Better for every child

FULL REPORT

The evaluation of the Nurture Programme: Infant Health and Wellbeing

The Atlantic Philanthropies
KHF Katharine Howard Foundation
HSE
CES The Centre for Effective Services
The Community Foundation for Ireland

Contents

Foreword

It is our pleasure to introduce this summary report of the evaluation of the Nurture Programme: Infant Health and Wellbeing 2015-2019.

The Nurture Programme has its roots in the generosity of Charles (Chuck) Feeney who, through The Atlantic Philanthropies (Atlantic), has for many years, supported a range of significant developments in services for children and families experiencing disadvantage in Ireland. As the work of Atlantic was drawing to a close, the organisation decided to support a number of legacy programmes, including the Nurture Programme, to mainstream the learning from the targeted programmes and improve the universal supports provided to all children and families in Ireland.

Pregnancy and early childhood have long been identified as key stages to provide supports to children and families, as these are the periods of most rapid development and lay the foundation for the rest of a child's life.

Atlantic decided to invest in child health services in the very early stages of pregnancy and childhood in partnership with:

- The Katharine Howard Foundation which has significant experience in managing and supporting a range of initiatives in early childhood
- The Health Service Executive, as the agency responsible for the provision of child health and wellbeing services, including information, advice and support to every one of the 61,000 children born in Ireland every year, and
- The Centre for Effective Services, which has significant expertise in supporting human services systems change programmes.

Since 2014, an integrated programme of work has been developed and implemented through the Nurture Programme with a view to strengthening HSE supports in pregnancy and early childhood. Some of this work, such as the www.mychild.ie website, the new *My Pregnancy* and *My Child* books and a comprehensive staff training programme, are already in daily use. Other upcoming resources and tools include the standardised child health record for Public Health Nurses and Community Medical Doctors, a standardised child development screening tool and standards for antenatal education.

We would like to pay tribute to the Nurture Programme team across our partner agencies and to every one of more than 100 people who have worked as part of the Implementation Teams and Subgroups. We would also like to acknowledge the many staff who have shared their views, participated in the training and who have supported parents' access to the resources developed through the Nurture Programme. We would also like to acknowledge the most important people of all: the parents who have shared their wisdom and advice so that the supports they receive are fully tailored to their needs.

We look forward to the work of the Nurture Programme being sustained and further developed under the auspices of the HSE's National Healthy Childhood Programme, ensuring every child gets the best possible start in life.

Finally, we would like to thank our independent evaluators, Quality Matters, in partnership with Dublin City University. Caroline Gardner and her team have produced a number of earlier reports that have informed the development of the Nurture Programme. This Summary Evaluation Report outlines the achievements of the Nurture Programme as well as some of the challenges it has faced and proposes several key recommendations to be addressed for the future.

These evaluation findings are very encouraging and clearly indicate the potential of our complex programme of work to have a long-term and positive impact on the lives of children and families.

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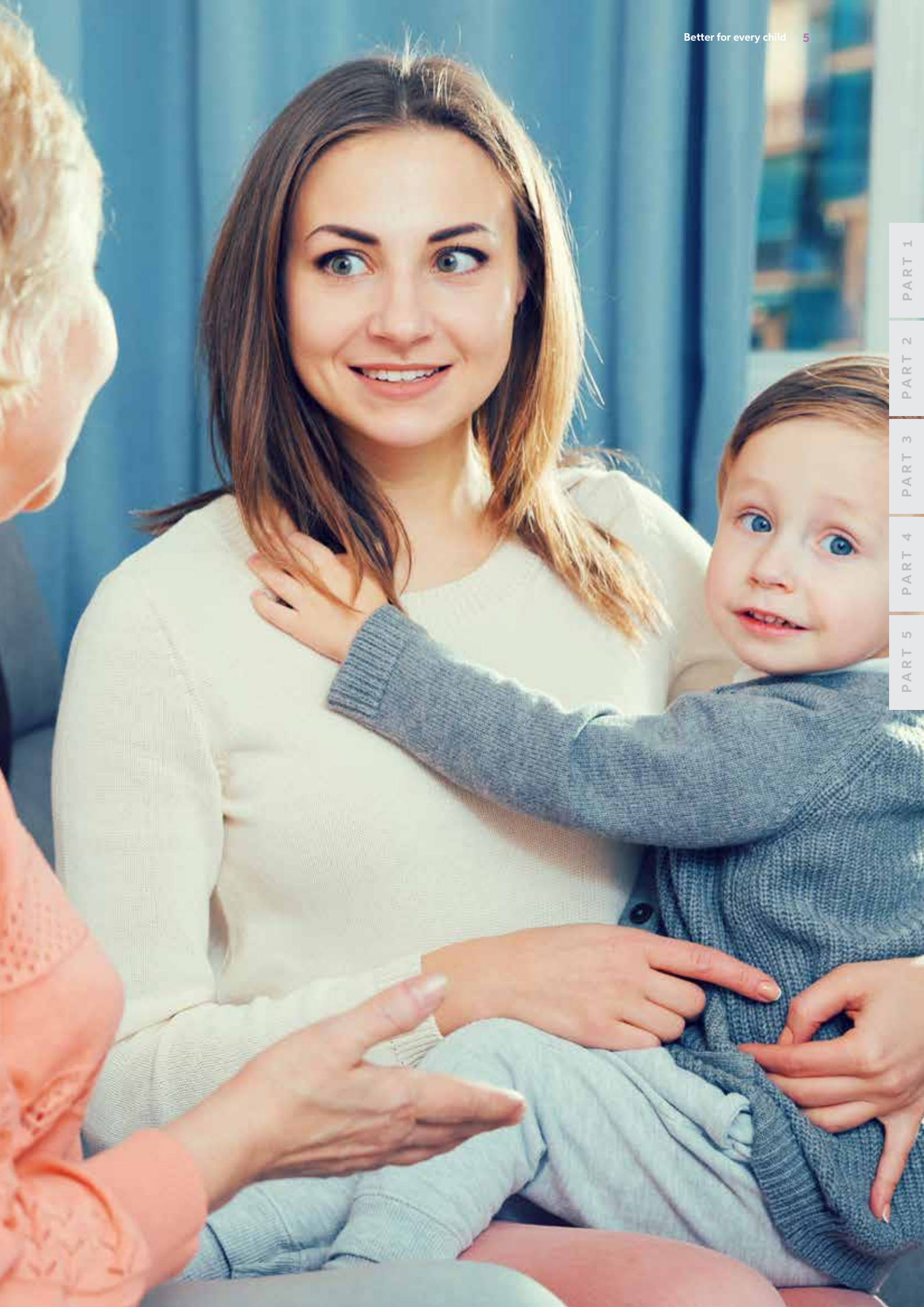

Executive Summary

Introduction

The Nurture Programme: Infant Health and Wellbeing is a quality improvement programme that aims to support the development of a 'universal integrated approach to evidence-based service planning and delivery in order to improve health and wellbeing outcomes for infants and their families from pregnancy to the child's third birthday [1].' The Programme's work is led by three main partners: the Health Service Executive (programme development and implementation), the Katharine Howard Foundation (programme management and support) and the Centre for Effective Services (implementation support). Guided by the principles of implementation science, the development and project management of the Programme was led by the HSE Nurture Programme team. The Programme's deliverables were created and carried out by six thematic Implementation Teams. The process engaged approximately 100 staff comprising members of a number of subgroups and additional subject experts. The Programme also sought feedback from parents and practitioners whenever possible. This systematic engagement of service users helped to fully align the resources with their needs and preferences.

Distinctive features of the Nurture Programme include its partnership approach, the use of implementation science as methodology, the focus on evidence-informed decision making and the integration of communications strategies into all branches of the work. These factors ensured that the Nurture Programme was built on and integrated into HSE systems, which were themselves subject to significant change and development over this period.

In just five years, the Nurture Programme has created a variety of new tools and resources for parents and child health practitioners. The changes that will stem from these new products and systems will affect all parts of the health service in its work with families and children under the age of three. This evaluation indicates that the Programme's tools, training, standards and resources show great promise for improving child health and wellbeing services, as well as outcomes for young children in Ireland. Furthermore, by early 2020, many of those deliverables in draft at the time of this report will be launched and in use.

The Nurture Programme sought to create positive change through six key deliverables. This evaluation draws on data from more than 400 people, attained through focus groups, surveys and interviews to assess whether the Programme goals have been achieved and to what extent.

The table below provides key data regarding the Programme's effects, including the areas where it has laid the foundations for future gains and where challenges have stood in the way of fully achieving objectives. These findings and subsequent recommendations are informed by a substantial body of qualitative and quantitative evaluative research, outlined in detail in the methodology section of the report.

This executive summary ends with nine detailed recommendations that describe a range of specific actions vital to stakeholders for embedding and sustaining the many gains of the Nurture Programme. These actions build on the strong foundations that this Programme has created to ensure that every child receives a world-class health and wellbeing service.

1 Katharine Howard Foundation. (2017). Proposal to Atlantic Philanthropies for Restructuring of Nurture Programme Budget. Dublin: Katharine Howard Foundation.

Summary of Key Findings

1 What was the impact of the development of the new HSE public-facing www.mychild.ie website?

Those interviewed for this evaluation consider www.mychild.ie to be one of the Programme's most useful and publicly-accessible accomplishments. Launched in December 2018, the site is the work of more than 60 HSE staff and partners who engaged in the development of more than 525 pages to date. The development of the new website represents a vital step toward all parents in Ireland having access to consistent evidence-based information about pregnancy, parenting and the physical, social and emotional development of children under three years old.

More than 85% of participants in an online survey of early users of the website felt that the site was trustworthy and reliable, said they would recommend it to others and thought they would return to the website in the future. Approximately three-quarters of respondents agreed that the site was written in clear language in a caring and compassionate tone, was easy to use, and was obviously written by health experts.

The site achieves its goal of writing to a level accessible to those with nine years of school or more, as assessed by the online Hemingway Editor application[2]. However, observation sessions with website users highlighted the importance of ongoing accessibility to users with linguistic and literacy challenges[3], especially those in disadvantaged groups.

The national survey of 236 public health nurses (Public Health Nurses) in August 2019 found that the vast majority (84%) of Public Health Nurses were aware of the site. Around two-thirds of Public Health Nurses refer parents to the site and just under this number refer to the site themselves for information.

As of November 2019, the website attracted 775,249 users who engaged in 1,214,163 sessions with more than 2.35 million page views.

2 What was the impact from the production of the new *My Pregnancy* book and the significantly revised *My Child: 0-2 years* and *My Child: 2–5 years* books?

In parent consultations, participants indicated that they want high-quality printed resources and a national website. To accomplish this, the Programme overhauled two existing child health books to include more content and updated the format and information on both emotional and physical health of children. This resulted in two publications: *My Child: 0 to 2 years*, a 228-page book, and *My Child: 2 to 5 years*, a 148-page book.

The HSE also created *My Pregnancy* book, a new 224-page resource for parents-to-be. Members of two different Implementation Teams drafted the three books and the www.mychild.ie website in a systematic engagement of more than 60 experts who contributed content.

The Public Health Nurse survey confirmed that the vast majority of respondents were aware of the books (82%) and saw the books as providing useful and appropriate information to parents and parents-to-be (86%). Nearly as many respondents agreed that these resources helped parents feel more knowledgeable about caring for babies (83%), more confident about caring for babies (76%), and better able to access services (69%).

The challenge of disseminating resources requires ongoing monitoring. A quarter of Public Health Nurse respondents strongly disagreed that parents were receiving the books in their region.

3 What was the impact of the newly developed Training Programme and Framework?

In the years prior to the Nurture Programme, child health training was not nationally co-ordinated; it was driven by local needs, interests and capacity. This lack of standardisation resulted in inconsistent messages being shared with parents and caregivers. To achieve the goal of standardising care, the Nurture Programme developed 35 standardised face-to-face, online and blended[4] training options, which range from 30-minute online courses to full-day class-based training.

2 The site achieved a AAA rating on http://www.hemingwayapp.com/
3 Since the website evaluation report, the HSE has taken steps to address these needs.
4 Blended learning involves a mixture of online and classroom based learning. In the context of the Nurture Programme this has included the addition of coaching or mentoring supports.

The response from Public Health Nurse survey participants is unambiguous: they appreciate and value the training. The vast majority felt that the training increased participant understanding of the evidence base that underpins their work (90%), supported integrated service delivery (79%), increased motivation of staff working in child health (87%) and increased morale for staff working in child health (82%). They also attributed better-informed referrals (90%) and an increased clarity on roles and responsibilities for child health professionals (88%) to the training.

In terms of the impact of the courses, Public Health Nurses largely acknowledged (76%) increased confidence in their ability to provide care to families and young children as a result of attending training. Slightly fewer people (70%) agreed they had the resources and skills needed to implement the course learning in the weeks after training.

However, qualitative and quantitative research with Public Health Nurses and Community Medical Doctors revealed another clear message: the child health workforce feels stretched to its limits. Overall, only around half of Public Health Nurses reported having the supports necessary to implement course learning (54%) or sufficient time to undertake the training (45%-59%, depending on training type).

4 What was the impact of the development of the first national standardised child health record for Public Health Nurses and Community Medical Doctors?

The Nurture Programme prioritised the creation of one national standard format for recording child health interactions within the community healthcare system. A new standardised child health record was created in collaboration with professionals in the sector with extensive consultation with practitioners.

Interviews with key stakeholders clearly showed their support for this process and their belief that standardisation will lead to more efficient and effective healthcare delivery. Standardisation of child health records is also important because it will allow for the collection of national patient level data, which can support ongoing improvements in healthcare. Creating a national standard of care for children and the standardised collection of child health data also paves the way for future development of electronic records and parent-accessible child health records, which are future priorities for the workforce, according to the evaluation.

5 What was the impact of the introduction of a standardised screening tool (the ASQ-3) and associated implementation supports?

The Ages and Stages Questionnaire - Third Edition (ASQ-3) provided a key tool in developing standardised and evidence-based care for all young children in Ireland. The ASQ-3 is an internationally recognised standardised developmental screening tool, which will be used with children in the 21- to 24-month age range. It is parent-led, which means that parents are encouraged to complete the questionnaire at home with their child and then bring it to their healthcare appointment to be used as part of the Public Health Nurse assessment. The results of these assessments can help practitioners determine when children need additional assessment for developmental delays. Once fully implemented nationally, ASQ-3 will inform the work of all Public Health Nurses who work with young children.

At the time of writing, the national rollout has been paused due to variation in local capacity to implement the ASQ-3 universally, which is being addressed in discussions with the Irish Nurses and Midwives Organisation. However, as of September 2019, 1027 practitioners had completed the one-hour online ASQ-3 eLearning Module, while 176 had completed the five-hour face-to-face Train the Trainer training as a part of the national rollout of the tool. Practitioners ranked ASQ-3 training very highly in terms of the match between the content of the training and their level of knowledge (eLearning: 77% agree, Train the Trainer[5]88% agree), and the relevance of the training's content to their work (eLearning: 85% agree, Train the Trainer: 92% agree).

Public Health Nurses also indicated that they felt more confident when providing care to families and young children as a result of the training (eLearning: 65% agree, Train the Trainer: 73% agree). They largely felt that they had the skills (eLearning: 65% agree; Train the Trainer: 65% agree) and the resources (eLearning: 57% agree; Train the trainer: 65% agree) necessary to implement course learning. However, between 30% and 40% of people reported lack of time or supports needed to implement course learning.

Public Health Nurses provided feedback that while ASQ-3 is very likely to improve child outcomes, the interventions require both additional time to become familiar with the tool and administrative support currently unavailable to many practitioners. However, those who currently use the ASQ-3 also shared that the 21- to 24-month child assessments became more efficient and professional as they became more familiar with it, including those for children with more complex challenges.

5 ADPHNs and PHN nominees were trained to share the formal training with colleagues at the LHO level. CMDs attended, as they may receive referrals as a part of the multidisciplinary child health team.

Future reviews of this important intervention also need to monitor onward referral pathways so that children who need additional assessment and supports can be referred to and access necessary services.

6 What was the impact of the development for National Standards for Antenatal Education?

High-quality, standardised care for children needs to start during pregnancy. The Nurture Programme worked towards this goal through the development of Ireland's first set of national standards for antenatal education. The standards were developed in close consultation with parents, parents-to-be and antenatal education providers from a range of backgrounds. The standards are now finalised. The Antenatal to Postnatal Implementation Team and the HSE Nurture Programme leadership are working with the HSE's Women and Infants Health Programme on a sustainable implementation plan to embed the standards into practice by a wide range of providers. In early 2020, the standards and a new capacity-building training programme will be rolled out nationally.

7 Did the Nurture Programme achieve the systems change goal of creating greater knowledge and understanding of service delivery innovation?

More than three-quarters (76%) of respondents to this evaluation's annual stakeholder survey feel that the Nurture Programme has taken an innovative approach to improving child health and wellbeing in Ireland. Key innovative elements included the application of implementation science or a component of it (Implementation Teams, parent and practitioner consultation and focus on sustainability planning from the start). The partnership between the HSE and external agencies (KHF and CES) in the Programme was also noted as an innovative factor.

The majority (65%) of participants in the stakeholder survey also agreed that the outputs of the Programme were innovative. The factors most commonly noted as innovative were the move toward online and blended training, the inclusion of infant mental health in messaging across all resources and the creation of the www.mychild.ie website, including governance processes to keep it updated.

8 Did the Programme achieve the systems change goal of improving internal and external communication within and outside of the HSE?

Any successful systems change process relies on communications. Building understanding, enthusiasm and acceptance for the Programme requires explaining the initiative, the reasoning and evidence base for change and how the Programme will affect current practice. The Nurture Programme communications strategy took a multi-pronged approach that aimed to share information about Programme developments and wider child health messaging at multiple levels and in a consistent manner nationally.

In the annual survey of stakeholders, 72% reported a medium- to high-level of improvement in child health communication within the HSE. In a national survey of Public Health Nurses, 54% observed a positive change. The Assistant Directors of Public Health Nursing Nurture Programme network and the recruitment of the nine regional Healthy Childhood Programme Development Officers were also considered to be key features that support better communications across the national workforce.

Furthermore, in this evaluation's annual stakeholder survey, more than half (54%) agreed that the Programme's approach has increased collaboration among different HSE departments, while 58% agreed that the approach has increased collaboration between the HSE and allied agencies.

9 Did the Programme achieve the systems change goal of improving data systems to inform policy, planning and service delivery?

The Nurture Programme is centred on the collection and use of evidence. The improvements to child health data systems prioritised in the Programme included the standardisation of systems and tools to generate child health outcomes and to inform the continued advancement of child health. The Programme also created a specific role within the child health system to ensure that data is collected and used to inform local planning.

In this evaluation's annual survey of stakeholders, participants were asked the extent to which they thought the Nurture Programme had improved child health data collection. 33% chose no change, 37% of respondents chose small, and 24% chose medium. When asked the extent to which the Nurture Programme had improved the use of child health data, 29% chose no change, 27% chose small, and 31% chose medium.

In semi-structured interviews, stakeholders noted that some products will improve future data collection, such as the standardised child health record and the standardised developmental screening tool (ASQ-3), which have not yet been fully implemented across the country.

10 Did the Programme achieve the goal of improving systems for updating and reviewing public health information?

In this evaluation's annual survey of stakeholders, 84% agreed that the Nurture Programme improved how public information on child health is developed, while 81% indicated a medium or large change in the review of public information on child health.

Interviews with stakeholders identified the cause of these improvements as the extensive and high-quality processes used to create new tools and resources. The following processes were named as contributors: gathering evidence, consulting parents, families and practitioners, engaging subject matter experts, undertaking extensive review and revision of drafts, involving communications and subject experts and testing final products with parents and/or practitioners before a launch.

The majority of stakeholders considered the changes to the development and governance structures of information to be a legacy of the Nurture Programme and something that could operate as a blueprint to improve systems in other areas of the HSE.

11 Did the Programme achieve its systems change goal of creating greater integration on planning of child health services across policy agenda?

Increasing the integration of planning for child health services across departments and agencies is necessary to build a more consistent, effective and efficient system of care. Raising the profile of child health and future strategic requirements for the development of the sector was also a goal of the Programme. In this evaluation's annual survey of stakeholders, 57% agreed that there had been a large or medium change to the integration of planning for child health across agencies (e.g. Tusla). The diversity of professions working together in the Implementation Teams and subgroups was frequently noted as a significant strength of the Programme.

Survey respondents reacted positively when asked how much the Nurture Programme has increased the prioritisation of child health through the quality improvement and enablement of the National Healthy Childhood Programme. For this measurement, 39% of respondents chose large- and 36% chose medium-level change. Interviews with stakeholders revealed that they primarily credited the Nurture Programme for having improved the position of child health within government policy and strategy (*The Sláintecare Report* and *First 5: The Whole-of-Government Strategy for Babies*, Young Children and Their Families). Programme partners – particularly KHF – actively engaged allies in establishing and promoting a common advocacy agenda.

12 Did the Programme achieve its systems change goal of increasing knowledge of the evidence base for child health Public Health Nurse service?

Strengthening the Public Health Nurse role in child health underpinned most of the developmental work within the Nurture Programme. The development of an extensive programme of training for Public Health Nurses and Community Medical Doctors was key to creating a more evidence-informed child health workforce.

Public Health Nurses experienced the positive impact of training. 91% of respondents to a national survey indicated that training increased their understanding of the evidence base underpinning their work.

Public Health Nurses also felt positively about the effect that training had on their confidence and skills to provide care to families and young children. 77% of respondents agreed that they felt more confident and 74% thought they had the necessary skills to implement course learning. 70% felt that they had the resources needed to implement course learning.

Stakeholders expressed a hope that commitments in both *The Sláintecare Report* and *First 5: The Whole-of-Government Strategy for Babies, Young Children and Their Families* will facilitate the assignment of designated child and family Public Health Nurses.

13 Did the Programme achieve its systems change goal of supporting the earlier identification of child and maternal health and wellbeing needs?

The introduction of the standardised child health record is the primary driver toward better identifying the health and wellbeing needs of children and their mothers. The training and reference resources to support consistent practice and the standardised developmental screening tool also played an important role in improving the identification of needs.

The standards for antenatal education will also support parents in identifying and addressing their own health and wellbeing needs.

In the national Public Health Nurse survey, 70% of respondents agreed that the Nurture Programme has supported the earlier identification of child and maternal health and wellbeing needs. The annual survey of stakeholders revealed that 57% of participants saw a medium or large improvement in the identification of child health and wellbeing needs.

In semi-structured interviews, stakeholders noted that the standardised developmental screening tool (ASQ-3) would enable earlier identification of child health and wellbeing needs in the future. In addition to the screening tool, interviewees noted that the training programme for the child health workforce and public resources seeking to empower parents (e.g. www.mychild.ie and the *My Pregnancy* and *My Child books*) will also improve parental access to timely information.

When asked about the earlier identification of maternal health and wellbeing needs, 56% of stakeholder survey respondents reported a medium or large change. Interviewees noted that a smaller portion of the Programme focused specifically on maternal health and wellbeing than child health, but that both the antenatal education standards and the infant mental health training stand to improve maternal and child health and the identification of additional needs.

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14 Did the Programme achieve its systems change goal of creating sustainable change in relation to improvement in child health?

The Nurture Programme was designed to significantly improve the development and dissemination of child health information to the public. Achieving this goal required the establishment of new processes for the development of content. New systems were developed to update and review in a timely and consistent manner. These will help the HSE to maintain the high quality and relevance of these resources.

In semi-structured interviews, stakeholders showed positive impressions of the Nurture Programme's ability to effect change to the development and review of child health information. The vast majority agreed that the Programme has improved how public information on how child health is developed (84%) and how information on child health is reviewed (81%).

The full implementation of the agreed Nurture Programme Sustainability Plan is vital to sustaining continued development of the work undertaken under the Programme.

Recommendations for the Future of the Initiatives Developed by the Nurture Programme

After five years of work and the engagement of over 100 members of the child health workforce, the Nurture Programme has created a series of products and systems changes which stand to substantially improve child health and wellbeing in Ireland. This section offers recommendations related to the sustainability and continued development of the Programme's achievements to date.

Recommendations for Programme Deliverables

1 Maintain and continue to develop the www.mychild.ie website and the *My Pregnancy* and *My Child* books for parents:

a Ensure a system is in place to monitor whether parents receive the *My Child* and *My Pregnancy* books. This monitoring should include those who opt for homebirth and other situations where there may be barriers to accessing these resources.

b Ensure that a governance structure is in place to oversee the updating of the books and website in accordance with evolving evidence and parental feedback. This should include, at a minimum, a dedicated Communications Manager, a Child Health Data and Research Analyst and administrative supports.

c Further develop the website to make information more accessible to groups with linguistic and/or literacy issues or related disability challenges. This should be done in cooperation with organisations that have expertise in the needs of these target groups and in consultation with members of the target groups themselves. Any substantial changes should be tested in user observation and feedback sessions using the methodology employed in the evaluation of www.mychild.ie to assess website accessibility.

d Explore and cost the potential for adding local service contact information to www.mychild.ie or explore other alternatives such as including this information on the Children and Young People's Services Committee websites and creating a link.

e Ensure that effective links are in place between www.mychild.ie and the Tusla website https://www.tusla.ie/parenting-24-seven/.

f Address the recommendations outlined in the 2019 independent www.mychild.ie evaluation report (see Appendix F in the full report for a list of recommendations).

2 Continue to implement and develop the training framework:

a Enhance post-training supports by creating greater access to specialist expertise. This will ensure that staff feel competent and supported to implement learning from training as soon as possible following completion of training.

b Ensure that training and post-training implementation supports, such as coaching and/or mentoring, and access to relevant tools and approaches continue to be developed for effective implementation of training into practice.

c Ensure that information systems are in place to measure and capture regional rates of completion for training among different disciplines. Create a mechanism for effective follow-up action at the regional and national levels if staff participation targets are not being met.

d Implement strategies to enhance participation of HSE specialist child health staff in training. This would include those working in speech and language therapy, child occupational therapy, staff working with children and families in other relevant statutory agencies, community and voluntary sector services and other non-HSE child health staff (e.g. Pharmacists). Relevant training should include (although not be limited to) child development, child safety, infant mental health and breastfeeding modules. Wider participation in this training will maximise the common knowledge base of all staff who work with children and families, thereby extending the impact and value of the training developed under the Nurture Programme.

e Undertake an evaluation of the implementation and impact of the training resources developed through the Nurture Programme after the training programme has been fully running for 12 months. This evaluation should measure the extent to which new learning, skills and interventions are being utilised in practice and the extent to which they are improving outcomes for children. The evaluation should also identify any additional training content and methodologies needed.

f Continue to engage with third-level education providers to ensure that all relevant professional training courses for those who will work with children and families are aligned with recent practice developments, including those of the Nurture Programme.

g Address the recommendations in the 2019 independent training evaluation report (see Appendix G of the full report for a list of recommendations).

3 Implement the National Standardised Child Health Record:

a Ensure that the standardised child health record can be integrated with GP and maternity care patient records.

b Prioritise the development of an electronic version of the standardised child health record.

c Develop ways for parents to access and engage with their child's health records (e.g. online patient portals or applications).

4 Roll out the standardised screening tool, ASQ-3, nationally with engagement across HSE divisions to:

a Clarify assessment and referral pathways for treatment when indicated.

b Develop and implement standardised resource allocation models to identify the required staffing levels necessary to provide a good quality child health and wellbeing service across key disciplines and areas.

c Develop a feedback loop system to identify and quantify gaps in service accessibility when children with assessment and/or treatment needs are not able to access the appropriate service.

d Continuously review evidence from other relevant prevention and early intervention programmes to explore whether these are effective and can play a role in cost-effectively addressing child health and wellbeing needs. For example, it may be appropriate to advance parent-led interventions or group-based interventions. These could be advanced in partnership with community and voluntary sector services and potentially attract philanthropic support.

Recommendations: Related to Systems Change and Sustainability

1 **Adequately resource the HSE National Healthy Childhood Programme (NHCP) so it can fulfil its role.** The agreed Nurture Programme Sustainability Plan (August 2019) outlines the detailed resource requirements for the NHCP, which will manage, sustain and further develop the Programme. Some of the specific tasks include:

a Co-ordinating the management, delivery, monitoring and continuing development of the suite of child health and wellbeing training in co-ordination with other programmes (e.g. Integrated Care Programme for Children, National Women and Infants' Health Programme, Healthy Eating Active Living Programme).

b Developing and managing the next stage of a communications strategy for the broader child health and wellbeing sector. This includes ongoing communications with the public and parents or expecting parents and implementing systems to indicate whether communications have achieved their objectives.

c Managing and monitoring the national rollout of ASQ-3 standardised screening tool.

d Clarifying the governance, implementation, support and monitoring of the national antenatal education standards.

e Continuing to gather, analyse and disseminate relevant data to inform the delivery and further development of services, including reviewing and introducing additional KPIs to measure the long-term outcomes of this body of work.

f Engaging with other agencies working on child health and wellbeing to ensure work plan cohesion. This includes but is not limited to hospitals, Tusla, the Department of Children and Youth Affairs and the Department of Health.

g In collaboration with child health and wellbeing partners, continuing to engage with policy and decision-making fora, including Healthy Ireland, Sláintecare and First 5: The Whole-of-Government Strategy for Babies, Young Children and Their Families, on the implementation of child health and a prevention-based approach as core priorities for policy, service planning and resource allocation.

The National Healthy Childhood Programme Team will require clear governance, communications and planning structures with relevant HSE Divisions, including those that were involved in delivering the Nurture Programme, namely Strategic Planning and Transformation and Community Operations.

2 **Build on the work of Nurture Programme within the HSE by ensuring that a culture of staff and parental consultation informs all key decision making processes in relation to child health and wellbeing.** This culture of parental and staff engagement should include ongoing consultation and a periodic formal service review. A formal process should be developed to collate and review all feedback received from consultations.

Further, information on how their feedback was used and any actions taken to address suggestions should be shared with participants in a timely and clear manner. Additional and more specific recommendations on this topic can be found in the companion to this final report, Delivering Systems Change- Lessons from the Nurture Programme: Infant Health and Wellbeing.

3 **HSE to commence implementation of a dedicated child health workforce along with the agreement of a national Public Health Nurse resource allocation model (RAM), which defines the required Public Health Nurse levels by population.** This should consider factors such as deprivation rates and the implications of working with dispersed rural populations. The RAM should then be used to inform the HSE and the Departments of Health and Public Expenditure and Reform on the human resource and financial planning required for the provision of quality child health and wellbeing services to an agreed standard countrywide.

These developments should include consultation processes with Public Health Nurses, Assistant Director Public Health Nurses, Director of Public Health Nurses and their representative organisations. Staffing levels should reflect the agreed role of the Public Health Nurses based on international best practice on staffing levels, including management support, staff development and administrative support.

4 **The HSE to work across divisions to undertake research to clarify the minimum required levels of specialist service provision, the optimal national and regional spread, and the breadth and variation of existing referral pathways for children and parents who require specialist supports.** This research should consider the varied needs of diverse cultural populations within the country and should link with HSE Progressing Disabilities and the Integrated Care Programme for Children to adequately assess existing pathways.

Specialist services include but are not limited to those with expertise in sleep disturbances and challenges, speech and language, parental and infant mental health, parenting and community supports, lactation and breastfeeding, enuresis, and paediatric occupational therapy. Once service level requirements and pathways are clarified, the case should be made to allocate the resources necessary to implement the service requirements and develop clear pathways for parents so that specialist services are available on a nationally equitable basis.

5 **Develop an electronic patient management system that builds on the data standardisation work of the Nurture Programme.** This development must be guided by objectives related to supporting the work of child health professionals, reducing their administrative burden on practitioners and empowering parents through increased access to health information.

The system should be designed to support service review and planning and include plans for integration, in line with GDPR safeguards, with other health information systems (e.g. maternity services, GPs, Tusla). The system must be developed to include a facility for parental access to their children's health records.

Part One: Introduction

01 Introduction

> Today's children are the future of Ireland.
>
> STAKEHOLDER INTERVIEW

The earliest years of a child's life – from birth to age three – are a time of tremendous growth, development and learning. In these years, the foundation for all later development is built. What happens (or doesn't happen) before a child is three years old has a lasting impact on children's health, wellbeing and productivity throughout their lives (Centre on the Developing Child 2010). Approximately 61,000 babies are born in Ireland each year. With the youngest population in the European Union (HSE, 2016), the systems we create today to ensure that Irish children get a healthy start in life will help to build a healthy and prosperous future for our country.

With all of this in mind, leaders from The Atlantic Philanthropies (Atlantic), the Health Service Executive (HSE), the Katharine Howard Foundation (KHF) and the Centre for Effective Services (CES) set up the Nurture Programme: Infant Health and Wellbeing in 2015. The Nurture Programme is a far-reaching, multi-year quality improvement programme that aims to improve and standardise the care and supports provided to all young children and their parents by the HSE. The Programme engaged more than 100 members of the child health workforce in the leadership tasks required to accomplish its ambitious objectives. This leadership was drawn from all regions of the country and multiple disciplines in order to develop and implement a wide range of evidence-based tools, training, resources and new standards to help practitioners and parents.

Creating meaningful and lasting systems change is complicated, difficult and time-consuming. This is especially true when working to effect change in complex systems like the national health service. To maintain a focus on the importance of evidence, implementation and sustainability, the Programme was guided by the principles of implementation science and a range of structures to oversee and carry out implementation.

Reflecting the scope of the Nurture Programme, the outcomes of this work have been broad, touching many aspects of child health and wellbeing. This final evaluation report shares the outcomes from the last five years of interagency and interdisciplinary work. As an ongoing change programme, the results outlined in this evaluation are not an end point, but a description of a foundation for changes that should continue to be seen for years to come.

This report is divided into five main parts

- **Part one** provides the background necessary to understand the Nurture Programme and this report, including the Programme's structures and history.
- **Part two** outlines the methodology that guided the development of this report.
- **Part three** shares information about the main deliverables of the Programme: the new www.mychild.ie website, the new pregnancy and child health books, the suite of training created for the child health workforce, the standardised child health record, the introduction of a standardised developmental screening tool and the new standards for antenatal education standards.
- **Part four** assesses whether the Programme achieved its ambitious systems change objectives, including increasing knowledge and understanding of service delivery innovation, improvements to internal and external communications, improved data systems, improved systems for updating and reviewing public health information, improved planning for child health services, greater knowledge of the evidence base for practitioners and the earlier identification of child and maternal health and wellbeing needs.
- **Part five** provides a conclusion and outlines recommendations for the sustainability of the Nurture Programme's impressive accomplishments and for future initiatives.

02 Overview of the Nurture Programme

The Nurture Programme: Infant Health and Wellbeing is a national quality improvement programme that focused on the services delivered by the HSE to all children and families from pregnancy and in the first three years of life. The programme aimed to ensure that all young children in Ireland get the healthiest start possible by providing evidence-based advice and supports to their parents. Guided by the principles of Progressive Universalism[6] (HSE and Royal College of Surgeons of Ireland, 2009; Royal College of Physicians of Ireland, 2017), the Programme worked to create evidence-based, parent-informed resources for parents-to-be and new parents and to deliver consistent messaging about child health and wellbeing in early childhood.

The Programme was made possible by funding from The Atlantic Philanthropies (Atlantic) which is matched and leveraged by the HSE at a ratio of 1:5 during the Programme's implementation and for the ten years following its conclusion. The Nurture Programme was relatively unique in the context of change projects in the Irish health service, due to it being led through a partnership approach. The partners involved in the Programme are the Katharine Howard Foundation (KHF), which provided grant management and support, the Centre for Effective Services (CES), which provided implementation support, and the Health Service Executive (HSE), which led programme management and implementation.

Another unique aspect of the Programme was the application of an implementation science methodology, which guided all planning and delivery. Implementation science offers a series of methodologies that have been developed to support the translation of evidence-based interventions and programmes into health care practice and other human service settings. Some of the distinctive features of the Nurture Programme reflect this approach, including the consistent use of evidence to inform Programme actions, the focus on implementation and sustainability and the integration of communications strategies into all aspects of the work. This focus was important, considering the need to embed the Programme into the HSE, which itself was undergoing significant change in relation to organisational structures. Over the five years, two key national strategies were produced [7] that should impact child health services.

6 Progressive Universalism: All children will have access to defined core (universal) services as underpinned in legislation. There will be supports provided for those identified as requiring extra support or additional services. Source: https://www.hse.ie/eng/services/publications/clinical-strategy-and-programmes/universal-child-health-programme.pdf

7 Eg. *The Sláintecare Report, First 5: The Whole-of-Government Strategy for Babies, Young Children and Their Families, National Maternity Strategy*

03 The Nurture Programme Model

Initial exploratory conversations for what would eventually become the Nurture Programme started in 2014, when Atlantic, the HSE, CES and KHF met to discuss the need for strategic supports to develop systems and practice for health service provision within the 0-3 age group. CES facilitated the process of developing a logic model, which outlined the key actions that the partners considered requirements for achieving a wide-scale improvement in child health and wellbeing health services. This logic model, which was based on evidence from international literature and work undertaken previously by the HSE[8], formed the basis of a proposal to Atlantic by KHF for an ambitious change programme. In December of that year, the proposal was approved by Atlantic, in part because it aligned with Atlantic's strategic commitment to ensuring that the fund's final grants delivered long-term impact and sustainable systemic change to make a difference in the lives of children and families.

As Atlantic was in the process of winding down operations in Ireland and spending down its final resources, KHF was well-placed to provide grant management, support and oversight of the Programme's funding, evaluation and overall progress on Atlantic's behalf. Grant requirements, which were based on Atlantic's significant experience of funding large scale programmes, stipulated that implementation support needed to be provided by an organisation outside of the HSE. The CES brought experience and expertise in implementation science methodology to this role.

Much of 2015 was spent establishing implementation and governance structures. These included the Steering and Oversight Groups.

The Oversight Group was formed to provide high-level support for Programme planning and implementation. The seven- to eight-member group was formed in 2015 and aimed to meet quarterly.

The role of the Oversight Group

- Review and approve the Programme Implementation Plan
- Review and approve the Programme Evaluation Plan
- Review and make comments on progress reports
- Provide strategic guidance to the Steering Group
- Advise and make recommendations on learning from the implementation process
- Address any issues or concerns regarding the implementation of the Programme that may arise.

Regular updates were provided to the Oversight Group by the Steering Group through KHF.

8 In 2014-2016 the HSE undertook reviews of Best Health for Children (BHFC), the existing child health programme. The evidence base for the programme was reviewed and a supporting national governance structure was established: the Child Public Health Group and the Steering Group for the Revised Child Health Programme. A number of subgroups established to identify changes needed to the programme, including developmental surveillance, newborn clinical examination, health promotion and improvement and the introduction of infant mental health. Early planning identified the existing work of the HSE's National Healthy Childhood Programme as a natural fit for many of these activities, which would later be integrated into the Nurture Programme.

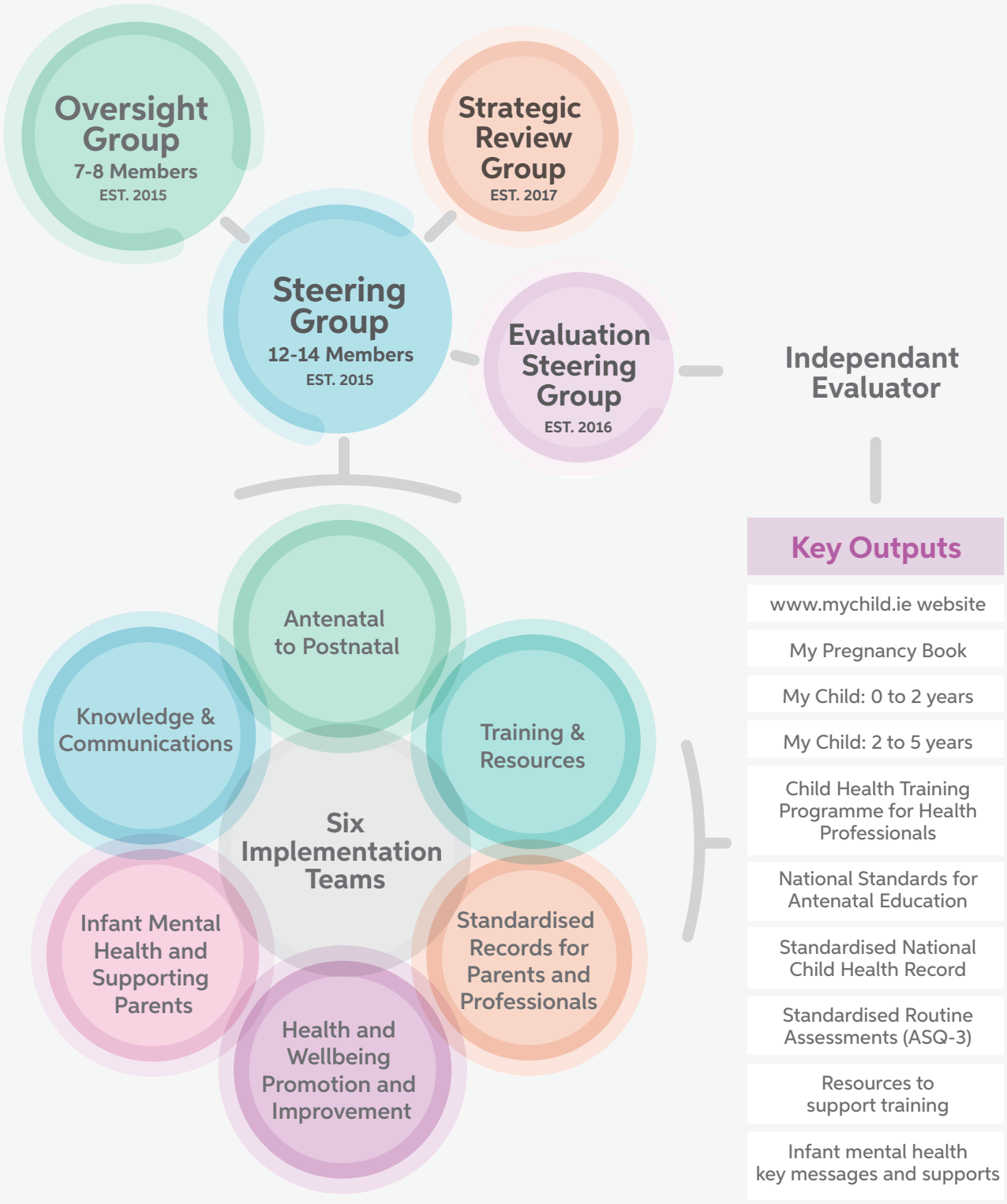
The Steering Group was formed to assist in developing and implementing the Nurture Programme with a focus on improving outcomes for children and families as outlined in the Programme logic model. The 10- to 13-member group was formed in 2015 and aimed to meet quarterly.

The role of the Steering Group

- Review and agree on the criteria and timeframe for scoping/audit of current services, projects and programmes for children from birth until their third birthday
- Review and agree on the Programme
- Prioritise work strands and activities based on the Programme
- Review and agree the Programme Implementation Plan
- Ensure that the overall Programme stays focused and operates within the agreed timeframe
- Ensure ongoing monitoring and review processes are implemented
- Share information gathered through the Programme
- Identify and engage with other relevant stakeholders
- Ensure reports required by the funder are prepared and submitted
- Advise and make recommendations on the learning and on influencing policy
- Identify key opportunities to share the learning with others
- Advise on the evaluation process
- Address any issues or concerns in relation to the implementation of the Programme that may arise
- Keep the Oversight Group updated on the Programme
- Highlight any issues that should be raised with the Oversight Group.

Please see Appendix C for the full membership of the two groups. See the diagram on the next page, which outlines the governance structures and their relationship to the six Implementation Teams responsible for guiding the development of the workplan (explained in detail further in this section) and the various subgroups in the Programme.

FIGURE 1: DIAGRAM OF NURTURE PROGRAMME STRUCTURES



Relationships between the partner organisations were clarified through a commitment letter from Atlantic to KHF and two partnership agreements: one between KHF and the HSE and the other between KHF and CES. During this period, the HSE also committed to matched or leveraged funding of five euro for every euro invested by Atlantic.

The guiding principles of the Programme were defined as follows:

- Engage with parents throughout the project. They are the lead partners and experts in the raising of their children
- Ensure our work is evidence-based, drawing on current and emerging Irish and international research
- Work collaboratively with statutory agencies and the community and voluntary sector
- Apply the concepts of implementation science to the Programme.

Sustainability of the work developed under the Programme was a consideration from the outset. The Programme's ability to build on existing HSE structures and programmes was critical to sustainability. The Nurture Programme worked in close partnership with the National Healthy Childhood Programme (National Healthy Childhood Programme), which covers the time period from pregnancy to a child's 18th birthday. The Nurture Programme helped to increase the effectiveness and reach of the National Healthy Childhood Programme with respect to pregnancy and the first three years of life while increasing the likelihood that changes introduced by the Nurture Programme's workplan would be sustainable.

Within the HSE, staff from the Primary Care and the Health and Wellbeing Divisions were involved in the early stages of the Programme's development, sometimes as members of the Programme governance structures. As the work developed, engagement of the HSE Divisions also grew to include the Communications Division and Maternity Services (through the Women and Infants Health Programme). In addition, the Programme committed to engage with partner agencies to inform planning, embed messaging and support interagency work. External partners included Tusla, the Department of Children and Youth Affairs and community and voluntary agencies.

In May 2016, the Programme formally launched its Implementation Plan, informed by a scoping report that identified, among other things, the need to build supports at the pre-conception and pregnancy stages to increase rates of breastfeeding. It also identified the need for continuity of care from birth and hospital care to home and community services with integration of care among the Health and Wellbeing, Primary Care and Acute Hospitals Divisions of the HSE.

To support the continuation of innovation and development within early parent and child supports, an endowment fund was established with financial contributions by Atlantic and the Community Foundation for Ireland (CFI). Named the Infant Development Fund, this legacy initiative will result in a modest continuing income stream to support strategic developments in the long term. The CFI matched Atlantic's contribution and committed to growing the fund to €5m by 2020. KHF will work in partnership with the CFI to guide the strategic application of this fund into the future. To date, the fund has made one grant for a strategic review of the Community Mothers Programme. Planning for this fund and its future use will take place in 2020. However, a clearly-stated goal is that the fund will support initiatives that extend the learning of the Nurture Programme and the KHF's Parenting Support Initiative (2013-2016).

To support the development of the Nurture Programme, an independent evaluation was commissioned by KHF through an open tender process. Awarded to Quality Matters in conjunction with DCU, this was primarily a process evaluation that aimed to inform the development of the Nurture Programme, review the overall outcomes from the Nurture Programme and extract the key lessons from the work for wider application. The evaluation included mixed methods process evaluations in 2017 and 2018 that focused on the experience of the six Implementation Teams and two separate evaluations in 2018 of the initial rollout of the training programme with the new www.mychild.ie website. This final evaluation report (2019), which includes the views of more than 400 key stakeholders, focuses on outcomes from the Programme and provides recommendations for mainstreaming the work from 2020 onwards.

In addition to this final evaluation report and the summary report, a companion report [9] outlines the key lessons for systems change from the Programme's implementation. The overall evaluation process was overseen by the Evaluation Advisory Subcommittee of the Steering Group, which included representatives from the HSE, the CES, KHF and an independent member. The membership is outlined in Appendix E.

9 *Delivering Systems Change - Lessons from the Nurture Programme: Infant Health and Wellbeing*

Programme Leadership

In 2015, KHF, the CES and the HSE[10] appointed designated leads for their respective agency's engagement with the Nurture Programme. Within the HSE, the core Nurture Programme team formed in late 2015. This team included a Nurture Programme Lead with administrative support, working in partnership with the National Healthy Childhood Programme team. Within the CES, an implementation support team was formed, which included an HSE seconded as an Implementation Specialist and a Data and Information Specialist.

In 2016, the HSE Programme Lead was to establish the core internal structures of the Nurture Programme, which included the formation of the six Implementation Teams (outlined below).

Over 2017 and 2018, additional roles were added to the HSE team, including a Communications Manager, a Project Manager and additional administrative supports. The CES Data and Information Specialist also transitioned into the HSE team as a Research and Data Analyst.

In 2018, the Nurture Programme recruited nine Child Health Programme Development Officers. These Officers work in each of the country's nine regional Community Healthcare Organisations (CHOs). The Child Health Programme Development Officer roles have been created on a permanent basis and will continue beyond the life of the Nurture Programme. Their role involves supporting the implementation of the National Healthy Childhood Programme at CHO level. Their work is undertaken in close partnership with regional managers and practitioners to develop and deliver services to recognised national standards. Importantly, the Child Health Programme Development Officers are supported by the National Healthy Childhood Programme team. Regular engagement with the national team ensures that national priorities are reflected in local and regional service delivery. The role has also been central to the establishing the child health governance groups and supporting child health leads in each CHO.

Implementation Teams

After the public launch in May 2016, six Implementation Teams were established to drive the multi-faceted work programme. The chairpersons and team members selection process took place over four months and involved HSE team engagement with multiple stakeholders to secure team chairpersons and members across a range of subject and discipline expertise, system knowledge and geographic locations. Five of the six teams were established by October 2016; the final team (Standardised Records for Parents and Professionals) was established in early 2017.

Teams included between seven and twelve core members along with Programme staff, specifically the members of the Nurture Programme administrative team, the HSE Nurture Programme Lead and the CES implementation support team. Teams met four to six times a year on average, with meetings lasting between a half day to a full day. Team members also engaged in several day-long planning sessions and implementation science workshops facilitated by a CES Associate who was the international advisor to the Programme. These workshops aimed to give team members a grounding in implementation science methodologies that would inform the planning of each team's work. The teams' membership numbers as of 2019 and their key work goals are outlined in the chart on the following page.

10 KHF: Programme Manager, HSE: National Programme Lead, CES: Programme Lead

FIGURE 3: MEMBERSHIP AND GOALS OF IMPLEMENTATION TEAMS

Team	Number of Members in 2019	Key Goals
Antenatal to Postnatal	9 members	• Create a new pregnancy book for parents • Develop national standards for antenatal education • Develop antenatal website content • Support embedding of antenatal standards in practice through training and supporting resources
Health and Wellbeing Promotion and Improvement	12 members	• Develop standardised key messages and content for parents and health professionals • Develop website content • Lead the updating of content for *My Child* books • Support the implementation of the HSE Breastfeeding Action Plan 2016-2021 and ensure alignment and collaboration with other programmes
Infant Mental Health and Supporting Parents	7 members	• Create staff and public awareness for infant mental health (IMH) • Embed IMH concepts and understanding into service delivery through IMH training, tools and resources, including website content
Knowledge and Communications	9 members	• Design and develop www.mychild.ie website • Provide oversight to parent and staff consultations on the scope and content of the website • Develop editorial and governance guidelines and recommendations for child health public information
Standardised Records for Parents and Professionals	7 members	• Develop and roll out national standardised child health record and practice reference resources • Support the standardisation of routine developmental assessment tools and resources • Support progress toward parent-accessible records
Training and Resources	11 members	• Develop a comprehensive blended learning training programme and supporting framework • Develop the training support infrastructure, training content and teaching methodology • Deliver a range of online and skills trainings to child health practitioners

Team members variously contributed to the work through specific work tasks including content development for training or public resources, research, communications, facilitation and participation in consultation events. This work was negotiated with individuals through the Team Chairs and the HSE Programme Lead, frequently undertaken on top of existing workloads. This work was also supported by the establishment of time-limited subgroups, drawing on a wider membership as required. In addition to team member roles, each team was supported by the HSE Programme Lead, dedicated administrative support, and received implementation support from CES. Additional expertise in the areas of dietetics and eLearning development were also contracted to support the relevant Implementation Teams.

Parent and Practitioner Consultation

From the beginning, the guiding principles of the Nurture Programme outlined its commitment to engaging parents and building opportunities for parental involvement and consultation. In practice, this took the form of systematically engaging parents, parents-to-be and other end users (such as healthcare practitioners) in directing and informing the work of the Programme throughout all stages of product development. The list below outlines some of the ways in which these groups were involved over the course of the Programme.

2015

- Focus group with parents of young children as part of the CES Scoping Report.
- HSE-commissioned consultation with representative focus groups of parents to inform the development of the Programme.

2016

- Focus groups of first-time mothers and fathers from different socio-economic backgrounds in Dublin, Mullingar and Mitchelstown.
- Online survey of 283 healthcare professionals to determine the main topics of interest to parents and parents-to-be.
- Consultation with Area Based Childhood (ABC) programmes, Children and Young People's Service Committees (CYPSCs), parenting support initiative projects and teenage support programmes, which identified the following:
  - Resources for parents and practitioners and training being delivered across Ireland and the relevance of these to implementation teams
  - How improvements could be made to the quality of service to infants and their families.

2017

- Focus groups of first-time pregnant women, new mothers, second-time mothers and fathers with babies under 12 months old. These groups were conducted in Dublin and in Cork.
- An analysis of www.breastfeeding.ie with parents and a survey of its users.
- Consultation with 116 healthcare professionals and 37 managers in community, maternity and private antenatal education services to understand how antenatal education is delivered in Ireland and inform the development of antenatal education standards.

2018

- A national consultation day regarding the antenatal education standards draft was held with approximately 100 attendees from around the country.
- Focus groups with parents whose voices are seldom represented in general research. Participants included parents transitioning from homelessness, parents seeking asylum in Ireland, teenage parents, parents from the Traveller community, and parents linked to an Area-based Childhood Programme site, which supports parents in areas of social disadvantage.
- Nationwide survey of more than 4,000 parents, of whom approximately 20% were expecting a baby.
- Survey with Directors of Public Health Nursing from 21 areas to ascertain details on professional developmental supports and structures available for Public Health Nurses and their views on priorities for supporting the professional development needs of Public Health Nurses in relation to child health.
- Ongoing consultation with the Assistant Directors of Public Health Nursing Child Health Network.

2019

- Consultation workshops with Public Health Nurses in Athlone, Cork and Dublin to inform the development of the child health record.
- Usability testing of the draft child health record with Public Health Nurses and families.
- Ongoing consultation with the Director Public Health Nurse and Assistant Director Public Health Nurse Networks.

Implementation Science

Implementation science methodology seeks to connect research to practice by identifying necessary system changes (such as in the health service) and defining the necessary steps to make those changes so that those implementing them can be successful (Duda and Wilson 2018). Put another way, implementation science is 'the scientific study of methods to promote the systematic uptake of research findings and other evidence-based practices into routine practice' (Eccles and Mittman 2006, p.1).

The application of implementation science to the Nurture Programme was led by the CES. Several day-long workshops with inputs from a CES Associate (an international leader in the field) familiarised the Implementation Team members with the approach. The CES also provided a two-day training programme in implementation science for Implementation Team members. The CES's other contributions include rapid evidence reviews, supporting implementation and sustainability planning, facilitating topic-specific meetings and workshops, designing and conducting consultations, facilitating usability testing, applying implementation tools and resources, and supporting use of evidence to inform decision-making.

The use of implementation science methodology can be seen in the specific tools and terminology used in planning, in the Programme's prioritisation of a broad implementation plan during its earliest stages, in its consistent focus on gaining input from families and practitioners, and in its work of planning for full rollout and sustainability. Other principles of implementation science are reflected in the Programme's generation of an evidence base for all initiatives and in the structure of the Programme itself through the Implementation Teams.

Key Milestones of the Nurture Programme

2014

July – Workshop facilitated by CES with 14 key stakeholders to develop the logic model for the Nurture Programme

September – Proposal for funding the 0-2 Infant Health and Wellbeing Programme submitted to Atlantic by KHF

December – Proposal approved by the Atlantic board with total funding of €10m

2015

Recruitment/assignment of programme leads by CES, KHF and HSE. Recruitment of Data and Information Specialist and Implementation Specialist by CES and Administrative Support by HSE

February – First meeting of the Programme Steering Group (subsequent meetings about every two months)

May – First meeting of the Nurture Programme Oversight Group (subsequently two to three meetings per year)

August – First CES implementation science workshop with a CES Associate and international advisor to the Nurture Programme (subsequently one to two workshops held per year)

First draft of scoping exercise submitted by the CES, which explored current service provision for 0-2-year-olds and their families and the structures, training and policies underpinning and supporting these services

October – First facilitated session for Nurture Steering Group with an independent facilitator (subsequent facilitated sessions of Steering Group occurred about every six months)

2016

February – Completion of Nurture Programme Implementation Plan by a small planning group made up of the HSE, KHF and the CES, leading to the creation of six interconnected Implementation Teams

May – Official launch of the Nurture Programme: Infant Health and Wellbeing

May – October – First meetings of the Training and Resources, Health and Wellbeing Promotion and Improvement, Infant Mental Health, Antenatal to Postnatal, and Knowledge and Communications Implementation Teams

July – Quality Matters, in partnership with Dublin City University, contracted to conduct the independent evaluation of the Nurture Programme

2017

January – Consultation event with antenatal education providers

April – First meeting of the Standardised Records Implementation Team

September – First meeting between the HSE Nurture Programme and Tusla Development and Mainstreaming Programme (subsequently continued to meet one to two times per year)

December – Phase One Evaluation report completed, informing future development of the Programme

2018

January – Completion of extensive round of consultations with parents and expectant parents to inform the work of the Nurture Programme

April – Rollout of the Ages and Stages Questinoaire-3 (ASQ-3) Train the Trainer training to Community Medical Doctors and Public Health Nurses

May – Research completed on the national standardised child health record

Rollout of the management of sleep behaviours training to Public Health Nurses

Needs Analysis Training for Community Medical Doctors completed

June – December – eLearning training modules on child safety, ASQ-3, breastfeeding and Newborn Bloodspot Screening commenced

October – Appointment of first of the nine Child Health Programme Development Officers to support Nurture Programme implementation – one in each of the nine CHOs

Distribution of 1700 Developmental Assessment Equipment Packs for all Public Health Nurse areas

December – Launch of the MyChild.ie website and new suite of books for parents: *My Pregnancy*, *My Child: 0 to 2 Years* and *My Child: 2 to 5 years*

Phase Two evaluation report completed, informing future development of the Programme

2019

June – Revised and updated Growth Monitoring module and five Nutrition eLearning units

July – Media campaign to promote www.mychild.ie website and resources

September – Sustainability Plan for the Nurture Programme approved by the Nurture Programme Oversight Group

November – Healthy Weight for Children e-Learning training modules launched

December – Final Nurture Programme evaluation report launched

Summary

The Nurture Programme was formally launched in May 2016. However, as this chapter outlines, the foundations of the Programme drew on the work and interagency collaboration that started as early as 2014 on the history of child health services in the HSE. The ambitious goals of the Nurture Programme were informed by many years of work by each of the key partners. Atlantic brought more than funding to the Programme: it helped to establish a partnership structure with the HSE, KHF and the CES, advocating for the use of implementation science, both of which ensured that the Programme was grounded in international best practices for making and sustaining change in the public sector.

Part Two: Methodology

04 Introduction

This chapter outlines the evaluation process undertaken from 2016 to 2019. It includes an overview of the questions which the evaluation sought to answer over the three years, the methodologies used to gather data, as well as the key methodological limitations and the steps taken to mitigate these.

05 The Three Reports that Inform the Final Evaluation

Over the course of the evaluation, four internal evaluation reports have been produced to inform the development of the Nurture Programme process. Two of these reports, produced in 2017 and 2018, focused on the overall Programme implementation process. The other two reports were evaluations of specific key Programme deliverables: the training programme, and the new website, www.mychild.ie. Both these reports were produced in early 2019. The final evaluation involves the publication of three reports: a full evaluation report (this report), a summary report of the full evaluation and a report on the Nurture Programme's key lessons[11].

11 To be published February 2020

06 Evaluation Research Objectives

The evaluation aimed to use the current available data to assess the impact of the Programme's work on child health and wellbeing services in Ireland. The research questions that framed this process were identified in the 2016 evaluation tender documentation and are described in the table below, along with the key methodologies used for data collection. In this chart, 'yes' means that the methodology was used to answer the research question; 'no' means that it was not.

FIGURE 4: RESEARCH QUESTIONS AND DATA COLLECTION METHODS

Research Questions	Key data collection methods					
	Individual and group interviews with 61 key stakeholders (averaging 45 minutes per person) and completion of a survey	Group interviews with specific disciplines (Assistant Director Public Health Nurses and Child Health Programme Development Officers) involving 22 people	Research with 210 website users (198 in survey, 15 of which were also interviewed, and 12 in observation and feedback sessions)	Semi-structured telephone interviews with 34 people who attended training programmes	Public Health Nurse Survey involving 232 people	Annual survey of Implementation Team members: **2017:** 63 respondents **2018:** 29 respondents **2019**: 23 respondents
How was programme planned and implemented overall?	Yes	Yes	No	No	Yes	Yes
Was implementation support provided effective?	Yes	Yes (in relation to specific deliverables)	No	Yes (in relation to training)	Yes (primarily in relation deliverables)	Yes
To what extent/level was universal service provision impacted upon?	Yes	Yes	Yes (in relation to access to information)	Yes (in relation to application of training content)	Yes	Yes
To what extent has the Programme led to practice change and improvements in the quality of service delivery?	Yes	Yes	Yes (in relation to access to information)	Yes (in relation to application of training content)	Yes	Yes
To what extent has the Programme impacted on systems change?	Yes	Yes	No	Yes (in relation to application of training content)	Yes	Yes
What components contributed to, or hindered successful implementation and practice/systems change?	Yes	Yes	No	Yes (in relation to application of training content)	Yes	Yes

The evaluation assessed the Programme through two lenses. The first was an assessment of the effects of the key Programme deliverables. This list of deliverables was developed based on the 2017 and 2018 evaluative data from stakeholders on how they understood the Programme. This resulted in a list of six key deliverables, compared to the nine deliverables initially set out in planning documents. Three aspects of the Programme identified in the initial planning documents (Child Safety Awareness Programme, infant mental health, and the implementation of the HSE Revised Breastfeeding Action Plan) were included as a subsection of larger deliverables, reflecting stakeholders' evolving understanding of the Programme.

The key programme deliverables, assessed in this evaluation

- The new www.mychild.ie website
- The new *My Pregnancy book* and the revised *My Child: 0-2 years* and *My Child: 2-5 years* books
- A new 35 module/course training programme and training framework (including specific training work programmes on breastfeeding and child safety and messaging in relation to infant mental health)
- The first national standardised child health record for Public Health Nurses and Community Medical Doctors
- The introduction of a national standardised developmental screening tool (ASQ-3)
- The development of national standards for antenatal education.

The second lens of the evaluation focused on the impact of the Programme's activities on broader systems change in the HSE. To structure this part of the evaluation, the short-term objectives for system change from the initial Programme logic model were used as key areas to assess, with one additional assessment of the overall theme of sustainability. This matrix was presented to and agreed upon by the Evaluation Advisory Subcommittee in the early phases of research.

The systems changes evaluated

- Greater knowledge and understanding of current service delivery innovation
- Improved internal and external communication within and outside of the HSE
- Improved data systems to inform policy, planning and service delivery
- Improved systems for updating and reviewing public health information
- Greater integration on planning of child health services across policy agenda
- Greater knowledge on evidence base for dedicated child health Public Health Nurse service
- Earlier identification of child and maternal health and wellbeing needs
- Sustainability of improvements in child health.

07 Qualitative Research

Qualitative research methods allow researchers to gather information that lends itself to a greater depth of content and analysis. Information was gathered primarily through semi-structured individual and group interviews. This approach is particularly useful in research that seeks to uncover interdependencies across data, since it allows the researcher to modify questions and capture additional information over the course of the investigation (Berkwits and Inui 1998; Miles, Huberman and Saldana 2013). Below is a brief description of the methods used and participants involved in the evaluation's qualitative research components.

FIGURE 5: QUALITATIVE RESEARCH CONDUCTED FOR EVALUATION OF THE NURTURE PROGRAMME 2017-2019

Method	Year	Number of participants	Target Audience	Notes
Semi-structured Interviews	2017	41	Implementation Team members, Programme governance, stakeholders and staff	26 individual interviews, 15 participants in small group interviews
	2018	29	Implementation Team members, Programme governance, stakeholders and staff	20 individual interviews, 9 participants in small group interviews
	2018	34	Public Health Nurses and Community Medical Doctors who attended training in 2018	To inform training evaluation
	2018	15	Early users of the www.mychild.ie website	To inform website evaluation
	2019	61	Implementation Team members, Programme governance, stakeholders and staff	54 individual and small group interviews, referred to as stakeholder interviews in this report
Group Interviews	2019	6	Child Health Programme Development Officers	To inform final evaluation
	2019	16	Assistant Directors of Public Health Nursing	To inform final evaluation
User Observation Sessions	2019	7	Immigrant and lower income parents and grandparents	To inform website evaluation
		5	Members of the Traveller community including grandparents	To inform website evaluation

Semi-Structured Interviews with Key Stakeholders

Senior staff in Implementation Teams and from allied departments and agencies

Semi-structured interviews were conducted with Implementation Team members, members of the Nurture Programme's Steering and Oversight Groups, and with staff from each of the key agencies in 2017, 2018 and 2019.

- In 2017, 41 people were interviewed (26 individual interviews, 15 in small group interviews)
- In 2018, 29 people were interviewed (20 individual interviews, 9 in small group interviews)
- In 2019, 61 people were interviewed (54 individual interviews, 7 in small group interviews)

This section describes the purpose and methods for the 2019 evaluation research. The 2019 semi-structured interviews assessed the effectiveness of the processes and methodologies used in the Nurture Programme and the effects that the Programme has had, both on the work of the HSE and the services received by parents and families. Interviews also provided an opportunity for participants to make recommendations for the future development of the work programme. As there are no data sets currently available on health outcomes as a result of the Programme, the impact of the work was assessed by interviewing a wide range of professionals familiar with child health service provision. A total of

61 people participated in stakeholder interviews. This group was intentionally chosen to reflect the broad perspective required for the final assessment of the Programme. Interview participants included members of the Programme's governance structures, chairs and members of the six Implementation Teams, key Programme staff in the HSE, representatives from different healthcare provider communities (e.g. Public Health Nurses, Community Medical Doctors and Practice Nurses), and representatives from affiliated bodies (e.g. Tusla, the Department of Health and the Department of Children and Youth Affairs).

Fifty-four individual interviews took place between 10th June and the 29th August 2019. Of these, 48 were conducted by telephone and six were conducted in person. Most interviews lasted approximately one hour, however, interviews with people external to the Programme (e.g. Tusla) lasted approximately 20 minutes, as they were less familiar with the Programme's deliverables and processes. Prior to the interview, respondents completed a brief survey ('paper survey' explained in section 4.5.1 below), which provided quantitative data on the impact of the Programme. Interviews were manually transcribed and edited for clarity shortly after the conclusion of the interview. Each participant was given the opportunity to review and edit the transcript of their interview. This step in the process increases reliability in the data collection process and provides interviewees with an additional opportunity to make sure their perspective has been adequately captured. When edited transcripts were returned to researchers, they were saved as the final version to be used in the subsequent thematic analysis.

In June and July 2019, seven key staff members the three lead agencies for the Nurture Programme participated in organisation-specific small group interviews (KHF, the HSE and the CES). Group interviews lasted between two and six hours (in this last instance the interviews were run over two sessions). As described above, interviewees had an opportunity to amend and add to the interview transcript to ensure it adequately captured their views.

For reporting purposes, 'stakeholder interviews' refers to the 54 individual interviews and the seven small group interviews with Programme partners. In total, there were 61 interviewees.

Stakeholder interviews ceased when the Evaluation Advisory Subcommittee agreed that a sufficient volume of data from the necessary perspectives had been included and saturation had been reached, based on no new themes occurring in the previous five interviews. All transcripts were kept in cloud-based storage to ensure confidentiality.

Semi-Structured Group Interviews with Specific Key Disciplines

Child Health Programme Development Officers

A group interview was held with six of the Child Health Programme Development Officers on the 25th June 2019. The 90-minute group interview was designed to gain insights into the experience of this key staff team, their view on what the Nurture Programme had achieved and their recommendations for the future development of the Programme. Participants also completed pre-interview surveys. The transcript was typed during the meeting and refined afterwards.

Assistant Directors of Public Health Nursing Group

A group interview was held with 16 Assistant Directors of Public Health Nursing on the 3rd September 2019. Each of the participants completed a pre-interview survey and contributed to the facilitated discussion about the progress of the Nurture Programme and the implications for practice, as described above. The group interview lasted approximately 90 minutes. The transcript was typed during the meeting and refined afterwards, it was then sent to seven members of the group who volunteered to review the document to ensure it adequately captured the views of the group.

Semi Structured Interviews with Public Health Nurses and Community Medical Doctors

As part of the evaluation of training programmes, semi-structured telephone interviews lasting 20-45 minutes each were conducted with 34 Public Health Nurses and Community Medical Doctors. Interviewees were randomly selected from a list provided by the HSE that contained details of all training participants who had opted in to be interviewed. Interviews were conducted between November 2018 and February 2019. Interviews ceased once saturation was reached, as evidenced by a lack of new themes for five interviews. Interviewees were Public Health Nurses and Community Medical Doctors who attended at least one of the following face-to-face training sessions developed through the Nurture Programme in 2018, namely:

- Behavioural Sleep Difficulties in Infants and Children (6 hours in class)
- Ages and Stages Questionnaire 'Train the Trainer' course (5 hours in class)
- Schedule of Growing Skills II Training (4 hours in class).

Each interview was manually transcribed and edited for clarity after its conclusion. Each participant was given the opportunity to edit the final transcript of their interview.

Semi Structured Interviews and Observation Sessions with Website Users

Website users who completed an online survey were invited to opt-in to participate in a 15-minute anonymous semi-structured telephone interview. Of the 198 survey participants, a total of 58 respondents provided their contact information for this purpose. Of these, 15 respondents were randomly selected to participate in the interviews. This group was stratified by their average scores on the website to include five who provided very high average marks on the site, five who provided average scores on the site and five who provided lower scores.

Participants were asked about their experience using the site, including questions regarding content accessibility, the quality and depth of information and thoughts on how to improve the site. All interviews were conducted via telephone and transcribed. Details of the transcription were periodically checked during the interview to support accuracy. Themes which emerged from the analysis of interviews were analysed alongside those from the surveys and feedback sessions for key themes. These themes were examined a minimum of three times.

In addition to semi-structured interviews, two website user group observation and feedback sessions were conducted with hard-to-reach populations in North Inner City Dublin circa early 2019. These sessions involved twelve participants from Traveller, new community and socio-economically disadvantaged groups who were recruited by local service organisations that work with these populations[12]. Participants were asked to think of a child health question. They were then asked to find the answer to this question using www.mychild.ie. The research team recorded all steps that service users undertook (e.g. search terms, success in finding information, levels of comprehension of information offered). The research team only assisted if the user reached a barrier they could not overcome. A feedback session then sought to understand the experience these users had when interacting with the site and to clarify any improvements needed from their perspective. Following the session, the steps were analysed to uncover structural, linguistic and systems issues that inhibited users from accessing information.

Qualitative Data Analysis

Thematic analysis involves a process of revisiting data several times to cull and narrow themes and then select data that most significantly represent key themes and sub-themes (Shank, 2006). Each interview was reviewed a minimum of three times and coded according to key themes. The first cycle of coding was largely descriptive and provided labels for important data, such as evidence, sustainability and project management. This level of coding was reviewed by a research team member to maintain as much objectivity as possible in the analysis. A second cycle of coding helped to further refine themes in a manner that aimed to recognise patterns, themes and connections among the data. Useful and relevant comments were collected in an excel workbook under each theme. These codes were again reviewed by a second researcher for coherence and consistency. The final combined codes into final categories, which are outlined briefly in the report as themes. These themes have not been represented by the numbers of respondents who made these points, as was the method in other Nurture Programme evaluation reports. The breadth of content discussed within the interviews meant that many interviewees only spoke about the specific aspects of this multifaceted programme with which they were familiar. Therefore, some useful points made by informed health professionals are minority views and providing numbers of respondents could serve to undermine these key points.

12 Pavee Point Traveller and Roma Centre and Hill Street Family Resource Centre

08 Quantitative Research

Quantitative research is an effective way to assess clear statements or perspectives if response sizes are large enough to provide a degree of reliability. Quantitative data collection was used in the evaluation when the research team and Evaluation Advisory Subcommittee considered that a significant proportion of the target population could be reached. Data on issues previously identified through qualitative methods could then be gathered. Quantitative data was also collected to assess to what degree, if any, stakeholders thought the Nurture Programme had achieved its system change objectives and what impact the deliverables had on service delivery. These methods are outlined below.

FIGURE 6: QUANTITATIVE RESEARCH CONDUCTED FOR EVALUATION OF THE NURTURE PROGRAMME 2017-2019

Method	Year	Number of participants	Target Audience
Annual online survey of Implementation Team members	2017	63	Implementation Team members, Programme staff and others working on the Programme
	2018	29	As above
	2019	23	As above Referred to as **2019 Stakeholder Survey** (data combined with paper survey below)
Stakeholder paper survey	2019	61	Stakeholder interview participants Referred to as **2019 Stakeholder Survey** (data combined with online survey above)
Online survey of Public Health Nurses	2019	232	Public Health Nurses
Online survey of website users	2019	198	Early users of www.mychild.ie website

Stakeholder Survey

Data for the stakeholder survey was collected in two different formats: the annual online Implementation Team survey and paper surveys distributed to participants in the semi-structured interviews. Together, these two streams of data comprise the 2019 Stakeholder Survey. This survey sought to assess the degree to which stakeholders (groups defined below) thought the Programme had met its objectives.

Online Survey with Implementation Teams

In 2017, 2018 and 2019, Implementation Team members were asked to complete an online survey on the implementation process and methodology of the Nurture Programme. In 2019, the survey focused on Programme impact, so questions on the process were eliminated in order to streamline the survey experience as much as possible.

The survey included 16 ranked questions, many of which were multi-part questions with an estimated survey time of 10-15 minutes. Participants were invited to complete the survey by Quality Matters on 8th July and received reminders at regular intervals until the survey was closed on the 13th August 2019. Quantitative data was collected and managed through the online survey platform www.sogosurvey.com.

The survey reached a 51% response rate, which is slightly lower than 2018 (53%) and significantly lower than 2017 (86%). This decreased response rate may reflect the winding down of the Programme's activities, the external challenges experienced by the Programme (discussed in section 4.7.4) or it may be due to evaluation fatigue (discussed in section 4.7.5). However, this level of response rate had been anticipated by the research team. To mitigate this, a series of quantitative questions were asked of each of the participants in qualitative research (as discussed above). Together, the data represents a robust quantitative picture of the Nurture Programme.

FIGURE 7:SURVEY RESPONDENTS BY IMPLEMENTATION TEAM 2019

Implementation Team	Number of participants completing survey	Number of participants in teams at time of survey	Percent of total team
Knowledge and Communication	1	9	11%
Antenatal to Postnatal	6	7	86%
Infant Mental Health and Parenting Support	2	7	29%
Health & Wellbeing Promotion and Improvement	5	9	56%
Standardised Records for Parents and Professionals	7	7	100%
Training and Resources	9	10	90%
Did not choose a team	1		
Total Unique Responses	**25**	**49**	**51%**
Total responses in relation to group membership[9]	**30**		

As noted above, the data collected in this survey was combined with paper surveys (where appropriate) and analysed for trends. This data was then merged with qualitative data to provide a view and analysis of the outcomes of the Nurture Programme. By combining quantitative and qualitative data, researchers can capitalise on the strengths of each mode of research (Meissner, Creswell, Klassen, et al. 2018). Throughout the multi-year evaluation process, qualitative data was used to uncover dependencies and relationships between findings, while quantitative data supported the confirmation or disposal of hypotheses that arose through the qualitative data.

Paper Survey with Key Stakeholders

In 2019, a paper survey was sent to participants in individual and group interviews in advance or provided at the outset of the interviews. Participants included key staff of the Programme and the HSE, members of both the Oversight and Steering Groups, members of the Assistant Director Public Health Nurse and Child Health Programme Development Officer groups, key stakeholders external to the HSE and Implementation Team chairs and members. The questions in this survey mirrored many of those in the online survey. Respondents were asked to identify which parts of the Nurture Programme they were most familiar with and then answer a series of ranked questions about their view on the Programme's impact. A total of 72 participants (of the 83 involved in qualitative research) completed this survey. 18 of the 21 questions in this paper survey matched those in the Implementation Team survey. As noted above, this data has been merged with the Implementation Team survey data in the final report. It should be noted that respondents were asked to only rank those issues with which they were familiar. This varied experience with the Programme resulted in a variation in the number of answers for each question.

Public Health Nurse Survey

To better understand the experience and professional needs of one of the Programme's key professional constituencies, a national survey of Public Health Nurses was conducted between the 2nd April and the 4th June 2019. Similar to the Implementation Team survey, the online SOGO platform was used to host the survey and manage data. The survey included a mix of 41 quantitative (ranking) and qualitative (open-ended) questions. However, the survey's branching logic allowed for participants to only respond to general questions and those related to the training that they had attended. While the entire survey was long, this branching allowed the length of time to complete it to be approximately 15-20 minutes. The survey largely focused on understanding Public Health Nurses' experience of training and their recommendations for the future of training support and the implementation of learning.

Due to external circumstances (explained in 4.7.4), researchers did not achieve the target number of 350 responses. However, 232 Public Health Nurses participated and provided valuable feedback on their experience with the Nurture Programme and suggestions for further development.

Website User Survey

Between 7th January and 6th March 2019, website users were given the opportunity to share their experiences and thoughts on the new website through a brief online survey. Visitors opted to participate in the survey through a pop-up window on www.mychild.ie. After they agreed to participate, they were redirected to an external site. In total, 198 people chose to complete the online survey[14]. Those who provided contact information went into the draw for a €100 One4All prise voucher, awarded in March 2019.

13 The total number of responses is higher than the number of people who participated in the survey, as participants were able to choose more than one option when they sat on a number of teams.
14 There was a large population of over 80,000 users between Dec 2018 and March 2019, so the numbers self-selecting to engage with the survey cannot be viewed as representative.

09 Research Ethics

Research ethics, which included safeguards for all those engaged in the research, were approved by the Dublin City University Ethics Committee in February 2017. Key provisions required everyone engaged in the research to be made aware that their participation was voluntary and that they could elect not to answer any questions or withdraw from the evaluation without consequence up until the beginning of analysis in each data collection period. Before participating in the research, researchers also made it clear that people's responses would be confidential and anonymised. The purpose of data collection was explained, as was how the data would be used. Data collected as part of this study was kept in a password-protected, cloud-based storage location to further protect the anonymity of participants. Interviewees were provided the opportunity to review and edit transcripts. Any transcript returned to researchers with edits from participants was saved as the final version.

10 Key Limitations

The mixed-method approach employed in this evaluation helped to verify results. However, the approach and the duration of the Nurture Programme presented some research challenges and the selected methodology contained limitations. This section provides an overview of the limitations most relevant to this evaluation and the ways in which the methodology aimed to mitigate these as far as possible.

Limitations of Online Survey

Self-selection bias can occur when respondents opt-in to survey participation. By its nature, this means that a section of possible participants has opted out of participating. This may result in a distortion of participant experiences, generally towards the positive, because of sampling (Wright, 2005).

End-avoidance and positive skew can occur in surveys that include Likert or ranked scales for responses. End-avoidance refers to the tendency for some respondents to avoid choosing the answers at the extreme ends of the ranking scale even if they accurately reflect their experience. Positive skew refers to a tendency of some respondents to prefer positive responses, which skews data away from the mid-point (Green and Browne, 2005).

To mitigate these challenges, researchers gathered both quantitative and qualitative data from over 400 respondents in several different formats. The sum of this data informed the overall report and helped to minimize the impact of over or underrepresentation in survey results.

Limitations to Semi-Structured Interviews

Respondent-induced bias, client memory: The process of conducting interviews for research may result in over or underreporting of participant experience or may be hampered by overall memory distortion (Graham and Naglieri, 2003). To address this limitation, researchers interviewed over 60 participants. This ensured sufficient data for key themes to be considered prevalent and salient.

Limitations of Group Feedback Sessions

Conformity effects: Limitations of feedback sessions include the tendency for certain types of socially acceptable opinions to emerge and for certain types of participant to dominate the research process (Bond, 2005; Smithson, 2000). To address this, facilitators asked attendees to consider key points prior to interviews or focus groups. During data collection, they paid close attention to participants' non-verbal cues and offered opportunities for different opinions to arise. Participants were also invited to provide additional information after the interviews concluded through the transcript validation process.

External Challenges

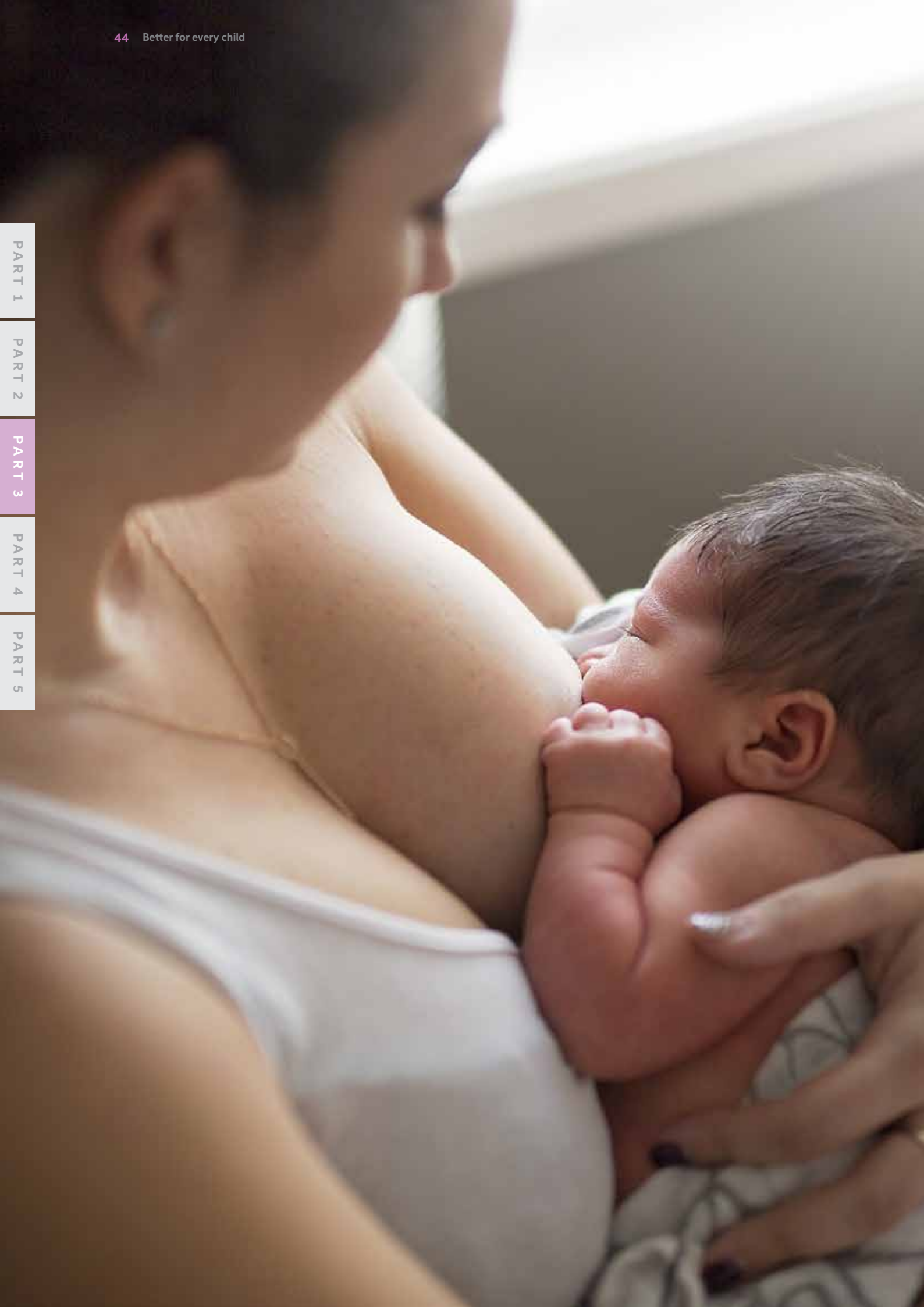
While conducting the research for this report, the Irish Nurses and Midwives Organisation (INMO) requested discussions with the HSE in relation to the impact of changes to the work of Public Health Nurses as a result of the Nurture Programme. Throughout this discussion process and based on communications with the INMO, some areas halted formal engagement with the Programme's deliverables (e.g. paused the local implementation of the ASQ-3). This pause also made it more challenging to reach the target number for the Public Health Nurses engaged in the survey. However, the 232 responses were considered acceptable for utilisation of the data.

Evaluation Fatigue

The Nurture Programme is an evidence-based programme that gathers input from end-users and from practitioners on its products and the ways in which it operates. After three years of gathering input from Implementation Team members and from practitioners, some expressed a level of evaluation fatigue, i.e. a lack of interest in or reluctance to participate in evaluative efforts due to frequent participation in past efforts. Responses to the Implementation Team survey may have been lower than previous years because many of the participants had been involved in several other consultations and evaluations. To address this, the evaluation team reduced the number of people included in the 2018 review to just core staff, and then focused efforts on gaining perspectives from over 400 stakeholders in the final year evaluation.

11 Summary

As the final evaluation report for the Nurture Programme, this report analyses the accomplishments and challenges faced by the Programme and makes recommendations for the future. This chapter explained the depth of research conducted to ensure that a diversity of perspectives and experiences were represented, and that the learning from the Programme is adequately documented. It also explored the limitations of the research methodology and how they were addressed. The next chapter provides an analysis of the Programme's deliverables.



Part Three: Nurture Programme Deliverables

12 Introduction

This section of the report provides an overview of six key deliverables of the Nurture Programme. The processes and products created over the duration of the Programme are examined and the outcomes and impact of this work is described with reference to the views of the key stakeholders and staff within the HSE. Included in this section are:

- The www.mychild.ie website
- The new *My Pregnancy* and *My Child* books
- The training and professional development framework and programme
- The standardised child health record
- The standardised developmental screening tool
- The standards for antenatal education.

Three deliverables originally identified in Programme Planning documents (infant mental health, child safety awareness and breastfeeding supports) have been included within the evaluation of the six overarching deliverables – a structure that reflects the way stakeholders understood the Programme in practice.

13 National Standards for Antenatal Education

Overview

Early in the planning process, project leadership determined that if the goal of the Nurture Programme was to provide all young children and their parents access to evidence-based, standardised care, it would need to start before birth. To do this, the Nurture Programme Implementation Plan prioritised the development of standards for the delivery of antenatal education. This coincided with the Health Information and Quality Authority publishing National Standards for Safer Better Maternity Services, which identify the need to regulate the provision of antenatal education in Ireland. The Antenatal to Postnatal Implementation Team was charged with several key activities, one of which was the development of Ireland's first set of national standards for antenatal education. .

Process and Product

The standards were developed in close consultation with parents, parents-to-be and antenatal education providers from a range of backgrounds. The process also included strategic collaboration between the HSE National Women and Infants Health Programme and the Office for Nursing and Midwifery Services Directorate (ONMSD) in order to ensure that these standards, which apply to many sectors and professions and include both public and private providers, are implemented throughout HSE funded settings.

> **Before this work in the Nurture Programme, there were no standards. When we did consultation with service providers, we learned that there is a huge variety of how classes are delivered across the country. This also came up in the parent survey.**
>
> STAKEHOLDER INTERVIEW 32

To inform the development of the standards, the team engaged a variety of key stakeholders in antenatal education across a range of service settings. This included interviewing antenatal service managers and antenatal educators in maternity and community services who delivered education publicly and privately. This was not a simple task, as no standards existed prior to the engagement in this work, implementation team members were required to create an entirely new product. Parents were also consulted about their experience of antenatal education to inform this process.

This process began with a review of antenatal education standards in other countries and consideration of the appropriate format for an Irish service context. Once the team had created a draft of the national standards, they brought together more than 100 stakeholders for a national consultation day, during which they shared the standards, encouraged feedback and sought views on the feasibility of implementing new standards. Stakeholders noted that this was the first time that this conversation had been facilitated at a national level and having engaged in this consultation, antenatal educators agreed that there is a need to recognise the importance of their work and to have national standards. In addition to providing feedback on the standards, the consultation day also provided those working in antenatal education the opportunity to network and share resources with colleagues from around the country.

> **Planning the antenatal care and education will help standardise care for all women in the country. Currently, not all women can get antenatal care classes because they are so limited in time and structure. But now you can identify in advance who needs additional help and can think about the dynamics. You can say if they need one on one classes or something else. This is huge because we are coming from zero - it isn't standardised.**
>
> STAKEHOLDER INTERVIEW 24

The consultation day identified the need to support implementation through increased capacity in training for antenatal educators. Stakeholders at the consultation day reported challenges in accessing the only, and much sought after, Level 8 training programme available in Ireland. This feedback led to a pause in launching the standards so an additional three-day skills-based, accredited 'Transition to Parenthood' educators training programme could be developed. The curriculum, supporting resources and a rollout plan for this training are at an advanced stage. Public facing materials, including the *My Pregnancy* book and website information, will be used to complement the material and support consistency of message. Resources for self-audit in implementation of standards will also be available.

At the time of writing, the standards are finalised and ready to launch in early 2020. The Nurture Programme is finalising discussions with key stakeholders regarding a sustainable implementation plan.

Outcomes

While the standards are due to be launched shortly, interviews with key stakeholders revealed their optimism about the outcomes that might be achieved. In addition to standardising antenatal education across the country, stakeholders pointed to the important role that standardised antenatal education can have in supporting expectant parents to navigate the multiple sources of information available, make sound judgements on the validity and evidence base of the information they access and to identify their own parental health and wellbeing needs while preparing for a new baby.

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14 www.mychild.ie Website

Overview

Research identified the need for the Nurture Programme to create one website to unify and enhance existing stand-alone online HSE resources and to provide up-to-date and accessible evidence-based information to parents and care givers. This objective, listed in the Programme's logic model, was a vital step toward consistent messaging for every parent in Ireland about pregnancy, parenting and the physical, social and emotional development of children up to three years old. The new website provided an opportunity to merge the HSE's existing online information with new web-based information on child health and wellbeing into one child health and wellbeing focused site. This consolidation is in line with the HSE's Digital Roadmap[15], which was published in 2017.

The development of www.mychild.ie represents the first large-scale project ever conducted in line with this strategy, and therefore offers important learning on good practice for the implementation of the roadmap.

For the majority of those interviewed in the evaluation, the www.mychild.ie website was the most visible and publicly-accessible product developed by the Nurture Programme. Launched in December 2018, www.mychild.ie was considered a milestone that involved a collaboration among HSE staff across various Divisions and disciplines, the interagency Communications and Knowledge Implementation Team and more than 60 subject matter experts who contributed to the site's design and content.

Process and Product

The Knowledge and Communications Implementation Team led the website development process with guidance from a dedicated child-health Communications Manager within the HSE Communications Team and the broader HSE Communications Digital Team[16]. The team developed a clear vision statement and established editorial and governance structures. These outlined how the site would be developed by a wide range of health professionals, keep a consistent voice across all pages and adhere to a challenging set of principles in relation to accessibility.

Keeping with the overarching values of the Nurture Programme, the Implementation Team prioritised the viewpoint of end users – in this case, families, parents and care givers. A series of consultations (outlined in Part One of the report) were held with parents, families and practitioners at different points in the process to fully understand their needs and to create a website responsive to these needs. These consultations and research on the HSE website user behaviours indicated that approximately 70% of users accessed websites on their phones, so the team took a "mobile first" approach to developing the site. All content was developed to be compatible with and easy to load and view on smartphones. As a result, the final website has a clean look with ample white space and few images[17], similar to that of the www.nhs.uk, a website regarded as a useful benchmark for many aspects of www.mychild.ie.

Consultation with end users also informed other aspects of the website, including its name, content, organisational structure and tone. For example, topics that parents prioritized in consultations were reviewed and developed first. From the consultations, team members learned that users wanted the site to have a 'collaborative' tone, rather than the more distanced 'expert' tone that could describe many state-managed health websites. To achieve this level of accessibility, a close editorial relationship between the HSE Communications Team and content experts was forged, with some articles requiring up to 12 edits to achieve the right balance between accuracy and accessibility. Clear guidance on tone and accessibility assisted in setting the high standards that informed the development of all articles and challenged some traditional ways of communicating, including the extensive use of images:

> **The process of fact checking and getting second and third looks was tight and rigorous. I was surprised by some things that were taken out, like removing images. The research showed that they take away from the message.**
>
> STAKEHOLDER INTERVIEW 13

The guidance recommended that language used in the website needed to be inclusive of different users, such as different life experiences (e.g. homelessness), family structures (e.g. LGBTI families) and cultural practices (related to diverse ethnicities). The site also needed to be accessible to users with lower levels of literacy or who do not speak English as their first language. This was, in part, accomplished by following the principles of Plain English, and the HSE policy of

15 https://www.hse.ie/eng/about/who/communications/digital/digital-transformation/hse-digital-roadmap-web.pdf
16 This post was created with seed funding for two years under the Nurture Programme and was filled in a permanent capacity.
17 Those few images which are included are technical or advisory in nature.

'Communicating Clearly' developed using the National Adult Literacy Association guidance. However, ensuring fully accessible content is an ongoing project. The work of providing closed captioning or sign language for all videos, for example, is a priority for future development.

In early 2019, in line with the HSE's digital strategy, the site merged content from standalone HSE online resources on child safety and breastfeeding together with new material into the main www.mychild.ie website. Another innovation in content development was the inclusion of the topic of infant mental health (the emotional development of the child) as a key theme woven throughout the website text.

In addition to creating the site, the Knowledge and Communications team developed robust governance structures for the future management of content. These include guidelines for editing and updating materials based on emerging need (such as a media focus on a new issue), a review of all articles every two years and the establishment of an expert panel to ensure that all articles are informed by relevant clinical guidance and expertise. As with the initial development, content will continue to be developed with the engagement of parents and subject and communications expertise. The effectiveness of these structures is beginning to become apparent:

> **After [the child health Communications Manager] went on maternity leave, we got a query about an article and were able to use our content governance system to identify the person who wrote it. We checked references, discussed it and made a small change. It was this beautifully orderly process. This is so different from many other experiences.**
>
> STAKEHOLDER INTERVIEW 22

Since the official launch of the www.mychild.ie website in December 2018, the HSE has promoted the website with a communications campaign. The site has grown to include 525 content pages as of September 2019. The website achieved AAA standard[18]. (a rating of reading level). As of November 2019, the website had been visited by 775,249 users, who engaged in 1,214,163 sessions and more than 2.35 million page views.

A specific process evaluation of the website was undertaken in early 2019. This evaluation produced 16 main findings, many of which are included in the outcomes section below. Those which are not specifically outcomes, are listed below:

User Experience

The website met user expectations. Most users said that the name was easy to remember and that they would both visit it again in the future and recommend it to others. Interview participants found the website accessible in both tone and language simplicity. When asked how to improve the site, users from each research method noted that including images, videos and additional colours would make the user experience more pleasant. The inclusion of images was deemed especially important for reaching users with lower levels of literacy and/or English fluency. Interview participants were interested in receiving a regular email bulletin tailored to their stage of pregnancy or child development[19]. The review also found potential to increase awareness of the website.

Challenges

Users with lower levels of literacy and English fluency did not find the search bar intuitively useful. For these groups, successful searching and comprehension of the site was impaired by complicated terminology, lack of spelling variants and a lack of images. When pages redirected from the www.mychild.ie website to the main HSE website, people with literacy difficulties frequently found the language used on the main website to be inaccessible. People with lower levels of literacy and English fluency rated the site highly, even when they did not get the information they needed, which also indicated a need for similar observation sessions in future reviews rather than rely solely on verbal or survey feedback that may be affected by positive responder bias.

The report also contained 24 recommendations (Appendix F) that were co-operatively developed with all key Programme partners. In general, the focus of these recommendations was to take steps to extend the benefits of a useful, relevant and engaging website to as many users as possible.

18 Level AAA is a widely recognized method of measuring the readability of a website. To achieve AAA, all content must be accessible to users with nine years of school or more.
19 The National Healthy Childhood Programme has received funding under the Sláintecare Integration Fund to create this enhancement to the website during 2020.

Outcomes

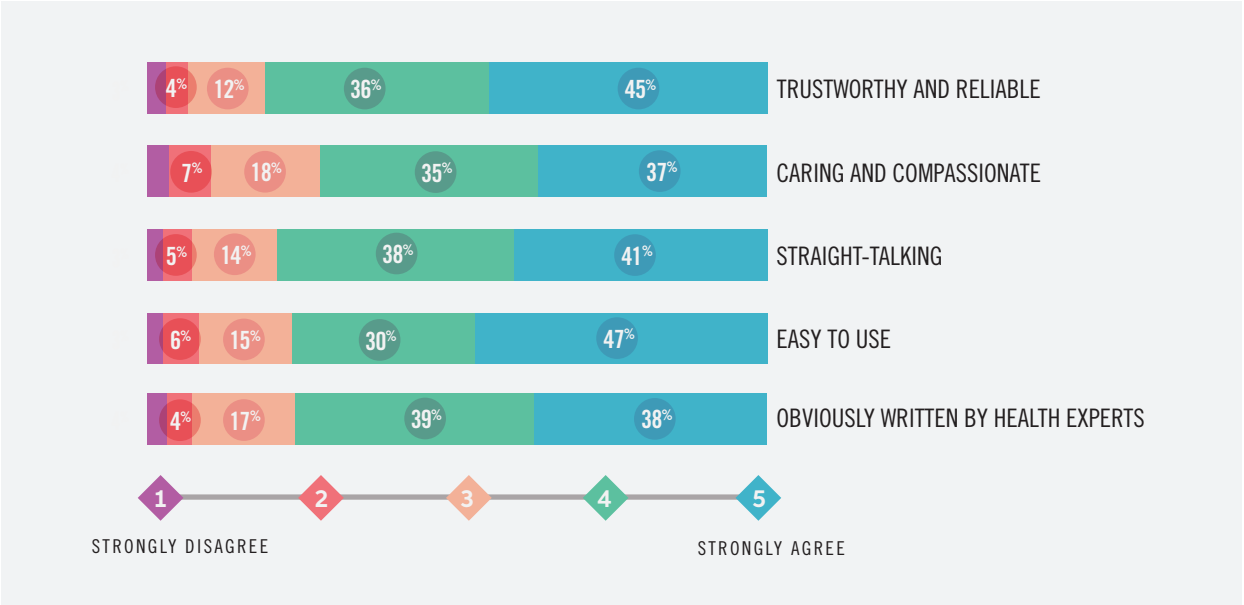
This section is informed by website users' feedback forms and a user survey (both managed by the HSE), semi-structured telephone interviews and observation sessions of website users by the evaluation team. Data from a national survey of Public Health Nurses and 2019 Nurture Programme stakeholder interviews were also used to inform this section on outcomes. Findings are presented in two sections: feedback from the website users and feedback from other stakeholders and practitioners.

Feedback from Website Users

Website users had a positive reaction to www.mychild.ie, considering it trustworthy and easy to use.

In a survey of 198 respondents, 81% agreed that the site was trustworthy and reliable. Agreement was nearly as high when asked if they felt that the site was straight-talking (79% agree) and easy to use (77% agree). Only slightly lower scores were provided when asked if the site was caring and compassionate (72% agree) and obviously written by health experts (77% agree).

FIGURE 8: WEBSITE USERS' REACTIONS TO WWW.MYCHILD.IE (N=198)



Semi-structured interviews also endorsed the trustworthiness of the site, with 13 of 15 interviewees (87%) choosing a variation of 'trustworthy' to describe the site. This choice was largely due to the website being affiliated with the HSE:

> It is backed by the HSE, which is a recognised body. It is better than a blog because it was written by educated and informed professionals. It is research based. I've only used the NHS in the past, so it is great to have something that relates to the Irish HSE and health system.
>
> WEBSITE USER INTERVIEW

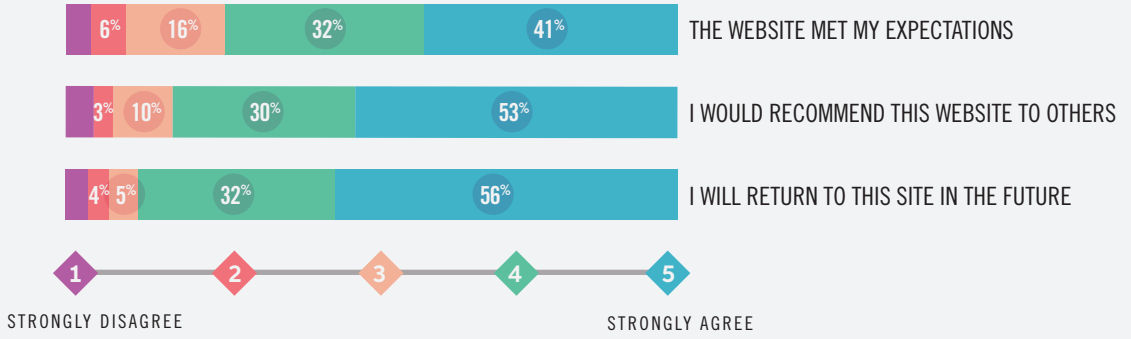
The observation sessions conducted with people from migrant, Traveller and socio-economically disadvantaged backgrounds involved researchers observing and recording the experience of users as they searched for information to a question they had about their own children. These sessions highlighted in clear terms how www.mychild.ie was more accessible than information on www.hse.ie in terms of structure and readability. However, while the site was successful in attaining a reading age of 11 (as measured by the Hemingway Editor Application[20]), this evaluation exercise indicated that additional steps could be taken to make this information more accessible to minority groups for whom literacy challenges, language or cultural differences impede accessibility of some key information.

20 Available at http://www.hemingwayapp.com/

Since the completion of the website evaluation report, the HSE has undertaken steps to implement these recommendations.

The website met user expectations with high intention to revisit and recommend to others.
Survey respondents agreed by large percentages with each of the three usage measures. When asked if the website met expectations, 73% chose to agree or strongly agree. A further 83% of users said that they would recommend the site to others and 88% said that they would return to the site in the future.

FIGURE 9: ONLINE SURVEY RESPONDENT WEBSITE USER EXPECTATIONS (N=198)

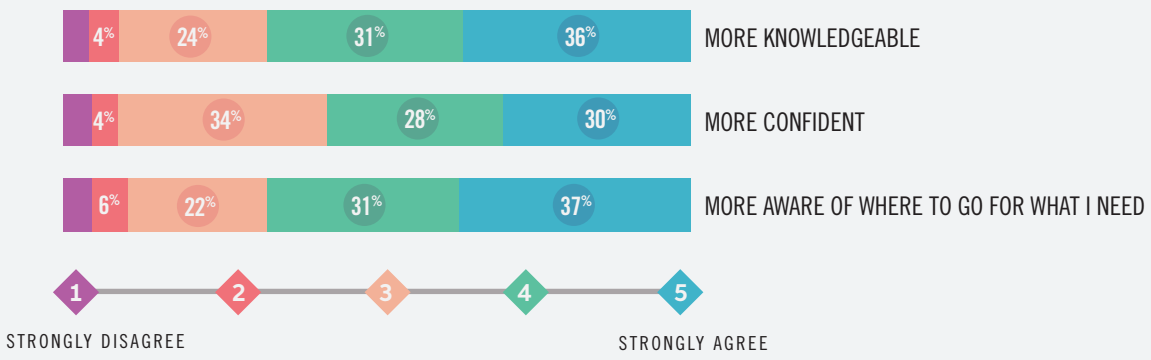


Semi-structured interviews indicated that prior to www.mychild.ie, interviewees were generally accessing health information from Public Health Nurses or Google, with U.K.-based websites often being the main source of information. After using www.mychild.ie, the majority of interviewees (9 of 15) indicated that this would be among the top sites they would go to for child health and pregnancy information in the future.

After visiting www.mychild.ie, users were more knowledgeable, confident and aware of where to go

67% of the 198 survey participants indicated that they felt more knowledgeable after visiting www.mychild.ie, and 68% of participants indicated that they were more aware of where to go for what they needed. More than half (58%) of respondents indicated that they were more confident after visiting the site.

FIGURE 10: WEBSITE USERS' PERCEIVED IMPACT OF WEBSITE USE (N=198)



The 'more knowledgeable' rankings were confirmed in semi-structured interviews, where participants were asked to rank their levels of knowledge before and after using the site. For this question, approximately half rated their level of knowledge to be higher after using the site than prior to using it.

One question in this section of the survey received slightly lower results from other questions. While 57% agreed that www.mychild.ie is 'the leading source of pregnancy and infant health information in Ireland', levels of support were noticeably lower than for the other questions, and nearly one-third (31%) of respondents chose a ranking of three (neither agree nor disagree), indicating room to grow audience connection with the site.

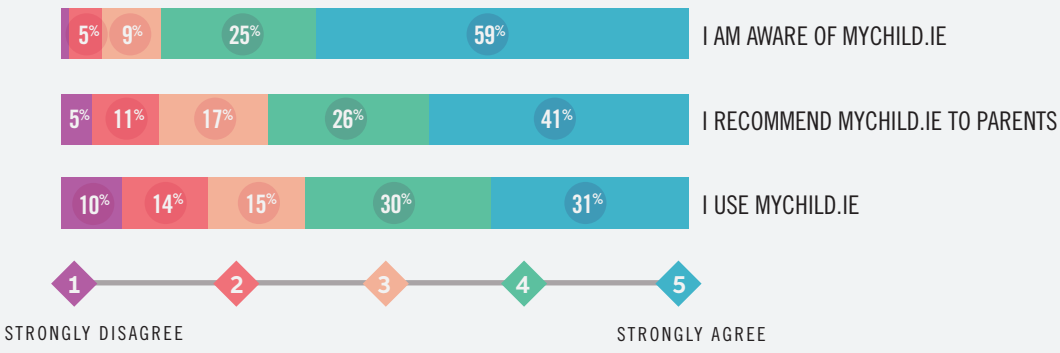
Feedback from Practitioners and other Key Stakeholders

Public Health Nurses are aware of the site, use it and recommend it to the families they serve

In the national survey of Public Health Nurses, which involved 232 respondents, 84% indicated they were aware of the site (agree and strongly agree). When asked if they recommend the site to parents they work with, 67% agreed. A slightly lower number (61%) of respondents indicated that they themselves use the site for information. The following quote outlines a commonly expressed view of the value of the website:

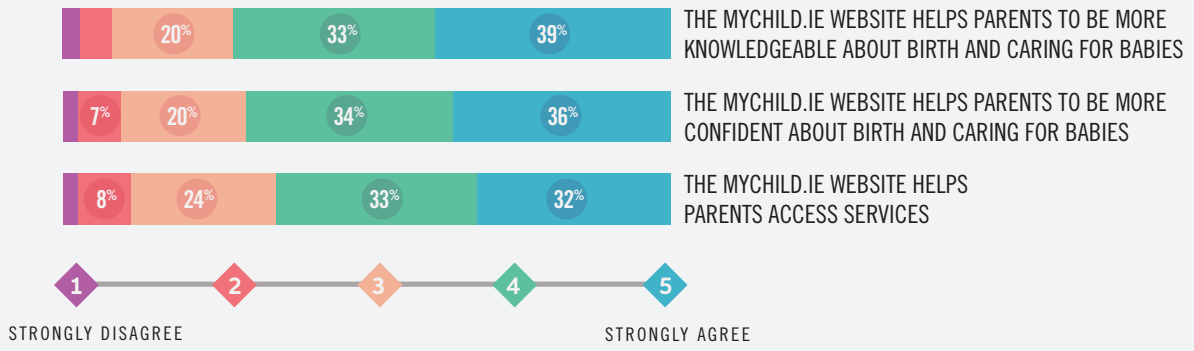
> The Mychild website is an exciting development because we have all of the information in one place. We have created a one-stop shop for trusted Irish information to support parents.
>
> STAKEHOLDER INTERVIEW 30

FIGURE 11: PUBLIC HEALTH NURSE AWARENESS, USE AND RATES OF RECOMMENDING WWW.MYCHILD.IE (N=232)



Public Health Nurses were very positive about the impact of the new website, with 72% indicating an opinion that the site helped parents-to-be more knowledgeable about birth and caring for babies and 70% agreeing that it helps parents be more *confident* about birth and caring for babies. While still largely in agreement, slightly fewer respondents agreed that www.mychild.ie helps parents access services (65%). This was connected by some key stakeholders in interviews to the absence of local service contact details on the site.

FIGURE 12: PUBLIC HEALTH NURSE PERCEPTIONS OF IMPACT OF WWW.MYCHILD.IE (N=232)



Key learning from the Evaluation of www.mychild.ie

The new website was mentioned by all participants in individual and group interviews. Interviewees tended to point to the website as a major accomplishment of the Nurture Programme with wide public reach.

> **The website should have a very large impact on the public access to good information. It is written to a high standard and it is full of reliable information. It is a slightly unusual website in that it is very simple and lean in terms of structure and makeup. That was all based on input from parents who were consulted on it.**
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> STAKEHOLDER INTERVIEW 3

In addition to helping the public more easily access information about pregnancy and child health, the extensive public and professional consultation was consistently noted by stakeholders as an important aspect of the process that resulted in an accessible and useful website.

Another theme in stakeholder interviews was the lasting impact that the process of developing the website and content could have on the wider HSE. Interviewees noted that significant organisational learning has occurred from the experience of designing the site and establishing a sustainable and high-quality governance system for content development and updates.

Another key lesson highlighted by stakeholders was the benefit of changing the tone of public communications. The structures and supports that enabled communications experts to work alongside content experts can be replicated in future website development programmes.

The benefits of the streamlined and quick-loading format, which runs counter to the design of most commercial, image-heavy websites, was also an important learning.

As one interviewee noted, the impact of this website could be long lasting because the website offers an opportunity for the HSE to build a relationship with parents at a time when they are more receptive to health messaging. If trust is built with users during pregnancy and child-rearing, they may be more likely to return to the HSE as a trusted resource at times outside of the focus of the Nurture Programme.

15 My Pregnancy and My Child Books for Parents

Overview

Early planning for the Nurture Programme indicated a need for a revision of existing resources and the creation of new printed parenting resources in order to achieve the goal of delivering consistent messaging about the physical, social and emotional development of young children to Irish parents and parents-to-be. The Health Promotion and Improvement Implementation Team undertook a redesign and content update of the three Caring for your Baby/ Caring for your Child books. The team worked with other relevant Implementation Teams and HSE Divisions to develop the *My Child: 0 to 2 years* and *My Child: 2 to 5 years* books. The Antenatal to Postnatal Implementation Team led the development of a new *My Pregnancy* book.

Keeping with the Nurture Programme's commitment to designing products to meet the needs of those who will ultimately use them, the new and revised books were informed by the experience of and feedback from parents-to-be, families and caregivers. The consultation process revealed that service users are interested in evidence-based information on a wide range of topics related to pregnancy and parenting. They want information to be presented in accessible language with a non-judgemental tone that speaks to them as partners or collaborators rather than as patients. The sessions also highlighted a strong desire of many parents to have books and printed resources in addition to the website.

The drafting of these books included the systematic engagement of more than 40 subject experts who created new content. These experts worked closely with the wider Nurture Programme team and child health communications manager to create accessible, accurate information focused on priority issues for parents:

> **We originally imagined that it would be a 75-page book and then we made three 200+ page books. It wasn't that we couldn't edit them. This was a deliberate and painstaking process of deciding what was important and testing all of the elements of it. Making sure that it is worth their while to put all of these pages in people's houses.**
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> STAKEHOLDER INTERVIEW 22

Findings in this section are informed by the national survey of Public Health Nurses and semi-structured stakeholder interviews.

Process and Product

After two years of working on these products, the Nurture Programme launched three new books for parents, parents-to-be and caregivers in December 2018. Each of the books is described below.

My Pregnancy is a new 224-page book that is given to all pregnant women at the time of their first antenatal appointment at their maternity unit. *My Pregnancy* provides expert information on pregnancy, labour, childbirth and early parenthood in an upbeat, approachable and conversational tone. The introduction to this book acknowledges the public's input into the process, noting that parents-to-be asked for 'common sense information and tips on pregnancy, advice on what to do if they had a problem, [and] details of which people and services to get in touch with for more help and support' (HSE 2018. P.3).

As of September 2019, 40,000 *My Pregnancy* books have been printed and disseminated to maternity services across the country. This number includes 1,600 books that were distributed to GP practices for reference. The new *My Pregnancy* book has been generally well received by the HSE staff:

> **There is now a level of consistent information given across the country to all women who are pregnant. Not just first-time mothers, but all mothers. It has surpassed expectations. This book is consistent, it is evidence based, it has credibility because it is from the HSE... People love how colourful it is and how much information they have. The fact that they're national is important – they are available in all counties and all maternity hospitals. We have one unified national resource.**
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> STAKEHOLDER INTERVIEW 8

My Child: 0 to 2 years is a 228-page revision of content from two shorter books (together totalling 132 pages of content) that were first produced in 2005. All new parents receive a copy of *My Child: 0 to 2 years* during their first home visit by the Public Health Nurse after their baby is born. The book aims to provide expert advice on caring for babies and children in an accessible and conversational tone.

As of September 2019, 58,000 *My Child: 0 to 2 Years* books have been printed and these have been disseminated to local health offices across the country. This number includes 1,600 books distributed to GP practices for reference.

My Child: 2 to 5 years is a 148-page revision of a 95-page book that was first produced in 2005. All parents receive a copy of this book from their Public Health Nurse close to their child's second birthday. Similar to the 2005 book, it aims to provide parents of young children with accessible and expert-informed information about caring for their children. However, the tone of the new book is much more accessible and conversational.

As of September 2019, 36,000 *My Child: 2 to 5 Years* books have been printed and disseminated to local health offices across the country. This number includes 1,600 books distributed to GP practices for reference.

Copies of each of the three books have also been circulated through national library services to 330 local libraries across Ireland as part of a Healthy Ireland initiative

Developing the books in tandem with the other products of the Nurture Programme, such as staff training programmes and the www.mychild.ie website, means that language and messaging are consistent across all products and platforms. It also means that the different priorities of the Programme could be addressed consistently across different products. For example, the *My Pregnancy* book includes detailed information on breastfeeding, which furthers the HSE and National Healthy Child Programme's goals of increasing Ireland's breastfeeding rates. Furthermore, all the books include information to encourage the understanding of the importance of infant mental health. The *My Child: 2-5 years* book includes content in relation to child safety.

Developing the resources simultaneously has meant that we can have a common voice, and that these should all complement each other. This is really significant as we were falling down on this previously. We were giving slightly different messages, as resources were developed at different times by different people, in different parts of the country.

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In addition to the books themselves, the teams developed detailed governance structures to create resources of the highest quality that would be regularly reviewed by experts in continuing consultation with parents.

Traditionally there was a focus on saying 'let's get so-and-so to write something' and that would be it. [The Nurture Programme] had a fact checking process, so we still identified someone in the system with expertise, but then we put the content through a rigorous review process. This involved up to three or four reviewers; the less straightforward the evidence was, the more reviewers. We also had a review in relation to communications, which was weighted equally to content. It wasn't just having the right facts, it was expressing these in an engaging and accessible way.

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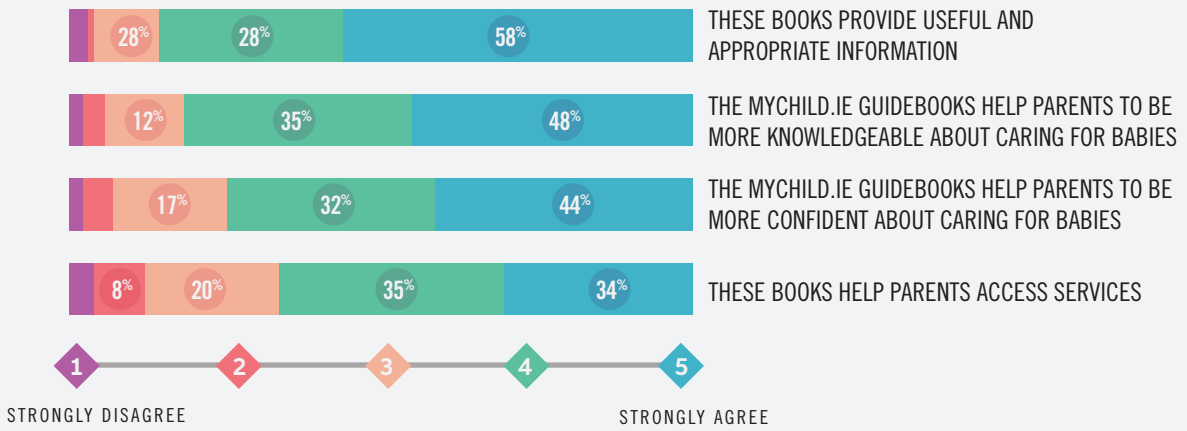
Copies of the *My Child: 0 to 2 years* and the *My Child: 2-5 years* books were sent to each of the 1,700 Public Health Nurses in advance of the books becoming available to parents to allow practitioners time to become familiar with the resource before the launch. The *My Pregnancy* books were also sent to each maternity hospital or unit in advance of the launch for the same purpose. CHO areas can re-order any of the new books through the www.healthpromotion.ie online portal.

Outcomes

The Public Health Nurse survey confirmed that the vast majority of respondents were aware of the books (82%). It is also clear that Public Health Nurses believe the books are having a significant effect on parents and parents-to-be. This is shown in the overwhelming consensus that the books provide useful and appropriate information to parents and parents-to-be (86%). A similarly large percentage of respondents (83%) felt that the books helped parents-to-be be more knowledgeable about caring for babies (83%), more confident about caring for babies (76%) and that they help parents to access services (69%).

FIGURE 13: PUBLIC HEALTH NURSE PERCEPTIONS OF IMPACT OF NEW BOOKS (N=232)



Stakeholder interviews confirmed enthusiasm about these new books from both health practitioners and parents. The broad appeal of the books is represented nicely in the following quote:

> Anyone I meet who is pregnant, I tell them about the mychild website and make sure that she has been given the [*My Pregnancy*] book. It is just an invaluable resource for the parents… In fact, I was speaking with someone yesterday who was pregnant with her sixth baby and she was so happy to have the resource. It is valuable that it is not just being given to first time mothers, but is given to all mothers. I also think that all of the resources have been very sensitive… They are geared toward a broad spectrum of people from homeless to traveller communities – including more marginalised groups.
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> STAKEHOLDER INTERVIEW 8

The challenge of disseminating these resources requires ongoing monitoring. When Public Health Nurses were asked in the national survey if all parents receive copies of the books, the responses were mixed. Around half (51%) agreed that parents did receive books, while one-third (33%) of respondents indicated that parents did not receive these books. Importantly, a quarter of respondents strongly disagreed that parents were receiving books in their region.

Similarly, stakeholder interviewees indicated concerns about the sustainability of these important resources. As the books are printed the process of updating and reprinting the resources will be more complex and more expensive than online information. If content becomes outdated, these resources will become less useful and may undermine efforts for the HSE to be a trusted voice and a main source of information for parents. To address this, there are plans for the online version to be updated more regularly and for resources to be secured to ensure that print versions will have regular revisions and reprints.

> Working alongside the website allowed them to be one project with consistent messages across the board. Funding helped to deliver the books this year. We need to get [the books] into recurrent funding by the HSE. The Nurture Programme allowed us to review and make the books much better. These books will exist long after Nurture, and now we have the platform to review things in a structured way and to do this in conjunction with the website and have co-ordinated messaging.
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> STAKEHOLDER INTERVIEW 26

16 Staff Training Framework and Programme

Overview

Standardising healthcare delivery during pregnancy and the earliest years of a child's life is one of the overarching goals of the Nurture Programme. In the years prior to the Nurture Programme, training in relation to child health was not nationally co-ordinated nor consistently delivered. Rather, it was driven by local needs, interests and capacity, resulting in a lack of standardisation in the training received by health staff across the country. Parental and staff feedback revealed that this lack of a standardised programme resulted in parents living in different parts of the country (and even different parts of a city) receiving different messages about pregnancy and early child health and wellbeing. At times, this lack of consistency in messaging and standards resulted in confusion and frustration for parents and practitioners alike.

To achieve the goal of standardising care, the Nurture Programme leadership prioritised the development of a 'blended learning' training programme (incorporating eLearning, face-to-face courses and coaching or mentoring) for the child health workforce. This training portfolio had a primary target audience of Public Health Nurses, Community Medical Doctors and practice nurses. Many modules are also relevant and are available to midwives, GPs and all allied health professionals working with children and families. This work was led by the Training and Resources Implementation Team with input on content from other Implementation Teams, primarily the Infant Mental Health and Supporting Parents team and the Health and Wellbeing Promotion and Improvement team, who were both responsible for developing specific content.

Findings in this section are informed by the national survey of Public Health Nurses, semi-structured interviews with Public Health Nurses and Community Medical Doctors, semi-structured interviews with stakeholders and the group interview with Assistant Director Public Health Nurses.

Process and Product

The staff training and professional development programme was designed to build on existing knowledge within the HSE, to build sustainable training systems and to develop internal expertise so that the Nurture Programme could be further developed and sustained within the HSE. In accordance with the Nurture Programme's principles, all training was based on current evidence and focused on helping staff to work collaboratively with parents and care-givers in order to honour their expertise.

A specific Programme objectives relating to the Child Safety Awareness Programme, infant mental health and implementation of the HSE Revised Breastfeeding Action Plan were advanced primarily through the development and rollout of specific training modules as part of the training programme. For example:

- In addition to training that focused specifically on infant mental health (IMH), principles of IMH and key messages are included throughout the content of all training.

- Two online breastfeeding training modules were produced, launching for Breastfeeding Week 2018. This work was done alongside the revisions of the guide: 'Breastfeeding - A Good Start in Life'. The development of the eLearning modules supports the implementation of the HSE Breastfeeding Action Plan, specifically the provision of training in the use of the Breastfeeding Observation and Assessment Tool. A skills-based training is also in development.

- Child safety resources and training have been reviewed and updated to include emerging safety issues, such as vaping and use of hair straighteners, to ensure relevance to parents in Ireland today. A comprehensive manual with checklist was also reviewed and updated.

Implementation Team members had the task of comprehensively reviewing child health service components and analysing each subject within a competency matrix of generalist, specialist and awareness requirements. Levels of knowledge and technical skills were found to vary across topics for each of the target practitioner groups. This informed the level and approach of training that was to be developed. The team also developed a rollout plan that was mindful of the challenges involved in engaging a busy child health workforce in a programme of ongoing training and development.

The team and other stakeholders prioritised the integration of the training outputs into the core curriculum for postgraduate training of Public Health Nurses. Following engagement with the three postgraduate training programmes, delivery of the core training content to student Public Health Nurses has commenced with the current cohort and the new supporting materials and resources will be provided to the Programme Directors.

Another significant challenge was launching a suite of online training to a workforce that has historically engaged in face-to-face training in a classroom setting. This challenge was partly addressed by provision of a short e-learning access guide, the development of hard copy practice reference resources and the close alignment of online and classroom-based training. Over the three years, the Training and Resources Implementation Team launched a series of face-to-face and online training modules for the child health workforce. These are intended to be supported by workplace-based coaching and/or mentoring. These are listed in the table below, along with the training hours, format and number of attendees for each training as of September 2019.

FIGURE 14: NUMBER OF ATTENDEES, TRAINING HOURS, FORMAT AND INTENDED AUDIENCE, BY TRAINING

Training available in September 2019	Training Hours	Format	Number of Attendees to date	Intended audience
Schedule of Growing Skills II Training for Community Medical Doctors	0.5 day	Face-to-face	103	CMD
ASQ-3™ tool © 'Train the Trainer' training	1 day	Face-to-face	174	PHNs & CMDs
Assessment and Management of Behavioural Sleep Difficulties in Infants and Children	1 day	Face-to-face	1142	PHNs
Community Paediatric Certificate for Community Medical Doctors, Module 1: Growth Monitoring	1 day	Face-to-face	165	CMDs
Community Paediatric Certificate for Community Medical Doctors, Module 2: Physical examination	1.5 days	Face-to-face	104	CMDs
Community Paediatric Certificate for Community Medical Doctors, Module 3: Child Development	2 days	Face-to-face	101	CMDs
ASQ-3™ tool © eLearning Module	1 hour	Online	1068	PHNs & CMDs
Breastfeeding eLearning Module Unit 1- Supporting Breastfeeding	1 hour	Online	1332	PHNs, Midwives, CMDs, Practice Nurses, all allied health professionals, GPs, Medical professionals in Paediatric and obstetrics, lactation consultants, Neonatal Nurses
Breastfeeding eLearning Module Unit 2 – Breastfeeding Challenges	1 hour	Online	1243	PHNs, Midwives, CMDs, Practice Nurses, all allied health professionals, GPs, Medical professionals in Paediatric and obstetrics, lactation consultants, Neonatal nurses
Child Safety Programme Unit 1 - Child Safety Inside and Outside the Home	30 minutes	Online	1159	PHNs & CMDs, Practice Nurses, Paediatric Nurses (including A&E)
Child Safety Programme Unit 2 - Child Safety in the Farm, in the Clinic and in the Community	30 minutes	Online	799	PHNs & CMDs Practice Nurses, Paediatric Nurses (including A&E)
Growth Monitoring	1 hour	Online	190	PHNs, Midwives, CMDs, Practice Nurses, dietitians, GPs, Medical professionals in Paediatric
Newborn Bloodspot Screening	30 minutes	Online	1348	PHNs & Midwives, Neonatal Nurses, Paediatric Nurses
Nutrition: Preconception and Pregnancy Nutrition	30 minutes	Online	26	PHNs, Midwives, CMDs, Practice Nurses, all allied health professionals, GPs, Medical professionals in Paediatric and obstetrics
Nutrition: Introducing Family Foods	30 minutes	Online	43	PHNs, CMDs, Practice Nurses, GPs, dietitians, Speech and Language Therapists
Nutrition: Feeding Related Challenges in babies 0 - 12months	30 minutes	Online	53	PHNs, Midwives, CMDs, Practice Nurses, all allied health professionals, GPs, Medical professionals in Paediatrics
Nutrition: Formula Feeding	30 minutes	Online	68	PHNs, CMDs, Practice Nurses, GPs, dietitians, Medical professionals in Paediatrics, Midwives
Nutrition: Recognising & Managing Food Allergy in the Community	1 hour	Online	60	PHNs, CMDs, Practice Nurses, GPs, dietitians, Medical professionals in Paediatrics

In addition to the training that has been launched, a suite of face-to-face training and eLearning modules is also in development to launch before the end of the Programme. This is outlined in the following table.

FIGURE 15: FACE-TO-FACE TRAINING AND ONLINE MODULES CURRENTLY IN DEVELOPMENT

Training in Development as of September 2019	Training Hours	Format	Intended audience
Undertaking the 72 Hour Child Health Assessment	1 hour	Online	PHNs & CMDs
Undertaking the 3 Month Child Health Assessment	1 hour	Online	PHNs & CMDs
Undertaking the 9 - 11 Month Child Health Assessment	1 hour	Online	PHNs & CMDs
Undertaking the 21-24 / 46 – 48 Month Child Health Assessment	1 hour	Online	PHNs & CMDs
Breastfeeding Skills Training	1.5 days	Face-to-face	PHNs, Midwives, CMDs, Practice Nurses, all allied health professionals, GPs, Medical professionals in Paediatric and obstetrics, lactation consultants, Neonatal nurses
Nutrition: Healthy Start for Toddlers	30 minutes	Online	PHNs, CMDs, Practice Nurses, all allied health professionals, GPs, Paediatricians
Nutrition: Healthy Weight for Children	30 minutes	Online	PHNs, CMDs, Practice Nurses, all allied health professionals, GPs, Paediatricians
Infant Mental Health Unit 1 - General Awareness Promoting Infant Mental Health	1 hour	Online	PHNs, Midwives, CMDs, Practice Nurses, all allied health professionals, GPs, Medical professionals in Paediatric and obstetrics
Infant Mental Health Unit 2 - Supporting the First Relationship	1 hour	Online	PHNs, Midwives, CMDs, Practice Nurses, all allied health professionals, GPs, Medical professionals in Paediatric and obstetrics
Infant Mental Health Unit 3 - Establishing Milestones in the First Relationship	1 hour	Online	PHNs, Midwives, CMDs, Practice Nurses, all allied health professionals, GPs, Medical professionals in Paediatric and obstetrics
Toilet Training and Enuresis	1 hour	Online	PHNs & CMDs
Working in Partnership with Parents	1 hour	Online	PHNs, Midwives, CMDs, Practice Nurses, all allied health professionals, GPs, Medical professionals in Paediatric and obstetrics
Community Paediatric Certificate for Community Medical Doctors, Module 4: Emotional / Behavioural -Assessment and Management Strategies	1.5 days	Face-to-face	CMDs
Child Developmental Practical Assessment Skills Training for Public Health Nurses	1 day	Face-to-face	PHNs
Antenatal Education – Transitioning to Parenthood Training Programme	3 days	Face-to-face	Midwives & PHNS
Infant Mental Health Skills Training	1 day	Face-to-face	PHNs, CMDs, Midwives and Practice Nurses
Coaching and Mentoring Skills	1 day	Face-to-face	ADPHNs in Child Health

In 2018, an independent process evaluation was undertaken of the training roll-out to date, which found the following:

Benefits of Training

Frontline child health professionals are eager to gain new skills. Most participants enjoyed the learning experience and found the material relevant and practical. Staff considered training programmes a welcome investment in the workforce by staff and an initiative that had the potential to improve the consistency and quality of interventions with parents, provided implementation in practice was continually supported. There was a high level of clarity on the learning outcomes and how these should be applied to practice. The majority of respondents saw investment in training and professional development as also having a positive effect on staff morale.

Challenges Experienced

Where training attendees had a previous experience with the tool or subject area, more generic training was found to be insufficient by some, while not advanced enough by others. Participants appreciated learning from trainers who had similar qualifications and personal experience with the topic of the training, especially within the Irish healthcare context. Conversely, when trainers did not have a good match to participant experience, either a specific discipline approach or the Irish context, they felt it detracted from the quality of learning. Some participants noted that they attended a training course and were either not able to use the learning in practice or they were locally requested to not undertake the practice changes (use of ASQ-3 tool) until a later date, which was considered a barrier to maintaining skills[21]. The challenge of adding new work to an already busy staff workload was listed by most participants as a difficult barrier to incorporating new learning and tools into daily practice.

Online Training

Public Health Nurses and Community Medical Doctors were largely in favour of offering future training in an online format. However, interviewees stated that challenges of connectivity and computer literacy must be further addressed in order to reach the full workforce. Interviewees identified two main drawbacks of learning online, as opposed to face-to-face training: the challenge of getting questions answered, and a loss of interaction with and the opportunity to learn from peers.

The recommendations were developed based on stakeholder feedback and with input from the key programme partners.

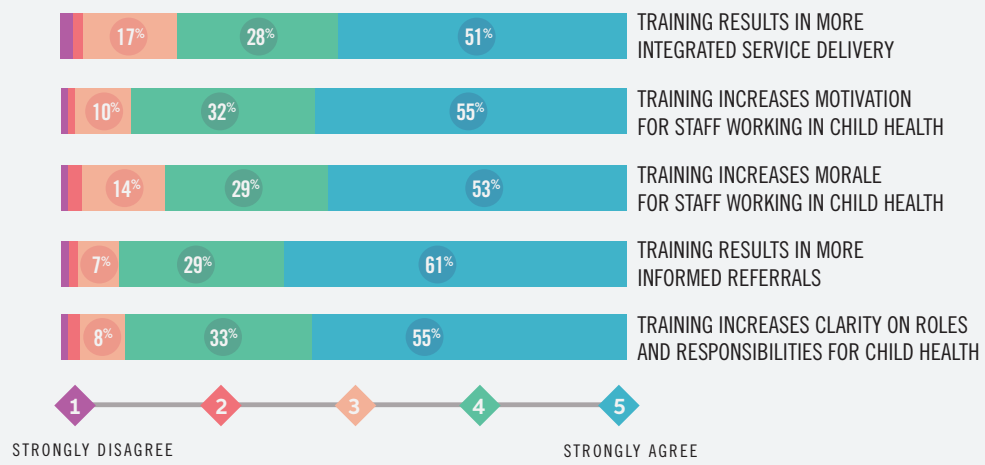
Outcomes

The response from Public Health Nurse survey participants is unambiguous regarding the positive effect that increased access to training had on child health services. Public Health Nurses viewed the training as resulting in more integrated service delivery (79% agreed), as increasing motivation for staff working in child health (87% agree) and as increasing morale for staff working in child health (82% agree). According to respondents, training resulted in more informed referrals (90% agree) and increased clarity on roles and responsibilities for child health (88% agree). The fact that more than half of respondents strongly agreed to these points indicates a high level of conviction behind the answers:

> **It brings a consistency to the way that staff engage with families… Nationally, that ensures that the quality standards are understood by all. This approach means we can be assured that all staff in this field have the requisite training and standards are consistent within teams.**
>
> STAKEHOLDER INTERVIEW 34

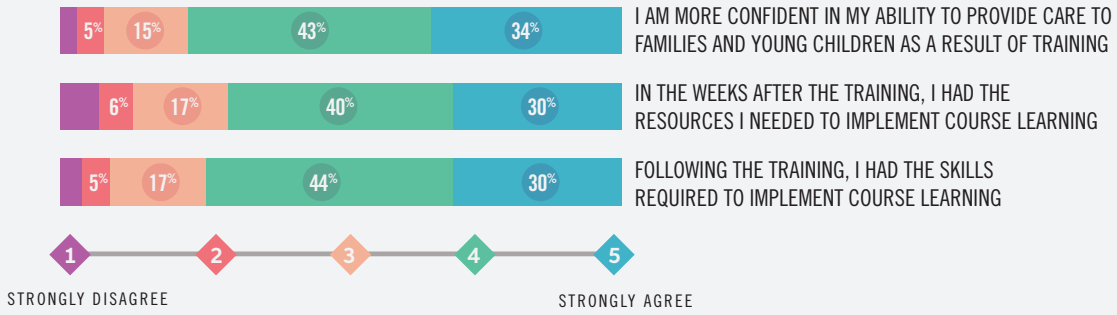
21 Delays were caused by a variety of factors, some of which had to do with local health areas wishing to have a coordinated rollout or having competing demands that slowed implementation, some of which were related to national industrial relations negotiations.

FIGURE 16: PUBLIC HEALTH NURSE PERCEPTIONS OF THE IMPACT OF TRAINING ON THE CHILD HEALTH WORKFORCE OVERALL (N=232)



Public Health Nurses also felt positively about the training's effect on their confidence and skills to provide care to families and young children: 77% of respondents felt more confident and 74% of respondents said they felt they had the skills required to implement course learning. They also felt that they had the resources needed to implement course learning (70%).

FIGURE 17: PUBLIC HEALTH NURSE RESOURCES AND SKILLS NEEDED TO IMPLEMENT COURSE LEARNING OVERALL (N=232)

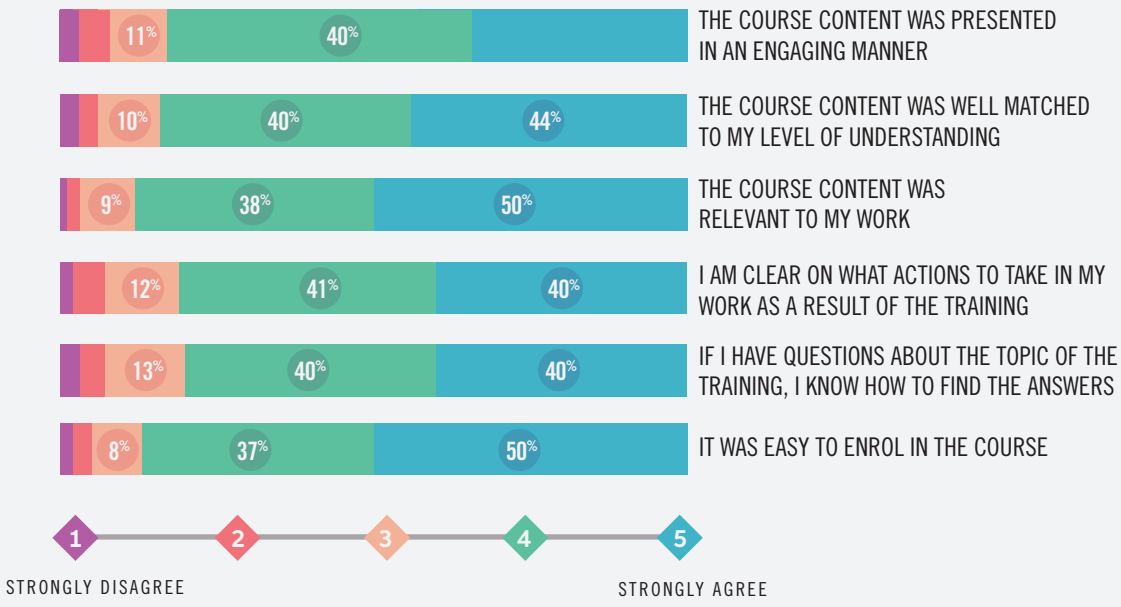


> [The training] was excellent. I felt a lot more equipped after leaving there. The last time I had an update on child health development was about 10 years ago. Afterwards, I felt more confident going out and doing the assessments again.
>
> PHN INTERVIEW 14

When asked to assess the training they attended[22], Public Health Nurse survey respondents delivered a similarly clear and positive message: the training is presented in an accessible and engaging manner (83% agree); they are well matched to their level of understanding (88% agree); they are relevant to their work (88% agree); they are clear on what actions to take as a result of the training (81% agree); if they have questions, they know where to find answers (80% agree) and they found it easy to enrol in the training (87% agree).

22 Both face-to-face and online training were represented in the survey.

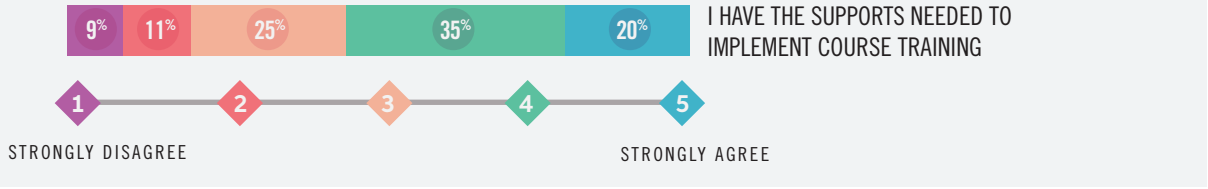
FIGURE 18: PUBLIC HEALTH NURSE RATINGS OF TRAINING COURSES (N=232)



However, qualitative and quantitative research with Public Health Nurses, Assistant Director Public Health Nurses and Community Medical Doctors reveals another clear message: the child health workforce (specifically Public Health Nurses and Community Medical Doctors) is stretched to its limits. Interviewees noted that the workforce has not had regular access to training and development for many years. Staff were enthusiastic about the training, but if they are to consistently implement new learning and tools, they need additional time to do so.

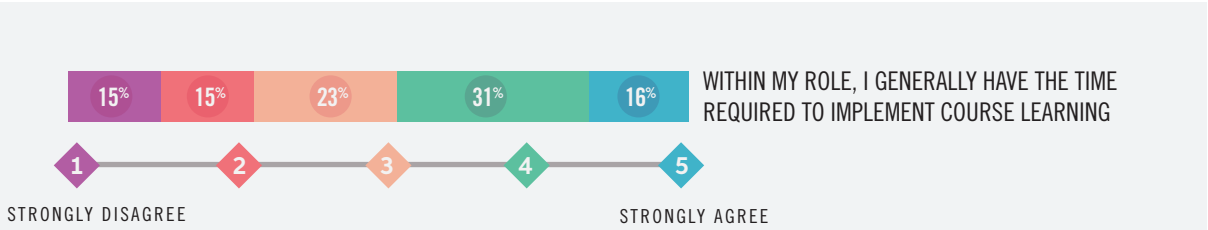
When respondents in the Public Health Nurse survey were asked if they had the time necessary to implement course learning and the supports to do so, rankings were lower than in other areas. Overall, 55% agreed that they had the supports necessary to implement course learning. The rankings for the child safety modules are higher, with 76% having the supports needed.

FIGURE 19: PUBLIC HEALTH NURSE PERCEPTIONS OF AVAILABILITY OF SUPPORTS TO IMPLEMENT LEARNING OVERALL (N=232)



When asked if they had the time necessary to implement course learning, rankings were similarly low, with just 47% overall agreeing that they had sufficient time.

FIGURE 20: PUBLIC HEALTH NURSE PERCEPTIONS OF AVAILABILITY OF TIME TO IMPLEMENT LEARNING OVERALL (N=232)



While participants gave the Sleep Difficulties training some of the highest levels of approval, qualitative answers from the survey reveal that many respondents have concerns about the amount of time it takes for practitioners to adequately complete sleep assessments and the lack of local specialist services to address needs when they are identified:

> **If sleep is an issue, it can be discussed, but something else in the assessment will not be discussed due to time constraints. It isn't feasible to bring clients back at present to discuss or develop a comprehensive care plan as there is no capacity in the caseload to do this. It's very beneficial to have the information and education but I think a second-tier clinic for sleep issues should be developed.**
>
> QUALITATIVE RESPONSE, PHN SURVEY

In qualitative questions in the Public Health Nurse survey, respondents identified the key reasons for the time pressures felt by their profession. These included the Public Health Nurses' 'cradle to grave' remit, large caseloads and unfilled positions or leave cover. These challenges resulted in practitioners feeling that they did not have time to implement the learning from the training (mentioned by 54% of respondents) or did not have time to attend training (mentioned by 16%).

Public Health Nurse survey participants reinforced earlier research in recommending that practitioners have greater access to additional training opportunities and refreshers that include opportunities for practical application of content. In addition to this, it was recommended that caseloads be limited, posts be adequately staffed and that the HSE create a child health specialist role for Public Health Nurses.[23]

Overall, the child health workforce is enthusiastic and appreciates the availability of new training that has been developed to meet their practice needs. They feel they benefit from the opportunity to refresh their professional knowledge and up-skill. Importantly, there is majority agreement that children and families will benefit from experiencing more standardised and informed health services. However, concerns remain for both Public Health Nurses and Community Medical Doctors about the ability of the workforce to incorporate new tools into their already stretched practice.

23 Both *The Sláintecare Report* and First 5 recommend a move to a dedicated child health workforce with child and family public health nurses, similar to the Health Visitor model in the United Kingdom.

17 National Standardised Child Health Record

Overview

The original aim for this part of the Nurture Programme's work was to 'review, align and implement parent-held records', as some parts of the country already had parent-held records and the Programme hoped they could be merged and rolled out nationally. Further scoping identified the need to standardise the professional record in the first instance, as the multitude of different records systems affected the consistency of service provision. This also effected data, both in terms of what was collected and how it was collected. This variation meant that data collected to inform KPIs for child health was not as accurate as it could be. By standardising the record in a manner that could be linked with maternity and GP services, the tracking of children's data and histories could be improved. The logic model of the Programme (Appendix H) predicted that this should lead to more consistent and informed interactions with healthcare professionals, therefore ensuring better continuity of care.

National efforts to develop electronic health records for the whole population has progressed slowly in parallel with the work of the Nurture Programme, reflecting the complexity and interdepartmental nature of technological change. Responding to this, the Nurture Programme concentrated on the implementation of a paper-based standardised national child health record for use by Public Health Nurses and Community Medical Doctors. This was designed to easily transition into an electronic health record system in the future and to facilitate parent access, when available. By creating a more efficient national system and define a common data set, the child health record will facilitate the standardisation of data collection and lay foundations for further electronic record development. Ultimately, the standardisation of the child health record will contribute to a long-term aim for parents to have access to their child's health record. This deliverable was led by the Standardised Records for Parents and Professionals Implementation Team in close consultation with the HSE Information Technology department.

Findings in this section are informed by semi-structured stakeholder interviews and the group interview with Assistant Director Public Health Nurses.

Process and Product

To support the development of the draft record, the Implementation Team commissioned research to assess existing child health records around the country. From this, the external research agency combined the common and important elements of existing local records to develop a draft national record. To ensure that all regions of the country have adequate information about and input into the process of developing the record, the Nurture Programme also engaged practitioners and key stakeholders in a variety of ways. For example, in 2019 Directors of Public Health Nursing were each asked to nominate a representative from their area to attend one of three usability workshops. In total, 26 Local Healthcare Organisations (LHOs) were represented at these meetings.

Special attention was given to those areas already using the Personal Health Record (PHR), as it was a priority to appropriately align the records and streamline the process for staff in order to protect the availability of the PHR while standardising the professional child health record. An additional workshop was conducted with the PHR areas, which included members from the PHR forum and Public Health Nurses from areas currently using the PHR. There is a commitment to ongoing engagement with the PHR forum as the record progresses. Together, these activities ensure a comprehensive final record aligned with other concurrent activities and understood and accepted by practitioners around the country.

The consultation with practitioners was an important feature of the process, without which eventual rollout of the tool would be difficult. Key stakeholders shared that involving end users throughout the process helped to avoid resistance from practitioners and created a common record that combined the best from all existing systems. This engagement was important because many local areas had invested significant time in developing their own independent records. Gaining agreement to change to a common system required winning hearts and minds.

To aid the national implementation of the new standardised child health record, the Nurture Programme developed a guidance document for the record, a new Public Health Nurse Practice Manual, a series of eLearning modules and skills-based training module. These resources aim to encourage consistent application and use of the record nationwide.

Outcomes

Overall, key stakeholders felt strongly that the standardised child health record would have a positive benefit on children, families and healthcare practitioners in Ireland. While it is too early to measure impact, the anticipated benefits as reported by key stakeholders ranged from improving the quality and consistency of care, to ensuring that the more transient populations receive more specific continuous and informed care, to laying foundations for a national unified electronic health record that is accessible to parents.

> **It was a huge need, as each area was using different records. Medical staff were having to work with many different forms, and the information on these was not commonly agreed, so nurses would have to chase up information they needed when they got new forms from other areas and this wasted their time. Saving time improves the system. Now everyone will be doing evidenced-based assessments, the things that are nationally considered good practice. Every child is getting the same evidence-based service. That's a significant win.**
>
> STAKEHOLDER INTERVIEW 50

Stakeholder interviews highlighted the potential that standardisation of child health records could have: they are not only important because they could standardise interactions with healthcare professionals, but also because they could allow for the collection of standard child health data. Stakeholder interviewees also pointed to the important role that the health record could have on the development of a national electronic patient record. This is a development which is viewed as a future priority by staff who participated in group workshops as part of the evaluation.

Interviews with the Assistant Directors of Public Health Nursing group revealed significant support for this work. Participants believed that the standardised record is an excellent foundation for standardisation of practice and care. However, they cautioned that the implementation process may work best if it is approached in a phased manner. This follows quality improvement methodologies and would allow for learning and adaptation.

The record has not yet been launched. At the time of writing, the design, layout and content of the record have been finalised and the Office of Government Procurement has issued the tender for printing.

18 Standardised Developmental Screening Tool

Overview

Part of achieving the goal of offering standardised, evidence-based care to all young children in Ireland was the introduction of a national standardised developmental screening tool. Following a review of available screening tolls, The National Healthy Childhood Programme identified The Ages and Stages Questionnaire – Third Edition (ASQ-3™) as the most relevant, reliable and appropriate tool to be used in child health monitoring by Public Health Nurses and Community Medical Doctors.

The ASQ-3 is an internationally recognised tool which helps practitioners screen and assess the development of young children. Keeping with the philosophy of the Nurture Programme, the ASQ-3 is a parent-led tool which will be used at the 21-24 months developmental assessment. This means that parents complete the questionnaire at home with their children and then bring it to the Public Health Nurse developmental appointment for discussion. The results of the ASQ-3 assessment enables practitioners to systematically determine when children need referral for additional assessment or treatment for developmental delays. Prior to the launch of the Nurture Programme, the ASQ-3 was introduced and evaluated in two HSE areas (Longford and Westmeath in 2007; Donegal, Sligo and Leitrim in 2011). It is currently in use in eight areas. Some areas are using the tool at a universal level with all children, while others are using it in a more targeted way (e.g. when the Public Health Nurse has a concern about a child's development). Once fully launched, this tool will inform the work of all Public Health Nurses who work with young children. It also has the potential to form a valuable national dataset regarding the development and wellbeing of young children in Ireland.

Findings in this section are informed by the national survey of Public Health Nurses and semi-structured interviews with Public Health Nurses and Community Medical Doctors.

Process and Product

The Standardised Records for Parents and Professionals Implementation Team convened an ASQ-3 Implementation subgroup to lead the planning for and implementation of the ASQ-3, chaired by the HSE Project Manager for Child Health Screening Programmes. An implementation plan was developed to manage this substantial change to practice. Included in this plan were the following:

- Consultation with staff already using the ASQ-3 to identify implementation learning
- The creation and launch of an eLearning module on 'How to use the ASQ-3'
- The provision of five accredited 'Train the Trainer[24]' education days
- The development of a national Policies, Procedures, Protocols and Guidelines (PPPG) to inform and guide all staff who will use the ASQ-3 about the requisite steps to be followed when using it in practice
- The provision of a set of resources for each Public Health Nurse and Community Medical Doctor providing developmental assessments

The team launched these implementation supports and was in the process of the testing phase of the implementation plan when concerns were raised in relation to perceived of change to practice for the Public Health Nurse workforce. In early 2019, practitioners paused the implementation of the ASQ-3 tool until these issues could be resolved. As this is a voluntary pause, some regions have moved forward with implementing the tool in practice and others have not. Stakeholder interviews noted that this process highlighted the importance of proactive early and frequent engagement with staff representative organisations in quality improvement initiatives. Several interviewees expressed disappointment or frustration that the huge potential of the ASQ-3 is not currently being realised. Discussions between the HSE and the INMO to resolve staff concerns are in progress as of writing.

Despite the pause in the national roll-out of the ASQ-3, progress continues to be made toward implementing the tool and learning from practitioners' experiences with it. As of September 2019, 1,027 practitioners have completed the one-hour online ASQ-3 eLearning Module, and 176 have completed the five-hour face-to-face Train the Trainer training.

24 Assistant Director Public Health Nurses and Public Health Nurse nominees were trained to share the formal training with colleagues at the LHO level. Community Medical Doctors attended, as they may receive referrals as a part of the multidisciplinary child health team.

Outcomes

Similar to the assessments of all training programmes, practitioners who took part in the evaluation ranked ASQ-3 training very highly in terms of the match of content to their level of knowledge (eLearning: 77% agree, Train the Trainer: 88% agree), relevance to their work (eLearning: 85% agree, Train the Trainer: 92% agree) and clarity on what actions to take as a result of the course (eLearning: 71% agree, Train the Trainer: 80% agree).

In addition to appreciating the content, Public Health Nurses felt more confident to provide care to families and young children as a result of the training (eLearning: 65% agree, Train the Trainer: 73% agree). They largely felt that they had the skills (eLearning: 65% agree; Train the Trainer: 65% agree) and the resources (eLearning: 57% agree; Train the trainer: 65% agree) necessary to implement course learning. However, when asked if they have the time and supports needed to implement course learning, practitioners expressed greater reservations, with nearly one-third disagreeing for each measure and a great level of variation among responses. The wide variation may indicate the differing experiences across regions. While some have been using the ASQ-3 for a while, others have paused implementation.

While respondents recognised the transformative effect that the ASQ-3 could have on practice, interviews with those who will be actually using this tool with families (Public Health Nurses and Community Medical Doctors) expressed serious concerns about their ability to incorporate it into practice because of understaffing, Public Health Nurses' high caseloads with a 'cradle to grave' remit, and the additional time that would need to be spent on administrative tasks. Those who were more experienced in the use of ASQ-3 suggested that while the child outcomes may be better, the interventions can require more time as practitioners become familiar with the tool. However, they also noted that as they became more familiar with the tool, the assessments were more efficient and professional, including for children with more complex challenges. The concern around the additional time needed to become familiar with the tool was also raised in the Assistant Director Public Health Nurse workshop, as was a lack of clear and consistent referral and treatment pathways for families with children who need additional support.

FIGURE 21: I HAVE THE TIME REQUIRED TO IMPLEMENT COURSE LEARNING (ELEARNING N=137; TRAIN THE TRAINER N=25)

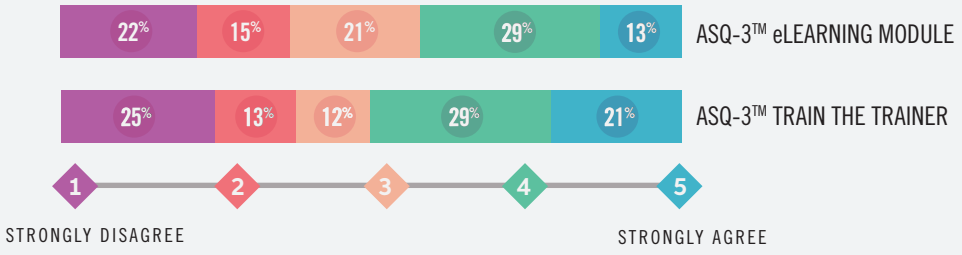
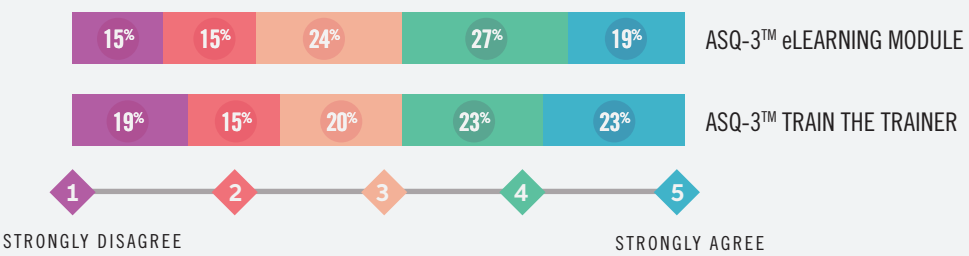


FIGURE 22: I HAVE THE SUPPORTS NEEDED TO IMPLEMENT COURSE LEARNING (ELEARNING N=137; TRAIN THE TRAINER N=25)



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Practitioners who had administrative support felt that it was more manageable to incorporate the ASQ-3 into practice than those with no support. However, many interviewees reported that if they do not have any administrative support, any new administrative work would fall to them, in addition to their clinical work. While practitioners were enthusiastic about the potential for standardising practice with new tools, the comment was also frequently made that a lack of administrative help may significantly hinder implementation and result in resistance to changing current practice.

At the time of the PHN survey, 37% of those who had completed either the online course or the train the trainer course had also implemented ASQ-3 in their area. Nearly two thirds (63%) of those who had completed training had not yet implemented the tool in practice. Unfortunately, this means that the practitioners who have been trained but not yet implemented the tool will need to be retrained when agreement on the rollout of the tool is achieved.

19 Summary

In five years, the Nurture Programme has succeeded in creating a variety of new tools and resources for both parents and child health practitioners. The changes that stem from these developments will affect all parts of the health service in its work with families though pregnancy to early childhood. In the final phase of the Programme in late 2019 into 2020, many of the deliverables in final draft phase will be launched and national implementation will commence.

The next section looks at the ways in which the Nurture Programme has effected change in the health service system in Ireland.

Part Four: Systems Change

20 Introduction

The Nurture Programme was designed to significantly improve child health and wellbeing services in Ireland. A variety of tools and resources were created for parents and the child health workforce, as outlined in the previous section. In order to maintain the changes to the system into the future and after the funding from Atlantic has concluded, Nurture Programme partners have identified a series of systems changes objectives that would help to ensure these developments become mainstreamed and embedded within the wider HSE system.

Creating sustainable change to large and complex systems (like the HSE) requires, among other things, clarity of vision, a willingness to adjust plans based on the reality in which they are being implemented. Due to the great deal of variability found in health service change projects, there are no generally agreed-upon guidelines on the timeframes for systems change. However, the literature does observe that systems change efforts should be tailored to the context in which they take place (Braithwaite 2018). The literature also acknowledges the that large-scale change takes considerable time and that accepting uncertainty is necessary (McKinsey and Company 2019; Britnell 2015; Nolte 2018; Kreger et al. 2007; Braithwaite 2018). This is particularly the case for projects such as the Nurture Programme, which seek to change behaviour and culture and employ a continuous learning model that allows for the adaptation of plans as the work progresses (Fillingham et al. 2016; Clay-Williams et al. 2014; Byrnes 2006). The success of such initiatives depends on the wider system and contextual factors that shape the pressures and incentives in the environment in which stakeholders operate (May 2016; Britnell 2015; Nolte 2018).

This part of the report seeks to describe the key actions undertaken to meet the short-term systems change objectives of the Programme, as defined by the Programme's logic model (see appendix). These were:

- Greater knowledge and understanding of current service delivery innovation
- Improved internal and external communication within and outside of the HSE
- Improved data systems for informing policy, planning and service delivery
- Improved systems for updating and reviewing public health information
- Greater integration on planning of child health services across policy agenda
- Greater knowledge on evidence base for child health service
- Earlier identification of child and maternal health and wellbeing needs
- Sustainability of improvements in child health (addressed in Part Four of the report).

21 Knowledge and Understanding of Service Delivery Innovation

Overview

The Nurture Programme sought to bring innovation to the HSE in relation to both its processes and products. This section of the report outlines stakeholder perceptions of whether the innovation goals were met. It also reviews whether the Programme was successful in spreading an understanding of the innovation to Programme staff not working directly with these new innovations. This section is informed by the evaluation's annual stakeholder survey and by semi-structured interviews with key stakeholders.

Outcomes

Innovative Approach and Outputs

Stakeholders felt strongly that the Nurture Programme has taken an innovative approach to improving child health in Ireland. More than three-quarters (76%) of stakeholder survey respondents agreed that this Programme had an innovative approach. When stakeholder interviewees were asked what they found to be innovative about the approach, they most frequently referred to the application of an implementation science approach (e.g. Implementation Plans and Teams, parent and practitioner consultation, focus on sustainability from the start, user testing, focus on evidence). In addition to this methodology, respondents pointed to the innovative approach of having the HSE partner with philanthropy (Atlantic, KHF and CFI) and involve other external partners (CES and Tusla) in the oversight, management and support of the Programme.

The majority (65%) of participants in the stakeholder survey agreed that the outputs of the Programme are innovative. The main products of the Programme were all mentioned as having innovative aspects. The move toward online training, the inclusion of infant mental health, and the creation of the www.mychild.ie website were most commonly noted. While nearly all participants pointed to some level of innovation resulting from the Programme, three specified that they were innovative for the HSE, two suggested that it was more hard work than innovation, and one suggested that the work laid the foundations for further future innovations.

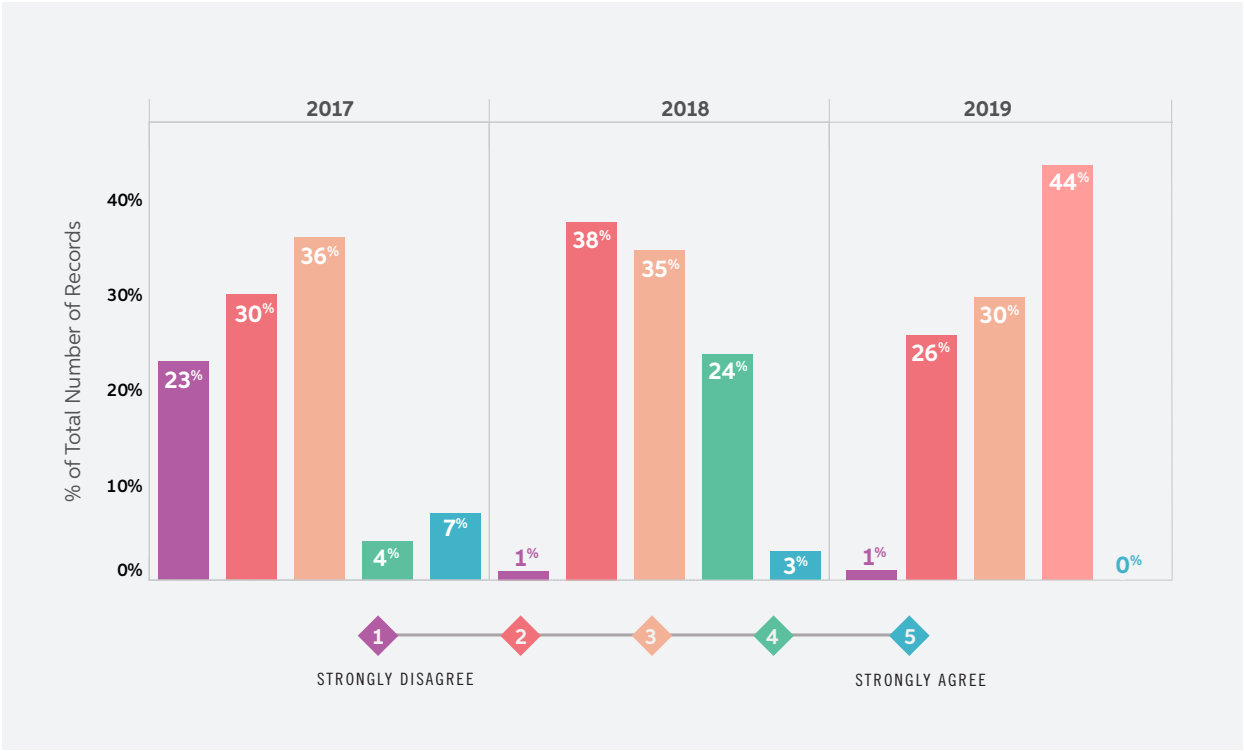
All respondents believed that the Nurture Programme has been a catalyst for change; most indicated that changes would not have happened or would not have happened to the same level or at the same pace without the Nurture Programme.

> **It has built a huge amount of capacity and evidence on the importance of child health being a priority. It has made a difference.**
>
> STAKEHOLDER INTERVIEW 6

Building Knowledge and Understanding of Innovations

Effectively disseminating information on the Programme to those outside the Nurture Programme's Implementation Teams has long been identified as a goal for the Programme. The Programme leadership was aware at the outset of the Programme that communicating with frontline staff across various Divisions and regions would be a challenge. Less than half (44%) of respondents to the stakeholder survey agreed that frontline staff are aware of the work done by the Programme. While this indicates significant room for improvement, the data over time clearly shows that participants' perceptions of these efforts have improved over the course of the Programme.

FIGURE 23: AGREEMENT THAT FRONTLINE STAFF ARE AWARE OF WORK DONE BY THE NURTURE PROGRAMME, BY YEAR

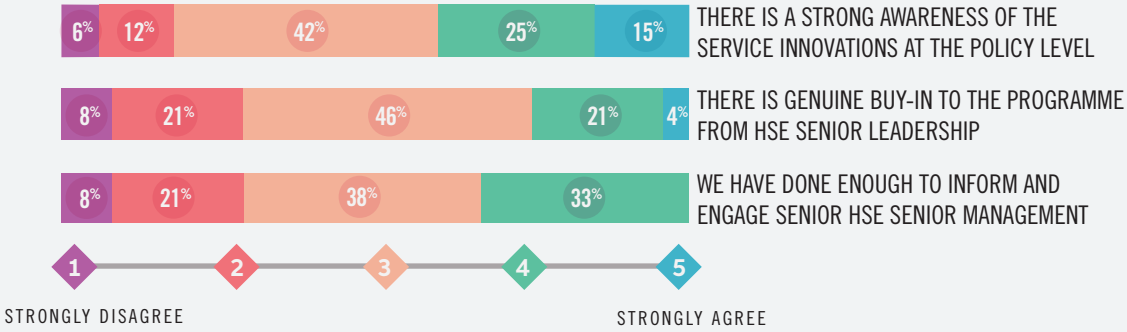


When asked of their level of agreement that the Nurture Programme has done enough to inform and engage frontline staff, stakeholder survey respondents who responded to this question indicated room for improvement. This is seen in 38% of respondents disagreeing that enough has been done and 38% choosing to neither agree nor disagree (three on a five-point scale).

Beyond frontline staff, awareness must be built at different levels within the HSE and outside of the HSE to other agencies that participate in similar or complementary work. Informing and engaging relevant parties at different levels showed some improvement from previous years, but there is plenty of room for continued improvement. Stakeholders were clear, however, that it had been appropriate to focus communications on internal HSE audiences at this stage and that the much of the work developed within the HSE has the potential to be rolled out to a wider audience over time.

To ensure ongoing prioritisation and resourcing of the work plan, the Nurture Programme needed to communicate its vision and importance to senior decision makers in the HSE and elsewhere (e.g. the Department of Health and the Department of Children and Youth Affairs). Overall, key stakeholders indicated that while work has been done to engage and inform HSE leadership, this is an area which needs greater attention in the remaining phase of the Programme and after the conclusion of the Nurture Programme, to mainstream this work. Stakeholder survey respondents were most positive about the strong level of awareness of service innovations at the policy level. For this question, 42% neither agreed nor disagreed and nearly as many respondents (40%) agreed. Respondents were less positive when asked if they agreed that there was genuine buy-in from HSE leadership, with 46% of the respondents choosing neither agree nor disagree and 29% choosing to disagree. When the same respondents were asked if they agreed that the Nurture Programme has done enough to inform and engage HSE senior leadership, rankings again suggest room for improvement, with answers evenly spread among categories: 33% agreed, 29% disagreed and 38% neither agreed nor disagreed.

FIGURE 24: STAKEHOLDER AGREEMENT IN LEVELS OF AWARENESS, BUY-IN AND ENGAGEMENT OF HSE SENIOR MANAGEMENT[25]



While rankings suggest that more work is needed, interviews with stakeholders revealed that this level of awareness is not surprising for this stage of the Programme, given the wider dynamics of healthcare policy in Ireland. Interviewees suggested that those more directly involved in child health are very aware of the Programme because it intersects with their work in clear ways. According to these stakeholders, it makes sense for this segment of the HSE to be most informed, as the HSE is a large and far-reaching organisation with decision makers who have complex briefs.

Stakeholder survey respondents felt relatively neutral in relation to whether the HSE managers understand the impact of the Programme on their area of responsibility, with 46% choosing to neither agree nor disagree (three on five-point scale) and 29% choosing to agree. This represents a slight improvement from 2018, when 50% chose neither agree nor disagree and 25% chose to agree.

Finally, regarding informing and engaging partner agencies in the community, respondents felt somewhat less negative, with 58% neither agreeing nor disagreeing and 25% agreeing that enough work has been done.

Overall, respondents indicated room for improvement in increasing knowledge and understanding of the service delivery innovations of the Nurture Programme. Overcoming the challenge of effectively spreading information about the Programme's work and innovations outside of those directly involved in the Programme has long been identified as a goal for all aspects of the work. However, lower levels of agreement in this section do not mean that work has not progressed over the duration of the Programme. Rather, they are an indication of the overall challenge of spreading information about new resources, training and standards in a complex communications environment.

25 Awareness of service innovations n=30; Buy-in from senior leadership n=25; Done enough to inform and engage n=25.

22 Internal and External Communications

Overview

Any successful systems change project relies on communications. Explaining the initiative, its reasoning and evidence base for change and how changes will affect current practice are all essential to building understanding of and acceptance for change. Key internal audiences for this work are Public Health Nurses, Community Medical Doctors and other health professionals (e.g. speech and language, occupational therapy) within the HSE who interact with child health and wellbeing. Key external audiences are those health professionals who work on child health and wellbeing outside of the HSE (e.g. General Practitioners, Practice Nurses, Department of Health, Tusla). In 2018, as deliverables became available for the workforce to engage with, a wide-ranging communications strategy, informed by implementation science principles, was developed in close collaboration with the HSE Communications Team. The strategy aimed to share consistent messaging about the Programme and child health in as many locations and mediums as possible, both within and outside of the HSE.

The findings in this section are informed by semi-structured interviews with Public Health Nurses, Community Medical Doctors and key stakeholders, group interviews with Assistance Director Public Health Nurses and Child Health Programme Development Officers, the Public Health Nurse survey and the annual stakeholder survey.

Process and Product

The HSE is a challenging environment for staff communications due to the sheer size and disparity of the workforce, the different ways that disciplines engage with information (e.g. some professions use email more often than others), the geographical spread and the quantity of internal communications, combined with large professional workloads. The Nurture Programme communications strategy took a multi-pronged approach to getting messages out. Stakeholder interviews highlighted that the role of a dedicated child health-focused Communications Manager was a key success factor in successful communications. Planning for communications at early stages of the Programme (carried out by the HSE Nurture Programme Lead and Programme Lead for the National Healthy Childhood Programme) was also considered a critical success factor.

> **Communications is not a graft-on after messages have been developed, the communications lens needs to be part of the very early design process.**
>
> STAKEHOLDER INTERVIEW 54

This wide-ranging strategy was designed to reach across staff in the HSE, to service provider partners and the community. Key actions are listed below:

- Facilitation of regular Nurture Programme meetings with key groups such as the Directors of Public Health Nursing, the Assistant Directors of Public Health Nursing Reference Group and the Child Health Programme Development Officers, all of which were charged with sharing information about the Programme with their colleagues.
- Intentional engagement with key constituencies throughout the process of developing tools and resources for future use. These consultations included specific outreach to those practitioners who would be engaging with the products most closely to gain their input and buy-in as well as user testing of resources in development.
- Intentional cross-sector and regional representation in each of the Implementation Teams, with an expectation that all members share information about the Programme with their colleagues. The Programme showed that in order for this method to be optimised, it is beneficial to support information sharing and to be explicit about the expectation that participants share information.
- Public launches of both the Nurture Programme and its high-profile products, www.mychild.ie and the *My Pregnancy* and *My Child* books. The launch of products included a social media and national radio campaign, which is ongoing at the time of writing and will need to continue to firmly establish these resources as go-to sources of information.
- Intentional sharing of updates and progress on all work with all Implementation Teams and with the Nurture Programme Oversight and Steering Groups so all structures within the Programme had an awareness of the progression of work.
- Development and updating of an external Stakeholder Analysis process led by CES at two key points of the Programme.
- Engaging key spokespeople from the Programme to share information and collaborate with different departments and initiatives within the HSE and with related programmes external to the HSE (e.g. Tusla, the Department of Health, DYCA, etc.).

- Working through networks and partner agency membership organisations so multiple voices were sharing the same core messages (e.g. Royal College of Physician of Ireland Faculty of Public Health Medicine, Children's Rights Alliance, Prevention and Early Intervention Network).
- Workshops and presentations with key target groups and health disciplines, e.g. the Paediatric Expert Group, Speech and Language Therapy, Occupational Therapy, Community Medical Doctors, Dieticians, practice nurses, Healthy Ireland LCDC meetings, Children and Young People's Services Committees, regional child health meetings, Directors of Midwifery, Public Health Nurse Preceptors, Directors of Public Health Nursing, Institute of Community Health Nursing and Principal Medical Officers.
- The creation of the National Healthy Childhood Programme's biannual newsletter. Six issues have been produced to date and are disseminated electronically to all staff of the HSE.
- Placement of six articles about the Nurture Programme's activities in Health Matters, an HSE magazine distributed to all HSE staff nationally.

The Programme sought to engage with all available communication channels within the HSE through a range of approaches. This process revealed that some disciplines and levels of management within disciplines did not have formal communication processes, which made engagement more challenging. The Assistant Director Public Health Nurse Reference Group was established in 2018 to support the implementation of certain aspects of the Programme and to provide a forum for Assistant Director Public Health Nurses to give feedback and engage with their peers on service issues. This group recommended external facilitation to help establish their internal agenda so the group can be more effective in influencing positive change.

Outcomes

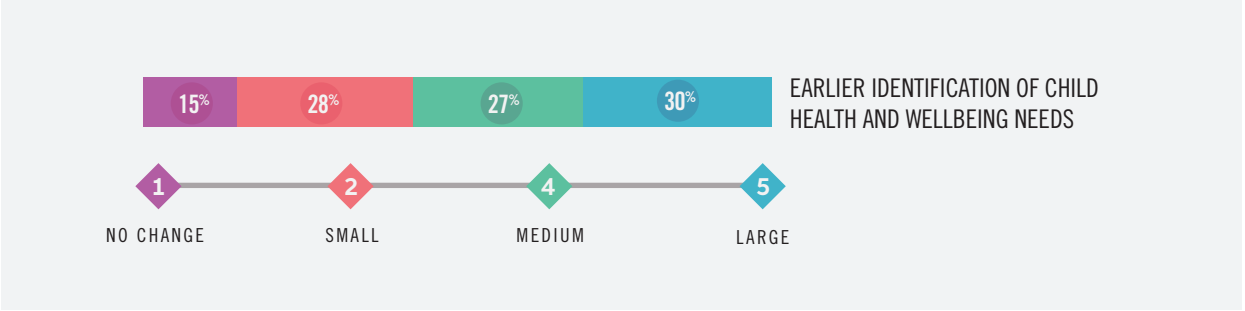
Communications efforts within the Programme were conducted in line with a communications strategy, which identified key messages and key stakeholders at different levels inside and outside of the HSE. This section outlines the outcomes of efforts make frontline and management staff understand the Programme's actions and where they would impact on their work.

Communications *Within* the HSE

As one stakeholder interviewee noted, the HSE is too large and complicated an organisation to have one answer to the question of the effectiveness of programmatic communications. Interviews with stakeholders and interviews with Public Health Nurses, Assistant Director Public Health Nurses, Child Health Programme Development Officers and Community Medical Doctors reinforced the fact that effective communications within the HSE is an organisation-wide challenge.

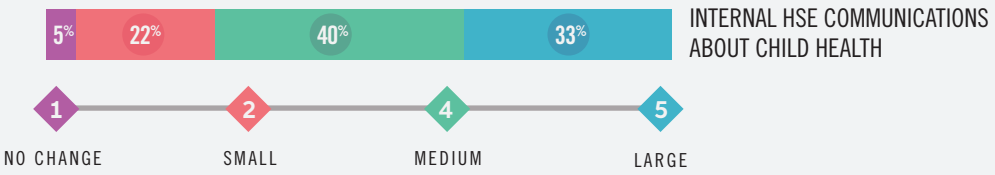
Stakeholders were asked to rank the level of improvement to communications about child health within the HSE as a result of the Nurture Programme on a scale of small, medium, large or none. The results were mixed, with 40% choosing a medium level of improvement and 33% choosing a large level of improvement.

FIGURE 25: LEVEL OF CHANGE TO INTERNAL HSE COMMUNICATIONS ABOUT CHILD HEALTH (N=33)



The respondents of the survey of Public Health Nurses were also mixed in their response to this question. When asked their level of agreement with the statement 'The Nurture Programme has improved internal communication within the HSE,' 57% indicated that they agreed, 22% neither agreed nor disagreed, and 18% disagreed.

FIGURE 26: PUBLIC HEALTH NURSE LEVEL OF AGREEMENT THAT THE NURTURE PROGRAMME HAS IMPROVED INTERNAL COMMUNICATION WITHIN THE HSE (N=232)



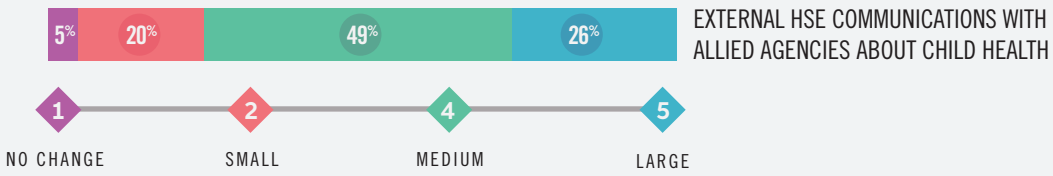
While respondents in both interviews and the online surveys indicated that communications strategies could continue to improve, respondents appreciated the gains made in increasing understanding and awareness of the Programme. For example, the intentional engagement of Assistant Director Public Health Nurses and the recruitment of the nine Child Health Programme Development Officers were considered an indication of commitment to sustainability and a way for the Programme to continue to build understanding and awareness of the tools and resources to come.

> We had a lot of working groups and subgroups working on the data and materials needed for the website, books, training, etc. That improved the level of knowledge and buy-in for the Programme just by the nature of having so many people involved. There is a bit of a cascading effect in communications. This was done well especially with our nursing colleagues disseminating information with their teams.
>
> STAKEHOLDER INTERVIEW 3

Communications and Collaboration *Outside* of the HSE

In the annual survey, stakeholders were also asked to rank the level of improvement to communications outside the HSE on a scale of small, medium, large or none. For this measure, 49% of respondents indicated that the Nurture Programme had improved this measure to a medium extent, while 26% felt that the Programme had improved this measure to a large extent.

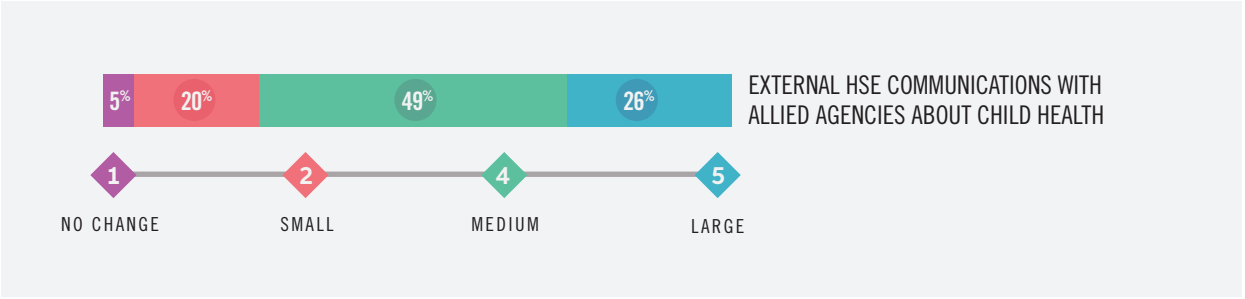
FIGURE 27: STAKEHOLDER RANKINGS OF LEVEL OF CHANGE TO EXTERNAL COMMUNICATIONS ABOUT CHILD HEALTH (N=29)



> It has facilitated conversations with external parties like Tusla, or the Department of Health. But this is not a core element of the work. It really is more focused on internal workstreams.
>
> STAKEHOLDER INTERVIEW 20

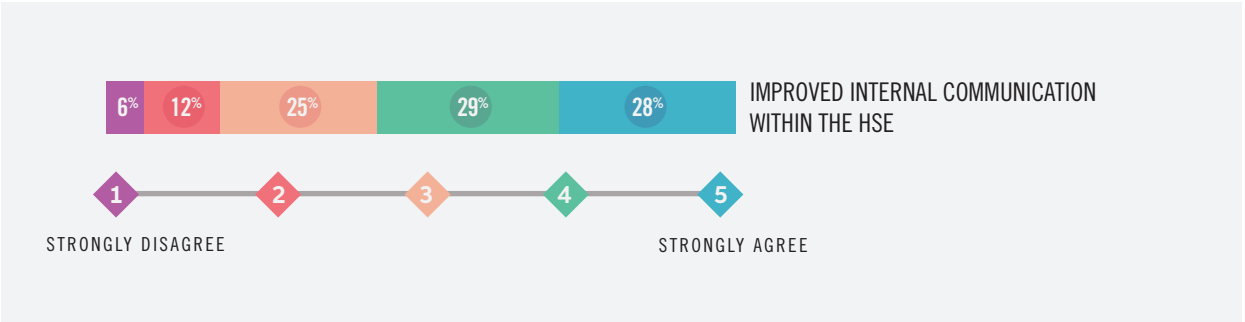
Further questioning confirmed that stakeholders believe more could be done to engage external agencies (e.g. Tusla, Department of Children and Youth Affairs). When asked to rate their level of agreement with the statement 'We have done enough to inform and engage partner agencies in the community,' more than half of stakeholder survey respondents (58%) chose a middle ranking of neither agree nor disagree. This outcome is understandable from the perspective of Programme leaders, who stated that the focus of communications necessarily needed to be on HSE staff for the first few years of the Programme. Once the Programme has adequately engaged core staff it will be more appropriate to share learning and resources outside of the HSE.

FIGURE 28: STAKEHOLDER AGREEMENT THAT ENOUGH HAS BEEN DONE TO INFORM AND ENGAGE PARTNER AGENCIES (N=25)



Interestingly, when stakeholder survey respondents were asked about the effect that Nurture Programme's communications has had on collaboration, they felt more positive. More than half (54%) of the 24 participants who responded to this set of questions agreed that the Programme's approach has increased collaboration among different HSE departments and 58% agreed that the approach has increased collaboration among the HSE and allied agencies. One-quarter of respondents for each of these measures chose to neither agree nor disagree, indicating continued room for improvement.

FIGURE 29: STAKEHOLDER SURVEY RESPONDENTS' LEVELS OF AGREEMENT WITH INCREASES TO COLLABORATION (N=25)



The work of the Nurture Programme to date has positively impacted the internal HSE Public Health Nurse and Community Medical Doctor staff. In the development and planning for the Programme, three other groups were identified as important in their roles in pregnancy and early parenthood: Midwives, General Practitioners and Practice Nurses. The level of engagement with and impact on the work of these key groups in supporting infant health and wellbeing has been limited to date and needs to be addressed in the future through the continuing work of the National Healthy Childhood Programme.

23 Improved Data Systems are Informing Policy, Planning and Service Delivery

Overview

The collection and use of evidence are at the very core of the Nurture Programme. Systems for the collection and use of child health data in the HSE prior to the Programme presented opportunities for improvement. The improvements prioritised in the Nurture Programme included the standardisation of systems and tools to generate patient outcomes and to generate information for the continued advancement of child health. The Programme also created a Research and Data Analyst role within the child health system to ensure that data is collected and used to inform local and national work. This post was created with two-year seed funding under the Nurture Programme with a view to it being established on a permanent basis.

The findings in this section are informed by the annual survey of stakeholders and semi-structured interviews with stakeholders.

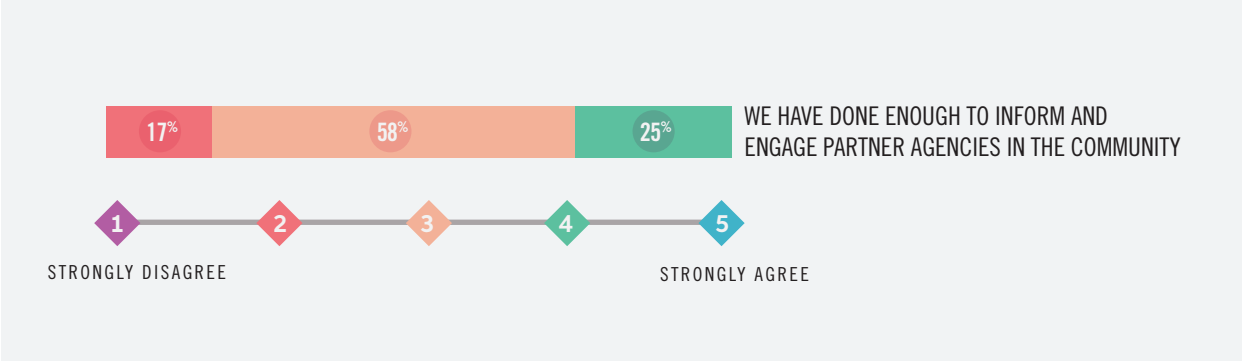
Outcomes

The Nurture Programme's commitment to producing evidence-informed or evidence-based products and messages was widely respected and appreciated by participants and practitioners. Most stakeholder survey respondents (60%) indicated that the they believed that the Nurture Programme has improved the evidence base for the child health workforce to a large extent.

Stakeholders were asked a series of questions related to child health data in the annual survey. When asked the extent to which they thought the Nurture Programme has improved child health data collection, 37% of respondents chose small, 33% chose no change, and 24% chose medium. When asked the extent to which the Nurture Programme has improved the use of child health data, 31% chose medium, 29% chose no change, and 27% chose small.

Interviewees noted that some products will improve collection of data, such as the standardised child health record and the standardised developmental screening tool, have not yet been launched.

FIGURE 30: LEVEL OF CHANGE TO CHILD HEALTH DATA COLLECTION AND USE OF CHILD HEALTH DATA AS A RESULT OF THE NURTURE PROGRAMME[26]



Stakeholder interviews indicated that the Programme's focus on the evidence base behind its work and the addition of the Research and Data Analyst for child health helped to bring data to the forefront of their work. Because of this, data is now presented in a more user-friendly way, which has helped the wider group to have a deeper understanding of the importance of collecting and using data.

26 Child health data collection n=35; Use of child health data n=36.

Data is becoming one of the biggest issues of our time. Data informs policy. The Nurture Programme has brought focus to the early years and brought that forward.

STAKEHOLDER INTERVIEW 35

Four stakeholder interviewees noted that the standardised child health record will have a positive impact on the data collection and availability to decision makers. However, barriers to the universal collection of child-focused data remain. Specifically, the lack of a standardised electronic health record means that data is largely collected by hand in Excel sheets. In addition, child health data may be inconsistent because collection may happen at the same intervals and for the same time periods. Having the Research and Data Analyst in post has helped to unify some different understandings of how to collect data, but not to unify all data collected in the country, especially since child health data is collected from a range of systems including maternity, Public Health Nurse service, allied health professionals, hospitals, other agencies and national registries.

To start to address the data needs of the child health workforce, specific work was conducted to collect and use child health information. The child health Research and Data Analyst and the Child Health Profiles Subgroup (of the National Steering Group for the National Healthy Childhood Programme) worked to develop child health profiles for each of the nine Community Health Offices (CHOs). This important work was accomplished by using recognised methods and indicators (e.g. premature mortality, health protection, wider determinants of health, health improvement and prevention of ill health) and built on the work of the Child Health Profiles Subgroup. The development and circulation of these profiles enabled each Child Health Programme Development Officer to evaluate the current child health population needs at county level and to compare their region's outcomes with national comparators. This data was also used by Child Health Programme Development Officers in their baseline work in establishing Child Health Governance Groups in each of the CHOs.

There is a need to report back to those collecting data about what their data says, People feel it is a tick-box exercise if you don't.

STAKEHOLDER INTERVIEW 12

The Nurture Programme also created new breastfeeding profiles for each CHO area. These reports represent a compilation of data from a variety of sources (e.g. HSE breastfeeding KPIs, the National Perinatal Reporting System and the Mapping Survey undertaken by the HSE Breastfeeding Implementation Group in 2017) that were combined for the first time to provide information about local rates of breastfeeding. The profiles are used by Directors of Public Health Nursing to evaluate the breastfeeding support in their area. The reports are also used by Child Health Programme Development Officers to advocate for breastfeeding supports and by Breastfeeding Committees to assess progress toward goals. Bringing this data together in one accessible report has allowed Public Health Nurses to see for the first time how the data they submit allows them to compare their work with the work of their colleagues in other areas.

It has allowed the presentation of child data in a more usable way; every CHO has their child health profile. Usually people say we submit data and we don't see it. Now, staff submit data on breastfeeding, and they get to see their local rates as compared to others. This was done in 2018 and will be done every two years. People can see if they are improving, that is so important.

STAKEHOLDER INTERVIEW 52

The new data reports were a subject of conversation in the group interview with Child Health Programme Development Officers. They confirmed that receiving data in an accessible format and tailored for their local area has enhanced their work and allowed them to focus more productively on the successes and challenges of their area. They also noted that the production of these reports coincided with them starting in their new roles, which was helpful in positioning them with the local workforce.

Finally, the Nurture Programme designated one Project Support team member as a Data Access Manager for eLearning, who to monitored completion rates for the eLearning units developed through the Nurture Programme. These reports were generated on a quarterly basis and circulated to Child Health Programme Development Officers and others, so those working in key positions could understand local completion rates and discuss them with local child health practitioners, including Assistant Director Public Health Nurses and Directors of Public Health Nursing, as necessary.

24 Improved Systems for Updating and Reviewing Public Health Information

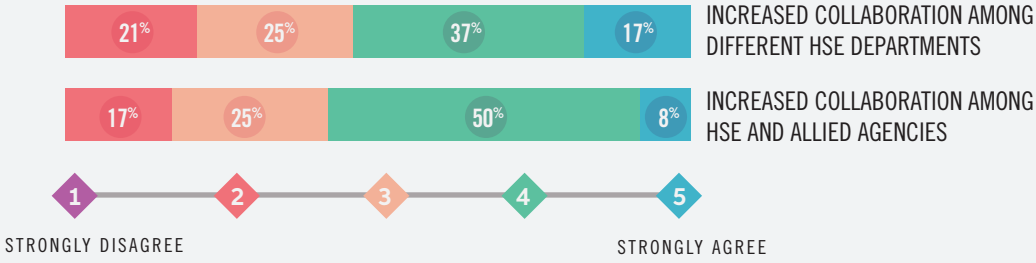
Overview

The Nurture Programme was designed to significantly improve the governance and management of child health information available to the public. Achieving this goal required the establishment of new content development processes. For resource sustainability, new systems were developed so information can be updated and reviewed in a timely manner, therefore maintaining the high quality of these resources as well as the reputation of the HSE. The findings in this section are informed by the 2019 stakeholder survey and semi-structured interviews with stakeholders.

Outcomes

Stakeholders were enthusiastic about the level of change to the development and review of child health information resulting from the Nurture Programme. When asked about the extent to which the Programme has improved how public information on child health is developed, the vast majority saw that a medium or large change had occurred in this area (84%). Similarly, 81% indicated a medium or large improvement to how information on child health is reviewed as a result of the Programme.

FIGURE 31: LEVEL OF CHANGE TO HOW PUBLIC INFORMATION ON CHILD HEALTH IS DEVELOPED AND REVIEWED, AS A RESULT OF THE NURTURE PROGRAMME[27]



In interviews, stakeholders frequently discussed the high-quality systems used for the creation of any tool or resource as a key achievement of the Programme. This included gathering evidence, consulting parents and practitioners, collaboration between communications and subject matter experts, extensive edits of draft written documents and, often, testing of the final draft product with end users before launch.

> **It is a big change in the way that we create content aimed at the public. It would have been written and released previously. Now, we look at all of the people who need to review a piece of information - maybe several experts as well as communications expertise and the importance of design. And the fact checking process on the website is new. The Nurture Programme really has had a big impact on those areas.**
>
> STAKEHOLDER INTERVIEW 14

A large number of key stakeholders considered the changes to the development of information and the guiding governance structures to be a key legacy of the Nurture Programme and something that could operate as a blueprint to improve systems in other areas of the HSE. Interviewees universally agreed that the changes during this time would either not have happened at all or would not have happened at the same level or speed without the Nurture Programme.

27 How public information on child health is developed n= 47; How public information on child health is reviewed n=43.

25 Integration and Planning for Child Health Services

Overview

Increasing the integration of planning for child health services across government departments and service providers is necessary to build a more consistent, effective and efficient system of care for children and families. Strengthening the profile of child health and wellbeing with a greater focus on prevention at the policy and budgetary levels contributes to the sustainability of the Nurture Programme. Connecting policy and planning to resourcing through to national, regional and local service provision is crucial if the goal of standardised, high-quality care is to be achieved and maintained.

The findings in this section are informed by the annual stakeholder survey and semi-structured interviews with stakeholders.

Outcomes

Stakeholder survey respondents were evenly divided in their assessment of how much the Nurture Programme has led to greater integration of planning for child health across agencies. 34% of stakeholder survey respondents indicated a large change, 23% of respondents chose medium, 20% chose small and 23% indicated that they felt there was no change.

Interviews with stakeholders defined integration largely by the diversity of professions working together in the Implementation Teams and subgroups. The new interdisciplinary approach introduced by the Nurture Programme was widely noted by stakeholders as important to the success of the Programme. This was also considered a feature that should be carried forward into other HSE change programmes.

The alignment of the Nurture Programme with the National Healthy Childhood Programme was also viewed as a positive alignment. This combination ensured that the achievements of the Nurture Programme complemented the wider developments in child health and wellbeing in the HSE. The National Healthy Childhood Programme has five child-focused programmes under its umbrella, which include:

- The Nurture Programme,
- Healthy Childhood (a policy priority programme for Healthy Ireland),
- Breastfeeding and the Implementation of the HSE Breastfeeding Action Plan (2016-2021), Child Health Screening
- Healthy Weight for Children (in partnership with Healthy Eating Active Living, also a policy priority for Healthy Ireland).

The Nurture Programme was well positioned to be a key enabler of the other four strands of work in the areas of pregnancy and early childhood through actions such as the development of national assessments and the national training programme, as well as in messaging within resources aimed at staff and parents. Stakeholders viewed the inclusion of child health, the Nurture Programme and the National Healthy Childhood Programme in annual HSE service plans as a clear indication of the improved profile and awareness of child health within the HSE.

Another advancement noted by stakeholders was the inclusion of child health in two key national strategies. This is a notable success because child health had not been included in previous years' key strategies. The Sláintecare Report and First 5: The Whole-of-Government Strategy for Babies, Young Children and Their Families, both included a focus on child health. While stakeholders did not wholly attribute this outcome to the Nurture Programme, the co-ordinated approach that the Nurture Programme took to policy advocacy was considered a main contributor to informing the strategies and therefore a success of the Programme.

KHF took a lead role in the advocacy work and supported the aligned advocacy goals in conjunction with child health focused alliances and stakeholder groups. Collaboration was built up around the preparation of submissions during the various consultation processes. However, as noted in the key learning report[28], the independence of KHF and the relationship it had with various government departments enhanced the policy making process.

28 Delivering Systems Change- Lessons from the Nurture Programme: Infant Health and Wellbeing.

KHF engaged with Children Rights Alliance (CRA), Royal College of Physicians (RCPI), Prevention and Early Intervention Network (PEIN) to ensure that submissions from all three organisations were supportive of the overall policy strategy coming from Nurture and the National Healthy Child Programme, this kind of interagency advocacy co-ordination will be difficult for the HSE in the future.

STAKEHOLDER INTERVIEW 54

Stakeholder survey respondents reacted positively regarding how much the Nurture Programme, in conjunction with the National Healthy Childhood Programme, has increased the prioritisation of child health. For this measure, 75% of respondents chose a large or medium level of change.

A lot of what happens within the health service focuses on the acute. So, prevention and early intervention don't always get the same consideration. Nurture has helped to push this. This is largely because of the investment of funding to support the Programme and because we have external parties… who are ensuring the accountability and deliverability of the Programme.

STAKEHOLDER INTERVIEW 13

Stakeholders were also clear in interviews that this advocacy has provided a good foundation for continued investment in and strategic development of child health. However, without ongoing work, relationship building and advocacy, these gains could easily be reversed.

26 Greater Knowledge of the Evidence Base for Child Health Service

Overview

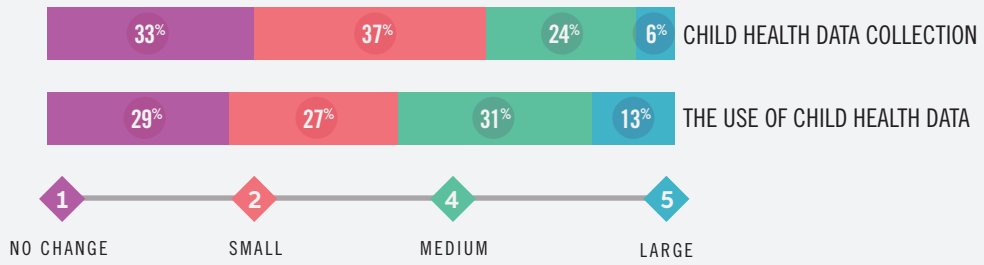
The role of the Public Health Nurse in child health is strengthened by the developmental work of the Nurture Programme, including the development of new standards and the introduction of new messaging, such as that related to infant mental health, a new topic for parent-facing information. The development of an extensive programme of training for Public Health Nurses and Community Medical Doctors, based on the most up to date research and knowledge in the field was also key to creating a more evidence-informed child health workforce.

The findings in this section are informed by the national survey of Public Health Nurses and the stakeholder interviews.

Outcomes

Public Health Nurses had a positive view of the impact of training in relation to this objective: 91% of respondents indicated that they felt that training increases trainee understanding of the evidence base which underpins their work. 62% of respondents strongly agreed with this statement.

FIGURE 32: PUBLIC HEALTH NURSE AGREEMENT THAT TRAINING INCREASES UNDERSTANDING OF EVIDENCE BASE (N=232)



The role of evidence within the Nurture Programme is echoed in stakeholder interviews, where the importance of referring to and establishing a strong evidence base was an overarching theme.

> The mantra as we were going through is making sure that what is implemented is evidence informed or evidence based. If we didn't have the evidence, we had to go get it. That was critical.
>
> STAKEHOLDER INTERVIEW 12

> Absolutely consistent national approach and far more professional materials, and these had not been updated for at least five or six years prior. Now we have lovely materials that are updated to include new risks such as e-cigarettes and hair-straighteners. There are always new risks and the pace of change for child products is increasingly fast with social media influencers and the like. To remain up to date it will need to be updated, we have designed the page to be able to be updated, the mychild website can also be updated as new resources and risks are recognised.
>
> STAKEHOLDER INTERVIEW 54

Stakeholder interviews pointed to implementation science as strengthening the need for evidence and supporting Programme leaders to design processes that allowed for the generation of this evidence base, whether from consultation with parents or practitioners, or in research and scoping exercises. Evidence-informed content was also a key benefit in the generation of the www.mychild.ie website and books.

Since creating an evidence base is not always a straightforward exercise, staff needed to upskill. However, evidence is not always aligned, needs to be matched to context, and can be insufficient or unclear on some issues. Staff needed support to triangulate various sources and arrive at evidence-based decisions on what was often imperfect data. Overall, stakeholders commonly felt that the evidence behind the Programme helped bolster the case for early intervention and prevention services.

Following on from the previous section, *The Sláintecare Report* established a policy of specialised child health Public Health Nurses, while the First 5 Strategy included a dedicated child health workforce.

27 Identification of Child and Maternal Health and Wellbeing Needs

Overview

In line with the Programme's commitment to collecting and using data for improvement, many of the deliverables of the Nurture Programme help to better identify the health and wellbeing needs of children and their mothers. This includes the standardised child health record, the standardised developmental screening tool and the standards for antenatal education.

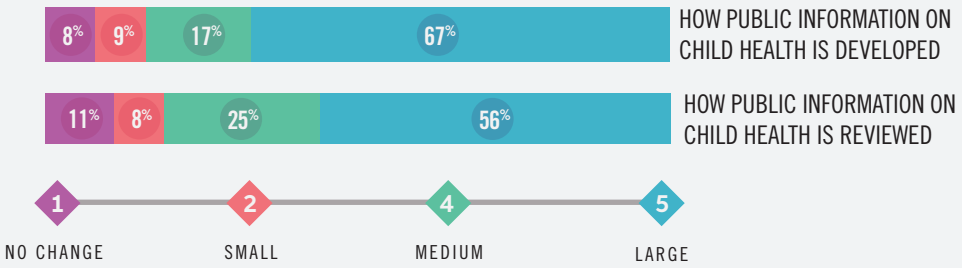
The findings in this section are informed by the national survey of Public Health Nurses, the annual stakeholder survey, stakeholder interviews and the group interview with Assistant Director Public Health Nurses.

Outcomes

Public Health Nurses, Implementation Team members and key stakeholders were all asked questions related to whether the Programme had resulted in earlier identification of child and maternal health and wellbeing needs. While the vast consensus was that the Nurture Programme had improved these aspects of healthcare, respondents had mixed feelings as to the level of change that had occurred.

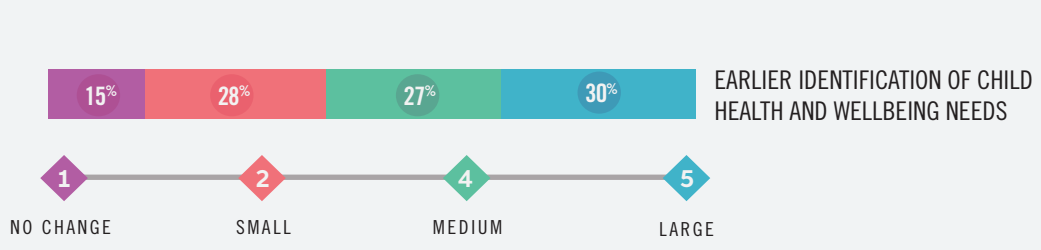
In the national survey of 232 Public Health Nurses, 70% of respondents agreed that the Nurture Programme has supported the earlier identification of child and maternal health and wellbeing needs.

FIGURE 33: PUBLIC HEALTH NURSE AGREEMENT THAT THE NURTURE PROGRAMME SUPPORTED THE EARLIER IDENTIFICATION OF CHILD AND MATERNAL HEALTH AND WELLBEING NEEDS (N=232)



In the annual survey, stakeholders were asked to rank the size of these changes. When asked if the Nurture Programme had resulted in small, medium, large or no change in relation to the earlier identification of child health and wellbeing needs, 57% of respondents chose either large or medium, 28% chose small and 15% chose no change.

FIGURE 34: STAKEHOLDER AGREEMENT THAT THE NURTURE PROGRAMME SUPPORTED EARLIER IDENTIFICATION OF CHILD HEALTH AND WELLBEING NEEDS (N=40)



Stakeholder interviews pointed to the national implementation of a standardised developmental screening tool (specifically, the ASQ-3) as facilitating earlier identification of child health and wellbeing needs. When implemented, this important foundation for standardised care will potentially impact the early identification of child health care needs in the future, even though some scores indicated a small change at the time of the research.

This is a positive development in formalising and standardising practice and bringing consistency across the board for the staff who are doing developmental checks. It brings a formalised piece to it… and gives Public Health Nurses the tools to address things in a more open and consistent way while also supporting families.

STAKEHOLDER INTERVIEW 34

Many people's assessment of change as small or no change can be attributed to some implementation not having yet occurred. Based on this, Assistant Director Public Health Nurses recommended that a further external evaluation be undertaken once current industrial relations discussions are concluded and after the ASQ-3 has been in use for 12 to 18 months. Their view is that only at this point will levels of change be able to be assessed. A further process evaluation was recommended to address the lack of adequate or consistent referral pathways observed in some areas. Assistant Director Public Health Nurses viewed this as a core challenge requiring further review.

In addition to the screening tool, interviewees noted that the child health record training for the child health workforce and public resources like www.mychild.ie and the *My Pregnancy* and *My Child* books will have a positive impact as well.

The standardised health record, the online training programmes and the face-to-face training - these will all lead to earlier identifications. If ASQ gets across the line, that would also result in earlier identification of child health and wellbeing

STAKEHOLDER INTERVIEW 5

When asked about the earlier identification of maternal health and wellbeing needs, the responses were similarly distributed across categories. Of those who answered this question, 35% chose medium, 24% chose either small or none, and 21% chose large. Interviewees recognised that a much smaller proportion of the Programme focused specifically on maternal or parental health and wellbeing, but that the development of the *My Pregnancy* book, the antenatal education standards and the infant mental health training will help improve maternal health and identification of additional needs.

Involving perinatal experts in the development of materials means that maternal health and wellbeing is being considered as is the impact on infant mental health as well. Providing pregnant women, mothers and partners with information on maternal mental health and post-natal depression will hopefully help people to get help if they need it.

STAKEHOLDER INTERVIEW 14

Interview participants universally agreed that these advances would either not have happened or not have happened as quickly and as thoroughly without the Nurture Programme.

28 Summary

Creating and maintaining systems change in complex health environments requires the establishment of structures, policy and practice that can continue beyond the life of a time-limited improvement programme. The Nurture Programme has worked to embed changes at different levels and with different professional groupings within the HSE. The concurrent development of an evidence base to show the effectiveness and usefulness of these changes is essential for maintaining changes developed under the Nurture Programme. If interventions are not achieving the desired outcomes, data must be available to drive the continued improvement of the system. This points to a need to further develop information collection to assess whether systems and service changes made through the Nurture Programme are having the desired effect of improving health and wellbeing outcomes for children and families across Ireland.

Part Five: Sustaining The Work Developed Under The Nurture Programme

29 Introduction

If fully implemented over the coming years, the Nurture Programme's work has the potential to contribute to positive changes in services and supports to pregnant women, young children and their parents and caregivers. However, as many participants in the research for this evaluation pointed out, what happens after the formal conclusion of the Nurture Programme will shape how well the Programme's achievements are maintained and embedded within the HSE. In contrast to many previous HSE programme developments, the Nurture Programme has been planning for its conclusion from its earliest days. This section of the Nurture Programme's evaluation focuses on how sustainability planning has been built into the work from the outset and the actions required to ensure sustainability of the gains made through the Programme.

30 Sustainability

Planning for Sustainability

A core consideration in implementation science methodology is the sustainability of system improvements at every stage of the change process. Planning for sustainability took place at the Oversight Group and Steering Group levels and at the senior Programme Team level. It has also been central to the work at the project level, through the Implementation Teams and subgroups. The outcomes from this planning informed how the Programme operated, who it involved, what it established and how the work could be sustained and further developed into the future.

Like pieces of a puzzle, each of the change projects and deliverables were key elements of the whole programme of work. This interconnection was purposefully designed to increase the impact and sustainability of the entire Programme. The Nurture Programme's change agenda was ambitious and complex, given the interconnected nature of the deliverables. Although working on a suite of deliverables in a co-ordinated manner helps to reinforce the overall changes, it brings the challenge of keeping all products in synch with the Programme's overall messaging, priorities and timeline. However, in interviews, stakeholders considered this multifaceted vision to be necessary, as each deliverable contributed to an important aspect of the overall framework required to support overall systemic change.

For example, in order to increase parental participation and empowerment, the team recognised that a few core actions need to take place. First, standardised training for the child health workforce both encourages national consistency of practice and focuses on the importance of working with parents as experts in their children's health and wellbeing. Secondly, the development of a variety of accessible and relevant resources on pregnancy, parenting and early child development for parents is needed.

Finally, practices should be encouraged and supported in standardised engagement with parents-to-be and young children and their parents. A paradigm shift that embraces parents as collaborators and partners in the task of promoting and achieving child health and wellbeing improvements underpins this work. Ongoing consultation with parents throughout the development and implementation of the Programme will play a key role.

The evaluation clearly shows that stakeholders across senior levels of the HSE and the relevant internal Divisions care about the future of this work and see its continuation and further development as vital. In the stakeholder survey 94% of respondents agreed that the outcomes of the Programme should be further developed and embedded within the HSE after the Nurture Programme's conclusion (note that only one respondent disagreed with this and the remaining three chose to neither agree or disagree).

> **It [Nurture Programme] has to become fully embedded and migrated from an externally conceived programme to an internally facilitated programme. The local operational managers need to have ownership of the Programme… [and] you need someone whose job it is within the HSE to make the case at the management level. Someone who keeps it on the table.**
>
> STAKEHOLDER INTERVIEW 43

In addition to direct deliverables of the Programme, a series of key national strategies were published over the course of the work that will impact the sustainability of gains made by the Nurture Programme. The chart below identifies these strategies and their key features that will support the future progression of the work and vision of the Nurture Programme.

FIGURE 35: NATIONAL STRATEGIES AND KEY ACTIONS THAT RELATE TO NURTURE PROGRAMME SUSTAINABILITY

National strategy	Key features that support the aims of the Nurture Programme
Healthy Ireland Framework (2019 - 2025) A government-led initiative aimed at improving the health and wellbeing of everyone living in Ireland	The National Healthy Childhood Programme has become a policy priority under Healthy Ireland. Healthy Ireland have responsibility for leadership on the implementation of the child health recommendations of First 5.
National Maternity Strategy (2016-2026) An overarching strategy for the development of Ireland's maternity services	The strategy promotes a health and wellbeing approach to pregnancy and maternity care and supports choice for women. It supports antenatal education and the implementation of the Breastfeeding Action Plan.
Sláintecare Report (2017) A ten-year cross-party strategy to transform Irish health services	Sláintecare recommends adequately resourcing child health and wellbeing services, including implementation of the National Maternity Strategy as well as Public Health Nurses specialising in child health.
First 5: A Whole-of-Government Strategy for Babies, Young Children and their Families (2019-2028)	Optimum physical and mental health is a key goal of this strategy, which includes detailed recommendations on the development of child health and wellbeing services under the auspices on the National Healthy Childhood Programme, including the development of a dedicated child health workforce.

Possible Challenges to Sustainability

Just over half (53%) of respondents to the stakeholder survey agreed that the Programme has been implemented in a way that supports sustainability in child health. Interviewees also highlighted concerns about the HSE's ability to maintain and build upon the Programme's successes, including a concern that the constant change of the HSE leadership, priorities and funding have potential to hinder progress and endanger sustainability.

Now that the investment has been made, it wouldn't be a huge financial impact to keep it on track. The problem is that there… needs to be a very small team, who is responsible for the continued maintenance of training and the website. If not, within a year or year and half, it will be outdated, less useful, obsolete.

STAKEHOLDER INTERVIEW 4

In interviews, staff expressed concern that if the Programme is not sustained, they will have a negative experience, similar to those with Best Health for Children (BHFC). Launched in 1999, BHFC was the first time that the then-health board areas had been brought together to develop a nationally-agreed child health programme. Despite many early gains, including standardisation of practice and development of training programmes, the momentum was lost when key staff left post and were not replaced.

The disappointment of the failure of BHFC to be fully implemented and sustained was a theme in stakeholder interviews (mentioned in six) and in interviews with Public Health Nurses and Community Medical Doctors, where it was mentioned in more than half of all interviews (53%).

If it is not sustained, the impact will be a high level of cynicism for those who deliver the service. That is there already, but there will be a greater sense of 'why should we bother.' And then in the next initiative we will find it much more difficult to engage those who participated.

STAKEHOLDER INTERVIEW 47

The comment above describes a larger systematic issue. If the initiatives developed by the Nurture Programme are not sustained, not only will this have a negative impact on workforce morale and reduce the potential quality of services to parents, it will also make any future system developments much more difficult.

Numerous stakeholders across a range of HSE Divisions and external agencies flagged the future need for sustained support for the National Healthy Childhood Programme office. An HSE commitment of continued support to the national programmatic approach to the development of child health services clearly show that the Department of Health and the HSE are committed to child health and wellbeing and

the progression of this work programme. Interviewees felt that the National Healthy Childhood Programme office would help to give child health and wellbeing a national profile, priority and standards. Some pointed out that the National Healthy Childhood Programme office is currently responding to frequent information requests from the HSE management and from government departments, including answering parliamentary questions. In this way, it is seen as a key and expert source of information on child health and wellbeing. The clinical governance of the National Healthy Childhood Programme is currently assigned to the Director of Public Health for the Midlands. The agreed Sustainability Plan for the Nurture Programme proposes that a dedicated Clinical Lead post be created in 2020.

According to interviewees, a major challenge to be overcome is that child health and wellbeing (which predominantly focus on preventive care) are often overlooked by key decision makers as a priority in the health service, due to the urgent demands of acute services. In times of highly constrained resources, the system tends to focus more on solving current acute health needs and systemic problems rather than preventing them.

Having an adequately-resourced National Healthy Childhood Programme office would provide the structure necessary for governance and continued development of the gains of the Nurture Programme. Importantly, it would also elevate child health and wellbeing to be on par with other health issues, giving children 'a seat at the table' where high-level strategic decisions are made.

> **A few years down the road we'll be looking at how to keep it going. When there is no Lead, how will things be sustained and maintained? How will we make sure that information gets to the frontline? It has been structured in a way that could be sustained if we have the proper structures and a lead person who takes responsibility for the Programme. The issue is that when people move on, they often aren't replaced. We need a champion to continue this work.**
>
> STAKEHOLDER INTERVIEW 33

Implementation Team members were asked to rank the importance of 10 Programme features that contributed to Programme sustainability and the Programme's efforts to advocate for them. The majority of respondents (56%) indicated that shared ownership across national Directorates within the HSE for children's health and wellbeing was important and 82% indicated that they felt that the Programme had done a good job of advocating for prioritisation of child health and wellbeing. Three-quarters of respondents to the survey agreed that the Department of Health prioritisation for child health and wellbeing was important and 81% of respondents felt that the Nurture Programme had advocated adequately for its sustainability. Finally, 71% of survey respondents agreed that clarity on how child health and wellbeing fits into new HSE structures is important and 71% felt that the Programme had advocated well for this to be defined.

> **Forward thinking and planning for the future aren't strengths [for the HSE]. They'll roll it out and expect it to run itself. But nothing runs itself. You need enforcement and accountability and you need evaluation to make sure that it is achieving its stated goal.**
>
> STAKEHOLDER INTERVIEW 15

In addition to the need for national structures for child health and wellbeing, evaluation participants across different HSE services and from outside of the HSE expressed deep concern for the capacity of the already stretched Public Health Nurse workforce to engage with the Nurture Programme developments. This dependence on Public Health Nurses to implement many of the Programme's deliverables presents a vulnerability to the sustainability of the work. The Assistant Directors of Public Health Nursing (Assistant Director Public Health Nurses) provided clear insights into the challenges faced by frontline practitioners in relation to engaging with developments in their field. They agreed that standardisation of evidence-based practice is an essential goal. However, they also expressed deep concern about the current workforce's ability to implement developments sufficiently, due to a lack of time. Time constraints were connected to not having enough staff, high levels of Public Health Nurse turnover and the challenge of providing cover or replacements for vacancies. Stakeholders across HSE services and other agencies highlighted a need for a restructuring of the Public Health Nursing service, including an agreed national Public Health Nurse resource allocation model, which would consider population trends, demographics and international comparators in order to define the required number of Public Health Nurses. This model is required to inform the HSE and the Department of Health human resource and financial planning and to ensure that quality child health services can be provided to an agreed standard in every area in the country.

As the deliverables of the Nurture Programme are implemented nationally, the increase in standardised screening and assessment of children will lead to more informed and appropriate referrals. This positive development highlights the need for effective onward referral pathways for further specialist assessment and treatment and the need for consistent national availability of special services so that the goal of early intervention can be attained for all Irish families.

Implementation of standardised electronic health records and patient management systems to reduce the administrative burden on health professionals is urgently needed to sustain the gains made through the Nurture Programme. Such systems need to include a patient portal or mobile applications that allows for patient interactivity. Across the HSE and external services, enhancing administrative supports to the Public Health Nurse service would allow Public Health Nurses to spend more of their precious time and skills on parents and children. And finally, to aid programme implementation and sustainability, Public Health Nurses and their representative organisations and groups should continue to be engaged in ongoing consultations on any relevant developments.

Key Success Factors for Sustainability

Stakeholder interviewees were asked to identify which critical success factors from the Nurture Programme should be brought into new initiatives in the future. Answers were self-generated, meaning that participants were not given any topics to choose from. The answers offered in the chart below exclude the views of the Programme leads from KHF, the HSE and the CES. These are instead outlined in detail in a separate companion evaluation report that summarises the learning from the programme[29].

FIGURE 36: CRITICAL SUCCESS FACTORS IDENTIFIED IN STAKEHOLDER INTERVIEWS

	Number of Mentions
Experienced project leadership	10
Staff with project management expertise	10
Parental consultation and engagement	10
Stakeholder and staff engagement	10
Implementation science	8
Implementation Teams	8
Communications and dissemination strategy	7
Secure annual funding	6
Subject experts and clinical input	4
Sustainability planning from the start	3
Monitoring and oversight	2
Prioritize PHN funding and support to carry out the Programme	2
Staff with data and research skills	1
CHPDO positions secured	1
Clear space for NHCP in HSE	1

The themes identified above endorse those outlined in the report: *Delivering Systems Change – Lessons from the Nurture Programme: Infant Health and Wellbeing*, a companion to this final report. This report also offers 16 key lessons from the perspective of the Nurture Programme leadership. The subsequent sections of this report provide overall conclusions and detail nine key recommendations for the future sustainability of the Nurture Programme.

29 *Delivering Systems Change - Lessons from the Nurture Programme: Infant Health and Wellbeing*

31 Conclusion

> To invest in childhood is to invest in the future of our country in every way.
>
> STAKEHOLDER INTERVIEW 8

The Nurture Programme set out an ambitious range of interconnected objectives to permanently influence the structures of work within universal child health and wellbeing services. After more than five years of intensive work planning, development and implementation, HSE child health staff overwhelmingly agree that there has been measurable progress in improving integrated delivery of services and supports to infants and their parents.

This far-reaching change programme involved more than 100 practitioners and subject experts in a work plan that valued collaboration and co-creation. According to key stakeholders, this approach is not usually supported in an environment defined more commonly by disciplinary segmentation of roles and responsibilities. Implementation science underpinned the approach by providing a framework for collective evidence-based planning and decision making and guiding the engagement of staff across the country and across Divisions in the HSE. The Programme was also considered innovative in relation to its approach, particularly in relation to parental and staff consultation and engagement, the approach to communications and in the establishment of clear governance structures for website and publication development content.

To conclude this final evaluation report, this section returns to the original research questions for the Nurture Programme and answers each in turn drawing on key data from this evaluation report.

1 How was the Programme planned and implemented overall?

Guided by implementation science methodology, the Nurture Programme represented a unique partnership across governmental (HSE), philanthropy (Atlantic, KHF, CFI) and not-for-profit organisations (CES). The overarching programme was developed through a logic modelling process that included ongoing consultation with families, parents-to-be and practitioners to ensure that the products would meet the real needs of those who would ultimately interact with them. €10m of philanthropic funding was secured for the Programme, to be matched by 5:1 matched/leveraged funding from the HSE. More than 100 child health professionals from all corners of the country worked to improve and standardise child health services through the development of the Programme's evidence-based interventions. Many thousands of staff are implementing aspects of the Programme in their day-to-day work with children and families.

To undertake the work, six topic-specific interconnected Implementation Teams were created. Members and chairs of these teams were carefully selected to ensure that they had the content knowledge, drive, supports and time required to contribute to the work. When necessary, time-limited subgroups were developed to advance specific products and topics. Teams were provided with project management support from the core HSE Nurture Programme team and implementation supports from CES. This core team also participated on Implementation Teams and subgroups to ensure that there was a consistency of message and integration across all projects, while also managing the production of work to agreed timelines.

Oversight of the work was provided by two groups: the Steering Group and the Oversight Group. Both included members from the partner organisations and helped to keep the Programme on track, making progress toward the goals and adjusting to the realities of its operating environment. The Programme was externally evaluated through a process managed by a sub-committee of the Steering Group.

All products, standards and messaging developed by the Nurture Programme were created to advance child health and wellbeing in Ireland, largely through the work of the HSE, supported by CES. External organisations such as the Department of Health, Tusla and others were engaged to increase understanding and to support interagency co-ordination of changes made to child health services.

2 Was the implementation support provided effective?

Implementation science offers a structured approach to connecting research to practice by identifying the necessary changes to a system and the steps needed toward those changes. For many involved in the work of the Nurture Programme, implementation science was a new approach to systems change. To encourage greater fluency with the model, CES engaged an international expert advisor to the Programme, to increase understanding of the methodology's foundations by project participants. A series of seminars were combined with day-to-day technical support and assistance, largely provided to Implementation Teams by CES. This further embedded implementation science in the regular work of the Programme.

Evaluative research shows a growing level of understanding of implementation science among Implementation Team members over time. In the 2019 semi-structured stakeholder interviews, participants were asked to identify the critical success factors that should be continued in order to maintain and build upon the Programme's success. A focus on Implementation was among the answers most frequently chosen by respondents. In more than 60 interviews, stakeholders discussed the importance of having a common methodology and common language, highlighting how implementation science encouraged a focus on evidence and planning for sustainability. Based on the enthusiasm for the methodology and how it was applied to advance the Programme's work, the evaluation finds that the implementation support was effective.

3 To what extent/level was universal service provision impacted upon?

Each of the Nurture Programme's change projects was an essential aspect of the overall vision to provide high-quality universal child health services in Ireland. The programme scope included six key deliverables that affected a wide range of core systems within the HSE, hospitals and allied agencies. This programme engaged training, communications and IT personnel in the HSE, HSE Public Health Nursing and Community Medical Doctors, maternity services and Tusla, HIQA and third level education providers. The broad scope of the Programme also meant various deliverables encountered implementation challenges. However, most challenges were overcome in the implementation phase and, at the time of writing, all deliverables are in final draft phase or have already been launched and implemented. A minority are planned for launch in early 2020.

Because of the staggered rollout and the depth of change the Programme involves, it is most appropriate to conclude that the changes to universal service provision are in their early stages and show real promise for the future. If the remaining deliverables are completed and launched (e.g. ASQ-3, standardised child health record, antenatal education standards, remaining training modules), the completed deliverables continue to be managed and updated (e.g. website, books, online training for Public Health Nurses and Community Medical Doctors) and a child health office is established, stakeholders maintain that the effects on universal service provision to children and families is likely to be substantial.

4 To what extent has the Programme led to practice change and improvements in the quality of service delivery?

The Nurture Programme aimed to build a system in which all children and families in Ireland would have access to the same high-quality health services, regardless of where they lived. The standardisation of practice for the child health workforce relies on accomplishing this goal. Throughout the Programme, Implementation Teams sought the best and most relevant evidence from child health and wellbeing experts and related literature to guide the development of work.

Deliverables such as the comprehensive suite of face-to-face and online training for Public Health Nurses, Community Medical Doctors and others; the standardised child assessment tool (ASQ-3); the antenatal education standards and the standardised collection and use of child health data (collected, among other places, by the ASQ-3 and child health record and then used by the National Healthy Childhood Programme office) all contribute to the building of a child health workforce informed by current best practices and implementing a consistent child health and wellbeing service across the country. Because these are standardised and informed by evidence of best practice, the services performed by practitioners who engage with them are more likely to be consistent and in keeping with the evidence.

Further, the development of public resources, such as the public-facing www.mychild.ie website and the *My Pregnancy* and *My Child* books that are given to all parents of young children as they engage with the health system, will increase consistent messaging that is accessible to and shared with all parents in the country. This consistent messaging overlaps with messages delivered to practitioners, which helps to build systematic message coherence in relation to child health and wellbeing.

As many products of the Nurture Programme have only recently been launched or are nearing their launch date, it is difficult to measure the extent to which practice change and improvements are occurring in practice. However, if the Programme continues to progress as anticipated, stakeholders maintain that service quality should be greatly improved.

5 To what extent has the Programme impacted on systems change?

To create sustainable change to large, complex systems like the HSE, knowledge and resources must be embedded in as many aspects of the system as possible and necessary structures built to support these changes. The Nurture Programme worked at a variety of levels within the HSE structures to effect systems change.

According to stakeholders the most significant of systems change was the development of content creation, quality review and governance structures for public facing resources such as www.mychild.ie and the three parent books. Interviewees viewed these systems improvements as vital to future quality service provision and considered them to be a template for other aspects of the HSE's work. Another key theme was the importance of parental and staff consultation in informing systems change.

According to stakeholders, the Nurture Programme has developed the foundations for continuing system improvements through the collection of standardised data. When fully implemented, the ASQ-3 and the child health record have the potential to improve planning and provide data to inform the evidence base for child health.

Creating new positions in child health services, such as the nine regional Child Health Programme Development Officers, the child health-focused Communications Manager, and the child health Data and Research Analyst (all of which will be co-ordinated and supported through the National Healthy Childhood Office) is essential to embed the knowledge and the work of the Programme into the existing systems of the HSE.

As was noted earlier, some of the products that will play a key role in advancing systems change require further support for full implementation. If maintained as key features of the system, this evaluation concludes that they will make potential large-scale improvements to the long-term child health and wellbeing landscape in Ireland.

6 What components contributed to or hindered successful implementation and practice/systems change?

The Nurture Programme took place within the larger and ever-changing environment of health services in Ireland. Over the course of the Programme, the HSE reorganised its national structures and the government produced a number of national strategies with components relevant to child health and wellbeing services. This constant change environment presented a challenge for the Programme and required ongoing work to embed the Nurture Programme's work within the developing policy and service structures.

The streams of work for creating entirely new content or products also faced challenges. For example, prior to the Programme, Ireland did not have antenatal education standards. The Programme thoughtfully engaged parents and practitioners in consultations to create the final product. However, this area of work overlaps with many different aspects of the maternity health system and required negotiations among different HSE Divisions to implemented them correctly. Similarly, the development of the deliverables related to infant mental health was significantly delayed from the original timeline, as introducing a new topic to the child health and wellbeing workforce required additional planning and exploration of evidence before the exact nature of final products could be agreed upon and advanced. Finally, variations in local readiness and capacity to implement the ASQ-3 have delayed the implementation of this assessment tool.

By contrast, many things contributed to the successes of the Programme to date. First, the unique partnership approach that brought together the HSE, KHF and the CES encouraged a wider, more comprehensive vision for change and important connections with organisations outside of the HSE. This partnership also allowed for project management and implementation science expertise to be available to Implementation Teams as they worked toward their goals and led to co-ordinated advocacy for the inclusion of child health in several national strategies.

Several stakeholder interviewees described having external funding from Atlantic as something that 'kickstarted' the work, allowing the Programme to 'accomplish 10 years of work in just three years.' It was acknowledged that many of the priorities of the Programme may have naturally occurred in the HSE, but they would not have advanced at the same pace, been driven by international best practice and local consultation to the same extent or have been as organised towards sustainability without the funding from Atlantic. External funding also helped to gain attention for child health within the HSE, a previous challenge noted by many practitioners.

The enthusiasm and dedication of all people involved in the Programme – from the leadership in the partner agencies to the Implementation Teams, to Public Health Nurses, practice nurses and Community Medical Doctors working in their communities – were vital assets to the Programme. Without the commitment of staff working to make and sustain change, the Programme would not have been possible. Furthermore, having a cohort of child health professionals committed to the advances of the Programme will help to engage the wider workforce when it comes to further national implementation and engagement.

The Programme was future-focused from the outset. The standardisation of work and data recording systems have laid essential foundations for the further development of child health as outlined by The Sláintecare Report. However, as one interviewee noted, this next phase is more like the beginning than the end of the process. With products launched and standards and standardised practices near full implementation, leaders and practitioners are now seeing changes to child health practice and their effects on children and families.

The next tasks are no less challenging than what has occurred over the last five years of the Nurture Programme. These are all focused on embedding Programme developments into the health system. This is no small task, and as stakeholders across the spectrum of services observed, a national prioritisation of continuing investment in the child health workforce, specialist treatment pathways for children and further system development is needed, particularly in the area of technology.

All stakeholders agreed that the progress outlined in this report would not have occurred without the investment and support of the Nurture Programme. This evaluation finds that the Programme has created the potential for a world-class child health and wellbeing health system. The onus is now on the Irish government to prioritise child health and wellbeing and for the HSE to build on this excellent work to make Ireland a country where every child and family have access to the highest quality health care.

32 Recommendations for the Future of the Nurture Programme

After five years of work and the engagement of over 100 members of the child health workforce, the Nurture Programme has created a series of products and systems changes which stand to substantially improve child health and wellbeing in Ireland. This section offers recommendations related to the sustainability and continued development of the Programme's achievements to date.

Recommendations Related to Programme Deliverables

1 Maintain and continue to develop the www.mychild.ie website and the *My Pregnancy* and *My Child* books for parents:

a Ensure a system is in place to monitor whether parents receive the *My Child* and *My Pregnancy* books. This monitoring should include those who opt for homebirth and other situations where there may be barriers to accessing these resources.

b Ensure that a governance structure is in place to oversee the updating of the books and website in accordance with evolving evidence and parental feedback. This should include, at a minimum, a dedicated Communications Manager, a Child Health Data and Research Analyst and administrative supports.

c Further develop the website to make information more accessible to groups with linguistic and/or literacy issues or related disability challenges. This should be done in cooperation with organisations that have expertise in the needs of these target groups and in consultation with members of the target groups themselves. Any substantial changes should be tested in user observation and feedback sessions using the methodology employed in the evaluation of www.mychild.ie to assess website accessibility.

d Explore and cost the potential for adding local service contact information to www.mychild.ie or explore other alternatives such as including this information on the Children and Young People's Services Committee websites and creating a link.

e Ensure that effective links are in place between www.mychild.ie and the Tusla website https://www.tusla.ie/parenting-24-seven/.

f Address the recommendations outlined in the 2019 independent www.mychild.ie evaluation report (see Appendix F in the full report for a list of recommendations).

2 Continue to implement and develop the training framework:

a Enhance post-training supports by creating greater access to specialist expertise. This will ensure that staff feel competent and supported to implement learning from training as soon as possible following completion of training.

b Ensure that training and post-training implementation supports, such as coaching and/or mentoring, and access to relevant tools and approaches continue to be developed for effective implementation of training into practice.

c Ensure that information systems are in place to measure and capture regional rates of completion for training among different disciplines. Create a mechanism for effective follow-up action at the regional and national levels if staff participation targets are not being met.

d Implement strategies to enhance participation of HSE specialist child health staff in training. This would include those working in speech and language therapy, child occupational therapy, staff working with children and families in other relevant statutory agencies, community and voluntary sector services and other non-HSE child health staff (e.g. Pharmacists). Relevant training should include (although not be limited to) child development, child safety, infant mental health and breastfeeding modules. Wider participation in this training will maximise the common knowledge base of all staff who work with children and families, thereby extending the impact and value of the training developed under the Nurture Programme.

e Undertake an evaluation of the implementation and impact of the training resources developed through the Nurture Programme after the training programme has been fully running for 12 months. This evaluation should measure the extent to which new learning, skills and interventions are being utilised in practice and the extent to which they are improving outcomes for children. The evaluation should also identify any additional training content and methodologies needed.

f Continue to engage with third-level education providers to ensure that all relevant professional training courses for those who will work with children and families are aligned with recent practice developments, including those of the Nurture Programme.

g Address the recommendations in the 2019 independent training evaluation report (see Appendix G of the full report for a list of recommendations).

3 Implement the National Standardised Child Health Record:

a Ensure that the standardised child health record can be integrated with GP and maternity care patient records.

b Prioritise the development of an electronic version of the standardised child health record.

c Develop ways for parents to access and engage with their child's health records (e.g. online patient portals or applications).

4 Roll out the standardised screening tool, ASQ-3, nationally with engagement across HSE divisions to:

a Clarify assessment and referral pathways for treatment when indicated.

b Develop and implement standardised resource allocation models to identify the required staffing levels necessary to provide a good quality child health and wellbeing service across key disciplines and areas.

c Develop a feedback loop system to identify and quantify gaps in service accessibility when children with assessment and/or treatment needs are not able to access the appropriate service.

d Continuously review evidence from other relevant prevention and early intervention programmes to explore whether these are effective and can play a role in cost-effectively addressing child health and wellbeing needs. For example, it may be appropriate to advance parent-led interventions or group-based interventions. These could be advanced in partnership with community and voluntary sector services and potentially attract philanthropic support.

Recommendations Related to Systems Change and Sustainability

1 **Adequately resource the HSE National Healthy Childhood Programme (NHCP) so it can fulfil its role.** The agreed Nurture Programme Sustainability Plan (August 2019) outlines the detailed resource requirements for the NHCP, which will manage, sustain and further develop the Programme. Some of the specific tasks include:

a Co-ordinating the management, delivery, monitoring and continuing development of the suite of child health and wellbeing training in co-ordination with other programmes (e.g. Integrated Care Programme for Children, National Women and Infants' Health Programme, Healthy Eating Active Living Programme).

b Developing and managing the next stage of a communications strategy for the broader child health and wellbeing sector. This includes ongoing communications with the public and parents or expecting parents and implementing systems to indicate whether communications have achieved their objectives.

c Managing and monitoring the national rollout of ASQ-3 standardised screening tool.

d Clarifying the governance, implementation, support and monitoring of the national antenatal education standards.

e Continuing to gather, analyse and disseminate relevant data to inform the delivery and further development of services, including reviewing and introducing additional KPIs to measure the long-term outcomes of this body of work.

f Engaging with other agencies working on child health and wellbeing to ensure work plan cohesion. This includes but is not limited to hospitals, Tusla, the Department of Children and Youth Affairs and the Department of Health.

g In collaboration with child health and wellbeing partners, continuing to engage with policy and decision-making fora, including Healthy Ireland, Sláintecare and First 5: The Whole-of-Government Strategy for Babies, Young Children and Their Families, on the implementation of child health and a prevention-based approach as core priorities for policy, service planning and resource allocation.

The National Healthy Childhood Programme Team will require clear governance, communications and planning structures with relevant HSE Divisions, including those that were involved in delivering the Nurture Programme, namely Strategic Planning and Transformation and Community Operations.

2 **Build on the work of Nurture Programme within the HSE by ensuring that a culture of staff and parental consultation informs all key decision making processes in relation to child health and wellbeing.** This culture of parental and staff engagement should include ongoing consultation and a periodic formal service review. A formal process should be developed to collate and review all feedback received from consultations.

Further, information on how their feedback was used and any actions taken to address suggestions should be shared with participants in a timely and clear manner. Additional and more specific recommendations on this topic can be found in the companion to this final report, Delivering Systems Change- Lessons from the Nurture Programme: Infant Health and Wellbeing.

3 **HSE to commence implementation of a dedicated child health workforce along with the agreement of a national Public Health Nurse resource allocation model (RAM), which defines the required Public Health Nurse levels by population.** This should consider factors such as deprivation rates and the implications of working with dispersed rural populations. The RAM should then be used to inform the HSE and the Departments of Health and Public Expenditure and Reform on the human resource and financial planning required for the provision of quality child health and wellbeing services to an agreed standard countrywide.

These developments should include consultation processes with Public Health Nurses, Assistant Director Public Health Nurses, Director of Public Health Nurses and their representative organisations. Staffing levels should reflect the agreed role of the Public Health Nurses based on international best practice on staffing levels, including management support, staff development and administrative support.

4 **The HSE to work across divisions to undertake research to clarify the minimum required levels of specialist service provision, the optimal national and regional spread, and the breadth and variation of existing referral pathways for children and parents who require specialist supports.** This research should consider the varied needs of diverse cultural populations within the country and should link with HSE Progressing Disabilities and the Integrated Care Programme for Children to adequately assess existing pathways.

Specialist services include but are not limited to those with expertise in sleep disturbances and challenges, speech and language, parental and infant mental health, parenting and community supports, lactation and breastfeeding, enuresis, and paediatric occupational therapy. Once service level requirements and pathways are clarified, the case should be made to allocate the resources necessary to implement the service requirements and develop clear pathways for parents so that specialist services are available on a nationally equitable basis.

5 **Develop an electronic patient management system that builds on the data standardisation work of the Nurture Programme.** This development must be guided by objectives related to supporting the work of child health professionals, reducing their administrative burden on practitioners and empowering parents through increased access to health information.

The system should be designed to support service review and planning and include plans for integration, in line with GDPR safeguards, with other health information systems (e.g. maternity services, GPs, Tusla). The system must be developed to include a facility for parental access to their children's health records.

Appendix

Appendix A: References

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Appendix B: Glossary of Terms

ADPHN: Assistant Director of Public Health Nursing

ASQ-3: Ages and Stages Questionnaire, Version 3

Atlantic: The Atlantic Philanthropies

BHFC: Best Health for Children

CES: Centre for Effective Services

CFI: Community Foundation for Ireland

CHO: Community Health Organisation

CHPDO: Child Health Programme Development Officer

CMD: Community Medical Doctor

DPHN: Director of Public Health Nursing

GP: General Practitioner

HSE: Health Service Executive

INMO: Irish Nurses and Midwives Organisation

IS: Implementation science

KHF: Katharine Howard Foundation

KPI: Key Performance Indicator

LHO: Local Health Office[30]

NHCP: National Healthy Childhood Programme

PHN: Public Health Nurse

PHR: Personal Health Record

PN: Practice Nurse

SGS: Schedule of Growing Skills Training

30 The LHO preceded the development of the CHOs, but some services are still working within LHO boundaries.

Appendix C: Members of Steering and Oversight Groups

Oversight Group: 7 – 8 Members

Atlantic Philanthropies[31]

Jane Forman, Programme Executive

Replaced by **Mary Sutton** (Country Director for the Republic of Ireland).

Community Foundation for Ireland

Tina Roche, Chief Executive

Health Service Executive

Stephanie O' Keefe, National Director of Health and Wellbeing. Remained on the group and nominated **Cate Hartigan** (Assistant National Director for Health and Wellbeing) and then **Helen Deely** (Assistant Director for Health and Wellbeing) attend on her behalf.

John Hennessy, National Director for Primary Care. Replaced following restructuring by **David Walsh** (National Director for Community Operations), who nominated **Siobhan McArdle** (Head of Primary Care, Community Operations) to attend on his behalf.

Phil Jennings, Child Health Lead, Health and Wellbeing Division. When unavailable, **Kevin Kelleher**, Assistant National Director for Public Health has attended in her place.

Anne Pardy, Programme Lead, Nurture Programme, in attendance.

Katharine Howard Foundation

Noelle Spring, Development Director and chair of the group after Atlantic Philanthropies' office closed.

Francis Chance, Programme Manager for the Nurture Programme, in attendance.

Steering Group: 10 - 13 members

Atlantic Philanthropies

Jane Forman, Programme Executive

Replaced by **Orla O'Hanlon** (Programme Executive).

Centre for Effective Services

Nuala Doherty, Director

Replaced by **Mary Rafferty** (Senior Manager) and then by **Liz Chaloner** (Senior Manager).

Stella Owens, Implementation Support Team Lead. Replaced by **Aisling Sheehan** (Implementation Support Team Lead).

Health Service Executive

Kevin Kelleher, National Assistant Director of Health and Wellbeing

Phil Jennings, Director of Public Health and Child Health Lead

Carmel Brennan, Project Manager, Child Health Programme

Aisling Heffernan, Project Manager, Primary Care Division. Replaced by **Barbara Bolger** during maternity leave.

Anne Pardy, Programme Lead, Nurture Programme

Anne Lynott, DPHN and Chair of DPHNs Group

Sheila Sugrue, National Lead Midwife, Office of the Nursing & Midwifery Services Director

Katharine Howard Foundation

Noelle Spring, Development Director

Francis Chance, Programme Manager

Tusla

Aisling Gillen, National Policy Development Manager Family Support.

Replaced by **Amy Mulvihill** (National Project Officer), **Caroline Jordan** (Regional Implementation Manager) and then **Catherine Donoghue** (Regional Implementation Manager).

31 Atlantic was involved in both groups until its Irish office closed in 2017.

Appendix D: Implementation Team Chairs and Members

Antenatal to Postnatal

Chair: Caroline Mason Mohan

Members: Ina Crowley
Geraldine Duffy
Carmel Lavin
Fiona McGuire
Sarah O'Brien
Rebecca O'Donovan
Maria O'Dwyer
Moira O'Reilly
Cathy O'Sullivan
Anne Pardy
Aisling Sheehan
Sheila Sugrue
Eilish Whelan

Health and Wellbeing Promotion and Improvement

Chair: Janet Gaynor

Members: Carmel Brennan
Carly Cheevers
Claire Deasy
Karen Heavey
Sarah Hensey
Siobhán Hourigan
Anne Lynott
Sarah McGlinn
Joanne O'Halloran
Margaret O'Neill
Anne Pardy
Brenda Shannon
Aisling Sheehan
Lynn Stoddart

Infant Mental Health and Supporting Parents

Chair: Conor Owens

Members: Carmel Brennan
Carly Cheevers
Jacinta Egan
Sara Hensey
Audrey Lonergan
Catherine Maguire
Patricia McLoughlin
Evan Murphy
Mari O'Donovan
Moira O'Reilly
Stella Owens
Anne Pardy
Brian Redahan
Cora Williams

Knowledge and Communications

Chair: Ann O'Shea

Members: Carly Cheevers
Ben Cloney
Evelyn Fanning
Paul Kavanagh
John Lawrence
Aoife Lawton
Brenda McCormack
Ruth McCourt
Dymphna McGettigan
Laura Monaghan
Sorcha Nic Mhathuna
Stella Owens
Bennery Rickard
Rachel Ryan
Anne Pardy
Laura Smith

Standardised Records for Parents and Professionals

Chair: Gráinne Gaffney

Members: Brid Brady
Carmel Brennan
Carly Cheevers
Paul Marsden
Brenda McCormack
Caroline McGoldrick
Áine McNamara
Moira O'Reilly
Anne Pardy
Virginia Pye
Noelle Ryan
Kerry Ryder
Aisling Sheehan

Training and Resources

Chair: Julie Heslin

Members: Sheila Geoghegan
Rita Lawlor
Eileen Maguire
Brenda McCormack
Ger McGoldrick
Helen Mulcahy
Margaret O'Meara
Grace O'Neill
Kathleen O'Sullivan
Moira O'Reilly
Stella Owens
Anne Pardy
Ailis Quinlan
Aisling Sheehan

Appendix E: Members of Evaluation Advisory Sub-Committee

Evaluation Advisory Sub-committee: 6 Members

Gail Birkbeck, Atlantic Philanthropies

Carmel Brennan, Health Service Executive

Francis Chance, Katharine Howard Foundation

Jane Forman, Atlantic Philanthropies

Claire Hickey, Centre for Effective Services

Helen Johnson, Independent Advisor

Appendix F: Recommendations from 2019 Process Evaluation of www.mychild.ie website

Learning for Other HSE Website Development Projects

1. **HSE to ensure that future website development processes benefit from the applied learning from www.mychild.ie.** The www.mychild.ie website was the first large scale site development project to be implemented following the publication of the HSE Digital Roadmap. The implementation of www.mychild.ie provides several good practice examples of how the roadmap can be implemented. These include but are not limited to the establishment of a senior-level multi-disciplinary implementation team to guide the process, access to a communications Project Manager and identification of a team with appropriate experience and adequate time for the project, clear methods to engage parents and practitioners and utilise information provided by this consultation within project planning, the engagement of subject area experts and the provision of clear guidance material on content development and editorial supports for subject experts that ensure equal weighting between technical and communication expertise.

User Engagement

2. **Ensure that user feedback continues to be collected on a routine and systematic basis from all site users, particularly those from harder to reach communities. Review this information regularly so it informs the continuing development of the site.** The engagement of parents and caregivers, particularly those from harder to reach groups provided valuable and relevant information for developers and was considered a significant and meaningful part of the work. Continued engagement with users will help to ensure that the site continues to meet the true needs of those who wish to use it.

3. **Engage users with lower levels of English fluency and/or literacy in ongoing user testing of the readability and accessibility of the website.** While the majority of survey respondents found the language to be simplistic, participants in user observation sessions found some passages to be unnecessarily complicated. Lower levels of literacy and/or fluency mean that these groups are less likely to participate in forums such as online surveys or opt-in to interviews. Because of this, it is essential that developers continue to facilitate opportunities to gather feedback on their experience with the site.

4. **Develop a strategy for the engagement of representatives from the Traveller community as content experts.** This should include representatives from national traveller groups, including Pavee Point Traveller and Roma Centre, which led the development for *Traveller Mothers and Babies: Supporting Traveller Women Before and After Pregnancy*, a web-based resource book. The strategy should include an articulation of the best methods for ensuring accessibility of key content to the Traveller community, for implementing these changes to the website by the HSE and a plan for regular content review.

5. **Develop a strategy for the engagement of people who are primary Irish speakers or speak English as a second language as content experts.** Similar to the previous recommendation, this strategy should engage with key leaders in the group as content experts. The strategy should outline how content will be offered in different languages (including which languages and which pages would be translated) and a plan for regularly reviewing the content.

Accessibility

6. **Expand search bar usability by including redirects from as many spelling variations as possible.** In addition to adding as many variants as possible for commonly-searched terms, developers should engage participants from key populations to help identify those cultural terms that may not be readily identified by website developers. It is particularly important to engage directly with users from the new migrant and established Traveller community, in order to ensure that information is both relevant and accessible to all.

7. **As a priority, the pages of the www.hse.ie website, which are most commonly visited from links or searches within www.mychild.ie (e.g. those pages related to vaccinations), should be updated to comply with the literacy and accessibility guidelines used by www.mychild.ie developers.** Users are redirected from www.mychild.ie to the main HSE.ie website for a number of searches. In user observation sessions, the language between sites changes significantly and the language used on the main site is much less accessible to users with lower literacy and fluency. Adjusting content on the main HSE website's child-focused pages that are not directly part of the www.mychild.ie site will give website visitors a more useful experience.

8. **Implement the HSE's new guidelines for adding closed captioning or sign language to all key videos.** This recommendation needs to inform a business case to ensure appropriate resourcing[32].

Content Development

9. **Include images and videos whenever possible to communicate instructional information.** Users consistently critiqued the website's lack of visual interest. In user observation sessions, many participants remarked that images and videos would help those with lower levels of literacy gain access to important information.

10. **Build detailed and in-depth content on the most frequently used pages of the website.** In all forms of research, another consistent recommendation for improvement of the site was to add more detail and links or downloads to the most frequently-visited pages. Many users wanted more information and were not satisfied with the recommendation of calling their GP. Some wanted links to other websites, others wanted to be able to download the HSE pamphlets (such as those handed out by Public Health Nurses) or booklets.

11. **Provide clear next steps and actions for parents on each page of the site.** Part of the additional information that users wanted was an answer to the 'now what' question. Including a section at the end of each page that outlines, for example, what is normal and what is concerning and should trigger next steps of action. The next steps should be explicitly listed for clarity. Including explanatory details about how to access providers and services will help those who do not know where to find such information.

12. **Include a home button on each page of the site that redirects to the main page of the www.mychild.ie website.** This home button will help those who get lost when searching the site. The repetitive, visual aspect of a home button (which could just be the logo) will also help those with lower levels of literacy, fluency and time to navigate more successfully.

13. **Continue to ensure that the website is well-designed for use on mobile phones.** Most users indicated that they had viewed the website on their mobile phone. In suggestions, some noted that the font could be smaller for use on phones. Some observed that formatting was sometimes inconsistent when viewing on the phone. The HSE should continue to employ and test the mobile-first approach to ensure that all aspects of the website work on this platform.

14. **Review all articles to ensure that there is clear next step actions and specific guidance on when additional steps should be taken.** The observation sessions revealed that when information was provided, in some cases users were not informed of what action they should take and when they should take this action.

15. **Develop a protocol to respond to 'hot topics' and clarify trigger mechanisms for this work.** This will ensure that the site is relevant and proactive on health issues in the public's attention. The communications team needs to be properly resourced to implement these protocols.

16. **Develop the newsletter or developmental update email series for parents and create an internal protocol within this service for when miscarriage or death occurs.**

32 These new guidelines have been distributed to the HSE Communications Division and all video production companies that make videos for the HSE.

17. **When possible, use pop-ups in place of redirection to pages outside of the website.** For example, when users click on the current cookie policy or privacy statement, they are redirected to a new page and not given a way to get back to the main site. A pop-up window would allow users to review the content and close the window to stay on the site.

18. **Offer print functionality on all pages.** This will enhance users' experience and repeated use of information on the website.

19. **Consider making visible the subject matter experts for www.mychild.ie content development and review.** Naming subject matter experts involved would increase the perception of reliability, authority or accuracy. This attribution could happen at the start or the end of the page.

Promoting the Website

20. **Promote the website widely and consider developing a branding strategy that is consistent with that of Quit.ie.** A frequently commented suggestion was to advertise the site more widely. Users suggested greater advertising in social media channels (such as Facebook and Instagram)[33] and considering other ways in which the site can rise up in search engine searches. To reach a variety of user groups, including underserved communities, advertise widely in community-based organisations and those that serve target populations. Having a recognizable brand and logo to use in that promotion will help to create a mental shortcut for users when they encounter www.mychild.ie content. Rather than wondering about the reliability of the site or information, it will be linked with the overall reputation of the website and the brand.[34]

Evaluation and Continued Content Development

21. **Key performance indicators for the website need to be established and clearly articulated and ongoing monitoring undertaken.** Indicators should relate to service user site experience and draw from multiple data sources. KPIs should measure the public's level of engagement with the website, relative to the HSE's other websites and other relevant child health websites.

22. **Ensure that user feedback continues to be collected on a routine and systematic basis from all site users, particularly those from harder to reach communities. Review this information regularly so it informs the continuing development of the site.** The engagement of parents and caregivers, particularly those from harder to reach groups, provided valuable and relevant information for developers and was a meaningful part of the work. Continued engagement with users will help to ensure that the site continues to meet the true needs of those who wish to use it.

23. **Conduct a thorough evaluation of the website in years two and three post-launch.** Consider establishing a baseline for public health literacy that can be used to track the HSE interventions aiming to increase health literacy in the Irish public.

24. **24. A clear business plan for this work should be developed and supported by the HSE.** Maintaining and promoting the site's content strategy requires ongoing budgetary commitment and support. If the site does not remain current, users will trust it less and it will become less relevant.

33 Since this report was published, the HSE has commenced this work and is planning to expand it in 2020.
34 This process has begun with the breastfeeding.ie Facebook page changing to the HSE www.mychild.ie page on May 9 2019. The website is also being promoted on Twitter.

Appendix G: Recommendations from 2019 Training Evaluation Report

General Recommendations

1. **Continue building the skill base and consistency of practice within the child health workforce by regularly offering high-quality training opportunities around the country.**

2. **Gather information about participant experience with the tools and/or content of the training beforehand and tailor the course to meet their needs.** There are several ways in which trainers can account for and even take advantage of different levels of knowledge within a training group. However, in order to do this, the trainer must gather information about participants' prior level of experience ahead of time so she or he may tailor the training accordingly. One suggestion is to send resources to attendees prior to the training to encourage a baseline of understanding. Another modification could be to use an online survey platform to ask for baseline information from participants when they register to attend the training. This would allow trainers to evaluate participant needs beforehand. Having a mixed group can also provide a resource to participants if trainers are able to encourage more experienced practitioners to work in groups with those who have less experience. A final option could be to offer additional course time to novices or invite those with more experience to attend only a portion of the training.

3. **To embed knowledge and allow for group learning, include opportunities for participants to work directly with new tools and/or content during training.** If not possible during the training, consider offering additional resources to attendees and the possibility of revisiting information a few months after the completion of the training.

4. **Recruit trainers who share a level of relevant and applied clinical experience with attendees, ideally including knowledge of the Irish healthcare system.** Where this is not possible, have trainers with international experience co-facilitate with local trainers, to ensure applied experience.

5. **Consider creative solutions to challenges with internet connectivity, such as allowing practitioners to complete training modules at home or offer opportunities for groups to come together at larger health centres to complete training in a blended learning environment.** Ideally, this would be guided by a national work programme to ensure that all child health professionals have access to a workplace computer and supports to engage with relevant materials and online learning portals.

6. **Provide support for those members of the workforce who are less comfortable with using computers, such as group learning opportunities or identifying a local contact who can provide IT support as needed.** In those areas where practitioners are less comfortable with using computers, it may be necessary to encourage practitioners to complete training together as groups, so staff can support each other or receive technical assistance collectively. If this is not possible, providing on-demand IT support to those trying to access training may address this issue, preferably by providing trainees with the name of a local support person. Members of the Training and Resources Implementation team suggested that this support person would likely only be required for an intermediate period, as these skills would be accessed within the team once everyone has used the online training once or twice.

7. **Consider encouraging managers to allow for protected time to complete online training.** Collect and regularly disseminate data on the proportion of the workforce completing training in each area.

8. **Help online learners to answer questions by offering access to additional resources, as is appropriate.** Blended learning opportunities, which include time for group discussion, may also help to unearth and address participant questions and could generate a list of frequently asked questions for inclusion in the online resource.

9. **Offer opportunities for continued learning and refresher courses, particularly for those who are not able to immediately put new knowledge to work.** Ongoing evaluation of the training should also review the role of coaching and mentoring in this light. It could be useful to ask trainers to leave participants with a resource list or to encourage regional conversations to take place about new tools and content.

10. **Training should take place close to the date of expected implementation.** When unavoidable delays occur, consider offering refresher webinars to trainees so they can ask questions and revisit recorded content at a later date.

11. **Create systems that ensure that child health professionals have the time needed to incorporate new tools into practice.** This may include protected time and/or facilitating opportunities for peer support to encourage buy-in and reduce time spent looking for solutions to common issues. If a lack of time is leading to reduced implementation, workload or caseload expectations may need to be adapted so key interventions to be implemented. This will require ongoing monitoring.

12. **Consider creative ways in which local areas which do not have administrative help may access the assistance needed to incorporate these new tools into practice.** For example, the HSE could consider implementing a resource allocation model to provide an appropriate level of administrative support to all Public Health Nurse teams nationally. This model should consider local factors such as urban or rural settings, child population, and varied demographics of the communities being served. The purpose of this approach would be to enable clinical staff to use their time most effectively with patients while supporting administrative staff to develop their child health role within the service.

13. **Continue to build opportunities for evidence-based standardisation of practice and include feedback loops and evaluation structures in order to evaluate training processes and the impact of the Programme on children and families.** The evaluation of change for children and families will meet the final level of good practice in relation to the evaluation of outcomes and impact (Tamkin, Yarnall and Kerrin model, as well as Implementation Science Models).

14. **Continue to build current practice and bolster the morale of the child health workforce by offering opportunities for professional development on a regular basis.**

Training-Specific Recommendations

Management of Behavioural Sleep Difficulties in Infants and Children

15. **Given that nationally, there are few public sleep specialists, the HSE to consider supporting and monitoring the progress of those trainees who have expressed an interest in organising a local or regional sleep clinic.** Studying the progress made in these initiatives could inform the development of a model that would be able to spread beyond the initial pilot locations.

Schedule of Growing Skills II Training

16. **Assess participant knowledge of the tool or topic in advance of the training and plan accordingly.** When very different levels of knowledge and/or experience exist, consider the ways in which the course may be tailored to meet the needs of those at different levels. Consider providing pre-training reading to encourage a shared baseline of understanding prior to the training.

17. **Provide practitioners with the tools necessary to successfully implement new standards and assessment tools.** If training is unavailable, ensure that they have access to additional resources and consider building opportunities for peer sharing and support.

18. **Develop a strategy to capture feedback on user experience and training needs as SGS is rolled out nationwide, as data collected for this study suggests the need for further research to support national implementation as well as to investigate the need for ongoing investment in training.**

Ages and Stages Questionnaire Train the Trainer

19. **Make all efforts to ensure that all practitioners have the necessary resources to implement the tool as soon as possible after the training.** This includes reminding practitioners of the smartphone application, and how to access printed questionnaires, even if they have been alerted to these before.

20. **Provide a refresher course or webinar to encourage implementation where there have been delays[35].**

35 Note that large numbers of practitioners have completed the online training and that current delays may be due to ongoing negotiations with the nurses' union.

Appendix H: Logic Model for the Nurture Programme

Overall Aim of the Initiative: To build and strengthen a cohesive, integrated child health and wellbeing service for 0 to 2s and their families

Objectives

To invest in holistic, universal health and wellbeing services for parents and families from pre-conception to the child's third birthday

To improve the health and wellbeing outcomes of 0-2s through prevention and early intervention services

To prioritise the health and wellbeing needs of the 0 to 2 years

To deliver a quality and consistent child health and wellbeing service

To build on best practice and national and international evidence

To disseminate and share core, consistent messages about the physical, social and emotional development of 0-2s

Inputs

Mothers, fathers, babies & infants, families & communities

Health and wellbeing service providers:

Health Service Executive (HSE)

- Public Health Nurses
- Maternity services including midwives, community midwives & obstetricians
- General Practitioners (GPs)
- Paediatricians
- Medical Officers
- Speech and Language
- Therapists/Occupational Therapists/Physiotherapists /Dietitians
- Psychologists
- Psychiatrists
- Social Workers (HSE)
- Pharmacists
- Early Intervention Teams

Policy & strategy

- Healthy Ireland
- Better Outcomes, Brighter Futures
- Paediatric Integrated Care Programme
- Maternal & Infant Care Scheme
- GP 0-6s contract
- Maternity Strategy
- Revised Breastfeeding Action Plan
- Obesity agenda
- Revised Child Health Model

Strategic Partners

- Atlantic Philanthropies
- Katharine Howard Foundation
- Community Foundation for Ireland
- Centre for Effective Services

Other Partners:

- Tusla
- Early Childhood Care and Education providers
- Schools and teachers
- Community and voluntary organisations

Key Activities & Outputs

System Development

- Child health and wellbeing leadership will position child health and wellbeing at the forefront of the HSE senior management agenda
- Make the case for development of a dedicated child health budget
- Develop integrated care pathways across GPs, primary care, maternity, public health, paediatrics & parent and family support services
- Develop the case for a dedicated child health PHN service
- Develop a communication plan – internal & external stakeholders
- Develop data collection & analysis processes to support data driven decision making, including KPIs
- Develop Child Health & Wellbeing section on HSE website
- Contribute to the development of an online information source on local services in partnership with CYPSCs & CICs
- Concept of infant mental health understood and applied across system
- Develop Parent Consultation Process to inform the Nurture Programme
- Review and development of referral pathways and processes for children and parents with additional needs

Ready for Baby (pre-conception to 6 months)

Pre-conception

- Develop and deliver public information (booklets, social media etc)

Antenatal

- Develop a pregnancy identification and notification system
- Develop standardised content for antenatal classes and resources
- Develop and disseminate resources to promote and support maternal and infant health and wellbeing, including diet and nutrition
- Promote positive parent-child relationships (attachment & bonding)

Postnatal

- Support the implementation of the Revised Breastfeeding Action Plan
- Develop and disseminate resources to promote and support parental and infant health and wellbeing
- Review, align and implement Parent Held Records
- Develop support networks, including parent-led e.g. Parent and Baby/Toddler groups
- Identify and support the delivery of universal evidence-based and evidence informed parenting programmes and parenting supports through a variety of structures
- Deliver Child Safety Awareness Programme

Ready for Toddler

- Support rollout of universal screening of health and wellbeing, in keeping with revised child health model
- Develop and disseminate resources to promote and support parental and infant health and wellbeing
- Identify and support the delivery of universal evidence-based and evidence informed parenting programmes and parenting supports through a variety of structures
- Promote play, exercise and parental interaction for child development and health
- Review, align and implement Parent Held Records
- Deliver Child Safety Awareness Programme

Ready for the Work

- Assess training and development needs of staff to deliver universal child health & wellbeing services and development of professional development strategy
- Develop an inter-disciplinary team to design & deliver training programme inside and outside of HSE

Short term outcomes (6 months- 3 years)

System Development

- Greater knowledge & understanding of current service delivery innovation
- Improved internal and external communication within and outside of the HSE
- Improved data systems are informing policy, planning and service delivery
- Greater integration on planning of child health services across policy agenda
- Greater knowledge on evidence base for dedicated child health PHN service
- Earlier identification of child and maternal health and wellbeing needs

Ready for Baby (pre-conception to 6 months)

- Parents more knowledgeable, confident and competent for pregnancy, birth and baby
- Pregnant mothers and potential mothers take better care of their health and wellbeing, including mental health
- Parents have greater understanding of their emerging relationships with their babies
- Parents have greater awareness of and are availing of antenatal care
- Increase in breastfeeding rates
- Improved diet and nutrition for babies
- Parents have more awareness and support for their mental health
- Better communication from antenatally
- Parents have access to a range of universal parenting advice and supports
- Greater availability of parenting programmes in area

Ready for Toddler

- Parents have accurate information and are more reassured about their children's health and development
- Parents have better knowledge and awareness of resources available for supporting them in their parenting role
- Increase in immunisation rates
- More timely and appropriate referral to other relevant agencies & services
- Reduction in child accidents and injuries

Ready for the Work

- Key, consistent messages about healthy child development will drive integrated service delivery
- Motivated workforce will be empowered to identify needs and make appropriate referrals early
- Workforce collecting & using data to inform practice
- Clarity on roles and responsibilities of

Longer Term Outcomes (3yrs +)

System Development

- HSE leaders consistently prioritise child health and wellbeing outcomes
- Dedicated child health budget
- Ireland is recognised as having best practice in the promotion of child health and wellbeing outcomes
- HSE influencing child health policy and practice outside of HSE (e.g. Tusla, courts, schools etc.)
- More integrated services
- Development of dedicated child PHN service, as appropriate
- Integrated maternity hospitals and community-based services for pregnant and new mothers and fathers is implemented

Ready for Baby (pre-conception to 6 months)

- Strong parent-child attachments
- Parents are better connected to and availing of their support networks (family, friends, peers, community, services)
- Parents fully informed and empowered in their parenting role
- Babies have improved health and wellbeing

Ready for Toddler

- Earlier intervention for identified child health and wellbeing needs
- Speedier and consistent access to services for those with additional needs
- Improved child developmental outcomes, e.g. oral language
- Improved parental wellbeing, self efficacy, skills & capacity
- Improved parent-child relationships
- Reduction in child obesity
- Parents have access to standardised, consistent information on child health and wellbeing

Ready for the Work

- All professionals/practitioners have common understanding of physical, social and emotional development of 0-2s
- An environment of continuous learning is fostered
- Shared responsibility for health and wellbeing of 0-2s across services
- Integrated approach to staff training

Evidence: Learning from Prevention and Early Intervention Initiative (PEII); consultation; Healthy Ireland & HSE reports/strategies

Appendix I: Key Lessons from Programme Leadership

These lessons are taken from *Supporting Sustainable Change: Lessons from the Nurture Programme: Infant Health and Wellbeing on Creating Lasting Change in Complex Healthcare Environments*, to be published February 2020.

Take time to get the right people into the right structures

1. Establish implementation teams and match the right the people to these roles
2. Implementation science supports achievement of programme outcomes and sustainability
3. Alignment between local, regional and national structures and context is key

Engaging staff in new initiatives requires commitment and support

4. To build credibility, frontline staff need to know that funding is committed
5. Maintaining the engagement of key staff requires significant effort and consideration
6. Evidence reviews are essential tools for creating a collective vision
7. Effective communication with frontline staff requires ongoing effort, stamina and creativity
8. Deliver tangible wins in a timely manner to build momentum for change
9. Online training creates equity of access
10. Specific programme roles, such as communications and data management require expert staff
11. Consultations with service users and with staff are key to success

Planning for programme sustainability takes time

12. Sustainability requires detailed planning, commencing at project set-up phase
13. Plan for scale
14. Philanthropy can leverage resources as well as strengthen project management
15. Effective multiagency partnerships require a significant investment of time and support
16. National policy change is best achieved through strategic partnerships and alliances

This external evaluation was completed by Quality Matters, in partnership with Dublin City University.

Quality Matters is a not-for-profit working with organisations across Ireland to improve social service provision. Our mission is to support the joint ambition of state funders, not-for-profits, charities and social enterprises to create high quality evidence-based services for marginalised communities and the individuals within them.

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supporting improvement in social services

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