What Works *for* Children's Social Care

Thriving Babies: Confident Parents

Pilot evaluation

December 2022

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Acknowledgments

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About What Works for Children's Social Care

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Glossary

ACEs	Adverse Childhood Experiences, for example: domestic violence; physical sexual or emotional abuse; neglect; caregiver mental illness experienced during childhood.
Care (in care)	being in the care of (looked after by) a local authority for more than 24 hours and, often, away from birth parents – for example with foster carers or in residential care
Care experienced (person)	a person who has, at some point, been and may be still in the care of a local authority
Care leaver	an adult person (aged 18 plus) who, as a child, has been in the care of a local authority for 13 weeks or more spanning their 16th birthday
Care proceedings	family court proceedings to decide whether or not a local authority will have parental responsibility for a child and can therefore determine where they live
IPC	Institute of Public Care
Looked after child	a child who is looked after by their local authority
Perinatal	the period during pregnancy and the first 12 months after childbirth
Social prescribing	where health professionals refer patients to local, non-clinical support in the community to help them with their health and wellbeing – for example: volunteering, arts activities, gardening, befriending, healthy eating advice, and a range of physical activities
TBCP	Thriving Babies: Confident Parents (programme) in Manchester

Executive summary

Introduction

The Thriving Babies: Confident Parents (TBCP) programme is a multiagency partnership of local authority children's services (Early Help and Social Care) and two voluntary sector providers with a national scope: Barnardo's and Home-Start.

The Partnership has provided a perinatal support to babies both pre- and post-birth and their (prospective) parents who are recognised as having specific vulnerabilities including: learning difficulties; mental ill health; domestic abuse; substance misuse; social isolation; being in care or a care leaver; or having had a child previously removed from their care.

Multiagency TBCP interventions have been led by a key family practitioner from one of three partner agencies. The role of the key family practitioner is also to build trust and deliver the core evidence-based parenting and therapeutic support to individual families.

A Think Family Coordinator was an integral part of the TBCP model, aiming to provide connectivity with adult-focused services as required for individual families – for example: for parental substance misuse, mental health and/or learning disability.

The content and duration of each intervention was tailored to the needs of individual families. However, the target commencement of the intervention was pre-birth (typically in the second trimester) and it could continue for up to six months post-birth, longer if necessary. The intervention was provided predominantly in family homes including weekly or twice-weekly sessions with the potential for other contact between these.

TBCP also aimed to provide targeted outreach and other forms of tailored support for families from ethnic minority communities to ensure that services were culturally attuned, and families were encouraged to engage positively in the programme of support.

Research questions

The research questions the pilot evaluation sought to answer were:

1. How feasible is it to deliver the Thriving Babies: Confident Parents (TBCP) programme?

- To what extent has the intervention been delivered as intended? Have there been any changes during implementation?
- What variation is there, if any, in delivery across teams and localities?
- How are families referred into the intervention and to what extent do the referral channels "work"?

- What are the key elements of the intervention?
- How well does the multiagency partnership work?
- What are considered to be the key supports for the programme?
- What are the (unit) costs of provision?

2. To what extent, how, for whom, and in what circumstances does the TBCP programme show promise in engaging high-risk babies/families; and providing better coordinated, culturally attuned services (including to meet adult as well as child needs) and assessments?

3. To what extent, how, for whom and in what circumstances does the TBCP programme, or aspects of it, show promise from the perspective of families, staff and other professional stakeholders in relation to promoting the following outcomes:

- Secure child and parent attachments
- Confident parenting
- Thriving babies
- Improved parenting capacity, including parental attunement to babies' needs
- More infants[2] able to remain safely at home in a sustainable way
- Increased early permanency for vulnerable infants
- Improved parent wellbeing and confidence about the future
- Reduced risk factors for compromised parenting and increased resilience factors including parents feeling able to ask for help before reaching a crisis
- No unintended consequences or negative effects of the intervention for parents.

Methods

The pilot evaluation was undertaken from May 2021 to August 2022. The study utilised mixed methods drawing on quantitative as well as qualitative data, using the following key methods:

- Secondary analysis of whole cohort and administrative data

[2] Note on terminology: the terms 'infant' and 'baby' are used synonymously in this report.

- Collection and analysis of outcome measures on parent–infant attachment and parenting confidence
- Child and family case file sampling:
    - Review of recently closed/closing case files of 36 child and parent dyads
- Semi-structured interviews with programme participants and stakeholders:
    - 16 parents who participated in a TBCP intervention
    - Eight key family practitioners delivering the intervention
    - Seven project team members responsible for the day-to-day management of the programme
    - Four social workers with experience of referring into TBCP or working alongside TBCP key practitioners
    - 11 Steering Group members from partner agencies in the voluntary and statutory sectors
- Costs/unit costs analysis.

Key findings and discussion

With a relatively detailed and evidence-based blueprint at the start and a sustained high level of local authority and partnership commitment and support, the evaluation found that in the first 12 months of its operation TBCP had:

- Established consistent, efficient and effective referral routes
- Achieved high-level engagement with individual families including from minority ethnic communities
- Developed evidence-based practice led by key professionals who know what they are doing and why
- Demonstrated effective operational management including supervision and governance arrangements
- Provided effectively engaging, multidisciplinary and culturally attuned support for parents and families presenting with high risks and relatively complex needs.

The evaluation found consistently high-quality interventions led by key practitioners. The interventions were evidence and strengths-based offering a mix of educational and therapeutic sessional work with parents, and practical support.

The Thriving Babies: Confident Parents model demonstrated strong, triangulated evidence of promise in terms of its potential for positive impact on children and families, particularly on parenting practices, parent attunement to their infant's needs, child/parent attachments, and reduced parent risk factors. The evaluation found:

- High levels of infant/parent attachments pre- and postnatally evidenced by parent-reported validated measures
- Confident parenting and positive parenting practices evidenced by case file analysis and stakeholder interviews
- Reduced risk factors for compromised parenting and positive choices evidenced by administrative programme data, case file analysis and stakeholder interviews
- Improved resilience, coping and wellbeing among parents based on parents' and professionals' accounts
- A high proportion of babies remaining at home with parents or extended family evidenced by administrative programme data.

Overall, the programme appeared to offer effective support and promise of positive impact for a varied group of parents in terms of level of need and previous experience, and in different circumstances. The realistic evaluation highlighted the importance and potential contribution of various programme components and characteristics:

- The programme was accessible to a range of parents via the open and effective referral mechanism
- TBCP was relatively well resourced: once a parent was accepted, work would start with them promptly and key practitioners could dedicate time and effort to build trusting relationships. The support offered to parents was timely – in most cases started relatively early in the prenatal period – varied and targeted to respond to specific needs
- The programme was well-led with strategic leadership from the three main partner organisations as well as a diverse, skilled and committed staff team.

Further embedding of the model is required to explore the extent to which it can achieve better coordinated support than before. The Think Family element has created some of the foundations and framework for this during the first year of the service; however, it is too early to evaluate the impact of these activities and will need further examination as TBCP reaches maturity.

The evaluation has some limitations as well:

- It should be considered as a mid-term evaluation providing a snapshot from the first year of the pilot that runs until April 2023

- There is no baseline or any other counterfactual data against which we could compare the main findings from the study
- The parent-reported outcomes data was generated by a relatively small sample of parents and does not allow in-depth exploration of personal characteristics associated with different outcomes. The outcome measures were administered by practitioners involved in the pilot implementation.

Conclusion and recommendations

The evaluation suggests that this pilot programme has been well implemented and has started to become consolidated in Manchester. The programme has demonstrated strong evidence of promise in terms of its impact. Key learning from the pilot study regarding the implementation of a model like this includes the importance of:

- Having a clear model with clear aims and desired outcomes
- Early and sustained messaging and "publicity" about the model across all statutory and partner services (just at the start is not enough)
- Sustained leadership support for implementation beyond a short pilot phase and into "mainstreaming"
- Having a multi-disciplinary panel as a platform to "receive" referrals, hold multidisciplinary discussions about, and undertake detailed planning in relation to, individual families
- Highly committed staff who have the capacity to engage effectively with parents in this cohort, to work effectively with children's social care services as well as a range of partner organisations, and to learn new skills
- Regular, high-quality supervision for operational staff
- Regular review and monitoring of outcomes for children and families.

Building on the evidence of promise presented in this report, future research could explore:

- The medium- to longer-term outcomes for the infants and parents who have experienced the programme
- The costed benefits of the programme over time for children and families, as well as services
- The outcomes for infants and parents who have experienced the programme compared with "business as usual"

- The optimal timing for starting an intervention during pregnancy, including the extent to which it can start “too soon”
- The medium- to longer-term benefits of involving fathers in this kind of intensive intervention
- The impact of the “Think Family” approach – multidisciplinary “team around the family” on outcomes for parents and infants.

1. Introduction

Background

The first years of a child's life are extremely significant in terms of laying the foundations for their cognitive, emotional and physical development (HM Government, 2021).

As the number of infants in care proceedings have continued to increase in recent years (Mason et al., 2022), local authorities and national policymakers are concerned to better understand and halt this upward trend. Many of the parents whose children are subject of safeguarding or care proceedings in infancy have themselves experienced adverse childhood experiences, including abuse or neglect, and some are also care experienced (Mason et al., 2022).

A specific concern is that support for many of these children and their sometimes very vulnerable parents is insufficient, or insufficiently holistic, and/or that it does not start sufficiently early to enable parents to demonstrate their capacity to parent adequately or to stop or reduce potentially harmful behaviours (Burch et al., 2020). The recent "Born into Care" study has cast a spotlight on a growing trend for local authorities to issue care proceedings at or soon after the birth of a child to a care leaver or otherwise vulnerable parent (Broadhurst et al., 2018; Pattinson et al., 2021). This raises concerns about what has been described as a "typically short window for pre-birth assessment" which means that prospective parents who are known to be vulnerable do not have enough opportunity to work purposefully on their parenting skills before the child is removed from their care.

Parents' vulnerabilities and risk factors, alongside the lack of adequate support, may make parenting very challenging for some parents in the first few months of a child's life. However, emerging evidence suggests that worse outcomes, such as the need for a child to become a looked after child of the local authority (in care), are not inevitable if early, coordinated and sustained support is put in place (Public Health England, 2016; Burch et al., 2020). There are emerging examples of promising pre- and perinatal services supporting parents with complex needs (Mason et al., 2022) as well as interventions designed to encourage parents whose children have already been removed from their care to "pause" further pregnancies and thereby potentially recurrent child removals (Boddy et al., 2020).

This evaluation of Thriving Babies: Confident Parents, a key practitioner-delivered service for vulnerable at-risk parents in Manchester, adds further evidence to emerging literature about the potential value of intensive support for vulnerable parents during the perinatal period (see for example Burch et al., 2020; Cox et al., 2020; Ryan, 2020; Mason et al., 2022).

Project context

In Manchester, there are high levels of deprivation and inequality and, before the Thriving Babies: Confident Parents (TBCP) pilot started, a consistently high number of infants were removed into care, including a large proportion of infants from ethnic minority backgrounds (46% in 2019). Commonly presenting issues where infants have been removed included domestic violence, parental substance misuse and mental ill health. At the same time, pathways for adult and child health and social care have not been routinely integrated so whole family interventions for babies at risk were not sufficiently holistic or early for greatest effectiveness.[3]

A small pilot project with 15 families in Manchester took place in 2019 in response to the high number of babies removed into care or requiring high-level social work intervention at birth. This demonstrated the potential for positive impact, with 83% of babies reported to remain living with their birth parent(s) post-intervention. However, the pilot also identified a lack of service capacity and coordination particularly with adult and voluntary services.[4]

The TBCP programme builds on the experiences of this early pilot and aims to improve outcomes for vulnerable, “high risk” babies by providing an early, coordinated, multiagency intervention. The programme was developed and implemented during the period of the COVID-19 pandemic and recognised that babies were especially vulnerable at this time due to social isolation and virtual working practices that had the potential to lead to reduced visibility of them by services.

The programme was launched in May 2021 to run for two years. The first 12 months of the programme were part-funded by the What Works Centre for Children’s Social Care, and the second year has been funded by Manchester City Council.

Description of Thriving Babies: Confident Parents

Based on the Template for Intervention Description and Replication (TIDieR) framework (Hoffmann et al., 2014), the main features of the TBCP programme are summarised in Table 1.1.

[3] Source: WWCSC Open Funding Round 2, Full proposal Stage 2 application form, Manchester City Council.
[4] Source: WWCSC Open Funding Round 2, Full proposal Stage 2 application form, Manchester City Council.

Table 1.1. Main features of Thriving Babies: Confident Parents

	Main feature
What?	• Multiagency partnership of local authority children's services (Early Help and Social Care) and two relatively large voluntary sector providers with a national scope: Barnardo's and Home-Start • Providing an early response to babies both pre- and post-birth and their (prospective) parents who are recognised as having specific vulnerabilities including: learning difficulties; mental ill health; domestic abuse; substance misuse; social isolation; being in care or a care leaver; or having had a child previously removed from their care • Targeted outreach support for families from ethnic minority groups, translation services and other support to facilitate cultural attunement and engagement • Involves work with both mothers and fathers, and extended family where relevant.
Who provided?	• Close collaboration between partner agencies to provide a "team around the family" approach and new perinatal pathways to accelerate and join up referrals, assessments and services, and support partner agencies to encourage or refer the right families into the programme • Intervention led by a key family practitioner from one of three lead agencies (local authority Early Help, Barnardo's or Home-Start) to ensure that assessment is strength- and evidence-based. The role of the key family practitioner is also to build trust and provide the core evidence-based parenting and therapeutic support to individual families • A Think Family Coordinator provides connectivity with adult-focused services that are required – e.g. substance misuse, mental health, learning disability • Referral and case allocation via a Resource Panel. The panel identifies the lead agency and whether service provision should be single or multiagency and at what time

	• Partnership support via a multiagency project team and Steering Group including key partners from the voluntary and statutory sectors, including the NHS to agree and sign off pathways and supports • Individual and group supervision arrangements for key family practitioners, supportive of the overall model and reflective practice • Extensive training for key family practitioners including in: adverse childhood experiences (ACEs); trauma-informed approaches; motivational interviewing; parenting assessments; signs of safety; domestic abuse; health in pregnancy; child development interventions; and more.
Where?	• Intervention provided predominantly in family homes and children's centres (if necessary) as regular weekly or two-weekly sessions with potential for phone or other contact between these.
When and how much?	• Ideally starting pre-birth (up to 5–6 months before the due date) and continuing until 3 to 6 months after the birth (i.e. 12 months or longer total duration).
Tailoring	• The content and duration of the intervention is tailored to the needs of individual families.

At an early stage of the evaluation, a logic model for the funded project and evaluation was co-produced by Manchester City Council managers, evaluators at IPC and representatives of the funding body (What Works Centre) in the context of an online workshop. The logic model set out the context and rationale for the pilot; key aspects of the innovation; mechanisms for successful interventions; and the intended outcomes for individual families and medium- to long-term effect on service-demand and whole-system working. The logic model is included in Appendix A.

Pilot evaluation

The pilot evaluation was undertaken by the Institute of Public Care at Oxford Brookes University between May 2021 and August 2022. It explored the key elements of TBCP, the programme's feasibility, and its evidence of promise with reference to the key aims of the project. We adopted a realistic approach, exploring not only whether the model seems to work but in what circumstances, for whom, why and to what extent (Pawson & Tilley, 1997). We also considered the acceptability of the programme for the target participants, and any barriers to their participation.

The evaluation was implemented in a collaborative fashion working with TBCP partners to generate the best learning about what works.

2. Evaluation methods

Research questions

The research questions the pilot evaluation sought to answer were as follows:

1. How feasible is it to deliver the Thriving Babies: Confident Parents (TBCP) programme? Feasibility refers to the programme design, procedures and governance, and whether the intervention can be implemented as intended.

- To what extent has the intervention been delivered as intended? Have there been any changes during implementation?
- What variation is there, if any, in delivery across teams and localities?
- How are families referred into the intervention and to what extent do the referral channels “work”?
- What are the key elements of the intervention?
- How well does the multiagency partnership work?
- What are considered to be the key supports for provision of the programme?
- What are the (unit) costs of delivery?

2. To what extent, how, for whom and in what circumstances does the TBCP programme show promise in engaging parents/families; and in providing better coordinated, culturally attuned services (including to meet adult as well as child needs) and assessments?

3. To what extent, how, for whom and in what circumstances does the TBCP programme or aspects of it show promise from the perspective of families, staff and other professional stakeholders in relation to promoting the following outcomes:

- Secure child and parent attachments
- Confident parenting
- Thriving babies
- Improved parenting capacity including parental attunement to babies’ needs
- More infants are able to remain safely at home in a sustainable way
- Increased early permanency for vulnerable infants

- Improved parent wellbeing and confidence about the future
- Reduced risk factors for compromised parenting and increased resilience factors including parents feeling able to ask for help before reaching a crisis
- No unintended consequences or negative effects of the intervention for parents.

Protocol registration and ethical review

The study received ethical approval from the WWCSC Research Ethics Committee on 4 June 2021.

Research design and data collection

Evaluators used a mixed-methods design based on the principles of realistic evaluation (Pawson & Tilley 1997; Tilley & Pawson 2000).

- Whole cohort data analysis
- Standardised measures' analysis
- Child and family case file sampling
- One-to-one interviews with parents
- One-to-one interviews with key family practitioners and broader stakeholders
- Costs/unit costs analysis.

Table 2.1 gives an overview of the evaluation activities including data sources, collection methods and procedures.

Table 2.1. Overview of evaluation activities

Evaluation activity	Detail	Date
Secondary analysis of administrative records	Programme dashboard data shared by MCC Case tracker completed by the programme team	May 2021-August 2022

	Costing data shared by the programme team	
Case file analysis	Review of child and family case notes and other relevant documentation in Liquid Logic and/or Home-Start's systems The recently closed/closing case files of 36 child and parent dyads were reviewed	February-July 2022
1:1 interviews with parents	Semi-structured interviews with 16 parents	January-August 2022 (rolling, as they finished interventions)
1:1 interviews with key family practitioners (core team)	Semi-structured interviews with 8 key family practitioners	June-July 2022
1:1 interviews with the project team	Semi-structured interviews with 7 project team members	June-July 2022
1:1 interviews with stakeholders	Semi-structured interviews with 11 Steering Group members	June-July 2022
1:1 interviews with social workers	Semi-structured interviews with 4 social workers with experience of referring into TBCP or working alongside TBCP key practitioners	July-August 2022
Self-reported parent outcomes: attachment and confidence	Collection and analysis of validated outcome measures	May 2021-August 2022
Observation of core team and project team meetings	Participant observation of online meetings (n=5)	August 2021-March 2022

Five validated measures were used to collect information on self-reported parent outcomes:

1. The Maternal Antenatal Attachment Scale (MAAS) (Condon, 1993): this consists of 19 items divided over two subscales: “quality of attachment’” (11 items) and “time spent in attachment mode” (eight items). The first subscale represents the quality of the mother’s affective experiences towards the unborn baby (feelings of closeness and tenderness versus feelings of distance and irritation). The second subscale represents the intensity of preoccupation with the unborn baby in terms of time spent thinking about and talking to them. MAAS scores were recorded for 35 mothers.

2. The Maternal Postnatal Attachment Scale (MPAS) (Condon & Corkingdale, 1998) assesses mother-to-infant bonding in an infant’s first year of life. The MPAS is also divided over three subscales, indicating “Quality of attachment”, “Absence of hostility” and “Pleasure in interaction”. MPAS scores were recorded for 21 mothers.

3. The Paternal Antenatal Attachment Scale (PAAS) is a 16-item measure which can be divided into two subscales: the Quality of the attachment (eight items) and Time spent in attachment mode (six items). PAAS scores were recorded for eight fathers.

4. The Paternal Postnatal Attachment Scale (PPAS) is a 19-item scale that measures Paternal patience and tolerance, Pleasure in interaction with the infant, and Affection and pride for the infant (Condon, 2015). PPAS scores were recorded for 21 fathers.

5. The Karitane Parenting Confidence Scale (KPCS) measures Perceived Parenting Self Efficacy (PPSE) in the parents of children aged 0–12 months. KPCS scores were recorded for 44 parents – mothers and fathers.

The case file analysis took place on site at Manchester City Council, Home-Start and Barnardo’s offices during three fieldwork visits in February 2022 and July 2022. Case notes and related documents relating to recently closed TBCP interventions were retrieved from Liquid Logic and Home-Start and Barnardo’s systems where parents had consented to the evaluation. Key information was captured in a data extraction form in Excel (see Appendix B).

An initial sample of seven case files were reviewed by two evaluators (first two authors) to ensure reliability and accuracy of recording.

Out of the 16 parent interviews, six took place face-to-face in family homes and ten were conducted remotely over the phone/WhatsApp or Zoom. All but one interview was conducted in English; one interview was bilingual (English and Urdu). All interviews were undertaken by the same evaluator, apart from the bilingual interview that was conducted by one English-speaking and one bilingual evaluator. All parents who participated in an interview received a £10 gift voucher as a “thank you”. The voucher was not used as an incentive in the consent/recruitment process. One-to-one professional and stakeholder interviews were conducted virtually by one of the evaluators on Microsoft teams. (See Appendix D for topic guides to semi-structured interviews.)

Outcome measures were administered by key practitioners during and as part of the intervention. They received guidance about the measures (e.g. when and how many times they need to be completed, etc.) and responses were recorded either on paper and then recorded using Microsoft Forms by the practitioner or directly recorded in Microsoft Forms with the parents.

Sample recruitment and selection criteria

All parents who received support from a TBCP key family practitioner were eligible to take part in the evaluation. At the time of reporting, there were 36 closed and 42 open cases. Parents received an information pack about the evaluation including a participant information document, privacy notice and consent form. The information was presented to them by the key family practitioner who also explained the voluntary nature of participation as well as the principles of anonymity and confidentiality. Reason for non-consent were not recorded.

For non-consenting parents, only completely anonymised administrative and demographic data was shared with evaluators.

Key family practitioners recorded parental consent for data sharing and then confirmed consent for the interview before closure. Informed consent was also checked at the beginning of the interview and parents were given the opportunity to ask questions about the evaluation – such as how their information would be used and presented, the purpose of the evaluation, and so forth.

For TBCP practitioner and stakeholder interviews, we approached all core team, project team and Steering Group members by email (n=42). In total, 28 people agreed to participate in an interview. Those who did not agree had either left their post or joined recently or were not closely involved with TBCP (some steering group members).

For the social worker interviews, we contacted ten people who were recommended by the project team, namely social workers who either made referrals to or worked with TBCP cases. Four social workers agreed to be interviewed.

All TBCP practitioners, stakeholders and social workers received information about the evaluation prior to the interview and were asked to confirm their consent verbally.

Steering Group and Core Team meetings were observed virtually under the Chatham House Rule, without recording names and directly attributable contributions.

Data management and processing

A Data Sharing Agreement signed by the What Works Centre, Manchester City Council and the Institute of Public Care (IPC) set out the terms and conditions of accessing, managing and processing personal data.

All interviews with parents and professionals were audio-recorded and transcribed using automatic transcription. Transcripts of parent interviews were anonymised, and all interviews were saved in Microsoft Word and transferred to NVivo for analysis.

Data from case files was recorded in a password-protected Microsoft Excel file.

Outcome measures were recorded in Microsoft Form, set up by Manchester City Council. Data was exported to Microsoft Excel to check completeness, data cleaning and then transferred to SPSS for statistical analysis.

Personal data was accessed, managed, and processed on Manchester City Council or IPC-owned and managed devices. Data on Manchester City Council (MCC) servers were accessed with an MCC login issued for the evaluators.

Analysis

Qualitative data analysis

Qualitative data from interviews was analysed thematically by the first author (AT) with the support of NVivo. A deductive coding frame was created including with reference to the research questions and these were refined subsequently. Themes in the data were developed from the codes (Braun & Clarke, 2012). Regular discussions were held by the first and second author (KB) to discuss the process of analysis and findings and to resolve any queries.

Qualitative data (descriptive information) from case files were analysed thematically summarised with reference to the headings of the data extraction form.

Quantitative data analysis

Quantitative data from administrative sources and case file analysis was summarised using basic descriptive statistics in Excel. Outcomes data from the validated measures was analysed in SPSS using descriptive and inferential statistics. Evaluators calculated descriptive statistics (medians and semi-interquartile ranges) for all variables; Mann-Whitney U test was applied for comparison of independent groups; and Wilcoxon signed-rank test for the “longitudinal” sub-sample of participants.

Evaluators used both within and across method triangulation to confirm and enhance the validity of findings, and each evaluation question has been addressed using multiple types and complementary sources of data (Bekhet & Zauszniewski, 2012).

3. Findings

Feasibility of Thriving Babies: Confident Parents

Feasibility means whether the programme can be carried out. It considers factors such as programme design, procedures, delivery mechanisms, governance and resources.

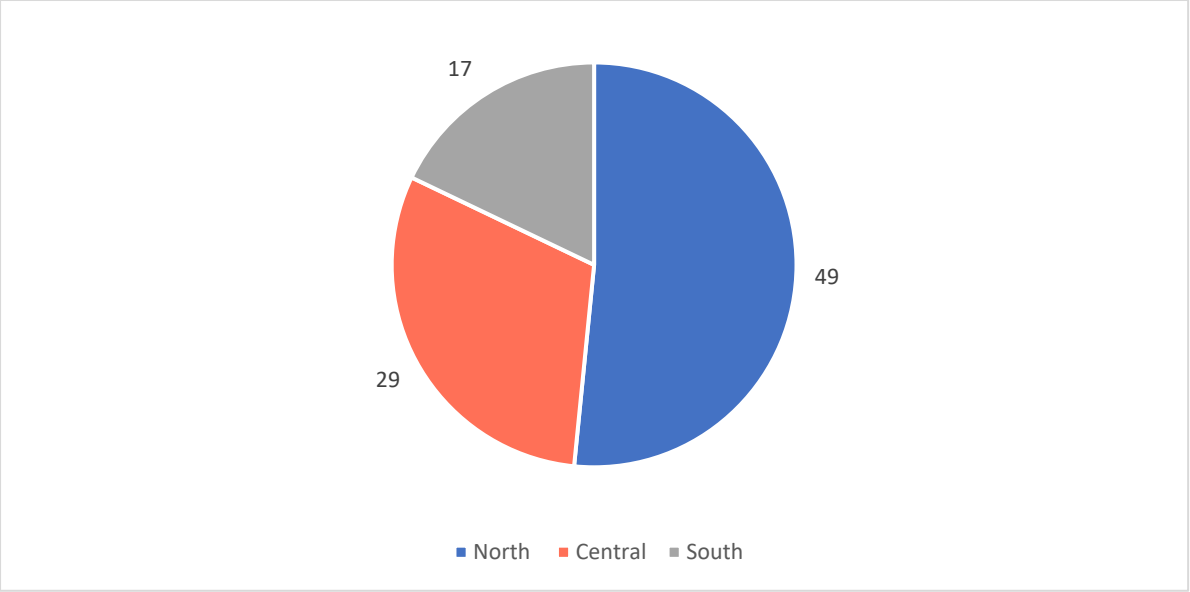
The drive for Thriving Babies: Confident Parents (TBCP) emerged from a local need that provided a clear rationale and was shaped by a strong tradition of multiagency collaboration between the statutory and voluntary sector in Manchester, as a high-level representative of the Steering Group explained:

> *"[We thought TBCP] would be a great opportunity for us to think about how we could build together the work of the voluntary and statutory sector but more importantly, connected to what we've [with] seen some of the gaps around services, particularly during the COVID pandemic. … Also, we were looking quite critically at what was that performance data telling us around the makeup of the children, both in terms of race and ethnicity, what was those children's journeys. And … we were starting to think about adult vulnerabilities impacting on ability to parent. So it just made sense to do something that absolutely prioritised babies and children. … But we knew we had to do something that was different and involved our Adult Social Care partners from the outset." (Steering Group 3)*

The importance of working with parents and families during the perinatal period in the context of the COVID-19 pandemic was recognised by stakeholders, therefore face-to-face contact to support parental engagement and learning was an integral part of the offer from the outset.

The programme was launched in June 2021 and, in the first 12 months, it received 95 referrals from three localities (see Figure 3.1). Parents referred into TBCP from the South area who were not eligible for the programme were redirected into the mainstream Early Help offer.

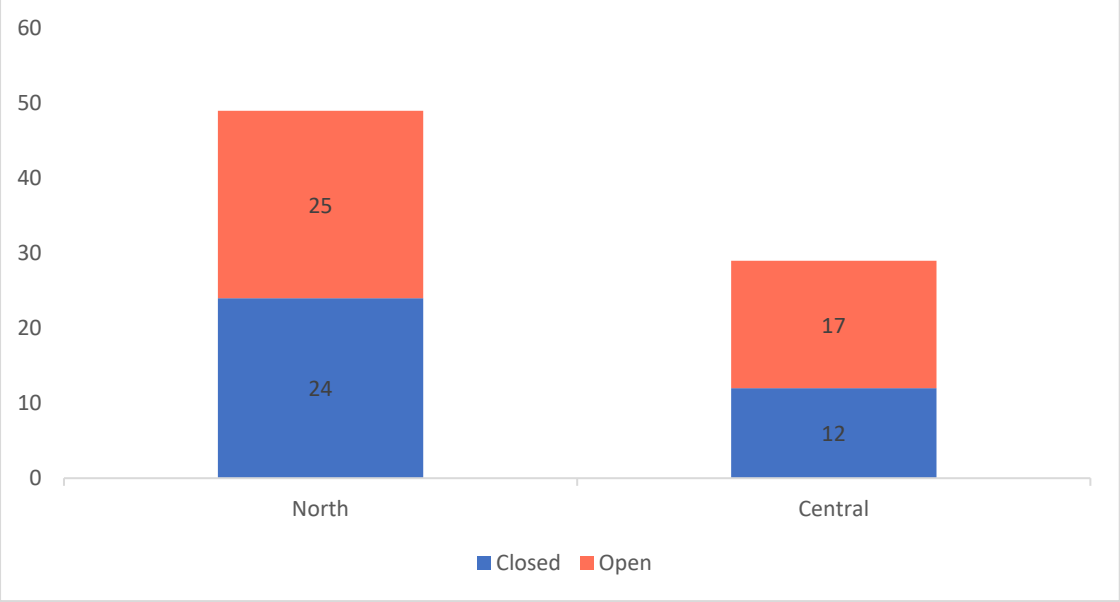
Figure 3.1. Referrals to TBCP by locality (by June 2022)



Source: Administrative programme data (June dashboard)

Of the 78 referrals accepted in the North and Central localities, there were a total of 36 closed and 42 still open cases by June 2022 (see Figure 3.2). The project has therefore met its target to involve 60 families in the intervention in the first 12 months.

Figure 3.2. Open and closed cases by locality (June 2022)



Source: Administrative programme data (June dashboard)

Has TBCP been implemented as intended?

This section presents evidence in relation to three evaluation questions:

- To what extent has the intervention been delivered as intended?
- Have there been any changes during implementation?
- What variation is there, if any, in delivery across teams and localities?

Looking at the first twelve months of the programme, evaluators found evidence of effective operational and management structures, governance procedures, and leadership. TBCP has been delivered as planned and intended (see Column 2 of the Logic Model in Appendix A).

The operational management of TBCP has been provided by a project team with representatives from the three organisations involved in delivery. The intervention has been delivered by a core team of eight key practitioners (one from Home-Start, two from Barnardo's and five from Manchester City Council). The programme was overseen by a Steering Group consisting of representatives of Health, Social Care, and Early Years organisations from the statutory and voluntary sector, including the NHS. The Steering Group has provided strategic direction and high-level visibility to the programme, bringing together a wide range of stakeholders.

The key aims of TBCP were early permanency for babies and improving parenting capacity for vulnerable parents, which were understood and endorsed by stakeholders. We found high levels of coherence and a shared sense of purpose, particularly among those involved in day-to-day delivery (i.e. project team and core team). Stakeholders with different backgrounds and levels of involvement in the programme articulated the aims both consistently and in-depth:

> *"Key aims at the beginning was permanency for unborn or the child if they're born. And by permanency I mean to have a permanent home, not necessarily with the birth parents, but to have a safe, secure home where they can thrive. I also do feel that it in most cases, one of the aims is to keep baby with parents, … to build the confidence of parents to see babies thriving. And ensuring there's a good attachment between parents and child. The other main aim is to empower parents to make positive changes for themselves." (Core Team 6)*

> *"From my understanding with working with the Thriving Babies, it's about that early intervention with families and babies. And it's about supporting parents to be the best parents they can be … to meet the children's needs and understand what the child needs and how those needs might develop over time." (Social worker 2)*

Slight variations in the emphasis were noticed among stakeholders describing the programme aims, with some focusing more on the aspect of developing parenting capacity

and others on permanency for children. However, there was no evidence of significant divergence of views across teams and sites with reference to either programme practice (methods) or programme outcomes.

When asked about the clarity of aims for other stakeholders, some participants from the project team and core team suggested that this might not have been clear to everyone at the outset.

> *"From a midwife's perspective, there was a lot of confusion between the Vulnerable Babies and the Thriving Babies Programme. Midwifes didn't really understand the differences between the two at the beginning. TBCP did a forum and sent a piece for the newsletter." (Steering Group 10)*

However, they considered that this clarity had improved because of consistent publicity, messaging and learning by the multidisciplinary panel members. It was also highlighted that, while the initial information sharing – presentations, information in newsletters, and so on – were important, this needed to be continued throughout the programme duration to ensure that partner agencies and staff working within them were regularly reminded of and understood the offer, particularly in the context of high staff turnover and other organisational pressures.

> *"And I think because it's such a high turnover of staff in social work … then people don't understand it. … So we just have to help them along in that way. they're not always clear about what it is that we're offering." (Project Team 2)*

In a relatively short time, the programme established a distinct identity that became increasingly well known among a range of professionals working with vulnerable parents and families, including social workers and midwives. This was noted by TBCP practitioners.

> *"Overall, [social workers'] awareness of our service is a lot better. And their understanding of our service is getting there." (Core Team 1)*

> *"People are asking about us now. They are more aware… social workers, health visitors, midwives. I was on a meeting this morning, the midwives weren't aware that we were involved. And she asked about the Thriving Babies worker being involved." (Core Team 7)*

No evidence of significant changes in the programme's aims or model during the first year of implementation were identified. However, the role of the "Think Family" coordinator shifted from the originally envisaged practitioner-led approach to a more strategic level to address the organisational barriers to multidisciplinary and multiagency collaboration and facilitate the provision of whole-family support in a timely way (the "Think Family" coordinator role is discussed in more detail later in this section).

How are families referred into the intervention and to what extent do the referral channels "work"?

Families were referred into TBCP via a multiagency resource panel meeting twice a month to receive referrals, decide about the allocation of families to lead agencies, and offer advice regarding the intervention.

During the evaluation period, the majority of referrals came from children's social workers. However, there was also an increasing number and proportion of families referred by other agencies, most importantly Adult Social Care and Midwifery, suggesting that the referral pathway became increasingly established and well known beyond Children's Services.

Of the 36 case files reviewed for this evaluation, approximately two-thirds (23) of referrals were from social workers and approximately one-quarter (10) from midwives. Two referrals came from the police.

Most stakeholders saw the panel as an important resource that, as well as providing a platform for multiagency discussion and planning for individual families, helped to promote the visibility and understanding of the programme's offer. It was noted that the panel had evolved as implementation progressed and ways of working became more established. Panel participants welcomed it's openness and positivity, broad and deep knowledge base, ability to triage effectively, and time to plan in an evidence-based way for individual families.

> *"Panel was really, really positive, a huge wealth of knowledge. And they were able to think about things we've never thought about in terms of service knowledge for babies. … So that was a massive positive. And I think the panel itself was nice and friendly." (Social worker 4)*

> *"I think the good thing has been about having the panel for the request to come through and having that open discussion in that arena with other professionals. … and also it's important to have health and social work on board and some of those other organisations, that has been really useful. (Project Team 2)*

Only one stakeholder expressed disagreement with the open approach of the panel and suggested that the Programme should be only for infants open to children's social care.

Panel meetings – and initially other meetings with professionals and stakeholders – were held online due to the Covid-19 pandemic, which was seen as helpful by the project team and other professionals and may have facilitated 'buy-in' from partners.

> *"The panel is a virtual meeting, and that's worked out so much better, because you're not travelling. … We wouldn't get the same buy-in if it was face-to-face all the time." (Project Team 2)*

"So far, the panel has always met on Teams. That's a strength for me … it's easy, and it's accessible. I like the way that people are able to drop into it and talk about their case." (Steering Group 9)

What are the key elements of TBCP?

The fourth evaluation question under the feasibility of the programme referred to its key elements. This question was answered using evidence from the analysis of programme records and case files, interviews with stakeholders, and observation of meetings. Five elements were identified that distinguished TBCP from Manchester City Council's existing Early Help "business as usual" offer and were seen as "core" to the model by professional stakeholders. These are:

1. Multiagency partnership of statutory and voluntary organisations.
2. A "Think Family" approach.
3. Very early identification and intervention with vulnerable families including relatively early in a pregnancy.
4. Use of therapeutic as well as educational (parenting) sessional work with families.
5. Practical support provided alongside sessional work.

Multiagency partnership (and how well is this working?)

TBCP was provided in partnership between Manchester City Council's Early Help Hub (North and Central), Home-Start and Barnardo's. As described by a high-level representative of the Steering Group, "The voluntary and community sector is an equal partner around the table." (Steering Group 3)

Table 3.1 provides an overview of the number and proportion of all families receiving a TBCP service by involvement of the three organisations.

Table 3.1. Number of families receiving a TBCP service where partner organisations were involved by June 2022

Partner organisation	Number of families receiving TBCP support
Early Help	80
Home-Start	20

Barnardo's	12

Source: Administrative programme data, June dashboard

Table 3.2 shows the distribution of open cases (at June 2022) by lead agency; this includes Although a considerable majority of cases were led by the local authority Early Help service, other partners also provided a key (lead) family practitioner in a proportion of cases.

Table 3.2. Number and percentage of open TBCP cases by lead agency, June 2022

Partner organisation	Number families	Percentage (%) families
Early Help	31	74
Home-Start	8	20
Barnardo's	2	5
Home-Start & Barnardo's	1	2
Total families	42	100

Source: Administrative programme data, June dashboard

Within the case files sampled for the evaluation, a similar proportion of interventions were led by Early Help (27; 75%), three (8%) were led by Home-Start, and six (17%) were led either sequentially or simultaneously by more than one agency.

There were differences in the sessional work and support offered by the three agencies, with each partner providing a defined and coordinated contribution to the overall provision of TBCP support, suggesting that the multiagency partnership was a successful element of the programme (see section below on 'Evidence-informed educative and therapeutic sessional work with families').

Although Barnardo's offer of trauma-informed therapeutic work was recognised as an important element of the programme from the outset, there were some initial challenges in finding the best time to include it in the intervention to maximise the benefit to parents. Although the "best time" for in-depth therapeutic work is difficult to locate very accurately for parents, and it may vary from parent to parent, the experience of TBCP practitioners suggested that this work should be carefully introduced when there is some trust established between the worker and the parent, and some capacity for the parent to engage with it. A

referral to the programme of a parent in crisis could be a strong indicator of the need to postpone such work for a short period of time. Therapeutic work was varied but included in particular facilitated conversations between the practitioner and parent to explore the parents' past including traumatic experiences, to understand these better, and to recover from them.

> "*It's very hard to explain to somebody [how] it's a therapeutic model. … We do repair work, we do trauma work. You can't do that at the beginning, you need to have them [parents] in a space of stability, or, you know, engagement. It could be more dangerous to pick them up at crisis point at panel when they come in." (Project Team 6)*

Case files provided clear evidence of multiagency coordination and working facilitated by key practitioners in three-quarters of cases (27/36). This typically involved work with or relating to:

1. Housing associations and supported living providers, for example negotiating repairs and improvements to ensure appropriate and safe accommodation for newborns; helping parents register and bid for social housing; or securing a new tenancy for the family to remain around existing support networks.

2. Benefits and finances – ensuring parents were aware of what benefits they were entitled to, helping with claiming benefits, Healthy Start vouchers, signposting to debt counselling/management, advising and supporting financial management (e.g. to obtain an ID document, open a bank account, understand the signs of financial exploitation).

3. Universal services, such as Sure Start, baby groups and courses.

4. NHS health and maternity services, including pre- and perinatal mental health, bereavement counselling, GP registration for parents and newborn, or referrals to social prescribing.

5. Voluntary organisations such as Women's Aid, Centrepoint, Change Grow Live (drugs service), Bridging to Change, Eclipse, Citizen's Advice and Afruca. Initiating new referrals and supporting ongoing work.

6. Statutory services such as probation and social work (mostly children's social workers but also adult social care including adult learning disability services and autism assessments).

Joint case work between social work(ers) and TBCP was evidenced in all case files. There were numerous examples of key practitioners regularly working closely with social workers and supporting parents throughout the child protection procedures; for example, explaining the process and the relevance of each step to parents, or providing information to professionals to reduce burden of parents having to repeat information. In the context of high

social worker turnover, this was identified by TBCP workers and other stakeholders, including social workers themselves, as a particularly valuable feature of the programme.

> *"Although [business as usual] early help has partners that work alongside them, they're not working and delivering on the same cases in a way that the thriving babies model does. We work much more closely with the social workers on Thriving Babies. In Thriving Babies like 99% of the referrals have a social worker at some point. When you look at early help [business as usual], it is like 25%. So there's a significant step up. I think we've been really well received by social work in the sense that this wasn't there before. There wasn't an offer for those pregnant moms." (Project Team 7)*

> *"We've had a nice relationship [with TBCP worker] in terms of we're really able to kind of discuss things together and see what we both think is best for support for the family because they've known them slightly longer than I have, because they were already involved when it was allocated to me. So that has been really helpful." (Social worker 1)*

A "Think Family" approach

The second key element of the TBCP model was the "Think Family" approach, based on the recognition that parents' and children's needs and outcomes are very often intertwined:

> *"So, part of the Think Family approach was we won't be able to improve outcomes for children unless we absolutely understand and respond to the whole family and the adult vulnerabilities. And it's not a new thing, we tested this out previously, but I think for the first time, we brought it together in a number of thematic pilots. TBCP is one of these with a thematic focus where you bring in practitioners together with a very clear, cohort-focused rationale." (Steering Group 3)*

Originally the role of a Think Family Coordinator for the pilot was envisaged as practitioner led. However, as pilot implementation progressed, the role shifted to address barriers between Adult and Children's Services at a more strategic level, rather than offering direct frontline practice around assessments, referrals and interventions. It was recognised that programmes of work with cohorts like TBCP, who often present with multiple and complex adult issues such as mental health, domestic violence and substance misuse, need to find effective ways facilitate multidisciplinary and multiagency collaboration in order to break down barriers or "disconnects" to key aspects of whole-family support being provided in a timely way.

> *"… there's looking at the wider system processes, and where we have disconnects between adults and children's and trying to get that coordinated support around the family, which again, is going to help them to achieve the outcomes for both parents and child." (Project Team 5)*

In the first year of the programme, the Think Family Coordinator worked to enable better coordination and more holistic support around the family by securing improvements in: the work of the joint resource panel; joint working protocols; and cross-department training. In particular, the Think Family Coordinator:

- Provided information and raised awareness of the TBCP offer in Adult Social Care Services and presented at children's social worker team meetings, shared information about key areas of Adult Social Care Services and how they could work with TBCP practitioners
- Facilitated information sharing, such as providing case notes for the TBCP resource panel from the Adult Social Care management system
- Invited adult social workers to attend training on children's safeguarding, etc.
- Brought in an additional service (i.e. substance misuse support) to the Resource Panel to enable it to combine adults' and children's resources
- Worked with Adult Social Care Services to identify areas to improve joint working, such as agreeing target timescales for picking up referrals, identifying gaps in provision for commissioned services, challenging service allocation decisions.

Stakeholders thought that realising the impact of having a Think Family approach and Coordinator would take time and that, in the meantime, some notable gaps in support for parents remained. Bringing on board mental health services in support of parents and families had been particularly challenging during the pilot evaluation period, attributed to limited capacity within that system.

> *"The project is evolving and improving. The gap is mental health and mental health services are extremely stretched. … it's unlikely that they would come in because it's just the capacity issue. And the waiting list is so long." (Project Team 5)*

Early identification and intervention

The third key element of TBCP was early identification and intervention. Unlike mainstream Children's Social Care and Early Help services, TBCP aimed to identify need and offer support early during a pregnancy.

From the administrative data, evaluators identified that a large majority (80%, or 27 out of 33) interventions started at least four weeks and, on average, (approximately) 16 weeks before the baby's due date. However, there were large variations in the timings of the start of interventions with some programmes of work starting as early as seven months before a due date (at 10–12 weeks of pregnancy), while a small number (two) started one week or less before birth and five cases (15%) opened when baby was already born. This variation was due to referral practices rather than waiting lists for commencement of TBCP work.

Once cases were accepted and lead agency/key practitioner allocated, the intervention started promptly, usually on the same day or within 48 hours first contact was made.

During the first year of its operation, TBCP had no waiting lists, which allowed a prompt response to families:

> *"I'm conscious that I don't want to have to have a waiting list. And I want to give a speedier response to these families so that we can get that support early on." (Project Team 2)*

Starting work with parents promptly and early in pregnancy was recognised as very important by all stakeholders including because this encourages parents to attune to their baby, make positive choices (and reduce risks), and to make practical plans for the birth and living arrangements before the event. Some stakeholders also thought that this time could present a "window" for critical, reflective work with the parent in support of both positive choices and emotional wellbeing.

> *"Hugely actually, and again, that just reflects what we're learning more and more so in our service and there's lots of research isn't there around reflective functioning and if you can encourage parents to have positive thoughts about their unborn baby then that is a really good predictor of outcome later on down the line. … I think, absolutely, pregnancy is where you need to be in there really. … in terms of health outcomes, supporting families to make the right health choices is obviously massively important antenatally. But from a relationship attachment point of view. I think antenatal is definitely where services need to all be heading." (Steering Group 6)*

> *"I think that's really important. I think part of that, you know, that work being completed prior to pregnancy. It's just important planning, to the families to get their minds around and think about the children's needs, identifying risks, how they can work with that risk and reduce that harm, is really important. And, you know, we worry about children in the womb, not just when they arrive, a lot of that important work still needs to happen during pregnancy." (Social worker 2)*

For key practitioners – especially those with an Early Help background – this meant a new way of working – that is, without a baby present – to which they needed to adjust. However, even for these practitioners, the advantages were evident.

> *"The earlier on in the pregnancy, the better as far as I'm concerned. Although for us, for people who have worked with families with children, it's really strange working with a parent with baby in utero, but it's the same. That baby is a baby. Yeah, inside outside, it makes no difference." (Core Team 6)*

There were some questions and dilemmas raised by interviewees about the timing of the intervention, particularly what represented "early" and to what extent the start timings could be "too early", and whether there were any potential disadvantages to starting "too early"?

> *"It's good to have it early. So you can start to build up that relationship. That's very important. But it's the bit when you've done all the sessions … how do you fill the gap before the baby's born? … If we could bring in the other agencies at that point and … when the baby arrives, we're there to observe to make sure that the parenting is consistent." (Core Team 3)*

As referenced above, another aspect of timing raised by some practitioners was about parents' readiness to engage in more targeted and specialist therapeutic work, with specific reference to relatively embedded "chaotic lifestyles", emphasising the importance of parent- and needs-led support:

> *"Sometimes … there was still quite a lot of and there still is quite a lot of chaos and a lot of other things going on sometimes which can make the therapeutic work impossible. It's got to be at the right time." (Core Team 4).*

Evidence-informed educative and therapeutic sessional work with families

From 25 closed cases where this administrative information was available, interventions lasted on average 25 weeks, ranging from 8 to 44 weeks. There were cases that remained open for more than 12 months, and in some cases, work continued with parents even after baby has been removed from their care.

The intensity and frequency of key practitioner support varied but, in the early stages, it included weekly or twice-weekly sessions, with telephone contact – calls and messages – between meetings. Sessional work took place in parents' own homes unless there were substantial risks to key practitioner's safety (identified in only one case). They were more frequent during initial or intensive periods and became less frequent towards the end of the intervention. As noted by one of the key practitioners, it was important to find the right balance for each family and to use one's professional judgement to ensure that sessions were undertaken at the right regularity so as not to overburden parents.

> *"But sometimes I wonder if sometimes we can overburden them with too many visits, or too many people involved? … It's for us to use our wisdom in some cases and work out what's best for the family." (Core Team 3)*

This was also echoed by parents:

> *"They wanted to do it [meet] every week but I felt that was a bit much for me, so they came out every fortnight. But if I needed anything in the meantime, I could always just phone them and let them know." (Parent 4)*

Support plans on case files were consistently strengths-based and holistic, and they accurately identified the key areas for support in all but three case files.[5] Structured, sessional work with one or both parents was evidenced in practice on all case files. A wide range of sessional support was undertaken by key practitioners and parents, with marked differences in Early Help, Home-Start and Barnardo's support.

Direct support from Early Help professionals typically consisted of:

- Education sessions during pregnancy covering topics on health; birth, caring for baby at home, safe sleeping; breastfeeding and bottle making; coping with crying; and learning about baby brain development (core – with all parents)
- Demonstration and practical modelling/practice of everyday baby routines and meeting baby's needs including feeding, weaning, and supporting play time and developmental milestones (e.g. explaining the importance of "tummy time") (core – with all parents)
- Domestic abuse work including the exploration of the impact of domestic violence and conflict on pregnancy and babies; work on couple and family relationships
- Support for emotional/mental health and coping
- Helping parents understand risk to themselves and baby, for example toxic relationships and (sexual/financial) exploitation, coercive control and support to address this risk
- Supporting parents' engagement with social and health services (attending prenatal appointments, etc.), the explanation of statutory processes (e.g. the importance of engagement with social workers, etc.) and emotional support
- Supporting contact arrangements with other parents or family members, or in cases where baby was removed from parents or hospitalised, supporting contact (if allowed)/visiting
- Referral to services, primarily VCSE sector but also some statutory services, practical support
- Support for parents to reduce social isolation and access broader community groups and activities.

[5] Of the three case files, in two cases the recording lacked detail and in one case – early in the programme – we noted some missed opportunities to support engagement via the involvement of interpreters.

Home-Start key practitioners offered:

- Practical support (core – for all parents)
- Referrals to other services, primarily VCSE sector but also some statutory services
- Support for parents to reduce social isolation and access universal services and broader community groups, activities with volunteers
- Support with administration and paperwork, including registering baby's birth, GP registration, etc.
- Support with contact arrangements with other parents or family members, or if baby removed from parents or hospitalised, supporting contact (if allowed) and visiting.

Barnardo's key practitioners offered:

- Targeted/specialist therapeutic work with parents exploring the trauma and adverse childhood experiences they had experienced, the impact of these on parenting, dealing with conflicts, window of tolerance and emotional triggers, attachment styles, healthy relationships
- An exploration of the significance of baby or child attachment and support for bonding (core – for all parents)
- Information about baby brain development (core – for all parents).

Key practitioners drew on a range of resources in evidence-informed sessional work. Key practitioners used existing resources, but they were also proactive in identifying materials for the specific needs of parents or tapping into their specific interest. In case files we found examples of the use of the following materials:

- NHS guidance on feeding and sterilising bottles
- NHS and Lullaby Trust advice on safe sleeping
- Three Houses worksheets
- Freedom Programme (Mr Right/Mr Wrong)
- Motivational Interviewing/discussion bubbles
- Genogram/family tree and support network mapping
- Culture map.

"There's a lot of NHS websites and things which I think are really, really good. And I'm looking constantly one different websites, because I do like to talk about baby brain development. … I'm always looking for simplified explanations on the internet that I can go through with parents about baby brain development and things." (Core Team 1)

Parents also commented on the materials key practitioners used with them, such as books about baby development and worksheets exploring various aspects of parenting or family support.

"She gave me a book about pregnancy. What happens every month, like how the baby grows and what age they start moving around and everything. That was very helpful." (Parent 11)

"They went through everything with us, we've done paperwork with them and going through like play cards like what's good and bad for a baby and putting them in the right selections, we had to do like a family tree of all the support we have. We've done loads and they have been brilliant for both of us." (Parent 10)

When asked how stakeholders would characterise TBCP's work with families, **four key features** were identified – these were also clearly reflected in the programme's training offer (see next section).

1. **It works positively with risk and it is flexible responding to parents' needs.**

   "So for me, it's quite positive to see actually there is a significant risk here. But we are going to work with it and see what we can do in the time space we've got." (Steering Group 9)

2. **It is strengths-based**, building on parents' resources and resilience factors, including motivation and engagement.

   "We look to their strengths and to help them to pursue their goals. And it's not about us telling them what to do, because you can tell someone to do something, but they give you the face value. So yes, I'm going to do it. But we always say to them, What do you want to achieve? And how can you achieve it? And we support them along the way." (Core Team 3)

3. **It is relationship-based** recognising that building trust with the key practitioners is central to positive engagement and that this trusting relationship can be therapeutic in itself.

4. **It is holistic**, focusing on the person and family as a unit (see Think Family).

Practical support for families

Practical support for parents has been a core part of the TBCP offer. This is based on the recognition that unmet basic needs, such as the lack of stable accommodation, appropriate and safe environment, food and baby items, can prevent parents from fully engaging with a parenting-focused intervention.

> *"I can't speak for everybody else, but for the therapeutic work, they need to be in a place to be able to do that therapeutic work, they need to be in the right headspace. … when that referral has been to the other services first, and the more practical things are a bit more settled and a bit more worked out. That's when it makes the therapeutic work a lot easier." (Core Team 4)*

Various examples of practical support were identified in case files and nearly all parents received one or more types of help in relation to:

- Finances, budgeting, and money management, including claiming benefits to which parents are entitled)
- Securing appropriate housing and improvement of home conditions (e.g. flooring, deep cleaning, etc.)
- Sourcing items for the home (e.g. washing machine), baby (Moses basket, pram, etc.) and accessing food and baby banks on a regular basis (nappies, formula, etc.)
- Support with administration and paperwork, including registering baby's birth, GP registration, etc.
- Negotiating emergency top-ups with energy providers.

Parents, especially those with learning difficulties, found the practical support very helpful.

> *"She was helping me with my bills, ringing and speaking to my housing workers about my rent. She helped me with my day-to-day life." (Parent 12)*

All forms of practical help were very highly valued by parents and instrumental in building trust and creating sustained engagement with the Programme.

> *"I will miss her because she was like my little fairy godmother to be honest. That's what I call it. She was brilliant. Absolutely amazing. Anything that I needed she helped with and she actually got me a lot of help with other things that other organisations that even social services didn't know about. She got me a lot of help with things." (Parent 14)*

Although there was a noted risk that practical support might create dependency, we found no evidence of this in the case files and help was generally provided with a clear long-

term/sustainable purpose (e.g. create safe and hygienic home conditions, improve financial situation, etc.).

What are considered to be the key supports for delivery?

Based on administrative/management data and stakeholder interviews, three key supports for the provision of an effectively functioning service were identified:

1. Highly committed staff and leadership.
2. Training tailored to the specific programme of support – planned and responsive.
3. Regular supervision (formal) and informal supports, peer support.

The core team and the project team were composed of professionals from diverse backgrounds, including: early years, children's social care, social work, youth work, health. We found high levels of ownership, motivation and commitment to TBCP among core staff, which was also recognised by stakeholders who were not part of the implementation.

> *"I think that it's got a strong management, grip and handle on the project. That group of managers are absolutely on it, and centralising it and absolutely driving it. Yes. With without a doubt. That is one of its strengths, I think, as well as the dedication." (Steering Group 5)*

Core staff were supported by an intensive and well-resourced training offer, consisting of the following elements:

- Motivational interviewing techniques
- Bespoke Cultural Competence training
- Attachment and endings
- Newborn Behavioural Observations (NBO) training
- Domestic abuse (Safe & Together)
- Presentations by invited professionals from partner agencies often responding to specific demand during the implementation of the programme (e.g. on perinatal mental health, foetal alcohol syndrome)
- Enhanced training for Home-Start volunteers (particularly around safeguarding).

In the interviews, key practitioners described the training as useful and there was evidence in case files that they applied the knowledge and skills in practice.

"But it really was for me, because it was a whole new way, again, of listening. … that has made a big difference." (Core Team 6)

Weekly or fortnightly supervision with managers, external supervision and peer support were described as helpful by all core team and project team members. Particularly peer support and the supportive environment were highly valued and identified as a key source of support for high-quality intervention work. Although the programme was established during the period of the COVID-19 pandemic, and practitioners worked as a dispersed team, close and supportive working relationships were noted in interviews and observed during core team meetings.

"I do think the team support is important as well, how we support one another as team members and things like that. With COVID, it's been very hard because we're a new team and were around and being built during the COVID-19 pandemic. But again, I suppose because we're trying to arrange regular gatherings, having WhatsApp and team WhatsApp and things like that just helped to support that relationship, even though we might not be seeing each other every day. So that's been really good. … if you do need a favour, like you need a joint visit, you don't feel uncomfortable asking because you just put it out there, you know, someone's going to volunteer." (Core Team 1)

Unit cost of delivery

The unit costs of the intervention for the first 12 months of provision (start-up) were calculated as between **£5,287** and **£6,661**.

The calculations underpinning the unit costs are presented in Tables 3.3 and 3.4. They are based on financial information provided by the programme administrators and overheads calculated from other available unit cost data (Jones & Burns, 2021).

Table 3.3. Breakdown of unit cost of provision (£)

	Manchester	Home-Start	Barnardo's	TBCP total
Staff (salary & on costs e.g. pension contributions)	230,058	25,787	39,313	197,463
Training	21,009	3,344	835	25,188
Travel	1,438	1,240	395	3,073

Equipment		1,150	141	1,291
Overheads	36,809*	10,611	-	
External services (e.g. translation)	217	-	-	217
Other MCC contributed services	40,000	-	-	-
Total	329,531	42,132	40,684	412,347

* Overheads for MCC are estimated at 16% to include general management and support services such as finance and human resources departments (see Jones & Burns 2021:p.124). This is likely to be an underestimate as it does not include any office and utilities such as water, gas and electricity.

Table 3.4. Estimated unit and weekly cost of provision (£)

	Total
Option A: average cost per intervention (78 accepted referrals) up to June 2022, as per Programme dashboard data)	£5,287
Option B: average cost per substantive intervention (62 cases; 78 accepted referrals minus 20% that did not start/engage as per June programme dashboard information on closed cases presented in Table 3.8.)	£6,661
Weekly cost per substantive intervention (Option B divided by the average length of an intervention – 25 weeks)	£266

Evidence of promise

The second part of this report considers emerging/early evidence from administrative data, outcome measures, case file analysis and professional and parent interviews about the effectiveness and outcomes of the intervention. The following questions were addressed:

1. To what extent, how, for whom and in what circumstances does the TBCP programme show promise in engaging parents/families; and in providing better coordinated, culturally attuned services (including to meet adult as well as child needs) and assessments?

2. To what extent, how, for whom and in what circumstances does the TBCP programme or aspects of it show promise from the perspective of families, staff and other professional stakeholders in relation to promoting the following positive outcomes, and avoiding any unintended negative outcomes:

- Secure child and parent attachments
- Confident parenting
- Thriving babies
- Improved parenting capacity including parental attunement to infants' needs
- More infants are able to remain safely at home in a sustainable way
- Increased early permanency for vulnerable infants
- Improved parent wellbeing and confidence about the future
- Reduced risk factors for compromised parenting and increased resilience factors including parents feeling able to ask for help before reaching a crisis.

Evidence of promise in identifying and engaging the intended cohort

This section summarises the evidence in relation to the needs of parents who have engaged with the programme, the characteristics of engagement, including differences between groups and TBCP's work with fathers, and findings about the extent of cultural attunement.

Identifying a cohort with relatively high needs and risks

At the start of the intervention, over half of all parents were identified as representing a "high risk" (55%; 19) and 26% (9) were identified as "medium risk" (source: Administrative Programme Data tracker shared with the evaluators).

Approximately half of the primary carers (19) were already known to Children's Social Care prior to the intervention; for 11 parents this was their involvement with Children's Social Care services as parents, and prior history was unclear in the rest of the cases (6). About one half of the primary carers (17) were first-time parents and the other half (19) had experienced other children being removed or had children living elsewhere (e.g. with another parent, extended family).

Over one-third of parents in the programme were care experienced (13) and six out of these (16% of the total cohort) were care leavers.

In nearly all cases, parents were noted to have had significant adverse childhood experiences and trauma, most typically associated with domestic violence, neglect, abuse and substance use in the family during childhood.

The risk factors or broader characteristics associated with the primary carer that were identified at referral are presented in Table 3.5. Over two-thirds of parents entering the programme presented with a trio of mental ill health, domestic violence, and substance use. Homelessness or unstable accommodation was also noted as a (potential) risk to the (unborn) baby in nearly half of all cases. Similar patterns of parent characteristics and risk factors were observed by stakeholders participating in an interview.

Table 3.5. Characteristics of primary carer at referral

Characteristic	N	% of total cases (n=36)
Mental ill health	27	75
Domestic violence	24	67
Substance use	22	61
Homelessness	16	44
Disability	8	22
Care leaver	6	16
Physical health	3	8
Other (coercive control or criminality)	2	5

Source: Case file analysis

In three cases, there were no major risk factors noted, only historic concerns and concerns associated with main carer's age or lack of parenting experience.

The programme also recorded actual or potential risks to the unborn baby in all cases. These are summarised in Table 3.6. Parental mental health was the most frequently presenting risk to the baby, identified in more than two -hirds of the cases. However, all other categories were also recorded in a high proportion of cases.

Table 3.6 Cases by (potential) risk to unborn baby at the start of the intervention

Risk to unborn baby	N	% of total cases (n=36)
Parental mental health	25	69
Domestic abuse	23	64
Neglect	21	58
Physical / emotional harm	17	47
Other	11	30

Source: case file analysis

More than 90% of children whose case files were reviewed had a statutory plan at the start of the intervention, mostly a Child in Need Plan but also relatively frequently a Child Protection Plan (Table 3.7).

Table 3.7 Case file sampled cases by type of plan at the start of the intervention

Type of Plan	N	% of total cases (n=36)
Lower-tier targeted early help	2	5
Complex targeted early help	1	3
Child in Need Plan	19	53

Child Protection Plan	14	39

Source: case file analysis

This evidence combined suggests that TBCP has identified and has been working with primarily statutory caseloads including families with relatively complex needs and characteristics that represent relatively high levels of risks to both children and parents. As explained by a member of the project team:

> *"TBCP criteria is different than what a normal early help offer would be. I would say early help works at a lower level. … I would say that Thriving Babies will work with much more complex higher risk families. … In that sense, we're working with a different cohort of families who we wouldn't normally work with from an early help point of view, we wouldn't work with someone so early in pregnancy, usually wait till the closest to the baby being born. And in terms of what we offer is far more targeted. It's far more specialist, it's far more intensive." (Project Team 7)*

Characteristics of engagement with families

Key practitioners and the project team considered that they were successful or very successful in engaging high-risk, vulnerable parents in the intervention. However, various factors were identified that might impede engagement in individual cases. These were:

- Parental substance misuse
- Parental mental ill health
- Parents' chaotic lifestyles, particularly homelessness or unsettled accommodation
- Domestic abuse and coercive control
- Parents' rejection of professionals based on prior experiences or current levels of professional involvement (i.e. too many professionals in their life, care experienced)
- Parents' learning difficulties/disabilities.

> *"Most difficult ones are young parents who have been through the system themselves, they've had Children's Services involvement, growing up, and then they find they've got their baby, and they've got children's services involved again, and they just want everybody to go away, everyone off their back. And I find them quite difficult to engage." (Core Team 4)*

> *"And sometimes some of the domestic abuse cases where there's been a lot of coercive control from the perpetrator, they've been quite difficult, even though we*

know we've been persistent and consistent. Trying to get in there. It doesn't always work. Well, because they're just not in the right place. Or just sometimes it's just about that readiness." (Project Team 2)

"I mean, let's say you get families that who just have very chaotic lives, and again, those families are going to be the ones that are very hard to engage. … it's just very hard to move forward with them. If you can't get in and have those initial appointments, so you've not been able to establish or build a good relationship, which I think is pivotal in getting that support." (Core Team 1)

The programme engaged with a varied group of parents in terms of age (the average age of mothers was 25, ranging from 17 to 36 years, the average age of fathers was 30, range 19–43, ethnic background (see section below on "Evidence of promise for culturally attuned services"), earlier trauma/care experience and current need (see previous section on "Identifying a cohort of parents with relatively high needs and risks"). However, there was no single characteristic identified that made engagement more likely or successful; professionals generally commented about the importance of parents' willingness to change and learn, and the importance of building trusting, positive relationships to encourage and leverage positive engagement.

"The families that do engage, or that where there is a, an impact quicker, are those that recognise that this support is going to be beneficial to them from the start. And I can gauge from the start with the service." (Core Team 1)

"I think with some of the younger parents, it has been quite successful. And I think a lot of younger dads say No, I didn't know any of that. It's been really good. You know, learning about all that kind of thing. So yeah, I think that cohort have been quite successful." (Project Team 2)

"And if we can get them at a place where they feel relaxed and feel about the service, not about judging them, or do this a, b, and c, but it's about helping them to be better parents, I think we get better results." (Core Team 3)

Other stakeholders also commented that TBCP was able to engage families effectively and build trust.

"The family feels really comfortable. I think they've built a very good relationship with them. Obviously, as a social worker, you have to build that relationship. But I think sometimes when you are on a Child Protection Plan, there's that element of, well, they're a bit more worried about what they might share with me, they might….. Whereas I think with the Thriving Babies worker, they saw them as someone specific for the baby. I think they just felt a lot more open." (Social worker 2)

Engagement with fathers and extended family

Of the 36 case files analysed for the evaluation, the infant's father was recorded as the main carer in three instances and in 26 cases (72%) both parents were present, at least at the start of the intervention. In one half of these cases (13) the parents were cohabiting.

Fathers' involvement (or key practitioners' clear attempts to involve them) was documented in 20 case files (36; 55%). Work completed with fathers included:

- Practical work to develop their knowledge, skills and confidence to meet the physical needs of a baby – such as preparing bottles, winding, dressing and nappy change, and bathing
- Work around baby development – such as crying, play and stimulation, communication, and the importance of routine
- Work on attachment and the impact of domestic violence or parental conflict on baby's development.

There were examples of joint work with parents and one-to-one work with fathers and mothers. There were positive examples of key practitioners working with parents separately to address sensitive topics.

> *"[key practitioner] is going to take the partner out, which is Dad, while I do some more confidential work with Mom. It just works really well. Because it's tapping into everything, really showing that we're a team, we're together." (Project Team 2)*

The core team had a male key practitioner, which appeared to further facilitate the engagement of fathers by providing a male role model.

> *"There are not many males in this role. When the women are coming around, I kind of feel a bit left out. But when [key practitioner] came out I was comfortable with him because he's a bloke and it was better for me personally to get a male's perspective. (Parent 15/Father)*

However, the involvement of fathers is one of the areas where practitioners and stakeholders believe the programme could be further strengthened, reflecting broader challenges and emerging trends in children's social work practice:

> *"Dads quite often aren't involved. But it is a gap that we're not addressing, their role, particularly if domestic violence has been involved. But I think that's a gap within society and services in general. … If the father doesn't want to be involved with the family at all, they're just walking away, but it just seems to be a missed opportunity, that we can't do a little bit more around there. (Project Team 5)*

Although two-thirds of case files (24) noted some family or support network around the parents, and this was often identified during early sessional work, there were fewer documented examples of actual work with extended family. It is unclear whether this is a gap in the service, the case notes, or simply reflects the composition of the cohort as one key practitioner highlighted.

> *"The parents that we're working with 99.9% of the time, their upbringing hasn't been ideal. Therefore, the family that they're surrounded by, having an influence on them, isn't ideal. A lot of the time, not always, but a lot of the time." (Core Team 1)*

Parents' experiences of engagement and disengagement with TBCP

An important aspect and determinant of engagement was the programme's acceptability among parents. The parents interviewed for the study generally spoke very highly about TBCP, and the majority experienced the intervention in a positive way.

> *"I cannot fault them, they are ten out of five, they honestly are brilliant and for all the mothers that I know will have other problems, they are a godsend like a little pack of fairy godmothers." (Parent 14)*

Parents valued all key aspects of the offer including practical help, developing parenting skills and learning about baby development, as well as emotional support (this is discussed in the section below on "Evidence on improved parent wellbeing and resilience").

Practical support from key practitioners, such as arranging food bank parcels and emergency top-ups or helping parents to secure suitable accommodation were mentioned frequently and were instrumental in allowing some parents to focus on the therapeutic/education aspect of the intervention (see also the section below on "Practical support for families").

Learning/educational aspects of the programme were also welcomed by parents, especially those who were first-time parents or have had children a longer time ago. Learning about how the baby brain and development as well as the opportunity to practise skills in the home environment with a supportive professional was valued by parents and potentially contributed to confident parenting (see the section on "Evidence on child and parent attachment, parenting confidence and capacity, and thriving babies" for more detail).

> *"They would teach us things like how to understand emotions, how babies develop and stuff we wouldn't have known. And also, about safe sleep and how to sterilise bottles." (Parent 15)*

With reference to the programme administrative data, relatively few parents (two) whose case was accepted by the panel refused TBCP support and about three-quarters of all parents had completed the intervention at least partially when the case closed (see Table

3.8). Around one-fifth of parents (20%, seven) did not start or just started the intervention when their case closed and only two parents refused support from TBCP.

Table 3.8. Completeness of intervention when case closed to Early Help

Intervention completed	N	%
Fully	15	42
Partially	12	33
Just started	2	6
Not Started	5	14
Refused support	2	6

Source: Administrative data (June dashboard)

High levels of sustained positive engagement of parents were identified in the case files, with the majority completing key aspects of the programme.

Overall, professional interviewees considered that TBCP was successful in maintaining parental participation.

> *"I don't think we've got a massive lot of disengagement. I think on the whole we keep people engaged." (Project Team 2)*

When asked about early disengagement from the programme, interviewees suggested that this happened sometimes because of the loss of a pregnancy or because parents moved away from the area, often as a result of housing problems and domestic violence. Analysis of all the qualitative data suggests disengagement sometimes also occurred when parents understood their baby would be removed, or the opposite, where things were perceived to be "going well" after baby's birth. Interviews with parents suggested some parents felt there were too many services involved in their lives. One parent explained how the number of different services led to them feeling overwhelmed and stressed.

> *"I had my baby. I'm on my own. I was homeless at the time, I had a homeless house given to me and I had social services and I got asked if I wanted to do this Thriving Babies thing. … I did it but it didn't really help me a lot so I just got rid of it. I did it for a bit and then I just stopped doing it because it was just too much stress and I didn't find it that helpful. … I went to one of those mum and baby*

groups. I was in Thriving Babies from when I was about 15 weeks pregnant until my baby was about two months old. By the end of it all, I had so many ... like I had a social worker, then I had [name] from the drugs team. ... I had too many people on me at once like. ... It was a stressful time anyway and by the end of it all I just didn't see the point in it. Don't get me wrong, [Key practitioner] was helpful but by the end of it, it was just too much." (Parent 5).

Evidence of promise for culturally attuned services

One of the main aims of TBCP was to work in a culturally attuned way with parents from minority ethnic communities including to address the high proportion of babies/children from ethnic minority background coming into care in Manchester.

Boolaky et al. (2017) identify two key aspects of cultural attunement: (a) structural features of a service that encourage diverse populations to engage, and (b) the cultural competence of the workforce. Structural features include factors such as the location of the service, the diversity of the workforce, and partnerships with local community groups. Cultural competence encompasses a general awareness and responsiveness to people's cultural perspectives, how this can affect behaviours and beliefs, as well as one's own unconscious bias.

According to administrative and case file data, of 36 TBCP participants, 17 were White British (47%), 18 (53%) were from an ethnic minority or mixed heritage background including two White Irish (traveller), and one participant's ethnicity was not known.

Evaluators identified evidence of promising culturally attuned and sensitive working in the case files, including key practitioners:

- Exploring parents' cultural and religious heritage, particularly for babies from a mixed ethnic/cultural background
- Engaging in a respectful and sensitive way with parents' beliefs, religious and cultural traditions around parenting and communicating current UK guidance and best practice (e.g. safe sleeping, weaning)
- Checking parental understanding (of the English language) and involving interpreters and translators if required
- Providing effective multiagency coordination and support including referral to community groups.

Four families spoke English as a second/additional language and three families were affected by their precarious/insecure immigration status. One key practitioner explained the challenges including limited resources (outside TBCP) available for families who speak little or no English:

> *"I've got a family whose first language isn't English. So, language is a barrier. They can still be referred to services, but some services don't necessarily have access to interpreters and things like that. So that that can sometimes be a problem. And also, although all the meetings and things like that, and all the official forms have always had translated the information that I gather, the universal information that it's around for everybody, that's not always translated. So it's very hard. I can read through them with the interpreter, but they can't really access things like the websites all the time that I give out. So it's not that I can't do those referrals, but there's not enough. They are not necessarily able to access them as effectively as other parents could." (Core Team 1)*

Although all key practitioners had completed a bespoke cultural competence training, the impact on their practice was not considered to be strong. Some practitioners described their practice in other ways, including that it was culturally "empathetic" (attuned).

> *"Although the training was good, it wasn't great. But there's just not a lot of it out there around cultural competence. So, I think it was useful for the workers to have. Do I think we're culturally competent following the training? Absolutely not. Do I think we're culturally empathetic and have humility? Yes." (Project Team 7)*

Evidence of promise: impact on parenting, attachment, and risk factors

The evaluation set out to examine emerging TBCP participant and whole family outcomes associated with various aspects of parenting, notably:

- Secure child and parent attachments
- Confident parenting
- Parenting capacity and parental attunement to babies' needs
- Baby development
- More infants can remain safely at home in a sustainable way
- Increased early permanency for vulnerable infants
- Reduced risk factors for compromised parenting
- Increased resilience factors including parents feeling able to ask for help before reaching a crisis
- Improved parent wellbeing and confidence about the future.

Evidence on outcomes was drawn from various sources including parent-reported outcome measures, case files sampling and interviews. However, it is important to emphasise that

given the timing and timeframe of the evaluation, findings reported in this section should be described as preliminary.

Evidence on child and parent attachment, parenting confidence and capacity, and thriving babies

The analysis of data from five parent-reported outcome measures relating to attachment, confidence and parental attunement suggested high and increasing levels of attachment and confidence as parents progressed through the programme. Detailed background information about the measures and analysis of the data is included in Appendix C.

Mothers reported high levels of antenatal and postnatal attachment and quality of attachment, with significantly higher levels after birth. For the small subgroup of mothers who completed both MAAS and MPAS (13), there was a statistically significant increase in total attachment scores over time, from an already high level pre-birth. Mothers in this subgroup also showed a high level of quality of attachment both antenatally and prenatally.

Fathers who completed the attachment questionnaire (PAAS) antenatally (8) reported very high levels of total attachment as well as quality of attachment and time spent in attachment.[6] Postnatally, fathers (21) also reported high levels of total attachment, along with high scores on the "patience and tolerance" and "affection and pride" subscales. From this very high starting point, fathers' attachment remained high postnatally with a statistically significant increase over time in total attachment.

Both mothers and fathers showed similarly high levels of attachment to baby after birth. There was no statistically significant difference in fathers' and mothers' overall attachment postnatally. Additionally, there was no statistically significant difference in fathers' and mothers' overall pleasure in interaction postnatally.

Parenting confidence is associated with more attuned parenting and has been shown to act as a buffer against factors that can compromise an infant's development, such as parental depression, anxiety and stress (Kristensen et al., 2018). Confidence is also positively associated with actual parenting competence and positive child outcomes (Jones & Prinz, 2005). Out of 44 parents who completed the KPCS, the majority (86%) showed levels of parent confidence in the non-clinical range, suggesting that their parenting confidence was comparable to that found in the general population. Mild and moderate clinical levels were found in 7% of mothers respectively. None of the mothers were found to be in the severe clinical range.

A small subgroup of mothers (6) completed a KPCS questionnaire at two time points post-birth. There were no statistically significant changes in parenting confidence over time (Median KPCS at T1=43, at T2=43.5, Z =.447, p>.05.). Generally, their confidence remained

[6] It should be noted that these statistics are based on a very small sample of fathers.

high. Similarly, there were no statistically significant differences between the parenting confidence reported by mothers and fathers after birth (p>.05.).

It is important to consider the limitations of the quantitative outcomes data. First, the sample sizes were relatively small. Second, the measures were administered together with key practitioners raising the potential of social desirability bias – parents responding in a way they thought was acceptable. Third, there was potential for selection bias, whereby parents who completed the measures could be more likely to be committed to the intervention.

However, there is other evidence about parental attunement from the pilot study including from key practitioner case notes (their recorded observations). In nearly all the case files examined for this study, positive parental attunement, also positive child/parent attachment, was evidenced, including by descriptions of warm/positive interactions and parental body language; parent responding positively to baby's cues and needs (e.g. crying, fussing); and baby reacting to parent's presence or absence (turning head, smiling at parent, becoming upset when parent leaves the room). Where concerns were noted – in one case only – the key practitioner initiated appropriate action to support the parent as well as referring baby for assessments, suggesting that key practitioners were able to spot and recognise atypical development and to refer families for diagnosis and early intervention.

Many parents participating in an interview also described how TBCP had helped them to better understand their baby's development and needs and, as a result, how they had become more competent and confident parents with "thriving babies".

> *"[The most useful thing I got out of TBCP was] probably the way you interact with baby. We don't talk to them like a baby, we talk to them like a little adult basically. Like they understand and [are] getting cleverer by the day, learning all the time. And we wouldn't have done that, we wouldn't have got as involved as we do now, without [key practitioner's] input. It's definitely got the best out of baby, everyone always says how developed they are for their age." (Parent 15/Mother).*

> *"She was so nice, she was really nice, she helped me a lot with everything. She explained this stuff. It's a lot different [from when I had my other children]. I was really scared when social services came back on my case and I lost my confidence and she helped me with that." (Parent 6)*

Practitioners participating in an interview reflected on how TBCP had helped parents to become attuned to their child's needs and to promote attachment by providing information about the importance of attachment, and the time and space to learn and practise including before birth. Many of the parents in TBCP had not previously had the opportunity to learn these skills or to draw on positive parent role models.

> *"A lot of the parents that I've been working with who were in Thriving Babies had no understanding of attachment and very limited understanding of play and safe sleep and things like that. And a lot of the work … has been around that, and I*

know the parents have found that really useful. So it's about that kind of information shown to parents that might have been quite vulnerable or not had a lot of understanding with had some adverse childhood experiences themselves." (Social worker 2)

Evidence on permanency, risk factors for compromised parenting and resilience

At the end of the intervention – where this information was available – the majority of parents were classified in the administrative (tracker) data as "low risk" (see Table 3.9 and there were very few cases (3; 9%) where the level of risk increased during the intervention (see Table 3.10).

Table 3.9. Cases by level of risk at the end of the intervention

Risk type	N	%
High risk	7	21
Medium risk	6	19
Low risk	19	60
Total	32	100

Source: Administrative data (tracker)

Table 3.10. Changes in level of risk

Direction and level of change		N	%
Positive change	High → Low	11	34
	High → Medium	4	13
	Medium → Low	4	13
No change	High → High	4	13

	Medium → Medium	2	6
	Low → Low	4	13
Negative change	Low → Medium		0
	Medium → High	2	6
	Low → High	1	3
Total		32	100

Source: Administrative data (tracker)

According to administrative data, 84% (28) of babies remained at home by the end of the intervention and 15% (5) became looked after by the local authority, including two babies placed with family members under a Supervision Order or Special Guardianship Order. One baby was adopted at birth and two babies/families were awaiting court decision at the time of analysis.

The distribution of cases by type of plan, representing level of need at the end of the intervention, is presented in Table 3.11. This also shows that fewer children had statutory plans at the end of the intervention than at the beginning, and there were five babies (16%) who were stepped down from Children's Social Care Services.

Table 3.11. Cases by type of plan representing level of need at the end of the intervention (Tracker)

Type of Plan	N	%
None	5	16
Early Help	4	13
Child in Need	13 (12)	41 (38)
Child protection	6 (5)	19 (16)

Looked after	5 (7)	16 (22)

Note: One family disengaged and their case closed when they were informed that their baby would be removed at birth. Another parent (mother) and baby were placed in mother & baby foster placement under interim care order. If these cases are recorded as "baby removed" then the figures are as follows: number of children remaining at home: 78% (25) – children LAC: 22% (7).

There were numerous examples of better decisions and actions taken by parents to reduce the risk to their (unborn) baby and themselves evidenced in the case files as well as in stakeholder interviews. Key practitioners often attributed this to parents' improved understanding of baby development, but poor parental mental health was considered a major barrier to good decision-making. In the case files, evaluators noted examples of parents making positive decisions or changes in the following areas:

- Their substance (mis)use – e.g. stopping or significantly reducing substance use or actively looking to reduce/prevent potential harm for babies
- Their interpersonal relationships – e.g. by recognising and, in some cases, terminating toxic relationships characterised by domestic abuse or coercive control
- Taking steps to improve their home living conditions.

> *"At that time [removal of previous child] I was also going through a family breakup, but I was badly depressed, and I started drinking and going off the rails. Now Thriving Babies helped me not to drink. With the advice and just being able to talk to someone has kept me straight." (Parent 4)*

Information on re-referrals to statutory and other services and the permanency/sustainability of outcomes is, understandably, limited at this stage, and it does not allow us to draw any conclusions about the medium- to longer-term outcomes of the intervention. Practitioners and stakeholders also referenced how difficult it is to predict these longer-term outcomes and emphasised the importance of some form of continued support being available for some TBCP parents at least at the end of an intensive intervention.

> *"Because quite often, in my experience, people can do really, really well for a period of time when they've got little babies, little honeymoon period." (Social worker 4)*

Stakeholders highlighted the importance of a service of this nature being able to offer effective exit strategies for all parents, whether via improved parenting and independent living skills or via a network of universal services and support. At the time of interviews, no practitioners had examples about parents coming back for support.

Similarly, supporting parents to achieve a "good ending" to the intervention regardless of the outcome of the statutory process was also seen as a key element of the intervention by the project team and key practitioners, and as something that should be offered to all parents.

They highlighted the potential benefits for parents and families such as increased trust in professionals, positive life choices and control over one's life, support with trauma, and, ultimately, the prevention of the need for (recurrent) care proceedings.

> *"Support does go on until court has made that final decision, but once we get to that point, we don't actually have any support network there. And it's just down to sort of normal services. So you're at the mercy of a referral into adult services or mental health and however long that takes to be processed. It's like you fall off a cliff edge there. … if we've got something sitting at the end, that can catch them and support them it's going to be better for everybody that we break that cycle." (Project Team 5)*

Evidence on improved parent wellbeing and resilience

In the short to medium term, key practitioners and the project team considered that TBCP had been successful in supporting parents' resilience and coping skills, although mental health often remained an important risk.

> "*I have seen huge growth resilience wise, that's really positive … But mental health is a barrier to resilience, massively." (Core Team 6)*

Nearly all parents interviewed for the study described how the intervention helped them to become more confident and had a positive impact on their wellbeing, mostly by offering emotional support and reducing social isolation. Many parents mentioned the positive relationship they had developed with their key practitioners, which was often described as non-judgemental and empowering.

> *"When TB got involved, I was just coming from a family breakup. So I was very like down and depressed in that. And they used to come out and it's just the company because since I had the baby it seems like all the friends disappeared. So obviously, I was in a house all the time by myself, so it was company. It was, someone to talk to about the problems and all that. And they listened brilliantly and gave me advice about all the things like my housing situation because I'm in temporary accommodation and they tried to move me miles away from my family where I knew no one. But they managed to sort out a house." (Parent 4)*

> *"It's just no judgement, no nothing there." (Parent 13)*

Parents particularly valued the individual and genuine attention they received from the TBCP practitioners as opposed to other professionals, such as social workers, whose primary concern was the baby.

> *"We would sit down and have a brew, and she [key practitioner] would say 'So how's your day been?' And when she says I'm looking healthy and stuff, it makes me proud of myself. Because I think when people are saying that I'm looking*

healthier, that means I am healthier. So that makes me feel good about myself and it's helping a lot." (Parent 12)

"[TBCP] is more down to earth, we can phone and have a conversation, and [key practitioner] would ask how we were doing and not just baby; [key practitioner] would also ask about our mental health, you know, like if we are coping mentally and physically. The social workers you know focus on the baby, whereas with the Thriving Babies it is us as a family the focus." (Parent 15/Father)

Many parents also spoke about how visits by TBCP workers and Home-Start volunteers helped with social isolation and encouraged them to leave the house, visit baby groups and community facilities, go for walks.

"The most helpful is coming to the house. Yeah, probably sometimes go for a walk with us, go to the park. If [name] wasn't coming once a week, I don't know how well I would have been." (Parent 7)

"She was just always there. That I was never on my own." (Parent 11)

"I think it's really good because now through this pregnancy and same now after I've had the baby that I've had so much support, whereas back in the day, we didn't have any of this like not much support, whereas now is a whole lot better." (Parent 10)

Finally, various parents mentioned self-regulation skills/techniques they learnt to help their mental health and emotional wellbeing, such as this parent talking about her experiences with the targeted therapeutic support.

"If there's anything wrong with me or I'm upset about anything, she's there to chat, because that's where I sometimes don't have no one to talk to. Also, I learnt things like techniques with my anger, calming down with them." (Parent 12)

4. Discussion

Discussion of findings

This evaluation of a multidisciplinary, intensive and perinatal support for parents with high-level vulnerabilities has demonstrated that:

- **A programme of this nature is feasible in terms of its swift and successful implementation within a local authority area.** With a relatively detailed and evidence-based blueprint at the start and a sustained high level of local authority and partnership commitment and support, the programme has, within a 12-month period, established: consistent, efficient and effective referral routes; high-level engagement with individual families including from minority ethnic communities; evidence-based practice led by key professionals who know what they are doing and why; and effective operational management including supervision and governance arrangements. Demand for the programme has been strong, demonstrated by the overall number of referrals including from a district that was not part of the pilot project. The unit cost of the pilot was estimated at between £5,287 and £6,661 in the first 12 months of the programme.

- **The Thriving Babies: Confident Parents model has provided effectively engaging, multidisciplinary and culturally attuned support for parents and families presenting with high risks and relatively complex needs.** The study found consistently high quality, including evidence and strengths-based interventions led by key workers, characterised by: a mix of educational and therapeutic "sessional" work with parents, and practical support. Engagement levels with parents were good and this was mostly sustained for planned intervention periods. The sessional work was diverse and tailored to individual parent and family needs. The extent to which the model and provision demonstrates better coordinated support than before is not as well evidenced, beyond the involvement of the three core partners and their ability to draw in support from a considerable range of agencies when working with individual families. The "Think Family" coordination element has delivered activities aimed at strengthening the model's multidisciplinary aspects in three main areas: joint resource panel and joint working protocols between children's and adults' services, and cross-department training. It is expected that these will deliver more tangible impact in the second year, as the model reaches maturity. The model's multidisciplinary aspects have not yet been able to address local, to some extent national, problems with accessing the right mental health support in a timely manner for parents involved in the programme. This is important as, for more than two-thirds of the participants thus far, mental ill health was a significant (risk) factor.

- **The Thriving Babies: Confident Parents model demonstrates strong, triangulated evidence of promise in terms of its potential for positive impact on children and families, particularly on positive parenting practices, parent**

attunement to their infant's needs, secure child/parent attachments, and reduced parent risk factors. This finding is supported by consistently high and increasing levels of attachment and attunement scores from antenatal and postnatal parent-reported outcome measures, as well as qualitative evidence from case file sampling and parent/worker interviews. In many cases, the risks to infants reduced during the course of the intervention. A high proportion (84%, 27) of babies remained with birth parents at the end of the intervention and only 15% (5) needed to become looked after. Where babies became looked after, there is evidence that the intensive work undertaken with parents pre-proceedings has enabled relatively swift decision-making and permanency planning, and there is also emerging evidence of positive impact on parent wellbeing. Programme workers and parents alike reflected that interventions were also likely to give parents improved resilience and coping skills and ability to make positive choices.

- **The Programme has highlighted some of the benefits of starting work with vulnerable parents early within their pregnancy including to encourage parental attunement to their infant, reduce risks, and encourage positive future planning.** Starting during pregnancy offers a "window" for important reflective work with the parent in support of both their positive choices and emotional wellbeing. The optimum timing for prenatal intervention can vary and needs further consideration. Parental (un)readiness to engage was suggested as a key barrier to starting work around the whole perinatal period.

- **The Programme appeared to offer effective support and the promise of positive outcomes for a varied group of parents in terms of level of need and previous experience, and in different circumstances.** Although the design of the evaluation does not allow us to attribute causal mechanisms to the observed outcomes, the realistic elements highlight the importance and potential contribution of various programme components and characteristics. First, the programme was accessible to a range of parents via the open and effective referral mechanism. Second, TBCP was relatively well resourced: once a parent was accepted, work would start with them promptly and key practitioners could dedicate time and effort to build trusting relationships. The support offered to parents was timely – in most cases in the prenatal period – varied and targeted to respond to specific needs. Finally, the programme was well led with strategic leadership from the three main partner organisations as well as a diverse, skilled, and committed staff team.

Study limitations

The key limitations for this study can be summarised as follows:

- This is only a mid-term evaluation providing a snapshot from the first 12 months of the two-year pilot

- There is no baseline or any other counterfactual against which we could compare the main findings from the study
- Outcomes data: the relatively small sample size of parents who have completed outcome measures does not really allow in-depth exploration of parent characteristics associated with different outcomes. Furthermore, the fact that the measures were administered by key family practitioners can raise questions around potential social desirability bias
- The study has only been able to examine the short-term outcomes of the pilot for individual families and collectively – that is, at the end of an intervention rather than beyond it.

Conclusions and recommendations

The evaluation suggests that this pilot programme has been well implemented and has started to become consolidated in Manchester. The programme has demonstrated strong evidence of promise in terms of its impact. Key learning from the pilot study regarding the implementation of a model like this include the importance of:

- Having a clear model with clear aims and desired outcomes
- Early and sustained messaging and “publicity” about the model across all statutory and partner services (just at the start is not enough)
- Sustained leadership support for implementation beyond a short pilot phase and into “mainstreaming”
- Having a multidisciplinary panel as a platform to “receive” referrals, hold multidisciplinary discussions about and undertake detailed planning in relation to individual families
- Highly committed staff who have the capacity to engage effectively with parents in this cohort, to work effectively with children’s social care services as well as a range of partner organisations, and to learn new skills
- Regular, high-quality supervision for operational staff
- Regular review and monitoring of outcomes for children and families.

The evaluation findings also identify some areas for further consideration or development within the pilot programme itself, in particular:

- To improve access to mental health or emotional wellbeing supports for parents and to strengthen the “Think Family” approach to realise its full potential and monitor its potential

- To further improve supports for fathers to participate well and benefit from the programme (a good start has already been made in this respect)
- Further consideration of the optimal timing for starting an intervention
- Strengthening learning and exchange of experiences across services working with families during pregnancy.

Directions for future research

This study, combined with others looking at similar pilot models in the UK (for example Burch et al., 2020; Cox et al., 2020; Ryan, 2020; Mason et al., 2022) have focused on the promise of intensive programmes for vulnerable parents starting during pregnancy. Future research could build on existing evidence of promise to explore:

- **What is the optimal timing for starting an intervention during pregnancy?**
  This study and others (e.g. Burch et al., 2020; Cox et al., 2020), suggest that starting an intervention early in pregnancy (rather than towards or immediately after the birth) brings considerable benefits. However, this study raises important questions about the more exact timing for starting an intervention during pregnancy including the extent to which it can start "too soon'" What is optimal?
- **What are the short- and medium- to longer-term outcomes for infants and parents who have experienced the programme compared with early help "as usual".**
- **What are the medium- to longer-term outcomes for the infants and parents who have experienced support during pregnancy?**
  For example, to what extent do the birth parent/child dyads remain together over time? To what extent do they experience further challenges (and require further support or statutory interventions) and at what stage and why? What are the lasting positive impacts of the primary intervention over time? This information will enable a better understanding of the real costed benefits over time for children and families, also for services, to enable them to make an evidence-informed judgement about implementing similar programmes.
- **The extent to which involving fathers in this kind of intensive intervention (particularly where they are not the primary carer post-birth) is not only desirable but also brings any particular medium- to longer-term benefits.**
- **Similarities and differences between existing and emerging service models, and the benefits of different approaches.**

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Appendices

Appendix A: (Revised) Logic model of Thriving Babies: Confident Parents

Context	Intervention key aspects	Mechanisms	Outcomes
•Deprivation and inequality levels are high in Manchester •A consistently high number of infants are removed into care, including a high proportion of BAME infants (46% in 20197) at around the same rate as in the overall population •Commonly presenting issues where infants are removed include: domestic abuse, parental substance misuse; parental mental ill health	•Extended pilot in North and Central localities •For approx. 60 families over 12 months •Delivered in family homes and children's centres •Providing an early response to babies pre- and post-birth and (prospective) parents who have complex vulnerabilities including learning disability; mental ill health; domestic abuse; substance misuse OR who have had a child previously removed – including care and social care experienced young people •A Lead Practitioner (mostly the child social worker but also Early Help practitioners) including to ensure assessment is strength and evidence based	•Earlier identification of and response to vulnerable and high-risk parents •Effective and sustained positive engagement of families by workers who come alongside and are culturally competent •Strengths-based assessment and support •Families positively supported by timely access to: •Information	•For individual families: •Good parenting capacity and confidence •Good attachment and parental attunement to baby's needs including good interactions •Good child development, meeting milestones •Improved parental wellbeing and self-esteem

[7] Note 45% of young people in Manchester are BAME including 21% Asian; 12% Black; 9% mixed; 3% other.

Context	Intervention key aspects	Mechanisms	Outcomes
•Pathways for adult & child health & social care are not routinely integrated so whole family interventions for babies at risk are not sufficiently holistic or early for greatest effectiveness •An early Thriving Babies pilot demonstrated the potential for positive impact, with 83% of babies remaining with their birth families – the pilot also identified a lack of service capacity and coordination particularly with adult and VCS services •COVID-19 has exacerbated social isolation for some vulnerable families	•Workers in a co-located core, gender diverse, multidisciplinary team including statutory and voluntary sector services will provide: •A "Key" Family Practitioner (Early Help, Barnardo's or other practitioner) to build trust and provide the core evidence-based parenting and therapeutic support to individual families •Peer support for parents (including from approx. 20 Home-Start volunteers) •A "Think Family" practitioner to provide connectivity with adult-focused services, e.g. substance misuse, mental health •Close work with partner agencies to provide a "team around the family" approach •A Resource Panel will support identification of lead (key) worker and whether multi-service provision is concurrent or sequential	•Tailored therapeutic and practical interventions delivered in an intensive way •Coordinated support for all aspects of family need (child and adult) •A trusting relationship and partnership working with parents •Ability to work with mothers and fathers •Families experience help in a positive way •Note: the possibility that (some) families become dependent on support.	•Reduced risk factors for compromised parenting and reduced negative environmental factors (e.g. social isolation) •Baby and parent remain together safely •Family resilience going forward (i.e. not needing further statutory referrals, assessments or interventions BUT asking for help appropriately) •Where babies need to come into care, permanency is achieved more quickly •Medium- to longer-term effect on service demand: •Fewer infants becoming looked after

Context	Intervention key aspects	Mechanisms	Outcomes
	• New perinatal pathways developed with partner agencies will accelerate and join up referrals, assessments and services (e.g. with parent mental health) and support for health practitioners to encourage or refer the right families into support – there will be some targeted outreach for BAME families • Training will be provided for core practitioners including in: ACEs (trauma-informed); motivational interviewing; PAMS; signs of safety; domestic abuse; health in pregnancy; culturally specific training (e.g. FGM); child development interventions • Training will be provided for all social workers in motivational interviewing • Translation services and other supports will be provided for engaging BAME families • There will be individual and group supervision arrangements for core team members, supportive of the overall model and reflective practice		• Fewer repeat referrals, assessments and statutory plans • Reduction in the cost of children coming into care/cost-effective service • Note: the possibility that more babies actually come into care because of the intensive work with parents at an early stage. • Medium- to longer-term impact on whole system working: • Workforce more understanding of the needs of these families and confident about working with parents and families in this way

Context	Intervention key aspects	Mechanisms	Outcomes
	• There will be partnership support for the model including via a multiagency Steering Group and Operational Group including key partners such as midwifery; Early Years Services; Big Manchester, Women's Aid – signing off agreed pathways and supports • Regular briefings will be provided for all relevant services to keep them up to date with progress on the pilot programme		• Better links between services, more timely interventions and coordinated delivery for families • More trusting relationships between partner agencies

Appendix B: Case file analysis template (headings)

Case ID
Area
Who made the referral
Date of referral
Lead agency
Parent known to agency prior
Start of TB intervention
Main carer
Other carer present
Comment
Mother
Age
Ethnicity
Care experienced
Comment
ACE

ACE 1
ACE 2
ACE 3
ACE 4
ACE 5
ACE 6
ACE 7
Further information
Risk factors at referral 1
Risk factors at referral 2
Risk factors at referral 3
Risk factors at referral 4
Risk factors at referral 5
Risk factors at referral 6
Risk factors at referral 7
Further information
No. of previous children

Child 1 age
Custody
Child 2 age
Custody
Child 3 age
Custody
Further information
Economic activity at referral
Housing situation at referral
Other agencies 1
Other agencies 2
Other agencies 3
Other agencies 4
Further information
Father
Age
Care experienced

Further information
ACE
ACE 1
ACE 2
ACE 3
ACE 4
ACE 5
ACE 6
ACE 7
Further information
Risk factors at referral 1
Risk factors at referral 2
Risk factors at referral 3
Risk factors at referral 4
Risk factors at referral 5
Risk factors at referral 6
Risk factors at referral 7

Further information
No. of previous children
Child 1 age
Custody
Child 2 age
Custody
Child 3 age
Custody
Further information
Economic activity at referral
Housing situation at referral
Other agencies 1
Other agencies 2
Other agencies 3
Other agencies 4
Further information
Other family and support network

Further information
Baby/pregnancy
Sex
Date of birth
Due date
Any identified health issues/disabilities
Start of intervention
Risk factor 1
Risk factor 2
Risk factor 3
Risk factor 4
Risk factor 5
Comments
Resilience factors
Overall risk level
Nature of the plan
Strength-based assessment

Holistic (systemic) assessment?
Accurately identify the key areas for support?
Parent-owned plan of support?
Further information
Intervention
Core service provided 1
Number of key worker sessions
Regularity of key worker sessions
Key worker provided direct work (including topics and materials)
Quality of the support
Impact of COVID-19 restrictions
Did the direct work involve the other parent?
Did the direct work involve extended family
Any other services involved
Description of key worker coordination activities
Any gaps in supports
Engagement

Comments
Outcomes
Did the child come into care at any point?
Information
Did child require a statutory plan at any point?
Information
Attachment to main parent
Attachment to other parent
Attachment to extended family
Parental empathy and attunement
Understanding of good enough parenting
Child well-cared-for
Child thriving (meeting milestones)
Parenting confidence
Positive choices during intervention
Negative choices during intervention
Changes in circumstances

Comments about case
End of intervention
Step-down arrangements
Comments about the case notes/recording

Appendix C: Background and analysis of TBCP outcome measures

Quantitative data for the evaluation was collected using the following five standardised outcome measures.

The **Maternal Antenatal Attachment Scale (MAAS)** (Condon, 1993): this consists of 19 items divided over two subscales: “quality of attachment” (11 items) and “time spent in attachment mode” (8 items). The first subscale represents the quality of the mother’s affective experiences towards the foetus (feelings of closeness and tenderness versus feelings of distance and irritation). The second subscale represents the intensity of preoccupation with the foetus in terms of time spent thinking about, talking to and palpating the foetus. All items are scored on a five-point scale. The minimum (lowest) score for the Total MAAS is 19 and the maximum (highest) is 95. The scores for subscales range from 11 to 50 and 8 to 40, respectively. High scores reflect a positive quality of attachment and a high intensity of preoccupation with the foetus.

The **Maternal Postnatal Attachment Scale (MPAS)** (Condon & Corkingdale, 1998) was developed as a self-report measure to assess mother-to-infant bonding in an infant’s first year of life. The theoretical framework on which the questionnaire is based is like that used for the antenatal bonding scale (MAAS). In a similar fashion to the MAAS, many of the questionnaire statements ask for a response based on the mother’s experience in the past fortnight. Each item has a range of two to five options reflecting the frequency with which such an experience occurs. An adjustment to allow for the different number of response categories per item is required before summing the items to obtain the MPAS total score. A higher score on the MPAS indicates higher quality of maternal attachment. The possible range of MPAS total scores is 19–95. The MPAS is also divided over three subscales, indicating “Quality of attachment”, “Absence of hostility” and “Pleasure in interaction”. Quality of attachment consists of nine items; Pleasure in interaction consists of five items; Absence of hostility consists of five items. The scores for each of the subscales are determined using the average of each of the items from that subscale, providing a range of scores for each subscale: 9–45 for Quality of Attachment; 5–25 for Absence of hostility; and 5–25 for Pleasure in interaction. Higher scores indicate higher quality of maternal attachment.

The **Paternal Antenatal Attachment Scale (PAAS)**. The PAAS is a 16-item measure which can also be divided into two subscales: the Quality of the attachment (eight items); and Time spent in attachment mode (six items). Scores for global attachment can be obtained by adding the two subscales together as well as the two remaining items. Scores range from 1 to 80 with a higher score indicating a greater level of attachment (Condon, 1993). The PAAS has demonstrated good internal consistency with a Cronbach’s alpha of .81 (Condon, 1993).

The **Paternal Postnatal Attachment Scale (PPAS)** is a 19-item self-report scale that measures Paternal patience and tolerance; Pleasure in interaction with the infant; and Affection and pride for the infant (Condon, 2015). Responses vary by question, are Likert-

type and range from two to five levels per question. A high score on the PPAS is indicative of an internal feeling of affection towards the infant leading to behaviours that support the paternal–infant bond (Condon et al., 2008). The PPAS has been shown to have high Cronbach's internal consistency (α = 0.80) and demonstrated strong test-retest reliability between 6 and 12 months with correlations for subscales ranging from r = 0.65 to r = 0.70. Convergent validity was demonstrated with significant and strong correlations found between the PPAS and multiple related constructs, such as mental wellbeing, positive affect, and infant temperament (Condon et al., 2008). In this study, the PPAS had an overall internal consistency of α = 0.83 and reasonably good internal consistencies for the subscales of patience and tolerance (α = 0.75) and pleasure in interaction (α = 0.63). The affection and pride subscale measured at a low internal consistency of 19 (α = 0.44). In the original validation study for the PPAS, the affection and pride subscale had an internal consistency of α = 0.71 at six months postpartum (Condon et al., 2008).

The **Karitane Parenting Confidence Scale** (KPCS) was designed to measure Perceived Parenting Self Efficacy (PPSE) in the parents of children aged 0–12 months. Validation data for the scale were gathered from mothers; however, the scale is also suitable for administration to fathers.

The KPCS is a self-report instrument. There is no specific minimum required period between administrations. Each item on the KPCS is scored 0, 1, 2 or 3, with scores summed to produce a total score. The general rule is that a high score indicates the parent is feeling confident on that item. Items have a common scoring order (that is, the first response option is always scored 0, the second always scored 1, etc.). Two items on the KPCS can be endorsed not applicable, for instance when the infant is exclusively fed by the partner (item 1), or where the respondent does not have a partner (item 9). These items are scored 2. The KPCS contains 15 items with a possible range of scores of 0–45.

Factor analysis revealed a three-factor structure – however, at this stage of the scale's development the developers recommend using only the KPCS total score. The scale showed good internal consistency and test–retest reliability. Further, the scale's validity was indicated by acceptable correlations with other measures of PPSE and associated constructs including stress and depression.

The cut-off score for the KPCS was determined as being 39 or less. It is important to note that the KPCS is not a diagnostic tool. Thus, while parents scoring 39 or less – in the "clinical range" – may be experiencing low levels of parenting confidence, this does not per se imply any formal "disorder".

Table C1. Clinical cut-off scores and clinical range specifiers for mothers completing the KPCS

Range	Score
Non-clinical range	40 or more
Mild clinical range	36–39
Moderate clinical range	31–35
Severe clinical range	31 or less

The KPCS covers the following themes that emerged through focus groups with parents and professionals: feeding, settling, establishing sleep routines, interpreting cries and cues, playing, communicating, responding to needs, management of minor illness, providing a stimulating environment and support from the partner. Designed to be simple to administer, complete and score, it is therefore easy to use for both researchers and practitioners working within a clinical setting with parents of infants up to 12 months old.

Data analysis

We calculated descriptive statistics (medians and semi-interquartile ranges[8]) for all variables. We applied Mann–Whitney U test for comparison of independent groups. Wilcoxon sign ranks test was applied for the "longitudinal" sub-sample of participants.

Parental antenatal and postnatal statistics

PAAS scores

The responses to eight PAAS questionnaires were analysed and the statistics for the Total score, Quality of Attachment and Time spent in attachment summarised in Table 2. Sample size was too small to compare scores by level of risk.

[8] The semi-interquartile range is one-half the difference between the first and third quartiles. It is half the distance needed to cover half the scores. The semi-interquartile range is affected very little by extreme scores. This makes it a good measure of spread for skewed distribution.

Table C2. PAAS statistics

PAAS scale	Median	Semi-interquartile range	Sample range	Possible range of scores
Total attachment	86.50	5.15	69–78	16–90
Quality of attachment	40.00	0.40	38.6–40	8–40
Time spent in attachment	25.00	2.50	19–29	6–30

PPAS scores

Twenty-one PPAS questionnaires were analysed and the statistics for the Total score, Patience and tolerance, Pleasure in interaction and Affection and pride are summarised in Table C3.

Table C3. PPAS statistics

PPAS scale	Mean	Standard deviation (SD)	Sample range	Possible range
Total attachment	97.05	5.82	76.30–95.00	19–95
Patience and tolerance	37.06	3.68	29.10–40.00	8–40
Pleasure in interaction	30.48	4.10	20.60–35.00	7–35
Affection and pride	19.51	1.02	16.00–20.00	4–20

PPAS statistics were also calculated for each fathers' risk level group.

Table C4. PPAS statistics by mothers' risk category

PPAS scale	Level of risk	N	Median	SIQR	Sample range	Possible range
Patience and tolerance						
	Low	1	-	-	-	8–40
	Medium	8	38.60	3.25	19.10–40.00	8–40
	High	4	35.00	2.55	32.10–37.20	8–40
Pleasure in interaction						
	Low	1*	-	-	-	7–35
	Medium	8	31.30	3.00	23.9–35.00	7–35
	High	4	31.80	1.95	29.6–34.00	7–35
Affection and pride						
	Low	1	-	-	-	4–20
	Medium	8	19.50	1.00	16.00–20.00	4–20
	High	4	20.00	0.40	19.00–20.00	4–20
Total attachment						

	Low	1	-	-	-	19–95
	Medium	8	85.70	6.50	76.30–95.00	19–95
	High	4	87.40	2.40	81.70–89.00	19–95

* Sample size too small to calculate statistics.

All but one father (low risk) postnatally was a partner of mother in a medium-risk group (62%) or high-risk group (31%).

Overall, fathers reported very high levels of Total attachment as well as Quality of Attachment and Time spent in attachment antenatally. However, it should be noted that these statistics were based on a small sample of fathers. Postnatally fathers also reported high levels of Total attachment, along with Patience and tolerance and Affection and pride.

From a very high starting point antenatally, father's attachment remained high postnatally. There was a statistically significant increase in PAAS Total attachment scores (Median=86.50) and PPAS Total attachment scores (Median=97.05), Mann–Whitney U=165.00, z=3.96, r=0.74 (very large effect). Subscales from PAAS and PPAS cannot be compared directly.

Maternal antenatal and postnatal statistics

MAAS

The responses to 36 MAAS questionnaires were analysed and the statistics for the Total score, Quality of Attachment and Time spent in attachment are summarised in Table C5.

Table C5. MAAS statistics

MAAS scale	Median	Semi-interquartile range	Sample range	Possible range
Total attachment	86.00	5.50	62–95	19–95
Quality of attachment	45.00	2.00	33–50	10–50

Time spent in attachment	28.00	3.50	12–35	16–35

MAAS statistics were also calculated for each mothers' risk level group.

Table C6. MAAS statistics by risk group

MAAS scale	N	Level of need		Median	Semi-interquartile range	Sample range	Possible range
Total attachment							
	1	Low	1*	-	-	-	19–95
	12	Medium	7	86.00	2.00	78–95	19–95
	7	High	12	88.00	4.50	70–95	19–95
Quality of attachment							
	1	Low	1	-	-	-	10–50
	12	Medium	7	47.00	5.00	45–50	10–50
	7	High	12	48.50	4.50	41–50	10–50
Time spent in attachment							
	1	Low	1	-	-	-	16–35
	12	Medium	7	28.00	4.00	23–35	16–35

	7	High	12	29.00	3.50	21–35	16–35

* Sample size too small to calculate statistics.

All but one mother (low risk) antenatally was in a medium-risk group (60%) or high-risk group (35%).

MPAS

Twenty-one MPAS questionnaires were analysed and the statistics for the Total score, Quality of attachment, Absence of hostility and Pleasure in interaction are summarised in Table C7.

Table C7. MPAS statistics

MPAS scale	Median	SIQR	Sample range	Possible range
Total attachment	92.30	2.65	46.7–95.00	19–95
Quality of attachment	45.00	1.10	22.4–45.00	9–45
Absence of hostility	25.00	1.35	8.00–25.00	5–25
Pleasure in interaction	24.50	1.00	14.00–25.00	5–25

MPAS statistics were also calculated for each mothers' risk level group.

Table C8. MPAS statistics by risk group

	N	Risk level	Median	SIQR	Sample range	Possible range
Total attachment						
	1	Low	-	-	-	19–95

	5	Medium	92.00	2.55	87.20–95.00	19–95
	11	High	91.00	4.45	84.20–95.00	19–95
Quality of attachment						
	1	Low	-	-	-	9–45
	5	Medium	45.00	1.40	42.20–45.00	9–45
	11	High	45.00	3.20	38.20–45.00	9–45
Absence of hostility						
	1	Low	-	-	-	5–25
	5	Medium	25.00	0.70	23.60–25.00	5–25
	11	High	25.00	1.20	20.90–25.00	5–25
Pleasure in interaction						
	1	Low	-	-	-	5–25
	5	Medium	23.00	3.50	20.00–25.00	5–25
	11	High	24.00	1.00	21.00–2.005	5–25

All but one mother (low risk) postnatally was in a medium-risk group (29%) or high-risk group (65%).

MAAS and MPAS

Mothers (n=27) reported a high level of antenatal and postnatal attachment: postnatal attachment was significantly higher than attachment before giving birth. There was a statistically significant difference between MAAS Total attachment scores (Median=86.00) and MPAS Total attachment scores (Median=92.30), Mann–Whitney U=658.00, z=3.70, r=0.49 (large effect). Furthermore, mothers showed a high level of antenatal Quality of attachment which increased postnatally. There was a statistically significant decrease between MAAS Quality of attachment scores (Median=45.00) and MPAS Quality of attachment scores (Median=45.00), Mann–Whitney U=270.00, z=-2.36, r=0.31 (medium effect).

A small subgroup of mothers completed a MAAS and an MPAS (n=13). There was a statistically significant increase between MAAS Total attachment scores (Median=84.00) and MPAS Total attachment scores (Median=90.00), Wilcoxon=624.00, z=2.88, r=0.56 (large effect). Mothers in this subgroup also showed high quality of attachment both antenatally (Median=48.5.00) and postnatally (Median=50.00). There was no statistically significant change in quality of attachment between MAAS and MPAS (Wilcoxon=39.00, z=.00, p>.05.).

Comparisons of fathers' and mothers' scores

PAAS and MAAS

Fathers' antenatal attachment overall was higher than mothers'. That is, PAAS Total attachment scores (Median=86.50) were statistically significantly higher than MAAS Total attachment scores (Median=86.00), Mann–Whitney U=320.00, z=4.43, r=0.64 (large effect). However, fathers' antenatal quality of attachment was lower than mothers'. PAAS Quality of attachment scores (Median=40.00) were statistically significantly lower than MAAS Quality of attachment scores (Median=48.00), Mann–Whitney U=304.00, z=4.02, r=0.58 (large effect).

PPAS and MPAS

There was no statistically significant difference in fathers' and mothers' overall attachment postnatally. PPAS Total attachment scores (Median=97.05) were not statistically significantly higher than MPAS Total attachment scores (Median=92.30), Mann–Whitney U=362.00, z=1.63, p>.05, r=0.64. Additionally, there was no statistically significant difference in fathers' and mothers' overall pleasure in interaction postnatally. PPAS Pleasure in interaction scores (Median=30.48) were not statistically significantly higher than MPAS Pleasure in interaction scores (Median=24.50), Mann–Whitney U=95.00, z=-5.03, p<.001, r=-0.64.

KPCS

Forty-four KPCS questionnaires were analysed and the statistics for the Total score are summarised in Table C9.

Table C9. KPCS statistics

	Median	SIQR	Sample range	Possible range	N
KPCS Total score	43.00	1.0	33–45	0–45	44
KPCS Total – Mothers	43.00	1.0	33–45	0–45	32
KPCS Total – Fathers	43.00	2.0	33–45	0–45	12

The frequency of KPCS clinical levels is summarised in Table C10.

Table C10. Frequency of clinical levels of KPCS scores

KPCS range	N	%
Non-clinical range1	38	86
Mild clinical range2	3	7
Moderate clinical range3	3	7
Severe clinical range4	0	0
Total	44	100

[1]40 or more, [2]36–39, [3]31–35, [4]31 or less

Most mothers and fathers (86%) showed levels of parent confidence in the non-clinical range – that is, “normal” levels of parenting confidence one would expect to find in the general population. Mild clinical levels were found in 7% of mothers; moderate clinical levels were also found in 7% of mothers. None of the mothers were found to be in the severe clinical range.

The numbers of mothers assessed as in low-, medium- and high-risk levels and in mild, moderate and non-clinical KPCS categories are summarised in Table C11.

Table C.11. Frequency of KPCS clinical range by mothers' level of need at start of intervention*

Level of need	KPCS Clinical range		
	Mild clinical	Moderate clinical	Non- clinical
Medium	2	0	4
High	0	1	11
Total	2	1	15

* The numbers are too small to conduct a statistical test.

A small subgroup of mothers completed a KPCS questionnaire at two time points (n=6) after birth. There were no statistically significant changes in parenting confidence over time (Median KPCS at T1=43, at T2=43.5, Z=.447, p>.05.); confidence stayed high.

There was no statistically significant difference between the parenting confidence reported by mothers and fathers after birth (p>.05.).

The small sample size and characteristics of the sample do not allow a more in-depth analysis of parenting confidence by parent attributes.

Appendix D: TBCP semi-structured interview topic guides

Core team questions

Name

Organisation

Date of interview

Interviewer

Questions about you

What is your role in TBCP?

How long have you been involved in TBCP?

How did you get involved in the programme?

- If applied to work in TBCP: ask why; motivations and expectations

What did you before this?

Questions about the TBCP model and how well it is working

How would you describe the key aims that the TBCP programme is trying to achieve?

Have these aims or your understanding of them changed in any way during your involvement?

- In what way?

To what extent do you think the aims of the programme are clear:

- To families?
- To other professionals? Probe: children's social workers, adult social workers, health visitors, midwifes, anything else?
- To stakeholders (e.g. council leadership, etc.)?

What do you see as the key elements of the model and its development (e.g. for anybody who wanted to replicate it)?

Have these changed at all since the start of the programme?

- If yes, how and why?

How is TBCP different from other family support (for families involved with social care) or targeted early help offers?

To what extent do you think TBCP is getting the right kind of referrals?

- Types of parents/needs
- Time in pregnancy
- Level of need.

How well are the referral pathways working?

- Has this changed during the programme?
- What helps and what are the barriers to getting the right referrals at the right time (i.e. early enough)?

How is the multiagency partnership working now (Home-Start, Barnardo's, MCC)?

- What are the strengths of the partnership (where things are working well/really well)? What's less of a strength, if anything?
- Has this changed during the programme? How?
- What do you think multiagency working adds to TBCP?
- What is working well and not so well?

How useful do you think is it to be embedded in a "Think Family" approach?

- What does this mean in practice?
- Is it working well? What's working well?
- How would you describe other agencies' involvement/contribution to the "Think Family" approach?
- Has this changed?
- What needs to improve?

Did the COVID-19 pandemic have any impact on the programme and how you work with families? Please explain.

What are the key tools and approaches you have been using in your work?

- To what extent are they useful/critical for your work with families? How well do you think they work with different parents (e.g. older/younger and different levels of need)? Why?

To what extent do you think it is important to start work with parents/families during pregnancy (as opposed to at or post-birth)?

- How important is it (on a scale of 1–10 when 1 is not at all important and 10 is vital)? Say more about your answer (i.e. why specifically it may be important).
- What difference does it make and why?

To what extent do you feel able to engage and form a trusting relationship with different families?

- For different types of parents (e.g. by age or type) / families?
- Can you give an example?

To what extent do you think TBCP is currently helping to increase family resilience?

- For different types of parents (e.g. by age or type) / families?
- Can you give an example?

To what extent do you think TBCP is currently helping parents to gain an understanding of effective (“good enough”) parenting including the importance of attachment?

- For different types of parents (e.g. by age or type) / families?
- Can you give an example?

To what extent do you think TBCP is currently helping parents to make better life choices?

- For different types of parents (e.g. by age or type) / families?
- Can you give an example?

Overall, are there any particular types of parents that respond better/worse to the programme?

- Why?
- What could be done to improve this?

To what extent are you able to engage extended family members in the work?

- How?

Are there any gaps in support services for families during the programme? What are these?

Have you had any families disengage with TBCP? Why?

- Do you think this could have been prevented? How?

What do you see as a “good ending”?

To what extent can you offer effective exit and support strategies and signposting for parents and babies when cases close?

- For different types of endings?
- Where are the gaps/what could be done differently?

How confident do you think parents are about coming back for support before reaching a crisis?

- Do you think their experience with TBCP will encourage parents to approach you again for light-touch support?

Are you aware of any parents coming back after TBCP (for more than light-touch support)?

Support for your role/daily work

What support do you receive for your role/in your work? For instance, one to one or group supervision/other?

To what extent does it help you to reflect on your practice?

What is the impact on your practice?

What are the important bits?

To what extent do you feel confident in undertaking your role?

Concluding questions

What are the ongoing challenges?

What are the key strengths?

Can you share a key/recent learning about TBCP and how it works with parents?

How do you see the future priorities for the programme?

How would you continue to improve the programme?

Is there anything else I haven't asked you about that you think is relevant or would like to mention?

To what extent do you think TBCP is currently helping parents to make better life choices?

- For different types of parents (e.g. by age or type) / families?
- Can you give an example?

Overall, are there any particular types of parents that respond better/worse to the programme?

- Why?
- What could be done to improve this?

(Continue here if they said "no" above):

Are there any gaps in support services for families who are the target group of TBCP? What are these?

What do you define as a "good ending"?

To what extent there are effective exit and support strategies and signposting for parents and babies when cases close?

- For different types of endings?
- Where are the gaps/what could be done differently?

How confident do you think parents are about coming back for support before reaching a crisis?

- Do you think their experience with TBCP will encourage parents to seek out light-touch support?

Are you aware of any parents coming back to the system after TBCP (for more than light-touch support)?

<u>Concluding questions</u>

What are the ongoing challenges?

What are the key strengths?

Can you share a key/recent learning about TBCP?

How do you see the future priorities for the programme?

How would you continue to improve the programme?

Is there anything else I haven't asked you about that you think is relevant or would like to mention?

Project team questions

Name

Organisation

Date of interview

Interviewer

Questions about you

What is your role in TBCP?

How long have you been involved in TBCP?

How did you get involved in the programme?

- If applied to work in TBCP: ask why; motivations and expectations
- What was your role before this?
- Barnardo's and Home-Start: how did your organisation get involved in the programme?

Questions about the TBCP model and how well it is working

How would you describe the key aims that the TBCP programme is trying to achieve?

Have these aims or your understanding of them changed in any way during your involvement?

- In what way?

To what extent do you think the aims of the programme are clear:

- To families?
- To the core team?
- To other professionals? Probe: children's social workers, adult social workers, health visitors, midwifes, anything else?

- To stakeholders (e.g. council leadership, etc.)?

What do you see as the key elements of the model and its development (e.g. for anybody who wanted to replicate it)?

Have these changed at all since the start of the programme?

- If yes, how and why?

How is TBCP different from other family support (for families involved with social care) or targeted early help offers?

To what extent do you think TBCP is getting the right kind of referrals?

- Types of parents/needs
- Time in pregnancy
- Level of need.

How well are the referral pathways working?

- Has this changed during the programme?
- What helps and what are the barriers to getting the right referrals at the right time (i.e. early enough)?

How is the multiagency partnership working now (Home-Start, Barnardo's, MCC)?

- What are the strengths of the partnership (where things are working well/really well)? What's less of a strength, if anything?
- Has this changed during the programme? How?
- What do you think multiagency working adds to TBCP?
- What is working well and not so well?

How useful is it to be embedded in a "Think Family" approach?

- What does this mean in practice?
- Is it working well? What's working well?
- How would you describe other agencies' involvement/contribution to the "Think Family" approach?
- Has this changed?

- What needs to improve?

Did the COVID-19 pandemic have any impact on the programme and how you work with families? Please explain.

What are the key tools and approaches TBCP is using?

- To what extent are they useful/critical for your work with families? How well do you think they work with different parents (e.g. older/younger and different levels of need)? Why?

To what extent do you think it is important to start work with parents/families during pregnancy (as opposed to at or post-birth)?

- How important is it (on a scale of 1–10 where 1 is not at all important and 10 is vital)? Say more about your answer (i.e. why specifically it may be important).
- What difference does it make and why?

To what extent do you feel TBCP is able to engage and form a trusting relationship with different families?

- For different types of parents (e.g. by age or type) / families?
- Can you give an example?

To what extent do you think TBCP is currently helping to increase family resilience?

- For different types of parents (e.g. by age or type) / families?
- Can you give an example?

To what extent do you think TBCP is currently helping parents to gain an understanding of effective (“good enough”) parenting including the importance of attachment?

- For different types of parents (e.g. by age or type) / families?
- Can you give an example?

To what extent do you think TBCP is currently helping parents to make better life choices?

- For different types of parents (e.g. by age or type) / families?
- Can you give an example?

Overall, are there any particular types of parents that respond better/worse to the programme?

- Why?
- What could be done to improve this?

To what extent is the programme able to engage extended family members in the work?

- How?

Are there any gaps in support services for families during the programme? What are these?

To what extent is family disengagement a problem for TBCP?

To what extent do you think disengagement can be prevented? How?

What do you see as a “good ending”?

To what extent can the TBCP programme offer effective exit and support strategies and signposting for parents and babies when cases close?

- For different types of endings?
- Where are the gaps/what could be done differently?

How confident do you think parents are about coming back for support before reaching a crisis?

- Do you think their experience with TBCP will encourage parents to approach you again for light-touch support?

Are you aware of any parents coming back after TBCP (for more than light-touch support)?

Support for your role/daily work

What support do you receive for your role/in your work? For instance, one to one or group supervision/other?

To what extent does it help you to reflect on your practice?

What is the impact on your practice?

What are the important bits?

To what extent do you feel confident in undertaking your role?

Concluding questions

What are the ongoing challenges?

What are the key strengths?

Can you share a key/recent learning about TBCP and how it works with parents?

How do you see the future priorities for the programme?

How would you continue to improve the programme?

Is there anything else I haven't asked you about that you think is relevant or would like to mention?

Steering Group questions

Name

Organisation

Date of interview

Interviewer

Questions about you

Which organisation do you represent in the Stakeholder Group?

What is your role within your organisation?

How long have you been involved in TBCP?

Were you involved in the creation of the TBCP programme?

- How do you recall the original motivation for the creation of TBCP?

Questions about the TBCP model and how well it is working

How would you describe the key aims that the TBCP programme is trying to achieve?

Have these aims, or your understanding of them, changed in any way during your involvement?

- In what way?

To what extent do you think the aims of the programme are clear:

- To families?
- To the TBCP team?

- To other professionals? Probe: children's social workers, adult social workers, health visitors, midwifes, anything else?
- To other stakeholders (e.g. council leadership, etc.)?

What do you see as the key elements of the model and its development (e.g. for anybody who wanted to replicate it)?

Have these changed at all since the start of the programme?

- If yes, how and why?

How is TBCP different from other family support (for families involved with social care) or targeted early help offers?

- How is it different from the offer of your organisation?

To what extent do you think TBCP is getting the right kind of referrals? (if they can comment on this)

- Types of parents/needs
- Time in pregnancy
- Level of need.

How well are the referral pathways working from your perspective? (if they can comment on this)

- Has this changed during the programme?
- What helps and what are the barriers to getting the right referrals at the right time (i.e. early enough)?

How is the multiagency partnership working now (Home-Start, Barnardo's, MCC)?

- What are the strengths of the partnership (where things are working well/really well)? What's less of a strength, if anything?
- Has this changed during the programme? How?
- What do you think multiagency working adds to TBCP?
- What is working well and not so well?

How useful is it to be embedded in a "Think Family" approach?

- What does this mean in practice?

- Is it working well? What's working well?
- How would you describe your own and other agencies' involvement/contribution to the "Think Family" approach?
- Has this changed?
- What needs to improve?

Check if they are able to comment on the effectiveness of the TBCP programme.

- **If yes, continue here**
- **If no, skip to the question "Are there any gaps in support services…"**

How well do you think TBCP works with different parents (e.g. older/younger and different levels of need)? Why?

To what extent do you think it is important to start work with parents/families during pregnancy? (as opposed to at or post-birth)?

- How important is it (on a scale of 1–10 when 1 is not at all important and 10 is vital)? Say more about your answer (i.e. why specifically it may be important).
- What difference does it make and why?

To what extent TBCP is able to engage and form a trusting relationship with different families?

- For different types of parents (e.g. by age or type) / families?
- Can you give an example?

To what extent do you think TBCP is currently helping to increase family resilience?

- For different types of parents (e.g. by age or type) / families?
- Can you give an example?

To what extent do you think TBCP is currently helping parents to gain an understanding of effective ("good enough") parenting including the importance of attachment?

- For different types of parents (e.g. by age or type) / families?
- Can you give an example?

To what extent do you think TBCP is currently helping parents to make better life choices?

- For different types of parents (e.g. by age or type) / families?
- Can you give an example?

Overall, are there any particular types of parents that respond better/worse to the programme?

- Why?
- What could be done to improve this?

(Continue here if they said "no" above):

Are there any gaps in support services for families who are the target group of TBCP? What are these?

What do you define as a "good ending"?

To what extent there are effective exit and support strategies and signposting for parents and babies when cases close?

- For different types of endings?
- Where are the gaps/what could be done differently?

How confident do you think parents are about coming back for support before reaching a crisis?

- Do you think their experience with TBCP will encourage parents to seek out light-touch support?

Are you aware of any parents coming back to the system after TBCP (for more than light-touch support)?

<u>Concluding questions</u>

What are the ongoing challenges?

What are the key strengths?

Can you share a key/recent learning about TBCP?

How do you see the future priorities for the programme?

How would you continue to improve the programme?

Is there anything else I haven't asked you about that you think is relevant or would like to mention?

Social worker questions

Name

Organisation

Date of interview

Interviewer

Where are you based (area of Manchester – North or Central)?

Approximately how many TBCP families/cases have you worked with so far?

How would you describe the key aims that the TBCP programme is trying to achieve?

What do you see as the key elements of the model?

How is TBCP different from other family support (for families involved with social care) or targeted early help offers?

- How is it different from the "usual" offer of your organisation?

What do you think the multiagency partnership adds to TBCP (Home-Start, Barnardo's, MCC)? – if they are able to comment on this.

- What are the strengths of the partnership (where things are working well/really well)? What's less of a strength, if anything?
- What is working well and not so well?

How would you describe your working relationship with TBCP practitioners? (the institutional aspects not on a personal level)

- What works well and what works less well?
- To what extent is this different from your working relationship with non-TBCP EY practitioners?

How well are the referral pathways working from your perspective?

- Has this changed during the programme?
- What helps and what are the barriers to getting the right referrals at the right time (i.e. early enough)?

To what extent do you think TBCP is getting the right kind of referrals? (if they can comment on this)

- Types of parents/needs
- Time in pregnancy
- Level of need.

In what way are they different from parents who are not allocated to the TBCP programme?

How well do you think TBCP works with different parents (e.g. older/younger and different levels of need)? Why?

To what extent do you think it is important to start work with parents/families during pregnancy? (as opposed to at or post-birth)?

- How important is it (on a scale of 1–10 when 1 is not at all important and 10 is vital)? Say more about your answer (i.e. why specifically it may be important).
- What difference does it make and why?

To what extent TBCP is able to engage and form a trusting relationship with different families?

- For different types of parents (e.g. by age or type) / families?
- Can you give an example?

To what extent do you think TBCP is currently helping to increase family resilience?

- For different types of parents (e.g. by age or type) / families?
- Can you give an example?

To what extent do you think TBCP is currently helping parents to gain an understanding of effective (“good enough”) parenting including the importance of attachment?

- For different types of parents (e.g. by age or type) / families?
- Can you give an example?

To what extent do you think TBCP is currently helping parents to make better life choices?

- For different types of parents (e.g. by age or type) / families?
- Can you give an example?

Overall, are there any particular types of parents that respond better/worse to the programme?

- Why?
- What could be done to improve this?

Are there any gaps in support services for families who are the target group of TBCP? What are these?

What do you define as a “good ending”?

To what extent are there effective exit and support strategies and signposting for parents and babies when cases close?

- For different types of endings?
- Where are the gaps/what could be done differently?

How confident do you think parents are about coming back for support before reaching a crisis?

- Do you think their experience with TBCP will encourage parents to seek out light-touch support?

Are you aware of any parents coming back to the system after TBCP (for more than light-touch support)?

Concluding questions

What are the ongoing challenges?

What are the key strengths?

Can you share a key/recent learning about TBCP?

How would you continue to improve the programme?

Is there anything else I haven’t asked you about that you think is relevant or would like to mention?

Parent interview questions

How did you get involved in the programme? How did it all start?

Get as much detail as possible. Ask other questions if appropriate, including to help the interviewee relax

What made you think you’d like to participate in this programme?

Were you hesitant or worried about getting involved in any way?

- Why? What in particular were you hesitant or worried)?
- What did you hope/want to get out of the programme?
- Have you ever used a similar service? Tell me more about it.
- If another same or similar service was accessed before, is there anything different about their experience this time round?

How well did [name of TBCP key worker] connect with you first?

- Did you meet them face to face or online?
- Was that OK for you?
- Do you remember what your first impressions were about the programme?
- Did the way they got in contact affect how you felt about engaging with the service? (Did this work for you or would you have preferred to connect [face to face/online]?)

How long were you involved with them/the service?

Approximately how often did you see [your key worker]?

- Was this face to face or online?
- Did you keep in touch between your meetings? [if yes, tell me a bit more about this]
- If using Zoom/telephone, etc., was that OK for you?
- What impact did this have on the work, positive or negative, if any? [What difference – if any – would have made if you could have had your meetings face to face?]

What did you do with [key worker]?

- Keep asking “anything else” to get a full list. Take the time to listen and record in detail.
- If a mix of Zoom and face to face, ask what things they tended to do face to face and what by Zoom.

Did you have a say in how the support looked like, for example the things you did or how often you met?

What was helpful about what you did, if anything?

What was the most helpful thing?

What was the least helpful thing?

To what extent did [your key worker] give you good advice?

Can you give me an example?

To what extent did they support you? [How helpful did you find the support for getting ready for baby's arrival? Can you give me an example?]

To what extent did [your key worker] involve the baby's other parent (father?) or your partner?

- How much did they do this (one off or throughout?
- Was it helpful?
- How?

Was anyone else in your family involved? For instance, your own parent(s) or grandparent(s) or siblings?

- How much?
- Was it helpful that they were involved?
- How?

Apart from [your key worker], who or what other supports/services did you get?

To what extent [How much] did the programme help you to be a parent?

- In what way(s)?
- How did that work?
- What was the most important thing that you learnt from the programme?

To what extent [How much] did the programme help you to bond with your baby/child?

- In what way(s)?
- How did that work?
- What was the most important thing that you learned from the programme?

To what extent were you helped to get good advice about your health? [How much did the programme help you to get advice about your health and baby's health – how to keep yourself and baby healthy?

How about your sexual health (during pregnancy, contraception, etc.)?

If first child:

How much did [key worker] help you to understand what to expect when baby arrives (e.g. giving birth, how you might feel after giving birth, what babies do, etc.)

If not first child:

How much difference did this support make compared to your past pregnancy/pregnancies? Can you tell me what was different this time?

What are your plans now/for the future? How much did the programme help you to feel confident about the future and your own future choices?

Explore how the programme helped the parent to reach their potential (e.g. through college/work/other) irrespective of whether the baby/child remained with them.

Was there anything that the service didn't or couldn't help with?

- What?
- How?

What would you say are the main changes or positive steps you've made, if any, as a result of being involved?

To what extent do you feel that the positive things have been sustained/kept going since you stopped working with the programme?

What's been more challenging or difficult to keep going?

How confident are you that you could ask for help again if you needed it? Who would you ask for help if you needed it? Can you tell me why?

(Can you think of) 3 good things about this service [that you liked]?

(Can you think of) 3 things that would help the service to improve [you didn't like about the service]?

To what extent would you recommend the service to a friend? [If you had a friend who was expecting a baby, how much would you recommend the service to them?]

Totally recommend – Kind of recommend – Kind of not recommend – Totally not recommend. Can you tell me why?

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