

Dadansoddi ar gyfer Polisi



Analysis for Policy



Llywodraeth Cymru  
Welsh Government

SOCIAL RESEARCH NUMBER:

65/2018

PUBLICATION DATE:

12/12/2018

# Evaluation of the Healthy Child Wales Programme: Interim report

Mae'r ddogfen yma hefyd ar gael yn Gymraeg.

This document is also available in Welsh.

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## Title: Interim Evaluation of the Healthy Child Wales Programme

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Views expressed in this report are those of the researcher and not necessarily those of the Welsh Government

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## Glossary

Acronym/Key word	Definition
ACEs	Adverse Childhood Experiences
CAMHS	Child and Adolescent Mental Health Services
Child Measurement Programme	The Child Measurement Programme is coordinated by Public Health Wales and standardises the way primary school children's height and weight are measured across Wales.
Enhanced services (under Healthy Child Wales Programme)	Additional interventions based on the assessment and analysis of resilience and identification of additional need.
Families First	Families First is a Welsh Government programme designed to improve outcomes for children, young people and families. It places an emphasis on early intervention, prevention, and providing support for whole families, rather than individuals.
Family Information Services (FIS)	The first point of contact for advice and information on local services for families and carers.
Flying Start	Flying Start is part of Welsh Government's early years programme for families with children under four years of age living in disadvantaged areas of Wales.
FRAIT	Family Resilience Assessment Instrument and Tool
Generic health visiting services	Health visiting services providing in non-Flying Start areas
HCWP	Healthy Child Wales Programme
Health Observation and Assessment of the Infant (HOAI)	A comprehensive assessment of the infant's physical, social and emotional well-being undertaken by the health visitor at the primary birth visit and before the 6-week medical.
Integrated Family Support Services	Integrated Family Support Services teams provide targeted support and help connect children and adult services, focusing on the family as a unit.

Intensive services (under Healthy Child Wales Programme)	These are further interventions, built upon ongoing assessment and analysis of greater need.
NWIS	NHS Wales Informatics Service
Progressive universalism	Universal services that are systematically planned and delivered to provide a continuum of support according to need
Prudent Healthcare	Prudent healthcare is healthcare that fits the needs and circumstances of patients and avoids wasteful care.
Schedule of Growing Skills (SOGS)	Schedule of Growing Skills is a tool that provides a snapshot of a child's developmental level, including areas of strength and potential delay.
Skill mix	Skill mix is the combination or grouping of different categories of workers that is employed in any field of work.
Universal services (under Healthy Child Wales Programme)	This is the core minimum intervention offered to all families, regardless of need.
WCCIS	Welsh Community Care Information System
WFGA	Well Being of Future Generations (Wales) Act 2015

# 1. Introduction

## Overview of the Healthy Child Wales Programme

- 1.1 The Healthy Child Wales Programme (HCWP) is a universal health programme for all families in Wales with children aged between 0 and 7 years. It was rolled out across all health boards in Wales from October 2016 and the expectation was that all health boards would be delivering the new, universal schedule of monitoring and child development contacts in full within two years. The HCWP includes a consistent range of evidence-based preventative and early intervention measures, and advice and guidance to support parenting and healthy lifestyle choices.
- 1.2 The HCWP sets out what planned contacts children and their families can expect from health visitors and other health professionals, from the time of maternity service handover up to the first years of schooling. These universal contacts cover three areas of intervention:
- screening
  - immunisation
  - monitoring and supporting child development.
- 1.3 The HCWP is built on the concept of progressive universalism<sup>1</sup> and therefore identifies a minimum set of key interventions to all families with pre-school children, irrespective of need. In recognition that some families will require a greater intensity of intervention, HCWP also sets out a framework for the provision of enhanced and intensive levels of support and intervention, based upon assessment and analysis of resilience and identification of additional need<sup>2</sup>.

## Aims and objectives of the evaluation

- 1.4 In October 2017, Miller Research was appointed to conduct a comprehensive evaluation of the implementation of the HCWP. The evaluation was commissioned in two phases; the first has concentrated on the initial implementation phase, whilst the latter will be undertaken once the programme has been fully implemented across Wales.
- 1.5 This report documents the main findings from the first phase of the evaluation.

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<sup>1</sup> Progressive universalism defines universal services that are systematically planned and delivered to provide a continuum of support according to need.

<sup>2</sup> For more details of the different levels of provision offered under Universal, Intensive and Enhanced levels of the HCWP, please see [An overview of the Healthy Child Wales Programme](#).

- 1.6 The first phase of the evaluation started very soon after the launch of the programme in most areas, and has necessarily been entirely formative in nature, focusing on the issues around implementation and adjustment to new ways of working required by the HCWP. More specifically, the evaluation has sought to identify:
- whether health boards are implementing the HCWP consistently across Wales;
  - variations in delivery based on health visitor caseload and other factors;
  - workforce implications of implementation, including how areas have used skill mix;
  - good practice, what is working well, what is presenting challenges and why;
  - lessons to be learnt to inform implementation and future development of the HCWP.
- 1.7 The second phase of the evaluation will concentrate more upon outcomes and emerging impacts from the HCWP and will provide recommendations for the provision of support to families with pre-school children following the full implementation of the HCWP<sup>3</sup>.

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<sup>3</sup> At the time of the evaluation fieldwork, not all health boards were implementing the HCWP in full. For example, in some areas, not all scheduled visits were being undertaken.

## 2. Evaluation Methodology

2.1 Phase 1 of the evaluation has been entirely qualitative in nature and has included:

- a desk-based review of policy and programme documentation
- reviewing, sense-checking and revising the existing theory of change and logic model for the HCWP
- telephone interviews with HCWP Board members<sup>4,5</sup> and policy leads for each strand of the HCWP<sup>6</sup>
- face-to-face interviews/mini-groups with practitioners in all seven health boards in Wales<sup>7</sup>.

### Desk-based review

2.2 A review of relevant policy and programme documentation was undertaken at the start of the evaluation, and included:

- the HCWP Healthy Child Wales Quality Assurance Framework
- the HCWP Health Visiting and School Health Nursing Component 0-7 years
- an overview of the Healthy Child Wales Programme
- minutes from HCWP Board meetings
- HCWP highlight reports
- the Family Resilience Assessment Instrument and Tool<sup>8</sup>.

### Review of the HCWP logic model

2.3 A logic model for the HCWP was developed by Welsh Government prior to the commissioning of this evaluation of the programme. As part of the evaluation, the evaluators were required to review and, if necessary, amend the logic model in readiness for the second phase of the evaluation. In consultation with the HCWP Board<sup>9</sup>, the logic model was reviewed, and minor additions and amendments were

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<sup>4</sup> The HCWP Board is comprised of representation from: Welsh Government, the All Wales Health Visiting and School Health Nursing Forum, Public Health Wales, the Welsh Immunisation Group and the Public Health Wales immunisation and vaccination programme, the Chief Nursing Officer Women's Reproductive Health, NHS Wales Informatics Service (NWIS) and various health boards.

<sup>5</sup> Please see Annex 1 for the topic guide used for interviews with HCWP Board members.

<sup>6</sup> Please note that we spoke to members of the steering group with responsibilities for different elements of the programme (e.g.: the FRAIT, the new Red Book) but not suppliers involved in developing the various elements of the programme.

<sup>7</sup> Specifically, Abertawe Bro Morgannwg UHB, Aneurin Bevan UHB, Betsi Cadwaladr UHB, Cardiff and the Vale UHB, Cwm Taf UHB, Hywel Dda UHB and Powys THB.

<sup>8</sup> The FRAIT has been developed with health visitors from across Wales specifically for the HCWP. It supports health visitors to make robust, consistent and reliable assessments of family resilience.

<sup>9</sup> This involved a group discussion at a HCWP Board meeting and feedback from HCWP Board members via email.



made to accurately reflect the theory of change underpinning the HCWP, in terms of inputs, processes, outputs, outcomes and impacts. The final logic model for the HCWP can be found at Annex 2 of this report.

### **Fieldwork approach**

- 2.4 Consent to participate in the research was obtained from the head of service in each health board and practitioners were recruited via team leaders in the relevant area. Interview appointments were arranged by team leaders and administrative staff and interviews took place on relevant health board premises. Given that the evaluation did not meet the definition of research used by the Health Research Authority, formal NHS ethics approval was not sought<sup>10</sup>.
- 2.5 Fieldwork with the health boards took place in December 2017 and January 2018. The evaluation team spent an average of two days in each health board, interviewing a range of professionals on a one-to-one basis or in small groups. Interviews and mini-groups lasted between 35 and 60 minutes. Please see Annex 1 for full topic guides used for the interviews.
- 2.6 In each area a minimum of ten health practitioners were consulted face-to-face from across the following professions:
- Professional leads<sup>11</sup>
  - Team leaders– generic<sup>12</sup> and Flying Start<sup>13</sup>
  - Health visitors – generic and Flying Start
  - A range of skill mix<sup>14</sup> (Band 2,3,4,5<sup>15</sup>), including nursery nurses and administrative staff
  - Child Health managers and clerks<sup>16</sup>
  - School nurses.

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<sup>10</sup> See [Definition of research](#).

<sup>11</sup> Typically, this was the Head of Children's Public Health Nursing and Paediatric Services in the health board

<sup>12</sup> Team leaders of health visiting teams providing services in non-Flying Start areas

<sup>13</sup> Flying Start is part of Welsh Government's early years programme for families with children under four years of age living in disadvantaged areas of Wales.

<sup>14</sup> Skill mix is the combination or grouping of different categories of workers that is employed in any field of work.

<sup>15</sup> These bands relate to the pay scales for NHS nursing staff in England, Wales, Scotland and Northern Ireland.

<sup>16</sup> These are managers and clerks who manage and administer the collation, processing, monitoring and reporting of data collected as part of the Healthy Child Wales Programme.

2.7 The table below provides a breakdown of the research sample by professional group across all seven health boards:

<b>Professional group</b>	<b>Total number interviewed</b>
Professional leads	7
Team leaders	13
Health visitors	46
Nursery nurses	10
Administrative staff	6
Child Health managers/clerks	7
School nurses	8

2.8 Interviews were recorded, and/or handwritten notes were taken, and notes/recordings were subsequently transcribed and analysed using Nvivo qualitative analysis software.

### **3. Background and policy context**

#### **The rationale for the HCWP**

- 3.1 The HCWP sets out what planned contacts children and their families can expect from their health board from maternity service handover to the first years of schooling (0-7 years). These universal contacts cover three areas of intervention: screening; immunisation; and monitoring and supporting child development (surveillance).
- 3.2 The implementation of the HCWP ensures a commitment to support the health and welfare of all children aged 0-7 years and aims to achieve the following key priorities:
- to deliver key public health messages from conception to 7 years, so that families are supported to make long term health enhancing choices
  - to promote bonding and attachment to support positive parent-child relationships resulting in secure emotional attachment for children
  - to promote positive maternal and family emotional health and resilience
  - to support and empower families to make informed choices in order to provide a safe, nurturing environment
  - to assist children to meet all growth and developmental milestones enabling them to achieve school readiness
  - to support the transition into the school environment
  - to protect them from avoidable childhood diseases through a universal immunisation
  - to ensure early detection of physical, metabolic, developmental or growth problems through an appropriate, universal screening programme.
- 3.3 Children and their families in the early years are supported by universal and specialist services across the NHS and its partners. These services range from families' first point of contact, the family General Practitioner (GP), to a wide range of services including: maternity; health visiting; school nursing; mental health and social services and education. It is essential that all these services work together and take every opportunity to engage, advise and support families and children during this crucial period of their development.

- 3.4 As part of an NHS Wales review of early years services, health boards agreed that there would be significant benefit derived from having an all-Wales approach to child surveillance, to ensure that all children and families in Wales receive the same service, regardless of where they live<sup>17</sup>. Specifically, this includes those services delivered by health visitors and school nurses (specialist community public health nurses). Prior to the HCWP coming in, the number and timings of contacts that families had with health visitors varied extensively; by standardising practice, it ensures that when families move from one area of Wales to another, they still receive the same health visiting service. It was also agreed that an all-Wales approach to child surveillance should be integrated with the current universal provision of immunisation and screening services. To support this, health professionals<sup>18</sup> developed the HCWP surveillance component based on the most current evidence base, as set out in a number of key influential documents<sup>19</sup>.
- 3.5 The HCWP includes a revised personal child health record (red book), which provides details of the different assessments that will be carried out as part of the HCWP and works in conjunction with Bump, Baby and Beyond document<sup>20</sup>.
- 3.6 At its core is an agreed all-Wales universal<sup>21</sup> schedule of health visiting and school nursing contacts for every child, with enhanced<sup>22</sup> and intensive<sup>23</sup> interventions delivered to those families and children with increased levels of need. Historically health boards had developed their own child health surveillance programmes resulting in significant differences in the way that this service was provided both within health boards and across organisational boundaries. Data collected through the child health surveillance programme is entered into the Child Health System, a software system used across Wales that maintains a quantitative record of the children resident in a given health board and used as a monitoring and call and recall system for essential services such as immunisation. The system also enables the aggregation of key information on child health at the national level. There was

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<sup>17</sup> [An overview of the Healthy Child Wales](#)

<sup>18</sup> *Ibid*

<sup>19</sup> For example, Hall, D.M.B and Elliman, D. (2006). *Health for all Children. Fourth Edition (Revised)*. Oxford: Oxford University Press.

<sup>20</sup> This is a 250-page book written by parents, health professionals and child psychologists, with information for parents to support them from the early stages of pregnancy up into the toddler years.

<sup>21</sup> This is the core minimum intervention offered to all families, regardless of need.

<sup>22</sup> These are additional interventions based on the assessment and analysis of resilience and identification of additional need.

<sup>23</sup> These are further interventions, built upon ongoing assessment and analysis of greater need.

some variation in the data collected across health boards as the systems in each board were different.

- 3.7 The Overview of the Healthy Child Wales Programme published by Welsh Government (undated) <sup>24</sup> states there is consistent evidence to suggest that investment in early years significantly improves health, social and educational development and long-term outcomes. Similarly, failure to address harmful behaviour in the early years can have dramatic impact on the child and society; the HCWP documentation specifically references the impact of adverse childhood experiences<sup>25</sup> (ACES). The HCWP aims to provide a structured national programme for children and their families to respond to these issues and support families in addressing potentially harmful behaviours.
- 3.8 Addressing health inequality is the health boards' primary driver in developing the surveillance component of the HCWP; especially the all-Wales universal scheduled contacts. Child poverty is a significant challenge to delivering improved health outcomes in Wales and the cohort of children living in poverty are the most likely to have unstable home situations and move between health boards. By developing and delivering services with a core set of all-Wales universal contacts, health boards will minimise the possibility of these children and families missing out on the positive impacts of an early intervention and public health programme.
- 3.9 The Welsh Government expects that every child and family will be offered the HCWP. The programme is underpinned by the concept of progressive universalism and sets out to provide a set of key interventions to all families with pre-school children, irrespective of need to ensure a consistent offer across Wales. For some families there is a need for additional interventions to facilitate more intensive support. This could include, for example, extra contacts with the health visitor or nursery nurse or referral to other professionals such as speech and language therapists or children and adolescent mental health services (CAMHS)<sup>26</sup>.
- 3.10 The HCWP is designed to promote consistency in the delivery of early years child health and school nursing services across Wales, ensuring that expectations of

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<sup>24</sup> [An overview of the Healthy Child Wales](#)

<sup>25</sup> These include alcohol, drug use, violence, sexual behaviour, incarceration, smoking and poor diet, as identified in Public Health Wales (2015). *Adverse Childhood Experiences and their impact on health-harming behaviours in the Welsh adult population*. Cardiff: Public Health Wales NHS Trust.

<sup>26</sup> For more details of universal, intensive and enhanced support under the HCWP please see Welsh Government (2016). *An overview of the Healthy Child Wales Programme*. Cardiff: Welsh Government.

services are clearly set out to parents, and developing a consistent approach to identifying and supporting families who may need enhanced and intensive support. A secondary outcome is improved standardisation in data collection across Wales and ensuring that children can move safely through different organisations and receive a consistent service.

### **Policy context and strategic fit**

- 3.11 The importance of enabling children and young people to develop healthy behaviours through their formative years is recognised throughout Welsh policy. The Programme for Government, *Taking Wales Forward*<sup>27</sup>, sets out Welsh Government's commitments for 2016 to 2021 and supports delivery of governmental commitment to the *Well Being of Future Generations (Wales) Act 2015 (WFGA)*. *Prosperity for All*<sup>28</sup> is the national strategy for delivering the commitments outlined in *Taking Wales Forward*. Early years is one of the five cross-cutting government priority areas within *Prosperity for All*, in recognition that early years play a pivotal part in determining an individual's chances of leading a healthy, prosperous and fulfilling life in adulthood. The strategy's vision for early years is to deliver appropriate support for all children, particularly those from deprived backgrounds, in order to break the poverty cycle, mitigate the impact of ACEs, raise universal aspiration and attainment, reduce inequality and promote well-being. *Prosperity for All* highlights the importance of 'confident, positive and resilient parenting' in providing supportive and inspiring environment for child development. However, the strategy acknowledges the challenges associated with being a parent and points to the need for help and support that is adaptable to the circumstances of individual families. As a cross-cutting priority, early years has implications for many of the policy areas covered within the strategy including education and learning, health and wellbeing and housing.
- 3.12 Families in Wales come into contact with a range of agencies and initiatives with an early years remit, including: schools and education professionals; GPs, health visitors, immunisation services, community paediatricians and CAMHS; Family Information Services<sup>29</sup>, and; speech and language therapy.

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<sup>27</sup> Welsh Government (2016). [Taking Wales Forward 2016-2021](#). Cardiff: Welsh Government.

<sup>28</sup> Welsh Government (2017). [Prosperity for All. The national strategy](#). Cardiff: Welsh Government.

<sup>29</sup> Family Information Services (FIS) are the first point of contact for advice and information on local services for families and carers.

- 3.13 Families First<sup>30</sup>, Flying Start<sup>31</sup>, and Integrated Family Support Services<sup>32</sup> have provided targeted support to families for many years. Families First in particular has adopted a strengths-based approach to improving outcomes for children, young people and families. Agencies support families to recognise the positives within their individual circumstances, which helps to build and create resilience and self-reliance and support empowerment and ownership of families' growth and development.
- 3.14 Focusing on resilience and adopting an assets-based approach to supporting families – identifying and building on strengths rather than focusing on weaknesses and risks – is a growing trend in the way families are supported in Wales, and very much aligns to the principles of Prudent Healthcare<sup>33</sup> and the core values of both the WFGA and *Prosperity for All*. It is intrinsic to the HCWP, particularly the Family Resilience Assessment Instrument and Tool (FRAIT), which has been introduced as part of the HCWP and aims to identify resilience within families as well as additional needs and potential safeguarding concerns. The FRAIT is intended to facilitate early identification of child and family resilience in order to inform the delivery of timely and appropriately planned interventions. Effective interventions and prevention in the early years of a child's life are vital to ensure the best start in life and reduce long term health and social issues.

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<sup>30</sup> Families First is a Welsh Government programme designed to improve outcomes for children, young people and families. It places an emphasis on early intervention, prevention, and providing support for whole families, rather than individuals.

<sup>31</sup> Flying Start is part of Welsh Government's early years programme for families with children under four years of age living in disadvantaged areas of Wales.

<sup>32</sup> Integrated Family Support Services teams provide targeted support and help connect children and adult services, focusing on the family as a unit.

<sup>33</sup> Prudent healthcare is healthcare that fits the needs and circumstances of patients and avoids wasteful care.

## **4. Evaluation Findings**

### **Management and governance**

- 4.1 The development and implementation of the HCWP has been overseen by a project board (the HCWP Board) administered by Welsh Government. In addition, the Health Visiting and School Nursing Forum, an existing group of health visitor and school nurse leaders in Wales played a significant role in planning and managing the implementation of the Programme and is represented on the HCWP Board.
- 4.2 The Health Visiting and School Nursing Forum was the main vehicle through which the seven health boards with responsibility for implementing the programme worked together on its practical implementation. This forum also had a problem solving role through the process and would escalate issues to the HCWP Board as necessary. Health boards reported that this was not always an agile process to respond to challenges in project delivery arising at local level.
- 4.3 The initial programme start date of early 2016 was postponed as not all the component tools and support documentation for the programme that were being developed nationally were available, and consequently the implementation of the programme commenced from September 2016.
- 4.4 Health boards delivered the programme through their existing management arrangements for health visiting services.
- 4.5 A key element of delivery of the programme is the role of the NHS Wales Informatics Service (NWIS) in hosting the Child Health System, through which the health boards are required to enter their local data secured through delivery of the programme. NWIS is also leading on the procurement and roll out of new software for the Child Health System and the Welsh Community Care Information System (WCCIS) that will support health visitors across Wales to move to more digitalised systems of patient record keeping, with additional potential advantages in respect of information sharing across disciplines and agencies. All health boards currently use the Child Health System and electronic and paper patient record systems in some areas will be replaced by WCCIS. NWIS has a place on the HCWP Board and it was reported that NWIS meets with each health board twice a year on a routine basis to discuss matters relating to the Child Health System.



- 4.6 All health boards were able to describe an internal management escalation process, mainly through existing management processes for child health services and/or strategic transformation boards, sometimes on a multi-agency basis. Some health boards described a direct line of sight to the corporate board<sup>34</sup> through these mechanisms. This had been used to good effect, for example, in one health board where the child health and health visiting leadership teams had been able to secure the additional investment in health visitors to deliver the HCWP to the standards required, through presenting the case for investment to the corporate board.
- 4.7 Communication within the child health staff body was observed to be good, and most health visitors and child health staff interviewed reported good communication about the implementation of the programme with their managers, and routes to senior staff that enabled problems to be raised and resolved. However, there was some concern about the delay in this process where issues needed escalation to a national level. In most cases however, decisions around changes to delivery of the programme – for example carrying out some core contacts in clinic instead of in the home, or delegating contacts to nursery nurses – were made at a health board level.
- 4.8 Health visitor teams reported that training provided was highly relevant, although the timing in some cases was out of sync with programme delivery expectations. This was most significant in relation to the FRAIT where health visitors described being provided with training well in advance of the tools for implementation being available. Generally, health visitors reported they had been provided with both training and support materials to deliver the programme and this training was relevant and appropriate to support delivery of the changes being put in place
- 4.9 Some staff involved in the implementation of the programme described communication as being less than optimum, particularly in respect of IT professionals, GPs and speech and language therapists, given that the programme is expected to have an impact on these other professionals, in terms of referrals. For example, one manager of the Child Health System was not part of the management structure of the health visiting team and so were outside of the formal communication process for implementation, as this was being managed through routine management structures rather than a stakeholder project team involving wider stakeholders. In these areas it was not clear whether communication about

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<sup>34</sup> The corporate board of each health board.

the programme was a national or local responsibility, and there appeared to be no clear plans in place for engagement with these groups.

- 4.10 We observed that leaders in health boards were striving to maintain the integrity of delivering the consistency required of the national programme, whilst also needing to make local judgements and decisions to suit local circumstances, particularly in relation to geographic issues and resource constraints. Of particular concern was the degree to which health visitors felt they could legitimately vary the requirements of the programme in line with their professional autonomy, for example in relation to effective use of existing skill mix opportunities or holding visits in a clinic rather than home setting.

### **Programme implementation and delivery**

#### *Interpretation and delivery of universal scheduled contacts*

- 4.11 Stakeholders generally expressed support for the standardisation and increase in number of contacts required by the HCWP compared with previous practice: *"it feels more thorough ... feels like I'm doing a proper job. More structure"* (health visitor). Health visitors described the new schedule as bringing greater structure and thoroughness to health visiting services and in the majority of cases, it was reported that families are seeing their health visitor more often than was the case prior to HCWP. Nonetheless, whilst there was widespread recognition of the need to move to a greater level of consistency, in some instances, health visitors suggested that the HCWP was too rigid: *"there was a lot of inconsistent practice before in terms of when visits took place, who does the visits and where ... now it's the other extreme - so prescriptive"* (health visitor).
- 4.12 Whilst many health visitors were critical of the timings of contacts, stakeholders also recognised and valued the concept of progressive universalism inherent to the programme *"it's also quite individual ... HCWP is flexible enough to let us deliver support to meet the needs of our case load"* (health visitor).
- 4.13 Nonetheless, despite acknowledged approval of the consistency introduced via the programme, there was extensive variation in compliance with the HCWP contacts schedule; some are being omitted (most commonly the prenatal<sup>35</sup>, 6 month and 3.5 years contacts), some done in clinic rather than in the home (e.g. the 6 month, 15 month and 27 month contacts) and some are being delivered through skill mix, for

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<sup>35</sup> This is a targeted visit undertaken by the health visitor from 28 weeks.

example by a nursery nurse instead of a health visitor (e.g. the 27 month contact). In all cases, the reason reported for this variance with the programme schedule was a lack of human resource. The main consequence of this practice was that family resilience assessment (using the FRAIT) was not being done as often as is required by the HCWP guidance, given that it is meant to be carried out by health visitors and not nursery nurses and that there is insufficient time in clinic to obtain the information required to complete the FRAIT.

- 4.14 The 8, 12 and 16 weeks contacts caused problems in some cases. Health visitors reported difficulties in achieving these contacts, given that the onus was on parents to come to clinic, often in the same week that their baby was receiving immunisations. In addition, given that data collection forms are not issued by Child Health System<sup>36</sup> for the 8, 12 and 16 weeks contact, the health visitor needs to keep track of when they are due, which can be an issue particularly with parents who choose to come to clinic on a frequent basis: *“because it’s drop-in people could come whenever they want, and then we have to look back and see if they were due a DCF [data collection form]”* (health visitor).
- 4.15 Innovative practice was noted in some cases, for example, the health visitor would collaborate with the practice nurse in the GP surgery in which they are based to get babies to come to be weighed immediately after vaccination, to avoid parents having to make a separate visit.
- 4.16 There was notable discussion around the appropriateness of the new timings for the scheduled contacts and it is clear that the evidence to support change to previous practice was not sufficiently communicated to practitioners. Many stakeholders were particularly critical of the six-month contact, on the grounds that it comes right at the start of the weaning process and was therefore deemed to be too early to pick up any issues: *“six months is too soon for some key assessments - weaning, physical development, sociability”* (nursery nurse). A nine-month contact, which was widespread prior to HCWP coming in, was commonly thought to be more appropriate, given it provides an opportunity to intervene if certain development milestones have not been reached, for example, the baby is not sitting up or eating solids. Furthermore, nine months often coincides with when mothers are returning to work and may have anxieties that the health visitor can help to alleviate.

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<sup>36</sup> The Child Health System is a Wales-wide information system developed by NHS Wales Informatics Service and is used to manage the care of children from birth to school leaving age.

- 4.17 Similarly, the 15-month contact was criticised for being too early to be meaningful in terms of identifying issues with walking and/or talking, which in turn can cause parents to worry unnecessarily: *“at 15 months, children may legitimately still not have started walking or talking and so you have to see them again at 18 months ... it leaves the parents thinking their child is behind”* (health visitor).
- 4.18 There was a notable level of concern over the 27-month contact, which was felt to have been ‘scaled down’ compared with contacts that happened at or around this age before the introduction of the HCWP: *“it should be a developmental review ... using blocks, beads ... like the old two-year review [which] made parents see the value of pushing their child forward more”* (nursery nurse).
- 4.19 Stakeholders – particularly nursery nurses – were critical of the timeframe and scope of the 27-month contact, which was perceived to be too limited: *“it’s wishy washy ... parents have taken a day off work and have gained nothing ... they are expecting to do a load of activities but we just ask a few questions ... you find you’re asking more questions just to fill up the time”* (nursery nurse).
- 4.20 Mixed views were expressed on the value of the 3.5 years contact. It was suggested that infants are typically in contact with other agencies (nurseries etc.) on a regular basis by the age of three and a half, and therefore health visitors have less of a role in surveillance. Logistically it can be challenging for parents to take time out from work for the contact, only two months after having brought their child for routine vaccinations. It was widely felt that the 3.5 years contact does not have to be in clinic on a universal basis, given by that age health visitors should be aware of any additional needs of the child including the need for a targeted home visit.
- 4.21 The 3.5 years contact does, however, provide a baseline for the Child Measurement Programme<sup>37</sup> taken forward in schools, and school nurses also pointed to the likely benefits in terms of earlier identification of behavioural problems, developmental delays and toileting issues, which can in turn be addressed prior to the child starting school.
- 4.22 In addition to standardising and in many cases increasing the number of contacts, the HCWP has also set out a schedule of contacts of which most are expected to take place in the home. The rationale for this links to the surveillance aspect of

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<sup>37</sup> The Child Measurement Programme is coordinated by Public Health Wales and standardises the way primary school children’s height and weight are measured across Wales.

HCWP and the need to understand the family's background in order to provide an appropriate level of support: *"You get far better insight seeing the child in their natural environment so they are more relaxed ... also it gives you a better idea that they might need support ... if you go to a house that's always immaculate and it's upside down, it gives an indication that there may be an issue"* (health visitor). Many health visitors emphasised the fact the information required to complete the FRAIT is more appropriately obtained in the home, despite the fact that actually completing the FRAIT is intended to be done at the health visitor's base: *"the FRAIT and home visits work hand-in-hand"* (health visitor).

- 4.23 As noted above, however, contacts are frequently being undertaken in clinic rather than in the home, primarily because it cuts out travel time for the health visitor. Health visitors in rural areas reported particular challenges with driving to families living in remote areas with poor road access and the toll this takes on their personal vehicles as well as the time lost in travel. It was also suggested that carrying out the contacts in the home on a universal basis can undermine some parents' independence: *"the programme involves home visits that take away the autonomy of the health visitor to say to the parents 'you're doing ok, come and see me in clinic'"* (health visitor).
- 4.24 There have been some transitional challenges in moving over to the HCWP schedule of contacts, particularly for babies and infants already in the system. Depending on a child's age at the time that HCWP came in and the schedule of contacts in place in the area before HCWP, a child could end up missing out on contacts or having extra contacts. For example, infants aged 16 or 17 months when HCWP was introduced in an area when visits were previously carried out at 12 and 18 months would be too old for a 15 months contact, and so would not be seen until 27 months. Similarly, infants in the same area who were aged 12, 13 or 14 months when the programme came in ended up being seen again at 15 months, only three months after they were seen previously (i.e. at 12 months). Nonetheless, these issues were only transitory and do not have any long-term relevance for the HCWP going forward.
- 4.25 In contrast to the pre-school element of HCWP, the guidance for school nursing service under HCWP is comparatively limited. This is partly because the introduction of the programme has resulted in very little change to school nursing: *"We've not really taken it on, just carrying on doing what we've always done. Our*

*practice hasn't really changed - it's what we were doing already*" (school nurse).

The only notable exception is in one health board area, where the vision screening at school entry has been reintroduced, following the introduction of HCWP. The review and refresh of the School Nursing Framework<sup>38</sup> carried out in 2017 was felt to have had more of an influence on school nursing practice, in terms of setting standards for safeguarding, child measurement and mental health.

- 4.26 Nonetheless, the evaluation has revealed some level of resentment amongst school nurses, who felt that the HCWP 0-7 had been developed and introduced without sufficient consultation with the school nursing profession, and that it has failed to provide sufficient clarity on what is expected of school nurses: *"HCWP has let us down as school nurses because it's not very clear about the handover process, it's very grey now and it's made the waters muddier for us"* (school nurse).

#### *Alignment with Flying Start*

- 4.27 The Flying Start Programme offers an enhanced health visiting service to those families with children up to the age of four years living in the most deprived areas of Wales. With the introduction of HCWP, families in Flying Start areas continue to receive the support available from this programme; however, there is an expectation that delivery of health visiting services through the Flying Start Programme would align with the scheduled contacts of the HCWP and that Flying Start health visitors would adopt the tools and approaches set down by HCWP, for example FRAIT and Health Observation and Assessment of the Infant (HOAI)<sup>39</sup>.
- 4.28 The HCWP has been comparatively straightforward to implement alongside Flying Start, primarily because Flying Start involves significantly more frequent visits than generic health visiting service and Flying Start health visitors typically have much smaller case-loads than generic health visitors. Therefore, the capacity challenges experienced by generic health visitors when HCWP came in were not such an issue for Flying Start health visitors.
- 4.29 The HCWP has been a valuable mechanism for aligning Flying Start and generic health visiting services in terms of public health messages, which is particularly advantageous for supporting families who move in and out of Flying Start areas.

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<sup>38</sup> The School Nursing Framework sets out three levels of support offered to all school aged children in primary and secondary school settings via a "team around the child" approach.

<sup>39</sup> The HOAI is a comprehensive assessment of the infant's physical, social and emotional well-being undertaken by the health visitor at the primary birth visit and before the 6-week medical.

- 4.30 Minor issues that were identified primarily related to skill mix. Flying Start teams were typically more used to working with nursery nurses to deliver some of their contacts and under the HCWP, most contacts beyond the HCWP universal scheduled contacts (e.g. additional Flying Start contacts or contacts delivered as part of an enhanced and intensive service under HCWP) can still be delegated to nursery nurses. Nonetheless in some cases, Flying Start health visitors expressed frustrations that they had less flexibility to use skill mix for the universal HCWP contacts.
- 4.31 A minority of Flying Start health visitors expressed disappointment over a perceived mandate to decrease the use of Schedule of Growing Skills (SoGS)<sup>40</sup> assessment following the introduction of HCWP. In reality, the programme states that a SoGS assessment should be undertaken on a targeted basis at 15 and 27 months, rather than being done routinely at 24 months, which had been the case under the Flying Start Programme previously. SoGS was described as a “*robust but easy to use assessment tool, based around play*”<sup>41</sup> (health visitor). The informal style of the assessment was also thought to put parents at ease, making it easier to discuss with them any concerns or delays in their child’s development.
- 4.32 It was also reported that in some cases, where Flying Start health visitors were providing additional contacts to families with very high needs, it rendered HCWP scheduled contacts inappropriate. For example, if a child was seen at five months and two weeks, the value of the six-month universal HCWP contact was called into question. As part of the Flying Start Programme, families are entitled to two and a half hours of free child care a day from when the child turns two. It has been suggested that the HCWP contacts of 15 months and 27 months do not fit with entry to Flying Start child care at two years, and that it would be preferable to see children at or just before 24 months, in order to ensure readiness.
- 4.33 Overall however, these concerns are comparatively minor, and given the additional resource afforded to Flying Start teams, there is flexibility around the scheduled HCWP contacts to overcome any critical issues.

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<sup>40</sup> Schedule of Growing Skills is a tool that provides a snapshot of a child’s developmental level, including areas of strength and potential delay. It examines nine key areas, namely passive posture, active posture, locomotor, manipulative, visual, hearing and language, speech and language, interactive social and self-care social.

<sup>41</sup> A SOGS assessment involves the use of colourful and engaging toys like building blocks, a doll, pegs and shapes, allowing professionals to observe and assess reactions while the child ‘plays’.

### *Use of the FRAIT*

- 4.34 The Family Resilience Assessment Instrument and Tool – or FRAIT as it is commonly termed – was found to be the most controversial element of the HCWP, for five main reasons.
- 4.35 First, many health visitors suggested that carrying out a FRAIT assessment and generating a score had little or no value in assessing the needs of a family:
- "You come out with a score of 23 but what does that mean?"* (health visitor).
- "It's not helped to make it easier to identify need at all"* (health visitor).
- "[It's] not clear how the tool relates to the instrument and what the final score means in terms of determining universal, enhanced or intensive status"* (health visitor).
- 4.36 This was partly thought to be a consequence of insufficient or inadequate training on the use of the FRAIT, before and more importantly after it was introduced: *"we need clarity on what the scores means for additional visits"* (health visitor). This differs from practitioners' views on other training received to support the introduction of the HCWP, which was generally rated highly. The FRAIT was compared unfavourably to the other assessment tools used prior to HCWP in a number of cases, for this purported lack of clarity over what the score means for the level of support required by the family.
- 4.37 Second, the questions that need to be 'answered' in order to complete the FRAIT were widely criticised. Some found the statements to be too fixed, making them difficult to align to the nuances of a typical family's circumstances: *"They are very definite statements that you have to commit to ... it's a really bad tool"* (health visitor).
- 4.38 Furthermore, in responding to some of the statements, many health visitors reported concerns that their responses were subjective: *"you can do it on the same person and come out with different results"* (health visitor). Many health visitors expressed concern about this perceived subjectivity and what it meant in terms of professional codes of conduct: *"it's our opinion ... it's contrary to our training which is that we shouldn't have an opinion"* (health visitor).
- 4.39 The statements relating to financial stability and educational attainment were called into question by many health visitors, for being at best inappropriate and at worst intrusive and detrimental to wellbeing: *"why do we ask about parents' education?"*



*It's a vulnerable time for mums and this is invasive ... it also assumes that if you are more intelligent [sic] you will be a better parent"* (health visitor).

- 4.40 Of more concern, particularly among health visitors, was the perception that in exploring some of the more sensitive issues, deep rooted problems could emerge with no means of addressing them:

*"[It] can lead to outpouring of issues but then there is nowhere to refer them ... how right is it to open up a can of worms and then do nothing about it?"* (health visitor).

*"The issue is what you do once you identify all this information ... we've been having a lot more of these troubling conversations since HCWP came in but then you've got nothing to offer them"* (health visitor).

- 4.41 Team leaders in a couple of areas expressed concern about the impact this issue was having on health visitors, as well as the families: *"we're asking all these questions [sic] and opening up these issues and then health visitors are left holding it as there is no other support and that's not good ... staff mental wellbeing is an issue"* (team leader).

- 4.42 The third main issue with the FRAIT as perceived by some health visitors is that it has made the process of health visiting less personal and has reduced the ability of health visitors to tailor the visits to the needs of individual families: *"I feel the visits have become more about our agenda rather than theirs ... I don't want to go in and feel I have to ask these questions just to tick those boxes"* (health visitor).

- 4.43 It was suggested that this goes against the intrinsic role that health visitors are there to perform, which is to support families by responding and adapting to their needs, rather than to ask a standardised list of questions, which many health visitors perceived the FRAIT to be in practice: *"the principles of health visiting [are] to identify needs, but the FRAIT dilutes this and undermines the therapeutic role of the health visitor"* (health visitor).

- 4.44 The fourth cause for concern lay in the fact the assessment is done without the families' knowledge, which was thought to contravene professional codes of conduct: *"I have a few concerns in relation to consent ... we were told to acquire the information in a conversational way and they're not aware you're going back and filling in forms afterwards ... it's not open and honest as per NMC [Nursing and Midwifery Council] principles ... I'm quite uncomfortable"* (health visitor).

- 4.45 Finally, the FRAIT was not deemed to be a user-friendly tool in terms of format:  
*"You shade in the box but there is no indication or explanation of why you came to the conclusion"* (health visitor).  
*"The format of FRAIT is rubbish ... it needs tweaking ... there is nowhere to add comments"* (health visitor).
- 4.46 In a small number of cases, health visitors identified strengths of the FRAIT, for example that it has helped to illuminate more about a family's background, which in turn has made it easier to identify needs. Some also welcomed the shift in philosophy from being focused on risk and deficit to identifying resilience and strengths within families: *"it's helped to change our mindset ... before we were calculating risk ... this is about looking at the positives more than the negatives"* (health visitor).
- 4.47 A specific example of this was given in the case of looked after children (LACs): *"FRAIT has helped with LACs ... previously we would have gone monthly as a matter of course, now FRAIT flags up that there is resilience and support from the foster home and they don't need so many visits ... it's the same with asylum seekers ... some are vulnerable but with others the resilience is very high"* (health visitor).
- 4.48 Moreover, whilst many health visitors had been critical of the ambiguity of the FRAIT as a tool to inform targeting of support, small numbers welcomed this as flexibility: *"It gives you more autonomy because you're not using the FAT which was prescriptive in terms of what you had to do"* (health visitor).
- Provision of enhanced and intensive support*
- 4.49 The introduction of HCWP has not really had any major effect upon how health visitors support families with higher-than-average needs: *"It's not really any different from before ... it's just that we use a different assessment tool"* (health visitor).
- 4.50 Practitioners described enhanced and intensive support as typically involving additional contacts by health visitors or nursery nurses or referral to other agencies: *"we're providing enhanced and intensive support the same as we did under the old programme ... it involves more frequent visits and referral to specific services – e.g.: for mental health or substance misuse...it's the same"* (health visitor).
- 4.51 In isolated cases, health visitors referred to the FRAIT as having had an influence on the provision of enhanced or intensive support: *"we're providing the same*

*support but the identification is different ... it's about those with low resilience rather than high risk ... before we'd visit some families and wonder why we were doing this when there was actually nothing wrong ... FRAIT has helped to prioritise our time"* (health visitor).

- 4.52 There was however, a general call for greater clarity and consistency over how FRAIT scores align to the provision of intensive and enhanced support.

## **Workforce and Resourcing**

### *Staffing*

- 4.53 All health boards reported they had insufficient health visitor capacity to deliver the programme in full, and were, as a consequence making adjustments to delivery of the programme to enable modified compliance.
- 4.54 There was variation in capacity to deliver within and between health boards. Flying Start teams universally reported they had sufficient capacity to deliver the programme. In some areas teams reported that where they had one full time health visitor per caseload of 250 children, and skill mix staff in place, they were able to deliver the core components of the programme in full. In teams where this level of capacity was compromised by absence, however, there were difficulties in delivering the programme, as in most cases there was no backfill of capacity to fill the gaps. At least one health board had moved to a more corporate model of managing health visitor capacity, that delivered a more flexible approach to moving capacity to meet demand, rather than the traditional approach of expecting individual teams to absorb additional work due to absence or vacancies. Some health boards reported they had limited existing, or no skill mix in their health visitor teams, while others had consistency across the organisation.
- 4.55 One health board had successfully made the case at corporate level for investment in health visitors to meet the requirements for delivery of the programme. Though the investment was agreed in principle the health board had been challenged to recruit up to the new level of health visitors required. It was suggested there was a need for additional health visitor training places to be made available, as had happened with the introduction of Flying Start, to meet the immediate shortfall. This will also be required on a wider basis as there was concern that the age profile of health visitors means there are potentially a large number that will be retiring in the next few years. If not already forecast, this warrants a structured workforce

planning approach, including looking at how skills can be retained in the service post-retirement.

- 4.56 There was a call for more guidance on the school nursing element of the programme stemming from a perceived lack of information on how to implement the HCWP for school nurses. It was perceived as the poor relation in terms of focus and guidance, for example national level guidance on what formal handover is required from health visitor to school nurse. Instead, programme documentations states that health boards should follow "appropriate, locally agreed processes"<sup>42</sup>. There was a great deal of variability in the age of entry of children into the education system, so some degree of local autonomy is probably required to meet local challenges. Some guidance had been developed at a local level such as a questionnaire for parents and letters sent to parents following the Child Measurement Programme growth screen. These local tools could form the basis of nationally agreed tools.
- 4.57 There were some areas where the implications of the programme on wider capacity in organisations appears not to have been fully considered. Child Health System managers reported that no additional resource had been made available to them for delivering the additional administrative processes in the programme. Health visitors also reported an increased level of referral to, for example, speech and language therapy. It is likely a more systematic approach may have an impact on other services, and this warrants further review in the next phase of evaluation.

#### *Skill Mix*

- 4.58 Skill mix in generic health visiting as well as Flying Start was evident across health boards and there were a number of features evident where skill mix existed. Skill mix included:
- Band 5 nurses (non-health visitor trained) in modular training or support roles
  - nursery nurses
  - administrative staff
  - a range of staff mentioned in relation to Flying Start including speech and language therapists and community psychiatric nurses.

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<sup>42</sup> [An overview of the Healthy Child Wales](#)

- 4.59 The use of skill mix was highly valued by most health visitors, given that it aligns to the prudent healthcare principle of making the most effective use of all skills and resources<sup>43</sup> Concerns were raised that the prescriptive nature of the HCWP meant that their ability to delegate elements of the programme within their professional judgement had been restricted.
- 4.60 Nursery nurses in particular were concerned about the impact of the HCWP on their practice. Nursery nurses felt that they were being de-skilled as they had been trained to undertake specific tasks that they were no longer permitted to undertake under the new programme.
- 4.61 Before the implementation of the programme health visitors felt they had greater autonomy in how they deployed nursery nurses and these nurses had taken the opportunity to extend the scope of their skills through training. Some nursery nurses now felt that the scope of their practice was restricted, and they were not able to use these skills due to the inflexibility of the programme. It was reported by managers and nursery nurses that there is a risk that some staff leave the service as a consequence.
- 4.62 In some areas the use of skill mix was resisted on professional grounds by health visitors, who expressed concerns about nursery nurses carrying out tasks without sufficient training, knowledge and/or skills. This warrants further work to consider the appropriate scope of how skills mix might be used, in line with Prudent Healthcare principles, to its maximum within the programme without compromising quality and supporting local autonomy in decision making.
- 4.63 There were areas where a more efficiently delivered service would release professional capacity in health visitors, with particular emphasis on the level of administration that health visitors were doing themselves, that could be undertaken by lower grades of staff, and also the greater use of skill mix in teams overall. A workforce tool would enable this to be quantified, and also help identify the potential investment in technology required to support efficiency in the use of resources.

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<sup>43</sup> [Making prudent healthcare happen](#)

### *Training and support*

- 4.64 Training on a number of new elements of the programme had been provided through the delivery of a train the trainer programme at a national level that was then rolled out at health board level. There was universal appreciation of the quality and usefulness of the training, although in some cases people felt that it was not timely. Health boards had supported this training with the provision of guidance materials to every health visitor team.
- 4.65 Most staff welcomed and valued the training that had been provided in support of delivery of the programme: “[the training] was pretty thorough which was important as [the HCWP] was a big change for us” (health visitor). The national roll-out of training on a train-the-trainer basis seems to have worked well, and most practitioners interviewed had been trained. The only exception to this was in respect of the FRAIT training; whilst the train-the-trainer element was delivered on time, the roll-out (i.e.: the trained trainers’ delivery of training on FRAIT to health visitors) were delayed in some areas. Even among those who had received training in FRAIT on time there seemed to be different levels of understanding of the purpose and delivery of FRAIT, as already noted. There were some concerns of the need to establish an on-going maintenance and update training programme, particularly given the scope of the initial training that had been received: “we need more training and probably on a regular basis, not just a one-off” (health visitor).

### *Future workforce planning*

- 4.66 Awareness of the planned acuity tool<sup>44</sup> was not high and tended to be stronger among management levels in health visitor services. The notion of a validated tool was broadly welcomed to add weight to the case being made for investment in local teams. There was concern around the need for the tool to be able to take local variation into account in respect of deprivation and also rurality (and consequent travel times between appointments). The implementation of the tool may be challenging due to the need to identify the level of capacity being used in administrative tasks and the unknown impact of digitising the way in which health visitors record and report their work.

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<sup>44</sup> A dedicated workstream under the HCWP Board is currently devising an acuity tool, which will provide a way of measuring caseload make up in relation to complexity.

## **Monitoring and data collection**

- 4.67 Most stakeholders referenced consistent data collection and record keeping across Wales as a key rationale behind the HCWP. It was stated that consistent notes would lead to easier transitions between professionals and health boards and would support the standardisation of the core programme of advice and support and allow for consistent monitoring of health boards' performance.

### *IT systems*

- 4.68 IT systems were seen as a barrier to effective data collection and monitoring across the majority of the health boards. There was considerable variation in local access to IT<sup>45</sup> across the health boards. Some health boards were found to be using entirely paper-based record systems for health visitors whereas others were partly digitised through the Paris software system, for example. Many health visitor teams reported sharing a single PC, but where software was in place, more terminals were available. There was limited access to mobile devices or bring-your-own device models of working<sup>46</sup>. All stated they had a positive view in anticipation of the implementation of the Welsh Community Care Information Service (known as WCCIS)<sup>47</sup> although there were concerns voiced at the current level of available devices to support its implementation. All interviewed stakeholders referenced the need for digitisation of processes and hand-held devices to combat duplication and time wasting, albeit with caveats in some cases (see section 4.70 below). In some health boards health visitors only have shared access to desktop computers, which is insufficient to meet basic access requirements to IT, for example, for checking e-mail and undertaking training.
- 4.69 The lack of IT infrastructure across the health boards means that time and resource is spent photocopying paper records into paper-based systems and separate data entry requirements onto the Child Health System. The majority of health visitors interviewed felt that a move to hand held technology would be beneficial, make their work more efficient and reduce administrative burden. It was reported that the introduction of HCWP had added to this administrative requirement where teams

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<sup>45</sup> This ranged from some health boards where health visitors had individual hand-held electronic devices for entering data to others where health visitors only had access to a shared desk-top computer.

<sup>46</sup> Bring your own device (or BYOD) refers to the policy of permitting employees to bring personally owned devices (laptops, tablets, and smart phones) to their workplace, and to use those devices to access privileged company information and applications.

<sup>47</sup> This is a new computer system that is currently being introduced in Wales that records information about all treatment or care that service users receive from health and social care professionals in Wales.

were undertaking more visits than in previous arrangements. As already noted, Child Health System managers stated they had been required to absorb the additional workload associated with issuing forms for completion and data entry, with no additional resource.

- 4.70 Nonetheless, despite a widespread call for investment in information technology, health boards with more embedded IT systems and technology available were found to face different challenges. Some areas with computerised systems were delaying implementing the programme due to the lack of administrative support and the need to adapt the data collection forms and their embedded systems. Furthermore, areas with hand held devices described an increase in working hours due to the ability for staff to 'take their work home'. Several health visitors reported using their devices to catch up or keep up with the higher paperwork demands brought in with the HCWP: *"our working day is now even longer ...I end up doing a lot of it at home"* (health visitor).
- 4.71 A number of health boards felt digitisation and an improved IT infrastructure is critical to the success of the HCWP. They noted that the programme urgently needs a reduction in paperwork and an update to the supporting IT infrastructure. It was reported that the current Child Health System is unable to provide performance management reports at individual health visitor, team or regional level and there is no mechanism to allow teams to validate data, leading to doubts over data quality. The Child Health System is perceived as out-dated, based on a DOS operating system (i.e. not Windows based) and lacking in flexibility. The perception is that the WCCIS system seems to be constantly delayed.

#### *Data collection forms*

- 4.72 Health visitors reported a number of issues with the data collection forms. Firstly, the design of the data collection forms was reported as having been undertaken without direct consultation with practicing health visitors. The documents were thought to be time consuming and difficult to fill in for a number of reasons.
- 4.73 The forms were reported as being designed for electronic use and do not print well; for example, large blank areas on a printed version are caused by drop-down menus on the computerised version. This leads to long forms with large areas of blank, wasted space.



- 4.74 Health visitors reported that the writing on the forms is small and difficult to read, and the space on the forms is insufficient for crucial information, for example when an NHS number needs to be added to the form manually.
- 4.75 The format of the forms was criticised for a number of reasons. Firstly, they are landscape which health visitors claimed makes it difficult to fill them out in the domiciliary visits (as health visitors typically fill out the forms on their laps) and flick back and forward to different pages. The forms also require health visitors to flick back and forward as, for example the family details are split over the first and second pages, which was criticised during the fieldwork.
- 4.76 To reduce printing costs, health boards are only able to print in black and white; however, the forms were designed in colour and health visitors claimed that highlighted or separate sections were not clearly visible in black and white.
- 4.77 Prior to implementation, the clerks in child health did not receive sufficient training on the use and transfer of the forms into the computerised system. Many of the forms filled out by health visitors can contain errors, missing information or abbreviations. In these cases, the information from the rest of the form cannot be inputted into the computerised system, and therefore show up as gaps in the quarterly reports: *“our computer system doesn’t accept things if one tiny thing is wrong on the sheet, for example, the date”* (health visitor).
- 4.78 There is a lack of feedback to health visitors in the data collection process. For example, data quality issues are not always fed back to the health visiting teams for verification or follow-up. This may cause inconsistency in data and incorrect representation of the success of the health board. In some health boards a small number of forms are sent back to be amended, thus creating delays in input, incomplete data or late reporting. Further issues experienced by the clerks include strain on budgets and time due to the increased amount of manual entry they are required to undertake, and the increased amount of printing and distribution of forms.
- 4.79 Production of the forms for the initial birth visit by child health can be hindered if there is an issue or delay with birth certificates. This has caused health visitors to use alternative forms and rewrite the data once the correct forms have been produced or even to put off their birth visits.

- 4.80 There was also an additional administrative burden in the transition from the old system to the new in health boards. When the HCWP was rolled out there was initial overproduction of forms. When child health switched to the new contact times, forms were produced for all children who fell within the grace period for each of the contacts. For example, forms were created for the six months contact for all children from the age of five to seven months as the system showed they had not been seen under the new system. This happened across many health boards for all contacts and caused clerks and health visitors a large administrative task, requiring them to cross reference all of the newly generated forms/visits with the old system to ensure those who had not been seen recently under the old system were prioritised. This is a transitional issue of implementation that may have been anticipated if more structured involvement of stakeholders had been in place.
- 4.81 A number of issues that were raised with the data collection forms and that are set out above would indicate that a greater degree of user involvement in the design of the forms would be helpful to ensure they are practical for health visitors to use and to collect the best quality data. This may be an issue for the new Child Health System if this is likely to supersede the current<sup>48</sup>.

#### *Data quality*

- 4.82 A number of the issues outlined in the above section on the data collection forms can impact the overall quality of the data. As already noted, data entry can be delayed or left incomplete due to errors, abbreviations or incomplete forms. Therefore, clarification is needed on how to report incomplete data. Furthermore, late generation of forms by child health due to delays in receiving birth certificates can delay birth visits or transfer of data from multiple, duplicate forms, further potentially compromising the quality of the data.
- 4.83 In a small number of health boards, health visitors were of the opinion they were completing more paperwork but to a lower standard. They felt they were collecting similar statistics, but in a more convoluted way involving multiple forms, leading to a lower standard of data collection. Health visitors were also concerned the Child Health System and the health visitor teams are not being shown how the data is being used and that there is therefore a lack of buy-in from staff in accurate data collection.

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<sup>48</sup> CCH2000 has been the Child Health Information System in Wales for over 15 years, but is in the process of being replaced by the Children and Young Persons Integrated System (CYPrIS)

4.84 The target success rate for contacts within the HCWP is 100%. There are a number of issues around having such a high target. There is no mechanism to highlight families who may have opted out of the visiting schedule. In three of the health boards there is a cross border impact for Welsh residents registered with an English GP who are not covered by the programme, although the forms are generated and visits expected by the Child Health System. Issues relating to the capacity of health boards to comply with the full requirements of the programme will also impact the contact success rates for health boards. Based on the reasons outlined above, Welsh Government may need to consider an appropriate performance threshold of less than 100%, at least in the short term.

## 5. Conclusions and recommendations for the HCWP Board

5.1 There is no doubt that the consistency of approach within and across health boards that has been brought in by the HCWP is embraced and welcomed by practitioners working with families in Wales. Health visitors newer to the profession were particularly welcoming of the structured approach and more experienced health visitors felt it returned them to practice they had been trained to deliver.

5.2 Health visitors were clearly and consistently able to describe the purpose of the HCWP as promoting standardisation in delivery of the child surveillance programme across health visitor services in Wales. The wider aims and objectives of the programme were less well articulated and further work could be put in place to ensure that health visitors are able to understand the link between the programme and the wider objectives for child health in Wales.

5.3 Health visitors are beginning to articulate the benefits of the programme, for example, in maintaining commitment to health promotion, working with fathers and increasing problem identification and referrals in specific developmental areas. These areas may require more focused evaluation to determine both outcomes and further training and support required to health visitors to deliver and understand the onward effects with other services. Further audit or evaluation approaches may be required to ensure there is consistency and quality in delivery at individual level, potentially triangulated with the experience of parents to verify delivery.

*Recommendation 1: to consider what is needed in terms of direction and scope from the next phase of the evaluation of the HCWP.*

5.4 The various tools and checklists are mostly well-received and used to support consistency, with the exception of the FRAIT. Health visitors are critical of the FRAIT for a variety of reasons. However, much of this criticism stems from a lack of understanding about how the FRAIT should be used and why it has been introduced.

*Recommendation 2: to task the FRAIT development board with revisiting the purpose, format and content of the FRAIT.*

*Recommendation 3: to develop and deliver additional training to health visitors on the purpose and application of the FRAIT.*

5.5 The digital support to the delivery of the programme still needs further development and the IT infrastructure currently available in most health boards is undermining the successful implementation of the programme. In terms of going forward, the HCWP Board should consider focusing attention on delivery of the wider enabling requirements for the programme, particularly in respect of ICT and digitisation to ensure focus and acceleration to support efficiency.

*Recommendation 4: to work with NWIS and Child Health teams in each health board to streamline the data collection process as far as possible.*

*Recommendation 5: to introduce sense-checking processes at each stage of data entry, analysis and reporting.*

5.6 Health boards require a greater level of guidance and advice on programme delivery. Simultaneously, the HCWP Board needs to hold health boards to account for developing strategic resource plans for the delivery of the HCWP through the Integrated Medium Term Planning process, to include health visitor services and school nursing services, skill mix and the wider implications for staffing of the Child Health System.

5.7 The impact of the programme on wider services such as GPs and speech and language therapy should also be identified and planned for accordingly. The HCWP Board should ensure that there is clear communication to all relevant stakeholders of the vision and values of the HCWP and the desired outcomes for child health through the development of appropriate delivery Key Performance Indicators (KPIs).

*Recommendation 6: to engage with health boards with the objective of ensuring a greater understanding of the rationale for the HCWP and achieving an appropriate level of investment in early years workforce, in particular health visitors.*

5.8 To support this, the HCWP Board needs to consider establishing a clear set of objectives for delivery of the next phase of the HCWP and ensure it has the right governance structures and guidance in place nationally and locally to ensure delivery, using a structured programme management approach.

*Recommendation 7: to develop comprehensive and up-to-date guidance for strategic stakeholders and practitioners on the HCWP.*

5.9 It has been evident that despite a considerable shift towards a standardised programme of screening and surveillance since the introduction of the HCWP, there is still a notable degree of variation in the extent to which health boards and

individual early years practitioners are adhering to the requirements of the programme. In many cases this is a capacity issue, which may be addressed in the medium term by investment in the early years workforce. In the meantime, however, the HCWP needs to agree an appropriate degree of leniency around programme delivery.

*Recommendation 8: to explore with relevant specialists what would be an appropriate margin of flexibility around the timings and locations of the contacts and who carries out the contacts.*

- 5.10 In summary, many of the problems identified with the HCWP are issues of transition and should be recognised as such. Within the current resource constraints – human and financial – that health boards and health visiting teams are facing, practitioners should be commended for implementing the programme to the standard that has been observed.

## 6. Annexes

### Annex A: topic guides

#### Evaluation of Healthy Child Wales Programme HCWP Board member interview topic guide

##### Confidentiality:

Please reassure interviewee that anything said during the interview will be treated in complete confidence and that we will be reporting on general issues and themes only. Where direct quotes are used they will be sufficiently anonymised to ensure that they cannot be attributed to any one individual, or we will ask for their consent to be quoted.

Interviews will be audio recorded and notes will also be taken on paper. Both audio recordings and textual notes will be destroyed once the evaluation is complete. The data will be processed only by Miller Research and it will not be passed onto any third-party organisation.

Please be assured that this research is being carried out in accordance with Market Research Society guidelines, which are in place to promote professionalism in the conduct of market, social and opinion research.

<b>Interviewee</b>	
<b>Role/organisation</b>	
<b>Time/date</b>	
<b>Interviewer</b>	

##### **Programme logic and background**

1. What do you think was the rationale for developing the Healthy Child Wales Programme?
  2. *Health Visiting in Wales - Child measurement programme – Flying Start Programme – Specialist Community Public Health Nursing (SCPHN)*
3. Do you think there was evidence behind the decision to implement HCWP or not? Why? What was this?
4. What, if anything, do you think the difference is between HCWP and previous practice?  
Not enough

##### **Inputs**

5. In your opinion does it have the right support from the different institutions involved in the delivery, or not?
6. Do you think the team on the ground is adequate to deliver the programme or not?  
Professional leads, HV, School nurses, midwives etc.
7. Do you think the expectations for the programme are adequate?
8. Do you believe that the systems needed to deliver the programme are in place or not?

##### **Process**

9. Do you consider the approach to the HCWP appropriate to offer a consistent delivery of universal health services for children up to seven years of age?

10. How adequate or inadequate do you consider the monitoring data in terms of assessing the programme's implementation?
11. As far as you are aware, have the health boards been given guidance on how to implement the programme or not?
12. In what way (if any) do you believe the programme has influenced the number of health visits/skill mix contacts?
13. As far as you are aware, has the programme been promoted via public health wales, or not? Are you aware or unaware of promotion from any other sources?
14. In your opinion, are the tools used to assess the needs of the family adequate or inadequate? Why?
  - The Framework for the Assessment of Children in Need and their Families DOH (2000)
  - Family Resilience Assessment Instrument and Tool (FRAIT) (Wallace et al. 2016)
  - Health Observation and Assessment of the Infant (HOAI) (2015)
  - Peri-Natal Mental Health mood questions (NICE 2015)
  - Growth Guidelines (Royal College of Paediatricians 2009)
  - Domestic Abuse Questions, Routine Enquiry (2015)
15. Do you know how the project is managed locally? How would you rate it? Why?
16. Has the ease of referral to other services changed in any way or not?  
Probe: toddler groups, financial issues, childcare and help with the cost of childcare (FIS),

***Outputs, outcomes***

17. How has the implementation of the HCWP gone thus far?
18. Are there any differences in implementation between the HBs?
19. How is the enhanced and intensive part of the programme being delivered?
20. Are the different professionals (HV, Midwife, School Health nursing) working collaboratively to deliver the programme, or not?
21. Have there been any particular challenges encountered so far, or not?
22. How are the monitoring data being used? (national approach, should be easier to assess when children are moving from on board to another)
23. How are they analysed and how is the feedback from the HB incorporated?
24. What impact and benefits has the HCW programme had on children and their families so far, if any? (possibly prompt)
  - More children receiving immunisation
  - Children with development delays identified and receive support
  - Parents received advice and support
  - Better transition to school arrangements - ??
  - Families are informed and feel empowered in their health decisions
  - Improvement of family resilience



## Evaluation of Healthy Child Wales Programme Drop-in surgery interview topic guide

This topic guide is intended to be used for interviews with:

- Director or assistant director lead for the programme (i.e.: person with senior responsibility);
- Professional lead for each relevant profession;
- Project lead or identified person charged with delivering the programme;
- A sample of all practitioners involved in delivering the HCWP, including: generic health visitors, Flying Start health visitors, school nurses, support health workers;
- Leads from Human Resources, IT and Finance if identified, to support delivery;
- Any other person deemed relevant by the health board.

Please note that some questions will be more relevant to certain respondent groups than others, and the range of questions that are asked in each interview will be tailored according to the role and perspective of each respondent. I.e.: not all questions will be asked of all respondents.

Miller Research has been commissioned by Welsh Government to undertake an independent evaluation of the Healthy Child Wales Programme.

The purpose of these interviews is to understand your role in the delivery of the Programme and how the implementation is currently going.

### Confidentiality:

Please reassure interviewee that anything said during the interview will be treated in complete confidence and that we will be reporting on general issues and themes only. Where direct quotes are used they will be sufficiently anonymised to ensure that they cannot be attributed to any one individual, or we will ask for their consent to be quoted.

Interviews will be audio recorded and notes will also be taken on paper. Both audio recordings and textual notes will be destroyed once the evaluation is complete. The data will be processed only by Miller Research and it will not be passed onto any third-party organisation.

Please be assured that this research is being carried out in accordance with Market Research Society guidelines, which are in place to promote professionalism in the conduct of market, social and opinion research.

<b>Interviewee</b>	
<b>Role/organisation</b>	
<b>Time/date</b>	
<b>Interviewer</b>	

### Background

1. What is your understanding of the rationale behind the HCWP? I.e.: what are the aims of the programme? What is it trying to achieve?
2. What is your role in delivering the programme locally?
3. How, if at all, does the delivery of the HCWP differ from the way in which families with young children were previously supported in your area?
4. (*Question for managers*): Was a local assessment of current practice in supporting families with young children against the HCWP undertaken initially? If so, was this documented? Was an implementation plan produced? Could you share any of this with us?
5. (*Question for practitioners*): Were you asked for your views about current practice in supporting families with young children before implementation of the HCWP? If so, from where did this question come? Through what channels were you asked to share your views?

## Governance

6. What project management arrangements are in place for delivery of the HCWP in your area? I.e.: who ensures compliance with the requirements of the programme? What processes are in place for doing this?
7. What are the accountability and progress reporting arrangements for delivery of the HCWP within your health board area? How is success reported and celebrated? How are problems escalated and resolved?
8. *(If not already ascertained from questions 6/7 above)* Is there a structured approach to implementing HCWP and is anyone senior within your health board responsible for this? What is their role?
9. What do you think of the management arrangements for the delivery of the HCWP in your area? Why do you say this?

## Inputs

10. What guidance have you received on how to implement the HCWP? (If applicable) how would you rate this guidance? How (if at all) could it have been improved?
11. To what extent are the right practitioners involved in delivering the HCWP? What evidence do you have?
12. Did you receive training before implementing the HCWP?
13. How would you rate the training you received on delivering the HCWP and, specifically, on the use of the FRAIT?

## Activities

14. How have staff involved in delivering the HCWP responded to the programme? In what ways have staff been involved in problem solving, decision making and reporting challenges with the delivery of the HCWP?
15. What are the main organisational challenges in delivering the programme?
16. How is the provision of Enhanced and Intensive support to children with high needs managed and delivered via the HCWP in your area?
17. How does this provision of Enhanced and Intensive support under the HCWP differ from the way support to families with young children with high needs was previously delivered in your area?
18. What is your perception of the role of Welsh Government in supporting/challenging the health board in delivering the HCWP?

## Outcomes

19. How would you rate the value of the FRAIT? To what extent has it helped to make it easier to identify the needs of families with young children in your area? How does it differ from assessment tools/mechanisms you used prior to HCWP?
20. To what extent has the HCWP affected referral of families with young children with specific needs in your area onto other agencies?
21. What do you perceive as the benefits of the programme to date?
22. Is there anything you would like to see changed about the delivery of the HCWP?
23. How, if at all, has the HCWP affected the skill mix in providing support to families with young children in your area? What might need to be done in the future?
24. Are you aware of the development of a Wales Health Visiting Acuity Tool? If yes, what do you believe to be the purpose of is the tool? *Prompt if necessary, it is a tool that is intended to enable each Health Board to more accurately determine local workforce requirements.*
25. Has any work been done in your area, since the implementation of the HCWP to consider future staffing requirements and associated costs for supporting families with young

children? If yes, what? Any examples/evidence? If no, do you think it needs to happen or not?

26. What have been the successes and challenges in terms of technology, data collection and reporting in relation to the HCWP? How, if at all, are any challenges being addressed? E.g.: what solutions are planned/being implemented?
27. What impacts do you think the HCWP is likely to have on families with young children in your area? What impacts do you think the HCWP is likely to have on families with young children in Wales as a whole? To what extent are these impacts being realised? What evidence do you have for your view? What might undermine the realisation of these impacts? Why?
28. Is there anything else that you would like to see explored as part of this evaluation or that you would like to raise with us?

**Thank you for your time.**

**Annex 2: HCWP logic model**







