps in that. And the parents, the families that I've worked with, have reported back that they feel abandoned, some of them will say. That they've had the family nurse intensively up 'till age two, and then they've got nobody because our timeline says, 27 months, and 48 months. So, I feel that

¹ The Family Nurse Partnership (FNP) is an intensive home visiting service offered to mother 19 years and under in mainland Scotland, from pregnancy until the child is aged two. FNP is also offered to some mothers aged 20-24 years in some areas of Scotland. Families that receive FNP will follow the UHVP through their family nurse until their child is aged 2 years and then they will transfer from the FNP service to the Health Visiting service.

creates more problems. You don't have a relationship with the family, it's very difficult for them and difficult for us as well (Health visitor).

Understanding the effects of trusting relationships

Contacting health visitors

Trusting relationships between parents and health visitors can create a positive atmosphere for parents to contact and talk to health visitors. The survey data shows that seven in ten parents (71%) agreed they could talk to their health visitor about anything (43% strongly agreed and 28% tended to agree). Seventeen percent disagreed with this statement (9% tended to disagree and 9% strongly disagreed) and 11% neither agreed nor disagreed and 2% did not know. Parents of children aged one or under were more likely than those within children in the older age groups to strongly agree that they could talk to their health visitor about anything (55%, compared with 43% of those answering about a 2 year olds, 41% answering about a 3 year olds and 38% of those answering about a 4 or 5 year olds).

In the qualitative interviews, parents said they felt able to contact health visitors by phone regarding issues affecting them or their baby because of the trusting relationships they have developed with them.

Oh, sure. Even like discussing [my baby's] milk and formula and things, I was in the shop one day, I was trying to look for like a reflux milk, so I couldn't find it at all. I phoned [my health visitor] in a panic, I was like I can't find this milk, oh my God, and she said don't worry, you can get this, this and she went through all the different ones with me. I literally just phoned her out of the blue because I was like what do I do here (Parent, first time).

Yeah, absolutely, so she is always on the end of the phone and I can just leave a voicemail and generally the same day she would get back in touch (Parent, three children).

However, parents' accounts of the health visitors' ability to respond promptly was not universal. A number of parents mentioned that they did not receive a prompt response from their health visitor, and one parent mentioned that part-time working pattern of the health visitor means it takes a little longer to receive a response.

I mean the only very slight negative is sometimes with, are, you have to, sort of, leave a message and wait for somebody to ring you back and it's not always the same day, which is fine, like, I do understand they're out and about. But I mean, that's the only thing sometimes it'd be good to have a slightly quicker response if you need them. But apart from that, I really, you know, they're very approachable, helpful, friendly and I've been really pleased with the whole process (Parent, four children).

Yes, the difficulty in our region is our health visitor only works part time. If you had to contact them outwith those hours, sometimes it could be a wee bit longer until someone got back to you (Parent, two children).

The inclination of parents to contact health visitors seemed stronger when parents felt confident in the health visitor's level of knowledge and ability to provide them with the necessary information or support.

Yes, it's good. She's very open and friendly, very knowledgeable. She's often there when I go to the health clinic to do the weigh-ins that you can get when you need them, just to make sure the baby's okay. She's often there. Yes, I feel like I can ask her anything; really, really knowledgeable, good ideas so, yes, I think it's very good (Parent, three children).

Yeah, it's good. [My health visitor] is easy to get on with. [My health visitors] is a very cheery, happy person and quite informative. [My health visitor], as I say, we've got a contact number for them. If we need [my health visitor], we can contact them directly. And there is an office number if we can't get hold of them (Parent, first time).

On the other hand, a couple of parents also mentioned that it was likely they would not contact their health visitor for support if required. However, this didn't appear to be a consequence of a poor relationship with the health visitor. Some of these parents empathised with health visitors' workload and assumed that others may require support more than themselves. Some parents also mentioned that in the situation of any urgent concerns, they would rather make contact with their GP. One parent explained:

I'm not sure if I would contact them, actually, maybe because of some of what I mentioned about feeling checked up on. We don't have any, like, real issues, I guess, but I'm not sure if I would contact them for support. I know other people have, but they seem quite busy. It's quite last-minute when we get our appointments through, and so unless it was something quite major, I don't think I would go and speak to them. And if it was something more urgent, I might end up going to see my GP instead, maybe, because I know them a bit better. I guess I have an awareness of what you might go and see a pharmacist or a GP for, but not necessarily a health visitor (Parent, two children).

Listening to concerns

The parent survey also explored whether parents felt their concerns were attended to once they contacted their health visitor. Eight in ten parents (81%) agreed that their health visitor listens to their concerns either 'very' (51%) or 'fairly' (30%) well. Just 10% said that they did not listen 'very' (6%) or 'at all' (4%) well while 8% did not know. As before, parents with younger children were more likely than those answering about older children to respond positively – 63% of parents of children aged one or younger, or aged 2 years felt their health visitor listened 'very well',

falling to 52% of parents answering for a 3 year-old and 38% for a 4 or 5 year-old. There were no other significant differences between parents of different ages, household incomes, or those living in different Health Board regions.

3. Impact of the pathway

Early identification of strengths and concerns

A key goal of the UHVP is to promote early identification of children and families' strengths and concerns. In the health visitors' survey, the vast majority said that the pathway (in full or part in almost all cases) enables them to identify concerns about a child at an early stage 'very well' (36%) or 'fairly well' (57%).

Amongst the 36% of health visitors who said the pathway enabled them to identify concerns about a child 'very well', those working full-time were more likely than their colleagues who worked part-time to say the pathway helped them to identify concerns 'very well' (44% versus 29% respectively). Also, those who had been delivering the pathway for over four years (51%) were slightly more likely than those who had been delivering it for less than four years to say this.

When asked the same question in relation to identifying concerns about parents at an early stage, health visitors responded in a similar manner: 34% said the pathway enabled them to do this 'very well', 61% 'fairly well' and 4% not 'very' or 'at all' well. Full-time colleagues were again more likely than those who worked part-time to feel it did this 'very well' (42% versus 25% respectively).

In the qualitative interviews, many health visitors explained that the pathway facilitated frequent interaction with families and enabled early identification of strengths and any concerns.

When you're seeing patients a lot more frequently or offering to see them a lot more frequently, it offers more opportunities for them to talk about or ask about, so therefore if there is any issues that are coming up then these will be identified earlier (Health visitor).

The frequency of visiting facilitated positive relationships between health visitors and parents [see theme 2] and allowed them to have a better understanding of the wider home environment and a family's circumstances.

I would say that the pathway allows you to identify [a family's strengths and concerns] and you can see how it changes. What can be a core family that you are visiting because you are following the timeline you can pick up on things that maybe you wouldn't because you are in more often and you are getting that better relationship with families, with mums and dads and grandparents and things that you

can see more so if a family is maybe reaching crisis and things like that and they do need extra help (Health visitor).

During the focus groups, health visitors agreed that the antenatal visit was particularly beneficial for identifying concerns around maternal mental health and allowed health visitors to provide support for this prior to the birth of a baby.

I'm doing a few antenatal visits and one of the things that's come out in most of them has been mental health issues. It's been women who share with you, because you don't have the distraction of a baby there. I find them so valuable, and often, [mothers] will share things at an antenatal visit, that they will not share with you at a new birth visit. You then go into that new birth visit, with knowledge about that family, that then informs everything else that you do ... I'm yet to find an antenatal [visit] that hasn't been valuable, in some way or another, compared to just going in on day 11 or day 12, and meeting them for the first time (Health visitor, Focus Group).

However, a few health visitors disagreed and shared views indicating that the frequent visits embedded in the pathway had little to no influence on early identification of families' strengths and concerns, as this was already embedded in practice.

I don't think it's necessarily changed. I think health visitors are doing that anyway. I think we have quite a good awareness of all of those issues, so I'm not really sure that the pathway has changed that (Health visitor).

It is difficult to explain this disparity, but it is likely that the variation in health visiting services across Health Boards that existed prior to the implementation of the UHVP may have influenced health visitors' responses regarding early identification of families' strengths and concerns.

The point at which strengths and concerns were recorded within case notes was also explored. The timeframe for identification of strengths and concerns is provided within Table 3.1.

Table 3.1 The time at which Assessment of Strengths and Concerns took place

| Health Board | Assessment of Strengths & Concerns | | | | | | | In addition | |
|--------------|------------------------------------|-----------------------------|------------------------------|------------------------------------|--------------------------|--------------------------------|---|---|--|
| | 10-14 days /possible cases | 6 – 8 weeks /possible cases | 3 & 4 months /possible cases | 6/12 record review /possible cases | 8 months /possible cases | 13 – 15 months /possible cases | | | |
| HB1 | 14/15 | 10/15 | 0/15 | 0/15 | 1/15 | 3/15 | 1 x at LAAC Review (112 weeks = 2 years and 2 months) | All records provided evidence that assessment of strengths and concerns had taken place either at the first visit or at 6-8 week assessment or both | |
| HB2 | 5/13 | 3/13 | 2/13 | 5/13 | 4/13 | 5/13 | | | |
| HB3 | None evident | 10/15 | None evident | None evident | 7/15 | 11/15 | 4/10 at 27 – 30 months | There is evidence that 14/15 had an assessment of strengths at some point; however for one this was not identified until 13 – 15 months. | |
| HB4 | 6/15 | 3/15 | 2/15 | None evident | 3/15 | 5/15 | | There is evidence that 14/15 had an assessment of strengths at some point; however for 2 cases this was not identified until 8 months. | |
| HB5 | None evident | 15/15 | None evident | None evident | None evident | 8/15 | | In all cases strengths were assessed at the 6-8 week assessment | |

The data collected indicated that **strengths** were identified in the records, in relation to both child and parents/carers; however, no specific strengths were named. Concerns, however, were identified and named; frequently indicating the need for health visitor action upon identification. This is an important step to ensure families receive appropriate support or help. Table 3.2 (children) and 3.3 (parents) show the identification of at least one concern during assessment. Appendices 8 and 9 show the type of concerns identified in relation to children and parents across the Health Boards.

Table 3.2 Where there is evidence of at least one Concern related to the baby/child

| Health Board | Evidence of at least one concern related to the baby/child identified during assessment in each of the following number of records | |
|--------------|--|------------|
| | Core | Additional |
| HB1 | 5/10 | 4/5 |
| HB2 | 3/8 | 3/5 |
| HB3 | 3/10 | 5/5 |
| HB4 | 4/11 | 3/4 |
| HB5 | 4/9 | 4/6 |

Table 3.3 Concerns identified in relation to the parents'/carers' behaviour/well-being

| Health Board | Evidence of at least one concern related to the parent/carer identified during assessment in each of the following number of records | |
|--------------|--|------------|
| | Core | Additional |
| HB1 | 2/10 | 4/5 |
| HB2 | 4/8 | 3/5 |
| HB3 | 2/10 | 4/5 |
| HB4 | 1/11 | 4/4 |
| HB5 | 4/9 | 6/6 |

Health visitors providing child wellbeing, safety and attachment advice and support

It was intended that the pathway would promote children’s wellbeing, safety and attachment. Health visitors were asked in the survey the extent to which the pathway gave them the opportunity to discuss a number of topics related to child safety and wellbeing with families. Table 3.4 represents proportions of health visitors who said ‘a great deal’/‘quite a lot’ for topics relating to child safety and wellbeing.

Table 3.4 The proportions of health visitors who answered ‘a great deal’ or ‘quite a lot’ to the question that the UHVP provided opportunities to discuss topics related to child safety and wellbeing

| Topic related to child safety and wellbeing | A great deal (%) | Quite a lot (%) |
|---|------------------|-----------------|
| Children’s learning and development | 46 | 41 |
| Child safety | 41 | 43 |
| Children’s general happiness and wellbeing | 36 | 46 |
| Parents’ mental health and wellbeing | 32 | 48 |
| The impact on children of parents’ smoking, drinking alcohol or using drugs | 28 | 41 |

Child wellbeing, safety and attachment was also explored in the qualitative study with health visitors. There were mixed responses regarding changes in practice as a result of the introduction of the pathway, some of the health visitors did not feel that the pathway had markedly influenced their advice or discussion around wellbeing, safety and attachment as this was embedded in practice prior to the introduction of the pathway. While others felt that the pathway had enhanced practice in these areas.

I wouldn’t say they’ve changed dramatically; I think because I’ve been a health visitor for several years, I know what’s gone before and personally, I am very committed to what I do as a health visitor. I think this acts as a prompt to remind me of when I need to do things but I don’t think the pathway has changed my practice, as such

because I am very committed to what I do as a health visitor, basically (Health visitor).

No. If you identify the safety issue, you would make a plan around about that. If you identified an attachment issue you would make a plan, you would adjust your visits accordingly. I don't think the pathway has made a difference to that (Health visitor).

I don't think [the pathway] has [made any difference to wellbeing, safety and attachment discussion]; I don't feel it really has at all. I think it's the same, the same as it always was for health visiting (Health visitor).

Although it appeared these issues had always been part of health visiting practice, other health visitors felt the pathway provided the opportunity to highlight the discussion of these issues overall, and the addition of the antenatal visit meant that these issues could be discussed at an earlier point.

So I think maybe there's been a growing awareness of the importance of attachment over the years. But I suppose because it's embedded in the pathway, then yes, it's something that we talk more about and raise the awareness with parents (Health visitor).

I think we have certain checklists, well we do have certain checklists that we go, antenatally and the first postnatal visit, which just looks at attachment. So I guess without the pathway, you wouldn't have your antenatal visits, so you wouldn't have that early opportunity to ask if the mum is bonding with her unborn baby. There's lots of research and evidence to suggest that this is hugely important. So without the pathway, without that visit, we wouldn't be able to do that, so that's obviously really important and the first visit as well, if there's any concerns that are raised from the attachment and bonding, then I guess you have your further pathway visits to help model and refer onto any further services or to do some extra work with the family, to help to improve that attachment. So I guess the pathway just sets it up, so there is an early opportunity to recognise any bonding issues that there may be (Health visitor).

Impact on parental understanding, choices and behaviour

Another main aim of the introduction of the UHVP is to improve families' understanding and application of positive parenting, ultimately leading to improved health and developmental outcomes for children. In order to achieve these outcomes, health visitors need to have an impact on families' understanding of a wide range of issues. The logic model for the UHVP evaluation includes: child development, wellbeing and safety; healthy lifestyle and behaviour choices (including smoke free home, breastfeeding, oral health); and attachment and its impact on children's brain development.

The evaluation explored parents' perceptions of (a) their own level of knowledge about a range of parenting and child development topics, and (b) the extent to which they felt their health visitors had provided them with information about these topics. The survey and qualitative research cannot definitively assess the impact of health visiting on parental understanding. This is because it is possible parents may have acquired knowledge from elsewhere and the survey questionnaire only assesses self-rated knowledge as opposed to actual knowledge, which may be higher or lower. However, the survey can provide an indication of areas where parents feel more or less well informed, and where there may need to be a greater focus as the UHVP is embedded, in order for it to meet its aims.

From the survey data, Table 3.5 shows perceived knowledge and reported receipt of information from health visitors for each of the items asked about. Across a large number of topics, almost all parents rated their level of knowledge highly. The highest levels of self-reported knowledge were for: 'the benefits of reading to children under five' (94% said they knew 'a great deal' or 'a fair amount' about this), 'keeping your child safe' (94%), 'options for feeding your child in the first 6 months' (92%), 'weaning/healthy eating for children' (91%) and 'the benefits of playing with children under five' (91%). Topics where fewer parents, but still a majority, felt well informed included: 'how to manage your own mental health and wellbeing' (77% felt they knew 'a great deal' or 'a fair amount' about this), 'how to handle behaviour that you find difficult from your child' (71%), and 'where to go for help with money issues or benefits' (55%). While it is possible that the latter issue may not affect all parents, managing one's own mental health and handling challenging behaviour are likely to be issues that arise at some point for all parents. It may be of value to consider these reported areas as opportunities to provide more information for parents.

Table 3.5 information provided by health visitor and own knowledge on a range of topics

| Item² | % of parents who felt they knew a great/deal a fair amount | % of parents who said they had received a great deal/a fair amount of info/advice on this from their health visitor |
|--|---|--|
| The benefits of reading to children under 5 | 94 | 53 |
| Keeping your child safe | 94 | 48 |
| Options for feeding your child in the first 6 months | 92 | 60 |
| Weaning/healthy eating for children | 91 | 61 |
| The benefits of playing with children under five | 91 | 55 |
| The impact on children of parents smoking, drinking alcohol or using drugs | 89 | 35 |
| How to support your child's physical health and development | 89 | 58 |
| How to build a secure relationship with your child | 87 | 38 |
| How to support your child's learning and development | 85 | 57 |
| How to talk with children under 5 | 85 | 42 |
| How to support your child's general emotional development and wellbeing | 81 | 50 |
| How to manage your own mental health and wellbeing | 77 | 41 |
| How to handle behaviour that you find challenging from your child | 71 | 28 |
| Where to go for help with money issues or benefits | 55 | 15 |

The proportion of parents reporting that they had received 'a great deal' or 'a fair amount' of information about each topic varied to a greater extent in comparison to self-reported knowledge. Topics where the greatest number of parents said they had

² There were very slight differences in the wording of the items for the question on information and advice from health visitor and perceived knowledge. For ease, the table contains the item wording for the perceived knowledge question only.

received information or advice were: 'weaning/healthy eating for children' (61%), 'options for feeding your child in the first six months' (60%), 'your child's physical health (58%), 'your child's learning and development (57%), and 'the benefits of playing with children under five' (55%). On the other hand, only 15% of parents said they had received a great deal or a fair amount of information or advice about where to go for help with money issues or benefits and just 28% said that they had received a great deal or a fair amount of information or advice about how to handle behaviours that they found difficult. Thirty-five per cent said they had received a great deal or a fair amount of information or advice about the impact on children of parental substance misuse, and 38% said the same in relation to information or advice about how to build a secure relationship with your child.

It is to be noted that the sample for this survey includes parents of children aged 0-5 years from across Scotland. Given the different stages of UHVP roll-out across Scotland, some parents – particularly those answering for children towards the older end of the age spectrum – were unlikely to have received the full UHVP for their child. A further breakdown of responses on each topic is provided below, with subgroup differences, including by age of child. This shows a general pattern for parents answering about children at aged 4 or 5 years. These parents are less likely than average to report that their health visitor had provided them with information/advice on all topics. This is with the exception of handling challenging behaviour and money issues and benefits, both of which are presumed to be more relevant for parents to require information on as their child gets older.

As mentioned above, it is possible that responses reflect the fact that parents with children at aged 4 or 5 years may be less likely to have received the full UHVP; the passing of time and reliance on memory recall may have also impacted parent's ability to remember any information received on particular topics. In addition, it can be assumed that some parents of pre-school children access information and support from a variety of sources including Early Learning and Childcare Staff. Nevertheless, as the UHVP is intended to impact on these areas, findings indicate where particular attention to topics and timing in relation to milestones may be needed to ensure that parents are getting the information and advice, they require to develop understanding and application of positive parenting skills and more widely meet the aims of the UHVP.

Survey responses indicate parents living in the most deprived areas of Scotland are most likely to report having received a great deal or a fair amount of information from their health visitor on specific topics. Survey responses, therefore, suggest that those living in the most deprived areas in Scotland are being offered or are accessing more support on these issues. Older parents, aged 35 years and above, were significantly less likely to say they had received information or advice on a number of issues. In part, this is likely to reflect the fact that parents in this age group are less likely to be first time parents and may be less likely to ask for or want further information or

advice. There was also a correlation between the age of the respondent and the age of child they were answering about, with older parents being more likely to be answering about an older child.

Child development, wellbeing and safety

Nine in ten (89%) parents felt they knew a great deal or a fair amount about **how to support their child's physical health and development**, with half of parents (49%) saying that they knew a great deal about this. Only a very small percentage of parents (3%) reported not knowing very much or nothing at all (see Appendix 10 for full responses to the parental knowledge questions).

Over half (58%) of parents reported that they had received a great deal or a fair amount of information from their health visitor on their child's physical health with just under a quarter (23%) saying they had received a great deal of information on this topic. One in ten (10%) said they had not received very much information from their health visitor on this topic, while 6% said they received no information at all (see Appendix 11 for full responses to the questions on advice and information provided by health visitors).

Parents living in the most deprived areas (SIMD 1 and 2) were most likely to say they had been given a great deal or a fair amount of information about their child's physical health (66% and 64% respectively, compared with 50% of those in the least deprived areas (SIMD 5). Parents answering about children aged 4 or 5 years were less likely to say they had been given a great deal or a fair amount of information on child's physical health (44%, compared with 59% of parents of 3 year-olds, 69% of parents of 2 year-olds, and 74% of those responding about a child aged one or under). A large majority (81%) of parents felt they knew a great deal/a fair amount about how to **support their child's general emotional development and wellbeing**, while 14% said they knew something about this and 5% that they knew not very much or nothing at all. The proportion saying they knew a great deal or a fair amount was highest amongst parents in the least deprived areas (87% in SIMD 5, compared with 75%-81% in other deprivation quintiles).

Half (50%) of parents said they had received a great deal (19%) or a fair amount (31%) of information on their **children's general happiness and wellbeing** while a fifth (22%) said they had received some information on this. A further fifth (20%) said they had not received much or anything, 6% that they had been offered but declined this information and 2% that they did not know. Reported receipt of information on this topic was lowest among parents aged 35 years and above (44% a great deal or a fair amount, compared with 58% of those under 30 years and 61% of those aged 30-44 years) and those answering about children aged 4 or 5 years (35%, compared with 64% of those answering for a child aged one or younger, 62% answering for a 2 year-old, and 53% answering for a 3 year-old).

Infant feeding

Parents were also asked about several specific child health and development topics, including options for feeding in the first six months, weaning and healthy eating.

Almost all (92%) parents felt they knew a great deal or a fair amount about **options for feeding their child in the first six months** (either breastfeeding or first infant formula milk or a combination of both), while just 1% said they knew not very much or nothing at all. Similarly, the vast majority (91%) of parents felt they knew a great deal or a fair amount about weaning and healthy eating for children, while just 1% reported knowing not very much about this. Six in ten (60%) parents said they felt their health visitor had given them a great deal or a fair amount of information on feeding their child in the first six months, with one third (32%) saying they had received a great deal of information on this topic. Just 15% of parents said they received not very much or nothing at all from their health visitor on this topic.

Those answering for older children were more likely to say they had not received any information about options for feeding in the first six months (12%, compared with 4% with children aged 2 years or younger). As noted above, this may reflect recall bias, since it will be longer since such information would have been offered to parents of children in this age group, or due the fact they have had less exposure to the full UHVP.

Parents in the most deprived areas (SIMD 1) were more likely than average to say they had received a great deal or a fair amount of information (69%, compared with 51% of those in SIMD 5). A similar proportion overall (61%) reported having received a great deal (28%) or a fair amount (33%) of information or advice from their health visitors on weaning and healthy eating, while 14% reported receiving not very much or nothing at all. Parents in urban areas were more likely than parents in rural areas to say they had received a great deal or a fair amount of information on this (63% compared with 53%). Parents answering about children aged 4 or 5 years were least likely to say they had received a great deal or a fair amount of information (54%) on weaning or healthy eating, with parents of two year-olds most likely to say they had been given information on this topic (71%). Parents in more deprived areas (SIMD 1/2) were also more likely than parents in other areas to report receiving a great deal of information on weaning / healthy eating (38% in SIMD 1 and 34% in SIMD 2, compared with 20%-28% in more affluent areas).

In the qualitative interviews, parents were asked to reflect on the feeding advice and support received from health visitors and state specific examples to illustrate how advice and support provided influenced their choices and behaviour, especially with regards to breastfeeding and weaning. It is to be noted that many parents from the qualitative interviews reported that they had received a great deal of information about feeding from their health visitor. In exploring how this information influenced

their behaviours, many parents felt it was impactful and were appreciative of the support; this was almost universal amongst those breastfeeding and formula feeding.

Well, I don't know, from the off I kind of wanted to breastfeed, but I guess I was ready to give up because [my child] wouldn't latch on to me herself and then [my health visitor] suggested the expressing, so I guess she influenced me to keep going then with it. I wouldn't say she influenced me in a bad way, she just tried to kind of prompt me to do what I wanted to do, but I was ready to give up (Parent, first time).

I think I may have gone, oh well, it's a day and a half so she can just have bottle milk for that day. But yeah, based on [my health visitor's] suggestion, we've been definitely more active with the breastfeeding, yeah (Parent, first time).

I did find the breastfeeding support that she provided very helpful (Parent, first time).

In the interviews with parents, all parents who needed weaning information said they received this information. However, it appears health visitors took a cautious approach in actively engaging women in discussions around weaning at the four month visit to prevent weaning too early. Many parents also reported being provided with weaning packs in advance to prepare for this stage.

She gave us a weaning pack, she gave us leaflets, she explained it all and what the most recent advice is about it being six months, and I can't remember if it was four months with my first daughter, I can't actually remember to be honest. But she basically went through all what's advised now and what to do and, yeah, that was all fine (Parent, two children).

Most parents who received the advice and information about weaning found it helpful irrespective of the age of their children and this was especially true for those who engaged in further discussions with the health visitor. The data suggests that information and advice might have increased parental understanding, although there is no evidence to demonstrate it influenced weaning behaviour.

Yeah, I found it really helpful, in particular the...one of the things that I wasn't 100 per cent sure was weaning and stuff. I solely breastfeed my baby and I know that the old advice was to start weaning at four months and the new advice is to start weaning at six months and how to do this, to do baby-led or to do spoon fed and all that, kind of stuff (Parent, first time parent).

Yes, she just, I, kind of, even though I've had three others, I, sort of, needed a bit of a recap again on how to, like, what, where do we start. So, she did help me and, sort of, talked me through that, and current thinking (Parent, four children).

As mentioned previously, within the UHVP, health visitors provide weaning information to parents at the four months visit and parents are expected to begin weaning at around six months. Some parents specifically shared feelings of a lack of

support during the critical period of weaning because of the time between the four and eight month visits. It appears some parents would have liked to receive weaning information and support nearer to six months rather than at the four-month stage.

She did say, you don't wean your baby until – well, you're recommended not to do it till they're six months, but she did the weaning chat at like four months and I couldn't understand it. But I did ask her why and she said, there's quite a lot of mums do it too early, and by the time she actually goes to do the weaning chat, they've started weaning, so she does it early so that she can catch some parents before they actually do it, but my wee boy didn't need weaned until he was six months, so that was a bit early (Parent, two children).

I, sort of, was, kind of like, wow, because I think they see you at five months and then the next time they see you is at eight months. So, if weaning's supposed to be six months, they completely miss that. So, they get you ready for weaning, so they dropped off a little book and a little pack. But it, sort of, kind of, when they, sort of, leave you at five-months and then say, alright we'll see you again at eight-months and I just feel like, wow, you're left on your own there. And it's really quite a, sort of, a steep, kind of, curve between five and eight months because you do introduce food and there's lots of different things going on, and lots of...and the development in a baby between five months and eight months is huge. So, I do feel like there's maybe an appointment that's, sort of, missing out the middle of those two (Parent, first time).

During the semi-structured interviews and focus groups with health visitors, similar concerns about the gap between the four and eight-month pathway visits were raised in the *pathway schedule* section above. Health visitors felt that the time between the four to eight month pathway visits needed to be highlighted because it is during this period that weaning usually begins.

Yeah, I think the weaning at four months, when you're encouraging them to wait until six months, is kind of, it doesn't quite align quite right with the pathway (Health visitor, Focus Group).

Sometimes it feels like maybe don't need both of these visits and that to maybe do one and maybe do a six month contact or a contact just after weaning, because weaning is quite a big thing and it's round about six to seven months, so we're given all the information here and then they're starting it around six months and then we're going in afterwards at around eight months. So it sometimes feels like, yeah, something like that could be a bit more useful, because parents get a bit anxious about weaning, and although we say, phone us, pick up the phone, they don't really very often do it in reality (Health visitor).

But I feel that the pathway visit at four months would be better if it was five or six months because we're kind of missing the key weaning, you know, introducing solid foods. By the time we do four months to eight months, there's a big gap,

everybody's stressing, mums are stressing because they haven't moved on to the next stage of weaning and they miss a whole lot of support at that time (Health visitor).

In one of the focus groups, all participating health visitors agreed that the gap between the four to eight month pathway visits is an important concern. Some health visitors also added that they usually make contact with parents at six months via telephone and use their professional judgment to make a decision on whether a parent may benefit from a visit or not. Another health visitor described how she used the six months update as opportunity to contact parents.

You're missing that whole, kind of, weaning period, but I always try and update the GIRFEC at six months anyway, so I always try and make a phone call at that point, at least, just touch base with a phone call, with the families, just to speak about weaning and things, and see if they've got any issues. And if they wanted a visit at that time, do you know, I would probably, I would do, like, a non-pathway visit, if they needed me to (Health visitor).

This was supported by some of the parents that were interviewed, who mentioned that in order to compensate for lack of support around 6 months, some health visitors make provision for additional visit around 6 months.

I mean, she helped me with an issue around the six month mark. I remember she came specifically, even though I don't think we needed to have an appointment, but she went ahead and came back because it was when I was supposed to start weaning. And so she came to offer specific advice and see if I had any questions, or needed advice regarding that. Every time she's come, she's offered plenty of advice and been able to answer all of my questions (Parent, first time).

Healthy lifestyle and behaviour choices

Improved family understanding of a healthy lifestyle and the impact of behaviour choices on the early years and beyond is another key outcome for the UHVP. The vast majority (89%) of parents of 0–5-year-olds who responded to the survey said they knew a great deal or a fair amount about **the impact on children of parents smoking, drinking alcohol or using drugs**, including two thirds (67%) who said that they knew a great deal about this.

However, parents reported receiving less information on this topic from their health visitor in comparison to other topics.

- Around a third (35%) of parents said they had received a great deal or a fair amount of information from their health visitor on the subject of **the impact on children of parents smoking, drinking alcohol or using drugs**.

- Almost as many parents (33%) said their health visitor had given them not very much or no information at all on it.
- A further 14% had been offered this information but felt they already knew enough about the topic.

An analysis of parents who reported being offered more information or advice on this topic reveals a number of significant differences across groups:

- Parents under 35 years were significantly more likely to say they had received at least a fair amount of information about the impact on children of parents smoking, drinking alcohol or taking drugs compared with parents aged 35 years and above (45% of under 30 years and 43% of 30-34 year-olds, compared with 29% of those aged 35 years and above).
- Parents in the most deprived areas (45% in SIMD 1) were more likely to report receiving a great deal or a fair amount of information from their health visitor on this subject than were parents in the least deprived areas (25% in SIMD 5).
- Parents answering about children aged 4 or 5 years were less likely than parents of younger children to say they had been given a great deal or a fair amount of information or advice on this topic (27%, compared with 40% of parents answering for a child aged one or under, 44% of those answering for a 2 year-old, and 34% of those answering for a 3 year-old).

Attachment

The survey also included questions on a range of issues relating to attachment, including building a secure relationship with their child and how to talk with children under 5 years. Most (87%) parents who responded to the survey said they knew a great deal or a fair amount about **how to build a secure relationship with their child**; just 3% said they knew not very much or nothing at all about this. However, although parents felt knowledgeable about this topic, a much smaller proportion said they had received information or advice about it from their health visitor: 15% said they had been given a great deal of information, 22% a fair amount, 17% some, 19% not very much, and 15% nothing at all.

Older parents (35 years and above) were less likely to say they had received a great deal or a fair amount of information or advice on building a secure relationship (33%, compared with 46% of those aged under 30 years and 47% of those aged 30-34 years). Those answering about children aged 4 or 5 years were least likely to say they had received information on building a secure relationship (28%), while parents answering about a 2 year-old were most likely to say this (49%).

Parents on lower incomes and living in more deprived areas were more likely to say they had received this information. For example, 68% of those earning less than

£15,599 said they had received great deal or a fair amount of information or advice on this topic, compared with 29% of those earning £36,400-£51,999 and 31% of those earning £52,000 or more. Also, 52% of those in SIMD 1 and 45% of those in SIMD2 said they had received a great deal or a fair amount of information on this topic, compared with 28% of those in SIMD 5.

The majority (85%) of parents also felt they knew a great deal or a fair amount about **how to talk with children under five**, while 9% of parents said they knew something and just 6% felt they knew not very much or nothing at all. Knowledge grows with direct experience – parents who had no other children in the household felt less knowledgeable than others (80% versus 87% of those who had other children), suggesting that first time parents may need more advice on this topic³.

How to talk to their child was one of the topics on which parents were least likely to have received information or advice from their health visitor. Four in ten (42%) said they had received a great deal (18%) or a fair amount (24%) of information but 28% said they had not received very much (14%) or anything at all (14%).

- In line with other findings in this section, it was parents of children aged 4 or 5 years who were least likely to say they had received this information (35%, compared with 50% of parents answering for a child aged one or under, and 49% of those answering about a 2 year-old).
- Parents in the most deprived areas were more likely to say they had received a great deal of information on this topic (32%, compared with 17% in SIMD 2, 16% in SIMD 3 and 14% in SIMD 4 and 5).
- Parents in the West Health Board Region were more likely to say they had received this information than those in the East (49% versus 35%).

Home learning environment

Improved family home learning environments was also identified as a key aim of UHVP in the logic model produced for this evaluation. This can encompass play as well as reading with young children. The vast majority of parents (91%) felt they knew a great deal or a fair amount about **the benefits of playing with children under five**, with 62% saying they knew a great deal; just 3% said they knew not very much or nothing at all. Parents in the least deprived areas reported a higher overall level of knowledge than others (97% in SIMD 5 said they knew a great deal or a fair amount, compared with between 86% and 92% in relatively more deprived areas).⁴

Over half of parents (55%) reported receiving a great deal (24%) or a fair amount (31%) of information from their health visitor on playing with their child. A further 18%

³ The question asked about other children in the household rather than whether they had other children. However, it is likely that most of those with no other children in the household will be first time parents.

⁴ The pattern was not completely linear, however – 88% in SIMD 1, 90% in SIMD 2, 92% in SIMD3 and 86% in SIMD 4.

had received some information while 8% said they had received not very much and 9% nothing at all.

Once more, parents answering about children aged 4 or 5 years were least likely to say they had received information (46% a great deal or a fair amount, compared with 57% - 64% of those answering in relation to younger children).

An even higher proportion of parents (94%) felt they knew a great deal/a fair amount about **the benefits of reading to children under five** with just 3% saying they knew not very much or nothing at all about this. Parents in the least deprived areas (SIMD 5) were most likely to say they knew a great deal or a fair amount about this (100%) while those in the most deprived areas (SIMD 1) were least likely to say this (88%).

As before, just over half of parents (53%) said they had received information from their health visitor on reading to their child (24% a great deal and 28% a fair amount), 19% had received some information, 9% had not received very much and 10% had received none at all. Parents answering about children aged 4 or 5 years were once again least likely to say they had received information (43%) and those answering about a 2 year-old most likely (62%). Older parents were again less likely to say they had received at least a fair amount of information on this (47% of those aged 35 years and above, compared with 62% of 30-34 year-olds and 58% of those under 30).

Similar to the survey findings, the qualitative interviews with parents found that most parents received information from health visitors about the importance of promoting a home learning environment and reading to the child. Those who said they did, mentioned that health visitors often used resources such as Bookbug to facilitate the discussion.

On reading, yes. Then she brought the Bookbug. She mentioned that it's a good idea to start reading with the baby. I could start as young as I wanted, and it was a good habit to get into (Parent, first time).

We had a conversation one day about that, yeah, and we had – I think we got a couple of little books and we've got a CD, it was like another pack that we got given, and there was a little leaflet in it that suggested ways to play and basically suggestions of basically how to talk to a baby and entertain them and sort of engage with them (Parent, two children).

It appeared that those who mentioned that they didn't receive much information or discussion about home learning and reading to their child were parents who already had older children and felt that health visitors assumed they already knew what to do.

I think she gave me some leaflets and a book about it, things like that, but again I'm a second time mum, I kind of know what to do with my wee boy to develop his social skills and things like that, we go to classes and things, so I've not really needed her involvement in that (Parent, two children).

Within the case note review however there was evidence of recordings where toys/books had been *observed* within the home (see Table 3.6).

Table 3.6. The number of cases where toys/books had been observed and recorded at least once

| Health Board | Number of case notes where Toys/books have been observed, and recorded in record at least once/possible cases | Percentage of Total cases |
|--------------|---|---------------------------|
| HB1 | 15/15 | 100% |
| HB2 | 8/13 | 61% |
| HB3 | 9/15 | 60% |
| HB4 | 13/15 | 87% |
| HB5 | 15/15 | 100% |

There was also evidence of recordings where *discussions about the importance* of toys, activities, and/or bedtime stories had taken place with the parent/carer at least once, as reported in Table 3.7.

Table 3.7. Numbers of Cases where the importance of toys/books/bedtime stories had been discussed with parents/carers at least once

| | Numbers where discussion had taken place and been recorded /possible cases | Percentage of total possible cases where discussion achieved | Comments |
|-----|--|--|---|
| HB1 | 8/15 | 53% | 6 x only at First New-born Visit |
| HB2 | 7/13 | 54% | 3 x only at First New-born Visit and 2 x at 6-8 week home visit |
| HB3 | 8/15 | 53% | no indication from data gathering when this was |
| HB4 | 12/15 | 80% | a wide range of ages including 8/12 and 13-15/12 |
| HB5 | 11/15 | 73% | no indication from data gathering when this was achieved |

Parenting and parenting techniques

The health visitors' survey also included a question on the extent to which health visitors felt the pathway they were delivering gave them the opportunity to discuss topics relating to parenting. Overall, responses were less positive than those relating to child safety and wellbeing. Table 3.8 shows the proportions of health visitors who indicated that the pathway promoted the discussion of parenting topics.

Table 3.8. Proportion of health visitors who indicated that provide opportunity to discuss parenting issues either 'a great deal' or 'quite a lot'.

| Topic related to parenting | A great deal (%) | Quite a lot (%) |
|--|------------------|-----------------|
| Support families with developing parent-child relationships | 34 | 45 |
| Talk to families about how to handle behaviour they find challenging from their children | 22 | 39 |
| Talk to families affected by money issues about where to find help | 22 | 36 |

A closer analysis showed that health visitors in the West Region and those who had been delivering the UHVP for more than four years were more likely than others to say that the pathway they were delivering gave them ‘a great deal’ of opportunity to:

- Support parents with developing parent-child relationships (39% in West versus 22% in East and 34% overall; 49% of those who had been delivering the UHVP for over four years, compared with 34% overall).
- Talk to families about how to handle behaviour they find challenging (28% in West versus 12% in East and 22% overall; 38% of those who had been delivering the UHVP for over four years, compared with 22% overall)
- Talk to families affected by money issues about where to find help (31% in West versus 11% in North, 10% in East and 22% overall; 32% of those who had been delivering the UHVP for over four years versus 22% overall).

These topics were also explored in the survey with parents. The survey asked parents about handling behaviour from their child that they find challenging, their own mental health and wellbeing, and support around money issues and benefits - all areas where the UHVP envisions health visitors offering support.

Just over two thirds of parents (71%) felt they knew a great deal or a fair amount about **how to handle behaviour that they find challenging from their child**, while 20% said they knew something about this and 8% said they did not know very much or anything at all. Handling challenging behaviour was one of the topics which parents were least likely to say they had received information or advice from their health visitor. Just over a quarter (28%) said they had received a great deal or a fair amount of information on this while 17% reported they had received some, 18% said they had not received very much and 26% reported they had received nothing at all. Parents in the least deprived areas (SIMD 5) were less likely to say they had

received information on this (16% said a great deal or a fair amount, compared with 27% to 36% of those in relatively more deprived areas).

Around three quarters (77%) of parents felt they knew a great deal or a fair amount about **how to manage their own mental health and wellbeing**, while 16% felt they knew something about this and 6% felt they knew not very much/nothing at all.

Around one in five (21%) said they had received a great deal of information or advice from their health visitor on this while similar proportions said they had received a fair amount (20%) or some information (20%) on this topic. A third had not received much (16%) or any (17%) information.

Younger parents were more likely to say they had received information about how to manage their own mental health and wellbeing 58% of parents under 30 said they had received a great deal or a fair amount, compared with 43% of those aged 30-34 years and 36% of those aged 35 years and above. Parents answering for children aged 4 or 5 years were also less likely to report having received information or advice about managing their own mental health and wellbeing (29%, compared with 40% of parents answering about a 3 year-old, 52% of those answering about a 2 year-old, and 54% answering for a child aged one or younger. Those in the least deprived areas were also less likely to say they had been given information or advice on this (29% in SIMD 5, compared with 51% in SIMD 1).

Parents' knowledge was lowest in relation to **where to go for help with money issues or benefits**. In part, this may reflect the fact that not all parents may need this information or support. Just over half (55%) of parents said they knew a great deal/a fair amount about this, while 21% said they knew something and 22% said they knew not very much/nothing at all. This was also the topic on which fewest parents reported receiving information or advice from their health visitor – just 15% had received a great deal/a fair amount of information on this while 57% had not received much/anything at all.

Parents on lower incomes and those living in the most deprived areas were most likely to have received this information:

- 35% of those earning less than £15,599 had received a great deal or a fair amount of information or advice on help with money issues or benefits, compared with 7% of those earning £36,400 - £51,999 and 8% of those earning £52,000+.
- 21% of those living in SIMD 1, had received a great deal or a fair amount of information or advice, compared with 6% in SIMD 5.

Impact on parental confidence

Another key aim of UHVP is to improve family confidence in positive parenting techniques.

Almost two thirds (62%) of the health visitors surveyed felt that the pathway they were delivering enabled them to support parents to become more confident (20% 'a great deal', 43% 'quite a lot'). Amongst those who said 'a great deal' or 'quite a lot' those who had been delivering the pathway for over four years were more likely to say this (68%).

When parents were asked a similar question, 59% of parents surveyed agreed that 'my health visitor has helped me feel more confident about making the right decisions for my child' (34% strongly agreed and 25% tended to agree). However, a fifth (21%) neither agreed nor disagreed and 17% disagreed (7% strongly). In line with other findings, parents answering about children aged one or under were most likely to agree their health visitor had helped them feel more confident (69%), and those answering about children aged 4 or 5 years were least likely (53%).

Perceived impact on health inequalities

Surveyed health visitors were invited to share their views on the extent to which the UHVP being delivered was contributing to a reduction in health inequalities between children of different backgrounds. Opinion was divided: 11% felt it was contributing 'a great deal', 23% 'quite a lot', 38% 'some', 19% 'not very much' 4% 'none at all' and 6% 'don't know/prefer not to say'. In line with other findings, those who had been delivering the UHVP for longest were more likely to feel it was contributing towards reducing inequalities (46% of those who had been delivering it for over four years said it was contributing 'a great deal'/'quite a lot', compared with 34% overall).

The 97% of participants who were currently delivering the UHVP, in part or in full, were asked how much impact it has had on opportunities for them to engage with families who may be less likely to engage with services. Two thirds (65%) felt it had had a positive impact (20% a major positive impact and 45% a small positive impact), a further 28% felt it had no impact one way or another while 3% felt it had had a negative impact.

Those who were working full-time were more likely than their part-time colleagues to feel it had had a major positive impact (28% versus 11%), while those who had been delivering it for more than four years were more likely than average to say this (33%, compared with 20% overall).

4. Partnership working with other agencies

Health visitors' views on how the pathway promotes multi-agency working was explored. In the survey, half of the health visitors felt that the UHVP has had a positive impact on providing opportunities to work with other agencies (13% a major positive impact and 37% a small positive impact), 43% felt it had made no difference

one way or the other while 5% felt the impact had been negative (4% major and 1% small). Those who had been practicing for 10 years or more were much less likely than others to think there had been a positive impact (35%, compared with 50% overall).

In the qualitative research there were mixed findings when health visitors were asked to comment on whether they felt the pathway promotes multi-agency working. Those who responded that it created opportunities for multi-agency working explained that the frequent visits embedded within the pathway promoted timely referrals to relevant agencies and the ensured interactions with these agencies. These were also facilitated by the visual representations of the pathway that helped to create awareness about the role of health visitors and the nature of the pathway.

I think the pathway is good as well for other agencies seeing what health visitors do, and what they deliver, as well. Which is, you know, beneficial. Because I think a lot of people out there were like, what do health visitors actually do, you know, with babies, you know. So in that sense, you can see, you know, what we're delivering, and other agencies can see that as well. So it's quite good from that point of view (Health visitor, Focus Group).

I suppose the other thing I like about the pathway is – and I'm not sure if this is the right place to mention this, but I like the visual aspect of it, so not everyone does but I put this in the front of the parent health record so that parents can see what's going on and I write my visits in here at the front, they know, they can plan what's happening next, look at the front, but I can also use this with other professionals to show them what we do, and I think that was one of the issues before, it was quite hard to explain what health visitors do. So I think it gives a visual representation of how we support parents and children is useful, yeah (Health visitor).

The broad areas that the pathway covers were also regarded as opportunities to engage with different professionals.

Yeah. I think it does because I think it includes lots of different things. You know, there's lots of different...child smiles, play at home, speech therapy, you know, community paediatrician, social work home start, charity organisation. So, I think that is included within the pathway, in terms of trying to sign post people to different resources and community organisations that would be useful. So, I think, in terms of that, yeah. I think there's a lot of information within that that was useful. Particularly, I think, if you were new into the post. Or newly qualified (Health visitor).

They also believed that the pathway had introduced more structure into how they engaged with other professionals, especially when dealing with requests for assistance⁵.

Yeah, definitely, it has changed [multi-agency working]. I think there was a lot more ad hoc type of requests for, you know, assistance. So, you know, whereas now we have the different stages, as I say the different developmental stages. They've always been there but I think it's probably a little more key sort of, you know, because it's...those particular developmental stages are being done within that timeframe, you know, whereas before maybe it was a little bit ad hoc. So for example we didn't have a 13 to 15 month assessment and that's obviously incorporated into the pathway. And I think, you know, we're not missing some of these babies who might present with various issues and problems, and we might then not have seen them till 27 to 30 months, so we're able to kind of, you know, assess things and detect things at various different stages. And I think our colleagues, you know, other health professionals, they're now aware of the universal pathway, they're aware of all the different developmental kind of types of visits (Health visitor).

Similar to the findings of the survey, other health visitors expressed the view that the pathway had not influenced any change in multi-agency working and that this had therefore remained the same. Some explained that other factors, have contributed more positively to multi-agency working rather than the pathway such as the use of the Getting It Right For Every Child (GIRFEC) national model and approach.

I don't know if it promotes it as such, I think that we do that anyway, so I would have done that regardless, even before the pathway, so again for me, personally, probably not. I don't think the pathway has been the key to that. I think there has been other things like GIRFEC that probably has done that rather than the pathway (Health visitor).

In the case note review, health visitor attendance at multi-agency meetings related to the baby/child was evident throughout. In most cases the children involved were predominantly allocated to HPI-Additional. The purpose of the multi-agency and multi-disciplinary meetings predominantly relate to child protection systems and processes.

Engaging families with relevant services

Supporting sustained engagement with relevant support groups or services is another ambition for UHVP. Many health visitors reported that the intensity of the pathway helped them to make timely referrals to relevant services. The services or

⁵ Request for assistance means the health visitor will formally refer the child/family to a specified service, whilst retaining responsibility for overall monitoring of the child's wellbeing and outcomes.

professionals that they felt they most frequently engage families with were speech and language therapists and early learning and childcare professionals.

It was mentioned that there had been changes in other services too and it was difficult to ascertain whether the delivery of the pathway had changed the way health visitors engaged parents with other services. For instance, it was noted that one Health Board used to have a long waiting list for Speech and Language Therapy, but this had been addressed independently of the pathway.

From what it seems we had our transforming health visiting pathway put in place and it seems that other agencies have also done a bit of transformation for their services. Well, particularly speech and language where there used to be a year's waiting list but now there's not a waiting list, which is a big difference in the area (Health visitor).

Health visitors in one Health Board reported that while they were able to identify concerns, it was problematic when relevant services required to provide support were not accessible to families at times. For example, speech language therapists had long waiting list, and this hindered access to such services. Although health visitors said that the waiting times would not influence their referral decisions, they further explained that at times they engage nursery or assistant nurse practitioners to provide interim support to such families whilst waiting for the services from the appropriate agency.

I would say yes it has improved that. Yes, it has improved that. But the knock-on effect is because we're picking up things a lot earlier, which is good for the children to make sure that they reach their full developmental potential by the time they get to school, but the services are not quite there for the number of children that are being picked up early (Health visitor).

Speech and language is probably about an eight month waiting list, so I suppose if there is not really that much out there, if so I probably would refer anyway but in the kind of interim period I would probably link in with the assistant nurse practitioner or the early years speech and language therapist to make sure that a child was still having some kind of intervention whilst waiting the eight months. So, I probably would still refer but I would still be looking for other services to help in the meantime (Health visitor).

In one Health Board, health visitors highlighted that measures had been put in place to overcome long waiting list for speech and language therapy. For instance, they mentioned that the early communication drop-in clinics for families had helped ease the pressure on speech and language therapists and provided them with an important avenue to refer families requiring such services.

I don't know if, say, for example, the early communication drop-in clinics that the Speech & Language therapy provide, I don't know whether that's necessarily linked with the pathway as such, but that's been a fantastic resource to be able to refer...tell parents about so that they don't need to wait a couple of months to see a speech therapist, they can go straight away to any clinic in [this area] and be seen – I think that type of service has been fantastic (Health visitor).

Health visitors felt that the pathway had also facilitated the discussion of certain issues, such as gender-based violence, which was discussed less routinely in the previous offering. Health visitors felt this enabled more timely referrals for these types of concerns.

I would think [the pathway] maybe makes referrals a little bit quicker. Things like, I think, gender-based violence...gender-based violence it's quite routine within the pathway now, and people are talking about it more, and it's not a difficult question to ask. So, I think for getting support in those areas it's... I think the pathway's enabled us to make referrals quicker, sort of, to support services (Health visitor).

A few health visitors reported that the pathway enabled early identification of strengths and concerns and had increased the overall number of referrals, which had inundated other services.

...I think more has developed since the introduction of the pathways because a lot of services must have been inundated with referrals when we started doing these regular contacts. So, they're actually putting together packages so that we can access resources before we refer. So, it's about having that tier one availability and support, so I think that's probably the biggest impact (Health visitor).

The survey found that health visitors who had been practicing for 10 years or more were much less likely than others to think there had been a positive impact of the pathway (35%, compared with 50% overall) in terms of engaging families with other services. Similarly, in the qualitative research, some of the more experienced health visitors disagreed that the pathway enabled them to link families more to relevant services compared with what they were previously delivering prior to the pathway. However, they acknowledged that the pathway added some additional value around the identification of concerns and referral processes.

It hasn't made that any better because I always did that anyway because it was a core part of my job. So the only thing I would say is that maybe the relationship building thing again and maybe some of the specific enquiries round for instance domestic abuse may make it more likely to, yeah, to highlight something that needs referral (Health visitor).

The survey also asked parents whether their health visitor had ever requested help from, or suggested that they contact, any other services. Fifty-nine per cent said they had been referred to a service while 40% had not. The 59% who had been referred to a service were then asked whether they had contacted a service as a result of their health visitor's suggestion. Ninety-one percent of these parents had, while 9% had not.

The specific services referred to and contacted are shown in Table 4.1 below. As shown, the services parents were most commonly referred to were: local doctors/GPs (35%), other services that support parents of young children (e.g. parent and baby/child groups, Children's Centres) (27%), other health services (e.g. Audiology, Optician, Speech and Language Therapy, Dietician, Child and Adolescent Mental Health Services) (22%), Paediatrician (13%) and Practice Nurse (11%).

Table 4.1 Referrals to wider services

| Service | % of parents who were referred to service by HV |
|---|--|
| Local doctor/GP | 35% |
| Other services that support parents of young children (e.g. parent and baby/child groups, Children's Centres) | 27% |
| Another Health Service (e.g. Audiology, Optician, Speech and Language Therapy, Dietician, Child and Adolescent Mental Health Services) | 22% |
| Paediatrician | 13% |
| Practice Nurse | 11% |
| Services that offer help accessing childcare | 5% |
| Services that help with food money or housing issues | 3% |
| Social worker | 3% |
| Any service | 59% |
| No service | 40% |
| <i>Base: all parents (550) and all parents referred to a service (322)</i> | |

Older parents were less likely than younger parents to have been referred to any service (54% of parents aged 35 year and above versus 67% of 16–29 year-olds and 65% of 30-34 year olds). Parents living in the most deprived areas (SIMD 1) were also more likely than those in the least deprived areas (SIMD 5) to have been referred to a GP specifically (41% versus 27%).

In the qualitative interviews with parents, it appeared that first time mothers and parents new to an area found engagement and signposting to groups and services more beneficial. In the quotes below, one parent explained how the health visitor helped her to engage with baby classes and baby sensory and massage classes. This she felt was important as she was feeling a little isolated. Another parent mentioned that the health visitor was instrumental in terms of engaging her with the groups in the new area she moved to.

Yeah, definitely, because obviously being a new mum I didn't really know anything about baby classes or anything like that, so [my health visitor] was always quite keen to...I guess because I was by myself as well, so she was quite keen to get me like moving and out and seeing people instead of being stuck in all the time. She told me about baby sensory and massage classes and things like that, so she got me involved in them and I went to them, so I did (Parent, first time).

So, definitely able to signpost me to...there's a group called [name withheld], which is held up in the library. It's got a playgroup and different activities going on at different points for different ages of babies and toddlers. So, health visitors were definitely able to signpost us to there. And they've also spoken about a playgroup that might be suitable for [my child] when she's turned two. So definitely, being able to signpost to that. I think when I first moved through, [my child] was only four weeks old. And it was really useful that they were able to signpost me to the one up at the library locally (Parent, two children).

A further exploration of how health visitors engaged families with other agencies was examined within the case note review. Evidence of effective communication with services can be demonstrated where other agencies identify their concern about children to health visitors. The case note review identified that concerns about children were communicated to health visitors from other agencies such as social workers, nursery teachers, police, and other healthcare professionals. An example from HB1, illustrated in Table 4.2 below, shows the types of concerns raised by other agencies that were relayed to health visitors.

Table 4.2. Concerns which were communicated to health visitors in HB1 from other agencies

| Child's age or gestation of mother | Concerns identified by other agencies and shared with health visitors |
|------------------------------------|---|
| 17 weeks of pregnancy | HV notified by SW that father known to Criminal Justice |
| 1 week | Prebirth concerns communicated from SW to HV |

| | |
|-----------|---|
| 27 months | SW notified HV that mother homeless due to relationship breakdown |
| 3.5 years | Nursery teacher informs HV that they are concerned because child fails to be brought to nursery |

There was also evidence in the case notes that health visitors were notified of children’s attendance or non-attendance at other service or agency appointments.

In each of the five Health Board areas the case notes review evidence related predominantly to information from other health disciplines. This does not fully reflect the range of agencies or disciplines referral are made to by health visitors. It is also possible that information about child attendance to other appointments may be held in another agency’s repository.

Health visitors and the appropriate use of health services for children

In the case note review, we explored how health visitors support the appropriate use of services for children. For instance, some records had dental registration identified (see Table 4.3), however the timeframe of when this was recorded varied. In reviewing the records, it is evident that ChildSmile discussions, and referrals, take place in the first few weeks. However, dental registration is not recorded until it has been confirmed by the health visitor. Health visitors are informed of dental registration at 27 – 30 month review, however the majority of children in the case note review sample had not reached this age at the time of the data gathering process. This means they had not reached a stage where this information was recorded by their health visitors.

Table 4.3 Registration with a Dentist

| Health Board | Evidence of noting of dental registration status in record | No evidence of dental registration status in record | Total records reviewed |
|--------------|---|---|------------------------|
| HB1 | 8 (most common time for recording is at 27-30 month review) | 5 | 15 |
| HB2 | 10 (most common time for recording is at 13-15 month review) | 3 | 13 |
| HB3 | 9 (an equal range of times when recorded; 6-8/52; 8/12; 13-15/12; 27-30/12) | 6 | 15 |
| HB4 | 6 (frequently at 13-15/12 – but a number of cases not at this age yet) | 9 | 15 |
| HB5 | 9 (a range of times but most frequently recorded x 5 – at 8/12 review) | 6 | 15 |

General Medical Practitioner (GP) registration is predominantly discussed, addressed and recorded early within the Pathway visits, as could be seen in Table 4.4.

Table 4.4 Registration with a General Medical Practitioner (GP)

| Health Board | Evidence of noting of GP registration status in record | No evidence of GP registration status in record | Total records reviewed |
|--------------|--|---|------------------------|
| HB1 | 8 (usually noted at 6-8 weeks) | 7 | 15 |
| HB2 | 10 (noted at First NB Visit and 6-8/52 Review) | 3 | 13 |
| HB3 | 13 (acknowledged but no date on data gathering tool) | 2 | 15 |
| HB4 | 14 (predominantly noted at First NB Visit) | 1 | 15 |
| HB5 | 15 (10 x logged at First NB Visit) | 0 | 15 |

Data on parents' use of services or agencies which provide emergency treatment and care for their child was collated. The number of visits appeared to increase after six months of age. The reasons for attending A&E/Out of hours are provided in Appendix 12. Whilst informative, without knowing the clinical circumstances it is not possible, or appropriate, to make a judgement about whether the health visitors have been able to support the appropriate use of emergency or urgent care in these cases.

Knowledge and awareness of local groups and services

In order to understand how health visitors engage with other services. It is important to explore their knowledge and awareness of groups and services within their local area. It was anticipated that the pathway would enhance health visitors' knowledge and awareness of community assets and referral pathways. Often, knowledge and awareness of local services were area dependent, with some areas, having a directory or local list of all services available in that particular area. According to health visitors, community profiling in terms of identifying relevant local services and signposting families to these services has always been part of their role, therefore many felt the pathway has not enhanced their knowledge and awareness of these services.

I don't think the pathway has done that [enhanced knowledge and awareness of community assets and referral pathways]. I think as a health visitor with your community profile that you do, like I've been in [this place] for a year and a half, so when I first came to [this place] a big part of what I did was going to find out what there is. I don't think the pathway does that for us, I think you do that as a health visitor yourself, I don't think it really does that at all...as a health visitor that should be your bread and butter. That's something I teach when I'm a community practice teacher, you know that's the kind of thing – go out and find out what there is (Health visitor).

Very few health visitors from the interviews and focus groups, including newly qualified ones or those who have relocated from a different Health Board area found the pathway to be helpful in terms of facilitating their knowledge and awareness of community assets and referral pathways. Most explained that the pathway had not directly enhanced their knowledge of community assets, however its inherent

timeline facilitates signposting of families to services relevant to age and stage of the child.

But I mean, I think the pathway does signpost different places that you're able to refer into. And the kind of time that you're doing it, you know what's right for the child and 13-month review safety features because of the age and things like that, so you're able to signpost them to groups and initiatives and things (Health visitor).

Health visitors who are new to a Health Board area may not be fully aware of the groups and services in that particular area. This means they may be unable to engage families with relevant local groups and services. One parent explained that she had to do her own research to identify relevant groups and services in her area and informed her health visitor about it.

...I had happily found out myself and told her that, and she just asked how they were and stuff, so, yes, probably just did it myself. But she did, you know, ask about it, so, yes, that's fine (Parent, three children).

It was clear that some parents had local knowledge of groups and services in their local area. They also found out more about groups and services through networks of similar groups and services.

Yes she has, she did tell me about groups that are happening yeah, I mean, I did a lot of...I found out about a lot for myself, it's one of those things if you go to a group, people tell you about other groups that exist as well (Parent, first time).

5. Health visiting workforce

Training, supervision and support

Two thirds (64%) of health visitors reported having informal discussions (e.g. a chat with colleagues) about delivering the UHVP and 41% had discussed the delivery of the UHVP in their supervision.

During the pathway implementation, continuing professional development courses were rolled out to all health visitors in post. Forty-one percent of health visitors reported they had undertaken UHVP training as part of a UHVP health visiting course. A further fifth (19%) had completed online training, 2% had done another form of training, while 2% said they had not undertaken any training on UHVP.

Participants who had recently joined the profession were most likely to have undertaken UHVP training at university (87% of those who had been practicing less than a year, compared with 41% overall). While those who had been in post for

longer were more likely to have attended formal training course while in practice (64% compared with 52% overall).

Although the vast majority of health visitors said they felt confident (90%) and skilled (91%) in their roles, only 59% felt they had sufficient opportunity to participate in relevant training. Twenty-two per cent said they had not had enough opportunity, while 18% were unsure. Those who had been delivering the UHVP for the longest time were most likely to feel they had sufficient opportunity for training (69%).

In the qualitative interviews and focus groups, health visitors across the case study Health Boards stated that they did not receive any formal pathway training prior to the introduction of the pathway as the pathway was mainly introduced through informal briefing and team discussion. Some health visitors noted receiving training specific to the Ages and Stages Questionnaire (ASQ), the nationally recommended tool for use at all child health reviews across Scotland around the time of implementation but not specifically around the pathway itself.

There were mixed views on the lack of pathway specific training as practitioners with more years of service felt this was not necessary as it aligned with their prior role, however, a few newly qualified health visitors in two Health Boards felt that their university training did not equip them well for delivering the UHVP. This is contrary to the survey findings however, which used much larger sample.

The pathway just came from above and that's where it was. There wasn't an awful lot of training around this pathway. There were masters classes for things but there wasn't much on the actual pathway (Health visitor).

From the point of view of the placement side of it, yes. But I don't think the university side of it focused very much on the actual pathway. It was expected that our practice educators would show us that (Health visitor).

In terms of support from peers and supervisors, health visitors in two Health Boards frequently reported that they felt well supported by their team leaders and managers. Many of them also discussed that they were part of cohesive and supportive teams, which positively contributed to their working environment. Peer-support within teams was commonly referenced with regard to caseload management with many health visitors identifying that support could be gained in this way before escalating a caseload issue to management.

A number of health visitors described the importance of team working when asked about the support they receive in terms of caseload management. Regular clinical supervision meetings between health visitors and their team leaders positively contributed to caseload management.

I think we support one another, within the teams. I think it's down to the team, and the relationship you have as a team, and we have weekly meetings and discuss, at a team level, the management of the caseload. How we're going to work out reviews, if somebody has got maybe more than their share, if you like, if they've got a lot of antenatal, and they're going to be having two weeks annual leave in the middle of that, you know, we'll share that all out (Health visitor, Focus Group).

On the whole, clinical supervision is pretty much embedded now. And it didn't really exist before. Particularly in the last two years, clinical supervision's become a regular occurrence; it's about every six to eight weeks. And the training opportunities are coming in more regular now. There's a lot of [training] programmes here. Particularly with the social care side of things and child protection (Health visitor).

The survey data showed that health visitors who were most likely to feel they had enough clinical supervision included: those working in the West and North Regions (73% and 71% compared with 46% in the East), and those who had been practicing for 1-2 years (78%, compared with 67% overall).

A large proportion of health visitors noted that they knew where to seek support, if necessary, to manage their workload and caseload complexity.

I would know the channels to go through if I was concerned. I think if you're working as part of teams then if you're in a supportive team then that kind of support is always ongoing, i.e. if you were really struggling, you've got colleagues there that you can have a conversation and review (Health visitor).

Although attention was drawn to team working and peer-support, many health visitors noted that they viewed themselves as autonomous practitioners with a number of responsibilities, including organising and managing caseloads.

Staffing level and resources

Staffing was seen as one of the key challenges affecting the pathway from being fully delivered in relation to workload implications. In fact, in the survey, workload was a concern for three in five (60%) participants, with 18% describing it as 'far too high' and 42% 'a bit too high'. Thirty-eight per cent felt it was about right, 1% that it was too low and a further 1% did not know/preferred not to say. Full-time professionals were more likely than those who worked part-time to feel their workload was 'far too high' (22% versus 13%).

During a focus group, one health visitor explained that although staffing levels had improved, it still posed the greatest challenge to the pathway, and all participants in the focus group appeared to agree with this.

On the whole, it's being delivered, but there are times that it's difficult to do that. And I wouldn't say that it's a hundred per cent being delivered, but there are various

factors that contribute to that, which will depend on staffing, primarily. It has improved significantly, the past year, but it is still a challenge in certain places, for various reasons (Health visitor, Focus Group).

Health visitors felt equipped to deliver the pathway in terms of identifying concerns in children and families because of their training, experience and available support. However, they felt that in terms of delivering adequate support to families, their capacity to do this in some cases was limited due to caseload sizes, resource constraints and external barriers such as waiting lists or limited availability of wider services.

Health visitors in one Health Board felt that staffing increases were insufficient as they were counteracted by other changes in the workforce such as retirements and maternity leave. In addition to this, there was agreement amongst health visitors that any fluctuations to staffing levels caused by temporary changes such as holiday leave, maternity leave and sick leave placed a considerable burden on teams because they had to accommodate additional caseloads.

Reassuringly, in areas where health visitors felt they have adequate staffing, it was reported that delivering the full pathway and additional visits was manageable.

If you had asked me that question [whether I feel equipped to deliver the pathway] months ago when our caseloads were a lot higher, I would have said yes but it put us under a lot of pressure. However, now that we have got a new staff member, I certainly feel equipped, yes (Health visitor).

Health visitors in one Health Board, reported that uplift and staffing changes lacked consistency across the Health Board region. Some health visitors commented that staffing uplifts were prioritised to areas with higher additional need rather than areas with very high caseloads and a smaller proportion of additional need in comparison.

Often health visitors reported that the administrative part of the pathway considerably increased their workload. It was clear that the need to provide targeted support to families identified as requiring additional support adds significant workload pressure to the delivery of the pathway.

So I've found that my caseload is quite a vulnerable caseload and I need to go out and see the families more frequently than the pathway says and I'm having a lot of Team Around The Child meetings called either by myself or by nursery or by social work which takes up a lot of my time as well. And then if I'm doing a Team Around The Child if I've called it I have to sort out the child's plan, so that can take up quite a lot of my time as well (Health visitor).

When asked whether they have the necessary resources to carry out their role and work in the survey, health visitors were, less likely to feel that they had sufficient resources available to them.

Three in five (60%) agreed (15% 'strongly' and 44% 'tended to agree') that they had the necessary resources to help them meet the needs of the families (e.g. leaflets, materials) while slightly fewer (55%) said they had access to the IT systems required to carry out their health visiting role effectively (18% 'strongly agreed' and 37% 'tended to agree'). Health visitors working in the North Region were more likely than those in the West to agree that they had the necessary resources (71% compared with 55%).

Responsibilities outside UHVP

In the survey, health visitors were also asked whether they were carrying out any tasks that were *not* a part of the UHVP. This was intended, primarily, to identify whether they were still delivering services that were not part of the pathway, such as drop-in clinics (14% were delivering these) and immunisations (4%). Participants were also able to write in other responses. The most common were: additional family visits (9%), breastfeeding support/groups (8%) and child protection (6%). Half (53%) said they were not delivering anything that was not part of the UHVP.

Reasons given for undertaking tasks that were not core UHVP included:

- The added value to families of delivering these elements (46% of those delivering tasks that are not core UHVP)
- Lack of capacity among (non-health visiting staff) to deliver them (43%)
- Involvement needed from a safeguarding point of view (40%)
- Parents prefer to receive them from their health visitor (28%)
- Lack of skills among other (non-health visiting staff) to deliver them (20%),
- Health Board asked them to continue delivering them (13%) and
- Health Board has not yet fully implemented UHVP (8%).

In order to understand more about why health visitors were engaging in activities outside the core UHVP, further qualitative research was undertaken. For instance, as a part of the implementation of the pathway, health visitors were no longer required to immunise children as part of their transformed role. Most of the Health Boards mentioned that they have immunisation teams to undertake this role, however, in some areas of one Health Board, health visitors were still involved in immunisation.

Currently we are involved heavily in immunisations. We are responsible for the pre-school booster clinic alongside an immunisation nurse. We are also on the days that we don't have an immunisation nurse here we would cover for holidays and sickness and things like that, so we'd be caught up in doing immunisations during that period of time as well. When I started last September we were three full time members of staff here. We're now down to myself and my colleague who work four days a week and my other colleague is still full time, and we have enormous caseloads, so we're just not physically able (Health visitor).

Health visitors in one Health Board also reported undertaking the 27-30 months and 4-5 year reviews as clinic visits rather than home visits. It became apparent that staffing challenges were highlighted as one of the reasons for undertaking contacts in clinics, especially for core families.

One health visitor explained in the focus group:

For us, when we had a full complement of staff, we were managing the contacts as they should have been done, at home. However, staffing has been an issue for our area, for the last two years, and we've had to change our way of thinking. So although we do the three month, and the four month, at home, we're having to take children in at 27 months. Unless we are aware that they have got, if they're vulnerable, if they're complex, or if they're going through child protection, whatever. But the ones that we're aware are core, we're having to take them into clinic. So it's not ideal. But to manage the contacts, and the assessments, we're having to do that (Health visitor).

In addition to this, it was mentioned that health and safety issues of carrying weighing scales also necessitated management decision to allow health visitors to carry out the 27-30 months and 4 to 5 years reviews in clinic in this particular Health Board.

Job satisfaction

The survey explored health visitors' satisfaction with their job. Seventy per cent of participants reported being satisfied with their current health visiting role (17% very satisfied and 53% fairly satisfied), a further 12% said they were neither satisfied nor dissatisfied while 13% were 'fairly' and 3% 'very' dissatisfied.

The length of time in practice was clearly linked to job satisfaction with those who had been practicing for under a year (86% very/fairly satisfied) and 1-2 years (82%) being most satisfied with their role and those who had been practicing for 10 years or more being the least satisfied (60%). Those that had been practicing for 10 years or more were also more likely than average to say they were very or fairly dissatisfied (22% versus 16% overall).

The vast majority of health visitors felt skilled and confident in their role. Ninety percent agreed (38% 'strongly' and 52% 'tended to') that they felt confident delivering all parts of their health visiting role. Confidence increased with experience, from 71% among those who had been practicing for under a year to 95% among those with more than 10 years' experience.

Ninety-one percent of health visitors agreed (40% strongly and 52% tended to agree) that they had the skills they needed to perform their job effectively. Once more, this increased with both overall experience and time delivering the UHVP. Ninety-six percent of those with more than 10 years' experience agreed, compared with 78% of those practicing for under a year and all (100%) health visitors who had been delivering the UHVP for more than 4 years agreed, compared with 91% overall.

In terms of the recognition and support health visitors receive, half (52%) agreed that they felt valued for the work they do (15% 'strongly agreed' and 38% 'tended to agree'). Some however, did disagree with this – 16% tended to disagree and 8% strongly disagreed. Those who had been in health visiting for 10 years and over were more likely to disagree that they felt valued (30% versus 14% of those who had been in health visiting for 2 years or less). However, there was no significant difference by length of time delivering the new pathway, or between full and part time health visitors.

A number of subgroups were more likely than average to feel valued: those in the North Region (61%), and those who had been practicing as a health visitor for under a year (65%) or between 1 and 2 years (64%).

6. Overall satisfaction with health visiting service

Around two thirds of parents (69%) were satisfied with the health visiting service they had received before lockdown started in March 2020, with 37% saying they were very satisfied and 32% fairly satisfied. Just over one in ten parents (12%) were dissatisfied with the service they had received (7% 'fairly' and 4% 'very') while 18% were neither satisfied or dissatisfied and 2% said they did not know.

Satisfaction with the health visiting service declined with the age of the child – the proportion 'very satisfied' fell from 52% among those answering for a child aged one or younger, to 39-40% among parents of 2 and 3 year-olds, and 26% of parents of 4 or 5 year olds. There were no significant variations overall by the age of the parent, area deprivation, Health Board region, household income or the number of other children in the household.

Importance of health visitors to families

In the qualitative research, when parents were asked to mention the most important aspect of having a health visitor, majority of them highlighted receiving support and reassurance from health visitors and overall accessibility as the most important.

Others also mentioned home visiting and the role health visitors play in helping to monitor their children's weight and development.

Support and reassurance from health visitors

Almost all parents mentioned that receiving reassurance is one of the most important aspects of having a health visitor. They felt that the support health visitors provide to them and their children is invaluable. Many parents also felt this was a secure and non-judgemental source of support.

I think just having that reassurance and knowing that you've got someone there that you can access easily and quickly. And there's not going to be any drama or any issue and or any judgement. I think it's just that feeling of security that you've got someone there that's accessible. So, I will say that's my big one (Parent, three children).

I think it's knowing that there's somebody there like whenever you need them that's always going to give you the right advice (Parent, two children).

I think it's probably somebody to go to if you're not sure what to do. I think every, sort of, every month when they're younger in age has different challenges with it, or new things that you're not expecting, perhaps, so I guess, a bit of a sounding board, somebody to talk to and ask them if things are normal – a bit of reassurance that what you're doing is the right thing (Parent, two children).

Accessibility (first port of call):

Another important aspect of having a health visitor that most parents mentioned was about accessibility and availability. They explained that being able to easily contact their health visitor was very important to them, especially when other health facilities and professionals were difficult to reach. They explained further that health visitors are not only accessible, but they also provide knowledgeable advice. Many mentioned that without the health visitor they would have visited their GPs more frequently, placing an additional strain on this service.

Just having them there. Just on the end of the phone just to ask questions. The doctor's surgery here is particularly stretched, the town is just growing phenomenally. It's so difficult to get an appointment, so between the health visiting team and the pharmacists it's, kind of...those are my ports of call before I would actually go to the doctor. I think it's just knowing someone's there and having them on the end of the phone. That I don't need to wait for an appointment, that I can just phone and leave a message and they will get back to me. Just, it does me the world of good, just to kind of have that security and knowing that's there. And that she knows me; that I don't need to explain things, like from scratch every time. That she knows me and she knows the children (Parent, two children).

I think having a central source of information and having easy access to them so that you don't feel like you're having to waste a doctor's time asking them niggly questions about why isn't my child sleeping, how much milk should they be drinking at this point, what kinds of foods can I feed them, when I'm weaning (Parent, three children).

Yeah, I think, that's the best thing, yeah you know, it would have been very hard without her, I think you know, we would have just, I think, to have not had a health visitor would have been a nightmare, I think, we would have always been at the doctors every week, I think you know, there's a problem with this, there's a problem with this (Parent, first time).

Monitoring child weight

Monitoring of the child's weight was also commonly discussed by parents. They mentioned that knowing from the health visitor how much their baby weighs was important to them and often provided positive feedback or assurance regarding their child's development which they found encouraging.

For me, I think it's keeping an eye on my baby's weight. So, I know she's, sort of, growing and developing and thriving and, sort of, having that line of advice there when needed (Parent, first time).

I think for me, that's probably the best bit about it, I actually quite look forward to the visits, I really look forward to knowing how much my son has grown, how much weight he's put on and basically to get that affirmation that you're doing a good job (Parent, first time).

Home visits

Some parents also highlighted that the most important element of having a health visitor is the opportunity available for the health visitor to visit them in their home. Parents said not getting dressed to go elsewhere to see the health visitor was convenient for them, and this was mostly highlighted by first time parents.

I think it's just knowing that somebody professional is coming round to your home. So, you don't need to leave the house, you don't need to get dressed, you don't need to, you know, venture outside if you're not ready. And it's...so, coming to your home is really important (Parent, first time).

Her coming here is brilliant. Us not having to go out, you know...for her coming to the house, you know...And she just comes in, you know, she knocks and just comes in and hello, you know (Parent, first time).

7. Suggested improvements to the UHVP

An open question included in the survey invited both health visitors and parents to make suggestions of how they felt that UHVP could be improved.

Amongst health visitors, the most common suggested changes to the UHVP related to:

- Resources (34%) – with suggestions including more staff, reduced caseload sizes, greater support from non-health visiting staff, better IT systems, more/better training, and more/better equipment e.g. scales.
- Contacts/visits (30%) – with suggestions including a less prescriptive service/more scope for professional judgement and the reintroduction of clinics.
- The pathway schedule (28%) – including combining the three and four month visits, adding a review around 18 months and conducting the 4-5 years review at clinic/nursery.
- Efficiencies (14%) – mainly relating to reducing/simplifying documentation and paperwork.

Amongst the parents, half (52%) suggested changes (in response to an open question) as to how health visiting in Scotland could be improved. Whereas a fifth of parents (20%) did not suggest any improvements as they were happy with the service while a further 27% did not know how it could be improved.

- Suggested changes fell under the themes shown in Table 7.1, with the most common suggestions relating to an increased number of contacts.
- The suggested improvements also provide an indication of the sources of dissatisfaction among those who said they were dissatisfied with the health visiting service as a whole. Among this group, 72% suggested improvements. The improvements in which there was a significant difference between those who were satisfied and those who were dissatisfied are shown in bold in the table below. They suggest that dissatisfaction may stem from issues related to levels of contact, relationship and communication with the (same) health visitor and feeling listened to and supported.

Table 7.1 Suggested improvements to the health visiting service

| Suggested improvement | Overall % | % of parents satisfied overall with health visiting service | % of parents dissatisfied overall with health visiting service |
|-----------------------|-----------|---|--|
| | | | |

| | | | |
|--|-----|-----|-----|
| <i>Communication</i> | | | |
| More contact with health visitor (in general) | 18% | 11% | 37% |
| Contact with the same health visitor | 6% | 6% | 15% |
| More contact for older children/children over 2 years | 3% | 3% | 5% |
| More face-to-face contact with the health visitor (responses did not always specifically refer to during lockdown) | 3% | 3% | 2% |
| Organise the appointments better/stick to appointments | 3% | 2% | 10% |
| Be easier to contact | 2% | 3% | 2% |
| Employ more health visitors/some areas have no health visitors | 2% | 2% | 5% |
| Reintroduce drop-in clinics | 2% | 2% | 2% |
| Better communication | 2% | 1% | 6% |
| Better communication between health visitors and other services – e.g. GPs/paediatricians | 2% | 1% | 6% |
| <i>Support</i> | | | |
| More advice/information (in general) | 7% | 8% | 10% |
| Listen to the parents/their concerns | 4% | 2% | 15% |
| Better qualified health visitors | 4% | 3% | 11% |
| More support for the mother/mother's mental health | 3% | 3% | 8% |
| Better professionalism/be less judgemental | 2% | 2% | 8% |
| More support for breastfeeding | 2% | 1% | 5% |
| <i>Base: all parents (550)</i> | | | |

8. Parents' experiences during the COVID-19 pandemic

In addition to questions focusing specifically on UHVP aims and outcomes, the parents' survey also included a small number of questions about experiences of the period between March and August/September 2020, when national COVID-19 restrictions were in place. The parents' survey was conducted in August and September 2020 and while questions about the pandemic were not originally part of the evaluation, the changing landscape and impact on services, deemed it important to capture this for context.

Contact with health services during the COVID-19 pandemic

Half (51%) of parents reported that they had some contact with any health services since March 2020, while 48% had not had contact with any of the services asked about⁶. Specific services contacted were:

- Health visitor – 32% of parents overall had contact (37% of these face-to-face, and 74% by another method⁷)
- GP – 21% had contact (51% face-to-face and 62% by another method)
- NHS24 – 11% had contact and (13% face-to-face contact and 88% by another method)
- Hospital (Non-urgent A&E) – 10% had contact (68% face-to-face and 40% by another method)
- A&E – 8% had contact (face-to-face in each case, though 2% said they had also contacted A&E through another method).

Parents of younger children were more likely to have had contact with health services since March 2020. This difference was greatest in relation to health visitors. Six in ten (59%) parents answering on behalf of a child aged one or under had been in contact with their health visitor since March, higher than parents of all other age groups (35% of parents of 2 year olds, 21% of parents of 3 year olds and 22% of parents of 4 or 5 year olds). Younger parents were also more likely to have had contact with their health visitor (43% of parents under 30, compared with 34% of 30-34 year olds and 28% of parents aged 35 years and above). There were no significant differences in whether parents reported having contact with their health visitor since March 2020 by area deprivation, urban and rural areas, or Health Board region.

Among parents who had had contact with their health visitor, there were certain groups less likely than average (37%) to have had face to face contact: parents answering about a four/five year old child (20%), parents with no other children in the household (22%) and parents working part-time/on maternity leave from a part-time job (20%).

Among the 68% of parents who had not had any contact with their health visitor since March, 20% said they would have expected to have some contact in this period, while 68% would not have and 11% were unsure. In line with the planned pathway visits, parents answering about children aged one or under were most likely

⁶ Public Health Scotland data showed a decrease in the use of health services of 60-80% among those aged 0-14 years during the pandemic (<https://scotland.shinyapps.io/phs-covid-wider-impact/>)

⁷ Percentages do not total 100% as parents could give more than one response.

to have expected to have contact (47%⁸) while parents answering about children aged 4 or 5 years were least likely to have expected this (13%). There were also differences by deprivation level with 30% of parents in SIMD 1 and 2 (most deprived) saying they would have expected to see or speak to their health visitor in this period, compared with just 10% of those in SIMD 5.

For each of the health services, at least four in five parents were satisfied with the contact they had had since March:

- A&E – 98% satisfied (80% ‘very’ and 18% ‘fairly’)
- Hospital (not A&E) – 91% satisfied (65% ‘very’ and 26% ‘fairly’)
- GPs – 86% satisfied (57% ‘very’ and 30% ‘fairly’)
- NHS24 – 85% satisfied (60% ‘very’ and 25% ‘fairly’).
- Health visitors – 80% satisfied (47% ‘very’ and 33% ‘fairly’).

Parents were also asked how comfortable they were about accessing health services in person with their child or inviting a health professional into their home at the time they undertook the survey (August and September 2020). It is to be noted that at this point in time, COVID-19 cases in Scotland were substantially lower than they had been in the few months prior. Most parents expressed they were comfortable with accessing health and care services via face-to-face contact.

- 92% said they would feel comfortable with a health professional visiting them at their home in relation to their child tomorrow (50% ‘very’ and 42% ‘fairly’)
- 89% said they would feel comfortable visiting their GP with their child tomorrow (48% ‘very’ and 40% ‘fairly’)
- 83% said they would feel comfortable visiting A&E with their child tomorrow (43% ‘very’ and 40% ‘fairly’)

However, parents who were not working (76%) and those on lower incomes (£15,600 - £25,999) (73%) were less likely than average to feel comfortable about visiting A&E. Parents in the least deprived areas of Scotland were also more likely than those in SIMD 1, 2 and 3 to feel comfortable (91% versus 75%, 80% and 78% respectively).

Parents were asked about their own mental wellbeing during the lockdown period. Just over half (58%) said it had stayed the same, 30% said it worsened while 11%

⁸ Note the base for this figure is low – 45 parents of children aged one or under said they had not had any contact with their health visitor since lock down.

said it had improved. There were no clear patterns as to which groups of parents felt their mental wellbeing had declined – it did not vary significantly by SIMD, income, parental age, or age of child.

The small number of parents (6%, n= 32) with children aged under 1 year were asked about access to online peer support over the last few months. At least half said they had not needed any type of peer support (16 had not needed any support with infant feeding, 17 had not needed support with weaning and 24 had not needed any antenatal classes). Of the remainder, the vast majority said they had found online peer support very easy or fairly easy to access.

Conclusion

This Phase 1 evaluation of the UHVP has highlighted implementation and delivery processes of the UHVP, as well as some short (process) and medium-term outcomes that the pathway is achieving as outlined in the logic model (appendix 2).

All Health Boards in Scotland are now delivering the UHVP, which means all families are largely receiving core visits and many are receiving additional visits when required. While the roll out of the pathway has varied across Scotland, the Scottish Government aim to deliver the pathway by January 2020 has been met.

Health visitors feel confident in their knowledge and skills to deliver the UHVP. They also feel supported by their supervisory teams and colleagues. It was clear from both parents and health visitors that the frequency of visits embedded within the pathway enhance the building of positive and trusting relationships. This is important because it offers parents the opportunity to contact health visitors when they have concerns and almost all health visitors felt that the pathway facilitates the early identification of strengths and concerns of children and parents.

A significant proportion of health visitors felt the pathway offered the opportunity to discuss and support parents on various topics, including child wellbeing, safety and attachment. Discussion of these issues can improve parents understanding and influence their choices and behaviour. For example, the vast majority (89%) of parents in the survey said they knew a great deal or a fair amount about the impact on children of parents smoking, drinking alcohol or using drugs. Similarly, 89% of parents felt they knew a great deal or a fair amount about how to support their child's physical health and development with half of parents (49%) saying that they knew a great deal about this. The source of their knowledge on these issues was often attributed to the health visitor.

There were differences by deprivation in terms of the information parents received from health visitors. The survey highlighted that parents living in the most deprived

areas of Scotland are most likely to report having received a great deal or a fair amount of information from their health visitor on some of the topics covered. This finding, therefore, suggests that those living in the most deprived areas in Scotland are being offered or are accessing more support on such issues. It is difficult to ascertain from the survey, qualitative research and case note review data how the information parents receive actually impacts on their behaviour, however, the outcomes evaluation particularly within the second phase of this evaluation will likely provide further insight into this and some of the other findings presented in this report.

Recommendations

The evaluation identified the following areas for further consideration:

Pathway Implementation

- The antenatal visit should be prioritised in the pathway schedule, because of its role in building positive and trusting relationships between families and health visitors, as well as facilitating the earlier identification of concerns relating to maternal mental health.
- The pathway should be considered in terms of perceived gaps in the visit schedule as identified by parents and health visitors. Additional visits could be introduced at 6 months and 18 months.
- Health visitors seem to be providing a substantial number of additional visits to families outside the core visits, and this should be adequately monitored and incorporated into their workload planning.
- The frequency of the pathway facilitates timely referrals to relevant services. However, in some instances, services for onward referrals such as speech and language therapy may not be available or accessible to families. It might be helpful to develop robust referral strategies in conjunction with such services to ensure families receive timely support.

Workforce

- The scope for the health visiting service to deliver appropriate interventions to children and families should also be explored. This could ensure that families receive some support whilst on the waiting lists of other services.
- Caseload sizes were a concern for many health visitors and may benefit from careful and regular review.
- Continuity of carer is important to families and seems to have improved since the introduction of the pathway. However, older children are more likely to see different health visitors during the last few pathway visits. This could be monitored and improved by Health Boards.

- More efficient ways of reducing or simplifying documentation and paperwork should be explored.

Information Provision

- A good proportion of parents felt they could benefit from more information about ways to manage their own mental health and wellbeing. Further attention to this is required to ensure parents are well informed and supported appropriately.

The above recommendations seek to address challenges identified around the delivery and implementation of the pathway. However, health visitors are generally very positive about the pathway and the overall Phase 1 findings indicate that the UHVP is supporting children and families in a constructive way.

The Phase 2 evaluation will use a similar methodology to ensure some of the findings from Phase 1 can be compared with Phase 2 to further increase understanding of implementation and delivery processes and the impact of the UHVP over a relatively medium to longer term.

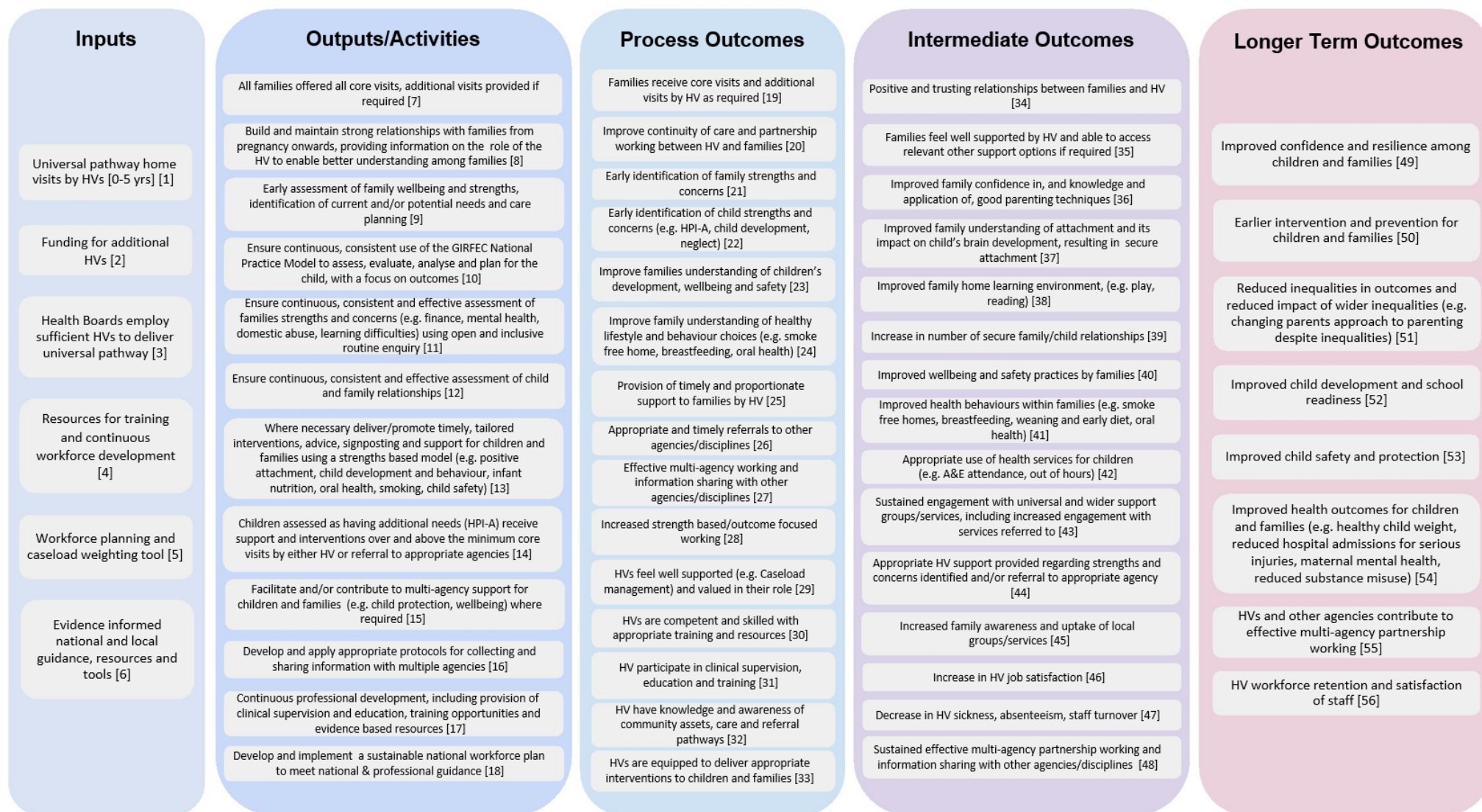
That said, due to the emergence of the COVID-19 pandemic when the Phase 1 evaluation was nearing completion (with the exception of the parents survey), it is unlikely that a full direct comparison between Phase 1 and Phase 2 will be feasible. As a result, the Phase 2 evaluation will also include identification of key lessons learned from the delivery of the UHVP during the COVID-19 pandemic and how these lessons can be used sustainably to improve the health visiting service in Scotland in the future.

Appendices

Appendix 1 Stage of implementation across Health Boards

| Contact point | Ayrshire and Arran | Borders | Dumfries and Galloway | Fife | Forth Valley | Grampian | Greater Glasgow and Clyde | Highland | Lanarkshire | Lothian | Orkney | Shetland | Tayside | Western Isles |
|----------------------|----------------------|---------|-----------------------|----------------------|--------------|----------------------|---------------------------|----------|----------------------|---------|--------|----------|---------|----------------------|
| Antenatal | Yes | Yes | Yes, but not for all | Yes, but not for all | No | Yes, but not for all | No | No | No | Yes | Yes | Yes | Yes | Yes, but not for all |
| 11-14 day | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Data unavailable |
| 3-5 week (contact 1) | Yes | Yes | Yes | Yes, but not for all | Yes | Yes | No | Yes | Yes | Yes | Yes | Yes | Yes | Data unavailable |
| 3-5 week (contact 2) | Yes | Yes | Yes | Yes, but not for all | Yes | Yes | No | Yes | Yes | Yes | Yes | Yes | Yes | Data unavailable |
| 6-8 week | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Data unavailable |
| 3 month | Yes | Yes | Yes | Yes | Yes | Yes | No | No | Yes/ or 4 month | | Yes | Yes | Yes | Data unavailable |
| 4 month | Yes | Yes | Yes | Yes | Yes | Yes | No | No | - | Yes | Yes | Yes | Yes | Data unavailable |
| 8 month | Yes | Yes | Yes | Yes, but not for all | Yes | Yes | No | Yes | No | Yes | Yes | Yes | Yes | Data unavailable |
| 13-15 month | Yes | Yes | Yes | Yes | Yes | Yes | No | Yes | Yes | Yes | Yes | Yes | Yes | Yes |
| 27-30 month | Yes | Yes | Yes | Yes | Yes | No | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Data unavailable |
| 4-5 years | Yes, but not for all | Yes | Yes, but not for all | Yes, but not for all | No | No | No | No | Yes, but not for all | No | Yes | Yes | Yes | Yes |

Appendix 2 Revised Logic Model – Universal Health Visiting Pathway



Appendix 3 Topic Guide (Health Visitors)

1. How long have you been qualified as a health visitor?
2. Are you able to offer the families you see all core visits and additional visits as required? If not, why do you think this is so?
3. Are you always the same Health Visitor that provides all the visits to a family? If not, why do you think this is so?
4. Does the Pathway allow you to strengthen relationships with families? If so, how?
5. Does the Pathway allow you to provide timely and proportionate support to families? If so, how?
6. Does the Pathway allow you to provide appropriate and timely referrals of families to other agencies or professionals? If so, how?
7. In what ways has the Pathway enabled you to link to wider services such as social work and Speech and Language Therapists? Has this changed?
8. Could you give me some examples of additional interventions or supports that you have been able to access for families due to the more frequent contacts?
9. Has the Pathway enhanced your knowledge and awareness of community assets, care and referral pathways?
10. In your opinion, does the Pathway promote:
 - a. Multi-agency partnership working? If so, how?
 - b. Information sharing? If so, how?
11. What do you feel about the Pathway in terms of:
 - a. Early identification of family's strength and concerns?
 - b. Early identification of child strengths and concerns (e.g. HPI-A, child development, neglect)?
12. How do you feel you are equipped to identify concerns in children and their families and provide appropriate support?
13. Children's wellbeing, safety and attachment are of key importance to give children the best start in life.
 - a. How has your practice of these issues changed as a result of the Pathway?
14. I understand that you have now moved to strength-based and outcome focused working.
 - a. How has this influenced your practice?
 - b. What do you think is the benefit to families in terms of working in in this way?
15. Has the Pathway enhanced your participation in clinical supervision and appropriate training? If so, in what ways?
16. How would you describe the support you receive in terms of caseload management?
17. In your experience, how have you found the process of implementing the Pathway to be in your health board?
18. Do you have any further comments you'd like to add with regard to the Pathway?

Appendix 4 Topic Guide (Parents)

Background information:

Number of children:

Experience of previous service:

Age of child (months/Years):

Postcode (without the last two letters):

1. Could you tell me how many visits you have received from your Health Visitor before and after you had your baby?
2. How do you feel about the number of visits you have received from your Health Visitor so far?
3. Have these visits been carried out by the same Health Visitor? If not, why do you think this is so? Which other health professional(s) have visited you?
4. How would you describe your relationship with your Health Visitor?
5. Do you feel that you are able to contact your Health Visitor with any concerns?
6. Has your experience of having a Health Visitor changed? (**Only** for those who have older children or have previous experience of health visiting service)
7. What support and advice did you receive from your health visitor regarding your child's development, wellbeing and safety?
 - a. Was this helpful for you?
 - b. If not, what else would have helped?
8. How has your Health Visitor helped you to understand your relationship with your baby? **Prompt:** How has your Health Visitor helped you to respond to your baby's needs in a sensitive and consistent ways (attachment)?
9. What support and advice did you receive from your health visitor regarding breastfeeding, weaning, early diet, oral health or smoke free home?
 - a. Has this improved your understanding of these issues?
 - b. Has this influenced your choices in any ways?
10. In terms of the supports and information you received from your Health Visitor, do you feel they were offered at the right time?
11. Has your Health Visitor helped you to understand the importance of having a home learning environment (e.g. play, reading)? If so, in what ways?
12. Do you feel your Health Visitor has made you more aware of groups and services within your local area? If so, could you give me some examples please?

13. Has your Health Visitor helped in terms of engaging your family with appropriate services or professionals? If so, in what ways? Was this timely?
14. What is the most important part of having a Health Visitor to you?

Appendix 5 Health visitors' questionnaire

[INTRO SCREEN]

Thank you for entering the survey.

QA1

[ASK ALL]

Single code

Can I just check, are you currently employed primarily as ...?

1. A midwife
2. A health visitor
3. A family nurse?

MIDWIVES WILL ONLY BE ASKED BABY BOX QUESTIONS. HEALTH VISITORS AND FAMILY NURSES WILL BE ASKED BOTH BABY BOX AND EHVP.

INTRO FOR MIDWIVES ONLY

[ASK IF QA1 = 1]

Thank you for entering the Baby Box survey. The survey should only take around 10-15 minutes to complete. If you would like to complete the survey later, or to be able to pause the survey and finish it later, then please enter your email address now. We will then email you a unique link that you can use to access your survey again whenever you choose.

[SCRIPTER – PLEASE SET UP SO THAT THEY CAN ENTER EMAIL AND BE EMAILED A UNIQUE LINK TO GET BACK INTO THEIR OWN SURVEY]

[INTRO SCREEN 2]

[ASK IF QA1 = 1]

Ipsos MORI, the independent research organisation, has been asked by the Scottish Government to evaluate the Baby Box Scheme. As part of this evaluation, we are gathering feedback from midwives and health visitors, to find out how you think the scheme is working and how it could be improved. The findings will inform the future development of the scheme in Scotland.

As someone who works with new mothers in Scotland, your views are very important – we hope that as many midwives and health visitors as possible will take part, so that we have a reliable picture of how the Baby Box Scheme is working.

[NEXT SCREEN]

[ASK IF QA1 = 1]

Your responses will be kept strictly confidential in accordance with General Data Protection Regulations (GDPR) – it will not be possible to identify individuals from the findings, which will be reported as percentages (e.g. “50% of midwives and health visitors thought that ...”). We will not share your individual responses with anyone else.

If you would like any more information on the survey, please contact ScotlandBabyBox@ipsos.com or phone 0808 238 5376 and ask to speak to one of the project team (Rachel, Diana or Jane). If you would like to read the survey privacy policy, this can be accessed here: ADDRESS.COM

Please click ‘next’ to begin the survey.

HEALTH VISITORS AND FAMILY NURSE INTRO SCREENS

[ASK IF QA1 = 2 OR QA1 = 3]

Thank you for entering the National Health Visiting survey. The survey should take no longer than 25 minutes to complete. If you would like to complete the survey later, or to be able to pause the survey and finish it later, then please enter your email address now. We will then email you a unique link that you can use to access your survey again whenever you choose.

[SCRIPTER – PLEASE SET UP SO THAT THEY CAN ENTER EMAIL AND BE EMAILED A UNIQUE LINK TO GET BACK INTO THEIR OWN SURVEY]

[INTRO SCREEN 2]

[ASK IF QA1 = 2 OR QA1 = 3]

This survey is being conducted by Ipsos MORI, the independent research organisation, on behalf of the Scottish Government and in collaboration with the University of Edinburgh. We are particularly interested in your views on two key initiatives – the **Universal Health Visiting Pathway** (UHVP) and the **Baby Box** scheme.

Your views are very important – we hope that as many health visitors and family nurses as possible will take part, so that we have a reliable picture of how these key initiatives are working. The findings will inform the future development of both initiatives.

[NEXT SCREEN]

[ASK IF QA1 = 2 OR QA1 = 3]

Your responses will be kept strictly confidential in accordance with General Data Protection Regulations (GDPR) – it will not be possible to identify individuals from the findings, which will be reported as percentages (e.g. “50% of health visitors and family nurses thought that ...”). We will not share your individual responses with anyone else.

If you would like any more information on the survey, please contact HVSurvey@ipsos.com or phone 0808 238 5376 and ask to speak to one of the project team (Rachel or Jane). If you would like to read the survey privacy policy, this can be accessed here: [ADDRESS.COM](#) [SG PRIVACY POLICY TO BE INSERTED]

Please click ‘next’ to begin the survey.

SECTION A - BACKGROUND AND DEMOGRAPHIC INFO

QA2 [HB]

[ASK ALL]

Single code

Which Health Board are you based in?

1. Ayrshire and Arran
2. Borders
3. Dumfries and Galloway
4. Eilean Siar (Western Isles)
5. Fife
6. Forth Valley
7. Grampian
8. Greater Glasgow and Clyde
9. Highland
10. Lanarkshire
11. Lothian
12. Orkney
13. Shetland
14. Tayside

QA3 [LENGTH PRACT]

[ASK ALL – textfill as appropriate from QA1]

Single code

How long have you been practising as a <midwife/health visitor/family nurse>?

1. Under a year
2. 1-2 years
3. 3-5 years
4. 6-10 years
5. Over 10 years

6. Not sure
7. Prefer not to say

QA4 [FTORPT]

[ASK ALL]

Single code

And do you work full-time or part-time?

1. Full time (30+ hours/week)
2. Part time (under 30 hours/week)
3. Not sure
4. Prefer not to say

SECTION B – UHVP EVALUATION SECTION [HVs and FNs only]

[ASK IF A1 = 2 or A1 = 3]

SCRIPTER – SECTION B only to be asked of HVs and FNs (codes 2 and 3 at QA1), NOT OF MIDWIVES. However, we also want to alternate the order they are asked sections B and C in – so half of HVs and FNs will be asked B first, then C, and half will get C first, then B.

[Bintro_1]

[ASK IF BEING ASKED SECTION B FIRST]

The first set of questions are about your experiences and views of the Universal Health Visiting Pathway (UHVP).

IF FAMILY NURSE B_INTRO

(ASK IF QA1 = 3)

As a family nurse, we realise that delivering your Board's health visiting pathway is only one aspect of your role. However, when you are answering these questions, please focus on your **health visiting role**, rather than the things you do as part of FNP.

[Bintro_2]

[ASK IF BEING ASKED SECTION C FIRST]

The next set of questions are about your experiences and views of the Universal Health Visiting Pathway (UHVP).

IF FAMILY NURSE (IF QA1 = 3)

As a family nurse, we realise that delivering your Board's health visiting pathway is only one aspect of your role. However, when you are answering these questions, please focus on your **health visiting role**, rather than the things you do as part of FNP.

QB1 [LENGTH UHVP]

For how long have you personally been delivering the Universal Health Visiting Pathway (UHVP) – **either fully or in part?**

1. I have not yet started to deliver the UHVP
2. Under 6 months
3. 6 months but less than 1 year
4. Over 1 year but less than 2 years
5. Over 2 but less than 3 years
6. Over 3 but less than 4 years
7. Over 4 years
8. Not sure
9. Prefer not to say

QB2INTRO

We understand that different areas are at different stages of implementing the new UHVP. A number of questions in this survey ask for your views on 'the pathway you are currently delivering'. Please answer these questions thinking about the pathway being delivered in your area at the moment – which could be the full UHVP, part UHVP/part previous pathway, or the previous pathway.

RELATIONSHIPS WITH FAMILIES

The next few questions are about your visits with families

QB2 [PATHWAY ELEMENTS]

[ASK ALL WHO ARE DELIVERING UHVP FULLY OR IN PART [CODES 2-7 AT QB1]]

Which elements of the universal health visiting pathway are you currently delivering to **all or most** of your families?

PLEASE SELECT ALL THAT APPLY.

1. Antenatal home visit
2. New baby home visit
3. 3-5 weeks home visits
4. 6-8 weeks home visit
5. 3 month home visit
6. 4 month home visit
7. 6 month review
8. 8 month home visit
9. 13-15 months developmental and wellbeing review
10. 27-30 months developmental and wellbeing review
11. 4-5 years developmental and wellbeing review
12. None of these – I'm not yet delivering the UHVP to all/most of my families
13. Not sure
14. Prefer not to say

a)

QB3 [WHY NOT ALL VISITS/ELEMENTS – codes 1-11 at QB2]

[ASK IF HAVE NOT SELECTED ALL VISITS LISTED AT QB2 – i.e. NOT SELECTED ALL OF 1-11]

We are aware there are lots of reasons why health visitors or family nurses might not be delivering all the core elements of the UHVP. Which of these are reasons why you are not currently delivering all the core elements to all/most of your families?

PLEASE SELECT ALL THAT APPLY.

1. My Health Board is not yet delivering all elements
2. Personal caseload pressures
3. Insufficient training
4. Other [Please say what]
5. Don't know
6. Prefer not to say

b)

QB4 [ADDITIONAL VISITS] [OUTCOME 19]

Single code

And thinking only about the families in your personal caseload who have been identified as needing **additional visits (that is, extra visits on top of the core health visiting pathway visits)**, what proportion of these families receive all or most of the additional visits they require?

1. All of them
2. Most of them
3. Some of them
4. Only a few of them
5. None of them
6. I don't have any families who need additional visits
7. Don't know
8. Prefer not to say

QB5 [ELEMENTS OF OLD PATHWAY]

[ASK ALL WHO ARE DELIVERING UHVP FULLY OR IN PART [CODES 2-7 AT QB1]]

MULTICODE

And are you personally delivering any of the following in your health visiting role?

PLEASE SELECT ALL THAT APPLY.

1. Immunisations
2. Drop in clinics
3. Other tasks which are not part of the Universal Health Visiting Pathway (UHVP) [please say what]
4. No – I'm not delivering anything that is not part of the UHVP
5. Don't know
6. Prefer not to say

QB6 [WHY ANY ELEMENTS IN OLD PATHWAY]

[ASK IF ANY CODE 1-5 AT QB5 [ELEMENTS OF OLD PATHWAY]

MULTICODE

We are aware there are lots of reasons why health visitors or family nurses might be delivering things that are not core elements of the UHVP. Which of these reasons apply to you?

PLEASE SELECT ALL THAT APPLY.

LIST OF PRECODES e.g.

1. Lack of capacity among other (non-health visiting) staff to deliver them
2. Lack of skills among other (non-health visiting) staff to deliver them
3. Parents prefer to receive them from their health visitor/family nurse
4. Health Board has asked you to continue delivering them
5. Health Board has not yet fully implemented the UHVP
6. Added benefit to families of delivering this/these elements
7. My involvement is needed from a safeguarding point of view
8. Other [Please say what]
9. Don't know
10. Prefer not to say

QB7 [CONT.VISITS]

[OUTCOME 20]

Single code

And thinking about the health visiting contacts received by families in your personal caseload, how many of the visits do you *personally* make?

1. All of them
2. Most of them
3. Some of them
4. Only a few of them
5. None of them
6. Don't know
7. Prefer not to say

QB8 [CONT.REVIEWS] [OUTCOME 20]

Single code

And thinking about the child health reviews for families in your personal caseload, how many of the reviews do you *personally* undertake?

1. All of them
2. Most of them
3. Some of them
4. Only a few of them
5. None of them
6. Don't know
7. Prefer not to say

QB9 [POS RELATIONSHIPS] [OUTCOME 34]

Single code

How many of the families in your personal health visiting caseload would you say you have developed a positive relationship with?

1. All of them
2. Most of them
3. Some of them
4. Only a few of them
5. None of them
6. Don't know
7. Prefer not to say

CHILD SAFETY AND WELLBEING

The next few questions are about outcomes for children and families. Please answer these questions thinking of the health visiting pathway being delivered in your area at the moment – which could be the full UHVP, part UHVP/part previous pathway, or the previous pathway.

QB10 [SAFETY AND WELLBEING] [OUTCOME 22, 21, 24, 41, 23]

Single code

For each of the following statements, please state how well the health visiting pathway you are currently delivering...

QB10a) ...enables you to identify concerns about a child at an early stage? (e.g. HPI-A, child development, neglect)

QB10b) ...enables you to identify concerns about a family at an early stage?

1. Very well
2. Fairly well
3. Not very well
4. Not at all well
5. Don't know
6. Prefer not to say

QB11 [OPPORTUNITY_SAFETY AND WELLBEING]

Single code

How much opportunity does the health visiting pathway you are currently delivering give you to discuss each of the following with families?

QB11a) Children's learning and development

QB11b) Children's general happiness and wellbeing

QB11c) Child safety

QB11d) Parents' mental health and wellbeing

QB11e) The impact on children of parents' smoking, drinking alcohol or using drugs

1. A great deal
2. Quite a lot
3. Some
4. Not very much
5. None at all
6. Don't know
7. Prefer not to say

CHILD DEVELOPMENT AND PARENTING TECHNIQUES

QB12 [OPPORTUNITY_DEVELOPMENT] [OUTCOME 37, 36, 38, 49]

Single code

And how much opportunity does the health visiting pathway you are currently delivering give you to...

QB12a) ... support families with developing parent-child relationships?

QB12b) ... talk to families about how to handle behaviour they find challenging from their children?

QB12c) ... offer information and support with home learning (e.g. play, reading)?

QB12d) ... talk to families affected by money issues about where to find help?

1. A great deal
2. Quite a lot
3. Some
4. Not very much
5. None at all
6. Don't know
7. Prefer not to say

QB13

And to what extent do you feel the health visiting pathway you are currently delivering enables you to support parents to become more confident?

1. A great deal
2. Quite a lot
3. Somewhat
4. Not very much
5. None at all
6. Don't know
7. Prefer not to say

PERCEIVED IMPACT ON EQUALITIES

QB14 [REDUCED INEQUALITIES] [OUTCOME 51]

Single code

To what extent do you feel the health visiting pathway you are currently delivering is contributing to reducing health inequalities between children from different backgrounds?

1. A great deal
2. Quite a lot
3. Somewhat
4. Not very much
5. None at all
6. Don't know
7. Prefer not to say

c)

QB15 [FAM ENGAGE] [OUTCOME 51]

[ASK ALL DELIIVERING UHVP IN FULL OR PART – CODES 2-7 AT QB1]

Single code

And how much impact, if any, do you feel the UHVP has had on opportunities for you to engage with families who may be less likely to work with services?

1. A major positive impact
2. A small positive impact
3. No impact one way or another
4. A small negative impact
5. A major negative impact
6. Don't know
7. Prefer not to say

QB16 [FAM ENGAGE2] [OUTCOME 51]

[ASK ALL NOT DELIIVERING NOT CURRENTLY DELIVERING UHVP – CODES 1 and 8-9 AT QB1]

Single code

Thinking now about the UHVP, how much impact, if any, do you feel the UHVP *will* have on opportunities for you to engage with families who may be less likely to work with services?

1. A major positive impact
2. A small positive impact
3. No impact one way or another
4. A small negative impact
5. A major negative impact
6. Don't know
7. Prefer not to say

JOB SATISFACTION AND TRAINING

The next few questions are about your current job satisfaction

QB17 [JOB SATISFACTION] [OUTCOME 46]

Overall, how satisfied or dissatisfied are you with your current health visiting role?

1. Very satisfied
2. Fairly satisfied
3. Neither satisfied nor dissatisfied
4. Fairly dissatisfied
5. Very dissatisfied
6. Don't know
7. Prefer not to say

QB18 [STRENGTH] [OUTCOME 28]

Single code

And to what extent do you agree or disagree that “the health visiting pathway I am delivering supports an outcome focused approach”?

1. Strongly agree
2. Tend to agree
3. Neither agree nor disagree
4. Tend to disagree
5. Strongly disagree
6. Don't know
7. Prefer not to say

QB19 [WORK ABILITY] [OUTCOME 29]

Single code

How far do you agree or disagree with each of the following statements about your health visiting role?

d)

QB19a) I feel confident delivering all parts of my health visiting role

QB19b) I have the skills I need to perform my health visiting role effectively

QB19c) I have the resources necessary to help me meet the needs of families (e.g. leaflets/materials)

QB19d) I have access to the IT systems required to carry out my health visiting role effectively

QB19e) I feel valued for the health visiting work I do

QB19f) I have enough opportunity to participate in clinical supervision

1. Strongly agree
2. Tend to agree
3. Neither agree nor disagree
4. Tend to disagree
5. Strongly disagree
6. Don't know
7. Prefer not to say

QB20 [WORKLOAD]

How would you describe your current workload?

1. Far too high
2. A bit too high
3. About right
4. A bit too low
5. Far too low
6. Don't know
7. Prefer not to say

QB21 [TRAINING] [OUTCOME 31]

Single code

What, if any, training or education have you had on delivering the UHVP?

PLEASE SELECT ALL THAT APPLY.

1. Training as part of a university health visiting course
2. Formal in person training course attended while working
3. Online training completed while working
4. Discussions during supervision
5. Informal discussions, e.g. a chat with colleagues
6. Something else – PLEASE SAY WHAT
7. None of the above
8. Not sure
9. Prefer not to say

QB22 [SUFF TRAIN]

[ASK IF CODE 1-6 AT QB21 – i.e. if have received ANY training or info]

Single code

Do you feel you have had sufficient opportunity to participate in training or learning to support you in delivery of the UHVP?

1. Yes
2. No
3. Not sure
4. Prefer not to say

MULTI AGENCY WORKING

The next questions are about working with other agencies

QB23 [PART'SHIP WORKING] [OUTCOME 27 AND 48]

[ASK ALL DELIIVERING UHVP IN FULL OR PART – CODES 2-7 AT QB1]

Single code

Overall, how much impact, if any, do you feel the UHVP has had in terms of **opportunities for partnership working** with other agencies?

1. A major positive impact
2. A small positive impact
3. No impact one way or another
4. A small negative impact
5. A major negative impact
6. Don't know
7. Prefer not to say

QB24 [REFERAL] [OUTCOME 32]

Multi-code

Which, if any, of the following services do you signpost to or request assistance for families from on a regular basis?

1. Local doctor/GP
2. Practice nurse
3. Social worker
4. Educational Psychologist
5. Parent and baby/child groups
6. Breast-feeding support
7. Speech and language therapy
8. Child and Adolescent Mental Health Services (CAMHS)
9. A Children's Centre
10. Child Healthy Weight programme
11. Your local library/Book Bug
12. Eligible 2 year-old nursery place
13. Another education or support service
14. A parenting programme or course
15. ChildSmile website or dental services
16. Childcare Link website or phonenumber
17. ParentLine Scotland website or phonenumber
18. Money or benefits advice/support
19. Other service [please say what]
20. No – none of these
21. Not sure
22. Prefer not to say

OVERALL IMPACT OF UHVP

QB38 [IMPACT ON INTERACTIONS]

[ASK ALL WHO ARE DELIVERING UHVP IN FULL OR PART – CODES 2-7 AT QB1]

Single code

Overall, would you say that the UHVP has had...

1. ... A positive impact on your interactions with parents
2. ... A negative impact on your interactions with parents
3. ... No impact on your interactions with parents
4. Don't know
5. Prefer not to say

QB39 [OVERALL PERCEPTIONS]

And which of the following best describes how you think the UHVP *will* impact on outcomes for children and families, when it is fully implemented?

1. A major positive impact
2. A small positive impact
3. No impact one way or another
4. A small negative impact
5. A major negative impact
6. Don't know
7. Prefer not to say

QB40

OPEN ENDED

What specific changes do you think could be made to the UHVP in the future?

[OPEN TEXT]

SECTION C – BABY BOX QUESTIONS [ASK ALL UNLESS OTHERWISE ROUTED]

[ASK IF QA1 = 2 OR 3 (I.E. HV OR FNP, SO WILL HAVE BOTH SETS OF QUESTIONS)

[Cintro]

The next set of questions are about your experiences and views of the Baby Box scheme. They should only take about 10 minutes to complete.

[ASK IF QA1 = 1 – I.E. MIDWIFE]

The next few questions are about the aims of the Baby Box scheme.

AIMS OF THE SCHEME

QC1

[ASK ALL]

Single code

To what extent do you agree or disagree that “I feel I have a clear understanding of what Scotland’s Baby Box scheme is trying to achieve”?

1. Strongly agree
2. Tend to agree
3. Neither agree nor disagree
4. Tend to disagree
5. Strongly disagree
6. Don’t know
7. Prefer not to say

QC2

[ASK ALL]

[randomise order answer options 1-6 appear in]

Multi-code

Scotland's Baby Box scheme is part of wider efforts to improve support for young children and their families with the aim of giving all children in Scotland the best start in life. Which, if any, of the following do you think are the main ways in which Scotland's Baby Box scheme is intended to help contribute to positive outcomes for children and parents in Scotland?

PLEASE SELECT ALL THAT APPLY

1. Helping to reduce inequalities in health between children from different backgrounds
2. Helping to reduce inequalities in health between new mothers from different backgrounds
3. Helping families financially by providing essential items for their new babies
4. Helping to increase opportunities for health professionals to engage with parents
5. Helping to encourage positive parenting behaviours in parents
6. All of the above
7. Some other way – PLEASE SAY WHAT
8. Not sure
9. Prefer not to say

QC3

[ASK ALL]

Single code

How confident do you feel about discussing the Baby Box scheme with parents?

1. Very confident
2. Fairly confident
3. Not very confident
4. Not at all confident
5. Don't know
6. Prefer not to say

TRAINING ON THE SCHEME

QC4

[ASK ALL]

Single code

How do you feel about your own role in relation to the Baby Box scheme?

1. Very clear
2. Quite clear
3. Neither clear nor unclear
4. Quite unclear
5. Very unclear
6. Don't know
7. Prefer not to say

QC5

[ASK IF QC4=4 or 5]

Open question

What are you unclear about with respect to your role and the Baby Box scheme?

QC6

[ASK ALL]

Multi code

What, if any, information or training have you had about the Baby Box scheme?

PLEASE SELECT ALL THAT APPLY.

1. Written information, such as leaflets or factsheets
2. Training – either in person or online
3. Informal verbal information, e.g. a chat with colleagues
4. A demonstration, where you were shown a Baby Box, and its contents
5. Something else – PLEASE SAY WHAT
6. None of the above
7. Not sure
8. Prefer not to say

QC7

[ASK IF CODE 1-5 AT QC6 – i.e. if have received ANY training or info]

Single code

Do you feel you have received sufficient **training** about the Baby Box?

1. Yes
2. No
3. Not sure
4. Prefer not to say

QC8

[ASK IF QC7 = 2]

Multi code

Which, if any, of the following aspects of Baby Box would you like more **training** on?

1. The contents of the box
2. The aims of the Baby Box scheme
3. The registration process
4. The delivery process
5. How to use the box for sleeping
6. The contents of leaflets included in the box
7. Something else – PLEASE SAY WHAT
8. Not sure
9. Prefer not to say

QC9

[ASK IF CODE 1-5 AT QC6 – i.e. if have received ANY training or info]

Single code

Do you feel you have received sufficient **information** about the Baby Box?

5. Yes
 6. No
 7. Not sure
 8. Prefer not to say
- e)

QC10

[ASK IF QC9= 2]

Multi code

Which, if any, of the following aspects of Baby Box would you like more **information** on?

1. The contents of the box
2. The aims of the Baby Box scheme
3. The registration process
4. The delivery process
5. How to use the box for sleeping
6. The contents of leaflets included in the box
7. Something else – PLEASE SAY WHAT
8. Not sure
9. Prefer not to say

REGISTRATION AND DELIVERY PROCESS

Thinking now about the process of registering parents for a Baby Box...

QC11 [ASK IF QA1 = 1 OR 3 – I.E. IF THEY ARE A MIDWIFE OR A FAMILY NURSE – NOT ASKED OF HVS]

Are you involved in registering parents for baby boxes?

(If you hand out registration forms to parents, please tick 'Yes')

1. Yes
2. No
3. Don't know

QC12

[ASK IF QC11=1]

Single code

When completing the Baby Box registration form, which of the following usually applies?

1. I arrange for the form to be posted, once the mother has filled out her information
2. The mother takes the form away and posts it back herself
3. Sometimes I send the form off, and sometimes I give the form to the mother to return
4. Don't know
5. Prefer not to say

QC13

[ASK IF QC11=1]

Single code

From your perspective, overall how well does the registration process for baby boxes work?

1. Very well
2. Fairly well
3. Not very well
4. Not at all well
5. Don't know
6. Prefer not to say

QC14

[ASK IF QC13 = 3 OR 4 – i.e. registration process does not work well]

Open

Why do you feel the registration process does not work well?

QC14

[ASK ALL]

Single code

How clear or unclear are you about the process of cancelling a Baby Box in the event of a bereavement?

1. Very clear
2. Quite clear
3. Neither clear nor unclear
4. Quite unclear
5. Very unclear
6. Don't know
7. Prefer not to say

PERCEPTIONS OF USE BY PARENTS

QC15

[ASK ALL]

Single code

How often, if at all, do you see parents using the Baby Box or its contents on home visits?

1. Always
2. Often
3. Sometimes
4. Rarely
5. Never
6. Don't know
7. Prefer not to say

QC16

[ASK ALL]

[randomise order 1-18 appear in]

Multi code (up to 5 responses, 20-22 are single codes)

We are interested in whether the right items are included in the Baby Box. Which of the items included in the Baby Box, if any, do you think are the **most important** to include? Please choose **up to 5 items**.

1. The box itself (for sleeping)
2. The digital ear thermometer
3. The clothes
4. Cellular blanket
5. Baby wrap
6. Hooded bath towel
7. Bath and room thermometer
8. Baby books
9. Play mat
10. Comforter toy
11. Travel changing mat
12. Reusable nappies voucher
13. Nursing pads
14. Maternity towels
15. Condoms
16. Leaflet on using the box for safe sleeping
17. Leaflet on postnatal depression
18. Leaflet on breastfeeding
19. Something else in the box (PLEASE SAY WHAT)
20. None of them
21. Don't know/can't choose
22. Prefer not to say

QC17

[ASK IF 'Something else' – CODE 19 -AT QC16]

What other items do you think are among the most important included in the box?

OPEN TEXT.

QC18 [ASK ALL]

[randomise order 1-18 appear in]

Multi code (up to 5 responses, 20-22 are single codes)

And which of the items included in the Baby Box, if any, do you think are the **least important** to include? Please choose **up to 5 items**.

1. The box itself (for sleeping)
2. The Digital ear thermometer
3. The clothes
4. Cellular blanket
5. Baby wrap
6. Hooded bath towel
7. Bath and room thermometer
8. Baby books
9. Play mat
10. Comforter toy
11. Travel changing mat
12. Reusable nappies voucher
13. Nursing pads
14. Maternity towels
15. Condoms
16. Leaflet on using the box for safe sleeping
17. Leaflet on postnatal depression
18. Leaflet on breastfeeding
19. Something else in the box (PLEASE SAY WHAT)
20. None of them least / less important
21. Don't know/can't choose
22. Prefer not to say

QC19

[ASK IF 'Something else' – CODE 19 – AT QC18]

What other items do you think are among the least important included in the box?

OPEN TEXT.

PERCEIVED IMPACT ON ENGAGEMENT WITH SERVICES

INTRO

[ASK ALL]

We're interested in what you as a health professional think about the impact of the Baby Box scheme.

QC20

[ASK ALL]

Single code

Overall, would you say that the Baby Box scheme has had...

1. ... A positive impact on your interactions with parents
2. ... A negative impact on your interactions with parents
3. ... No impact on your interactions with parents
4. Don't know
5. Prefer not to say

QC21

[ASK ALL]

Single code

How much impact, if any, do you feel the Baby Box scheme has had on opportunities for you to engage with families who may be less likely to work with services?

1. A major positive impact
2. A small positive impact
3. No impact one way or another

4. A small negative impact
5. A major negative impact
6. Don't know
7. Prefer not to say

QC22

[ASK ALL]

Single code

How strongly would you agree or disagree with the following statements?

“The Baby Box scheme has been a useful tool in supporting conversations with new parents”

1. Strongly agree
2. Tend to agree
3. Neither agree nor disagree
4. Tend to disagree
5. Strongly disagree
6. Don't know
7. Prefer not to say

QC23

[ASK ALL]

And how much would you agree or disagree that the baby box has helped support your conversations with parents about **safe sleeping** specifically?

1. Strongly agree
2. Tend to agree
3. Neither agree nor disagree
4. Tend to disagree
5. Strongly disagree
6. Don't know
7. Prefer not to say

QC24

[ASK ALL]

How much would you agree or disagree that the Baby Box scheme is making a useful contribution to supporting families with new babies in Scotland?

1. Strongly agree
2. Tend to agree
3. Neither agree nor disagree
4. Tend to disagree
5. Strongly disagree
6. Don't know
7. Prefer not to say

PERCEIVED IMPACTS ON EQUALITY

QC25

[ASK ALL]

Single code

And how much would you agree or disagree that the Baby Box scheme is an effective way of ensuring every family has access to new born essentials?

1. Strongly agree
2. Tend to agree
3. Neither agree nor disagree
4. Tend to disagree

5. Strongly disagree
6. Don't know
7. Prefer not to say

QC26

[ASK ALL]

OPEN ENDED

What specific improvements do you think could be made to the Baby Box scheme in the future?

[OPEN TEXT]

SECTION D – CONSENT TO RECONTACT FOR BABY BOX

[scripter – to ask right at end of survey, after whichever of section B or C is asked last]

QD1

[ASK ALL]

As part of our research on the baby box, we would like to speak to some health professionals in a little more detail about their views of the scheme. Would you be happy for us to contact you again to see if you would be interested in taking part in this? You would be free to decide at the time whether you actually wanted to take part.

1. Yes
2. No

QD2

[ASK IF QD1 = 1]

Could you just confirm the best email address to contact you at?

QD3

[ASK IF QD1= 1]

And could you confirm the best number to contact you on?

END

[ASK ALL]

[TEXTFILL – IF QA1 = 1, TEXTFILL = ‘the Baby Box scheme’, if QA1 = 2 or 3, textfill = ‘the Universal Health Visiting Pathway and the Baby Box scheme’]

Thank you very much for taking the time to complete this survey. The findings will help inform the future development of <the Universal Health Visiting Pathway and the Baby Box scheme / the Baby Box scheme> in Scotland. Your individual responses will be kept strictly confidential.

Appendix 6 Parents - online questionnaire

Telephone only text is in blue

Online only text is in red

Intro – telephone

Good morning/afternoon/evening – Please can I speak to <NAME FROM SAMPLE>?

My name is [NAME] and I’m calling from Ipsos MORI, the independent research company. We’re getting in touch because you took part in a Scottish Government survey in the last couple of years and indicated that you would be happy to be contacted for follow-up research.

[CONSENT1]

We’ve been commissioned by the Scottish Government to conduct research with parents of babies and young children in Scotland about the health visiting service in Scotland. You may have received a letter or email mentioning the research.

Would you be willing to take part in a short interview to share your views?

f)

IF NECESSARY, ADD THE FOLLOWING

As parent of a young child/children in Scotland, your views are really important. It should only take around 20 minutes. If you do not have time now, we can make an appointment for you to complete the survey at a later date, or you can complete it online from the link in the email we sent you.

NOTE – If they say they are not the parent who dealt with the Health Visitor, ask if we can speak to the parent or carer who had most contact instead.

1. Yes – happy to take part now
2. Yes - later (MAKE APPOINTMENT)
3. Wants to complete online (RE-SEND EMAIL)
4. Refused

READ OUT

Just to reassure you that your responses will be kept strictly confidential in accordance with General Data Protection Regulations (GDPR). We will not share your individual responses with anyone else.

If you would like to read the survey privacy policy, I can give you the website address just now (READ OUT IF NECESSARY – PRIVACY POLICY LINK). You are free to withdraw or refuse to answer a question at any time.

INTRO – online

Thank you very much for taking part in this survey. We really appreciate you taking time to share your views.

The Scottish Government has commissioned Ipsos MORI, the independent research organisation, to conduct research with parents of babies and young children in Scotland. We want to understand your experiences of seeing a health visitor or family nurse, and how, if at all, the health visiting service can be improved.

As parent of a young child/children in Scotland, your views are really important. The survey should only take 15-20 minutes to complete. If you want to pause the survey and finish it later, you can get back into it by re-entering the unique link from the letter or email we sent you. If another parent or carer in your family would be better able to answer questions about experiences of seeing a health visitor or family nurse, please pass this survey on to them to complete.

[NEXT SCREEN]

Your responses will be kept strictly confidential in accordance with General Data Protection Regulations (GDPR) – findings will be reported as percentages (e.g. “50% of parents thought that ...”). We will not share your individual responses with anyone else.

If you would like any more information on the survey, please contact HVsurvey@ipsos-mori.com. If you would like to read the survey privacy policy, this **can** be accessed here: [ADDRESS.COM]

Taking part in this survey is voluntary. You do not have to answer any questions you do not wish to answer, and you are free to end the survey at any point.

CONSENT

Are you happy to take part in this survey? You are free to withdraw or refuse to answer a question at any time.

1. Yes
2. No

INITIAL SCREENER

[screen1]

Can I just check, are you currently resident in Scotland?

1. Yes – CONTINUE
2. No – THANK AND CLOSE

[screen2]

And can I just check, do you currently have any children aged 5 or under living at home with you?

1. Yes – CONTINUE
2. No – THANK AND CLOSE.

SCRIPTING NOTE – TEXTFILLS COMMONLY USED IN THIS SURVEY

{**CHILDAGE** year/month-old} = age of child (in years) as randomly selected by the script after Q4. Should show as 'x year-old' where age is known in years, or 'y month-old' where age is known in months.

{**health visitor/family nurse**} = text substitute based on whether they have indicated they see a health visitor or a family nurse

IF Q7 = 2 TEXT SUB = 'Family Nurse'

IF Q6 = 3-9 OR Q7 = 1 TEXT SUB = 'Health Visitor'

There are also variants on this, based on whether they see one or more health visitor/family nurse.

CHILDREN IN THE HOUSEHOLD

[ASK ALL]

First, a few questions about you and your household.

ASK ALL

Q1 How many children aged under 18 do you have living with you?

1. None
2. Numeric response 0-19

IF Q1 =NONE, THANK AND CLOSE

ASK AS LOOP [FOR AS MANY CHILDREN AGED <18 AS IN HOUSEHOLD]

Q2 And how old (in years) is your [youngest / second youngest / third youngest etc.] child? If they are under a year-old, please enter '0'.

1. *Numeric response, range 0-17*
 2. Don't know
 3. Prefer not to say
- g)

ASK IF ANY CHILDREN UNDER 1 (0 AT Q2)

Q2b

How many months old is your baby?

1. *Numeric response, range 0-11*
2. Don't know
3. Prefer not to say

ELIG1

CALCULATED NUMBER OF CHILDREN AGED 0-5 IN HOUSEHOLD

ELIG2

CALCULATED NUMBER OF CHILDREN AGED 0-4 IN HOUSEHOLD

ELIG3

CALCULATED NUMBER OF CHILDREN AGED 5 YEARS IN HOUSEHOLD

ELIG4

CALCULATED NUMBER OF CHILDREN AGED 4 YEARS IN HOUSEHOLD

SCRIPTER: IF DO NOT HAVE ANY CHILDREN AGED 0-5 (ELIG1 = 0), THANK AND CLOSE.

Checking whether 4/5 year-olds are in primary education

ASK ALL WHO HAVE 1+ 4 YEAR OLDS AND NOT CODE 2 OR 3 AT Q3

TEXTSUBS – IF ELIG4 =1 ‘four year-old’, if ELIG4 >1, ‘four year-olds’

Q4a Prior to COVID and lockdown had your {four year-old / four year-olds} started primary school education? (not including pre-school education)

1. Yes
2. No
3. Prefer not to say

ASK ALL WHO HAVE 1+ 5 YEAR OLDS AND NOT CODE 2 OR 3 AT Q3

TEXTSUBS – IF ELIG3 =1 ‘five year-old’, if ELIG3 >1, ‘five year-olds’

Q4b Prior to COVID and lockdown had your {five year-old / five year-olds} started primary education? (not including pre-school education)

1. Yes
2. No
3. Prefer not to say

SELECTING CHILD TO BE THE FOCUS OF THE QUESTIONNAIRE

SCRIPTER NOTE: IF ANY CHILDREN AGED 4 OR YOUNGER (I.E. ELIG2 >0), RANDOMLY SELECT ONE IN THIS AGE GROUP TO BE THE FOCUS OF THE QUESTIONNAIRE.

IF ONLY HAVE CHILDREN AGED 5 (ELIG2 = 0 AND ELIG3 >0), SELECT YOUNGEST CHILD (I.E. 5 YEAR-OLD MENTIONED FIRST IN THE LOOP)

SHOW ON SCREEN (CHILDAGE = AGE OF CHILD SELECTED BY SCRIPT, AS ABOVE).

[CHILDSEL]

For the rest of the survey, we would like you to answer in relation to your {CHILDAGE year/month-old} child. (If you have twins or triplets the same age, please answer for all of them).

ASK ALL

Q5a Can I just check, what is your relationship to this {CHILDAGE year/month-old}?

(SINGLE CODE)

DO NOT READ OUT

1. Parent (including stepparent)
2. Foster parent
3. Grandparent
4. Other – PLEASE SAY WHAT
5. Prefer not to say

ASK ALL

Q6 How old are you?

1. 19 or under
2. 20-24
3. 25-29
4. 30-34
5. 35-39
6. 40-44
7. 45-49
8. 50+
9. Prefer not to say

ASK IF Q6 = 1 OR 2 (i.e. aged <25). DO NOT ALLOW DON'T KNOW.

Q7 TEXT SUBSTITUTES:

IF ONLY HAVE 1 ELIGIBLE CHILD AND THIS CHILD IS IN PRIMARY EDUCATION (Q4A or Q4B = 1) – vA textsubs

IF THIS DOES NOT APPLY (I.E. SELECTED CHILD IS NOT IN PRIMARY EDUCATION), vB textsubs

vA textsubs

Q7 Most families with young children in Scotland see a health visitor, but some young families see a family nurse instead. As far as you are aware, {did} you { } have a health visitor or a family nurse for your {CHILDAGE year/month-old} {before they started school}?

(If you are not sure, you probably {had} a health visitor, so please select that option)

vB textsubs

Q7 Most families with young children in Scotland see a health visitor, but some young families see a family nurse instead. As far as you are aware, {do} you {currently} have a health visitor or a family nurse for your {CHILDAGE year/month-old} { }?

(If you are not sure, you probably {have a health visitor, so please select that option)

1. Health Visitor
2. Family Nurse
- h) NO DK

TEXT SUBSTITUTES FOR REMAINDER OF QUESTIONNAIRE: IF Q6 = 3-9, OR Q7 = 1, 'health visitor'. IF Q7 = 2, 'family nurse'.

SHOW IF Q4A or Q4B = 1

INSTRUCTION FOR THOSE WITH ONLY ONE ELIGIBLE CHILD, WHO IS NOW AT SCHOOL

[INSTSCHA]

As your {CHILDAGE year/month-old} has already started primary education, we are aware that you probably no longer see your {health visitor/family nurse}. Please answer the remainder of the **questionnaire / survey based on the time before your {CHILDAGE year/month-old} started primary education.**

CONTINUITY OF CARE

TEXT SUBSTITUTE: IF Q6 = 3-9, OR Q7 = 1, 'health visitor'. IF Q7 = 2, 'family nurse'.

The next few questions are about visits from your {health visitor/family nurse}

ASK ALL

Q8 Thinking about all the contact you have had with a {health visitor/family nurse} for your {CHILDAGE year/month-old}, is there one main {health visitor/family nurse} you have seen for them most of the time?

TEL: DO NOT READ OUT

1. Yes
2. No
3. Don't know
4. Prefer not to say

ASK IF Q8= 2, 3 OR 4

TEXT SUB – IF Q7 = 2, TEXT SUB = 'family nurses'. OTHERWISE = 'Health visitors'

Q9 How many different {health visitors/family nurses} have you had contact with for your {CHILDAGE year/month-old}? If you are not sure, please try to give your best guess.

1. NUMERIC ANSWER 2-20
2. Don't know
3. Prefer not to say

ASK ALL WHERE REFERENCE CHILD IS 6+ MONTHS OLD (I.E. DO NOT ASK IF REFERENCE CHILD IS 5 MONTHS OLD OR YOUNGER)

Tel: DO NOT READ OUT ANSWER OPTIONS

Q10 Thinking about the 12 months up to March 2020 (i.e. before lock down) - how many times did you have contact with a {health visitor/family nurse} in relation to your {CHILDAGE year/month-old} over those twelve months? This could be either by phone or in person. If you can't remember exactly, please give your best guess.

1. Numeric answer 0-100
2. Not had any contact in the last 12 months
3. Not sure
4. Prefer not to say

ASK IF Q10 =2 (not had any contact in the 12 months before COVID)

Q11 Before March 2020, when was the last time you had contact with a {health visitor/family nurse} in relation to your {CHILDAGE year/month-old}? This could be either by phone or in person.

1. Within the last 18 months
2. 18-24 months ago
3. More than 2 years ago
4. Not sure

ASK ALL ASK IF Q10 =2 (not had any contact in the 12 months before COVID) AND WHERE REFERENCE CHILD IS 6+ MONTHS OLD (I.E. DO NOT ASK IF REFERENCE CHILD IS 5 MONTHS OLD OR YOUNGER)

[INTROHV]

IF Q6 = 3-9, OR Q7 = 1 AND Q8 = 1, 'health visitor'

IF Q6 = 3-9 OR Q7 = 1 AND Q8 = 2-4, 'health visitors'

IF Q7 = 2, AND Q8= 1, 'family nurse'

IF Q7 = 2, AND Q8 = 2-4, 'family nurses'

The next questions are about your views of the {health visitor/health visitors/family nurse/family nurses} you have or had for your {CHILDAGE year/month-old} child. When answering these questions, as far as possible please think about the contact you had with them BEFORE lock down started – that is, before March this year.

i)

CONTACT WITH HEALTH VISITOR

ASK ALL AND WHERE REFERENCE CHILD IS 6+ MONTHS OLD (I.E. DO NOT ASK IF REFERENCE CHILD IS 5 MONTHS OLD OR YOUNGER)

TEXTSUBS:

IF Q6 = 3-9, OR Q7 = 1 AND Q8 = 1, 'health visitor'

IF Q6 = 3-9 OR Q7 = 1 AND Q8 = 2-4, 'health visitors'

IF Q7 = 2, AND Q8= 1, 'family nurse'

IF Q7 = 2, AND Q8 = 2-4, 'family nurses'

Q12 Thinking back to the contact you had with your {health visitor/health visitors/family nurse/family nurses} before lock down started - how often did you {health visitor/health visitors/family nurse/family nurses} phone or visit when they said they would?

TEL ONLY: Would you say they always did, usually did, sometimes did, rarely did or never did?

1. Always
2. Usually
3. Sometimes
4. Rarely
5. Never
6. Don't know
7. Prefer not to say

ASK ALL WHERE REFERENCE CHILD IS 6+ MONTHS OLD (I.E. DO NOT ASK IF REFERENCE CHILD IS 5 MONTHS OLD OR YOUNGER)

TEXTSUBS:

IF Q6 = 3-9, OR Q7 = 1 AND Q8 = 1, 'health visitor'

IF Q6 = 3-9 OR Q7 = 1 AND Q8 = 2-4, 'health visitors'

IF Q7 = 2, AND Q8 = 1, 'family nurse'

IF Q7 = 2, AND Q8 = 2-4, 'family nurses'

Q13 Again, thinking back to the contact you had with your {health visitor/health visitors/family nurse/family nurses} in the 12 months before March 2020 - how do you feel about the level of support you had from them in relation to your {CHILDAGE year/month-old} child? Was it too much, about right, or not enough?

1. Too much
2. About right
3. Not enough
4. Don't know
5. Prefer not to say

DISCUSSIONS WITH HEALTH VISITOR

ASK ALL

TEXTSUBS AS ABOVE

Q14

Thinking about all the contact you have had with your {health visitor/health visitors/family nurse/family nurses} about your {CHILDAge year/month-old}, how much information or advice have they given you about each of the following? This could either be talking to you about it or sharing written information.

SINGLE CODE

TEL: READ OUT ANSWER OPTIONS FOR FIRST TOPIC (AND REPEAT AS NECESSARY) – WOULD YOU SAY THEY HAVE GIVEN YOU A GREAT DEAL, A FAIR AMOUNT, SOME, NOT VERY MUCH, OR NOTHING AT ALL IN TERMS OF INFORMATION OR ADVICE ABOUT THAT?

ASK ALL. ROTATE ORDER

- 14.1. Options for feeding your child in their first 6 months
- 14.2. Weaning / healthy eating for children
- 14.3. Playing with your child
- 14.4. How to talk with your child
- 14.5. Reading to your child
- 14.6. Your child's learning and development
- 14.7. Your child's physical health
- 14.8. Your child's general happiness and wellbeing
- 14.9. How to build a secure relationship with your child
- 14.10. Keeping your child safe
- 14.11. How to handle behaviour that you find challenging from your child
- 14.12. Your own mental health and wellbeing
- 14.13. The impact on children of parents smoking, drinking alcohol or using drugs
- 14.14. Help with money issues or benefits

1. A great deal
2. A fair amount
3. Some

4. Not very much
5. Nothing at all
6. Information/advice was offered but I felt I already knew enough so didn't take it up
7. Don't know
8. Prefer not to say

ASK ALL

Q15

In general, how much do you feel you know about each of the following?

SINGLE CODE

ASK ALL – ROTATE ORDER

- 15.1. Options for feeding your child in their first six months
- 15.2. Weaning / healthy eating for children
- 15.3. The benefits of playing with children under 5
- 15.4. How to talk with children under 5
- 15.5. The benefits of reading to children under 5
- 15.6. How to support your child's learning and development
- 15.7. How to support your child's physical health and development
- 15.8. How to support your child's general emotional development and wellbeing
- 15.9. How to build a secure relationship with your child
- 15.10. Keeping your child safe
- 15.11. How to handle behaviour that you find challenging from your child
- 15.12. How to manage your own mental health and wellbeing
- 15.13. The impact on children of parents smoking, drinking alcohol or using drugs
- 15.14. Where to go for help with money issues or benefits

TEL: READ OUT ANSWER OPTIONS FOR FIRST TOPIC (AND REPEAT AS NECESSARY) – WOULD YOU SAY YOU KNOW A GREAT DEAL, A FAIR AMOUNT, SOME, NOT VERY MUCH, OR NOTHING ABOUT THAT?

1. A great deal
2. A fair amount

3. Some
4. Not very much
5. Nothing at all
6. Don't know
7. Prefer not to say

SERVICES/REFERRALS

ASK ALL

TEXTSUBS:

IF Q6 = 3-9, OR Q7 = 1 AND Q8 = 1, 'health visitor', 'Has'

IF Q6 = 3-9 OR Q7 = 1 AND Q8 = 2-4, 'health visitors', 'Have'

IF Q7 = 2, AND Q8 = 1, 'family nurse', 'Has'

IF Q7 = 2, AND Q9 = 2-4 'family nurses', 'Have'

MULTICODE

Q16 [Has/have] your {health visitor/health visitors/family nurse/family nurses} ever requested help from or suggested that you contact any of these services in relation to your {CHILDAGE year/month-old} child?

TEL: READ OUT CODES 1-9 AND CODE EACH MENTIONED

1. Local doctor/GP
2. Practice nurse
3. Paediatrician
4. Another health service for your child (e.g. Audiology, Optician, Speech and Language Therapy, dietician, Child and Adolescent Mental Health Services)
5. Other services that support parents of young children (e.g. parent and baby/child groups, Children's Centres)
6. Social worker
7. Services that offer help accessing childcare
8. Services that help with food, money or housing issues
9. Any other services – PLEASE SAY WHAT
10. No – they didn't refer me to any services
11. Not sure
12. Prefer not to say

ASK IF Q16 = 1-9

IF Q6 = 3-9, OR Q7 = 1 AND Q8 = 1, health visitor's

IF Q6 = 3-9 OR Q7 = 1 AND Q8 = 2-4, health visitors'

IF Q7 = 2, AND Q8 = 1, family nurse's

IF Q7 = 2, AND Q8 = 2-4 family nurses'

Q17 And which, if any, of these have you contacted, used or attended as a result of your [health visitor's/health visitors'/family nurse's/family nurses'] suggestion?

TEL: READ OUT CODES 1-9 AND CODE EACH MENTIONED

1. Local doctor/GP
2. Practice nurse
3. Paediatrician
4. Another health service for your child (e.g. Audiology, Optician, Speech and Language Therapy, dietician, Child and Adolescent Mental Health Services)
5. Other services that support parents of young children (e.g. parent and baby/child groups, Children's Centres)
6. Social worker
7. Services that offer help accessing childcare
8. Services that help with food, money or housing issues
9. Any other services – PLEASE SAY WHAT
10. None of these
11. Not sure
12. Prefer not to say

ATTITUDINAL QUESTIONS – CONFIDENCE, SATISFACTION, RELATIONSHIP

ASK ALL ASK IF IS 6+ MONTHS OLD (I.E. DO NOT ASK IF REFERENCE CHILD IS 5 MONTHS OLD OR YOUNGER)

SINGLE CODE

Q18

Thinking about the period before lock down started in March, in general how satisfied or dissatisfied were you with the health visiting service you received for your {CHILDAGE year/month-old} child?

TEL: Would you say you were...(READ OUT CODES 1-5)?

1. Very satisfied
2. Fairly satisfied
3. Neither satisfied nor dissatisfied
4. Fairly dissatisfied
5. Very dissatisfied
6. Don't know
7. Prefer not to say

ASK ALL

SINGLE CODE

TEXTSUBS AS ABOVE

Q19

And overall, how satisfied or dissatisfied are you with **the advice and information** you have received from your {health visitor / health visitors / family nurse / family nurses} in relation to your {CHILDAGE year/month-old} child?

TEL: Would you say you were...(READ OUT CODES 1-5)?

1. Very satisfied
2. Fairly satisfied
3. Neither satisfied nor dissatisfied
4. Fairly dissatisfied
5. Very dissatisfied
6. Don't know
7. Prefer not to say

ASK ALL

SINGLE CODE

TEXTSUBS AS ABOVE

Q20 Do you agree or disagree that “I can talk to my {health visitor / health visitors / family nurse / family nurses} about anything”?

TEL: IF AGREE PROBE: is that strongly agree or tend to agree?

IF DISAGREE PROBE: is that strongly disagree or tend to disagree?

8. Strongly agree
9. Tend to agree
10. Neither agree nor disagree
11. Tend to disagree
12. Strongly disagree
13. Don't know
14. Prefer not to say

ASK ALL

TEXTSUBS:

IF Q6 = 3-9, OR Q7 = 1 AND Q8 = 1, 'health visitor', 'listens'

IF Q6 = 3-9 OR Q7 = 1 AND Q8 = 2-4, 'health visitors', 'listen'

IF Q7 = 2, AND Q8 = 1, 'family nurse', 'listens'

IF Q7 = 2, AND Q8 = 2-4, 'family nurses', 'listen'

Q21 And how well would you say your {health visitor/health visitors/family nurse/family nurses} {listens / listen} to your concerns?

TEL: READ OUT CODES 1-4: Would you say they listen ...

1. Very well
2. Fairly well
3. Not very well
4. Not at all well
5. Don't know
6. Prefer not to say

ASK ALL

SINGLE CODE

Q22 Would you say you agree or disagree that “**My <health visitor / family nurse > has helped me feel more confident about making the right decisions for my child**”?

TEL: IF AGREE, PROBE: WOULD YOU SAY YOU AGREE STRONGLY OR TEND TO AGREE

TEL: IF DISAGREE, PROBE: WOULD YOU SAY YOU DISAGREE STRONGLY OR TEND TO DISAGREE

1. Agree strongly
2. Tend to agree
3. Neither agree nor disagree
4. Tend to disagree
5. Disagree strongly
6. Don't know
7. Prefer not to say

POST-LOCK DOWN EXPERIENCES OF HEALTH VISTING

j) ASK ALL

Q23 Thinking now about the period since lock down started, in March 2020. Have you had any contact about your {CHILDAGE} year-old child with any of the following NHS services since March 2020?

(MULTICODE)

TEL: READ OUT CODES 1-5 AND CODE ALL MENTIONED

1. Health Visitor or Family Nurse
2. GP
3. Accident and Emergency
4. Hospital (not A & E)
5. NHS 24
6. No, none of these (UNIQUE CODE)
7. Don't know
8. Prefer not to say

k)

LOOP AND ASK FOR ALL THOSE SERVICES MENTIONED AT Q23

Q24 And was that contact with <service> about your {CHILDAGE} year-old child face-to-face, or by some other method (e.g. telephone or email)?

ALLOW MULTICODE (1 AND 2 OK TOGETHER)

1. Face-to-face
2. Some other method
3. Don't know
4. Prefer not to say

l)

LOOP AND ASK FOR ALL THOSE SERVICES MENTIONED AT Q23

Q25 And how satisfied or dissatisfied have you been with the contact you had with <service> for your {CHILDAGE} year-old child since lock down started?

TEL: WOULD YOU SAY YOU WERE...(READ OUT CODES 1-5)

1. Very satisfied
2. Fairly satisfied
3. Neither satisfied nor dissatisfied
4. Fairly dissatisfied
5. Very dissatisfied
6. Unsure
7. Prefer not to say

m)

ASK IF NOT CODED 1 AT Q23 (I.E. NO CONTACT WITH HV SINCE LOCK DOWN)

Q26 Would you have expected to have any contact with your {health visitor/family nurse} over this period (that is, between March and now)?

1. Yes
2. No
3. Unsure

ASK ALL

Q27 If you needed to visit A & E tomorrow with your {CHILDAGE} year-old child, how comfortable would you feel about attending in person?

TEL: WOULD YOU SAY YOU FEEL VERY COMFORTABLE, FAIRLY COMFORTABLE, FAIRLY UNCOMFORTABLE OR VERY UNCOMFORTABLE?

1. Very comfortable
2. Fairly comfortable
3. Fairly uncomfortable
4. Very uncomfortable
5. Don't know
6. Prefer not to say

Q28 If you needed to visit a GP surgery tomorrow with your {CHILDAGE} year-old child, how comfortable would you feel about attending in person?

1. Very comfortable
2. Fairly comfortable
3. Fairly uncomfortable
4. Very uncomfortable
5. Don't know
6. Prefer not to say

n)

Q29 If a health professional was to visit you at home tomorrow in relation to your {CHILDAGE} year-old child's health how comfortable would you be about having them in your home?

1. Very comfortable
2. Fairly comfortable
3. Fairly uncomfortable
4. Very uncomfortable
5. Don't know
6. Prefer not to say

Q30. During the last few months, do you feel like your mental health and wellbeing has stayed the same, got better or got worse?

1. Got better
2. Stayed the same
3. Got worse
4. Don't know
5. Prefer not to say

ASK IF AGE OF ELIGIBLE CHILD <1

Q31 During the last few months, how easy or difficult have you found it to access online peer support – that is, support that brings parents together to share their experiences - if you needed it around ...

- a. Infant feeding
- b. Antenatal classes
- c. Weaning support

TEL: ASK AFTER a AND IF NECESSARY AFTER b and c:

Have you found it very easy, fairly easy, not very easy or not at all easy to access online peer support around this issue?

- 1. Very easy
- 2. Fairly easy
- 3. Not very easy
- 4. Not at all easy
- 5. Not needed this kind of support
- 6. Don't know
- 7. Prefer not to say

o)

Q32

OPEN ENDED

Based on your experience of health visiting for your {CHILDAGE} year-old child, what, if any changes, do you think could be made to the health visiting service in the future?

[OPEN TEXT]

DEMOGRAPHICS

Finally, a few more questions about you. These will be used for analysis purposes only – for example, to look at differences between groups of parents. Your answer will be kept confidential and will not be used to identify you.

ASK ALL

SINGLE CODE

Q33 Which of the following best describes you at the moment? Are you currently ...

(Please select one response only)

TEL: READ OUT AND CODE FIRST MENTIONED

1. On **maternity/paternity leave from a part-time job** (8-29 hours a week)
2. On **maternity/paternity leave from a full-time job** (30 hours or more a week)
3. **Working part time** (8 - 29 hours a week)
4. **Working full time** (30 hours or more a week)
5. On **furlough** from a part-time job
6. On **furlough** from a full-time job
7. Not working (under 8 hrs) – **looking after children**
8. Not working (under 8 hrs) – **unemployed** (registered)
9. Not working (under 8 hrs) - **unemployed (not registered** but seeking work)
10. Not working (under 8 hrs) - **retired**
11. Not working (under 8 hrs) - **student**
12. Not working (under 8 hrs) - **other** (inc. sick or disabled)
13. Don't know
14. Prefer not to say

Q34

ASK ALL

SINGLE CODE

Are you currently living with a husband, wife or partner?

1. Yes
2. No
3. Prefer not to say

Q35 How would you describe yourself?

TEL: ... As a man, as a woman or in another way?

ASK ALL

SINGLE CODE

1. As a man
2. As a woman
3. In another way
4. Prefer not to say

Q36 Does your {CHILDAGE year/month-old} child have any ongoing physical, mental health or developmental condition or disability?

ASK ALL

SINGLE CODE

1. Yes
2. No
3. Don't know
4. Prefer not to say

Q37 Do you yourself have a physical, mental health, developmental condition or disability lasting or expected to last 12 months or more?

ASK ALL

SINGLE CODE

1. Yes
2. No
3. Don't know
4. Prefer not to say

Q38 What is your ethnic group?

1. White Scottish
2. White - Other British
3. White - Irish
4. Gypsy / Traveller
5. Polish
6. Other white ethnic group
7. Mixed or multiple ethnic group
8. Pakistani, Pakistani Scottish or Pakistani British
9. Indian, Indian Scottish or Indian British
10. Bangladeshi, Bangladeshi Scottish or Bangladeshi British
11. Chinese, Chinese Scottish or Chinese British
12. Other Asian, Asian Scottish or Asian British
13. African, African Scottish or African British
14. Other African
15. Caribbean, Caribbean Scottish or Caribbean British
16. Black, Black Scottish or Black British
17. Other Caribbean or Black
18. Arab, Arab Scottish or Arab British
19. Other ethnic group
20. Don't know
21. Prefer not to say

Q39 We're interested in how experiences of health visiting vary between people with different incomes. You don't have to answer this if you don't want to, but we hope most parents will as it will help us better understand different experiences. Please could you tell me if it's easier for you in general to think about your current household income in weekly, monthly or annual amounts?

1. Weekly
2. Monthly
3. Annual
4. Prefer not to say

(SCRIPTER – NO DON'T KNOW)

ASK IF Q39 = 1

Q40a

What is your household's total weekly income from all sources, including child benefits and any other benefit, BEFORE any deductions for income tax?

TEL: READ OUT BANDS IF NECESSARY

1. Less than £100
2. £100 to £199
3. £200 to £299
4. £300 to £399
5. £400 to £499
6. £500 to £699
7. £700 to £999
8. £1,000 to £1,499
9. £1,500 or more
10. Don't know
11. Prefer not to say

ASK IF Q39 = 2

Q40b

What is your household's total monthly income from all sources, including child benefits and any other benefit, BEFORE any deductions for income tax?

TEL: READ OUT BANDS IF NECESSARY

1. Less than £433
 2. £433 to £899
 3. £900 to £1,299
 4. £1,300 to £1,699
 5. £1,700 to £2,199
 6. £2,200 to £2,999
 7. £3,000 to £4,349
 8. £4,350 to £6,499
 9. £6,500 or more
 10. Don't know
 11. Prefer not to say
- p)

ASK IF Q39=3

Q40c

What is your household's total annual (yearly) income from all sources, including child benefits and any other benefit, BEFORE any deductions for income tax?

TEL: READ OUT BANDS IF NECESSARY

1. Less than £5,200
2. £5,200 to £10,399
3. £10,400 to £15,599
4. £15,600 to £20,799
5. £20,800 to £25,999
6. £26,000 to £36,399
7. £36,400 to £51,999
8. £52,000 to £77,999
9. £78,000 or more
10. Don't know
11. Prefer not to say

ASK ALL

Q41 According to our records, your postcode as

SHOW POSTCODE FROM SAMPLE

Is this still correct?

1. Yes – THANK AND CLOSE
2. No – GO TO Q41b

Q41b

What is the postcode for your home address?

(We're asking this because we'd like to be able to compare the experiences of parents living in different areas of Scotland – for example, rural areas and cities. To do this, we need people's postcodes. Only the research team at Ipsos MORI will see your full postcode – it will be stored separately from your other responses and will not be shared with anyone else.)

What is the postcode for your home address?

OPEN TEXT BOX – FORMATTED FOR POSTCODES (SCRIPTER – PLEASE ADD CHECKS AS APPROPRIATE IF POSTCODE NOT IN EXPECTED FORMAT)

1. Prefer not to say

THANK AND CLOSE

Appendix 7 Reasons for, and timings of, extra health visitor home visits

| Reasons for, and timings of, extra health visitor home visits, over and above the Pathway visits, from within all Boards | | | |
|--|---|---------------------------------------|---|
| 6 – 8 weeks | 3 & 4 months | 8 months | Between 13 - 15 & 27 - 30 months |
| Child Protection Meeting | Concern baby/mother interaction | Maternal mental health -x 2 | Feeding |
| Family support | New HV First Contact to kinship carers | Sleep issues x 2 | Financial support x 2 |
| Formula feeding and colic x 3 | Slow weight gain | Support to parents | Maternal Mental Health x 2 |
| Maternal depression | Support to parents | Weaning x 3 | Support following partner incarceration |
| Support to parents x 2 | | | Support to foster carers |
| Between 6-8 weeks and 3&4 months | Between 3&4 months and 8 months | 13 – 15 months | Support to parents |
| Breastfeeding support | Child Health concern | Children's Clothes; Financial Support | Support with a medical condition x 10 |
| CP Meeting | Domestic Abuse | Child's development x 2 | Visit to new sibling |
| Feeding concern | First HV contact with Foster Carer | Feeding/diet | Weight |
| Following telephone call from Police re Event | Formula for CM allergy x 4 | Following Domestic Abuse Report | 27 – 30 months |
| Formula feeding and colic | Joint visit with EYSW | Following police report | Child Behaviour |
| Maternal mental health x 3 | Looked After Child Health Assessment | Joint visit to introduce new HV | Child development |
| Review development | Maternal mental health x 3 | Maternal Mental Health | Grandparents concerned re development |
| Slow weight gain x 2 | Mum concerned re sleep | Support to foster carers | Speech, Language and Communication x 2 |
| Support to parents x 2 | First Contact to parents as changed GP Practice | Support to parents | Tonsillitis |
| | Review of Baby's development | | Visit to new sibling |
| | Review of Maternal Mental Health | | Between 27 - 30 months and 4-5 years |
| | Support to kinship carers x 2 | | Child development |
| | Support to parents x 8 | | Physical health |
| | Weaning x 2 | | Support to parents |
| | | | Toilet training |

Appendix 8 The range of Concerns identified in relation to the age of the baby/child

| Closest assessment where known (otherwise age in brackets) | Weeks of age | |
|--|--------------|---|
| First Newborn HV Home Visit | 2 | Born with a long term condition |
| | | Impact of maternal depression |
| | | Minor illness |
| | | Impact of Mum's mental health |
| | | Physical health |
| | | Poor weight gain and medical condition |
| | | Tongue-tie |
| Routine Home Visits | 4 | Housing conditions |
| | 5 | Poor weight gain |
| 6 – 8 week Review | 6 | Child on Child Protection Register |
| | | Concern re gross motor development |
| | | Physical health |
| | | Physical health |
| | 7 | Concern re growth |
| | | Physical health |
| | 8 | Admitted to hospital |
| | | Physical health |
| | 9 | Poor growth |
| | 10 | Idiopathic scrotal oedema |
| 3 month Review | 14 | Home environment |
| 4 month Review | 23 | Formula feeding |
| | 24 | Feeding and specialist milk provision |
| 8 month Review | 34 | Lack of warm clothing |
| | 35 | Cognitive development |
| | 37 | Baby not sleeping |
| | | Impact of domestic abuse |
| | 38 | Poor growth |
| | 39 | Impact of domestic abuse |
| | 41 | Physical development delay |
| | | Poor growth |
| | 42 | Speech Language and Communication delay |
| | 49 | Multiple infections |
| 13 – 15 month Review | 51 | Impact of parental substance misuse |
| | 54 | Emotional and physical neglect |
| | | Night terrors |
| | 55 | Cognitive development |

| Closest assessment where known (otherwise age in brackets) | Weeks of age | |
|---|-----------------|---|
| | 57 | Physical health |
| | 59 | Physical health |
| | 61 | Cognitive development |
| | 61 | Vision concerns |
| | 61 | Weight - for review |
| | 62 | Walking issue |
| | 64 | Development delay |
| (18 months) | 76 | Development delay |
| (21 months) | 91 | Concerns re safety |
| (21 months) | 94 | Concerns re safety |
| (25 months) | 109 | Audiology concerns |
| | | Speech Language and Communication delay |
| 27 – 30 month Review | 111 | Concerns re safety |
| | 118 | Speech Language and Communication delay |
| | 121 | Not walking |
| | | Speech Language and Communication delay |
| | | Vision need |
| | 128 | Speech Language and Communication delay |
| 129 | Poor gait | |
| (36 months) | 157 | Speech Language and Communication delay |
| (42 months) | 182 | Child behaviour |

Appendix 9 The range of concerns identified by health visitors in relation to parents/carers identified

| Closest assessment where known (otherwise age in brackets) | Weeks of age | |
|--|--------------|--|
| Antenatal Contact | 39/40 | Financial concerns – Food Bank required |
| First Newborn HV Home Visit | 2 | CP Registration at Birth |
| | 2 | Finances |
| | 2 | Lack of parenting capacity and ability to meet child's needs |
| | 2 | Learning disability |
| | 2 | Maternal anxiety |
| | 2 | Maternal low mood |
| | 2 | Mum's mental health |
| | 2 | Social Work intervention required |
| | 2 | Support: Parent with a Learning Disability and deaf |
| Routine Home Visits | 3 | Mum's mental health |
| | 4 | Food bank required |
| | 4 | Housing |
| | 4 | Immigration advice required |
| | 4 | Lack of furniture |
| | 5 | Housing conditions |
| 6 – 8 week Review | 6 | Child Protection concerns |
| | 6 | Mum's mental health and substance misuse |
| | 6 | Parental behaviour |
| | 7 | Maternal depression |
| | 7 | Mum's mental health |
| | 7 | Parental support required |
| | 9 | Maternal depression |
| | 9 | Mum's low mood |
| 3 month Review | 14 | Home environment |
| | 14 | Housing |
| 4 month Review | 17 | Maternal mental health |
| | 19 | Parental anxiety |
| 8 month Review | 34 | Finances |
| | 37 | Domestic Abuse |
| | 37 | Maternal low mood |
| | 37 | Parent illness |
| (10 months) | 39 | Domestic Abuse |
| | 46 | Domestic Abuse |

| Closest assessment where known (otherwise age in brackets) | Weeks of age | |
|---|-----------------|--|
| | 47 | Financial instability, maternal mental health, parenting capacity |
| | 47 | Substance misuse |
| (1 year) | 51 | History of substance misuse with SW involvement |
| | 51 | Substance misuse |
| 13 – 15 month Review | 54 | Child Neglect |
| | 54 | Maternal emotional abuse |
| | 55 | Domestic Abuse |
| | 64 | Domestic Abuse |
| | 79 | Finances |
| | 79 | Fire safety |
| (21 months) | 92 | Maternal mental health |
| | 93 | Facing eviction |
| (25 months) | 111 | Maternal mental health |
| 27 – 30 month Review | 127 | Domestic abuse; SW involved |
| 4 – 5 year Review | 245 | Maternal mental health |
| | unknown | Mental health of father |
| | unknown | Older sibling |

Appendix 10 Amount of information or advice given by health visitor on topic

| Item | A great deal | A fair amount | Some | Not very much | Nothing at all | Offered, but not taken up | Don't know |
|--|--------------|---------------|------|---------------|----------------|---------------------------|------------|
| Reading to your child | 24% | 28% | 19% | 9% | 10% | 8% | 1% |
| Keeping your child safe | 22% | 26% | 18% | 12% | 10% | 10% | 2% |
| Options for feeding your child in the first 6 months | 32% | 28% | 14% | 7% | 8% | 9% | 2% |
| Weaning/healthy eating for children | 28% | 33% | 17% | 6% | 8% | 7% | 2% |
| Playing with your child | 24% | 31% | 18% | 8% | 9% | 8% | 2% |
| The impact on children of parents smoking, drinking alcohol or using drugs | 17% | 18% | 13% | 9% | 24% | 14% | 4% |
| Your child's physical health | 23% | 35% | 19% | 10% | 6% | 5% | 1% |
| How to build a secure relationship with your child | 15% | 22% | 17% | 19% | 15% | 9% | 2% |
| Your child's learning and development | 23% | 34% | 19% | 9% | 7% | 7% | 1% |
| How to talk with your child | 18% | 24% | 18% | 14% | 14% | 9% | 3% |
| Your child's general happiness and wellbeing | 19% | 31% | 22% | 12% | 8% | 6% | 2% |
| Your own mental health and wellbeing | 21% | 20% | 20% | 16% | 17% | 5% | 1% |
| How to handle behaviour that you find challenging from your child | 13% | 15% | 17% | 18% | 26% | 7% | 3% |

| | | | | | | | | |
|---|----|--|----|----|-----|-----|-----|----|
| Where to go for help with money issues or benefits | 6% | | 9% | 9% | 15% | 42% | 15% | 4% |
|---|----|--|----|----|-----|-----|-----|----|

Appendix 11 Self-assessed knowledge on a range of topics

| Item | A great deal | A fair amount | Some | Not very much | Nothing at all |
|--|--------------|---------------|------|---------------|----------------|
| The benefits of reading to children under 5 | 64% | 31% | 3% | 2% | 1% |
| Keeping your child safe | 66% | 28% | 4% | 1% | 1% |
| Options for feeding your child in the first 6 months | 59% | 33% | 6% | 1% | 1% |
| Weaning/healthy eating for children | 55% | 36% | 7% | 1% | * |
| The benefits of playing with children under 5 | 62% | 29% | 6% | 2% | 1% |
| The impact on children of parents smoking, drinking alcohol or using drugs | 67% | 22% | 6% | 1% | 2% |
| How to support your child's physical health and development | 49% | 40% | 11% | 3% | * |
| How to build a secure relationship with your child | 53% | 34% | 9% | 3% | 1% |
| How to support your child's learning and development | 46% | 39% | 11% | 3% | * |
| How to talk with children under 5 | 49% | 36% | 9% | 4% | 2% |
| How to support your child's general emotional development and wellbeing | 41% | 41% | 14% | 4% | 1% |
| How to manage your own mental health and wellbeing | 35% | 42% | 16% | 5% | 1% |
| How to handle behaviour that you find challenging from your child | 27% | 45% | 20% | 6% | 3% |
| Where to go for help with money issues or benefits | 24% | 31% | 21% | 16% | 6% |

Appendix 12 Reason for baby/child being taken to Accident & Emergency

| Between 2 and 6-8 weeks | 6 – 8 weeks | 3 & 4 months | Between 4 and 6 months | 6 months | between | 8 months |
|-------------------------|-------------|--------------|-----------------------------|-------------------------|-------------------|---------------|
| | | | House fire | | | |
| | | | Minor accident | | Medical condition | |
| | | | Minor illness x 2 | | Minor accident | |
| Hospital admission | | | Upper Respiratory Infection | Urinary Tract Infection | Minor illness x 2 | Minor illness |
| Urinary Tract Infection | | | | | | |

| Between 8 and 13-15 months | 13 – 15 months | Between 15 and 27 months | 27 – 30 months | between | 4 – 5 years |
|----------------------------|---------------------------------|-----------------------------|----------------|-----------------------|-------------|
| | Medical condition | Medical condition x 2 | | | |
| | Minor accident x 2 | | | | |
| Medical condition | Minor illness x 2 | Minor accident x 4 | | | |
| Minor accident x 2 | Mottled skin and URTI | | | Minor accident x 2 | |
| Minor illness x 2 | Upper Respiratory Infection x 4 | Minor injury x 2 | | Minor illness x 2 | |
| Road Traffic Accident | | Upper Respiratory Infection | | Road Traffic Accident | |
| Urinary Tract Infection | | | | | |

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