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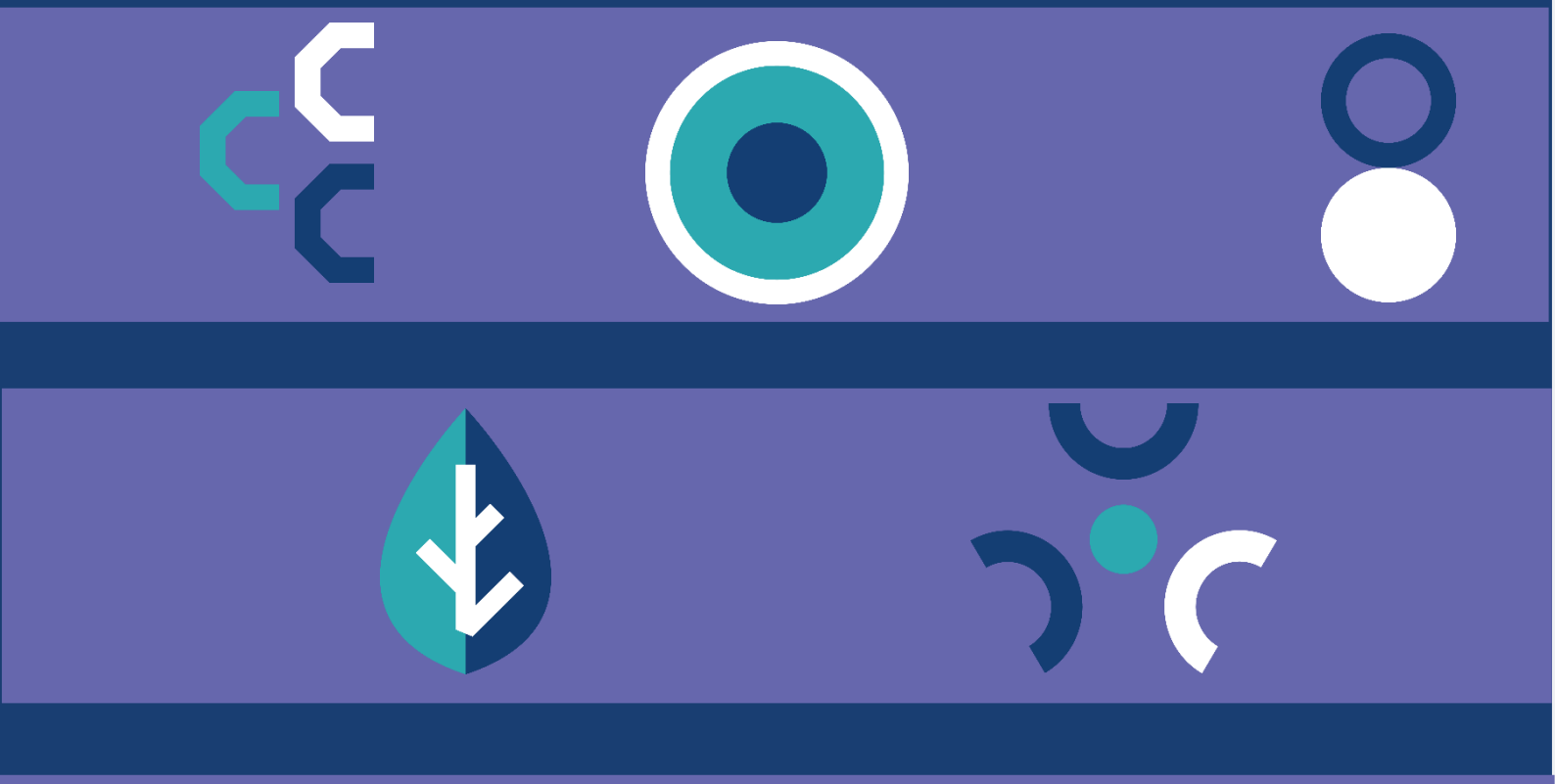
Rotherham Healthy Child Programme: Evaluation of the universal 3-4 month visit

Interim report



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Background

Healthy Child Programme

The Healthy Child Programme (HCP) sets a national framework for promoting health from pregnancy to age 19. It includes five mandated core reviews (antenatal, newborn, 6–8 weeks, 1 year and 2–2.5 years) that monitor growth, immunisations, development and parental wellbeing (1). The programme is led by health visitors, whose training in child development, safeguarding and family support enables early identification of need and targeted advice on parenting, nutrition and wider social determinants of health (2).

Rotherham's additional 3-4 month review

Rotherham Metropolitan Borough Council has used Family Hubs and Start for Life grant funding to add a universal 3–4 month visit. Previously available only to families requiring enhanced support, the visit is now offered to all parents and is delivered by nursery nurses and health visitors. Practitioners review child development, provide guidance on breastfeeding and safe weaning, and support parental mental health. From September 2023, the visit was piloted and targeted at first-time mothers and those at higher risk who were not already eligible for additional visits. From January 2024, general rollout to the entire population began. As this review is not nationally mandated, the council is evaluating its impact to assess the case for retaining it locally and to influence wider national policy.

Existing evidence

A 2012 Department of Health case study reported 100% uptake of a pilot 3–4 month visit, as well as stronger parent-practitioner relationships, staff morale gains and earlier detection of issues that could reduce long-term costs (3). Public Health England's rapid evidence review of the HCP in 2015 identified that the gap between the 6-8 week and 1-year reviews was too long for many families, and that a 3-4 month visit may be of benefit (4).

More broadly, the review found face-to-face health-visiting and home-based family programmes, delivered consistently by skilled practitioners, outperform remote contacts in sustaining breastfeeding, resolving severe feeding problems, and improving safety for children under five (4). Subsequent studies link health visiting to sustained breastfeeding (5) but report the need for sensitive communication on the topic of feeding that respects parental autonomy (6). COVID-19-related service disruptions showed reduced face-to-face access disproportionately impacted vulnerable children, highlighting the protective role of early home visiting (7). Health visitors can also identify health and wellbeing needs and risk of adverse childhood experiences, providing referral routes to wider support (8, 9).

No studies since 2015 have specifically assessed adding a universal 3-4 month review, meaning this evaluation can make a timely and important contribution to the evidence base. Here we provide interim findings from the evaluation of Rotherham's universal 3-4 month visit ahead of a full report. Note: In this document, we use the term 'parent' to refer to the parents, carers and guardians eligible for a 3-4 month visit.

Methods

Quantitative

We examined the reach of the universal 3-4 month visit by tracking, month-by-month, how many eligible babies received it and whether it happened on time. Visit completion was described by demographic factors, including socio-economic deprivation, ethnicity, maternal age and parity, and we also described developmental scores at 3-4 months. We used a statistical model, adjusting for the same demographic factors as well as the child's NHS team, to show whether different population groups were more or less likely to: receive a visit, have an on-time visit, and have maternal mood recorded at the visit.

To assess effectiveness, we compared children's 12-month development scores before and after the review became universal, again controlling for background factors and imputing missing data, although we could not take trend into account. Planned work to describe breastfeeding rates, carer confidence, referrals and immunisations could not take place because the necessary data were not available.

Qualitative

Qualitative interviews and focus groups were used to explore acceptability of the 3-4 month visit for parents and staff. Factors associated with delivery and uptake of the visit were examined. Feedback on implementation was also sought from the local authority commissioning team. In total, 15 individual interviews with parents and two focus groups were completed; one focus group comprised parents who had and had not taken up the visit (n=7) and the second took place at a local mosque with a community breastfeeding group (n=9). Seven nursery nurses took part in a focus group, with four public health staff and commissioners from the local authority taking part in a mixture of focus groups and individual interviews.

Transcripts from all interviews and focus groups were reviewed and coded for emerging themes. To ensure reliability, three researchers coded the transcripts and cross-checked the findings. Core themes were then mapped across staff and parent data to explore similarities and differences between the two groups.

Findings

Quantitative

- 3-4 month visit rates stabilised at around 80%, below the ~95% visit rates of the 8 week and 9-12 month visits. In an average month, just under 200 babies and their families received a 3-4 month visit.

- Of those who received a visit, the rate of completion of an Ages and Stages Questionnaire (ASQ) for the baby stabilised at around 80%, which is comparable to the ASQ completion rate for the 9-12 month visit.

- 3-4 month visit uptake appeared to be equitable across socio-economic deprivation, ethnicity and maternal age groups, but families with more than one child were around 70% less likely to receive a visit (adjusted odds ratio (AOR) of 0.29, 95% confidence intervals (CI) 0.22 - 0.37).

- Compared to those living in the most socio-economically deprived quintile (IMD 1), on-time visits were more common for those living in the second most deprived areas (IMD 2: AOR 1.42, 95% CI 1.037 – 1.939) or the middle quintile (IMD 3: AOR 1.78, 95% CI 1.163 – 2.717). Odds of an on-time visit increased with maternal age (AOR 1.57 per age band, 95% CI 1.048 – 2.357). Ethnicity showed no clear differences and parents with more than one child were 30% less likely to receive an on-time visit (AOR 0.70, 95% CI 0.534 – 0.906).

- Maternal mood recording rates were consistent across deprivation quintiles and ethnic groups. However, odds of having mood recorded rose sharply with each maternal age band (AOR 2.17, 95% CI 1.49 - 3.16) but was 25% less likely for parents with more than one child (AOR 0.78, 95% CI 0.64–0.94).

- At the 9-12 month visit, children eligible for a universal 3-4 month visit had higher likelihood of scoring above the close-monitoring cutoff in the ASQ domain of problem solving (AOR 1.41, 95% CI 1.03-1.95). Communication, gross motor, fine motor and personal social domains showed no significant change compared with the pre-intervention cohort.

- The cost of delivering each 3-4 month visit in Rotherham is estimated to be approximately £46.

Qualitative

General themes:

- Parents valued having an additional visit between the 6-8 week and 9-12 month reviews.
- The 3-4 month visit was positively received and widely supported, especially for new mothers and parents who felt they were struggling or had specific questions.
- Parents had positive opinions about the 0-19 service, which was supported by positive experiences with the 3-4 month visit.
- Parents found the support services offered through the family hubs to be very helpful, particularly for meeting other parents and for support during weaning.
- Community groups, such as those delivered at a local mosque, provide an important way of delivering information and support to diverse communities.
- Macropolitical factors, including pending governmental decisions around family hub funding, have led to uncertainty and impacted planning within the service.
- The need for continued local data collection to support commissioning decision-making was highlighted.

Aligned findings

Staff and parent responses aligned across the following topics:

- Parents felt the visit was more developmentally focused than other visits, aligning with nursery nurse skills in developmental screening.
- The visit, service, and the information provided to parents was perceived to be culturally adaptable, aligning with a core service aim.
- The visit supports parents' knowledge and preparedness for upcoming developmental milestones, providing parental reassurance.
- The length of the visit (approx. 1 hour) is a positive feature, providing more time for parents and delivery staff to build relationships.
- Parents and staff felt maternal wellbeing was a key topic that should be addressed in the visit, although this was not consistently screened.
- Tailoring of advice to family and baby needs is key, although parents did not always experience this.
- Staff and parents felt signposting to additional supports (such as the family hubs) is a core part of the visit.
- Staff consistency across visits is important for relationship building from both staff and parent perspectives.

Discrepant findings

Staff and parent responses diverged across the following topics:

- Parents wanted a slightly later visit (4-5 months) to align with the relevant developmental stages discussed in the visit (i.e. weaning). This relied on parents' knowledge that weaning activity begins at 6 months. Staff felt that the 3-4 month timeframe was appropriate to pre-empt upcoming milestones and counter misinformation.
- Parents noted discrepancy in information amongst delivery staff and other healthcare professionals (e.g. guidance on weaning foods), leading to mistrust. Staff felt that consistent communication was key to successful service delivery.
- Parents perceived the visit to be informal and low burden. However, staff felt the visit led to higher workload burden due to current staffing levels and resources.
- Staff felt the timing of the visit was flexible to parents' schedules, although parents found the 'all day appointment window' challenging and inhibitive of daily routines.
- The goals of the visit were not clear to parents, and many perceived the visit to be mandatory. The commissioning team felt there should be clarity around the aims of visit and active consent sought to proceed.

Key messages:

- *Acceptable visit:* Parents felt strongly that it was important to have an additional visit between the 6-8 week and 9-12 month visits, but suggested this could be delivered at a later time to align with weaning (e.g. 4-5 months).

- *Equitable reach*: Both qualitative and quantitative data suggest equitable uptake across deprivation and ethnicity, with cultural adaptability of the 3-4 month visit reported.

- *Lower uptake*: Uptake of the 3-4 month visit stabilised at 80%, which is 15 percentage points lower than mandated visits. Lack of parental clarity on the purpose of the visit may contribute to this.

- *Improved problem-solving skills*: A statistically significant increase in scores on the ASQ problem-solving domain were observed between the pre- and post-intervention groups. Some parents reported receiving tailored advice based on their child's/family's developmental needs, which may potentially link to the observed improvements in ASQ domain scores. No other significant differences were found in ASQ scores.

- *Maternal mood:* The younger the mother, the less likely it was for her maternal mood to be recorded. Parents felt that maternal mood and wellbeing was not screened consistently but was an important component of the visit. The service could consider how conversations around maternal mood are approached, particularly with younger mothers, ensuring equity across age groups.

- *Ongoing data collection*: To facilitate ongoing evaluation and commissioning decision-making, it is important to collect baseline data of validated measures of feeding, ASQ and maternal mood consistently from an early stage. Consideration should also be given to how electronic records between mother and child can be linked to allow analysis of immunisation, maternal mood and other child health outcomes.

- *Improved clarity*: The aims of the review were often not clear to parents. Despite the person-centred and flexible nature of the visit, the core visit objectives could be more clearly defined by the service. This may enhance consistency of information provided to parents from delivery staff.

Conclusions

Overall, the evaluation indicates that the 3–4 month review is a valued addition to the Healthy Child Programme, offering a point of contact between the 6–8 week and 9–12 month visits and supporting families during a period of rapid developmental change. The visit appears feasible to deliver, culturally adaptable and acceptable to parents, though work remains to ensure consistent communication, equitable maternal mood support, and ongoing data collection to monitor outcomes. These findings provide evidence for Rotherham stakeholders to consider when deciding on the future of the review and may contribute to the wider national debate on delivery of the Healthy Child Programme.

References

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Appendix: Figures and tables

Figure 1: HCP visit completion in Rotherham by birth month

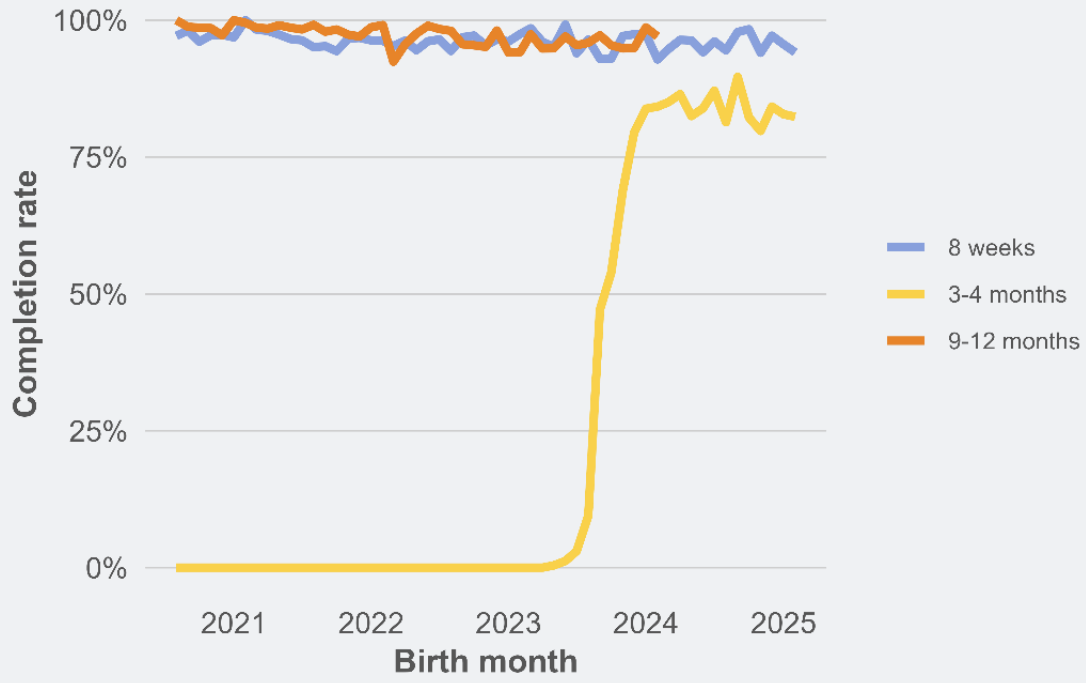


Figure 2: ASQ completion by birth month and visit checkpoint

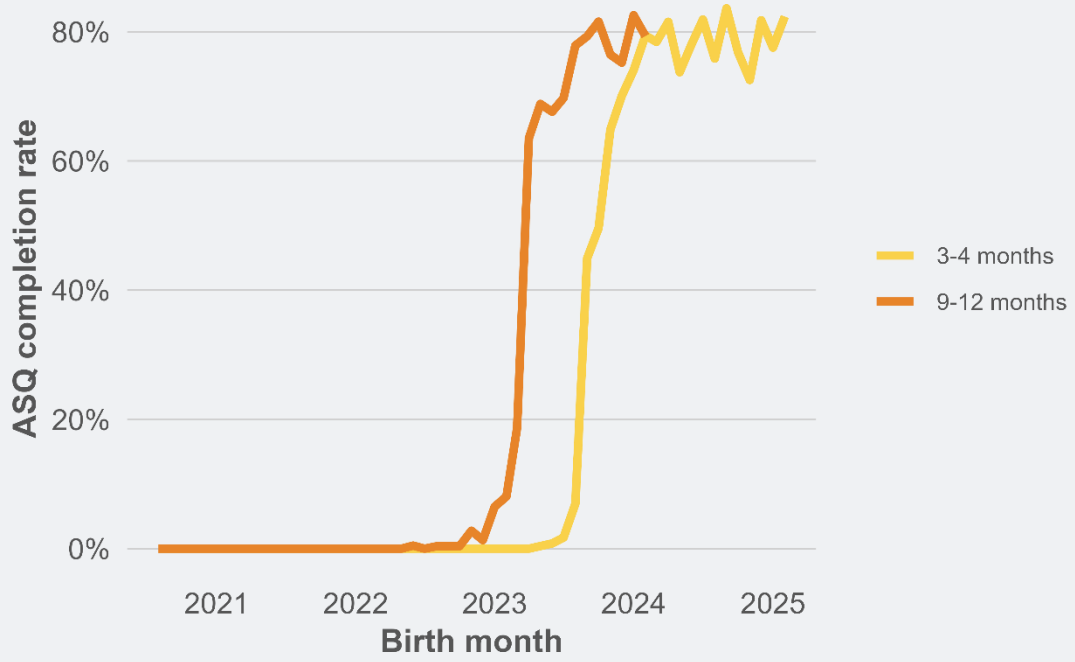


Figure 3: Number and proportion of 3-4 month visits by birth month

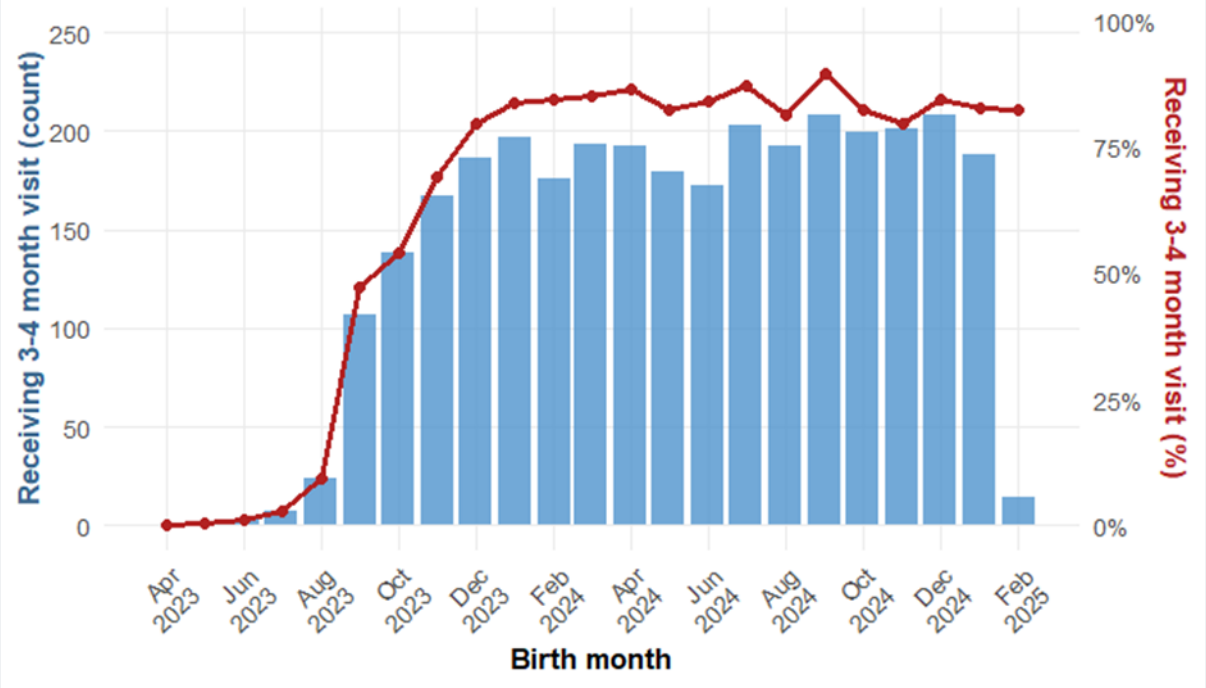
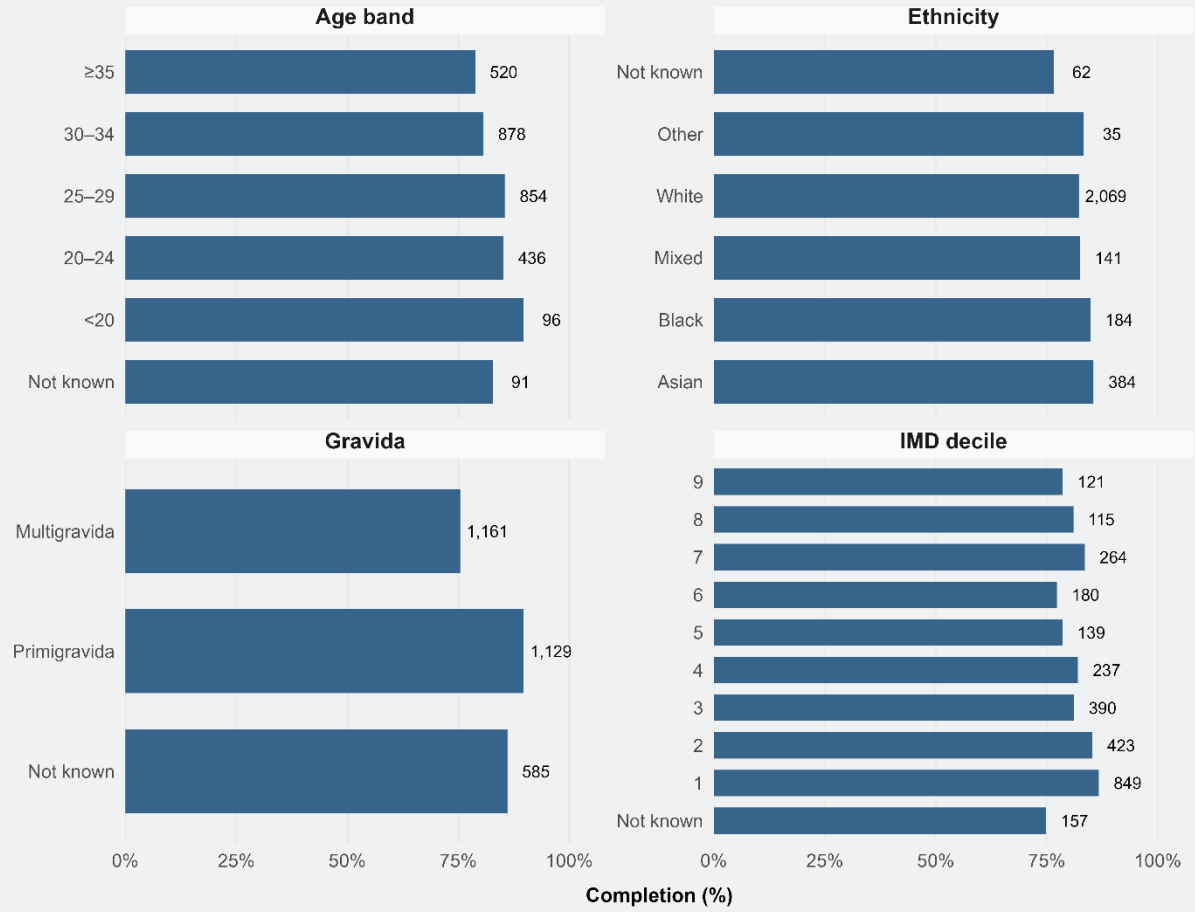


Figure 4: 3-4 month visit rate and count by demographics



(IMD decile: 1 = most deprived, 10 = least deprived. No visits to those in 10th decile).

Table 1: Illustrative interview quotes

Key finding	Example quote
Addition of visit at 3-4 months was well received; parents perceived it to be helpful to have an additional visit between the 6-8 week and 9-12 month visits (especially for new parents)	*I think it is a great support to have in there. As I said, with my first I didn't get that and I was a new parent, never done it before, so it was very much a "you're in the dark and figure it out". So I do think it's a great step to have in the children's development steps and check-ups. (Participant 009)*
Advice was perceived to be adaptable to cultural needs	*When it came to circumcision, I weren't sure and she told me what to do, how to do it and I were really a bit shocked thinking "great she gave me the advice for circumcision and that". Yeah, so she gave all that support and advice for circumcision. (Focus Group Participant 002).*
Advice improved parents' knowledge and preparedness with key developmental milestones, such as weaning.	*Very positive and very informative. I gained a lot of confidence from the review in terms of how to care for my baby, next steps with weaning and teething when it eventually comes. (Participant 005)*
Maternal mood and wellbeing was perceived to be an important topic for parents; some felt it was glossed over, whilst others felt it was covered in detail	*I think it really can't be underestimated, the importance around the mental health discussion for parents. I think for me it felt like sometimes that was a little bit glossed over or not really given the opportunity to talk about that enough. I'm really open with how I was feeling and I was quite open to say "Look, I'm struggling here." But I can imagine if someone wasn't as comfortable to say that, if it wasn't proactively mentioned or discussed, it might go under the radar. (Participant 014)*
Advice could vary by health visitor and healthcare professional, causing confusion and mistrust	*So they told me to use purees and things like that and then they said not to use purees, to just give her basically what I eat because saliva and her gums she'll be able to eat it, so then I were like "well do I give purees or do I give her solid food?" (Participant 001)*

Key finding	Example quote
Staff tailoring advice to the developmental needs of children and families is key.	*I've had a case before where I've gone into the home and we spoke about floor time, tummy time and things, but the room is just not appropriate for the baby to be on the floor, so it's giving the advice to the parents 'oh we could move this and rearrange' and then you've maybe done a follow up call or something and the parents have actually seen the benefits of changing things around, especially if it's a first time mum, it gives them a lot of reassurance and advice if they've not had it before. (Nursery Nurse 003)*
Higher burden visit for staff amidst staffing and resource pressures.	*I think for us, we're busy, very busy, nonstop, especially we've got lots of other commitments with the CDC (Child Development Centre) referrals and things like that. So, it is a lovely, you know, we like to do that visit, but it has sort of put extra pressure on, for my team anyway, on capacity and things like that. I don't know if other areas have found that, it's been, you know, we've juggled it, but it's been hard going. And without another staff member it would have been quite tricky." (Nursery Nurse 002)*
Macropolitical factors around continued funding has led to uncertainty and impacted planning.	*At the moment there are 75 local authorities that are directly supported to develop their family hubs. That's roughly half of all the local authority that there are, so it could be that they will extend the programme to be effectively across the whole country, which might then mean that we get a smaller slice of the cake. (Commissioning stakeholder 004)*