Parents 1st: Impact and measurement

Evaluation report based on the support of the Centre for Social Action Innovation Fund for Parents 1st

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Renaisi

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Executive Summary

Parents 1st and their affiliate partner deliver an asset based peer support initiative focused on early prevention during the key life transition of pregnancy, birth and post birth. This is achieved through working with volunteers, building relationships and working collaboratively with the organisations and the communities it works in. This gives it a set of specific evidence needs.

Scope

This report brings together the learning from the support that was provided to Parents 1st as part of the Centre for Social Action Innovation Fund to scale up and evidence its model.

This work has designed new tools, based on existing evidence and the perspectives of stakeholders, to track systematically how Parents 1st builds resilience, confidence and parenting capacity across multiple domains. This will allow for individually tailored peer support and clearer statements about how the programme creates different benefits for different communities.

Challenge

It is clear that there is a role that Parents 1st plays in reducing need for other services though preventative work with families and early intervention. This research has identified significant challenges in adequately measuring that reduction in need, finding both economic valuation models unhelpful and a move towards controlled trials not relevant for such a relationship-based and context dependent model. Two measures for tracking service use have been designed for the new framework.

Current impact

The existing data about the approach, previously endorsed as level 2 standard of evidence by Nesta, evidences that Parents 1st is having highly statistically significant impact on parents' resilience during pregnancy, birth and early parenting, and is giving them a sense of progress about issues they are worried about. Importantly, given the strengths-based peer support model, there is also good evidence that the approach is reducing isolation, and shaping norms for parenting including a visible increase in breastfeeding rates. This combination of data suggests the value of the peer support as an approach, and suggests great potential for its partnership with other services.

A new approach

The issue of attribution when evaluating an informal peer support initiative is the clearest research challenge that this study has identified, and this leads to important next steps for Parents 1st to consider as it further develops its evidence quality for its model. Given the complexity of this informal peer-to-peer initiative, which works so closely with the context of an area, adapts to the unique circumstances of each parent and the relationships across service provision in that area, then outcomes will be context dependent. The systematic collection of data that has been implemented through this work will allow Parent 1st to make clear statements about the value of its work, in context and in partnership with other services.

Introduction

This report is designed to bring together a new evaluation strategy for Parent's 1st which is based on the research and learning support that was provided to Parent's 1st as it developed its model through the support of Centre for Social Action Innovation Fund.

There are, within this, four objectives:

- To provide insight into what the Parents 1st model is and how this model has specific needs for how it measures and understands its impact
- To set out the new evaluation framework for Parents 1st that support its ambition for scale and impact
- To explore the work achieved by Parents 1st in reducing need for other services, and the challenges of robustly measuring this reduction of need
- To present data of impact achieved by the programme during the period of investment.

Evaluation requirements

The Centre for Social Action Innovation Fund was designed to support the growth of innovations that mobilise people's energy and talents to help each other, working alongside public services. Evaluation support was a significant part of the wider support that the Centre gave to the projects and services that they supported.

Parents 1st measures impact for two sets of beneficiaries:

1. Volunteer peer supporters
2. The parents whom the volunteers support

Parents 1st specifically needed evaluation support for the second set of beneficiaries, the parents who received volunteer support. This was in the following areas:

- To review the data currently collected and its appropriateness, including for the requirements of current and future commissioners and health professionals they work alongside;
- To review Parents 1st pre-existing data collection tools and methods and consider the best ways to approach this going forward, including where suitable recommending appropriately validated evaluation tools or data sets;
- To develop an appropriate end to end data capture and analysis process that the internal team can implement, and train 3-6 Parents 1st staff members on its implementation. This included an annual schedule laying out key data collection milestones throughout the year;

- To support the team in the analysis of the first data set from the two established Essex programmes and the Isle of Dogs programme, following the successful implementation of the new evaluation framework, and review and validate an impact report created by the Parents 1st team for external audiences including current and future commissioners.

This highlights that the work for this project was heavily focussed on rethinking data capture approaches and supporting the team to develop the most appropriate approach for data capture to put it in a strong position in the future. There is also an element of work to think through the best way to position the evidence needs of Parents 1st as there is considerable debate about how social enterprises such as Parents 1st should measure and describe their impact.

Methodology

The research that took place to deliver this work included a number of methods, which contributed towards those objectives.

A significant review of existing internal data capture processes

All of the existing data capture and measurement tools that were used by Parents 1st for parents supported were assessed and reviewed. This was done in partnership with the team at Parents 1st, and enabled a full understanding of how beneficiaries came into contact with any data capture system by Parents 1st. This highlighted a very large and complicated picture of questionnaires and tools, and these were reviewed to understand their purpose and how they were helping contribute towards an understanding of the impact, processes or quality assessment work of Parents 1st.

Interviews with staff and volunteers

A set of semi structured interviews with staff and volunteers to understand how they work with, support and understand the variety of needs of families was undertaken. These were done in staff/volunteer pairs, and designed to explore levels of need of the people that Parents 1st works with. This was designed to qualitatively explore levels of need, and to identify the wide range of areas in which the Parents 1st approach supported those families. This approach found a wide range of levels of severity of issues affecting the families, and highlighted that the peer support can work with a diverse range of parents across tiers 2 to 4[1]. The range of issues identified that parents and peer supporters worked on together were used to develop a wide ranging set of measurement areas, but also it underlined that the approach should not attempt to pre-define that need level, as it often emerged as peer supporters started supporting parents how serious issues were. This methodology therefore encouraged an approach towards breadth of issue and distance travelled by each individual parent.

Semi-structured interviews with commissioners

A range of commissioners, selected purposively based on their knowledge of Parents 1st, were interviewed to understand what they valued about the approach, the ways in which

[1] DH 2000 "Framework for the Assessment of Children in Need and their Families" London. The Stationary Office.

it could fit into their commissioning thinking, and what value they perceived such asset based approaches to have.

Amended willingness-to-pay interviews with public sector partners

A set of interviews were conducted that were designed to use willingness-to-pay methodologies to get those partners to consider what was of value to them, and how they would quantify that value in comparison to other parts of their own service. This methodology was incredibly useful in understanding the range of ways in which the approach worked with other services, but they all struggled to quantify it in any way. This highlights the significant challenge of financially measuring the value of the service.

A wider practice review to inform the writing of this report

A review of existing practices and approaches to measuring impact of asset based approaches was undertaken, to give guidance as to other ways of doing this, and what matters most for an approach like Parents 1st.

A redesign of impact questions to measure the impact of delivery

Based on all of the above, work was done to design, in partnership with Parents 1st, a new set of impact measurement tools, and to do so in a way that did not undermine the strengths-based and informal peer support mode of delivery.

Developments

As the project developed, it was clear that the initial aspiration for measuring the economic value of the reduction in service need created by Parents 1st was not practically possible, and inappropriate for a peer support model. These changes to methodology and approach are highlighted within the report, and reflect much of the essential learning from this project.

Final reporting

Two large interim reports were created to detail the findings of the process orientated work to develop the new tools.

Objectives of this report

The aspiration of this report as a whole is to provide an understanding and rationale for a new measurement framework for Parents 1st which will demonstrate their impact with robust data. This report is not an evaluation of Parents 1st, it is not a review of the literature that justifies the model, and it is only a part of the learning from this process. It does, however, use learning from a range of sources, and the experience of this process, to argue for the new measurement framework.

It will be followed up by a further report in October 2016, which will assess the first year of new data created by the tools of the new framework. At least a full year of data is required, to capture impact of the work of the volunteer peer supporters with families from pregnancy to the postnatal period.

Parents 1st

Parents 1st is an award winning social enterprise dedicated to building successful Community Parent volunteer peer support initiatives in less advantaged communities. Its national work involves supporting other organisations to implement and deliver the initiative, adapting it to suit each local context.

The model

The foundation of the Parents 1st peer model is using asset based approaches to achieve social impact. A key feature is its close collaboration with maternity, GP, Healthy Child Programme and early years services. A particular component is the use of focused home visits using a relational model of support. Based on principles of active listening, mutual respect, self-help, and sharing evidence-based resources, the peer supporters enable parents to explore, reflect on and achieve self-selected goals. Embedding this practical framework enables Community Parent volunteers to nurture and motivate parents to achieve positive parenting, health and wellbeing outcomes so as to give babies the best start in life. Theories underpinning the approach include:

- Adult learning;
- Social learning;
- Self-efficacy (Bandura);
- Bio-ecological (Brofenbrenner);
- Evolutionary theory; and
- Social capital (Bourdieu).

National and local delivery

Parents 1st is a national development agency that supports new evidence-based Community Parent initiatives delivered by other grass roots organisations, and also a local delivery organisation in that it directly delivers a local Community Parent initiative in a specific locality in Essex. The work is developed within communities facing significant social, health and educational inequalities.

Context

Birth rates are rising, creating pressures on maternity services. Child birth can be a difficult experience for those who are lonely and wary of professionals. Poor physical and emotional wellbeing results in behaviours which negatively impact on parents and babies, causing long-term disenfranchised communities. There is clear evidence, and a growing consensus (illustrated through the work of the 1001 Critical Days Manifesto[2], amongst other routes) about the essential role the period from conception to two years has in supporting outcomes later in life.

Importantly for Parents 1st, the 1001 Critical Days Manifesto includes the following point about the opportunity of this period:

[2] http://www.1001criticaldays.co.uk/

Pregnancy, birth and the first 24 months can be tough for every mother and father, and some parents may find it hard to provide the care and attention their baby needs. But it can also be a chance to effect great change, as pregnancy and the birth of a baby is a critical 'window of opportunity' when parents are especially receptive to offers of advice and support.

Early prevention

Statutory sector professionals typically intervene when families are in crisis. As an independent social enterprise Parents 1st focuses entirely on early prevention. Local Community Parent volunteers are carefully recruited for lived experience and ability to build trusting peer relationships. This enables them to reach marginalised parents in ways that professionals cannot. As intermediaries, they build bridges between marginalised parents and professionals by enabling positive two-way communication and overcoming barriers to help them to access and benefit from the services available.

Community Parents

Parents 1st defines 'Community Parents' as being volunteer mothers, fathers, grandparents and carers with specific personal qualities who are recruited for their potential to build trusting peer relationships. They receive accredited training and supervision. They "walk the journey" with parents through pregnancy, birth and the early months of parenthood offering a continuum of intensive but informal one-to-one peer support in the parents' own homes and in hospital. Parents supported describe their Community Parent as "someone in my corner" who helps them to feel valued.

Key elements of a Community Parents initiative include:

- Skilled implementation by a Volunteer Coordinator (pivotal) and an experienced Community Development Nurse
- Community outreach activities to engage with expectant parents, and promote health and wellbeing during pregnancy
- Continuum of one-to-one focused but informal home visiting through pregnancy, birth and the early months of infancy
- Emotional and physical support during labour and birth (doula support)
- Bridge between vulnerable parents and professionals
- Useful information and timely access to services by disengaged families

Training, Supervision and Personal Development

The Community Parent volunteering experience is based on giving to the community and receiving in terms of new knowledge and skills, personal development and employment opportunities. Volunteers enter an enjoyable group learning process and many describe the experience as 'life changing'. Parents 1st provides specifically designed training to all Community Parents, of which the City and Guilds Level 3 3599 Award (meeting National Occupational Standards for Work with Parents) is an integral component.

This programme of training begins with a short taster course for potential peer supporters to 'test the water', build confidence and explore suitability. Following mentoring, informal interview, DBS checks and references, those who are recruited to become Community Parents progress onto an ongoing training and supervision process in tandem with their

volunteering experience and covering topics appropriate to their chosen peer support role. It is vital to ensure that they are able to provide effective and good quality support to parents including maintaining confidentiality and practicing active listening skills which are crucial to the trusting relationships developed.

Ongoing supervision and occasional accompanied visits monitors the quality of support given to parents, nurtures confidence, and enables ongoing learning and reflection. Role boundaries need to be adhered to and made explicit; ground rules such as health and safety are essential; and it is important that a Community Parent avoids trying to 'fix things' creating a dependency. There is a particular emphasis on the processes required to nurture self-help and build resilience.

Asset based approaches

As alluded to in the content of the training, Parents 1st is an asset based programme. It works with the strengths and capabilities of individual parents, volunteers and of the other agencies in a community to improve outcomes for that community. It does not try to dwell on deficits or problems, rather focussing on solutions and progress made, and the future for all participants. It achieves this through building purposeful, supportive relationships using a semi-structured approach to enable focus on the informal peer support process enabling parents to feel valued, respected, supported and socially connected. Peer supporters also help parents to engage positively and effectively with local services. These are essential parts of how the programme is delivered, and must be recognised as key components of what makes Parents 1st, Parents 1st.

Evidence journey

At the start of the support from the Centre for Social Action Innovation Fund, Nesta validated Parents 1st as being at level 2 on their standards of evidence (see table 1, page 14 for all levels). This was down to the fact that it used a number of pre and post evaluation tools. These included:

1. Antenatal and postnatal adapted MYCaW[3] questionnaires completed by parents
2. An introductory discussion with the expectant mother (and partner, where possible) in the home during which a range of self-assessed baseline measures were established
3. Post support evaluation tools to assess the qualitative views about the model

These tools provide support findings which can be used to articulate impact in certain ways, but they also have challenges. This report details the outcomes measured by these tools in a later section. The MYCaW is heavily subjective, which makes it a valuable tool for an asset based approach, but it does not explore all areas of a person's life at baseline, and so risks missing positive, but not predicted, effects of the work.

The qualitative and process evaluation work that was completed between March and June 2015 to further understand the work of Parents 1st underlined a need to gain a more rounded picture of impact that could be tracked consistently as a programme. This study began by reviewing the evidence journey, and how it linked to the delivery of the model.

[3] http://www.bris.ac.uk/primaryhealthcare/resources/mymop/sisters/

The following diagram demonstrates how various data points were collecting information from parents throughout the support process.

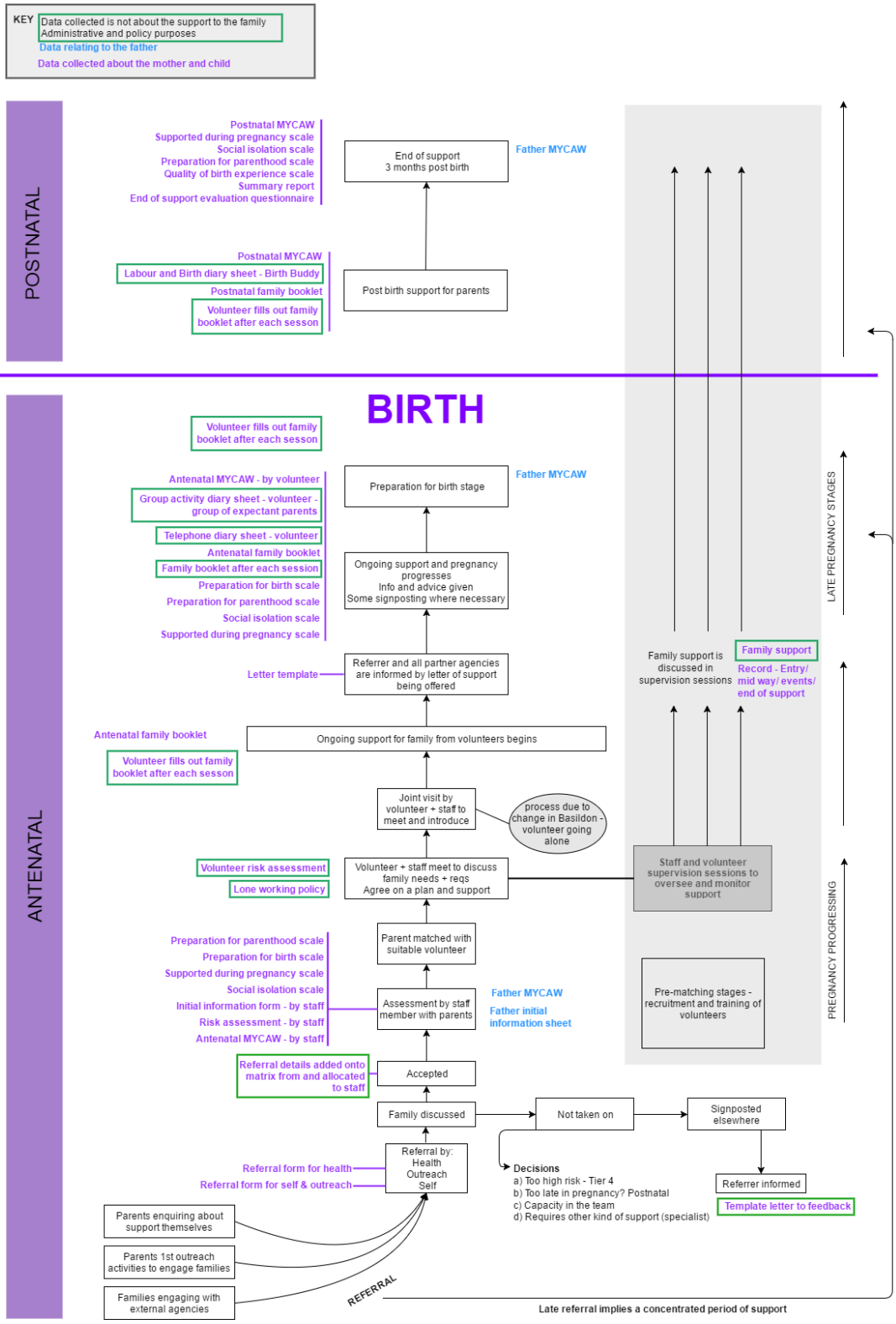


Figure 1 - initial measurement framework for Parents 1st

Through working with the staff team and also a number of volunteers and partner agencies, it became clear that this approach was collecting a lot of information and data, but not telling the whole story of what Parents 1st was doing for individuals. The partner agencies included community midwives, social workers, health visitors and GP / walk in centre practice managers.

It was clear that all parties identified that Parents 1st contributed to supporting the impacts in the following places:

- Impacts on parents in various parts of their lives (from housing situations to personal confidence)
- Impacts on babies and future outcomes as a result of that impact on parents
- Impacts on volunteers who give support
- Impacts on the wider community as a result of the new connections
- Value to public services that see a reduced need for services and support in an area, and /or an increased confidence of parents to access and use services effectively

It is important to connect this to the wider description of how Parents 1st is delivering its outcomes, and this can be seen most clearly in the Theory of Change.

Theory of Change

The diagram overleaf is the Theory of Change for Parents 1st in relation to the parents and their children. This highlights that the ultimate objective for Parents 1st is that 'Babies have a better start in life'.

The assumptions built into the theory of change, and intermediate outcomes along the journey towards the ultimate objective, have broadly been supported by the detail identified in this process for parents and their children. This suggests that there are outcomes all along the journey that can be tracked and understood. They will be understood in different ways, and not all of them are easily measurable. As with any theory of change it is important to consider what is proportionate to measure, in relation to how the model works and how data collection would influence delivery. It is also important for Parents 1st to develop its Theory of Change for the other areas in future, and ensure that they work across the organisation.

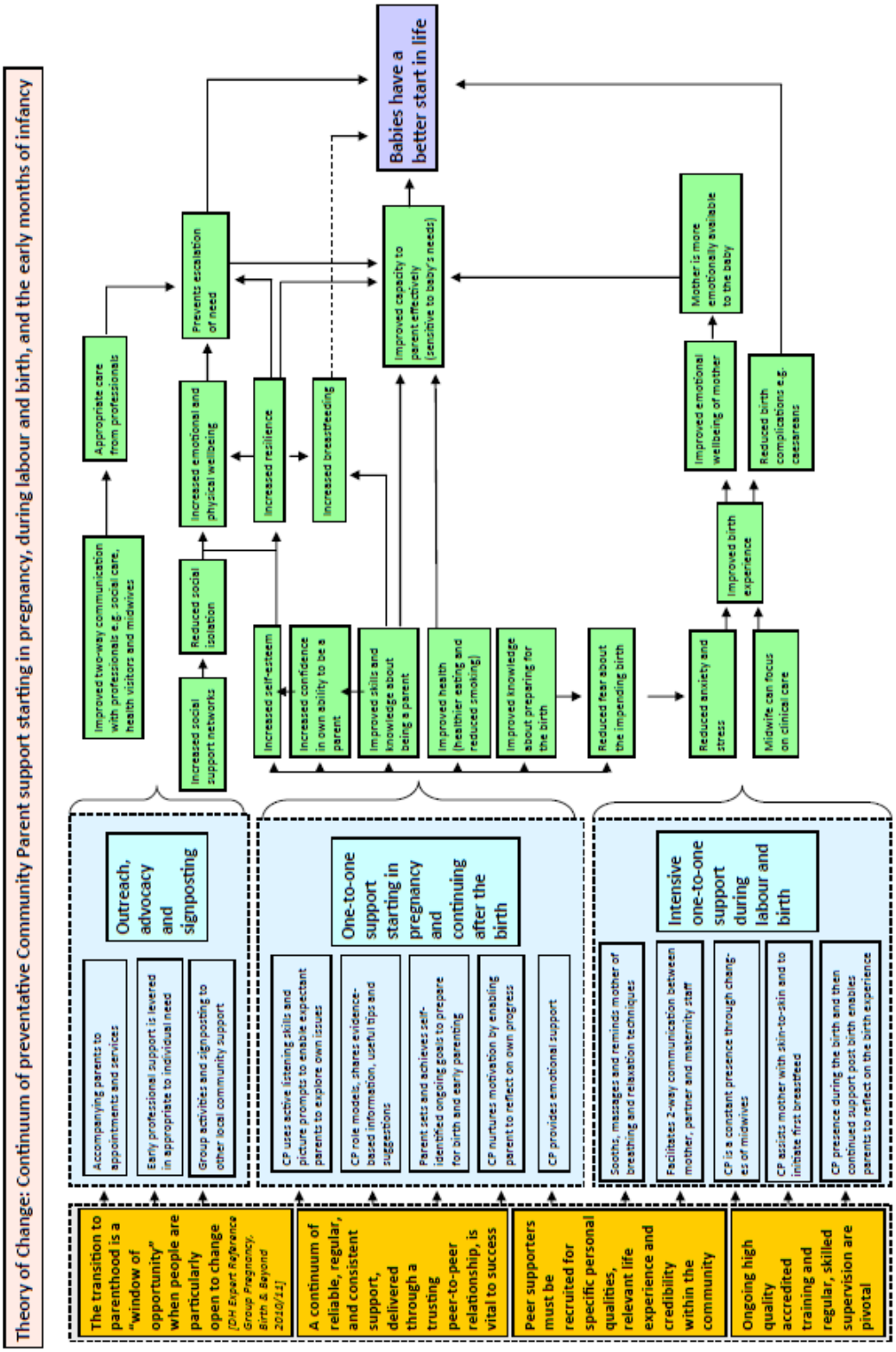


Figure 2 - Theory of Change

Questions of impact

There is no such thing as a perfect measurement framework. The nuances and subtleties of projects which work with people and engage with different parts of who they are and how they consider themselves cannot be easily codified and measured. This is particularly the case for projects that do not focus on outcome areas with agreed indicators of success (getting a job, reducing mortality rates, gaining a qualification level). As a result, everything is a proxy for impact, and the task is to create and justify the best proxy possible. This section explores the issues that influence these decisions for Parents 1st.

Multiple impacts

Parents 1st have designed their approach with intention of creating multiple impacts; for individual parents, the volunteers, the children (or children to be) and the wider community. The work in this study has primarily focussed on the parents.

There are two ways to think of multiple impacts. One is that it creates a variety of impacts for people, and that each person may notice a different impact in a different part of their life, depending on what they need. In some instances this may be on very specific issues such as support the uptake of breastfeeding, meaning that the impact of the model can be seen in higher breastfeeding rates in a community, and in other areas this may be seen in the confidence levels of parents to access services. The other, and perhaps more relevant to the Theory of Change of Parents 1st, way of seeing multiple impacts is that the holistic approach creates such significant change through thinking about all parts of somebody's life, that the confidence in one area has such a wide range of effects in other parts of life of a parent-to-be. Because each parent is worked with on their own terms, the relationship will find benefits to their life in a way that is meaningful to them. This may mean that there is an impact on something specific, such as breastfeeding rates, but to focus solely on this would reduce and devalue the holistic approach of the model. This is harder to measure, track and quantify, but will have significant impacts on the life of that parent and family, and likely the wider community.

Value

Value is very similar to impact, but not always the same. It is the areas of work that people who engage in the model find valuable to them and what they do. For a parent, what is valuable is often also an impact (increased confidence levels), but they might not see it in the same way (they may not value that they breastfeed their child, as they have no counter-factual, but it is impactful based on research and experience). Value is often identified by the organisations that a project works with, as much as the people it works for. These in-between points of value – ensuring that a parent gets to an appointment on time – are often missed in classic approaches to tracking impact, but have significant value for the local service landscape, ultimately saving services and the local area time and money.

Asset based approaches

Measuring impact in public services is often structured around reducing problems. Much of the language of measurement tools is designed to identify a problem, and track progress in alleviating it.

In a very different domain to the work of Parents 1st, this can be seen in tools such as the well-respected Gierveld tool for measuring loneliness.[4] The wording of those questions is incredibly negative, and can be seen as off-putting when services use them, even if well respected as academic measures.

This problem is particularly stark for Parents 1st, as it is an asset based approach. The language of measurement cannot detract from delivery, and there is always a risk that a deficit phrasing of a question could negatively impact upon the relationship that a Parents 1st member of staff or a Community Parent volunteer has built up. This creates a tension between two significant demands for the project, and therefore needs to be considered when choosing the appropriate monitoring and evaluation methods and questions.

Evidence quality

Any project will collect information in the administration and management of that work. We have, for the purposes of this document, identified information as being about the **processes** of delivery, the **quality** of delivery or the **impact** of delivery. Each of these categories of data are important, and each helps support the overall narrative of what a project does.

As well as there being different types of data, there are also different qualities of data that can tell better stories about impact and value. Nesta use five levels of evidentiary quality for projects to consider and use in judging their own processes and systems. These are beginning to be adopted and considered by other funders and commissioners, and even if not used by all are shaping the thinking and demands of funders.

Level	Description	Typical methodologies
1	You can describe what you do and why it matters, logically, coherently and convincingly	Descriptive Theory of change
2	You capture data that shows positive change, but you cannot confirm you caused this	Pre and post surveys Regular interval surveys
3	You can demonstrate causality using a control or comparison group	(Randomised) Controlled Trial Control group analysis Difference in difference
4	You have at least one independent replication evaluation that confirms these conclusions	External replications of 3
5	You have manuals, systems and procedures to ensure consistent replication and positive impact	Fidelity and process evaluations

Table 1 - Nesta levels of evidence

[4] Gierveld, J. and Tilburg T., (2006). A 6-item Scale for Overall, Emotion and Social Loneliness, *Research on Aging.* 28 (5), pp. 582-598.

This approach and framework for evidence puts Parents 1st in a challenging position, as it suggests the next level of evidentiary quality would be a controlled trial of some kind. This is very challenging in a community based initiative, where services evolve in partnership with parents, volunteers are often the ones collecting data, and the holistic model does not create single outcome areas to be simply measured.

There are a number of studies which have started to question the relevance and reliability of such evidentiary approaches, particularly in public health interventions. The challenges raised in these reports are highly relevant to Parents 1st as it develops, and can be seen below.

Inappropriate method for public health

"Use of randomized controlled trials to evaluate health promotion is, in most cases, inappropriate, misleading, and unnecessarily expensive."[5]

"Randomized controlled trials or corresponding experimental designs should not be used to measure the effectiveness of health promotion interventions."[6]

"Whilst Randomised Controlled Trials (RCTs) are the gold standard for medical treatments, their use is limited in social/behavioural interventions to those that are uncomplicated and explicitly definable. Health promotion interventions are usually complex and multifaceted, limiting the use of RCTs for the following reasons: it may not be ethical to withhold the intervention, nor to objectify people; achieving random allocation is problematic; and it is difficult to avoid contamination of a control or comparison group. Health promotion interventions may suffer if inappropriate methods of assessing evidence are applied, or health status outcomes and individual behaviour change are given too much weight."[7]

Decontextualize issues

"Uncritically accepting designs that isolate, decontextualize, and simplify issues has dramatically decreased the applicability of the current results. The key problems of today are "wicked" problems that are multilevel, multiply determined, complex, and interacting. Physicists employing mechanistic and decontextualizing, isolation design approaches learned the limitations of such approaches at reductionism decades ago and have since moved to chaos and complexity theory, and more contextual approaches.

The RCT designs and hegemony around systematic reviews have worked well to create an initial body of research but have not worked for producing replicable results that matter or translate. The system that is built stifles creativity and thinking by holding that efficacy RCTs are always the highest or only type of evidence considered."[8]

[5] World Health Organization (WHO). Health Promotion Evaluation: Recommendations to Policymakers. Report of the WHO European Working Group on Health Promotion Evaluation. Copenhagen, Denmark: WHO; 1998.
[6] International Union for Health Promotion quoted by Rimpela A. Challenging current evaluation approaches: Lessons from the conference for the research community. In: Norheim L, Waller M, eds. Best Practices, Quality and Effectiveness of Health Promotion. Helsinki, Finland: Finnish Centre for Health Promotion; 2000:180.
[7] O'Connor-Fleming, Mary Louise and Parker, Elizabeth A. and Higgins, Helen C. and Gould, Trish (2006) A framework for evaluating health promotion programs. *Journal of Australia* 17(1):pp. 61-66.
[8] Kessler R, & Glasgow RE (2011). A proposal to speed translation of healthcare research into practice: dramatic change is needed. American journal of preventive medicine, 40 (6), 637-44 PMID: 21565657

Evidence

The final section of this chapter looks at the evidence that exists to support the Parents 1st model. This is not a literature review to support the model of Parents 1st, as that work has been done in other settings and was not the role of this study.[9] The research for this study instead looked for examples of how other similar projects or research tried to consider the measurement challenge in the context of existing evidence of what works in service delivery for families in the first 1001 days.

There are two documents, each with their own large supplementary literature, which were particularly important in shaping thinking about the measurement challenges and priorities for Parents 1st. One focusses on the pregnancy and birth side of the model, and the other the whole family functioning element which Parents 1st supports.

DH Expert Reference Group for Pregnancy, Birth and Beyond (2011): This underlines that the transition to parenthood is a key transition when parents are particularly open to change. The following six areas were identified as being particularly important when supporting expectant and new parents through a successful transition to parenthood: Our developing baby; Changes for me and us; Giving birth and meeting our baby; Caring for our baby; Our health and wellbeing; People who are there for us. These insights have informed and shaped the Parents 1st training and home visiting resources, and it was important to build from this in thinking about what to measure for Parents 1st.

Integrated Theoretical Framework of Family Functioning (Harnett & Dawe 2014): This is a model designed to inform effective assessment of family functioning by identifying needs and strengths across multiple domains. It is primarily designed to assess high risk families, however the principles it uses are universal, based on child development theory which identifies parenting values and expectations, and emotional availability to the baby as being critical for positive childhood development outcomes, with these factors being supported by ecological factors such as economic security and support networks. By exploring multiple domains and how these relate to parenting capacity, Harnett and Dawe argue that parenting initiatives must be based in a robust understanding of the circumstances of parents across domains to enable individually tailored provision. This validates the Parents 1st approach, and reiterates the need for comprehensive measurement across domains. The below diagram has been taken from that study.

[9] For example: http://www.parents1st.org.uk/best-practice/

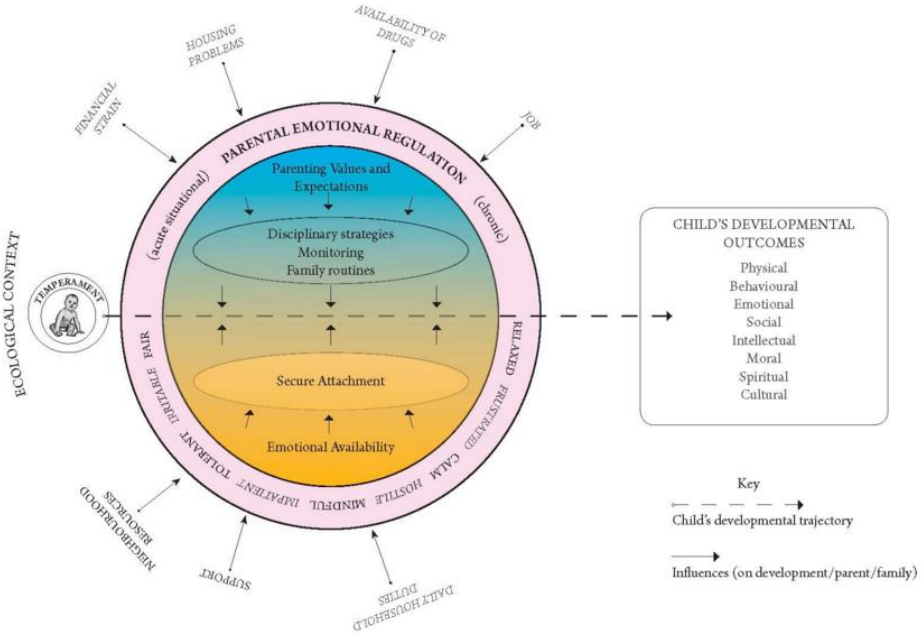


Figure 3 – Framework of Family Functioning

Link to other literature

These two areas of focus have particularly shaped the thinking of measurement tools, but there is a significant literature that supports the model of Parents 1st. It is important for any charity or service delivery organisation to not try and prove that their model of delivery works. It is far better to use existing research to build the key elements of an approach, and use measurement approaches to track where impact is occurring, but also to understand process performance and quality.

In December 2015, Parents 1st and IVAR (Institute for Voluntary Action Research) published phase one of the evidence review for the Big Lottery "A Better Start" programme.[10] This review undertook an initial examination of evidence to support the work of the "A Better Start" partnerships that Big Lottery is funding, and so is not exclusively focussed on peer support. That whole review is a useful evidence base for the Parents 1st model, for example:

1. **Strengths-based**: empower volunteers and enable parents to take control
2. **Relationships**: positive interpersonal relationships
3. **Mutuality**: mutual operation alongside other services
4. **Governance**: importance of safeguarding robust recruitment, boundaries, ground rules, appropriate volunteer training and ongoing skilled supervision

Again, these principles are reflected in the measurement review.

[10] IVAR and Parents 1st, A Better Start Evidence Review: Report to Big Lottery Fund, December 2015. http://www.parents1st.org.uk/news/wp-content/uploads/2016/03/Parents1st_ABetterStartEvidenceReview_PhaseOne_FINAL2.pdf

Preventing escalation of need

The previous chapter highlights the new measurement approach for Parents 1st which is in place to track the impact of the approach on individuals across a wide range of circumstances. This will allow for more systematic and meaningful tracking across the model. One issue that continued to come up in research, and also alluded to above in the literature review, was the role of volunteering approaches in supporting other services that work in an area, and preventing an escalation of need by families.

A part of this study was to use an amended willingness-to-pay methodology to assess and understand the sorts of impacts that the partners and commissioners of Parents 1st saw as valuable and were, in principle, worth paying for from their perspective. This amended approach stripped back much of the detail of a full willingness-to-pay survey, an example of which is the demand for solid waste collection and disposal services, used by the World Bank.[11] The approach in the methodology for this study asked a small number of questions to test the applicability of the approach in this setting.

This highlighted:

- Significant impact around confidence and how this influenced a range of other behaviours and attitudes.

- A focus on issues which may be relevant for different geographic partnerships areas, such as a direct impact on breastfeeding rates, but may not be collected by all partnerships in future.

- That supporting parents to take up appointments, not miss them, or not overuse services that they did not need had significant costs and resource benefits for them.

Stakeholder views

Commissioner interviews

A sample of current commissioners was consulted to understand their priorities and perspectives on the value of Parents 1st. This raised a number of challenges and opportunities in evidencing the data of value to commissioners.

The Parents 1st model, due to its holistic approach, appeals to a broad spectrum of commissioners, from those interested in specific health outcomes based in CCGs to those interested in community resilience and building more integrated systems of working at the local authority level. This highlights both a strength and challenge for the programme: there are opportunities for the approach to feed into a wide array of policy priorities, however there are also challenges in demonstrating the value of the model across such a wide spectrum and in capturing data accordingly.

[11] http://www.worldbank.org/urban/solid_wm/erm/Annexes/US%20Sizes/New%20Annex%204D.3.pdf

Consistently, commissioners saw value in the specific role played by a community parent, noting that it was distinct to a professional role, providing personalised practical and emotion support which disadvantaged and marginalised parents were likely to be responsive to. This was understood to offer something both additional and complementary to professional services.

The most valuable cost saving perceived by commissioners was in child protection. Due to the complexity and intense volunteer supervision required, Parents 1st only work with a small number of high risk cases. The value placed on this work by commissioners reflects the focus on crisis support as opposed to early prevention. Although it suggests the importance of tracking how and where Parents 1st make an impact on service engagement in these cases, a choice needs to be made between early prevention and crisis support and the best use of scant resources.

As a preventative approach, commissioners were not expecting Parents 1st to necessarily reduce engagement in services, but to support parents to engage in them appropriately to their need. A net reduction in service use for parents accessing Parents 1st is, therefore, not necessarily desirable. However, evidence that parents are accessing services they feel to be appropriate to their need is a meaningful way to demonstrate the positive impact the model has on appropriate engagement in services. This is, therefore, highlighting that the model can be both a way to make productive use of services, and as a route to using local knowledge and intelligence which could shape effective commissioning in future.

With tightening budgets, commissioners also value approaches which build community capacity. As such, the focus of the framework on building confident, resilient parents, across the domains identified as well as in ability to engage with services appropriately, is designed to reflect the need to evidence this. This was recognised by the commissioners, but it is important to stress that they did not fully understand how it could work, and did not necessarily know what effective community capacity building looked like. The Parents 1st model draws volunteers from the same community as the beneficiaries, and there is significant potential and acknowledgement of this process of building self-support networks, and support for the community. This was acknowledged, but not always a core part of the understanding of commissioners.

Partner interviews

To determine the perception of value of Parents 1st from partner agencies, five staff members from different agencies working in the local community with pregnant women and families were interviewed. This included two children's centre managers, a midwife, a child protection social worker, and a women's services coordinator for a health service.

The interviews explored the types of issues that service users present with, the awareness of what kinds of support Parents 1st offer and the value of that support to the professionals in their roles. The data allows for an exploration between the perception of value of the approach and the areas where Parents 1st can contribute to cost savings, and these are explored below.

Renaisi

Presenting issues

The frequent issues that the partner services faced in providing support differed depending upon service and roles; however there were some commonalities among the group regarding the issues they faced when working with mothers such as missed appointments, a language barrier, parents struggling with their emotional health, domestic violence, children in need or at risk, parents with drug or alcohol dependency problems, and parents in poor physical health.

The impact that these issues were reported to have on the role of the professionals include increased time and resources to work with cases where these elements are present. Where appointments are missed, then the availability of time in a clinic or at a service is reduced, and further time is taken to re-schedule those appointments.

Where there are emotional health problems, or issues of risk, then general appointments take longer as professionals are required to spend more time with each parent to establish detailed information about the situation and act accordingly, making onward referrals for specialist support. In cases where the mother would be experiencing pre or post-natal depression, then the midwife would visit every day.

Support available from Parents 1st

The level of partnership working between the partner services and Parents 1st varied, and as such the knowledge and awareness of available support differed among the group.

The awareness among the five interviewees of the kind of support available from Parents 1st most frequently reported were:

- Practical support in pregnancy, birth and beyond;
- Emotional support;
- Confidence building and empowerment;
- Accompanying parents to services and helping them to widen their social networks.

The overall sense from the partners was that they viewed the support from Parents 1st either as a useful element of support, taking place alongside their role by adding value to complement and enhance the experience of support for the family. Or alternatively, as providing something in addition that is inherently different to what their roles provide or are able to achieve. This was especially true for the professionals from statutory services that would be providing their interventions to families notwithstanding the family's interaction with Parents 1st. *The whole premise of the approach is that there is something unique provided by the peer support, but that it is not in isolation from the wider, professionally-led service. The two, together, create the outcomes for the families, and that in collaboration these outcomes are greater than they would have been with only the single service. This leads to a sense of mutuality.*

Mutual support for other services

When considering the value of the support offered by Parents 1st the Midwife described how much of the benefit of the approach is for the women themselves rather than to her in her specific role. As a statutory health worker with a job to do, she would carry out her

role the way she is expected to rather than do anything different as a result of the work of Parents 1st. *However, the midwife reported that the main aim of her role is to get a good outcome for the parent, and by drawing on the available support from Parents 1st and making them part of a package of support, she is assisted in that aim to get a good outcome for the parent.*

Many of the examples offered regarding the support provided to mothers by Parents 1st were things that the midwife would not be required to do, or have time to do, but which are highly valuable. The midwife said that "knowledge is power and knowledge enables you to make your decision", which has benefits for hospital staff and the women at the time of labour.

She offered another example of Parents 1st working with a woman who was in touch with Social Services to practically help them to engage in that process, and create a more stable platform from which to work from and address the wider issues. This is time consuming practical work undertaken by the volunteers that demonstrates how Parents 1st "Enable someone to take control of that mess of their lives and start to make some sense of it."

The value of the volunteer role in relation to professionals

The Child Protection Social Worker clearly has a predominantly, high risk and intensive caseload of families to work with. Although she had only worked in partnership with Parents 1st on one case, she was easily able to provide examples of the value of their work. *The main value that she felt Parents 1st provided was that as a volunteer they were able to make a connection with the parent in a way that is different to how a social worker would*. She reported how the element of trust is really important and that a volunteer would be better placed to gain the parent's trust at a time when there is intensive involvement from statutory services that is often daunting and confusing for the parent.

She described how this made a big difference to the work she was able to do with this parent as the volunteer helped to 'Keep mum well and truly emotionally stable' at a really difficult time. The volunteer had time to talk and listen and spend time assisting the parent with practical issues that are beyond the scope and available resource of the Social Worker. She reported that this enables them to better engage with the process, are less fearful and that the Parents 1st model is a potentially helpful step down service for when Social Services feel it is appropriate to withdraw. She recommended that the service become involved in more similar cases at an earlier stage.

This again is indicative of how the support can be influential in assisting statutory services to obtain a positive outcome for the families, rather than escalate to an irrevocable and more costly outcome of permanent removal of children for example.

Social services and NHS workers do not have the resource available to spend intensive time with parents on the practical elements and the peer support from Parents 1st could be said to assist the de-escalation of need by supporting positive outcomes in partnership with other services undertaking wrap-around support.

Accompanying to appointments

The children's centre workers reported that the accompanying to appointments and the outreach provision to engage with parents was a valuable activity from the Parents 1st team as this enables them to not need to go and visit parents themselves when they miss an appointment therefore taking more resources to re-schedule and assess the circumstances.

It was evident from a number of interviews that missing appointments not only costs money and reduces the availability of provision to other service users, but it also is a preventative measure in being able to assess risk and not miss situations where the need or risk may have escalated. This is clearly a valuable role that Parents 1st provide which saves resource in other areas. Parents 1st go further than merely accompanying though as they assist and empower parents to attend on their own once their confidence is increased, which has added value for the parent in the future. They also help parents understand what was said by the professional and help them to plan their questions to professionals so as to make the appointment more productive.

Rationale for the impact measurement framework

The partner agencies all work with pregnant women, families and young children; however, as demonstrated above, the issues affecting the client group they work with are broad ranging and not solely focused on pregnancy, maternity care and early years. As such, the data gathered from partner agencies supports the rationale for building the impact framework that incorporates measurement across a broad set of circumstances that families may face during pregnancy, birth and beyond.

It is also supportive of the wider development of the process for uncovering each parent's strengths and challenges in the initial stages of their interaction with parents, as this allows for a broader understanding of how the contact can be beneficial both to the parents, and also where value can be added to the work alongside other agencies. In addition, the tools developed to systematically capture activity of the Parents 1st staff and volunteers, and evidence of partnership working will allow a more comprehensive understanding of where and to what extent this is happening, and the effect that it is having on the families and the additional service use.

Examples of partners' views

These following quotes from the partner interviews highlight a range of perspectives and key insights from those partners.

How Parents 1st help the partners in their work:

> ***'Not a huge impact on my job but a big difference to the women's lives.'***

Practical information for parents, local services and parenting:

> ***'They give them support and let them know. For me again, I think the key thing would actually be the emotional support they give to these patients.'***

Uncovering the needs of parents:

> ***'They tend to evaluate what the parents needs are…It's really very important, it makes the job easy for people like me because once they have seen the Community Parent they know what to do, so it helps really.'***

Accompanying to appointments:

> ***'Definitely a 5 I think [out of 5], if they are doing that then that is really helpful to us.'***

Language barrier

> ***'It impacts in the sense that it can take, sometimes that might take five minutes with somebody where we are both speaking the same language… and somebody where English is a 2nd or 3rd language it might take me fifteen or twenty minutes.'***

Asset based approaches and attribution challenges

All of these quotes and pieces of evidence support an image of an approach that gains benefit from the asset-based approach, and that the parents and wider service community benefit from that style of work. These approaches do raise questions of how evidence is collected, and what kinds of evidence can be possible for asset based approaches to collect, especially if the approach to data collection undermines the very way of working.

An approach that could, in theory, deal with the challenges of measuring the level of reduced need of other services, would be to set up a control group and to run a trial. In practice, however, the ability for Parents 1st to run such a trial would be practically challenging, and impossible based on the principles of the model. Any kind of controlled trial requires something to be controlled for, and would ideally be the model of delivery. Long causal chains make a Community Parent initiative unsuited to such study designs which were developed for clinical interventions with short and simple causal chains. An asset based approach is led by relationships and adaptation that would need very precise information to track what is leading to effects. This is impractical, and goes against the ethos of asset based approaches, when so much of the model is delivered by volunteers.

This is exacerbated further by the realities of how services are commissioned, and how cost is considered. The economic measures that were attempted in this research came from a systemic challenge, as service partners could not practically separate out the value of the peer element of work that Parents 1st provided. The only way to deal with this in practice would be to embed peer support into the heart of a system, and measure the full impact in that area. This would require the sorts of collaboration and collective working described in a recent piece by Geoff Mulgan, before becoming measurable, and as a result Parents 1st would risk creating an approach in a vacuum that did not recognise the whole.[12] In reality, the conclusion is that this is impractically challenging for a single organisation.

The research undertaken for this study also highlighted other methodological problems for understanding the model. This is most specifically around the challenge of attribution. The willingness-to-pay methodology that was used in this study did not work, as none of the partners who worked with the model were able to consider its work in any kind of financial way, nor were current or potential commissioners able to price out the work of the Parents 1st approach in a landscape of wider provision.

This links back to the point in the literature about mutuality of service support and outcomes. Asset based volunteer peer support approaches add to a landscape of provision, but they cannot be disentangled from services because they are not services. They are instead approaches which enhance a relationship, create conditions for change such as improved levels of confidence that can support another service. The quality of implementation and context of each Parents 1st delivery area are vital components to achieving impact.

[12] http://www.nesta.org.uk/blog/collaboration-and-collective-impact

Evidence of impact

The new measurement framework for Parents 1st that is described in this report began collecting data in autumn 2015. Given the length of support of the model, a good quality data set will not be ready until autumn 2016 at the earliest. This chapter reports on the data available from previous measurement tools for impact on parents.

The focus of this work has been on the two partnership areas of the Isle of Dogs and Essex. In those two areas, there were different numbers of families supported, over different periods of time. Data was mainly collected from mothers before and after the birth but also included a small number of fathers who were present during the peer support visits.

In the Isle of Dogs, 61 expectant parents were supported between April 2014 and November 2015. Before and after data throughout pregnancy and up to 3 months post birth was available for 18 parents.

In Essex, 108 expectant parents had one-to-one support from August 2013 – November 2015. Before and after data throughout pregnancy and up to 3 months post birth was available for 65 parents.

Data was missing for the other parents because:

- Some were late pregnancy referrals (preventing collection of before and after data during pregnancy);
- Some volunteers did not collect the data; and
- Some parents were still in the process of being supported

	Essex	Isle of Dogs	Essex and Isle of Dogs
Antenatal	65	18	83
Postnatal	33	14	47

Table 2 total responses for Antenatal and Postnatal periods by area

This section presents the impact of Parents 1st on expectant parents, based on this data, and has been supplemented with independent statistical analysis on this data, which was provided pro-bono to Parents 1st.

This data is valuable, but it does not fully demonstrate the breadth of impact created by Parents 1st and this is part of the rationale for the new approach which is described in the next chapter.

Progress on objectives

The adapted MYCaW (Measure Yourself Concerns and Wellbeing) tool was used to track improvements in subjectively important issues for parents supported. Each parent selected two issues that they wanted to see improvement in through the support of the volunteers at antenatal and at postnatal points in support, and then rated how severe that issue was for them on a scale of 0-6. *0 is 'as good as it could be' and 6 is 'as bad as it could be'. A higher score is, therefore, worse.* They were also asked how well they would rate their wellbeing, using the same scale.

The two areas, when combined for the focus of antenatal support, can be seen to have selected the following issues to work on six broad areas. Table 2 highlights the trend.

Issue	Issue 1	Issue 2	Total
Social inclusion	15	9	24
Pregnancy, labour & birth	36	22	58
Parenting skills	9	20	29
Breastfeeding	6	9	15
Emotional wellbeing	13	18	31
Accessing services	4	5	9

Table 3 – Issues chosen by parents by area of focus in antenatal period

The two areas, when combined for the focus of postnatal support, can be seen to have a very similar spread of issues, with pregnancy, labour and support being replaced by practical issues (for obvious reasons). Table 3 demonstrates the distribution of the focus across the two areas.

Issue	Issue 1	Issue 2	Total
Parenting skills	15	15	30
Breastfeeding	13	1	14
Emotional wellbeing	9	19	28
Social inclusion	5	5	10
Accessing services	3	6	9
Practical support	2	1	3

Table 4 – Issues chosen by parents by area of focus in postnatal period

Collectively this shows an interest from parents in gaining support around the most pressing issue of keeping healthy and well during the pregnancy, preparing for labour and birth, and parenting skills after birth. In both time periods, emotional wellbeing was a significant second area of focus, particularly after birth.

Accessing services and gaining practical support were much lower down the list of collective priorities for parents.

Combined data and change

A statistical test[13] was performed in order to assess whether differences between the before and after ratings identified by mothers for self-identified issues in pregnancy and general wellbeing were statistically significant or not. The analysis uses statistical testing to assess whether differences between before and after ratings for self-identified issues and wellbeing can reasonably be attributed to chance, or if mothers receiving support from Parents 1st volunteers are likely to have led to a real change in the issues raised and general wellbeing.

When looking at the first issue in the antenatal period across both areas, figure 4 highlights the frequency of parents whose scores improved, and to what degree. 0 shows that their score has not changed, a positive score shows that it has improved, and a negative score that it has got worse. Over 50% (42 out of 83) of parents moved their rating for the first issue by three points or more.

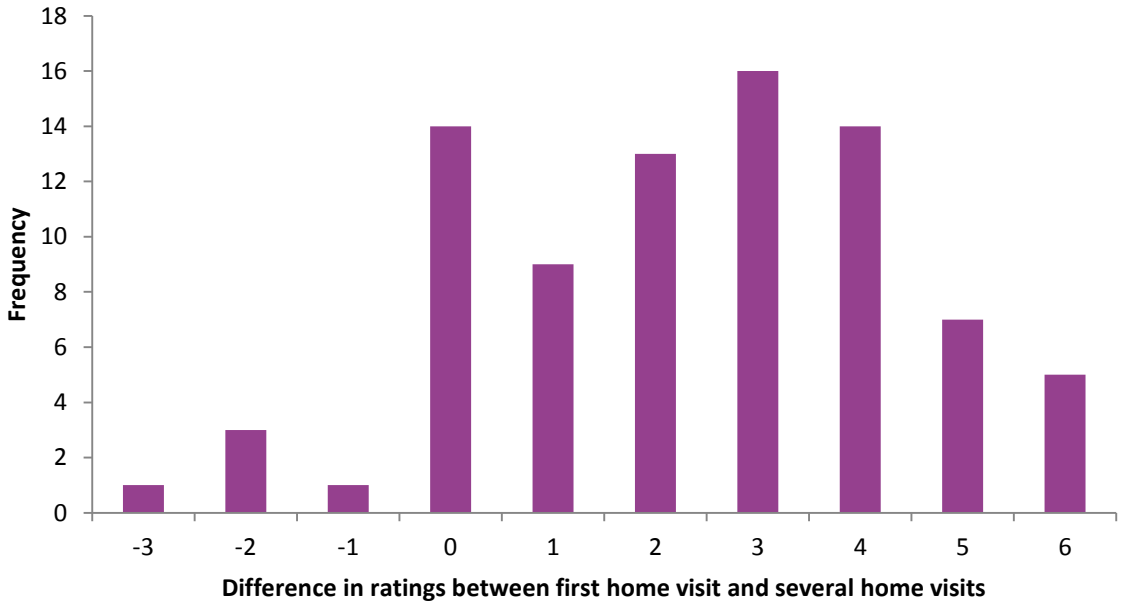


Figure 4 - Differences between ratings for issue 1 in the antenatal period

The analysis that was undertaken indicates that the majority of expectant mothers who received the intervention, experienced real improvements in the first self-identified issue in the antenatal period. The probability that the differences in ratings occurred due to chance was less than 1 in 1,000.

In terms of the second issue (figure 5), there are fewer cases of movement by 3 or more scale points (32 out of 83 (39%)), but like the first issue, only 5 cases saw a negative movement. Again, following statistical testing, the probability that the differences in ratings occurred due to chance was less than 1 in 1,000.

[13] Wilcoxon matched-pairs signed-ranks test.

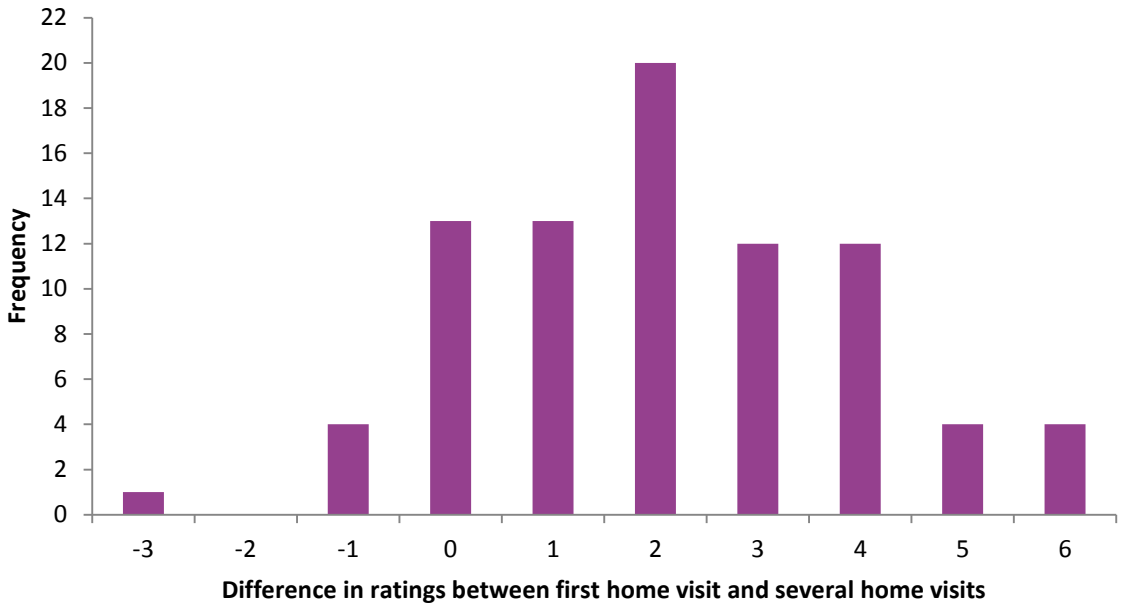


Figure 5- Differences between ratings for issue 2 in the antenatal period

Finally, for the antenatal period, the wellbeing changes are smaller than for the two issues but, on average, still a very positive one. 22% of parents (18 out of 83) saw their wellbeing score fall over the period, and 59% increased (49 out of 83). This distribution can be seen in figure 6, and again these changes are highly statistically significant, with the probability that the differences in ratings occurred due to chance less than 1 in 1,000.

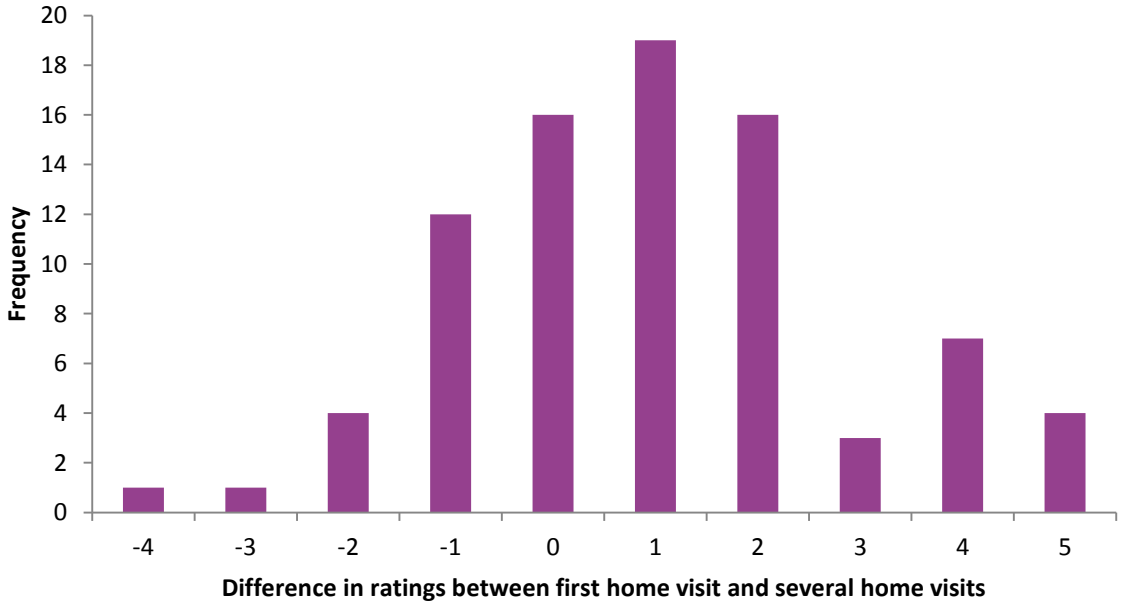


Figure 6 - Differences between ratings for wellbeing in the antenatal period

This trend of change, and also the statistical significance of that change, continues into the postnatal period. The number of parents that completed data for the postnatal period is smaller, but the significance of the change continues with the probability that the differences in ratings occurred due to chance less than 1 in 1,000.

Figure 7 highlights the change in issue 1, and over 9 out of 10 parents saw an improvement in this issue. Issue 2 is described in figure 8, and 41 out 47 parents saw an improvement in this issue. Finally, figure 9 describes the wellbeing changes, and 44 out of 47 parents saw a positive change.

This wellbeing change is much higher than in the antenatal period, and this is worthy of further consideration by the service in future. Is this difference due to the different points in the parents' natural wellbeing journey, with the worry and concerns of child birth dampening that score in the antenatal period, and the highs of new parenthood raising the score immediately after birth? Or is it more to do with the value being generated by peers over time, and that wellbeing takes longer to be embedded? These are just two potential hypotheses, and this sort of data gives Parents 1st the opportunity to consider why particular kinds of success are being generated at different points in the journey.

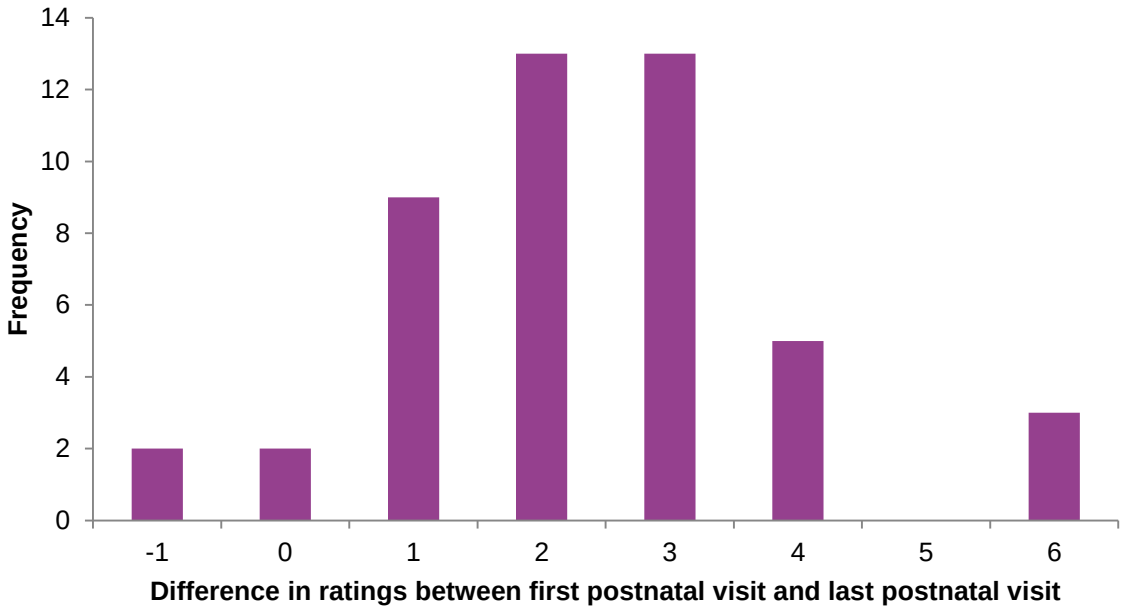


Figure 7 - Differences between ratings for issue 1 in the postnatal period

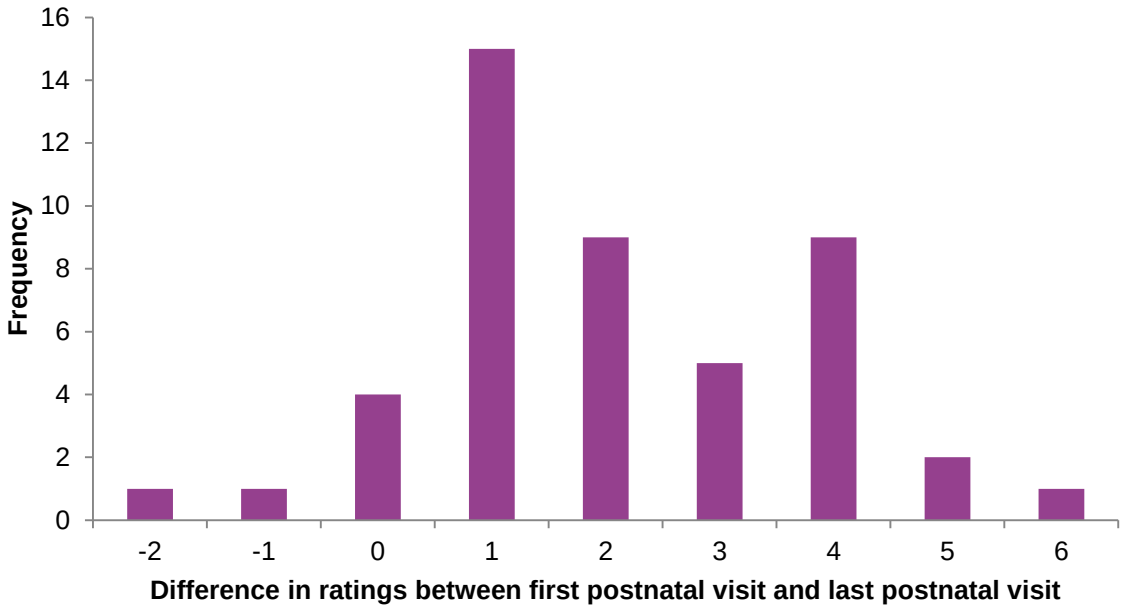


Figure 8 - Differences between ratings for issue 2 in the postnatal period

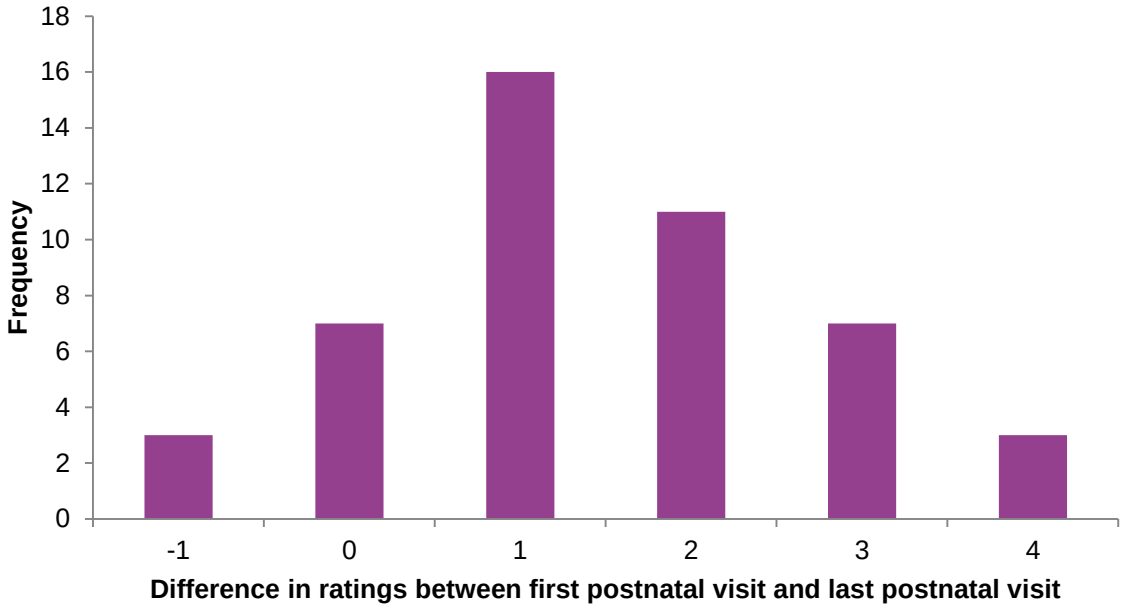


Figure 9 - Differences between ratings for wellbeing in the postnatal period

The statistical analysis that has been completed in this section underlines that there is positive change, and that it does not happen by chance. This does not say anything about the levels before and after. These are less important for an understanding of the impact of the service, but do give a descriptive picture of each area.

Isle of Dogs

In the Isle of Dogs, changes by issue during pregnancy can be seen below, and there is a 47% improvement in the mean average for issue 1 for all of the women, a 43% improvement in the mean average for issue 2, and a 37% improvement in the mean average for wellbeing.

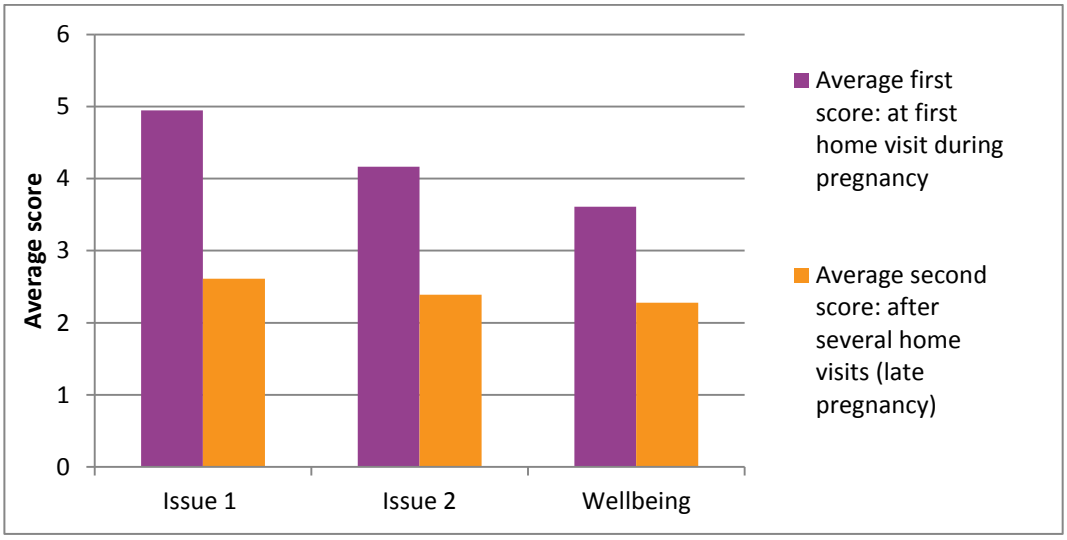


Figure 10 - antenatal pre and post scores IOD

In post-natal scores, changes can be seen below, and this sees a very similar trend with 41%, 33% and 43% improvements against the three issues.

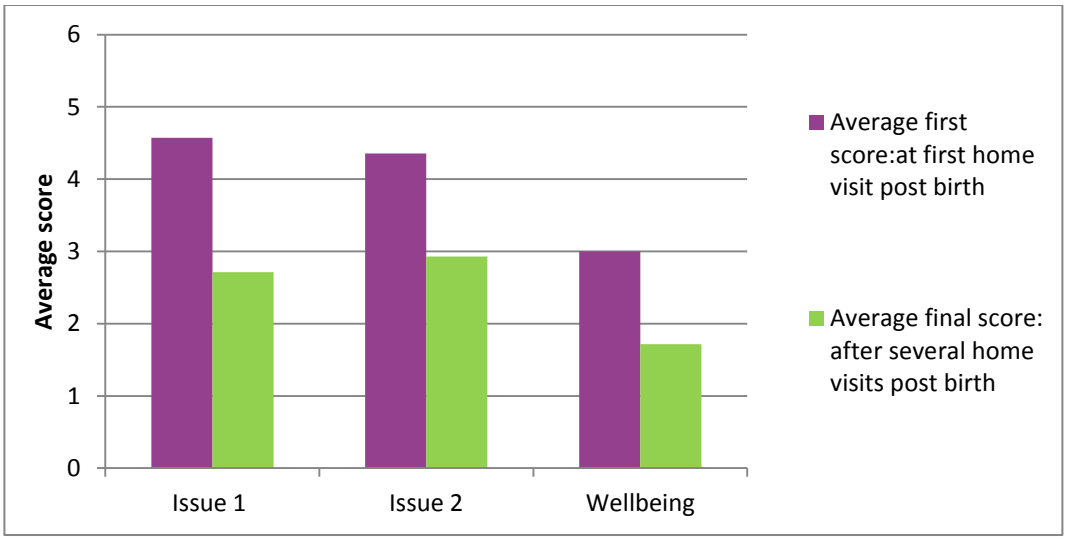


Figure 11 - postnatal pre and post scores IOD

Essex

In Essex, changes by issue during pregnancy can be seen below, and there is a 48% decrease in the score for issue 1, a 45% decrease in the score for issue 2, and a 29% decrease in the score for wellbeing. With the slight exception of the wellbeing scores, these mirror the data from the Isle of Dogs.

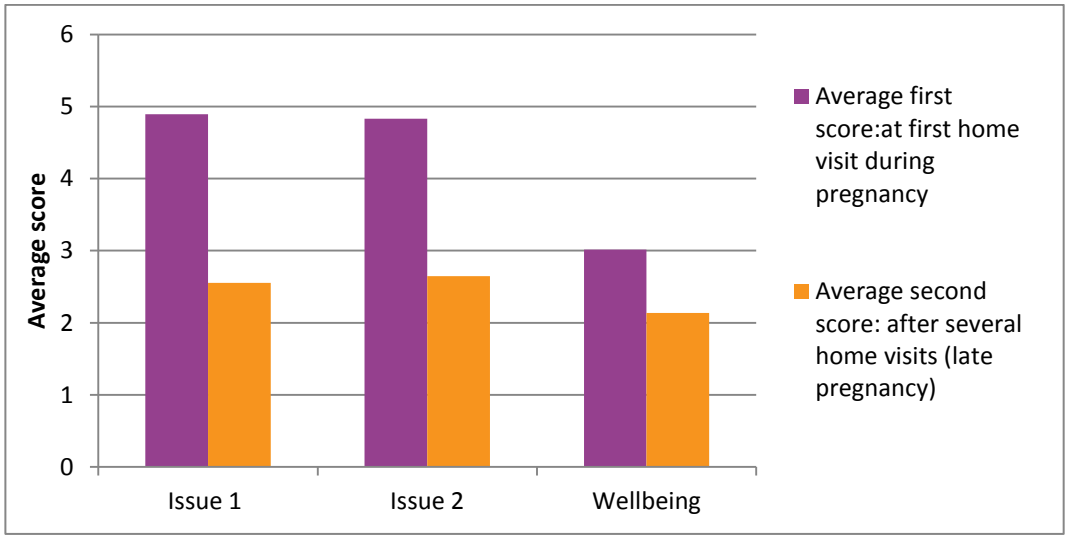


Figure 12 - antenatal pre and post scores Essex

In post-natal scores, changes can be seen below, and again see a similar trend, but the change is far starker in Essex with 66%, 63% and 54% decreases against the three issues.

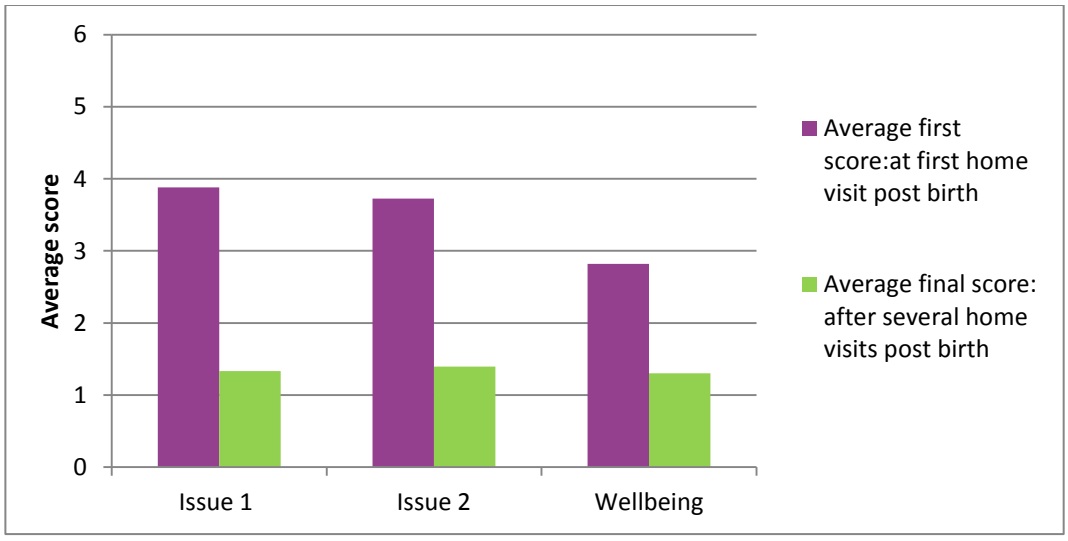


Figure 13 - postnatal pre and post scores Essex

Overall there is clear evidence that the areas which the parents choose to focus on with the volunteers see large and significant improvements, both antenatal and postnatal, with the first issues marginally seeing greater decreases in both instances.

There are differences across the sites, but not in terms of the trend. The main difference is in the greater decrease postnatally in Essex.

This data set gives strong evidence that there are large reductions in perceptions of how much important issues are bothering the parents in both areas at both antenatal and postnatal periods. The consistency of the results across areas reinforces the evidence and demonstrates that there are significant effects due to the Parents 1st model.

The challenge, as highlighted above, is that the adapted MYCaW does not give consistent information about where changes are occurring in people's lives, and which areas the model is more effective in supporting parents with.

Preparing for birth

To build on this, therefore, analysis of a simple data set about how prepared parents feel for birth, and also for parenting before and after birth is analysed below. On a scale of 0-10, parents were asked at different points in support about feeling prepared for birth and responsibility for caring for a baby.

As the two tables below show, there are again similar experiences across both sites, although with slightly higher scores in Essex, and a very high increase in feeling prepared for the birth, but also a large increase in feeling ready to take on the responsibility for a baby.

	Prepared for birth Initial	Prepared for birth Late Pregnancy	Increase
Isle of Dogs	3.33	5.73	72%
Essex	3.94	7.66	94%
Both sites	3.84	7.22	88%

	Responsible for baby Initial	Responsible for baby Late Pregnancy	Responsible for baby Post Birth	Increase
Isle of Dogs	4.50	5.60	6.00	33%
Essex	6.42	8.13	9.38	46%
Both sites	5.85	7.38	8.38	43%

This, when combined with the MYCaW data, suggests strong effects for parents in feeling more confident about birth and parenting, and less concerned about the fears associated with birth and connected issues.

Combined, it is clear that the Parents 1st model is making positive and large improvements in the confidence and sense of preparedness levels of parents to be, and doing so relatively consistently across two sites.

Social isolation

As well as looking at the confidence levels, pre and post intervention data has also been collected from parents about their social connections (or isolation). They were asked at three points whether they had anyone close by to talk to, with options including, 'No, no one', 'Only one person', 'Yes, one or two people', and 'Yes, lots of people'.

The two figures below (14 and 15) demonstrate a similar trend across the two sites, which suggest that there is reduction across the two sites in levels of social isolation and that there is a move towards 'one or two people' and 'lots of people' suggesting it is not just the volunteer who is now the social contact. This movement occurs most clearly at the middle point, but also continues post birth.

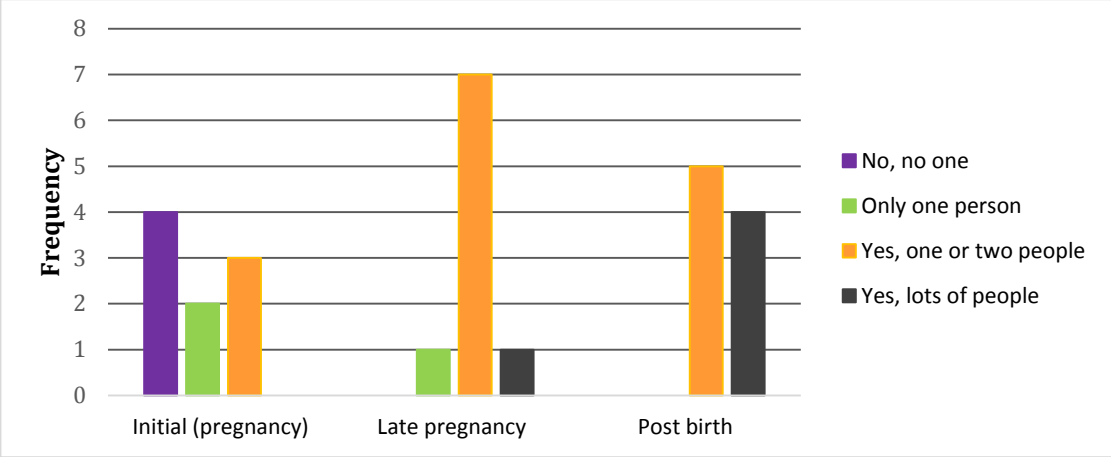
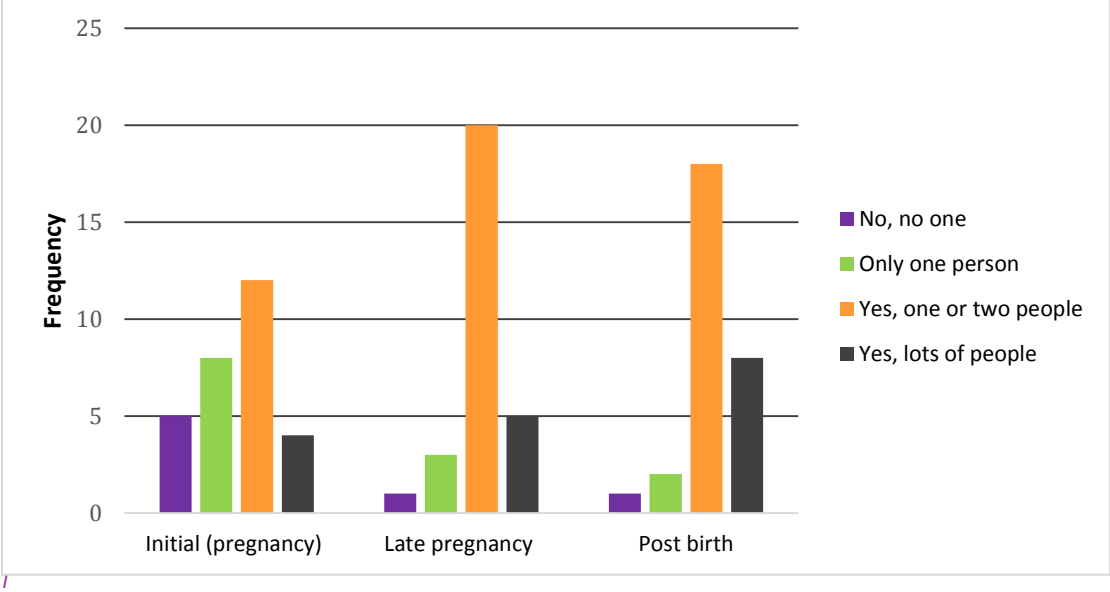


Figure 14 - social isolation changes IOD



isolation changes Essex

Breastfeeding

The above data sets are useful pre and post data, but they are not about wider outcomes or external impacts from the model. One area where wider data, which can suggest outcomes, can be found is in the breastfeeding data.

		Initiated breastfeeding	Breastfeeding @ 10 days	Breastfeeding @ 6 weeks	
Total babies data known		52	47	40	
Total babies data unknown		19	24	31	
Parents 1st	**Totally Bottle fed**	6	5	6	
	Breast fed	46 (88%)	36 (77%)	23 (57%)	
	(Exclusively Breastfed)		22	16	
	(Partially breasted)		12	6	
	(exclusive / partial not known)		2	1	
SW Essex		70%	N/A	36-43% Basildon	43-51% Thurrock
England (2014/15)		74%	N/A	43%	

Table 5: Infant feeding data for babies of parents supported in Essex

This is highly positive data, with significant effects seen in an area of public health policy that can be hard very hard to influence.

Based on the combination of this data with qualitative data from the partner interviews, there are two potential, although certainly not mutually exclusive, reasons for this. One is a strong endorsement of the peer-support and volunteering role, which persuasively use social norms and are effective messengers, which leads to changes in behaviour. The other is that the peer support role is holistic and that a wider range of issues impact on breastfeeding. The fact that the role engages in all areas of confidence and support for expectant parents, rather than solely communicating about breastfeeding, could make the influence clearer.

There is evidence from other studies that volunteers improve breastfeeding rates, both in terms of the number of women who start breastfeeding and who continue to at least 6-8 weeks. This is greater for volunteer doulas compared with breastfeeding peer supporters,

and this may be attributable to the long-term multi-faceted relationship between doulas and the mothers they support. [14]

This endorses the value for Parents 1st areas to continue to measure service outcomes, where possible, in partnership with local service providers. Comparator data sets like this enable clear data findings that suggest the impact of the increased confidence and reduced isolation that is highlighted in the earlier data sets.

Overall

There is evidence that Parents 1st peer support improves the parents' perception of their confidence during pregnancy, birth and the early stages of parenting. There are, however, challenges with this data alone, and this has motivated the creation of the new tools.

The highly statistically significant data on the changes in the MYCaW data, when corroborated with the other data sets, suggests that the peer supporters are improving the subjective experience of parents and their confidence during and after pregnancy, and that the peer support is influencing increases in breastfeeding levels, alongside shifts to isolation levels.

These are clear effects, despite small samples, that in future will need to be measured systematically. The breastfeeding data also highlights the value of linking the progress of parents with wider data sets that can be compared with other communities.

Despite the strengths, and the significant data that has been produced, what this data does not show is *how* the work of the volunteer is supporting the parents to experience this change, and this will be a significant part of the new measurement approach.

[14] Spiby, H., Green, J.M., Darwin, Z., Willmot, H., Knox, D., McLeish, J., Smith, M. Multisite implementation of trained volunteer doula support for disadvantaged childbearing women: a mixed-methods evaluation, Southampton (UK): NIHR Journals Library, March 2015.

Measurement framework

The previous chapters described the Parents 1st model, evidence needs, impact challenge and evidence. This chapter now looks at the new approach that has been established to meet with these needs and challenges.

Wheel of circumstance

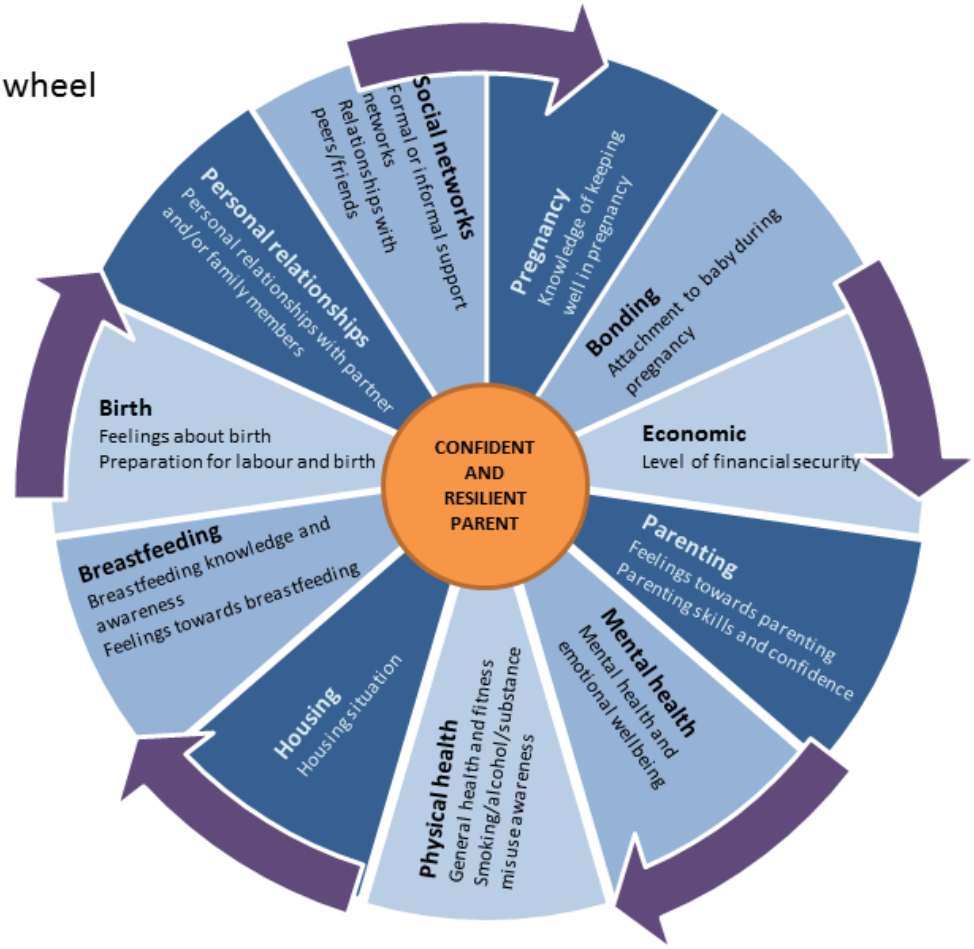
The fundamental finding from the review of the evaluation framework with Parents 1st is the very broad range of areas of a parent's life that the approach can support, and how these can add up, in different ways, to the achievement of the overall objective. Different parents will experience that benefit differently.

What Parents 1st did not collect is any information on the range of circumstances that it has the potential to influence in the lives of parents. In asking them their priorities through the MYCaW, it is not able to see effects systematically. The previous data, therefore, is good for seeing progress in individual parents, but it does not allow Parents 1st to tell a compelling story about all of its work to the range of partner agencies that it works with.

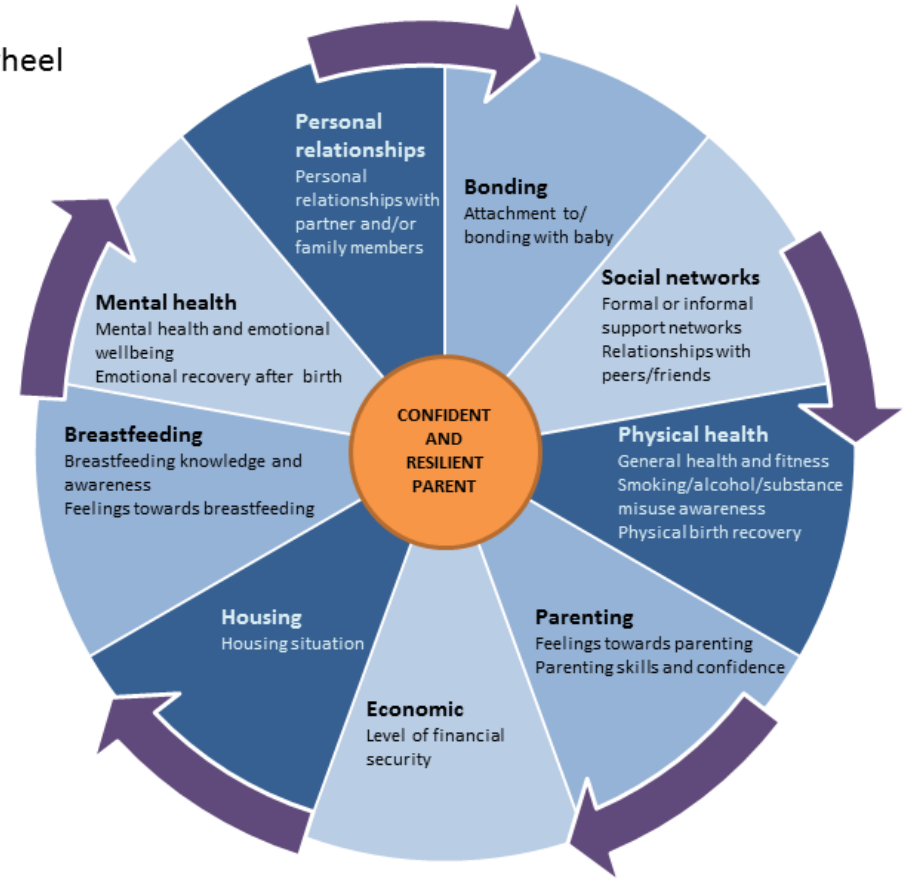
Based on the primary and secondary research for this study, a range of scales questions to ask of parents about a number of areas of their life has been developed. This can be added to for parents that want to work specifically on particular areas, but all parents will be asked pre and post questions. This has been represented as two wheels of circumstances, which can be seen to build on the Integrated Theoretical Framework of Family Functioning (Figure 3). Each of these wheels has the parent or carer in the middle, with each of the segments being domains of life.

The two wheels are slightly different for ante and post-natal situations, and can be seen overleaf.

Ante natal wheel



Post natal wheel



This gives 11 domains which are explored to track the impact of the peer support in enabling a parent to become confident and resilient.

Each of these 11 domains has an overarching strengths-based question which has been designed to be asked of parents as both 'pre' and 'post' survey questions, which allow for change to be tracked and monitored. Importantly, these overarching questions are asked by a member of staff so as to relieve the burden of requiring consistent data collection by the volunteers.

This overall holistic change is what really matters in seeing improvements for parents.

It assumes that parents who move up the scale in these area are, on average, becoming more resilience and confident, and that in doing so are better able to give their babies, and their family as a whole, a better start in life.

This approach does not try to make a measure for what a better start in life may empirically look like, leaving that instead to the parents to own for themselves, but to assume that the value they and agencies that work with Parents 1st place on it is a reflection of the process improvements.

Appendix 1 details all of the newly created tools. These include many of the pre-existing Parents 1st tools, some of which were amended as part of this study. Details are provided about when they are used, by whom and for what purpose.

This full list of all tools that have been created highlights the range of areas where data and learning is collected by Parents 1st, and the different applications for it. The scale questions, which emerge from the wheels of circumstance and are collected using a 10 point scale, can be seen below. These are crucial for measuring change systematically across different areas of the wheel. The difference between the pre and post scores in these scale questions will be the key progression scores for the new measurement model, but, as can be seen above, they are not the only point of measurement.

	Parent Impact as described in the new model
Birth	I feel prepared for labour and birth
Pregnancy	I know how to look after myself and my developing baby during pregnancy
Parenting	I feel prepared to look after my new baby
Bonding	I feel a close bond with my baby
Breastfeeding	I feel confident to breastfeed my baby if I choose to do so
Physical Health	I feel physically healthy
Mental health	I feel emotionally well
Economic	I feel secure about money
Housing	I feel happy with my housing situation
Personal relationships	I feel happy with my closest relationships
Social networks	I feel there are people I can turn to in my community if I need support
Service use	I feel able to access services when I choose to I feel confident to communicate with professionals involved in my care

The final area of this table, service use, does not sit within either of the two wheels. The use of a service is not an intrinsic part of somebody's life, but the research with partners and commissioners as well as parents and volunteers, all highlight the value of the approach in helping parents to engage in the use of other services.

Conclusions and learning

The Parents 1st model is specifically designed as a holistic and asset based approach to supporting parents, and its impact measurement framework needs to recognise and reflect this. This design influenced the creation of the theory of change, and the tools needed to reflect that theory of change.

This work was designed to create that measurement approach, and this report details the range of issues and challenges that have been navigated to go with the approach that is proposed. In doing this, there is a significant amount of learning, about the new tools, the existing data, but also the very question of how to think about measurement for asset based volunteer peer support approaches.

Whilst there is a wealth of learning throughout the process of creating these new tools, there are four particular points that are important to highlight:

1. The new tools that have been developed aim to measure a broader range of impacts on parents in a consistent and systematic way, and should be **given two years to collect data across different sites to allow for a good bank of data**. This should allow a greater understanding of the impact in relation to different geographical and commissioning contexts that Parents 1st is operating in. In some areas, certain partnerships may well result in better outcomes for parents in one domain, such as breastfeeding, and in another there may be greater effects in confidence to parents. This contextual knowledge together with measuring the quality of implementation will be essential for the approach to develop.

2. The evidence that exists suggests the model is effective at building the confidence of families around the birth and their early parenting skills, and that it is helping them alleviate their own fears about pregnancy and birth. This is clear across both sites, and it is clear that the confidence extends to growing social networks and a reducing sense of social isolation. Finally, there is evidence in the realm of breastfeeding outcome data that there is a link between the approaches that Parents 1st takes, and wider outcomes. The breastfeeding data is so strong as to suggest a **significant role for peer support in influencing outcomes which are valued by external partners and commissioners**. This existing data is enough to justify the theory of change and argument about the difference that the model is making, and to continue to collect further data.

3. The asset based nature of the approach, and the essential role that relationships play in the success of it – both between volunteers and parents, and across services – mean that attempting to move the evidentiary quality of the approach towards a controlled trial of some kind would be impractical and unhelpful. **The growing challenge towards RCT-style evidence as the correct route for complex community based initiatives to evidence their impact is being made most clearly in relational approaches, and Parents 1st should not be encouraged by funders to follow that route.**

4. There is consistent anecdotal information about reduction in need, but there are challenges to measure that. An attempt to explore this from a financial perspective in this work was attempted but found to be inappropriate because without a different approach to commissioning it would give a false sense of the economic benefits of volunteer support. Unless services are commissioned differently, and in partnership with a peer support approach like Parents 1st as integral to the whole system, then it would likely appear more expensive than it is, as it will be seen as additional costs, when it contributes towards intermediary outcomes of a wider partnership. This work has provided **insights into the challenges and complexities of measuring the cost benefits of peer support volunteering as part of wider systems**. The BIG Lottery "A Better Start" partnerships offer an excellent opportunity to assess economic benefit in terms of collective impact across a broad early prevention "system" partnership that could provide more accurate information for funders.

This report will be supplemented by a further report in October 2016 when there is a full year of data from the new data collection approaches.

Appendices

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Summary of Tools of Evaluation Framework

Form	When	Who	Purpose	Content
Initial Information form 2 Versions: 1. Mums to be 2. Dads to be	Initial assessment visit during pregnancy following a request for one-to-one visits from a Community Parent	Staff member	Collect picture of circumstances. Collect baseline impact data: • Baseline service use • Baseline over-arching scales (see "Wheel of Circumstances" document)	Basic information, circumstances: pregnancy, birth, relationships, health, money, housing, employment, social networks; services being accessed; consent to information sharing; conclusions and actions; how data will be used. Baseline over-arching scales (11 ante-natal scale questions and 2 service use scale questions).
Antenatal Family Booklet			Guides peer supporter how to plan and organise.	
One to one Diary Sheets	Completed after each one-to-one session	Peer supporter	Records type of activity undertaken by peer supporter and time spent volunteering	Quantitative data: number of support sessions delivered, time spent and type; concerns identified during a visit
Telephone record sheets	Significant telephone contact recorded throughout support process	Peer supporter		Record of date, length and content of telephone support
Where are we now? Evaluation (p3-4)	At 34-36 weeks pregnancy	Peer supporter and parent	Self-assessment of quality of peer-to-peer relationship for learning and reflection	Feelings about circumstances: usefulness of visits; whether or not feelings listened to; review of progress; whether wants visits to continue; next steps

Form	When	Who	Purpose	Content
What would you like to work on? Booklet Pregnancy Menu of topic areas for parents to choose; Detailed before and after scales to be completed for each chosen topic to work on together; Tick boxes within each topic area of things to work on and if completed by mother and father. Goal setting tool	On-going throughout the home visiting process during the pregnancy. .	Peer supporter and parent	Primarily to provide a structure and purpose to the home visiting process and for the parent to keep a record of what they have achieved (booklet returned to parent after data entered) Record of activity during visits including the goals that the parents set and achieve (enables parents to track their own progress) Impact data: detailed scales (before and after working on each topic area) that links up with the Wheel of Circumstances.	Menu of 11 specific topic areas that the parents choose from to work on with their peer supporter (topics relate to pregnancy and link up with Wheel of Circumstances). Each topic area has a detailed set of scales that the parent completes before and after working on a set of sub-topics set out in checklists. Goal setting tools
Services Drawn In (addition to family record)	Peer supporter supervision sessions and in response to ad hoc issues raised by peer supporter throughout the entire home visiting process	Staff member	Feedback info for commissioners (if service helped and how / if service didn't help and why not)	New services drawn in Why needed Whether perceived to be useful
Mid-support Evaluation Questionnaire	After at least 4 home visits have taken place	Completed by a member of staff in the parent's home or over the	To understand the quality of the relationship between the peer supporter and parent	How things are going; feelings about peer supporter; improvements; what they've been doing; view of peer

Form	When	Who	Purpose	Content
		phone	Collect mid-support follow-on impact data: • Service use • Over-arching scales (see "Wheel of Circumstances" document)	supporter understanding Over-arching scales
Postnatal Family Booklet				
One to one Diary sheets	Completed after each one-to-one session	Peer supporter	Guides peer supporter how to plan and organise. Records type of activity undertaken by peer supporter and time spent volunteering	Quantitative data: number of support sessions delivered, time spent and type; concerns identified during a visit
Telephone record sheet	Significant telephone contact recorded throughout support process	Peer supporter		Record of date, length and content of telephone support
Labour and birth diary sheet (p3) Birth Summary (p4-6) Birth information (p7- 8) Postnatal support checklists (p10-12)	Following birth	Peer supporter	Process and impact (record actual breastfeeding rates etc)	Record of labour and birth; baby details; skin on skin record; breastfeeding role; birth details; peer supporter presence and role; birth partner's presence and role; support given; volunteer rating of supporting birth
Final feedback with parents (p13-14)	Last visit	Peer supporter and parent	Self-assessment of quality of peer-to-peer relationship for joint learning and reflection. Collect service use data.	• Access to children's centre services • Baby immunisation status • Attendance at A&E since birth and why • Visits to GP since birth and why

Form	When	Who	Purpose	Content
				• Whether parent felt listened to during visits • Reflections on the quality of the visits
What would you like to work on? Booklet Post birth Menu of topic areas for parents to choose; Detailed before and after scales to be completed for each chosen topic to work on together; Tick boxes within each topic area of things to work on and if completed by mother and father. Goal setting tool	On-going throughout the home visiting process after the birth	Peer supporter and parent	Primarily to provide a structure and purpose to the home visiting process and for the parent to keep a record of what they have achieved (booklet returned to parent after data entered) Record of activity during visits including the goals that the parents set and achieve (enables parents to track their own progress) Impact data: detailed scales that links up with the Wheel of Circumstances.	Menu of 10 specific topic areas that the parents choose from to work on with their peer supporter (topics link up with Wheel of Circumstances and relate to post birth). Each topic area has a detailed set of scales that the parent completes before and after working on a set of sub-topics set out in checklists. Goal setting tools
End of support evaluation questionnaire	When one-to-one home visiting ends and usually completed in the parent's home	Member of staff	To understand: • Quality and usefulness of the peer support • Any ongoing support needs Collect final set of follow-on impact data: • Service use • Over-arching scales (see	Usefulness of peer support Relationship with peer supporter Whether support started early enough during pregnancy Any improvements needed Whether would recommend to a friend Feelings regarding support finishing Whether parent would consider becoming a peer supporter

Form	When	Who	Purpose	Content
			"Wheel of Circumstances" document)	themselves Over-arching scales