Department for Education

Behavioural Science: Increasing uptake of family hub services

Evaluation Protocols

February 2024

Madelynne Arden, Holly Wilcockson, Helen Humphreys, Rachael Thorneloe, Danielle Paddock, Elaine Clarke, Abigail Millings (Sheffield Hallam University, SHU)

Government Social Research

Contents

List of figures

List of tables

Executive Summary

This report details research undertaken by the Centre for Behavioural Science and Applied Psychology (CeBSAP) at Sheffield Hallam University (SHU) and commissioned by the Department for Education (DfE). The research aimed to i) develop interventions informed by behavioural science to promote the uptake of family hub services across four local authorities/organisations, with a particular focus on disadvantaged and vulnerable families; and ii) develop research protocols for evaluating those interventions.

The four projects are:

- London Borough of Redbridge (LBR): increasing uptake of the 2-2.5 year health visitor review by parents living in Loxford (an area of high deprivation).
- London Borough of Merton (LBM): increasing uptake of the Early Learning Together programme for babies aged up to 8 months.
- Fellowship of St Nicholas (FSN): increasing uptake of a temporary accommodation hub service by families living in temporary or insecure accommodation in the Hastings area.
- Sheffield City Council (SCC): increasing uptake of infant feeding support services by young expectant mothers (aged 25 years and younger) in Sheffield (particularly those living in areas of high deprivation).

The work comprised:

- Evidence reviews of factors associated with uptake and/or engagement with equivalent services by the target populations for each of the four projects. These factors were categorised as capability (physical or psychological), opportunity (physical or social) and motivational (reflective or automatic) barriers and facilitators (The COM-B model (Capability, Opportunity, Motivation – Behaviour; Michie, Atkins & West, 2014).
- Qualitative focus groups (FSN, SCC) or interviews (LBM) to explore barriers and facilitators with uptake and/or engagement with the specific family hub services by members of the target population, with findings categorised as capability (physical or psychological), opportunity (physical or social) and motivational (reflective or automatic) barriers and facilitators (Michie, Atkins & West, 2014).
- Co-design workshops with stakeholders and members of the target population, informed by findings from the evidence reviews and qualitative research and using the behaviour change wheel approach (Michie, Atkins, & West, 2014) to explore potential intervention functions, behaviour change techniques and modes of delivery using the APEASE criteria (Acceptability, Practicability, Effectiveness, Affordability, Side effects, Equity). These workshops guided decisions about which interventions to progress.

- Co-design workshops with stakeholders to design the evaluation of the intervention informed by an agreed theory of change and logic model.

Table 1 outlines the targeted barriers and facilitators by capability, opportunity and motivation factors for each intervention and the co-designed interventions to address those targets for each project:

Table 1: Targeted barriers and facilitators and co-designed interventions, by project.

Project	Capability needs	Opportunity needs	Motivation needs	Agreed intervention
LBR	Understand what the service is and why it is beneficial to attend. Understand how to complete the Ages and Stages questionnaire (ASQ-3) that accompanies the service.	Accessible materials (letter and questionnaire). Remove complicated booking process.	Increased beliefs that the service is beneficial. Reduced fear of unknown.	Improved invitation letter incorporating behavioural science techniques. New letter to include links to translations in four languages and an informative video.
LBM	Understand what the Early Learning Together Baby (ELTB) programme is, who it is for and how to access it.	Clear, accessible communication materials. Easy booking and self-referral. Key information about the service distributed via healthcare professionals (referrals) and between parents.	Increased beliefs that the service is inclusive and welcoming. Belief in the benefits of attending. Reduce concerns about judgement.	Improved messages and communications about the service (i.e. what it is, how to book, benefits and testimonials from other parents). Use of QR code link direct to booking website. Use of social media to promote the service.

Project	Capability needs	Opportunity needs	Motivation needs	Agreed intervention
FSN	Knowledge about the service on offer including what it is like to attend the Temporary Accommodation (TA) hub.	Well-timed, accessible information for parents about the TA hub (including early referral upon entering TA and online information). Benefits of the hub conveyed by others with similar lived experience.	Reassurance about safety and non-judgement; reduce shame associated with accessing services for families in TA. Positive expectations about attending the TA hub.	Brief, online, behavioural science-informed training for professionals working with families living in TA about how and why to refer to the TA Hub. Video including testimonials from parents talking about why they visit the hub and why they would encourage others to do so, for parents.
SCC	Understand what the service is, how to access it, and the value and benefit of accessing the service.	Access to a young-mum specific service providing in-person antenatal support delivered in an easily accessible venue.	Avoid fear of judgement (i.e., from older mothers) and feelings of pressure to breastfeed. Want to meet other young mothers like them.	Delivery of an antenatal service for expectant mothers aged ≤25 years in an easily accessible venue. Messages and communications about the new service (i.e., what it is, how to access it) that address concerns.

The protocols for evaluations of each intervention include a range of mixed methodologies and the key components are outlined in Table 2. All evaluations were scheduled to take place over a 3-month period.

Table 2: Key components of the mixed-method evaluations, by project.

Project	Quantitative evaluation methods	Qualitative evaluation methods
LBR	Analysis of data to explore: • a comparison of attendance figures over a 3-month period before and after the new letters are distributed (primary outcome) • a comparison of the number of pre-review questionnaires correctly completed by parents • the number of views of the video and the translated letters	Interviews with a sample of parents who have received the new letter to explore: • acceptability of the intervention • the effectiveness of the intervention to address key barriers • the impact of the intervention on intentions to access wider family hub services in the future.
LBM	Analysis of data to explore: • referrals/self-referrals to ELTB and uptake/attendance over a 3-month period compared to the same 3-month period in the previous year (primary outcome)	Interviews with a sample of parents who i) have been referred and subsequently attended/signed up ii) have been referred but not attended/signed up to explore: • acceptability of the intervention • effectiveness of the intervention to address key barriers • impact of the intervention on intentions to access wider family hubs services in future
FSN	Analysis of data to explore: • a comparison of referrals to TA Hub in 3-month period following professional referral training with the same 3-month period from the previous year (primary outcome) • conversion of referrals to attendance/engagement with service • number of views of parent testimonials video	Interviews with a sample of parents who i) have been referred and subsequently attended/engaged with the TA Hub, and ii) have been referred but not attended/engaged to explore: • acceptability of the intervention • effectiveness of the intervention to address key barriers • impact of the intervention on intentions to access wider family hubs services in future

Project	Quantitative evaluation methods	Qualitative evaluation methods
SCC	Analysis of data to explore: • a comparison of uptake of the new antenatal service over a 3-month period compared with uptake of infant feeding support services in the previous year (primary outcome)	Focus groups with a sample of 10 – 14 expectant young mothers who have attended the antenatal service to explore: • acceptability of the intervention • the effectiveness of the intervention to address key barriers • the impact of the intervention on intentions to breastfeed • the impact of the intervention on intentions to access wider family hub services in the future

The evaluations will run concurrently with the interventions, from October 2023 to March 2024, and the findings of the evaluations will be published in 2024.

Introduction

Family hubs bring together services to improve access and to enable the building of relationships between families, professionals, services and providers. They offer support to families with children aged 0-19, or up to 25 for those with special educational needs and disabilities (Family Hubs and Start for Life Programme, 2022). Given the vital importance of the 1001 critical days from conception to age 2, and the value of early intervention and holistic care (Hambrick et al., 2019), family hubs play an important role in giving families the support they need. Family hubs transformation funding is being used by 75 local authorities (LAs) to open family hubs in 2023 with an expectation that they will be fully functional by the end of 2024-25 (Family Hubs and Start for Life Programme, 2022), with a further 13 LAs having received transformation funding in 2021. However, services such as those offered by family hubs are only effective when people engage with them, and the most disadvantaged and vulnerable families are those least likely to engage (Early Intervention Foundation, 2019).

This work programme looks at ways to address the barriers and facilitators to uptake or engagement with family hubs services by families, especially those who are disadvantaged or vulnerable. The work draws on behavioural science theory and is informed by the findings of and learnings from the first round of this research programme (see Millings et al., 2022a; Millings et al., 2022b). This report details the work undertaken by the Centre for Behavioural Science and Applied Psychology (CeBSAP) at Sheffield Hallam University (SHU) with four LAs/organisations. One LA was in receipt of transformation funding in 2021 (London Borough of Merton) and two were in areas receiving 2023 transformation funding (Sheffield City Council and the Fellowship of St Nicholas, a charity based within East Sussex LA). The fourth LA (London Borough of Redbridge) was not in receipt of family hubs transformation funding.

This report details an evidence review, qualitative research on the barriers and facilitators to service uptake, co-design of interventions informed by behavioural science frameworks, and co-design of protocols for the evaluation of those selected interventions.

Theoretical approach of the work programme

The behaviour change wheel (BCW) approach to intervention development (Michie, Atkins and West, 2014) sets out a systematic approach to identify relevant interventions (Table 1). It is underpinned by the COM-B model (Capability, Opportunity, Motivation – Behaviour;) which describes the range of factors that can influence behaviour and can be used to undertake a behavioural analysis. A description of each of the factors is presented in Table 3.

The BCW approach utilises the APEASE (Affordability, Practicability, Effectiveness/Cost-effectiveness, Acceptability, Side-effects/Safety, Equity) criteria (Michie, Atkins and West, 2014) to make systematic and evidence-based decisions at each point of the process.

This is highly compatible with co-design work enabling stakeholders and members of the target population to contribute to these decisions alongside behavioural science experts.

These approaches were used to guide the methodology, the analysis and decision-making throughout the programme of work.

Table 3: The Behaviour Change Wheel

Sources of behaviour	Intervention functions	Policy categories
Physical capability	Education	Environmental/social planning
Psychological capability	Persuasion	Communication/marketing
Social opportunity	Incentivisation	Legislation
Physical opportunity	Coercion	Service provision
Reflective motivation	Training	Regulation
Automatic motivation	Enablement	Fiscal measures
	Modelling	Guidelines
	Environmental restructuring	
	Restrictions	

Table 4: Description of the Capability, Opportunity, and Motivation (COM) factors

COM factor	Description	Example
Physical capability	Physical skills, strength and stamina to do the behaviour	Having the physical ability to travel to and access face-to-face parenting groups
Psychological capability	Knowledge or psychological skills, strength and stamina to do the behaviour	Knowing about a family hub service and how to access it
Physical opportunity	The environmental resources, time, locations and money to engage in the behaviour	Having the money for public transport to travel to the family hub service
Social opportunity	Interpersonal influences, social support and social norms to engage in the behaviour	Having support from family members to attend the family hub service
Reflective motivation	Intentions and evaluations about the behaviour as being good or bad	Believing that the family hub service offers valuable support to families
Automatic motivation	Emotional reactions, desires, impulses, habits, and drives	Feeling anticipated fear of being judged

Round 1 of the programme (2022-2023)

Round 1 of the programme included four local authorities (Durham, Sheffield, Wakefield and Wolverhampton) who had designed interventions to promote uptake of family hubs services (Millings et al., 2022). Recommendations included that future interventions should be designed with behavioural insights from the start. This recommendation, along with other learnings from the work, informed round 2 of the programme.

Round 2 of the programme (2023-2024)

Aims

The aims of the round 2 programme are split over three phases involving four projects:

- Phase 1 consisted of discovery and research design. The aim was to gain an in-depth understanding of the needs of each project (described below), explore the literature (evidence reviews), and design in detail phase 2.
- Phase 2 comprised behavioural analysis and intervention development. This involved gathering and analysing qualitative data (where required) and using this alongside behavioural science theories and the findings of the evidence reviews during co-design workshops with stakeholders and services users to develop and refine the interventions.
- In Phase 3 the aim is to undertake mixed-methods evaluations of the interventions and to identify shared learning.

This report details the results from Phases 1 and 2. Phase 3 results will be reported in 2024. The four behavioural insight projects are:

London Borough of Redbridge (LBR)[1]

- Target behaviour: Uptake of the 2-2.5 year health visitor review.
- Target audience: Parents living in the Loxford region of LBR.

London Borough of Merton (LBM)

- Target behaviour: Uptake of the Early Learning Together Baby (ELTB) programme
- Target audience: All families across the borough, but particularly families living in areas of deprivation.

Fellowship of St Nicholas (FSN), Hastings

- Target behaviour: Uptake of the Temporary Accommodation (TA) Hub services
- Target audience: Families living in TA in the Hastings area.

Sheffield City Council (SCC)[2]

- Target behaviour: Uptake of antenatal infant feeding support services
- Target audience: Young expectant mothers (aged up to 25 years), particularly those living in areas of deprivation.

[1] For FSN, LBR and LBM projects, parents and other carers with significant responsibility for children's wellbeing were included in the target population, however for brevity hereafter the term 'parents' is used.
[2] For SCC, when the phrase 'young mothers' is used, this refers to young mothers particularly those living in deprived areas.

Overview of Methods

This section describes the overall approach taken across the four projects.

Phase 1

Evidence review

A quick scoping review (Collins et al., 2015) was undertaken to identify relevant literature for each of the four projects. For each of the four projects, database searches were conducted on CINAHL, MEDLINE, PsycArticles, PsycInfo, and Web of Science. The reference lists of relevant full-text articles were scanned, and additional searches of websites and databases relevant to the topic were conducted. Project-specific search terms are available in Appendix 1. Project specific supplementary searches are available in Appendix 2. Papers were exported to Covidence (software for managing and streamlining scoping reviews) to remove duplicates and to undertake full-text screening. Inclusion and exclusion criteria for each project are available in Appendix 3. Papers that met these criteria were retained (PRISMA diagrams are available in Appendix 4). Characteristics of papers (i.e., country, design, population, aims, methodology) were extracted and are available for each project in Appendices 5,7,9 and 11. Data relating to barriers and/or facilitators to the target behaviour (i.e., uptake of project-specific services) were extracted.

Data relating to barriers and/or facilitators to the target behaviour (i.e., uptake and/or engagement with the target services) were mapped onto Capability (physical or psychological), Opportunity (physical or social), and Motivation (reflective or automatic) components (Michie, Atkins and West, 2014). The types of data under each COM-B component were analysed and themes arising from the data were identified to create sub-categories (i.e., beliefs or experiences within the COM-B components). Where possible, these sub-categories were related to increasing uptake of and/or engagement with the target behaviour.

Phase 2

Gathering Behavioural Insights

For areas where existing local insights work had not previously been undertaken, primary qualitative research was conducted using focus groups or interviews. These explored barriers and facilitators to uptake of the target family hub services for the target population. A semi-structured topic guide was developed based on the COM-B model. Participants were recruited from the target population by local authorities/organisations. Recruitment strategies included local social media, direct contact with service users and via contact with people signed up to local mailing lists. Participants were incentivised to

take part with a £30 e-voucher. Focus groups (lasting 1-1.5 hours) and interviews (lasting between 30 and 45 minutes) were conducted by a researcher.

Interview and focus group transcriptions were initially coded using deductive framework analysis into Capability (Physical or Psychological), Opportunity (Physical or Social) and Motivation (Reflective or Automatic) factors. Where text could be coded into more than one category, it was coded under the domain that was most amenable to change. For example, language barriers could be coded as a 'skills' deficit (physical capability) but was coded as an 'environmental context and resources' issue (physical opportunity) because language barriers can best be addressed by providing opportunities for access (e.g., translated materials). Inductive thematic analysis was then used to code text into specific categories of barrier or facilitator.

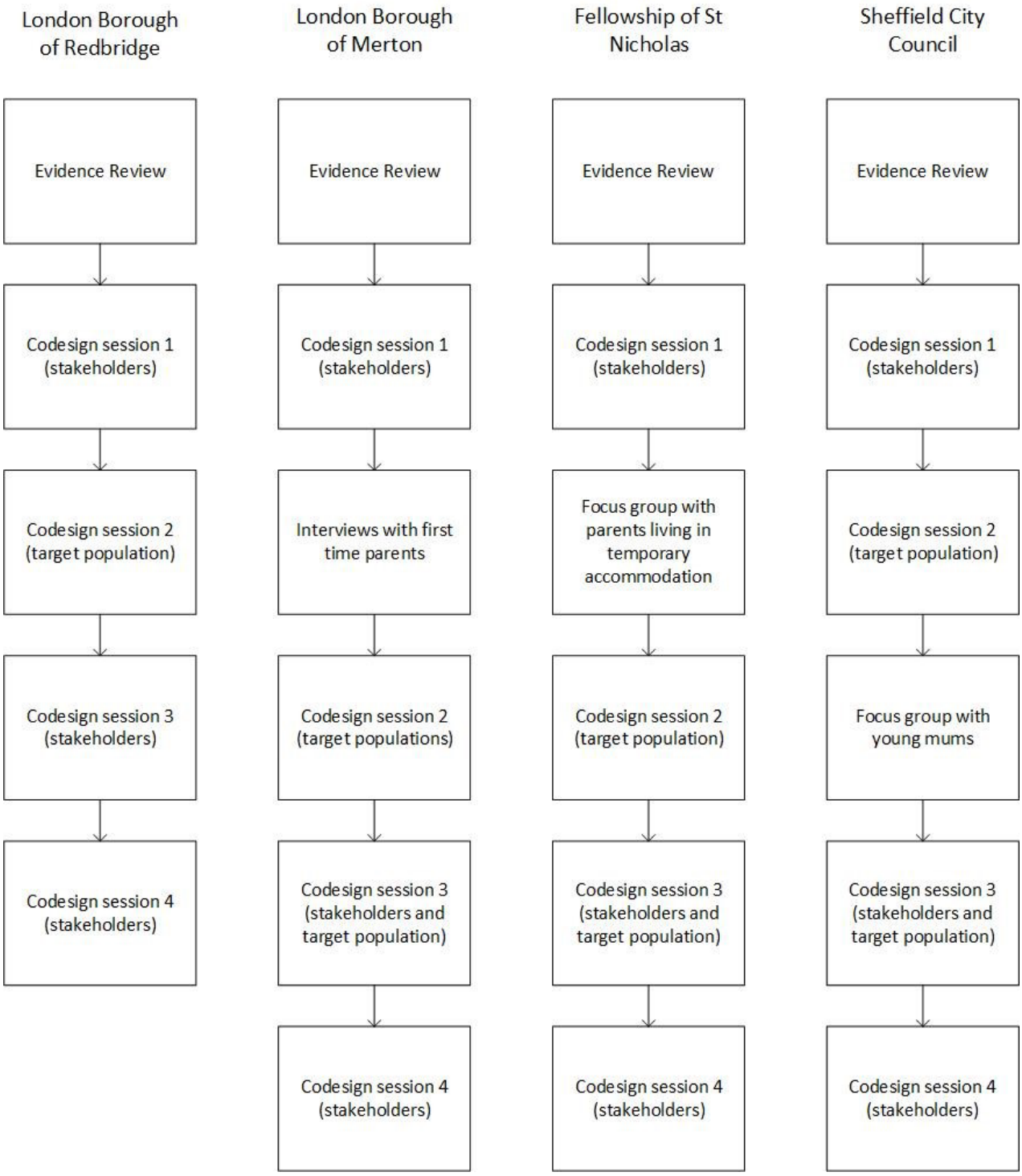
Co-designing the intervention and evaluation

A co-design methodology was used that brought together the views and experiences of stakeholders and members of the target population. These views and experiences were integrated alongside the COM-B model and existing evidence from the reviews by utilising the BCW framework for intervention development. For all projects, barriers and facilitators to uptake of the target family hubs service were identified, followed by discussion and appraisal of potential intervention functions to address these. For each of the projects, four co-design workshops were held:

- **Co-design workshop 1** with professional stakeholders to understand the family hub service being delivered, professionals' perceptions of the barriers and facilitators to uptake and/or engagement with the target family hub service and initial intervention ideas.
- **Co-design workshop 2** with members of the target population to explore from their perspective the key barriers and facilitators to uptake and/or engagement with the family hub service and initial ideas for how these could be overcome in an intervention.
- **Co-design workshop 3** with both professional stakeholders and members of the target population (where possible) to identify and prioritise intervention options and to explore the feasibility of delivery. This discussion was used to develop or refine the theory of change and logic model and to define the specific BCTs that would be utilised within the interventions.
- **Co-design workshop 4** with professional stakeholders to co-design the evaluation of the proposed intervention, and to finalise the theory of change and logic model, including data availability/management, roles and responsibilities, and timelines.

The structure and flow of the projects varied for each LA/organisation and are illustrated in Figure 1.

Figure 1:The structure and flow of the projects for each local authority/organisation



London Borough of Redbridge

Background

Outcomes related to health and wellbeing for children and adults are greatly influenced by factors operating during the early years of life (Shribman & Billingham, 2009). Public Health England (PHE) committed to ensuring that every child in the country has the best start in life (Public Health England, 2021). A key contributor to achieving this ambition is the Healthy Child Programme (HCP) - a universal programme which aims to ensure that every child gets the best start they can.

The HCP includes five universal developmental reviews; the final one occurs when the child is 2-2½ years old. The HCP is a holistic review of child health, development and growth, to identify children who are not developing as expected and/or in need of additional support (Office for Health Improvement and Disparities, 2023a). The review provides an opportunity for parents to discuss their child's development with their health visitor and ensures that families receive timely support during the first years of their child's life so that they are 'ready to learn at two and ready for school at five'. The 2-2 ½ year review happens at a time when specific behaviour, speech and language problems may become evident (Public Health England, 2021).

Context

In the London Borough of Redbridge (LBR), uptake to universal services, including the universal development reviews, is poor. Though figures for the New Birth visit are good (86%), there is subsequently a significant and continued decline in uptake. Average attendance in LBR for the 2 -2½ year review has been consistently declining over the last 5 years, with a particular impact of the COVID-19 pandemic: 45% in 2017-18, 44% in 2018-19, 40% in 2019-20, 19% in 2020-21, and 11% in 2021-22 (Office for Health Improvement and Disparities, 2023b). These figures are significantly below regional and national averages (70-80% uptake, Office for Health Improvement and Disparities, 2023b). This means that a significant proportion of children with increased need for support are not identified until they start school. LBR is one of the most ethnically diverse LAs in the UK whereby 65% of respondents (based on the 2021 Census, Office for National Statistics, 2021) identified as belonging to an ethnic group other than White British. A Health Equity Audit (HEA) in 2021 (unpublished and available on request from LBR) reviewed access to universal developmental reviews in LBR (2019/20 and 2020/21) and found lower levels of attendance to universal health checks among ethnic minority residents when compared to white British residents.

Target service

The aim of this project is to explore how to increase uptake of the 2–2 ½ year review by families in the Loxford area of LBR. The top four countries of birth for residents in this area (based on the 2011 census) are 46.0% England, 13.5% Pakistan, 9.0% India and 4.1% Bangladesh, with low levels of English speaking or English as a first language demonstrated by some members of this population (Office for National Statistics, 2011).

Currently, families are invited to attend the 2–2 ½ year review with a health visitor via email when their child reaches 2 years 3 months old. Interpreters are available throughout the invitation and review process if needed. The majority of reviews take place on site in Childrens' Centres. The preference for conducting reviews on site at Childrens' Centres is that it has historically presented the opportunity to immediately introduce families to other services[3] that may be of relevance. However, since the COVID-19 pandemic, there have been fewer opportunities for this as services have not all been running in the same way and at the same times.

Evidence review

This review aimed to address the following research question:

1. What is currently known about the barriers and/or facilitators to disadvantaged and vulnerable families engaging with routine mandated universal health visitor checks?

Findings

A total of 21 papers were identified as relevant to the research question and these were included in the final review. There was a lack of evidence specific to families' engagement with the health visitor programme and no evidence was found that specifically focused on the 2 ½ year review. There was a lack of evidence discussing interventions for engagement. Most of the literature discussed professionals' experiences of working with ethnic minority populations and the experiences of the target population with health visit (and some broader perinatal healthcare) services.

Psychological Capability

A lack of knowledge about the nature of support available and how to access it (especially during the COVID-19 pandemic), and a lack of knowledge about the purpose or need for a health visitor check, were barriers to engagement with the services (Saunders and Hogg, 2020). Some ethnic minority families may be unaware that health

[3] Redbridge are not one of the 88 local authorities currently receiving funding to transform their Children's Centres into Family Hubs. They are exploring how they can progress within the 'Family Hubs Model framework': https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1096776/Annex_E_-_family_hub_model_framework.pdf

visitor services are free, due to having limited or no experience of such services in their own countries (Drennan and Joseph, 2005). Having knowledge about the value of health visitors and knowing what types of things health visitors can advise on was a facilitator for further engagement (Russell and Drennan, 2007). One study reported that having refugee experience (and the associated impact this has on mothers' health and wellbeing) can be a barrier to engagement amongst ethnic minority mothers (Drennan and Joseph, 2005).

Physical Opportunity

A lack of access to health visitors in the local area was a barrier to engagement with the services (Morton and Adams, 2022). This was a particular problem during the COVID-19 pandemic, whereby many health visitors were redeployed to other areas of the health service, and so digital services were offered instead. Although some parents reported that virtual contact was better than no contact at all, many faced digital exclusion and so could not engage in the health visitor programme at all (Morton and Adams, 2022). Some research suggests that services in the UK have not returned to normal following the emergence of COVID-19 (Hogg and Mayes, 2022) and so this barrier is still present.

The provision of services for parents whose first language was not English was a barrier to engagement. When mothers spoke limited English they were unable to communicate effectively with their health visitor which impacted on their experience (Hogg et al., 2015). There can be additional challenges involved when delivering a service via interpreters (Drennan and Joseph, 2005), such as the difficulty in building a strong and trusting relationship through a third person. However, some research suggests that the use of an official translator rather than family members enabled mothers to be more open and honest in the presence of someone they did not know (Almond and Lathlean, 2011). Willingness and accessibility of health visitors was a facilitator to health visit engagement and ethnic minority parents valued health visitors having the time and availability to listen and build a relationship with them (Russell and Drennan, 2007).

Social Opportunity

Different cultural, religious and family influences on parenting may act as a barrier for engagement with a health visitor (Hogg et al., 2015). Some cultures may be reluctant to engage with health professionals, instead placing responsibility for children on the family unit, including their extended family. For some parents, a lack of extended family close by facilitated engagement in the health visitor programme as they relied on their health visitor for advice and guidance and support in the absence of a family support system (Hogg et al., 2015).

A lack of culturally tailored resources was also a barrier to engagement. Some mothers from ethnic minorities suggested that they would benefit from more culturally tailored advice, such as food recipes that align with family culture or acknowledging that some cultures do not give children cold foods like yogurt (Hogg et al., 2015). When health

visitors are trained and given the resources to deliver a culturally appropriate non-judgemental service that focuses on meeting individual needs rather than delivering a uniform 'minimum' service then this may facilitate ethnic minority family's engagement (Hogg et al., 2015).

Reflective Motivation

A lack of service user confidence in accessing a health visitor reduced parents' motivation to engage (Morton and Adams, 2022). Refugee families may have concerns about whether health visitors may be linked to state officials or the home office, and whether engagement with a health visitor may impact on their status as a refugee (Drennan and Joseph, 2005). Some ethnic minority parents may believe that by engaging with health visitors, they would be judged as a bad parent or may be pre-judged based on physical appearances or markers of socio-economic status (Roche et al., 2005).

Automatic Motivation

Previous positive or negative experiences impact parents' level of engagement with a health visitor. Parents who had previously experienced a positive and supportive partnership with a health visitor were more likely to engage in the future (Cowley et al., 2018; Russell and Drennan, 2007). However, negative past experiences decreased parents' motivation to engage. In one study, mothers reported that their health visitor had judgemental attitudes based on a fixed set of values which often resulted in mothers trying to avoid subsequent contact or conflict with their health visitor (Drennan and Joseph, 2005).

Research on 2-2 ½ year review

There is limited published evidence on the barriers and facilitators to ethnic minority parents' uptake and engagement with the 2-2 ½ year review. One report highlighted that the COVID-19 pandemic had put pressure on services and that during the pandemic, health visitors did not have capacity to chase families that did not respond to the 2-2 ½ year review offer (Hogg & Mayes, 2022). A report in 2017 highlighted that in West Sussex they integrated the 2-2 ½ year review in a nursery/local childcare setting along with staff and parents which resulted in a more friendly, relaxed, and familiar environment for both parents and children (Local Government Association, 2017). Feedback from parents (ethnicity unknown) revealed that they appreciated and welcomed the 2-2 ½ year review being done in this way and this potentially facilitated increased uptake.

Conclusion

Key barriers or facilitators to uptake and engagement with health visitor checks were: (1) a lack of knowledge about and expectations of the service on offer and what it can deliver; (2) cultural factors including social norms about the role of health professionals in

family support, and need for adaptations to the service including translation and; (3) relationship and trust building within the services.

Co-designing the theory of change

Workshop 1

The aim of this workshop was to:

- gain insight into how the 2 – 2 ½ year review service is currently run.
- better understand the current issues regarding engagement with the 2 – 2 ½ year review in the Loxford area of LBR.
- explore understandings of possible barriers to engagement with LA staff and health visiting (HV) team members.
- share existing intervention ideas to increase engagement (Appendix 6 shows the original theory of change submitted by LBR).

Participants

Workshop 1 was attended by various LA/HV team members including: Public Health Consultant, Official Lead for 0-19 Universal Services, Service Manager for Families Together Hub (LBR Early Help Service), Team Manager in the Families Together Hub, Strategic Lead for Children's Centres Early Years, and two community Nursery Nurses.

Findings

The delivery of 2.5-year health visitor review in the context of other services

Health Reviews are conducted in either North East London NHS Foundation Trust (NELFT) clinics or at a children's centre (CC). Where possible, they are conducted at CCs as this provides an opportunity to register the family with the CC (if not previously done so) and engage them in other facilities or services. Each month, parents whose children reach 2 years and 3 months old are sent an email invitation (with an accompanying text message) requesting they get in contact (via telephone or email) to book their child's 2 – 2 ½ year review within a month. The email includes a copy of the 'Ages and Stages Questionnaire' (ASQ3)[4] that they must complete before the appointment. Contact details for support are provided along with details of how to request

[4] Ages & Stages Questionnaires®, Third Edition (ASQ®-3) is a developmental screening tool designed for use by early educators and health care professionals. It is designed to be completed by parents and covers the child's communication, gross motor, fine motor, problem solving, and personal-social development and skills.

an interpreter. If families don't respond to the email (i.e., no appointment is made), HVs send another text message.

Defining the target population

The target population is ethnic minority families in the Loxford area of LBR who have a child approaching 2 ½ years old, for whom English is not their first language, and who are not engaging with the 2 – 2 ½ year review. Alongside language/cultural barriers, families in the target population are likely to face issues such as cost of living problems (e.g., struggling to pay bills) and housing challenges (e.g., homelessness / in temporary or unstable accommodation). These families may be more likely to be experiencing instability, to have other priorities, and may lack access to email.

Perceived barriers/facilitators from professional perspective

Participants were asked to share their perception of the barriers (B) or facilitators (F) to families in Loxford accessing the 2 – 2 ½ year review.

Psychological Capability Factors

- Not understanding the service / not being aware of the service (B)
- Whether they understand the invitation (B/F)
- General self-confidence to go and do it (B/F)

Physical Opportunity Factors

- Language issues[5] (B)
- Time / other demands (work/children) (B)
- Transient nature of families living in the area on temporary basis (B)
- Whether they receive the invitation (B/F)

Reflective Motivation Factors

- Trust / building trusting relationships / suspicion (B/F)
- Concerns/uncertainty around how it might link to other assessments (B)
- Whether there are incentives for doing it (B/F)

[5] As indicated previously, where text could be coded into more than one category, coding focused on the domain that was most amenable to change. Here, whilst language barriers could be coded as a 'skills' deficit (physical capability) they were coded as an 'environmental context and resources' issue (physical opportunity) because language barriers can best be addressed by providing opportunities for access for all, irrelevant of their language.

Automatic Motivation Factors

- Embarrassment (B)
- Feeling overwhelmed by the questionnaire (B)

Interventions previously tried and ideas for other possible new interventions

Stakeholders discussed various possible interventions that they had previously tried, for example offering group sessions for the review and routinely promoting the checks in early years settings. They also discussed ideas for new interventions, such as adapting the content of invitation letters and promoting the review in different ways e.g., through a video or animation, local professionals, parent champions or community groups.

Workshop 2

Workshop 2 was held with parents from the Loxford area to gain their understandings of the service, their thoughts around possible barriers to engagement with the service and their views concerning interventions which might increase engagement.

Participants

Workshop 2 was attended by the project lead from LBR LA (a Public Health Consultant), Public Health Principal, and 9 parents from the Loxford community (8 mothers and 1 father). One mother had only lived in the UK for less than a month. Eight children accompanied their parents. None of the recruited parents required a translator to be present.

- Two parents had attended their 2 – 2 ½ year review
- Six parents had not attended the review, had not received an invite and had children in the correct age bracket (two of these children were slightly too young to receive their invite yet, but the others would have expected to have heard)
- One parent had not attended the review and had not received an invite, and their child was too old for the review at the time of the workshop

Outcomes

Barriers to uptake of the 2 – 2 ½ year review

Participants were asked what they felt would prevent them and other families in Loxford from attending the 2 – 2 ½ year review. Their responses have been grouped into COM-B factors[6]:

Psychological Capability barriers

- Not knowing about the review and/or its purpose.
- Not knowing how to access the email invitation / PDF viewer (struggling with technology).
- Not being able to complete the questionnaire (not understanding questions, not knowing how to complete it).

Physical Opportunity barriers

- Not receiving an invitation (e.g., due to perceived poor communication from healthcare providers; emails might not be received, go to junk inbox, or get missed in an inbox).
- Overly complex process to engage, with multiple steps (e.g., it requires successfully receiving the email, being able to download the attached documents, being able to complete the questionnaire without support, and being able to contact the HV team to make the appointment).
- Not receiving a paper copy which would be easier to complete.
- Language issues (e.g., challenges in booking an appointment over the phone due to limited English).
- Financial cost of getting to the venue if it is more than a walk away (particularly with the cost-of-living crisis)

Reflective Motivation barriers

- Previous poor experience of HV reviews / healthcare services (e.g., believing that concerns raised by parents were dismissed by a healthcare professional; previous poor experience of needing to call the HV team several times to get a response).
- Perceived inequalities and unfairness regarding difference in service provision in neighbouring borough (whilst not a direct barrier to attending the review itself, there was clear anger and frustration about perceptions of differences in service provision

[6] Where a COM factor is not mentioned (for instance Physical Capability in this section) it does not mean that no physical capability factors exist for this topic, but that none of the participants identified any during the discussion.

leading to reduced trust in local services and consequently some mothers remaining registered with services elsewhere).

- (Not) having concerns about their child's development (e.g., if no review invitation was received and the parents did not have any concerns about their child's development, they would be less likely to chase up a review appointment).

Automatic Motivation barriers

- Negative feelings towards the service due to previous poor experience of HV reviews / healthcare services (e.g., poor experiences trying to attend the 1-year review put mothers off attending the 2 year one; previous appointments postponed and instances where a HV did not attend).

Facilitators to uptake of the 2 – 2 ½ year review

Parents were asked their views on ways in which they and other families in Loxford might be encouraged to attend their 2 – 2 ½ year review. They suggested the following (responses have been grouped according to the COM-B factors they address).

Psychological Capability

- Send an appointment time and date in the invite, rather than relying on parents' knowledge and skills to make the appointment themselves. For families with language barriers, and less confidence in UK systems, this would remove any confusion about how to make an appointment.

Physical Opportunity

- Send the letters and questionnaires by post and provide translated copies for those who may struggle with English. There was a strong preference for postal invites from all parents present at the workshop, and this was perceived to be "more official".
- Highlight/introduce more flexibility in the service. For example, by providing opportunities to receive support completing the questionnaire at the appointment, or clearly stating that reviews can be conducted at home if preferred.

Reflective Motivation

- Some of the mothers noted that being given an appointment might make them take it more seriously and put it straight in their diary. However, it was also noted that opt-in appointments (i.e., the current booking system) might be preferable to some working parents who could schedule them around work and so there needed to be some flexibility.
- Several parents expressed positive feelings about the review, stating that they would welcome the experience of a professional checking in and providing some reassurance.

LBR survey results

LBR had previously conducted a questionnaire with 52 individuals in the Loxford area (April 2022) to understand why their target population might not be accessing the 2 – 2 ½ year review. Responses indicated that:

- 23.07% of respondents were aware of the 2 – 2 ½ year review.
- Almost half of respondents (48.07%) were unaware of what happens at a developmental review.
- Reasons given for not attending appointments included:
    - COVID-19 lockdowns / services being moved online.
    - Not being given an appointment / not knowing they were supposed to have an appointment / finding out there had been an administrative error.
    - Believing they did not need the appointment (not useful / giving advice they already know).

These responses share some overlap with the findings of Workshop 2; respondents lacked knowledge (psychological capability) about the purpose and procedures of the review and failed to hear about the review or receive an invitation to it (physical opportunity). However, parents at the workshop did not view COVID-19 as a barrier to attending the reviews. Instead, some felt it was even more important for their children to be checked having missed earlier opportunities during lockdown (reflective motivation). Parents at the workshop also seemed predisposed to believing the reviews to be a positive opportunity for them and their child (reflective motivation).

Barriers and facilitators to uptake of the 2-2 ½ year health review, London Borough of Redbridge

Tables 4 and 5 show the full list of barriers/facilitators to attending the 2-2 ½ year health review that were identified by parents in the focus group/LBR survey, professionals in workshop 1 and/or the rapid evidence review.

Table 5: Summarised barriers to attending the 2-2 ½ year health review

Barrier	Parents	Professionals	Evidence review	COM Factor
Lack of knowledge about support available and how to access it	X	X	X	Capability (Psychological)
Lack of knowledge about the purpose / need for a health review	X	X	X	Capability (Psychological)
Lack of knowledge that services were free (particularly if no experience of similar services in their own country of origin)	-	-	X	Capability (Psychological)
Not understanding the invitation / questionnaire	X	X	-	Capability (Psychological)

Barrier	Parents	Professionals	Evidence review	COM Factor
Not knowing how to access the email invitation / PDF attachments / required apps (struggling with technology)		-	-	Capability (Psychological)
Not having the general self-confidence to engage with the process	X	X	-	Capability (Psychological)
Poor maternal mental health and wellbeing – particularly amongst refugee communities	-	-	X	Capability (Psychological)
Some cultures place responsibility for children within the family unit (including extended family) rather than with health professionals	-	-	X	Opportunity (Social)
A lack of culturally tailored resources	-	-	X	Opportunity (Social)
Lack of access to HVs – particularly during COVID	X	-	X	Opportunity (Environmental)
Digital exclusion	X	-	X	Opportunity (Environmental)
Language barriers / struggles with communication	X	X	X	Opportunity (Environmental)
Use of interpreters making it more challenging to build rapport and trust	-	-	X	Opportunity (Environmental)
Lack of time / other demands (work, children etc)	X	X	-	Opportunity (Environmental)
Not receiving the invitation	X	X	-	Opportunity (Environmental)
Overly complex process to engage with	X	X	-	Opportunity (Environmental)
Financial cost of getting to venue	X	-	-	Opportunity (Environmental)
Transient nature of families living in the area on temporary basis	-	X	-	Opportunity (Environmental)
A lack of service user confidence that they could access a health visitor	X	-	X	Motivation (Reflective)
Concerns about whether health visitors may be linked to state officials or the home office	-	X	X	Motivation (Reflective)
Fears of being judged as a bad parent / based on physical appearance or markers of socio-economic status	-	-	X	Motivation (Reflective)
Negative past experiences with HVs / health services	X	-	X	Motivation (automatic)
Lacking trust / struggling to build trusting relationships / suspicion	-	X	X	Motivation (automatic)
Fear / uncertainty about possible links to other assessments	-	X	-	Motivation (automatic)
Feeling overwhelmed by what needs to be done (especially around the ASQ3 and booking process)	X	X	-	Motivation (automatic)
Embarrassment	-	X	-	Motivation (automatic)
Not understanding the benefits/incentives for doing the review	-	X	-	Motivation (automatic)

Table 6: Summarised facilitators to attending the 2-2 ½ year health review

Facilitator	Parents	Profes sionals	Evidence Review	COM Factor
Having knowledge about the value of health visitors and knowing what types of things health visitors can advise on	-	-	X	Capability (Psychological)
Lack of extended family close by (creates reliance on the HV for advice, guidance and support in the absence of a family support system)	-	-	X	Opportunity (Social)
Training HVs and giving the resources to deliver a culturally appropriate non-judgemental service that focuses on meeting individual needs rather than delivering a uniform 'minimum' service	-	-	X	Opportunity (Social)
Health visitors having the time and availability to listen and build a relationship with parents	X	-	X	Opportunity (Environmental)
Accessibility of health visitors	X	-	X	Opportunity (Environmental)
Previous experience of a positive and supportive partnership between themselves and a health visitor	-	-	X	Motivation (Automatic)

Co-designing the intervention

Workshop 3

Workshop 3 aimed to:

- Review the previously gathered evidence to determine what helps/hinders parents in Loxford from accessing their 2 – 2 ½ year review.
- Prioritise which factors can be addressed through the intervention.
- Review the solutions offered by different stakeholders.
- Develop an intervention and start to plan for delivery.

Participants

Workshop 3 was attended the following LA/HV team role holders: Public Health Consultant, Official Lead for 0-19 Universal Services, Group Manager for Children's Centres, two community Nursery Nurses, a 'Hard to Reach' health visitor from LBR. Three parents from Workshop 2 had consented to take part but did not show up on the day.

Intervention specification

The agreed intervention aims to target two behaviours of parents in the Loxford area of LBR:

1) completing the ASQ3 prior to attending their child's 2 – 2 ½ year review appointment
2) attending their child's 2 – 2 ½ year review

It was agreed that the best way to address as many of the identified barriers as possible would be to make changes to the invitation letter and remove the need for a booking process by providing opt-out appointments (i.e., appointment times which require action to be changed or cancelled, rather than action being required to make the appointment in the first place). The intervention will therefore consist of a behavioural science informed postal letter to invite parents to the 2 – 2 ½ year review.

In conjunction with this, a short video will also be created (from a parent perspective) of:

- What the review is and why it is important.
- How to complete the ASQ3.

This video will be hosted online by the NELFT, and a link to it provided through a QR code on the invitation letter. The letter will also contain links to translated versions of the letter in the top four languages in Loxford that are not English (Urdu, Bengali, Panjabi, and Tamil).

Co-designing the evaluation

Workshop 4

Workshop 4 aimed to:

- Review the agreed intervention and explore the practicalities involved in planning and implementation.
- Develop a logic model.
- Develop an evaluation research protocol, including allocating roles and responsibilities.

Participants

Participants included the following LA/HV team role holders: Public Health Consultant, Official Lead for 0-19 Universal Services, Group Manager for Children's Centres, a community Nursery Nurse, a 'Hard to Reach' health visitor from LBR and a Performance Manager for NELFT.

Evaluation protocol for the LBR initiative: Increasing uptake of the 2 – 2 ½ year review in Loxford

The logic model, co-designed with LBR, can be seen in Figure 2, and informs the research protocol that follows.

Research questions

Primary questions:

RQ1: Does the new invitation letter and associated features result in higher levels of uptake of the 2 - 2.5-year review, compared to the standard invitation?

RQ2: Does the intervention result in increased intentions to access wider family services?

Secondary questions:

RQ3: Does the new invitation letter result in increased capability, opportunity and motivation to access the 2 – 2.5-year review?

RQ4: Is an 'opt out' appointment system acceptable to parents eligible for their 2 - 2.5-year review?

RQ5: Does an 'opt out' appointment system have any negative consequences: e.g., increased rate of families not attending booked appointments?

RQ6: Do parents have a good understanding of what the ASQ3 is for and how to complete it?

RQ7: Do parents complete the ASQ3 prior to their review visit?

RQ8: Do parents access the additional resources available (video support and translated versions)?

Figure 2: London Borough of Redbridge Logic model

Inputs	Activities	Target group	Short-term outcomes	Medium- and long-term outcomes
Redbridge team creating an informative video Redbridge service user being filmed for video Redbridge providing translated versions of the new letter Redbridge finding space to host new video and translated letters online SHU team providing an updated invitation by letter informed by behavioural science SHU team advising on content for the video	Deliver a new communications strategy in the form of: • A behavioural science informed appointment invitation letter (translated into 4 non-English languages) • A new informative video showing a parent talking about their experience of the review and working through completion of the ASQ Default appointment sent (without opt out option)	Parents in the Loxford area of Redbridge with children aged 2 - 2 1/2 years Particularly those from ethnic minority backgrounds, for whom English is a 2nd language, or who might have other barriers to engaging	Increased knowledge about the review and its purpose Increased motivation, confidence and reduced concerns about attending the review Increased understanding about what the ASQ is for and how to complete it Increased parent attendance at the 2 - 2 1/2 year reviews in Loxford Increased completion rates for the ASQ prior to review visit Greater parent intentions to use other Family Hubs services	**Medium term** Improved parental self-esteem and confidence Improved parental understanding of healthy lives and activities Better health and wellbeing of families Increased sign-up/use of other Family Hubs services e.g., Chatter Matters Earlier identification of needs/SEND **Long term** More children achieve a good level of development at Early Years and Foundation stages Improved school readiness Improved attainment at primary/secondary school

Intervention

The planned intervention has 3 components:

- **Letter**
  - The letter will include information about the review and its purpose and will address common concerns about the review. It will be available in English and the top four non-English languages spoken in Loxford. It will be posted to eligible parents rather than emailed (as is current practice).

- **Video**
  - This will reassure parents about what the review involves and explain how to complete the questionnaire. The video will include the voice of other parents who have experienced the review.

- **Appointment process**
  - The letter will include the date and time of the appointment for the health visitor review (default). This will be a group appointment, but parents will be given the option to request an individual appointment if they wish. There is also the option for parents to change the time or to cancel (opt out).

Evaluation Methodology

1. Quantitative analysis of data collected by LBR (RQs 1, 5, 7, 8).

   The following quantitative data will be collected, anonymised and shared with the SHU team. No personal data will be shared.

   - Attendance figures for the 2 – 2 ½ year review for parents of eligible children in Loxford during the evaluation period.
   - Attendance figures for the 2 – 2 ½ year review for parents of eligible children during the previous 3-month (excluding the summer holiday period) time period during which the standard email invitation was used.
   - Attendance figures for the 2- 2 ½ year review for parents of eligible children during the same 3-month period as the service evaluation period in the previous year.
   - Figures on the number of ‘did not attends’ during the evaluation period.
   - How many participants attended group appointments (and/or how many opted for an individual appointment).
   - Figures on the number of appointments amended by parents (i.e., rejecting the allocated ‘opt out’ appointment during the evaluation period).
   - Figures on the number of correctly completed ASQ3 questionnaires brought to the review appointment.

- Number of views of the video and clicks on the translated versions of the letters.

2. Interview study with qualitative analysis (RQs 2, 3, 4, 6, 8)

   Interviews with 5-8 parents who received the new version of the letter to understand its effectiveness at overcoming barriers to attending the 2 – 2 ½ year health review. This includes potential impact on their capability, opportunity and motivation to attend, and any outstanding barriers to attendance. Parents will also be asked about whether the letter and the appointment (if attended) have affected their thoughts about wider family services, and their likelihood of using those.

Participants

From the start of the intervention, all parents from the Loxford area of LBR who have 2 – 2 ½ year old children will be invited to their child's health review using the new version of the letter.

Participants for the interview study will be a sample of these parents who agree to take part in the evaluation study.

Recruitment

Recruitment of participants for interview will be via multiple channels, including:

- Sharing recruitment materials through LBR/Loxford social media platforms.
- Sending invitations to take part using contact lists held by the children's centres / parent sign-ups.
- Recruitment flyers/posters in children's centres where HV reviews take place.
- Exploring possibilities to share recruitment materials with local nurseries/libraries/other places that families with young children might see them.

Expected Outcomes

There are four main expected outcomes from this research project:

- An understanding of the effect of an intervention to increase uptake of the 2 - 2.5-year health visitor review.
- An understanding of how the invitation letter and video are received by parents.
- An understanding of any additional barriers and facilitators to uptake of the health visitor 2 - 2.5-year review that are not addressed by the intervention.
- An understanding of whether attending the review increases the likelihood of parents engaging with wider family services.

London Borough of Merton

Background

The children of parents living in higher deprivation are at greater risk of emotional and behavioural problems and worse education outcomes (Flouri, Mavroveli and Tzavidis, 2012). The reasons for this increased risk are complex but some of these effects are thought to be related to early parenting practices (Kiernan and Mensah, 2010). Providing parents with the knowledge, skills and understanding to improve parental practices and reduce parental stress has the potential to reduce these risks (Barlow and Coren, 2018). However, the barriers for parents from socio-economically disadvantaged backgrounds to access parenting programmes tend to be greater than for other groups, and uptake of such services by these groups can be low (Leijten et al., 2017).

Early Learning Together Baby (ELTB) is a five-week programme designed for parents of children aged below 8 months which helps parents understand their child's development and learn how to support them through attachment and bonding. The programme is available to all first-time parents living in the London Borough of Merton (LBM).

Context

LBM is aiming to increase uptake of ELTB across the borough but particularly by families living in areas of deprivation. Approximately 200 new babies are born each month in LBM, although not all are to 'first-time' parents (Office of National Statistics, 2020). 2021-22 data from LBM shows that 450 first-time parents with a new baby accessed the ELTB programme, with 113 (25%) of those, living in <30% IDACI areas (Index of Deprivation Affecting Children). The most deprived parts of the Borough are in the East (The Merton Story, 2021) and residents include a mixture of ethnic minority, white British and Eastern European families.

LBM was a recipient of the DfE family hubs transformation fund 1 in 2022 and launched their Family Hub brand and timeline in August 2023. The Merton Family Hub will operate initially from two primary hub locations with over 18 satellite locations throughout Merton, becoming hubs by Spring 2024. The hub exists as a collection of 24 services, focused on meeting the needs of local communities. These provide a range of support for families from the beginning of parenthood through to 19 years (or 25 years for SEND families).

Target service

The ELTB programme combines baby massage with key messages about the importance of early brain development, communication, and bonding, underpinned by the Five to Thrive model[7]. It is available to all first-time parents living in Merton whose baby is

[7] https://fivetothrive.org.uk

under 8 months of age. Parents are invited to sign up or can be referred to the programme, as part of the offer from the family hub.

Evidence review

Method

The evidence review for LBM aimed to address the following research question:

1. What is currently known about the barriers and facilitators for new parents living in deprived areas and neighbourhoods from accessing and engaging with baby development programmes?

For this review, literature on all “new” parents as opposed to only “first-time” parents was included, because the latter term yielded too limited a set of search results, and it was concluded that barriers and facilitators for new parents also applied to first-time parents (Appendix 3).

Findings

A total of 14 articles were identified and these are included in the final review.

The data presented in this review is based upon research conducted in the UK (n = 9), Ireland (n = 2), Australia, (n = 3) and Finland (n = 1). Data from a review article, which included worldwide data, identified barriers and facilitators relating to uptake and initiation of services, and engagement with services or programmes over time. Some studies focused on families living in areas of deprivation and some focused more generally on new parents. Overall, the majority of evidence extracted drew upon experiences and views of those who had already engaged with the service (and/or dropped out), which provided some insights into participants’ motivations to attend.

Psychological Capability

A lack of knowledge about who the services are for is a barrier for engagement. One study found that parents perceived groups to be directed specifically at mothers rather than all parents (Barnett, Hanna and Fitzpatrick, 2018). Uncertainty about whether parents would be eligible for support (i.e., whether their challenges justified access to help) was also a barrier (Action for Children, 2021). A lack of knowledge about the content of services was also a barrier (Taket and Crisp, 2021); providing this information in advance (i.e., in adverts/communications about the service) may raise parental awareness of programme topics and promote uptake and engagement (Leckey et al., 2019). Equipping parents with knowledge about what the services are and how to access them is likely to facilitate uptake (Underdown, Norwood and Barlow, 2013).

Physical Opportunity

A lack of accessible information and communications about parenting support services was a barrier to uptake, with one study reporting that the formal invitations to attend first-time parenting groups were considered ambiguous and did not specify who was welcome to attend (Barnett, Hanna and Fitzpatrick, 2018). A lack of financial resources to attend the service (e.g., bus fare), a lack of time to attend, or being too busy with work commitments or other priorities (e.g. shift work) impacted parents' uptake of services (Leckey et al., 2019; Tacket and Crisp, 2021). Other practical barriers to uptake included a lack of transport (Hickey et al., 2021).

Early support, outreach or receiving taster sessions were identified as facilitators for uptake and engagement among new parents (Leckey et al., 2019; Taket and Crisp, 2021). Receiving formal invitations from a healthcare practitioner (e.g., health visitor) was also a facilitator to uptake (Cox and Docherty, 2008).

Services that were too time intensive or held in a venue that were difficult to access were barriers (Leckey et al., 2019; Cox and Docherty, 2008). Conversely, holding sessions in accessible locations (Cox and Doherty, 2008), having a higher number of attendees in the group (Barnett, Hanna and Fitzpatrick, 2018), and allowing for the opportunity for social engagement (Underdown and Barlow, 2011) were facilitators.

Social Opportunity

A lack of social norms for attending parenting support services was a barrier to uptake. One study reported that all fathers who attended an initial session with the intention of regular attendance subsequently discontinued their attendance due to a lack of other fathers attending (Barnett, Hanna and Fitzpatrick, 2018).

Receiving support from practitioners was a facilitator for disadvantaged and vulnerable mothers attending a programme like baby massage. Having a trusting relationship with the practitioner, who issued a personal invitation and then facilitated the group making sure their individual needs were met, encouraged ongoing attendance (Underdown and Barlow, 2011). Receiving support from other parents during the programme also facilitated engagement. Mothers living in disadvantaged areas valued the opportunity to discuss issues with peers and the group facilitator, helping them feel less alone in their experience (Underdown and Barlow, 2011). A warm, friendly, and non-judgemental environment with other parents promoted engagement and overall satisfaction with baby development programmes (Action for Children, 2021).

Reflective Motivation

Many parents believed that attending a service could lead to stigmatisation and judgement from other parents (Barnett, Hanna and Fitzpatrick, 2018), wider society (Action for Children, 2021), or from service providers (Department of Health and Social

Care, 2021). Some parents had concerns that attending the service would have a negative impact on their wellbeing, for example, if they had previously experienced miscarriage or stillbirth and anticipated difficult or upsetting conversations (Barnett, Hanna and Fitzpatrick, 2018). A lack of perceived need for support and/or change in parenting behaviours was also identified as a barrier to engagement with services (Hickey et al., 2021).

It is not just the content of services that is of interest to new parents but also the opportunity to meet other parents in a similar position. When new parents have an intention or a goal to meet and interact with other new parents then this leads to greater engagement with services (Hickey et al., 2021). When parents believe that there would be positive outcomes this was likely to facilitate uptake and engagement of parent support services. Perceived positive outcomes included: getting information about caring for their baby, meeting other new mothers, increased parenting confidence, opportunity to leave the house, observing babies of a similar age, obtaining advice, and wanting support from the group (Cox and Docherty, 2008).

Automatic Motivation

Experiencing negative outcomes from engaging with the service, such as dissatisfaction (Barnett, Hanna and Fitzpatrick, 2018; Underdown, Norwood and Barlow, 2013), stigmatisation and judgement (Barnett, Hanna and Fitzpatrick, 2018), lack of enjoyment (Hickey et al., 2021), not feeling comfortable (Underdown and Barlow, 2011) and disliking the content of the service (Taket and Crisp, 2021) were all identified as barriers for new and disadvantaged parents. However, experiencing positive outcomes reinforced and facilitated engagement for new parents, including increased confidence (Leckey et al., 2019; Underdown, Norwood and Barlow, 2013), increased knowledge (Cox and Docherty, 2008; Sourander, Laakso & Kalland, 2021), enjoyment (Taket and Crisp, 2021), opportunity to develop social support networks (Underdown and Barlow, 2011), receiving support (Hanna et al., 2002; Hickey et al., 2021), experiencing benefits for parent-baby relationships and parental relationships (Taket and Crisp, 2021; Leckey et al., 2019), and improved mood/well-being (Hickey et al., 2021).

Conclusion

The timing and salience of interventions and communications is important. Communications need to detail the relevant available support in a continuous and updated way (e.g., as and when parents need it) (opportunity) and provide sufficient knowledge about services and how to access them (capability). Perceived stigma about accessing targeted support was a barrier to uptake and engagement. There needs to be sensitivity associated with ‘parenting support’ rather than parents being perceived as ‘failing at parenting’ or ‘at risk’. Efforts should be made to reduce other negative expectations or perceptions and maximise positive experiences (motivation). Services need to be delivered flexibly to minimise accessibility issues including cost, timing, and barriers associated with travel (opportunity).

Co-designing the theory of change

Workshop 1

Workshop 1 aimed to:

- Clarify the aims of the LBM project (Appendix 8 shows the original theory of change submitted by LBM).
- Establish what was already known/planned/done regarding promotion of services amongst the target population.
- Identify what professionals perceive as being barriers to family hub engagement for the target population.
- Discuss how to gather further insights from parents.

Participants

Participants included five professionals representing LBM: Strategic lead (Start for Life), family hubs participation and engagement manager, Health visiting team lead, Information services manager and Information/data officer.

Current delivery of the ELTB

Professional stakeholders discussed how parents currently engaged with ELTB. This included referrals via health visitors and occasionally social workers, or self-referral whereby parents book on to ELTB via an Eventbrite weblink.

Perceived barriers/facilitators to engage with the family hub service from professional perspectives

Professionals highlighted a range of capability, opportunity, and motivational barriers (B) and facilitators (F) that they believed were relevant to engagement with the family hub service.

Psychological Capability Factors

- Lack of digital literacy required to book via the website (particularly amongst vulnerable families e.g., those with learning difficulties or limited English language skills) (B)
- Sleep deprivation/overwhelm for first-time parents may reduce their likelihood of attending (B)

Physical Opportunity Factors

- Link to ELTB website through the main family hubs ‘Directories’ webpage facilitates self-referral for some parents (F)

- Digital exclusion e.g., not having the right type of device, unable to access an Eventbrite booking 'code', lack of Wi-Fi (B)
- Cost of living e.g., some parents cannot afford to travel to the ELTB venues (B)
- Lack of information on the website about what ELTB is (B)
- Lack of information leaflets/posters that 'sell' the programme in an attractive way (B)
- Pressures on healthcare professionals e.g., reduced capacity to provide information about the programme or to make referrals (B)
- Competing life priorities and life stresses e.g., insecure housing mean that parents have other needs or concerns above attending parenting programmes (B)
- Early registration with family hubs (known at the time of workshops as children's centres) (F)
- Links/reminders from Eventbrite (F)

Social Opportunity Factors

- Referral/signposting by healthcare professionals (such as health visitors and midwives) (F)
- Lack of support network; post pandemic effects included some families being subject to high mobility, and thus were unfamiliar with services and venues in LBM (B)
- Opportunities for mothers to socialise (F)
- Baby massage may not be considered culturally appropriate for some ethnic minority parents (B)

Reflective Motivation Factors

- Not inclusive for fathers (B)
- Not fitting in (e.g., young parents might feel intimidated by older and more 'experienced' mothers) (B)
- Believing that they would be uncomfortable or out of place (e.g., perceiving the ELTB programme to be for more affluent parents) (B)
- Not feeling welcome at the centre (B)

Automatic Motivation Factors

- Fear of judgement (B)

Key considerations for an intervention (from professionals' perspectives):

Professional stakeholders suggested a range of potential intervention approaches to increase uptake of ELTB, including new communications and messaging about the service, ensuring that communications are delivered via other local services (e.g., GPs, pharmacists, voluntary sector organisations, community hubs), and delivering outreach services.

Insight gathering: Interviews with first-time parents

Interviews were conducted with parents living in LBM to explore their views regarding barriers and facilitators to attending the ELTB programme and other family hub services, and their views on what sort of intervention activities might address these.

Method

Participants

A text message was sent by LBM to all parents living in parts of the Borough with higher levels of deprivation who had been referred and had signed up to the ELTB programme (some of whom had not completed all the sessions). LBM also posted social media advertisements directed at parents who had not previously accessed the ELTB programme. Ten parents (all mothers) were recruited and interviewed[8].

Table 7: Summarised demographics of the participants for LBM interviews

Demographic	Participants in sample
Age range	32 to 39
Ethnicity	Participants identified as the following: White British, Black African, White European, British Bangladeshi, Pakistani British, British Asian
Number of children	1 to 4 children
Age of child / Age of youngest child	4 months to 11 months old
Living in an area of higher deprivation (based on areas identified as higher IDACI)	Living in an area of higher deprivation (5), Not living in an area of higher deprivation (3), Unsure whether living in area of higher deprivation (2)

Findings

Psychological Capability factors

Participants needed knowledge that the programme is free to attend, and how to get further information about the programme and other family hub services. Participants reported that they did not always have this knowledge. Participants felt that there might be language barriers to accessing the service that would need to be addressed in order to facilitate completion of the programme for all.

[8] Despite targeted recruitment efforts, no participants were recruited who had not previously attended at least one ELTB session. Interviewees were encouraged to consider barriers that might exist for other parents in their local community who had not attended the programme.

> “there was a Mum on my baby massage group who didn’t speak any English. So she only turned up to one session and then she dropped off...”

People needed to have to skills to sign up, which were potentially challenging in the period immediately after having a baby.

> “…I think a lot of these things you get overwhelmed as a new parent. I kind of feel like unless someone puts something in front of you, you’re not going to go looking for it because your brain’s not working, I don’t know if you’re a parent yourself but it’s terrifying.”

Social Opportunity factors

A key facilitator was being referred to the service by a health visitor. However, referrals differed based on access and interactions with health visitors due to the place and nature of birth and other factors.

> “The only reason that I heard about it was purely the health visitor basically got me to sign up when she was in my house doing the first visit but yes I haven’t seen any leaflets, or I hadn’t heard”.

Others felt that having a recommendation by other parents or knowing other parents who had attended was important, but this was likely variable depending on people’s social networks.

> “I’m a first-time parent, I knew nothing about anything so I don’t know if anyone else had [attended] it. I’m the only one in the family that has a baby, so I don’t know about anyone else and I’ve not really asked them.”

Physical Opportunity Factors

Some participants identified other places that could provide an opportunity to find out about the programme (e.g., on the Merton website, library, and social media platforms). Having a free programme (and advertising that) was identified as important, especially for women on maternity leave and with the current cost of living crisis.

Participants identified a range of needs about the location of the service that were important including distance from home, accessibility, the need for public transport, and ability to bring a pram. The timing of sessions was also important to enable access, especially for parents who worked, but also so that the classes could fit in with baby’s routine. There was a perception that their baby would need to be awake to enable them to attend and take part on the session.

> "I think also there are times when people think, I would like to go, but my baby's napping and I think you know then you feel like, oh, if I go late, will they think I'm, you know would that put you off going, that sort of thing"

Other opportunity factors included whether parents knew the area or were new to LBM which could be a barrier to accessing the programme. There were also concerns about digital exclusion, given that the signup process for the programme was online.

Reflective Motivation factors

Participants reported mostly positive beliefs about the value of the programme for themselves and their babies. Other anticipated benefits included the opportunity to socialise with other parents.

> "I wanted to do something every day of the week to get me up and out of the house for my mental health and, you know, I want my baby to grow and develop, and I didn't really know what to be doing with her"

Participants reported some concerns about judgement and stigma from others.

> "But I can imagine if I'd have felt judged or kind of you know something in that situation had made me feel like, oh, you're not doing a good job and that's why you're here. I can imagine that might have prevented you coming back. Because I think a lot of new mothers all the time, feel the sense of you know, I'm trying my best, but is it good enough."

Key issues surrounding the process of accessing and finding out about the service appeared to impact on parents' awareness of the ELTB programme. Notable barriers were a lack of early referral and signposting by healthcare professionals, and a lack of accessible communication or advertising about the programme (e.g., through social media). Participants highlighted the importance of knowing that the programme was free to attend and believing there would be benefits for both baby and parent from attending, with additional communications and advertising about the ELTB programme on social media and through referrals by a professional.

Barriers and Facilitators to accessing the ELTB programme

The following tables (Tables 7 and 8) show the full list of barriers/facilitators to attending the ELT baby programme that were identified by parents in the focus group, professional stakeholders in co-design workshop 1 and/or the rapid evidence review.

Table 8: Summarised barriers to attending the ELT baby programme

Barrier	Parents	Professionals	Evidence review	COM Factor
Knowledge (or lack of) about wider FH services	X	-	-	Capability (Psychological)
Lack of knowledge about how to get information about services such as ELTB	X	X	X	Capability (Psychological)
Not having the confidence to attend	X	-	-	Capability (Psychological)
Language barriers	X	X	-	Capability (Psychological)
Lack of knowledge about who services are for	-	-	X	Capability (Psychological)
Lack of knowledge about content of service	-	-	X	Capability (Psychological)
Lack of referral by health visitor	X	X	-	Opportunity (Social)
Lack of social influences	X	X	-	Opportunity (Social)
Lack of social norms for fathers to attend groups	-	-	X	Opportunity (Social)
Not hearing about it at the right time	X	-	-	Opportunity (Physical)
Lack of online link/website to attend	X	X	-	Opportunity (Physical)
Lack of promotion via local services / online	X	X	X	Opportunity (Physical)
Lack of social media presence	X	-	-	Opportunity (Physical)
Distance/accessibility problems	X	X	X	Opportunity (Physical)
Lack of time / other commitments	X	X	X	Opportunity (Physical)
Social isolation	X	-	-	Opportunity (Physical)
Timing of the programme i.e. not fitting daily routines	X	-	X	Opportunity (Physical)
Digital exclusion	X	X	-	Opportunity (Physical)
Perceptions about who the programme is for (i.e. not mums like me)	X	X	-	Motivation (Reflective)
Perception that there is limited space available	X	-	-	Motivation (Reflective)
Lack of perception of social opportunities for new parents	X	-	-	Motivation (Reflective)
Lack of beliefs about benefits / beliefs about negative consequences	X	-	X	Motivation (Reflective)

Barrier	Parents	Professionals	Evidence review	COM Factor
Fear of judgement/stigma	X	X	X	Motivation (Reflective)
Perception that they don't need help or support	-	-	X	Motivation (Reflective)
Not having the confidence to sign up	X	-	-	Motivation (Reflective)

Table 9: Summarised facilitators to attending the ELT baby programme

Facilitator	Parents	Professionals	Evidence review	COM Factor
Knowledge that it is free to attend	X	-	-	Capability (Psychological)
Confidence to attend	X	-	-	Capability (Psychological)
Recommendation by other parents	X	-	X	Opportunity (Social)
Support from other parents	X	X	X	Opportunity (Social)
Referral by health visitor	X	X	X	Opportunity (Social)
Recommendation by breastfeeding support clinic	X	X	X	Opportunity (Social)
Cost-free programme available	X	-	-	Opportunity (Physical)
Online link/website to attend	X	X	-	Opportunity (Physical)
Promotion via local services / online	X	X	-	Opportunity (Physical)
Distance/accessibility good	X	-	X	Opportunity (Physical)
Child-friendly location	X	-	-	Opportunity (Physical)
Perception of social opportunities for new parents	X	-	X	Motivation (Reflective)
Perceived benefits of attending	X	-	X	Motivation (Reflective)
Trust associated with Council	X	-	-	Motivation (Reflective)
Having a positive experience	X	-	X	Motivation (Automatic)

Co-designing the intervention

Workshop 2

Workshop 2 was held with parents from the target population and aimed to:

- Revisit barriers/facilitators identified from the parent interviews and prioritise which were perceived as the most influential.
- Explore in more depth any suggestions for interventions identified during the interviews.

Participants

Five parents living in LBM attended the workshop. Table 9 summarises participant characteristics:

Table 10: Demographics of participants attending the workshop (LBM)

Demographic	Participants in sample
Age range	31 to 39
Ethnicity	Participants identified as the following: Black African, White European, British Bangladeshi, Pakistani British, Black British African
Number of children	1 to 4 children
Age of child / Age of youngest child	4 months to 11 months old
Living in area of LBM with higher deprivation	Participants identified as the following: Yes living in an area of higher deprivation (4), Not living in an area of higher deprivation (1)

Outcomes

Barriers and facilitators

Findings from the interviews were discussed and barriers and facilitators were prioritised by participants:

- A lack of early referral and signposting by professionals such as midwives, health visitors and GPs and a lack of accessible communication or advertising about the programme were highlighted as the most important barriers.
- Knowing that the programme was free to attend, believing that the programme would have benefits for the baby and the parent, and receiving information about the programme along with a referral by a professional were highlighted as key potential facilitators.

Discussion around proposed interventions

Participants took part in a discussion about the merits, drawbacks, and practical application of various ideas for intervention activities that had been suggested during the interviews with parents.

1. Referral by midwives, health visitors and the hospital

All participants agreed that health visitors were key to referral but also discussed that hearing about the programme from multiple touchpoints including healthcare professionals both antenatally and postnatally (midwives, GPs, health visitors) would be even more effective. Several participants suggested that written information in the form of a simple and clear leaflet would enhance the referral process and potentially increase knowledge and buy-in to the programme. However, it was noted that circumstances around the time of birth could vary, meaning that some parents may have significantly less contact with health professionals. Concerns about baby or mothers' health might also take priority over conversations about programmes such as ELTB.

2. Online promotion and social media

All participants agreed that increased online information about the programme would be useful. Some suggested that social media could be utilised, noting that new parents often spent significant time at home and would be actively using social media, particularly Instagram. Instagram advertising was considered acceptable if there was clear and credible LBM branding. Participants suggested that a handle, link or QR code shared by professionals and printed onto leaflets, linking to all the necessary information about how to register for the programme would be useful.

3. Approaching parents via food banks, libraries and places of worship

The participants discussed where first-time parents were likely to spend their time, highlighting potential opportunities for promoting the service. Locations suggested included bus stops, libraries, supermarkets, places of worship, food banks and other baby groups. However, one participant noted that it may not be easy to make a cold approach to a new parent in these public spaces.

4. Increasing word of mouth recommendations between parents

Participants were less sure about how word of mouth recommendations between parents could be increased. Despite the suggestion that parents could be encouraged to recommend the programme using incentives, this was overall a less popular intervention approach amongst the participants.

5. Postal mailing

Participants queried the practicality of postal mailing as they were unsure how the LA would access information about first-time parents given that there was no hospital located within LBM, and most babies were therefore registered as born in neighbouring

Boroughs. It was suggested that health centres might have this information but remained unclear how feasible this would be to implement.

6. Improvements to ELTB programme materials

Participants discussed how materials used to advertise the programme could be improved. Suggestions included: ensuring that the benefits for parent and baby from accessing the ELTB programme are clear and relevant to the parent; ensuring materials are simple and eye-catching; making it explicit that the ELTB programme is free to attend and that the service is local, accessible, and held in familiar venues and making sure that materials are distributed by health visitors and other professionals. Participants also discussed the importance of showing people what the ELTB programme is like (e.g., using videos, images, or parent testimonials that illustrate inclusivity, diversity, and representation of parents). Participants made recommendations for improving the process of registering onto the programme (e.g., information about the programme needs to be clearer and easier to find), as well as recommendations for improving the delivery of the programme, including ensuring that classes are tailored for non-English speakers (e.g., offering live interpreters).

Workshop 3

Co-design workshop 3 was run with parents and professionals and aimed to:

- Review the evidence gathered about barriers and facilitators for parents living in deprived areas of Merton to accessing ELTB and wider family hubs services.
- Prioritise which factors can be addressed within the scope of this project.
- Review solutions offered by different stakeholders to address the needs of the target population.
- Develop an intervention and delivery plan.

Participants

Workshop 3 was attended by eight professionals from LBM including: Strategic Lead Start for Life, Family Engagement Manager, Childrens Centre Group Manager, Family Engagement Coordinator, Family Engagement Officer, Family Hubs Participation and Engagement Manager, Information Services Manager and Information/Data Officer.

Three parents also attended the workshop. All were from an ethnic minority group and had one child aged under one. Two reported living in an area of higher deprivation.

Outcomes

An overview of barriers and facilitators were discussed in the context of the needs of the target population and in relation to APEASE criteria. Personas to represent parents

facing a range of barriers to accessing the ELTB programme were presented and discussed in relation to different intervention suggestions, to encourage consideration about which activities might be most effective for different parents.

Parents identified that it was difficult to discern the focus on baby massage from the ELTB name. However, professionals agreed that a name change would require further consultation beyond the scope of these co-design workshops because 'Early Learning Together' was the brand for a series of child/parent interventions available as part of the LBM family hubs offer. It was suggested instead that future publicity or advertising should clearly highlight that the programme included baby massage as a core feature.

Co-designing the evaluation

Workshop 4

Workshop 4 aimed to:

- Agree and confirm a proposed intervention.
- Discuss practicalities around the planning and implementation of the intervention.
- Develop an evaluation research protocol, with consideration of logistics, capacity and available data.

Participants included the Information Services Manager, Childrens Centre Group Manager and the Strategic Lead for Start for Life.

Evaluation protocol for London Borough of Merton initiative: Uptake of ELTB programme by first-time parents living in Merton

Research questions

Primary questions

RQ1: Does behavioural science-informed communications promoting the ELTB programme increase referrals (including self-referrals)?

RQ2: Does a behavioural science-informed communications promoting the ELTB programme increase uptake/attendance of the programme?

RQ3: Does the intervention result in increased intentions to access other family hub services?

Secondary questions

RQ4: Does inclusion of a QR code improve access to online information about the ELTB programme?

RQ5: What do parents living in the most deprived areas of Merton think about the updated advertising/communications?

RQ6: Does the intervention increase parents' capability, opportunity and/or motivation to attend ELTB?

Intervention

The planned intervention has 2 components:

1. Leaflets/posters

    These promotional materials will highlight the benefits of ELTB and the key information deemed necessary prior to signing up for the programme.

2. QR-linked booking

    The inclusion of a QR code on leaflets and posters to take parents directly to the Eventbrite booking page.

The intervention materials will be distributed to parents during referral conversations (by health visitors, GPs, Pharmacists and Midwives), via family hubs and social media.

Figure 3 details the logic model for the intervention

Figure 3: London Borough of Merton logic model

Inputs	Activities	Target group	Short-term outcomes	Medium- and long-term outcomes
Merton team creating posters/leaflets Merton hosting materials online Merton arranging for the new leaflet/poster to be distributed via children's centres, on social media and during referrals SHU team provided a brief for the new materials informed by behavioural science	Deliver new communications in the form of: • A behavioural science informed poster/leaflet • QR code link to booking page	First time parents in the London Borough of Merton with babies aged 8 months and under Particularly those from the lowest 30% of IDACI (income deprivation affecting children index) areas	Increased knowledge about the ELT baby programme Increased motivation, confidence and reduced concerns about attending the ELT programme Increased social opportunity to access the ELT baby learning programme Increased uptake and attendance at the ELY baby programme Greater intentions to use other family hub services	**Medium-term** Improved parental wellbeing Increased access to social support from other parents Improved infant wellbeing Improved parental understanding of early brain development, communication and bonding Increased sign-ups/use of other family hub services **Long-term** Happier, healthier families Continued use of family hub services Trusting relationships built with professionals offering support

Methodology

The methodology is comprised of two phases:

1. Quantitative analysis of data collected by LBM

   The following quantitative data will be collected:

   - Number of referrals/self-referrals received by LBM during the 3-month evaluation period (RQ1).
   - Number of referrals/self-referrals received by LBM during the same 3-month period in the previous year (RQ1).
   - Attendance at each of the 5 sessions of the ELTB before and after the intervention is rolled out (RQs 2 and 3)
     - This will include data on date of referral, who is making the referral, details of person being referred including age of child and IDACI index (based on postcode). LBM will provide this data in an anonymised format.

2. Interview study with qualitative analysis

   SHU will undertake interviews with 8-10 parents who are referred following the launch of the intervention. The interviews will explore parents' experiences of their referral, their views about the new communications and the reasons why they accessed or did not access ELTB following a referral. Interviews will also explore parents' intentions to use other family hub services (RQs 3,4,5,6).

Participants

Participants for the interviews will be first-time parents living in LBM with infants aged 8 months or younger and who are referred or self-refer to the ELTB programme. Recruitment will target those who attend and do not attend the programme following their initial referral.

Recruitment

A purposive sample of parents who have been referred or self-refer to ELTB will be invited to take part in the interview study. LBM will contact parents via email/text message or telephone and invite them to contact SHU directly if they would consider taking part in an interview either online or on the telephone. The invitation will include information about a £30 incentive for taking part. The research team, on receiving contact from an interested participant, will send them the participant information sheet and consent form either by email or on paper (depending on participant preference and digital access). Once a consent form has been completed, a time and mode for the interview will be arranged: online (Zoom or Teams) or telephone. Participants with different characteristics will be included, such as whether they accessed the programme following

referral or not, age and ethnicity. Invitations will be sent to batches of participants, with latter invitations targeting participant groups less represented in the sample.

Expected Outcomes

There are three main expected outcomes from this research project:

- An understanding of the effect of new behavioural science informed messages/ communications to increase and improve uptake of the ELTB programme.
- An understanding of the acceptability of the new behavioural science informed messages/ communications for parents living in LBM.
- An understanding of whether attending the ELTB programme increases the likelihood of parents engaging with other family hub services.

Fellowship of St Nicholas (FSN)

Background

Stability and security at home is crucial to a child's education, health and wellbeing (Childrens Commissioner, 2018), yet the numbers of families living in temporary accommodation (TA) have been increasing steadily since 2011, with a sharp increase at the start of the Covid-19 pandemic (Wilson and Barton, 2023). Families in TA face multiple disadvantages including increased risk to parental mental health and adverse childhood experiences (Marcal, 2018; Rosenthal et al., 2022). TA is often overcrowded and poor quality, with limited access to WiFi, cooking and washing facilities and inadequate space for children to learn and play (Rosenthal et al., 2020). A critical shortage in the availability of suitable TA means that families are increasingly housed in accommodation further away from their communities, work and/or schools. This contributes to the isolation of parents and children and leaves families without access to a range of vital support (Children's Commissioner, 2019).

Context

In Hastings there were 530 households living in TA between January-March 2023 including 478 children living in TA (Department for Levelling Up, Housing and Communities, 2023). This number has quickly risen over the past three years: there were 203 households and 147 children in Hastings living in TA over the same period in 2020 (Ministry of Housing, Communities and Local Government, 2020). FSN are a charity based in Hastings, East Sussex who run a range of projects and services to support families including nurseries, youth projects and parent-baby groups. They also run a TA hub specifically designed for families in TA. East Sussex County Council (ESCC) has received DfE family hubs transformation funding and was awarded trailblazer status in 2023 (Department for Education and Department of Health and Social Care, 2023). The TA Hub at FSN is funded by National Lottery Community Fund but is run alongside St Leonards family hub, which is owned by FSN but is part of the East Sussex network of family hubs. FSN signposts families using their TA hub services to the wider family hubs services run by ESCC. Since starting their St Leonards TA Hub in 2021, FSN are now also funded by ESCC Supporting Families to deliver a second TA Hub in nearby Eastbourne, which launched in June 2023.

Target service

FSN's TA Hub is open four evenings per week between 3.30 – 6pm for families living in TA to access facilities and support. This includes a communal hot meal, access to laundry facilities, indoor and outdoor space for children to play and do homework, opportunities to get advice from FSN staff about accessing financial support benefits and navigating local services, and informal support from other parents and families. Parents who attend the TA hub benefit from increased social support and can gain knowledge

and be signposted to wider local family hub-related services. FSN seek to increase uptake of the TA Hub amongst parents living in TA through the development of a behavioural science-informed intervention.

Evidence review

This evidence review aimed to address the following research question:

1. What is currently known about the barriers and/or facilitators to families living in TA engaging with outreach, peer support or family services like those offered by the TA hub?

Findings

A total of 22 articles were included in the final review.

The review found evidence from the UK (n = 12) and US (n = 7), including parenting programmes delivered within homeless shelters and transitional housing (both mandatory and voluntary). Data was also extracted from three systematic reviews. Interventions ranged from parenting support and/or psychoeducation to early intervention, risk reduction and engagement with health visiting/statutory services (Bradley et al., 2020; Brott et al., 2022; Haskett, Loehman and Burkhart, 2016). Some papers focused on challenges of conducting interventions from professionals' perspectives rather than focusing on barriers and facilitators for uptake and engagement amongst the target population.

Psychological Capability

Knowledge about services was a barrier and facilitator to accessing and engaging with services. If a family living in TA did not know about the existence of, or content of services this posed a barrier to them engaging with or attending those services (Tischler et al., 2004). When families were provided with the right information and given knowledge about a range of services offered then this was a facilitator to them engaging with services (Haynes and Parsons, 2009).

A lack of interpersonal skills needed to access services, including lack of education, literacy or confidence were barriers for families living in TA (McCoy et al., 2015; Swick, 2009). The impact of living with an insecure housing situation (including significant stress and poor mental health and wellbeing) impacted negatively on engagement (Carson, Powis and Imperato, 2016; Holtrop et al., 2015; Kilmer et al., 2012).

Physical Opportunity

Practical barriers to accessing services included families having a lack of time or being too busy with other life commitments (Jenkins and Parylo, 2011), and families moving

around frequently and thus being unable to attend services regularly or consistently (Gewirtz et al., 2013).

Receiving practical support to attend services, such as assistance with travel arrangements or childcare, acted as a facilitator for families engaging with services (Kilmer et al., 2012; Sheller et al., 2018; Swick, 2009). In addition, well-structured services that consist of the following features: (i) consistent and predictable availability (Crasnow et al., 2020), (ii) appropriate timing of and length of sessions (Holtrop and Holcomb, 2018; Sheller et al., 2018), (iii) flexibility in services such as offering drop-ins (Crasnow et al., 2020), and (iv) having formal and informal sessions (Swick, 2009) were facilitators to engagement for families living in TA. Having services which involve group sessions that are confidential and safe, and with group leaders that reflect the target population were considered as facilitators to engagement (Sheller et al., 2018; Carson, Powis and Imperato, 2016; Holtrop and Holcomb, 2018). Accessible and timely communications and messaging about the services (e.g., weekly texts or leaflets through doors), especially for those who are new to the area may facilitate and encourage engagement (Champions Project, 2021; Crasnow et al., 2020; Haynes and Parsons, 2009).

For some families, services delivered in TA environments (e.g. hostels) may be off-putting as there may be conflict or hostility, negative emotional associations or challenges around privacy associated with the accommodation (Carson, Powis and Imperato, 2016; Sheller et al., 2018). However, some families may find travelling to a different location difficult, so holding services in the TA itself could facilitate engagement.

A lack of resources to support language barriers prevented some families from minority groups engaging with services (Kilmer et al., 2012). However, providing translation and/or English literacy support facilitated engagement (Kilmer et al., 2012).

Social Opportunity

The presence of staff and/or community service navigation advisors who were perceived by target users to have expert or valued knowledge was a facilitator (Champions Project, 2021; nef Consulting, 2015).

A lack of social support may mean parents are less likely to access services (Kilmer et al., 2012). However, experiencing support from other parents who attend the service and/or within the wider community may act as a facilitator for engagement and uptake, as seeing other families access and benefit from the service encourages others to do so (Haynes and Parsons, 2009; Swick, 2009; nef Consulting, 2015). The evidence also suggests that service leads or coordinators with lived experience of TA provided reassurance for families and encouraged engagement (Brott et al., 2022; nef Consulting, 2015).

Reflective Motivation

Several studies reported that families felt a perceived stigma and judgement from others as they believed that they were failing in their role as a parent (Crasnow et al., 2020). Some also reported a perceived stigmatisation of parenting support and interventions (Kilmer et al., 2012; Sheller et al., 2018), some had feelings of mistrust or fatigue associated with statutory services (Bradley et al., 2020; Carson, Powis and Imperato, 2016), and some experienced shame associated with using support services that were linked with homelessness (Swick, 2009). Parents were worried about their parenting practices being under scrutiny and there was concern about a perceived conflict between their own parenting strategies and the support offered by those services (Holtrop et al., 2015). This perception may reduce parents' motivation to engage with support services.

Some studies found that parents held self-critical beliefs about the reasons for their homelessness or insecure housing situation which negatively affected their feelings of worth or motivation to access support (Brott et al., 2022; Crasnow et al., 2020). However, despite the challenges of homelessness, many parents expressed their desire to meet the parenting role and associated responsibilities, and this may act as a facilitator to uptake and engagement of support services (Holtrop et al., 2015).

Perceived benefits from accessing the services were identified as a facilitator for family engagement and uptake with services. When families have a desire to learn strategies for improving child behavioural and emotional difficulties from services or an opportunity for peer support then this encourages engagement (Bradley et al., 2020; Harris-McKoy et al., 2015). Some research also suggested that engagement is motivated when parents believe that the content of an intervention is tailored to the specific needs or unique contexts of families in TA (Harris-Mckoy et al., 2015). A belief that the staff delivering the service will be non-judgemental and make parents feel comfortable also increases parents' motivation to engage with the services provided (nef Consulting, 2015).

A final aspect of reflective motivation that may act as a barrier or facilitator to uptake is having either weak or strong intentions to access the services, which is influenced by other competing priorities associated with raising children in TA, such as financial hardship (Harris-McKoy et al., 2015; Holtrop and Holcomb, 2018).

Automatic Motivation

Previous positive or negative experiences when accessing services can act as a barrier or a facilitator for future uptake and engagement. Some research suggested that when parents felt dissatisfied with a service (e.g. it was not specific to their child's behaviour problems) then this would prevent them accessing services in the future. However, research also found that when parents had positive experiences, such as, increased self-esteem, sense of accomplishment, feeling refreshed in their approach to parenting, these reinforced the need for these services and so increased uptake in the future (Bradley et al., 2020). In one study, parents received incentives and rewards for attending services

(e.g., household items) and this encouraged ongoing engagement with services (Champions Project, 2021).

Conclusion

This evidence review highlighted common themes such as the social and physical isolation and mental exhaustion of this target population when engaging with services. This involved a loss of social networks, independence and confidence, feelings of guilt and shame, fear of perceived stigma and judgement from social networks and service providers, and feelings of service fatigue. Despite these significant challenges, many parents demonstrated a desire to access parenting support. Overall, the evidence suggests that there is a need for flexible, non-stigmatised services that meet the specific needs of families living in TA. Providers need to provide accessible and timely information about their services, and the review highlighted that engagement is supported when frontline delivery staff are trusted and perceived as having expert knowledge about living in TA or have relevant lived experience. Practical considerations include the need to offer flexibility to allow the target group to engage with services amidst other life challenges or priorities, offering a range of formal and informal sessions whilst also providing consistency in terms of the support available. Support with travel and childcare can also facilitate engagement. Some families may find it acceptable for services to be delivered within TA, but careful consideration must be given to the need for sufficient space, privacy and security.

Co-designing the theory of change

Workshop 1

Co-design workshop 1 aimed to:

- Clarify the aims of the project and build an understanding of the target population (Appendix 10 shows the original theory of change submitted by FSN).
- Establish what is already known/planned/done regarding promotion amongst the target group.
- Identify the perceived barriers to FSN TA hub engagement for people living in TA (from the perspective of stakeholders).
- Establish what parameters the organisation(s) are working within (i.e., what is possible).

Participants

Workshop 1 was attended by the FSN Chief Executive, FSN TA Hub Manager and FSN support worker, two representatives from East Sussex County Council, one

representative from Eastbourne and Lewes Councils, and the TA team leader for Hastings Borough Council.

Defining the target population

Professionals at the workshop gave an overview, based on their experience of the types of families in TA within the Hastings area. They described a large number of households living in TA in Hastings with varied characteristics. These included a significant number of single parent families as well as whole families, refugee and asylum seeking families and parents not currently living together with their children (for example, fathers 'sofa surfing') and included families with children of all ages. The reasons for living in TA were reported as varied and many families had experienced multiple moves before finding longer term TA. All families were welcome to access the TA hub, although currently the majority were single mothers with a young child. The most current attendees of the TA Hub were white British but some were of Sudanese or Bangladeshi heritage.

Perceived barriers/facilitators from professional perspective

Professionals highlighted a range of capability, opportunity and motivational barriers (B) and facilitators (F) that they believed were relevant to engagement with the TA hub.

Capability Factors

- Poor mental health and wellbeing affecting confidence or skills to access services (B)
- Lack of knowledge or understanding about what services exist in Hastings and who they are for (B)

Opportunity Factors

- Placement in TA which might take the family physically away from, or contribute to breakdown of their social support network (B)
- Perceiving the TA hub to be too far to travel to if not in walking distance (B)
- Unfamiliarity with professional language used in family support service which may lack meaning or be unclear for some people (B)
- Having or not having a 'buddy' to attend the service with (F/B)
- Poor physical health of children (more vulnerable to illness because of poor living conditions) (B)
- Lack of financial means to travel to the hub, for example needing to prioritise getting children to school over other local travel (B)
- Being placed in TA which is in an area of Hastings unfamiliar to the family (B)
- Receiving a word-of-mouth recommendation from another parent (F)
- Promotion of the TA Hub via local community organisations such as church groups (F)

- Face-to-face referrals and introductions to build trust (perceived as more effective than written leaflets) (F)
- Referral to, and attendance at, the TA Hub by health visitors (F)
- Initial phone call from the TA Hub Manager following referral to provide key information and build trust (F)
- Signposting or advertising of the TA Hub by TA providers via noticeboards or information resources for residents (F)
- Promotion or referral from other linked programs e.g., Future Options advisors, Moving on Up supporting into work and wellbeing programme (F)

Motivation Factors

- Time delay between referral and access (potentially due to hesitancy about attending or other barriers) (B)
- Perceived stigma about accessing services for families in TA (particularly for families or parents with no previous experience of accessing support or benefits) (B)
- Fear of accessing services (B)
- Stigma around accessing 'targeted parenting' services e.g., fear of being judged as a bad parent or mistrust of services associated with perceptions of what 'safeguarding' questions might be raised (B)
- Having experienced positive or negative previous experiences of services (B/F)
- Fear of picking up illness with physically vulnerable children (B)
- Chaotic lives, other priorities and challenges perceived as more pressing (B)
- Incentives for engagement including free day trips for families e.g., zoo (F)

Parameters for the intervention

Professional stakeholders highlighted that a key function of any intervention would be relationship and trust-building, in spaces that were safe and familiar to parents living in TA. Collaboration and working with other professionals were highlighted as key, particularly for promotion of the TA hub and referral of families by local professionals who were aware of their housing status. Word-of-mouth amongst families in TA and demonstrating to families what the TA hub could offer were also highlighted as important.

FSN had previously trialled outreach which involved FSN staff going into TA to make contact with families. This had not previously been successful as the accommodation was often not accessible, lacked appropriate spaces for discrete and sensitive conversations, and did not constitute a safe space for some families.

Behavioural science insights: Focus group with parents living in TA

Participants

Six parents living in TA were recruited by FSN. These were parents who had previously attended the TA Hub or another FSN service e.g. mother and baby support groups. Table 10 summarises their characteristics.

Table 11: Demographics of participants attending the focus group (FSN)

Demographic	Participants in sample
Age range	19 to 39
Ethnicity	Participants identified as the following: White British, Black African, Other White
Number of children	1 to 4 children
Employment Status	Employed (2), Unemployed (4)

Findings

The key barriers and facilitators to accessing the TA hub included:

- Not knowing about the hub - Some participants reported that there was little awareness of what the TA hub is (Psychological Capability, Barrier).
- Lack of referral by Council/housing officers - Some participants were concerned that they had not been told about the hub by housing officers who were the first to know that they were a family living in TA because without a referral people were left without knowledge of the support available (Social Opportunity/Psychological Capability, Barrier)

  > "[Housing officers] don't tell you about this which is weird because you would think that they would want you to be supported and things"

- Concern about how they would be received at the hub - Some focused on a lack of awareness of the kind of place it is and how they might not feel welcomed, might be judged, and might not feel comfortable to attend (Reflective Motivation, Barrier)

  > "I just thought for some reason that it would be a massive hall… I didn't think people would be as friendly as they were I thought people would be a lot more judgemental than they were but they don't know what it's like until they try it"

- Belief in the value of a service specific to the needs of families in TA - Participants valued a service that met the needs of both parents and children living in TA. (Reflective Motivation, Facilitator)

- Promotion of the hub by other parents living in TA - Participants talked about the value of hearing about the hub and the value of it from others living in TA with whom they could relate. (Social Opportunity, Facilitator)

> "Having someone work with them who's been through the emotional [challenges] and has experienced what temporary can be like would maybe like reassure people that actually…they are there to help"

- Mistrust of the service and perceived connections to other services - Some participants discussed mistrust of the hub and how it might be connected to other services, particularly social services, who participants feared might take their children into care. (Reflective Motivation, Barrier)

> "[If] there's people saying things about it that ain't true erm for instance that they get social services involved then people are like oh I'm not going to go there I'm not going to risk having social services looking into my life and blaming me for something that I've not done or something like that"

- Stress and life challenges of living in TA - Some participants spoke about the challenges of living in TA and its impact on their mental health. They noted that TA was often located some distance from key services which created challenges in accessing and engaging in those services (Physical Opportunity/Psychological Capability, Barrier)
- Social isolation - Some spoke about their needs for additional support as a result of not having family support available to them. (Social Opportunity, Barrier)

> "…I'm not really close with my family that much so it's weird I wouldn't I didn't want to go to them to use their washing machine I'd rather go to someone who's offering it [who] makes you feel like you're not being a burden"

- Cost of travel/transport - Participants felt that the costs of bus fares could be an important barrier to attending the hub for people who live further away. (Physical Opportunity, Barrier)

Participants' ideas for interventions that could address some of the problems included:

- Referral to FSN by housing officer - Participants believed that at the point of being housed in TA, the housing officer should point families in the direction of the TA Hub as this is potentially a time when families need the support the most.

> "I don't even know if [housing officers] know about [the TA Hub] because I don't think they're even bothered about looking into it but if a housing officer told me about [the TA Hub] I'd come sooner

because I'd know about it as soon as I was going into that temporary accommodation"

- Promotion through social media - Participants suggested that promoting the TA Hub through social media sites like Facebook and TikTok would increase uptake. In particular, they described how closed Facebook groups that target parents with children may be a useful place to advertise the hub.

The focus group discussion identified issues associated with the process of being referred to the TA hub and the impacts of that on parents' awareness and engagement with the service. Participants also highlighted factors that more broadly affected parents' ability to access the TA hub and their willingness to do, including a potential lack of clarity about what the service might be like, whether they might be judged and concerns about links to statutory services. Participants were keen for housing officers or other professionals to refer them to the TA hub as soon as they entered TA with additional communications about the services more widely available on social media.

Barriers and Facilitators to accessing the FSN TA Hub

Tables 11 and 12 show the full list of barriers/facilitators to attending the TA hub that were identified by parents in the focus group, professionals in workshop 1 and/or the rapid evidence review.

Table 12: Summarised barriers to attending the TA hub

Barrier	Parents	Professionals	Evidence review	COM Factor
Lack of knowledge about the existence OR content of the services i.e., what is being offered	X	-	X	Capability (Psychological)
Not having the physical ability and the interpersonal skills needed to access services e.g., literacy, confidence, life skills	X	-	X	Capability (Psychological)
Not receiving information about the hub at the right time/too late	X	-	-	Opportunity (Social)
Not being referred to the hub by housing officers	X	-	-	Opportunity (Social)
Social isolation due to living circumstances / not having anyone to attend with	X	X	X	Opportunity (Social)
Lack of time/ being too busy/ other life commitments	-	X	X	Opportunity (Environmental)
High mobility of families in temporary accommodation – cannot attend regularly or consistently	-	X	X	Opportunity (Environmental)
Service location – distance, cost, unsuitable public transport (bus) routes / times	X	X	X	Opportunity (Environmental)
Lack of financial means to travel to the hub (having to prioritise other basic family expenses)	X	X	-	Opportunity (Environmental)
Not having sufficiently good mental or physical health (parents or children) to access the services	-	X	X	Opportunity (Environmental)
Having a stressful life/poor mental health and well-being inc., stress, guilt, self-blame, shame, loss of self-esteem, uneasiness or fear	-	X	X	Motivation (Reflective)
Mistrust or fatigue associated with statutory services	X	X	X	Motivation (Reflective)
Perceived stigmatisation/ judgement from people around them and/or service providers – fears around safeguarding/interference from social services	X	X	X	Motivation (Reflective)
Perceived conflict between own parenting strategies and support offered by the services	-	-	X	Motivation (Reflective)
Not expecting the hub to be so friendly/expecting it to be more impersonal – negative expectations about what the hub will be like	X	-	-	Motivation (Reflective)
Concerns around privacy and confidentiality	X	X	X	Motivation (Reflective)
Dads not feeling comfortable/believing the hub is for mothers	X	-	-	Motivation (Reflective)
Beliefs about reasons for homelessness; reduced self-efficacy; reduced sense of agency/autonomy	-	-	X	Motivation (Reflective)
Post-COVID-19 concerns around socialising	-	X	-	Motivation (automatic)
Shame associated with using support services associated with homelessness	-	X	X	Motivation (automatic)

Table 13: Summarised facilitators to attending the TA hub

Facilitator	Parents	Professionals	Evidence Review	COM Factor
Providing information about a range of services	X	X	X	Opportunity (Environmental)
Practical support to attend e.g., assisting with travel arrangements/childcare	X	X	X	Opportunity (Environmental)
Appropriate timing of and length of sessions	X	-	X	Opportunity (Environmental)
Flexibility: drop-in, same-day, responsive support	X	X	X	Opportunity (Environmental)
Formal and informal sessions – including fun, hands-on sessions	X	X	X	Opportunity (Environmental)
Service location – positive thoughts about the TA; reassurance about privacy	X	-	X	Opportunity (Environmental)
Language support, interpretation, translation for non-English speakers	X	-	X	Opportunity (Environmental)
Complementary virtual information and support resources (inc. social media promotion)	X	X	-	Opportunity (Environmental)
Accessible, timely communications and messaging about the service	X	X	X	Opportunity (Environmental)
Materials to support families with navigating local services – especially if new to the area	X	X	X	Opportunity (Environmental)
Open Days/Information Days	-	X	-	Opportunity (Environmental)
Introducing community service navigation advisors to aid and direct families to information and support	-	X	X	Opportunity (Social)
Group sessions	X	X	X	Opportunity (Social)
Face-to-face conversations to build trust	X	X	-	Opportunity (Social)
Peer-led programmes / peer facilitators – trust, inspiration/optimism	X	X	X	Opportunity (Social)
Buddying/ attending with another parent	-	X	X	Opportunity (Social)
Word of mouth between families in TA	X	X	X	Opportunity (Social)
Referrals from professionals e.g., health visiting team	X	X	X	Opportunity (Social)
Promotion via linked services / organisations	X	X	-	Opportunity (Social)
Promotion via the TA provider e.g., noticeboards	-	X	-	Opportunity (Social)
Perception of community/support network – having links to others	X	-	X	Opportunity (Social)
Confidentiality and perceived safety	X	-	X	Motivation (Reflective)
Having a role/identity as a good parent	-	-	X	Motivation (Reflective)
Beliefs that the content of an intervention is tailored to the specific needs of families in TA	X	X	-	Motivation (Reflective)
Staff making parents feel comfortable – not feeling 'judged'	X	X	-	Motivation (Reflective)

Co-designing the intervention

Workshop 2

Co-design workshop 2 was held with parents living in TA and aimed to:

- Revisit and prioritise the barriers/facilitators identified in the focus group according to which participants felt were most likely to affect uptake and engagement with the TA hub.
- Generate ideas for improving parents' "journeys" to the TA hub.
- Explore in more depth some of the suggestions for outreach made by parents in the focus group.

Participants

Workshop 2 was attended by two parents who lived in TA.[9] Participants were both White British, single and had one child.

Outcomes

The findings from the focus group were discussed and the barriers and facilitators were prioritised by participants. The 'journey' to the TA hub (i.e., how they came to know about it, and the process of engaging with it) was mapped out and strategies to improve that journey were discussed. Participants also fed back on the outreach ideas that had been identified by FSN and input into the development of the future interventions.

Benefits of the TA hub

The potential benefits to parents of attending the TA hub that had been identified by parents in the focus group were revisited and participants were asked to highlight up to 5 factors that they felt were the most important to communicate to parents living in TA, to persuade them to attend. The benefits that were highlighted by parents converged into three key themes. First, that the hub is a welcoming, friendly and supportive space. Second, that the hub provides practical facilities (e.g., free laundry and cooking facilities) and specific support and advice (e.g., support with benefits and housing paperwork). Third, that the hub provides an opportunity to meet and receive support from others.

Journeys to the TA hub

Participants discussed how they would like to hear about the hub via social media (e.g., TikTok, Facebook), via referrals from housing officers and via other community groups in Hastings targeted at vulnerable families (e.g., church playgroups and food banks).

[9] It was challenging to recruit parents living in TA to participate in this workshop, which reflects the challenges of engaging with this target population, many of whom have competing priorities. Five parents had volunteered to participate but three were unable to attend on the day due to unforeseen circumstances.

Participants wanted communications and messages about the hub to include benefits of attending the hub that are relevant for parents, information about where, when, and how to access it (and that it is free service), and reassurance that the hub offers a safe and supportive space that is not run by social services.

Developing ideas for outreach further

Working with FSN staff, participants discussed how ideas put forward during the previous focus group discussion might work in practice.

1. Use of social media - Younger parents in both the focus group and this workshop particularly felt that there needed to be an increased social media presence about the TA hub, as this was a key place where parents would be likely to see information and develop opinions about it.
2. Promotion via schools and nurseries - Participants discussed that schools could be a key place to identify parents living in TA, however, there was also some discussion about the risk of stigma and shame associated with being 'singled out' at the school as a parent living in TA and this would need to be delivered very sensitively.
3. Ensuring parents know that the hub is safe and non-judgemental - Participants discussed how important it was that professionals making referrals to the TA hub highlighted that it was run by an independent charity, and that parents who had previously attended the hub could play a role in providing reassurance, acting as peer champions or ambassadors. Videos or testimonials were highlighted as an opportunity to convey this message.
4. Receiving timely information about the hub - Participants thought that getting a formal referral by their housing officer, or other local professionals and services working with the family was key to ensuring that parents knew about the hub as early as possible.

Workshop 3

Co-design workshop 3 was run with parents and professionals, and aimed to:

- Review the evidence gathered so far on the barriers and facilitators to accessing the TA hub.
- Prioritise – what barriers and facilitators can be addressed in this intervention?
- Review whether the interventions suggested by different stakeholders would sufficiently overcome the barriers to accessing and engaging with the TA hub.
- Develop and agree the intervention.

Participants

Three parents (aged between 19 and 40) attended the workshop. Participants had between 1 and 4 children, and one was from an ethnic minority group. One participant was employed and the other two unemployed.

Workshop 3 was also attended by the FSN Chief Executive, FSN TA Hub Manager and FSN support worker, two representatives from East Sussex County Council, one representative from Eastbourne and Lewes Councils, and TA team leader for Hastings Borough Council.

Outcomes

Barriers and facilitators identified in workshops 1 and 2 and the focus group were reframed in terms of needs, for example “cost of transport” as a barrier became “parents need accessible/affordable transport options”. These were discussed in the context of the APEASE criteria and were used to guide what should be addressed within this intervention.

Various ideas for an intervention were then discussed, based on suggestions from parents in the focus group and workshop 2. These ideas were considered in the context of how they might work for different personas representing different types of parents.

Intervention specification

The intervention targets two behaviours in two target groups at different layers of the system:

1. Effective referrals to the TA hub by relevant professionals, such as housing officers.
2. Parents in TA accessing the TA hub.

The interventions are described in full in the following protocol.

Co-designing the evaluation

Workshop 4

In workshop 4, a logic model (Figure 4) for the agreed intervention was developed, identifying the inputs required and roles and responsibilities for those inputs between the SHU research team, FSN and other stakeholders, and deciding what short-term outcomes could be evaluated given logistics and available data.

This workshop aimed to:

- Review the agreed intervention and discuss practicalities around planning and implementation.
- Develop a logic model.
- Develop an evaluation research protocol.

Participants

Workshop 4 was attended by the project lead and two key stakeholders from FSN, one representative from the TA team at Hastings Borough Council and one from East Sussex County Council.

Evaluation protocol for the FSN initiative: Uptake of TA hub services by families living in temporary accommodation

Research questions

Primary questions

RQ1: Does behavioural science-informed training for professionals working with parents in TA increase their referrals to the TA Hub at FSN?

RQ2: Do increased referrals to the TA Hub by professionals working with families living in TA result in more parents attending the TA Hub?

RQ3: Do online images/parent video testimonials increase parents' uptake of the TA hub?

Secondary questions

RQ4: What are professionals' perspectives on completing the referral training?

RQ5: What do parents living in TA think about the online parent testimonials/images of the hub?

RQ6: Does the intervention increase parents' capability, opportunity and/or motivation to attend the TA hub?

RQ7: Does the intervention increase professionals' capability, opportunity and/or motivation to refer parents living in TA to the TA hub?

RQ8: Does the intervention result in increased intentions to access other local family hub services?

Intervention

The planned intervention has two components:

Brief, online behavioural science-informed training for professionals working with families living in TA in Hastings who could refer into the TA hub service. It will address:

- Capability i.e., education to increase knowledge about the hub and its offer, and training on how to include conversations about the hub with all families moving into or living in TA.
- Opportunity i.e., appropriate resources to help signpost and inform families about the services on offer.
- Motivation i.e., education and persuasion about the value of the hub services to meet the needs of families living in TA.

The training will be delivered via a brief online video to facilitate flexibility in delivery to fit in with the busy and varied schedules of the professionals working with families in TA. Professionals targeted with the training will include housing officers, social workers, health visitors, employment advisors, advice caseworkers and social prescribers.

Parent-facing materials

Parent-facing materials will include video testimonials from different parents talking about why they visit the hub and why they would encourage others to do so. The materials will be distributed to parents during referral conversations and via social media.

The materials will address:

- Capability i.e., education to increase knowledge about the hub and its offer.
- Opportunity i.e., access to information from other families who have used the hub services in the past.
- Motivation i.e., education and persuasion about the value of the hub services to meet the needs of families living in temporary accommodation.

Figure 4 presents a logic model for the intervention.

Figure 4: Fellowship of St Nicholas Logic model

Inputs	Activities	Target group	Short-term outcomes	Medium- and long-term outcomes
FSN team creating video of hub and hub users FSN service users being filmed for videos SHU team advising on content for parent-facing video	Professionals who can refer to TA hub trained to change the way in which they refer Parents provided with videos of other service users talking about the service offered and why they like it	Local professionals working with parents living in TA, including housing officers, TA officers, health visitors, early help keyworkers, FSN staff from other projects, Eastbourne food bank, ESTAR, CAB, Jobcentre+, local housing associations, EYP family hubs. Families/parents living in temporary accommodation in Hastings.	**Professionals** Increased motivation to make referrals to the TA hub Increased knowledge and plans to make referrals Increased referrals to the TA hub **Parents** Increased knowledge about the TA bub and services offered Increased motivation, confidence and reduced concerns about accessing TA hub Increased social opportunity to access the hub Increased parental attendance at the TA hub Increased signposting to other family hub services Greater intentions to use other family hub services	**Medium-term** Improved parental self-esteem and confidence Increased parental knowledge of other services Earlier identification of needs Increased sign-ups/use of related family hub services in Hastings Homelessness Outcomes Star **Long-term** Children and parents protected against the most severe negative impacts of living in TA e.g. mental health problems, child behavioural or development problems, physical health issues

Methodology

The methodology comprises 3 distinct phases:

1. Evaluation survey of referrer training

The training will be made available online embedded into a Qualtrics survey. A link and instructions will be sent to professionals by email, and they will be invited to complete it at their convenience. The number of professionals completing the training and in which service they work (e.g., housing officer, health visitor etc.) will be recorded. The Qualtrics survey will include closed questions after the video to explore the trainee's capability, opportunity and motivation to have discussions/refer into the hub service and open-ended questions where they can provide further detail about both their experience of the training and of the hub service and their referrals into it. Trainees will be invited to provide their email address to receive a further short survey at the end of the intervention to explore how their practices changed/whether the changes have been maintained. (RQ4)

2. Quantitative analysis of data collected by FSN

The following quantitative data will be collected, anonymised and shared with the SHU team using a secure method of data transfer. No personal data will be shared.

- Number of referrals received by FSN before and after the intervention is rolled out (RQ1)
- Number of parents who are referred and subsequently attend the TA hub before and after the intervention is rolled out (RQs2 and 3)
- This will include data on date of referral, who is making the referral, details of person being referred including age, languages spoken, number and ages of children, disabilities and ethnicity. FSN will provide an anonymised summary of referrals received (no personally identifiable details will be shared).
- Number of referrals/signposting recommendations made to other family hubs services and/or other local organisations providing support for families living in TA.

3. Interview study with qualitative analysis

Interviews with 8-10 parents who are referred following the training and given access to information about the hub. The interviews will explore parents' experiences of their referral, and the reasons why they accessed or did not access the TA hub following

a referral. Perspectives on the video about the TA hub and intentions to use wider FH services will also be explored (RQs 2-8)

Participants

Participants for the training component will be staff and organisations who could potentially make referrals to the TA hub. These include: Health visitors; Housing officers from Hasting Borough Council; Early Help keyworkers; FSN staff from other projects (5 across the region) including nurseries; Rother Borough Council Housing staff; Citizens Advice Bureau staff; Food bank (Eastbourne) staff; Early years practitioners from Eastbourne and Hastings family hubs; Job Centre Plus; Salvation Army Housing Association support workers.

Participants for the interviews will be parents of children who are living in TA in the Hastings area and who are referred to the FSN hub. Those who attend and do not attend the hub following this referral will be included.

Recruitment

FSN will cascade the link to the online training/survey via emails, newsletters and other communications. Professionals will be asked to complete the training within one month (although they can continue to access it beyond this period). A participant information sheet will form the first page of the online survey and will explain that there are two parts: i) the training video; ii) a short optional survey following the video. Participants will be asked to consent to completion of the survey online and their response recorded.

A purposive sample of parents who have been referred to the TA hub will be invited to take part in an interview. FSN will contact parents via email/text message and invite them to contact SHU directly if they would consider taking part in an interview either online or via telephone. Participants with different characteristics will be recruited including whether they accessed the TA hub following referral or not, age, number and age of children, and ethnicity.

Expected Outcomes

There are four main expected outcomes from this research project:

- An understanding of the effect of the intervention to increase and improve referrals on uptake of the FSN TA hub.
- An understanding of how the training is received by professionals who can refer to the service.

- An understanding of the acceptability of the intervention for parents living in temporary accommodation and of any additional barriers and facilitators to uptake of the family service that are not addressed by the intervention.
- An understanding of parents' intentions to use other local services including local family hub services.

Sheffield City Council

The original Theory of Change for Sheffield City Council (SCC) was based on increasing uptake of childhood vaccinations. As the primary goal of this work programme is to evaluate what works to increase uptake of family hub services, the project was rescoped to better meet these research objectives. This project focused on increasing uptake of infant feeding services delivered within Sheffield family hubs amongst young mothers, particularly those living in deprived areas. In this section and for brevity, the phrase 'young mothers' is used to refer to young mothers in Sheffield, particularly those living in areas of deprivation.

Background

The benefits of breastfeeding for both mother and baby are well established. Benefits for baby include reduced risk of infections, diarrhoea and vomiting, and obesity (NHS, 2023; Victoria et al., 2016). Benefits for mothers include reduced risk of breast cancer, ovarian cancer, and type 2 diabetes (NHS, 2023). The World Health Organisation (WHO) recommends exclusive breastfeeding for the first 6 months (World Health Organization, 2021). However, breastfeeding rates in the UK are low (UNICEF, n.d.). The 2010 UK-wide infant feeding survey reported that only 1 in 100 mothers exclusively breastfed for the first six months of a baby's life (McAndrew et al., 2012). Breastfeeding rates vary among different population groups, with higher incidences of breastfeeding found among mothers aged 30 or over, minority ethnic groups, and those living in the least deprived areas (McAndrew et al., 2012).

Context

SCC have been awarded trailblazer status to become a national leader for the family hubs and start for life programme (Department for Education and Department of Health and Social Care, 2023). Sheffield's family hub and Start for Life Services span seven hubs across all areas of Sheffield and provide a wide range of help and support for expectant parents, babies, children, and their families, including:

- The Sheffield Volunteer Doula programme – one-on-one practical and emotional support for vulnerable pregnant women from around 34 weeks of pregnancy.
- Preparation for birth and beyond – a 5-week antenatal course aimed at first time pregnant women who are between 28 and 34 weeks pregnant.
- New you, New Me baby group – a 6-week group for parents of young babies.

- Baby massage – opportunities to learn baby massage techniques online and across family hub venues.
- Baby and toddler workshops – sessions include my baby and toddler senses, music sessions, low-cost play, and story sessions.
- Weaning online seminars – information, support, and advice on when to wean your baby and how,

Target service

Sheffield Start for Life Services and family hubs offer a wide range of support for all aspects of infant feeding including:

- Infant feeding peer support – a dedicated team who work closely with midwifes and health visitors to provide information and support to expectant mothers and those who have recently given birth, about all aspects of feeding and bonding with their baby.
- Breastfeeding groups – friendly and informal groups who provide information and support around breastfeeding available online and in family hub community venues and network sites across Sheffield.

Evidence review

This review aimed to address the following research question:

1. What is currently known about the barriers and/or facilitators to young mothers living in areas of deprivation from accessing breastfeeding/infant feeding support services in community settings?

Findings

A total of 8 articles were included in the final review.

Summary of findings

The data presented in this review is based upon research conducted in the UK (n = 6) and USA (n = 1; note that this paper also presented data from Chile). Data from a review article which included data from countries across the world was also reviewed. The majority of research in this review focused upon breastfeeding support services and only one study explored infant feeding support services, more generally.

Psychological Capability

A lack of knowledge about the services available is a key barrier for young mothers signing up to breastfeeding support services. Research suggests that breastfeeding support groups are not well advertised, and so young mothers have little to no knowledge about these support groups and programmes (Bengough et al., 2022; Watson et al., 2014). Some research highlighted how parents may lack the memory, attention, and decision processes to engage in services. For example, some young and vulnerable mothers may not have the mental capacity to engage with services due to coping with wider issues such as food insecurity and a lack of social support (Hunt et al., 2022). However, providing regular reminders from breastfeeding peer supporters and/or healthcare professionals (i.e., text messages or phone calls 48 hours before) may facilitate uptake (Hunt et al., 2021).

Physical Opportunity

A lack of accessible information and communications about the services were key barriers to uptake. One study highlighted a lack of access to information early on and a lack of signposting from healthcare professionals (Watson et al., 2014). There can also be practical and cost barriers to accessing services, with many young mothers suggesting that they were less likely to travel to a group outside their locality given poor transport links (Watson et al., 2014), and that perceived costs of getting to the group acted as a barrier to accessing support groups (Bengough et al., 2022). Services that facilitated a friendly and comfortable environment mitigated any preconceived uncertainty (Andrews, Symon & Anderson, 2015) and this was a physical opportunity facilitator to engagement with services.

A lack of specific advice or content provided within the service was identified as a potential barrier to engagement (Watson et al., 2014), whereas, if the service facilitated a stress-free environment (Bengough et al., 2022) or focused on building connections between mother and baby rather than solely on breastfeeding, then these factors seemed to facilitate mothers' engagement (Watson et al., 2014). Furthermore, service accessibility was identified as both a barrier and facilitator to uptake and engagement. Some research highlighted how the suitability of the venue is often a barrier to uptake for mothers (Watson et al., 2014), with some studies reporting how multiple locations, availability of sessions and flexibility of how and when sessions are run are all key facilitators to uptake and continued engagement with services (Bengough et al., 2022; Watson et al., 2014).

Social Opportunity

A barrier to uptake was having unsupportive family members, with some young mothers reporting that they do not access services due to family members being

unsupportive of breastfeeding (Hunt et al., 2022). Cultural norms surrounding breastfeeding in public were identified as being both a barrier and facilitator to uptake and engagement. One study identified that engagement in breastfeeding support services for ethnic minority mothers is low and one reason for this is that women are not allowed to breastfeed in public in certain cultures (Watson et al., 2014). Another aspect of social opportunity that may act as both a barrier and facilitator to uptake of services is mothers' initial access to support services. For example, having a supportive and strong partnership with healthcare professionals who recommend the services is identified as a key facilitator as they provide you with the information relevant to access services (Hunt et al., 2021; Fox, McMullen & Newburn, 2015) but equally if this relationship is not present then this may be a key barrier for uptake.

The service provider having personal experiences of breastfeeding and/or infant feeding was considered a facilitator to uptake and engagement. Shared experience was highly valued by mothers and made them more receptive to the content being delivered (Bengough et al., 2022). Other facilitators identified were having supportive social contact, as many mothers experienced loneliness so the support services provided an opportunity to create new friendships and a place where breastfeeding knowledge and experiences can be shared (Fox, McMullen and Newburn, 2015), suggesting that services are not simply just a source of information but also provide a support network.

Reflective Motivation

Many young mothers did not feel confident accessing services due to their age and feeling like they are being judged by other mothers (Fox, McMullen and Newburn, 2015), and this acted as a barrier to uptake of services. Other barriers impacting on engagement are feelings of uncertainty and nervousness (i.e., not knowing the type of environment or group of people that they will be arriving to) about what to expect if they attend the service (Bengough et al., 2022; Fox, McMullen and Newburn, 2015). Another factor that was identified as a potential barrier and/or facilitator to uptake was intention to access services. Some mothers had the intention or goal to breastfeed so would actively want to access a service, however for those mothers who did not have the intention to attend a service and/or goal to breastfeed then this acts as a barrier to accessing support services (Watson et al., 2014).

Automatic Motivation

Positive experiences from attending services reinforced mothers' motivation to engage with those support services. One study identified that mothers thought breastfeeding and infant feeding groups provided a source of information and support, created an opportunity to meet others and develop a social network, helped

build confidence, and helped them find techniques to overcome challenges (Watson et al., 2014). Other positive experiences included: a source of information and instrumental help for less severe issues that do not warrant professional help, creating safe places to practice breastfeeding skills, and an opportunity to talk about own and other people's embarrassment and emotional status (Bengough et al., 2022). However, negative experiences from attending services could be a barrier to future engagement with those services. This included perceiving peer pressure to breastfeed. One study reported that mothers describe antenatal breastfeeding support content as 'prescriptive' and they often feel like they might be 'bulldozed' into breastfeeding (Watson et al., 2014) and this was a barrier to future engagement.

Conclusion

Key things that young mothers need in order to access and engage with infant feeding support services include:

- Knowledge about the services available and how to access them (Psychological capability).
- Access to timely information during and after pregnancy about the support on offer (Physical opportunity).
- Having the resources to access services (Physical opportunity).
- Access to services that are delivered in a friendly, supportive environment (with flexibility) which focus on wider issues around caring for a baby (Physical/ social opportunity).
- Access to support from others to access and engage with the services (Social opportunity).
- No peer pressure/fear of judgement (Reflective motivation).
- Having intentions to breastfeed (Reflective motivation).
- Having positive experiences from attending services (Automatic motivation).

Co-designing the theory of change

Workshop 1

Workshop 1 aimed to:

a) Explore the nature of infant feeding support services delivered in Sheffield family hubs.

b) Establish why an initiative to increase uptake of infant feeding support services is needed and for whom.

c) Explore what has already been done, or planned for the future, to support uptake of infant feeding services among the target population group.

d) Explore stakeholder understanding of possible barriers and facilitators to uptake of infant feeding support services among the target population group.

Participants

In total, 11 professional stakeholders attended Workshop 1, with representation from Sheffield's family hubs and linked NHS services, including infant feeding support teams, youth workers, new parenting practitioners, and midwifery.

Findings

Defining the nature of infant feeding support services in Sheffield Family Hubs

The benefits of breastfeeding are well established (Victora et al., 2016) and the World Health Organisation recommends that infants are exclusively breastfed for the first six months of life (WHO, 2021). However, the UK has some of the lowest breastfeeding rates worldwide, with 80% of women stopping breastfeeding before they want to (UNICEF, n.d). The factors that influence early breastfeeding discontinuation are complex, with some socio-demographic factors (e.g., younger age, white ethnicity, area deprivation) associated with early breastfeeding cessation (Oakley et al., 2014).

Sheffield family hubs and Early Years Services offer a wide range of services to support breastfeeding and wider aspects of infant feeding. They have a dedicated infant feeding support team who work closely with Midwifery and Health Visiting teams and community organisations across the city, to provide information and support to families and parents with all aspects of feeding, caring, and bonding with their baby. Breastfeeding support groups are available, which are delivered by trained infant feeding support workers and available online or in local family hub centres across Sheffield. The delivery of infant feeding support is flexible, including individual or group sessions delivered in family hubs or their outreach sites, and support delivered online, by telephone or WhatsApp groups. The main route into the service is antenatally - the infant feeding support team typically contact expectant mothers around 32 weeks pregnant, using information from Sheffield Teaching Hospitals NHS Foundation Trust. Mothers are contacted twice by telephone and once by text message, to encourage registration with Sheffield family hubs.

Defining the target population

Within Sheffield family hubs and Early Years Services, there is a priority among stakeholders to support uptake of infant feeding services among younger mothers (aged 25 years and younger), especially those living in deprived areas (as defined by IDACI) in Sheffield (e.g. areas in the North of the City). Based on their experience, younger mothers are less likely to answer the phone and register with Sheffield family hubs when they are contacted by the infant feeding support team and are less likely to access and engage with the services on offer.

Exploring what has already been done, or planned for the future, to support uptake of infant feeding support services among the target population group

Currently Sheffield family hubs are not specifically targeting younger mothers. Regardless of age, all mothers receive the same phone calls and text messages from the infant feeding support team, and there are no infant feeding or breastfeeding support services or resources specifically tailored for younger mothers.

Perceived barriers/facilitators from professional perspectives

Professionals highlighted a range of capability, opportunity, and motivational barriers (B) and facilitators (F) that they believed were relevant to uptake of infant feeding support services among young mothers.

Psychological capability

- A lack of knowledge about the services available in Sheffield family hubs (what they are, what they offer, where they are, and who will be there) (B)
- A lack of knowledge that services provide support for all aspects of feeding, caring, and bonding with their baby, not just breastfeeding (B)

Physical opportunity

- No services or resources specifically for younger mothers (B)
- Young mothers are not contacted in ways that are suitable and preferred by them (B)
- Young mothers dislike being contacted by telephone (B)
- Poor liaison between different professionals and stretched services (i.e., services may not always know about these young mothers) (B)
- Lack of resources to be able to access the services (financial resources, transport) (B)

- The timings of the groups or services may be at inconvenient times (B)
- Language barriers (B)
- Access to information about infant feeding support as early as possible in pregnancy (F)
- Access to information about infant feeding support using different modes of delivery and formats that are suitable for young mothers (e.g., promoting the service on social media and newsletters) (F)
- Promoting infant feeding support services at community events and at schools (F)
- Access to young mum-specific and tailored information (e.g., ensuring young mothers are represented within the resources) (F)
- Offering access to other types of support, alongside infant feeding support (F)
- Offer groups just for young mothers (and advertise this) (F)
- Tailor the timing of the sessions (F)

Social opportunity

- Peer or family pressure or discouragement (B)
- Have more young staff delivering the services (F)
- Provide mothers with recommendations from people who attend the service (F)
- Staff need to support young mothers to access the service (i.e., staff need to talk to young mothers about how to get to the centre, offer to meet people for a chat and show them the centre beforehand, and have a dedicated person or team to build relationships with mothers and wider professionals) (F)
- Normalise breastfeeding (e.g., talk to young mothers about people they know or famous people who breastfeed and talk about breastfeeding in public) (F)
- Ensure mothers are able to attend services with a friend or family member (F)

Reflective motivation

- A lack of perceived need for support (B)
- Fear of judgment from others, especially from older mothers (B)
- Worries about being the ‘odd one out’ if they attend services (B)
- Lacking confidence, feeling embarrassed, or self-conscious (B)

- Fear of being pushed or pressured to breastfeed (B)
- Mistrust of services and feeling isolated from services (B)
- Lack of willingness to access services (B)
- Post-COVID-19 concerns about leaving the house and infection risk (B)
- Avoid feelings of pressure (F)

Automatic motivation

- Offer incentives like free lunch or snacks, or reduced transport costs (F)

Behavioural science insights: Co-design workshop

Workshop 2

Workshop 2 aimed to:

a) Explore what young mothers know about infant feeding support services in Sheffield.

b) Allow sharing of ideas for how young mothers would like to find out about infant feeding support services.

c) Explore what gets in the way, and what would help, young mothers to access infant feeding services.

Participants

In total, two female participants in their early twenties attended Workshop 2[10]. Both were from the North of Sheffield, had a young baby, and one participant was from a minority ethnic group.

Outcomes

Participants ideas about the barriers and facilitators to uptake of infant feeding services were:

Psychological capability facilitators

- Having knowledge about where to go to get in-person, face-to-face support.

[10] It was challenging to recruit young mothers to participate in this workshop, which reflects the challenges of engaging with this target population. It is acknowledged that the participants recruited might not reflect common ideas about the barriers and facilitators to uptake of infant feeding services.

- Knowing that the services are free.
- Knowing that infant feeding support isn't just about breastfeeding.

Psychological capability barriers

- Having (incorrect) knowledge that services provide support mainly for breastfeeding, rather than wider aspects of infant feeding.
- A lack of knowledge about the range of support on offer and whether it matches their needs and would benefit them.

Physical capability barriers

- Travelling to support services can be practically and physically challenging as a new mum.

Physical opportunity facilitators

- Receiving information and support about infant feeding and the services on offer during pregnancy.
- Receiving information about infant feeding support using different modes of delivery and formats suitable for younger mothers (e.g., email, text message, social media platforms). Receiving information about infant feeding support at local locations where young mothers may go such as universities, Libraries, Playcentres, Baby groups.
- Adverts and services need to be suitable for people who do not speak English.
- Promote the service using posters and leaflets (for those without digital access).
- Messaging and communications about the service need to include other forms of feeding (other than breastfeeding) and advertise the support on offer.
- Having access to infant feeding support that is delivered in-person, in a physical location.
- Having access to infant feeding support that is delivered with flexibility (e.g., offering video calls or community drop-in sessions).
- Offer in-person groups and services just for young mothers.
- Offer other services alongside infant feeding support and ensure that services focus on the mum's well-being, as well baby's well-being.
- Services need to provide bottle feeding support groups, as well as breastfeeding support groups.

- Ensure that services are in an easily accessible venue for all young mothers, for example, in a Sheffield City Centre location.

Social opportunity facilitators

- Offer young mothers the opportunity to bring someone else such as their partner with them to the service if they are not comfortable attending alone (and advertising that).

Physical opportunity barriers

- Receiving information and support about infant feeding and the services on offer after giving birth.
- Dislike being contacted by telephone (e.g., it is inconvenient when you have a newborn).
- Difficulty finding and accessing information about infant feeding support services.
- Too many appointments in the new-born period.
- Lack of time to travel to services.
- Lack of available transport to get to the services.

Social opportunity barriers

- Experiencing pressure from family to adopt the same infant feeding practices as their parents.
- Experiencing pressure from their family to access infant feeding support services.

Reflective motivation facilitators

- Wanting information and support with all aspects of infant feeding (i.e., how to feed on your lap, how to burp baby, latching, pumping, how much to feed).
- Avoiding fear of judgement by older mothers.
- New mothers need a reason to leave the house (e.g., wanting to make friends with other mothers and for their baby to meet other babies).
- Avoid feelings of pressure to breastfeed.

Reflective motivation barriers

- Lack of perceived need to access services if the young mum is not breastfeeding.
- Feeling pushed or pressured to breastfeed.
- Feeling stigmatised about not knowing how to take care of their baby.

- Being worried about asking for help.
- Fear of judgement from others, especially if they choose not to breastfeed.

Participants were asked what they thought were the most important barriers to uptake of infant feeding support services among young mothers. These were:

- A lack of information about the services and support on offer, e.g., that infant feeding support is not just about breastfeeding (psychological capability/ physical opportunity barrier).
- A lack of information about how to access that support (psychological capability/physical opportunity barrier).
- Not being able to travel to the service (physical opportunity barrier).
- Fear of judgement from others if they are not breastfeeding which is further compounded by how information about infant feeding services is about breastfeeding (reflective motivation barrier).

Participants were asked what they thought would be the most important things that would help young mothers to access infant feeding support services. These were:

- Services need to provide groups specifically for younger mothers (aged 18 – 24 years) (physical opportunity facilitator).
- Young mothers need support from other people, such as their partner, to help them find out and access the support available (social opportunity facilitator).
- Young mothers want to meet other young mothers and have the opportunity to do fun activities with their baby (reflective motivation facilitator).

Behavioural science insights: Focus group

Professional stakeholders in workshop 1 and young mothers in workshop 2 both discussed the need for a young-mum specific infant feeding support service or group. During informal discussions between SHU and SCC, the feasibility of developing and evaluating this type of new service was explored and SCC discussed how a new young-mum specific service (with associated messages and communications to promote and advertise the new service) would be something that they could feasibly implement and evaluate within the timeframe of this project, and they had the necessary resources to do so. This preliminary intervention idea was explored in a focus group with young mothers.

The aims of this focus group were to explore:

a) The barriers and facilitators to accessing infant feeding support services among young mothers in Sheffield.

b) Whether a young mum-specific service (and associated messaging to promote the new service) could be effective in promoting facilitators and overcoming barriers to accessing infant feeding support for young mothers.

Method

Participants

In total, three participants attended the focus group[11]. Participants were aged between 18 and 25, with two aged 18 years of age. One participant was from a minority ethnic group. One participant reported that they had not accessed any infant feeding support, one participant had accessed a breastfeeding group, and one participant had accessed infant feeding support at their local family hub.

Findings

Psychological capability facilitators

- Knowing about infant feeding support - Participants discussed having some awareness of infant feeding support services. One participant discussed how they had first heard about infant feeding support while they were in hospital, and they were aware of (and had accessed) local family hubs.

> "[The hospital] had… an infant feeding support work[er] come round, obviously to help with feeding and figure out… what feeding you were going to do. But at my family centre…I know they've got…support workers there and… you can talk to them about feeding."

Psychological capability barriers

- Having limited awareness about Sheffield family hub services - Participants had limited awareness of services available within Sheffield family hubs.

Physical opportunity facilitators

- Having access to a young-mum specific service - All participants were interested in attending a young mum specific service if it was easily

[11] It was challenging to recruit young mothers to participate in this focus groups, which reflects the challenges of engaging with this target population. It is acknowledged that the participants recruited might not reflect common ideas about the barriers and facilitators to uptake of infant feeding services, or their viewpoints about whether a young-mum specific services could be effective.

accessible (for example, if it was held in a central city location). Some discussed how the service should cover all aspects of infant feeding and provide wider support for caring for a newborn plus opportunities to meet and connect with other young mothers.

> "…there should be, like, a young mothers', like, group that could meet up in the city centre…and then have access from that young mum group to other things like infant feeding groups and other things like baby massage. But all, like, in the same place, like, in the city centre so they're all easy to access."

- Provide information about infant feeding support during pregnancy - Some discussed how they had first heard about the services and support on offer after they had given birth. However, they believed it would have been more helpful if they had first heard about the services during their pregnancy, for example from midwives or within NCT classes.

> "I think midwives are a great source of information for that. And starting it when you're pregnant as well really helps too…"

- Provide information about infant feeding support using different modes of delivery suitable for younger mothers - Participants discussed how they would like to receive information about the services and support on offer. This included text messages, emails, WhatsApp messages, and on social media platforms used by younger mothers (i.e., Instagram). Some suggested that text message would be preferable as they did not regularly check emails.
- Provide information about infant feeding support in colleges and schools – Participants suggested that information about the services and support on offer need to be shared in schools and colleges so young mothers can be signposted to the support on offer.
- Information about infant feeding support needs to be brief and enticing for younger mothers - Some discussed how messages need to be brief, bold, and enticing for younger mothers. Messages need to avoid being too lengthy in content or text heavy.
- Having access to free infant feeding support – Participants suggested that services need to be free (and should be advertised as such).
- Having access to confidential infant feeding support - Some discussed how services need to provide confidential support (and needs to be advertised as such). Some would not want family or friends to know that they have accessed support.

- Infant feeding support services need to be easily accessible - Participants suggested that services need to be in a local venue within walking distance of their house, or in an easily accessible central location, such as in Sheffield city centre.
- Having access to infant feeding support that is delivered in person and online - Participants discussed how services need to provide both in-person and online support.

Physical opportunity barriers

- Lack of information provided about infant feeding support - Some first heard about infant feeding services after having their baby and reported receiving a lack of information about the support on offer.
- Difficulty in accessing information about infant feeding support - Some discussed the challenges with finding out about the services and support on offer within Sheffield family hubs. One participant reported how their midwife had advised them to use Facebook to find support groups, but that they had found it difficult to find any information on the services available in their local family hub.
- Lack of comfortable facilities provided within breastfeeding support groups - Some discussed how breastfeeding groups do not provide comfortable facilities and resources, such as breastfeeding pillows, comfortable chairs, or feeding clothes, which can make it difficult to breastfeed.

Social opportunity barriers

- Not knowing any young mothers who have accessed infant feeding support - Some discussed how they don't know other young mothers like them, and therefore haven't spoken to other mothers their age to know whether and where they are accessing information or support.

> "And also, because I haven't really, like, spoken to any, like, mums that are my age or anything like that or new mums that are my age, it's not like I can converse with them to, like, see who they've been with or, like, get information off them. So it's kind of difficult…"

Reflective motivation facilitators

- Wanting to breastfeed - One participant discussed how they wanted to breastfeed but couldn't access information and support so swapped to mixed feeding (combining breastfeeding and bottle feeding).

- Wanting support with infant feeding - Some discussed how they wanted support with infant feeding, as they were struggling with feeding and knowing how much to feed their baby. Others wanted to access support to help with new experiences and to take the weight of being a new mum off their shoulders.
- Believing that infant feeding support services are for everyone – Some discussed how services need to be promoted as offering inclusive and unpressured support. Mothers need to believe that the services are of value and benefit to them and their baby, even if they do not feel that they need support with infant feeding.

    "… I think for somebody to be able to just say, like, oh, it's fine, even if you don't feel like you need support, still come along because you will learn things anyway."

- Wanting to get out of the house - One participant discussed how they accessed breastfeeding support groups to do something.

    "…So I went not really to access support specifically but just kind of leave the house."

- Wanting to meet other young mothers like them - Participants discussed how they wanted to access a young mum specific service, so they had the opportunity to meet and socialise with other young mothers like them.

    "…It's, like, really difficult to find, like, other mums. And then obviously I want my son to have, like, friends at, like, his age as well but then I want to be able to communicate with their mums as well…Even if they're from, like, other areas of Sheffield it's, like, nice and, like, if you did have…a support group of younger mums that are 18- to 20-something then you could have, like, a Whatsapp group chat as well so you could all keep in contact other than in the group as well."

- Willing to attend an easily accessible young mum-specific service covering all aspects of infant feeding, alongside wider issues around caring for a baby - All participants were interested in attending a young mum specific service that covered all aspects of infant feeding, alongside wider issues around caring for a baby. They discussed how they would feel more comfortable attending a young-mum specific group, and the service needs to be advertised as such. Group facilitators needed to be friendly, supportive, and non-discriminative.

Automatic motivation facilitators

- Having positive experiences from accessing breastfeeding support groups - One participant discussed how they felt more confident to keep breastfeeding after they had accessed the support group.

> "...it gave me a bit more confidence to keep breastfeeding because I think not a lot of young – I think it's quite unusual for a young mum to breastfeed..."

Reflective motivation barriers

- Feeling sceptical about infant feeding support - One participant (who had not accessed infant feeding support) was sceptical about accessing the services as they did not know whether the service was free or affordable and was uncertain about what the service offers.
- Fear of judgement from older mothers - Some discussed how they anticipated feeling intimidated if they attended a group or session with older mothers and they were fearful of being judged by others. For some, this worry had stopped them accessing services.

> "…Like at my family group as well, like a lot of people there, I have seen come in and out of it are a lot older than me. So it's like you feel like I don't know why but in my head I feel like if I was to go to one of these groups I feel like I'd get judged. But I think I would love to go to one because I feel like if I had gone to one as well I would have got the support I needed."

- Having concerns about using public transport to access infant feeding support - Some participants had concerns about the safety of using public transport to access services if their baby had not yet had their vaccinations. Others reported concerns about using public transport after having a C-section.

Summary

Participants would like more information about infant feeding services to be provided during pregnancy rather than after giving birth and they currently found it difficult to find information about the support on offer. Text messages were viewed as a useful way of getting in touch with young mothers, and services and support groups need to be promoted on social media platforms commonly used by younger mothers (e.g., Instagram). Ensuring that it was easy to get to services and support groups was a key concern for participants. Meanwhile, fear of judgement from older mothers was a barrier to accessing services; participants wanted the opportunity to meet and

socialise with other young mothers like them. All participants were willing and keen to access a free and confidential young-mum specific service. Such services should provide support for all aspects of infant feeding, alongside other aspects of caring for a newborn, delivered in an easily accessible city centre location by friendly, inclusive, and supportive facilitators.

Barriers and facilitators to accessing infant feeding support services

Tables 13 and 14 show the full list of summarised barriers to accessing infant feeding support services that were identified by young mothers in workshop 2 and in the focus group, professional stakeholders in workshop 1, and the rapid evidence review.

Table 14: Summarised barriers to accessing infant feeding support services

Barrier	Young mothers	Profes sionals	Evidence review	COM factor
Lack of knowledge about Sheffield Family Hub services	✓			Capability (Psychological)
Lack of knowledge/ awareness about the full range of infant feeding support on offer and how to access that support	✓	✓	✓	Capability (Psychological
Lack of mental capacity to engage with services due to coping with wider issues (i.e., food insecurity)			✓	Capability (Psychological
Difficulty travelling to infant feeding services as a new mum.	✓			Capability (Physical)
Content of information - lack of information about the range of infant feeding support on offer	✓			Opportunity (Environmental)
Access to information - difficulty finding and accessing information about infant feeding support	✓		✓	Opportunity (Environmental)
Timing of information - receiving information/ support *after* giving birth (i.e., feeling overwhelmed/ too many appointments in the new-born period)	✓		✓	Opportunity (Environmental)
Method of contacting mothers - dislike being contacted by telephone about infant feeding support and the services on offer / young mothers are not contacted in ways that are suitable for them	✓	✓		Opportunity (Environmental)
Generic services - no services (or resources) specifically for younger mothers		✓		Opportunity (Environmental)

Barrier	Young mothers	Professionals	Evidence review	COM factor
Language barriers		✓		Opportunity (Environmental)
Service delivery - timings of the groups or services may be at inconvenient times for young mothers.		✓		Opportunity (Environmental)
Service facilities - lack of comfortable facilities provided within breastfeeding support groups	✓			Opportunity (Environmental)
Service content – lack of specific advice or content			✓	Opportunity (Environmental)
Lack of joined-up services/ professionals/ stretched services		✓		Opportunity (Environmental)
Lack of time to travel to services	✓			Opportunity (Environmental)
Lack of available resources (transport, finances) to get to the services	✓	✓	✓	Opportunity (Environmental)
Not knowing any young mothers who have accessed infant feeding support	✓	✓		Opportunity (Social)
Peer or family pressure or discouragement/ lack of support	✓	✓	✓	Opportunity (Social)
Lack of support from professionals to find out about and access support and build relationships with mothers			✓	Opportunity (Social)
Cultural norms around breastfeeding in public			✓	Opportunity (Social)
Feeling sceptical/ uncertain about infant feeding support and what to expect	✓		✓	Motivation (Reflective)
Fear of judgement from others (i.e., from older mothers, or if they are not breastfeeding)/ feeling stigmatised about not knowing how to take care of their baby	✓	✓	✓	Motivation (Reflective)
Feeling pushed or pressured to breastfeed	✓	✓	✓	Motivation (Reflective)
Being worried about being the ‘odd one out’ if they attend services (as a young mum)		✓		Motivation (Reflective)
Being worried about asking for help/ worried about asking ‘silly questions’ / lacking confidence, feeling embarrassed, or self-conscious	✓	✓		Motivation (Reflective)
Lack of perceived need to access services (e.g., if the young mum is not breastfeeding)	✓	✓		Motivation (Reflective)
Mistrust of services and feeling isolated from services.		✓		Motivation (Reflective)

Barrier	Young mothers	Profes sionals	Evidence review	COM factor
Lack willingness to access services.		✓		Motivation (Reflective)
Lack intentions to breastfeed			✓	Motivation (Reflective)
Post-COVID-19 concerns about leaving the house.		✓		Motivation (Reflective)
Having concerns about using public transport to access infant feeding support as a new mum.	✓			Motivation (Reflective)

Table 15: Summarised facilitators to accessing infant feeding support services

Facilitator	Young mothers	Profes sionals	Evidence Review	COM factor
Having knowledge/ awareness about the full range of infant feeding support on offer and how to access it	✓			Capability (Psychological)
Knowing where to go to get in-person support (i.e., what centres to go to)	✓			Capability (Psychological)
Knowing that services are free and confidential	✓			Capability (Psychological)
Reminders from breastfeeding peer supporters and/or healthcare professionals (i.e., text messages or phone calls 48 hours before)			✓	Capability (Psychological)
Content of information – information about the service includes other forms of infant feeding (other than breastfeeding) and advertises the full range of support on offer	✓			Opportunity (Environmental)
Access to information - using different delivery modes and formats suitable for younger mothers (text message, Instagram, TikTok, videos); brief and enticing messages for younger mothers using suitable language and imagery; paper-based materials for mothers without digital access	✓	✓		Opportunity (Environmental)
Adverts and services suitable for people who do not speak English.	✓			Opportunity (Environmental)
Advertising the services more widely – at colleges and schools, and at other locations where young mothers may go (e.g., playcentres, baby groups)	✓	✓		Opportunity (Environmental)
Timing of information - receiving information and support about infant feeding during pregnancy	✓	✓		Opportunity (Environmental)

Facilitator	Young mothers	Profes sionals	Evidence Review	COM factor
Provide (and advertise) free and confidential infant feeding support	✓			Opportunity (Environmental)
A young-mum specific service	✓	✓		Opportunity (Environmental)
In-person (at a physical location) infant feeding support delivered in-person in a physical location	✓			Opportunity (Environmental)
Flexible delivery of infant feeding support (e.g., in person, by phone, video calls, or online) / tailored timing of sessions	✓	✓	✓	Opportunity (Environmental)
Provide other services alongside infant feeding support (e.g., parent support groups) / focus on the mum's well-being, as well baby's well-being.	✓	✓	✓	Opportunity (Environmental)
Provide bottle feeding support groups, as well as breastfeeding support groups.	✓			Opportunity (Environmental)
Having friendly and supportive staff who deliver the services/ friendly and comfortable environment	✓		✓	Opportunity (Environmental)
Have more young staff delivering the services.		✓		Opportunity (Environmental)
Infant feeding services need to be easily accessible (e.g., local venues within walking distance, or easily accessible venues in the city centre)	✓			Opportunity (Environmental)
Support from family/ friends to find out about and access support	✓			Opportunity (Social)
Support from professionals to find out about and access support and build relationships with mothers		✓	✓	Opportunity (Social)
Offer young mothers the opportunity to bring someone with them to the service (and advertising that).	✓	✓		Opportunity (Social)
Recommendations from people who access the service.		✓		Opportunity (Social)
Normalise breastfeeding - talk to young mothers about people they know/famous people who breastfeed and talk about breastfeeding in public.		✓		Opportunity (Social)
Cultural norms around breastfeeding in public			✓	Opportunity (Social)
Service provider having a shared experience (i.e., of breastfeeding)			✓	Opportunity (Social)
Supportive social contact with other mothers			✓	Opportunity (Social)
Wanting to breastfeed	✓		✓	Motivation (Reflective)

Facilitator	Young mothers	Profes sionals	Evidence Review	COM factor
Wanting information and support with infant feeding	✓			Motivation (Reflective)
Believing that infant feeding support services are for everyone	✓			Motivation (Reflective)
Wanting to get out of the house	✓			Motivation (Reflective)
Wanting to meet other young mothers like them (and for their babies to meet with other babies and do fun activities)	✓			Motivation (Reflective)
Willing to attend a young mum-specific service	✓			Motivation (Reflective)
Avoid fear of being judged by older mothers	✓			Motivation (Reflective)
Avoid feelings of pressure (i.e., to breastfeed)	✓		✓	Motivation (Reflective)
Having positive experiences from accessing breastfeeding/ infant feeding support groups	✓		✓	Motivation (Automatic)
Offer incentives like free lunch or snacks, or reduced transport costs		✓		Motivation (Automatic)

Co-designing the intervention

Workshop 3

Workshop 3 aimed to:

- Review the evidence on what young mothers need in order to access infant feeding support services.
- Explore solutions offered by professional stakeholders, using APEASE.
- Develop a plan for the development and implementation of the intervention.

Participants

In total, four professional stakeholders from Sheffield family hubs attended Workshop 3. These were a health team manager, an early years practitioner for infant feeding, an infant feeding peer support worker, and an infant feeding lead). The two young mothers who had attended workshop 2 were invited but did not attend the workshop[12].

[12] It was challenging to recruit young mothers to participate in this workshop, which reflects the challenges of engaging with this target population. However, it is important to note that this research

Intervention specification

The agreed upon intervention will aim to increase uptake of the infant feeding support services among young mothers in Sheffield aged 25 years and younger, particularly those from deprived areas.

SCC were keen to deliver a new in-person antenatal and postnatal service for young mothers (aged ≤ 25 years old) delivered in a central city centre location in Sheffield. However, due to associated city centre venue costs, SCC decided to focus on the delivery of a new in-person antenatal service only in an easily accessible venue (APEASE – affordability).

Outside of this programme of work, Sheffield family hubs are launching a new young person parenting programme called 'Baby and Us', which aims to empower and support young parents. This in-person programme is expected to be launched in January 2024, and will be run by the parenting team hub staff and volunteers at an easily accessible location. All young expectant mothers who attend the new antenatal service will be encouraged to attend the 'Baby and Us' programme after they have had their baby in order to continue receiving support from the family hubs team.

The intervention includes two components:

1) A new in-person antenatal service for expectant young mothers (aged ≤ 25 years old) delivered in an easily accessible location in Sheffield, providing support for all aspects of infant feeding, alongside wider support for caring for a baby.
2) New behavioural-science informed messages and communications to promote the new service among young expectant mothers (aged ≤ 25 years old).

SCC will lead the design and delivery of the new service. SHU will advise on key behavioural science content to include in messages and communications to promote the new service, with the messages finalised and delivered by SCC.

Co-designing the evaluation

Workshop 4

Workshop 4 aimed to:

explored young mothers' thoughts and ideas about the proposed young-mum specific service and what they would want it to look like in the previous focus group.

- Review the agreed intervention and to explore the practicalities involved in planning and implementation.
- Review the co-designed Theory of Change.
- Develop a logic model.
- Develop an evaluation research protocol, including allocating roles and responsibilities.

Participants

Participants to Workshop 4 included three stakeholders from Sheffield family hubs infant feeding support team.

Evaluation protocol for the SCC initiative: Increasing uptake of infant feeding support services among young mothers

The co-designed Theory of Change informed by the workshops with professional stakeholders and young mothers was reviewed (see Appendix 12). The logic model, co-designed with SCC can be seen in Figure 5 and informs the research protocol that follows.

Research questions

Primary questions

RQ1: Does the new service for young mothers result in higher levels of uptake of infant feeding support services?

RQ2: Does the new service for young mothers result in increased awareness of and intentions to access other family hub services?

Secondary questions

RQ3: Does the new service for young mothers result in increased capability, opportunity, and motivation to access infant feeding support services?

RQ4: How did young mothers find out about the new service and what do they think about the messaging and communications?

RQ5: Does the new service for young mothers result in increased intentions to breastfeed?

RQ6: Does the new service for young mothers result in increased knowledge about other aspects of caring for a baby (e.g., vaccinations, sleep, brain development, skin to skin, bonding with baby) and increased intentions to access other health services (e.g., baby vaccinations)?

Figure 5: Sheffield logic model

Inputs	Activities	Target group	Short-term outcomes	Medium- and long-term outcomes
SCC team creating a new young-mum specific service. SHU team advising on content for messaging and communications to promote the new service (e.g. key behavioural science content to include in messages).	SCC will deliver a new young-mum specific service. SCC will deliver new messages and communications to promote the new service.	Young expectant mother aged 25 years and younger, living in Sheffield Particularly those from deprived areas in Sheffield	Increased knowledge about infant feeding services Increased motivation, confidence, and reduced concerns about accessing infant feeding services. Increased physical opportunity to access infant feeding services Increased social opportunity (norms, social support) to access infant feeding services. Increased uptake of infant feeding support services. Increased awareness and intentions to access other Family Hubs services. Increased intentions to breastfeed. Increased knowledge about other aspects of caring for baby (e.g., bonding with baby).	**Medium-term** Increased knowledge, confidence, and skills amongst young mums. Improved health and wellbeing of young mums and their babies. Increased sign-ups/use of other Family Hub services. Increased sign-ups/use of other health services (e.g., childhood vaccination). **Long-term** Long-term positive benefits for infant health, maternal health, relationship-building and mental health, cost savings for NHS

Intervention

The planned intervention has 2 components:

A new young-mother specific service

A new service will be developed and delivered by Sheffield family hubs for young expectant mothers who are 25 years and younger. SCC will design the content of the new service and deliver the new service. Although the new service is still under development, it is likely to include the following:

- An antenatal support group for expectant young mothers (aged ≤ 25 years old). The group will cover various topics around what to expect when having your baby, birth choices, virtual tour of Jessops, chance to ask a Midwife anything, as well as support around feeding choices, addressing breastfeeding myths, and providing young mothers with the opportunity to meet other expectant young mothers. The group will discuss and provide support around infant feeding, which will be embedded within other wider aspects of support and signposting to other family hub services.
- The group will last approximately 1 ½ hours.
- The group will be facilitated in-person by the infant feeding support team, at a location that will be easily accessible to most young mothers using public transport.
- It is expected that the groups will be held weekly, and those who attend the antenatal group will be encouraged to attend the young person 'Baby and Us' family hub programme after having their baby (which aims to empower and support young parents) which is being developed outside of this work programme.

New messaging and communications to promote the service

New messages and communications that seek to educate and persuade young mothers to access the new infant feeding support services will be developed. Young mothers in the focus group discussed how they dislike being contacted by telephone and would prefer to receive information about the services and support on offer via text. Sheffield family hubs infant feeding support team contact mothers via text message antenatally, however the text messages sent are not standardised and do not utilise behavioural science. SHU will advise on key standardised behavioural science content to include in the text messages to promote the new service, and SCC will develop and send these text messages to mothers whose date of birth identify them as being 25 years or younger. Young mothers also discussed how they would like to receive information via social media platforms, including Facebook, Twitter, and Instagram. SHU will advise on key behavioural science content to include in social media messages, and SCC will develop

and deliver these on their social media platforms. SCC will also deliver messages using other existing family hub communication channels, including websites, leaflets, and posters).

The messages will:

- Educate young mothers about what the service is and what it offers, that it is free, and where, when, how, and who can access the services, and who will be there.
- Persuade young mothers about the value and benefit of accessing the services (e.g. opportunity to access information and support, and meet other young mothers from across Sheffield) and address any concerns (e.g., friendly environment with other young mothers like them from Sheffield).
- Signpost to further information about where, when, and how they can access the services.
- Use local branding (e.g., Sheffield family hubs) and where possible (for example in the case of social media messages), use imagery of younger mothers.
- Consider differing literacy levels and use accessible language.

Methodology

This evaluation comprises two distinct phases: (1) a service evaluation of the new young mother-specific service (with associated new messages and communications) with quantitative analysis of data collected by SCC and; (2) focus group study with qualitative analysis. These two phases are described below.

1) **Service evaluation with quantitative analysis of data collected by SCC (RQ1)**

A service-evaluation of the new young-mother specific service will be undertaken to examine its effectiveness in encouraging expectant young mothers (aged ≤ 25 years old) to access infant feeding support services. The service evaluation will run for 3 months (October 2023 – December 2023).

The following quantitative data will be collected and anonymised by SCC and shared with the SHU team using a secure method of data transfer. No personal data will be shared.

Uptake of the new service:

- Number of young mothers (aged ≤ 25 years old) who access the new antenatal group during the evaluation period.
- Details of the young mother who access the new service, including: age of mother, deprivation indices, ethnicity, first baby/baby number.

Uptake of previous services:

- Number of young mothers (aged ≤ 25 years old) who accessed infant feeding support services during the same 3 month-period as the service evaluation in the previous year (October 2022 – December 2022).
- Number of young mothers (aged ≤ 25 years old) who accessed infant feeding support services during a 3 month-period in the Spring in the previous year (to account for weather as a confounding factor in uptake of services) (March 2022 – May 2022).
- Details of the young mother who access the previous infant feeding support services including: age of mother, age of baby, deprivation indices, ethnicity.

2) Focus group study with qualitative analysis (RQ2 – RQ6)

Two 1-hour focus groups will be undertaken, each with 5 – 7 young mothers (in total approximately 10 - 14 young mothers). A third focus group will be offered, depending on recruitment. The focus groups will be hosted in person, at the location of the antenatal service.

The focus groups will explore:

- young mother's experiences of the new service, what they liked and disliked about it, how they found out about the new service and what is on offer, the reasons why they accessed it, and how it could be improved in the future.
- the impact of the service on young mother's intentions to breastfeed.
- young mother's awareness of and intentions to use other Sheffield family hub services.
- the impact of the service on young mother's knowledge about other aspects of caring for baby and intentions to access other health services (e.g., baby vaccinations).

A focus group topic guide will be created by SHU and will be informed by the COM-B model (to explore barriers and facilitators to accessing services) and the Theoretical Framework of Acceptability (to explore young mother's perceptions of the new service and associated messages and communications).

Participants

Participants in the service evaluation will be young expectant mothers all aged 25 years and younger.

Participants for the focus group study will be young mothers aged 18 years – 25 years who have attended the new antenatal service. SCC will seek to recruit participants with different characteristics including: age of mother; deprivation indices; ethnicity.

Recruitment

Service uptake data will be collected and anonymised by SCC and shared with the SHU team. No personal data will be shared.

A purposive sample of young mothers who have accessed the antenatal service will be invited to take part in a focus group. SCC will invite mothers who have accessed the antenatal service, either face-to-face or via email, text message, or telephone. The invitation will include information about a £30 incentive for taking part and details about when the focus group will take place. The focus group will take place at the location of the antenatal service, either before or after a session has run.

Expected outcomes

There are five main expected outcomes from this research project:

- An understanding of the effect of the new service (and associated messaging and communications) to increase uptake of infant feeding support services among young mothers.
- An understanding of any additional barriers and facilitators to uptake of infant feeding support services that are not addressed by the new service.
- An understanding of whether attending the new service increases intentions to breastfeed.
- An understanding of whether attending the new service increases young mum's knowledge about other family hub services and the likelihood of young mothers engaging with other family hub services.
- An understanding of whether attending the new service increases young mum's knowledge about other aspects of caring for baby and the likelihood of young mothers engaging with other health services.

Ethics

For all projects, ethical approval will be obtained from Sheffield Hallam University ethics committee. All participants who take part in the research activities (e.g., interviews, focus groups, surveys) will be provided with a participant information sheet and a consent form. Informed consent will be obtained from all participants prior to taking part in any research activity.

References

Action for Children (2021). *Adapting to a new world: Supporting the youngest children and their families through the pandemic.* Available at: https://media.actionforchildren.org.uk/documents/Digital_Provision_briefing.pdf?_ga=2.75328145.2066975940.1690464245-1415166035.1656510065

Action for Children. (2021). *Parenting through the pandemic: Parents need more support.* Available at: https://media.actionforchildren.org.uk/documents/Parenting_through_the_pandemic2.pdf

Almond, P., and Lathlean, J. (2011). Inequity in provision of and access to health visiting postnatal depression services. *Journal of advanced nursing, 67*(11), pp.2350-2362.

Andrews, E. J., Symon, A., and Anderson, A. S. (2015). 'I didn't know why you had to wait': an evaluation of NHS infant-feeding workshops amongst women living in areas of high deprivation. *Journal of Human Nutrition and Dietetics*, *28*(6), pp.558-567.

Barlow, J. and Coren, E., (2018). The effectiveness of parenting programs: A review of Campbell reviews. *Research on Social Work Practice*, *28*(1), pp.99-102.

Barrett, N., Hanna, L. and Fitzpatrick, O.V., (2018). Barriers to first time parent groups: a qualitative descriptive study. *Nursing & Health Sciences*, *20*(4), pp.464-471.

Bengough, T., Dawson, S., Cheng, H. L., McFadden, A., Gavine, A., Rees, R., ... and Hannes, K. (2022). Factors that influence women's engagement with breastfeeding support: A qualitative evidence synthesis. *Maternal & Child Nutrition*, *18*(4), e13405.

Bradley, C., Day, C., Penney, C. and Michelson, D., (2020). 'Every day is hard, being outside, but you have to do it for your child': Mixed-methods formative evaluation of a peer-led parenting intervention for homeless families. *Clinical child psychology and psychiatry*, *25*(4), pp.860-876.

Brott, H., Kornbluh, M., Banfield, J., Boullion, A.M. and Incaudo, G., (2022). Leveraging research to inform prevention and intervention efforts: Identifying risk and protective factors for rural and urban homeless families within transitional housing programs. *Journal of Community Psychology*, *50*(4), pp.1854-1874.

Cane, J., O'Connor, D. and Michie, S. (2012). Validation of the theoretical domains framework for use in behaviour change and implementation research. Implementation Science, 7, pp.37.

Carson, S., Powis, P. and Imperato, J., (2016). Consolidating homeless support by the early years family team in Cardiff Flying Start. *Community Practitioner*, *89*(7), p.43.

Census Data. (2011). *Loxford Demographics (Redbridge, England).* Available from: http://loxford.localstats.co.uk/census-demographics/england/london/redbridge/loxford

CHAMPIONS Project. (2021). *Update on the CHAMPIONS Project.* Available here: https://www.championsproject.co.uk/

Children's Commissioner (2018). Stability Index 2018: Overview and Findings. Available here: https://www.childrenscommissioner.gov.uk/resource/stability-index-2018/

Children's Commissioner. (2019). *Bleak houses: Tackling the crisis of family homelessness in England.* Available here: https://assets.childrenscommissioner.gov.uk/wpuploads/2019/08/cco-bleak-houses-report-august-2019.pdf

Collins, A., Coughlin, D., Miller, J., & Kirk, S. (2015). *The production of quick scoping reviews and rapid evidence assessments: A how to guide.* Available from*:* https://nora.nerc.ac.uk/id/eprint/512448/1/N512448CR.pdf

Cowley, S., Malone, M., Whittaker, K., Donetto, S., Grigulis, A., and Maben, J. (2018). What makes health visiting successful—or not? 2. The service journey. *Journal of Health Visiting*, *6*(8), pp.404-412.

Cox, P. and Docherty, K., (2008). Assessing the impact of a first-time parenting group. *Nursing Times*, *104*(21), pp.32-33.

Crasnow, E., Lammer-Triendl, S., McKinstrie, F., Macadam, C., and Ashary, S. (2020). The Anna Freud National Centre for Children and Families (AFNCCF) Parent–Toddler Group model in a homeless hostel. *Journal of Child Psychotherapy*, *46*(1), pp.35-50.

Department for Education and Department of Health and Social Care (2023). *Trailblazers for the family hubs and start for life programme.* Available at: https://www.gov.uk/government/publications/trailblazers-for-the-family-hubs-and-start-for-life-programme/trailblazers-for-the-family-hubs-and-start-for-life-programme

Department of Education and Department of Health and Social Care (2022). *Family hubs and start for life programme guide*. HM Government. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1096786/Family_Hubs_and_Start_for_Life_programme_guide.pdf

Department of Health and Social Care (2021). *The best start for life a vision for the 1,001 critical days the early years healthy development review report.* Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/973112/The_best_start_for_life_a_vision_for_the_1_001_critical_days.pdf

Department for Levelling Up, Housing and Communities (2023) *Statutory homelessness: detailed local authority level tables.* Available at: https://www.gov.uk/government/statistical-data-sets/live-tables-on-homelessness

Drennan, V. M., and Joseph, J. (2005). Health visiting and refugee families: issues in professional practice. *Journal of Advanced Nursing*, *49*(2), pp.155-163.

Early Intervention Foundation. (2019). *Engaging disadvantaged and vulnerable parents an evidence review.* Available at: https://www.eif.org.uk/reports/engaging-disadvantaged-and-vulnerable-parents-an-evidence-review

Family Hubs Network. (2020*). What is a Family Hub?* Available at: https://familyhubsnetwork.com/

Flouri, E., Mavroveli, S. and Tzavidis, N., (2012). Cognitive ability, neighborhood deprivation, and young children's emotional and behavioral problems. *Social psychiatry and psychiatric epidemiology*, *47*, pp.985-992.

Fox, R., McMullen, S., and Newburn, M. (2015). UK women's experiences of breastfeeding and additional breastfeeding support: a qualitative study of Baby Café services. *BMC Pregnancy and Childbirth*, *15*(1), pp.1-12.

Gewirtz, A., Burkhart, K., Loehman, J. and Haukebo, B., (2013). Research on programs designed to support positive parenting. In *Supporting families experiencing homelessness: Current practices and future directions* (pp. 173-186). New York, NY: Springer New York.

Hambrick, E.P., Brawner, T.W., Perry, B.D., Brandt, K., Hofmeister, C. and Collins, J.O., (2019). Beyond the ACE score: Examining relationships between timing of developmental adversity, relational health and developmental outcomes in children. *Archives of Psychiatric Nursing*, *33*(3), pp.238-247.

Hanna, B.A., Edgecombe, G., Jackson, C.A. and Newman, S., (2002). The importance of first-time parent groups for new parents. *Nursing & health sciences*, *4*(4), pp.209-214.

Harris-McKoy, D. E., Woods, S. B., Brantley, C. W., and Farineau, H. M. (2015). Experiences of family therapists working with families in a transitional homeless community. *Journal of Marital and Family Therapy*, *41*(2), pp.192-204.

Haskett, M.E., Loehman, J. and Burkhart, K., (2016). Parenting interventions in shelter settings: A qualitative systematic review of the literature. *Child & Family Social Work*, *21*(3), pp.272-282.

Haynes, J., and Parsons, T. (2009). Families in transit: The journal of the health visitors' association. *Community Practitioner 82*(9), pp.16.

Hickey, G., McGilloway, S., Leckey, Y., Stokes, A., Bywater, T. and Donnelly, M., (2021). “Putting Meat on the Bones”: Understanding the Implementation of a Community-Based Early Intervention and Prevention Programme—Contextual, Person, and Programme Influences. *Prevention Science*, *22*, pp.113-129.

Hogg, R., de Kok, B., Netto, G., Hanley, J., and Haycock-Stuart, E. (2015). Supporting Pakistani and Chinese families with young children: perspectives of mothers and health visitors. *Child: Care, Health and Development, 41*(3), pp.416-423.

Hogg, S., and Mayes, G. (2022). *Casting long shadows: The ongoing impact of the COVID-19 pandemic on babies, their families and the services that support them.* Available at: https://ihv.org.uk/wp-content/uploads/2022/11/F1001D-Casting-Long-Shadows-FINAL-NOV-22.pdf

Holtrop, K., and Holcomb, J. E. (2018). Adapting and pilot testing a parenting intervention for homeless families in transitional housing. *Family process*, *57*(4), pp.884-900.

Holtrop, K., Chaviano, C. L., Scott, J. C., and McNeil Smith, S. (2015). Identifying relevant components to include in a parenting intervention for homeless families in transitional housing: Using parent input to inform adaptation efforts. *American Journal of Orthopsychiatry*, *85*(6), p.600.

Hunt, L., Thomson, G., Whittaker, K., and Dykes, F. (2021). Adapting breastfeeding support in areas of socio-economic deprivation: a case study approach. *International Journal for Equity in Health*, *20*(1), pp.1-13.

Hunt, L., Thomson, G., Whittaker, K., and Dykes, F. (2022). Non-profit breastfeeding organisations' peer support provision in areas of socio-economic deprivation in the UK: A meta-ethnography. *Maternal & Child Nutrition*, *18*(1), e13271.

Jenkins, M., and Parylo, C. (2011). Evaluation of health services received by homeless families in Leicester. *Community Practitioner*, *84*(1).

Kiernan, K.E. and Mensah, F.K., (2011). Poverty, family resources and children's early educational attainment: the mediating role of parenting. *British educational research journal*, *37*(2), pp.317-336.

Kilmer, R. P., Cook, J. R., Crusto, C., Strater, K. P., and Haber, M. G. (2012). Understanding the ecology and development of children and families experiencing homelessness: implications for practice, supportive services, and policy. *American Journal of Orthopsychiatry*, *82*(3), p.389.

Knowledge Change Action Ltd. (2023). *Five to thrive.* Available at: https://fivetothrive.org.uk/

Leckey, Y., Hickey, G., Stokes, A. and McGilloway, S., (2019). Parent and facilitator experiences of an intensive parent and infant programme delivered in routine community settings. *Primary health care research & development*, *20*, p.e74..

Leijten, P., Raaijmakers, M.A., Orobio de Castro, B., van den Ban, E. and Matthys, W., (2017). Effectiveness of the incredible years parenting program for families with socioeconomically disadvantaged and ethnic minority backgrounds. *Journal of Clinical Child & Adolescent Psychology*, *46*(1), pp.59-73.

Local Government Association. (2017). *Improving outcomes for children and families in the early years: A key role for health visiting services.* Available at: https://www.local.gov.uk/sites/default/files/documents/improving-outcomes-childr-bf1.pdf

Mangrio, E., Hellström, L., Nilsson, E. L., and Ivert, A. K. (2021). An extended home visit programme within the swedish child healthcare system for first-time parents in Scania, Sweden: A study protocol. *Frontiers in public health, 9,* 537468.

Marcal, K., (2018). Timing of housing crises: Impacts on maternal depression. *Social work in mental health*, *16*(3), pp.266-283.

McAndrew, F., Thompson, J., Fellows, L., Large, A., Speed, M., & Renfrew, M.J. (2012). *Infant feeding survey 2010: summary.* Available at: https://files.digital.nhs.uk/publicationimport/pub08xxx/pub08694/ifs-uk-2010-sum.pdf

McCoy, E., Ross-Houle, K., Eckley, L., Oyston, J., Cochrane, M., Harrison, B., & Timpson, H. (2015). *Children at risk of becoming not in Education, Employment or Training: An evaluation of Shelter's Knowsley Family Support Service intervention*. Available here: https://assets.ctfassets.net/6sxvmndnpn0s/6czybhT7yapYXlYnEwJPGW/e7a00550081d6e8b90b518ce1f65a6cf/Evaluation_of_Shelters_Knowsley_Family_Support_Service_Final_Report.pdf

Michie, S., Atkins, L. and West, R., (2014). The behaviour change wheel. *A guide to designing interventions. 1st ed. Great Britain: Silverback Publishing*, *1003*, p.1010.

Michie, S., Richardson, M., Johnston, M., Abraham, C., Francis, J., Hardeman, W., ... and Wood, C. E. (2013). The behavior change technique taxonomy (v1) of 93 hierarchically clustered techniques: building an international consensus for the reporting of behavior change interventions. *Annals of behavioral medicine*, *46*(1), pp.81-95.

Millings, A., Wilcockson, H., Clarke, E., Lamb, M., Humphreys, H., Paddock, D., Jordan, C., Thorneloe, R., Arden, M., and Coldwell, M. (2022a). Applying behavioural science to promoting uptake of family hubs services: Research report. Available from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1123977/Applying_behavioural_science_to_promoting_uptake_of_family_hubs_services.pdf

Millings, A., Wilcockson, H., Harris-Evans, J., Thorneloe, R., Arden, M., and Coldwell, M. (2022b). Behavioural insights: Increasing uptake of family hub services. *Department for Education.* Available from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1059574/Technical_report_behavioural_insights_increasing_up_take_of_Family_Hub_services.pdf

Ministry of Housing, Communities and Local Government (2020). *Statutory homelessness: detailed local authority level tables.* Available at: https://www.gov.uk/government/statistical-data-sets/live-tables-on-homelessness

Morton, A., and Adams, C. (2022). Health visiting in England: The impact of the COVID-19 pandemic. *Public Health Nursing*, *39*(4), pp.820-830.

nef Consulting. (2015). *Evaluation of Hackney family service shelter.* Available here: https://www.nefconsulting.com/wp-content/uploads/2016/06/HFS-evaluation-report-FINAL-06.08.15.pdf

NHS (2023). *Benefits of breastfeeding* Available at: https://www.nhs.uk/conditions/baby/breastfeeding-and-bottle-feeding/breastfeeding/benefits/

Oakley, L. L., Henderson, J., Redshaw, M., and Quigley, M. A. (2014). The role of support and other factors in early breastfeeding cessation: an analysis of data from a maternity survey in England. *BMC pregnancy and childbirth*, *14*, pp.1-12.

Office for Health Improvement and Disparities (2023a). *Commissioning health visitors and school nurses for public health services for children aged 0 to 19.* Available from: Commissioning health visitors and school nurses for public health services for children aged 0 to 19 - GOV.UK (www.gov.uk)

Office for Health Improvement and Disparities, (2023b). *Child and maternal health statistics.* Available from*: https://www.gov.uk/government/collections/child-and-maternal-health-statistics#health-visitor-service-delivery-metrics*

Office for National Statistics (2020). *Births in England and Wales.* Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/livebirths/datasets/birthsummarytables

Office for National Statistics. (2021). *Census data*. Available from: https://census.gov.uk/census-2021-results

Public Health England (2019) *Achieving behaviour change: A guide for local government and partners.* Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/875385/PHEBI_Achieving_Behaviour_Change_Local_Government.pdf

Public Health England (2021). *Best start in life and beyond: Improving public health outcomes for children, young people and families.* Available from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/969168/Commissioning_guide_1.pdf

Roche, B., Cowley, S., Salt, N., Scammell, A., Malone, M., Savile, P., ... and Fitzpatrick, S. (2005). Reassurance or judgement? Parents' views on the delivery of child health surveillance programmes. *Family practice*, *22*(5), pp.507-512.

Rosenthal, D.M., Hayward, A., Ucci, M., Teakle, A., O'Toole, S., Whitaker, L., Hauari, H., Hollingworth, K., Cameron, C., Schoenthaler, A. and Lakhanpaul, M., (2022). 576 Parental mental health and associations between living in temporary accommodation and socio-political determinants during the COVID-19 pandemic.

Rosenthal, D.M., Ucci, M., Heys, M., Hayward, A. and Lakhanpaul, M., (2020). Impacts of COVID-19 on vulnerable children in temporary accommodation in the UK. *The Lancet Public Health*, *5*(5), pp.e241-e242.

Russell, S., and Drennan, V. (2007). Mothers' views of the health visiting service in the UK: a web-based survey. *Community Practitioner*, *80*(8), pp.22-27.

Saunders, B., & Hogg, S. (2020). *Babies in lockdown: listening to parents to build back better.* Parent Infant Foundation. Available here: https://parentinfantfoundation.org.uk/our-work/campaigning/babies-in-lockdown/#fullreport

Sekhon, M., Cartwright, M. and Francis, J.J. (2017). Acceptability of healthcare interventions: an overview of reviews and development of a theoretical framework. BMC Health Services Research, pp.17, 88.

Sheller, S. L., Hudson, K. M., Bloch, J. R., Biddle, B., Krauthamer Ewing, E. S., and Slaughter-Acey, J. C. (2018). Family care curriculum: A parenting support program for families experiencing homelessness. *Maternal and Child Health Journal*, *22*, pp.1247-1254.

Shribman, S., & Billingham, K. (2009). *Healthy child programme: Pregnancy and the first five years of life.* Available from: *https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/167998/Health_Child_Programme.pdf*

Sourander, J., Laakso, M.L. and Kalland, M., (2021). Mentalization-based families first group intervention for first-time parents: Parents' perspective. *Journal of infant, child, and adolescent psychotherapy*, *20*(1), pp.77-90.

Swick, K.J., (2009). Strengthening homeless parents with young children through meaningful parent education and support. *Early Childhood Education Journal*, *36*, pp.327-332.

Taket, A. and Crisp, B.R., (2021). The region-wide implementation of a relationship education program for first time parents delivered in the maternal and child health care setting: Evaluating reach and effectiveness. *TheAustralian Journal of Advanced Nursing*, *38*(4), pp.14-23.

Team, B.I., (2014). EAST: Four simple ways to apply behavioural insights. *Behavioural Insight Team, London*.

The Merton Story (2021). Available at: https://www.merton.gov.uk/system/files/The%20Merton%20Story%202021_final%20(1).pdf

Tischler, V., Karim, K., Rustall, S., Gregory, P. and Vostanis, P., (2004). A family support service for homeless children and parents: Users' perspectives and characteristics. *Health & Social Care in the Community*, *12*(4), pp.327-335.

Underdown, A. and Barlow, J., (2011). Interventions to support early relationships: mechanisms identified within infant massage programmes. *Community Practitioner*, *84*(4).

Underdown, A., Norwood, R. and Barlow, J., (2013). A realist evaluation of the processes and outcomes of infant massage programs. *Infant Mental Health Journal*, *34*(6), pp.483-495.

UNICEF (n.d.). *Breastfeeding in the UK.* Available at: https://www.unicef.org.uk/babyfriendly/about/breastfeeding-in-the-uk/

Victora, C. G., Bahl, R., Barros, A. J., França, G. V., Horton, S., Krasevec, J., ... and Rollins, N. C. (2016). Breastfeeding in the 21st century: epidemiology, mechanisms, and lifelong effect. *The Lancet*, *387*(10017), pp.475-490.

Watson, P., Peake, S., Shucksmith, A., and Shucksmith, J. (2014). *Exploring infant feeding and breastfeeding peer support services in Middlesbrough and Redcar & Cleveland.* Available at: https://moderngov.middlesbrough.gov.uk/Data/Health%20Scrutiny%20Panel/201511031600/Agenda/att1006639.pdf

Wilson, W., and Barton, C. (2023). *Households in temporary accommodation (England).* Available from: https://researchbriefings.files.parliament.uk/documents/SN02110/SN02110.pdf

World Health Organization (2021). *Infant and young child feeding.* Available at: https://www.who.int/news-room/fact-sheets/detail/infant-and-young-child-feeding

Appendices

Appendix 1: Example search terms and strategy for each evidence review

For all projects:

The 'OR' joins each of the terms within a given concept meaning the articles that were retrieved contained at least one of these search terms. The 'AND' joins the different concepts together limiting the search. Therefore, searches included at least one population term, intervention term, and vulnerability term (where appropriate for the specific project). *Note: *denotes multiple word endings including singular and plural; "_" denotes that only the full term will be searched for.*

London Borough of Redbridge:

Vulnerability terms	**Population terms**	**Intervention terms**
Disadvantage* OR Vulnerable OR Minority OR Ethnic OR Immigrant OR Refuge* OR	Famil* OR Parent*	"Health visit* review" OR "Health visit* check" OR "Health visit*" OR "Global development" OR "Ages and stages question*" OR "2 ½ year* review" OR "2.5 year* review" OR Mandated

London Borough of Merton:

Population terms	**Intervention terms**
“New parent” OR “First time famil*” OR “First time parent*” OR “New famil*”	“Parent and bab* support” class OR Course OR Program* OR Group OR “Mother and bab* support” OR “Baby development course” OR “Baby support class” OR "Baby support course" OR "Early child development course" OR "Early child development class" OR "Early years development class" OR "Early years development course" OR "Baby sensory" OR "Baby massage" OR "Five to thrive"”

Fellowship of St Nicholas:

Vulnerability terms	**Population terms**	**Intervention terms**
Homeless* OR Unhoused OR “Temporary accommodation” OR “Emergency accommodation”"	Famil* OR Parent*	Uptake OR Support OR Services OR Outreach OR Engag* OR Interven* OR “Family cent*” OR Voluntary OR Community

Sheffield City Council:

Population terms	**Intervention terms**
“infant feed*" OR breastfeed* OR "infant feed* service*" OR "breast feed* service" OR "infant feed* support" OR "breastfeed* support" OR "infant feed* guidance" OR "breastfeed* guidance" OR "infant feed* educat*" OR “breastfeed* educat*"	“young mum*" OR "young mother*" OR "young famil*" OR "young parent*"

Appendix 2: Supplementary searches for all evidence reviews

Additional searches of websites and databases relevant to the general topic of family hubs were conducted. All websites were identified as relevant to the topic area of each project through previous searches, liaison with expert advisors and discussions with each local authority and/or charity. These websites covered national and local government, the voluntary sector, and research organisations. The following grey literature websites were searched:

- Action for Children: https://www.actionforchildren.org.uk/resources-and-publications/
- Joseph Rowntree Foundation (JRF): https://www.jrf.org.uk/reports
- National Foundation for Educational Research (NFER): https://www.nfer.ac.uk/publications-research
- Social Care Institute for Excellence (SCIE): https://www.scie.org.uk/atoz/
- UK Government Web Archive: http://www.nationalarchives.gov.uk/webarchive/
- Local Government Association: https://www.local.gov.uk/publications
- The Magpie Project: https://themagpieproject.org/latest-news/
- House of Commons Library: https://commonslibrary.parliament.uk/
- JustLife/Shared Health Foundation: https://www.justlife.org.uk/our-work/national/households-in-temporary-accommodation-appg
- Shelter: https://england.shelter.org.uk
- Anna Freud Centre: https://www.annafreud.org
- Institute for Health Visiting: https://ihv.org.uk/for-health-visitors/resources/national-reports/
- National Childbirth Trust: https://www.nct.org.uk/about-us/annual-reports
- The Breastfeeding Network: https://www.breastfeedingnetwork.org.uk/

Appendix 3: Inclusion and exclusion criteria for each evidence review

When screening papers, the following criteria was prioritised for each evidence review:

London Borough of Redbridge:

Parameter	Inclusion Criteria	Exclusion Criteria
Origin of study	UK or countries with a similar health visitor programme (e.g., Sweden)	Research conducted with non-UK or Sweden samples
Population of focus	Disadvantaged or vulnerable families (e.g., low-income, ethnic minority groups, refugees/immigrants)	Families who access the health visitor checks.
Intervention of focus	Papers that explore uptake and engagement with mandated health visit checks.	Papers exploring uptake and engagement of other services.
Full-text	Free full-text articles	Abstract only
Publication language	English	Written in other languages

London Borough of Merton:

Parameter	Inclusion Criteria	Exclusion Criteria
Origin of study	UK or comparable countries including other European countries, the US, Canada, Australia, New Zealand.	Other international papers
Population of focus	First time or new parents. Prioritized studies that focused on parents living in deprived areas.	Papers that focused on parents with more than one child.
Intervention of focus	Papers that reviewed new parents' engagement or uptake of universal interventions or programmes that focus on baby development, bonding or peer support.	Papers that explored targeted-indicated interventions.
Full-text	Free full-text articles	Abstract only
Publication language	English	Written in other languages

FSN:

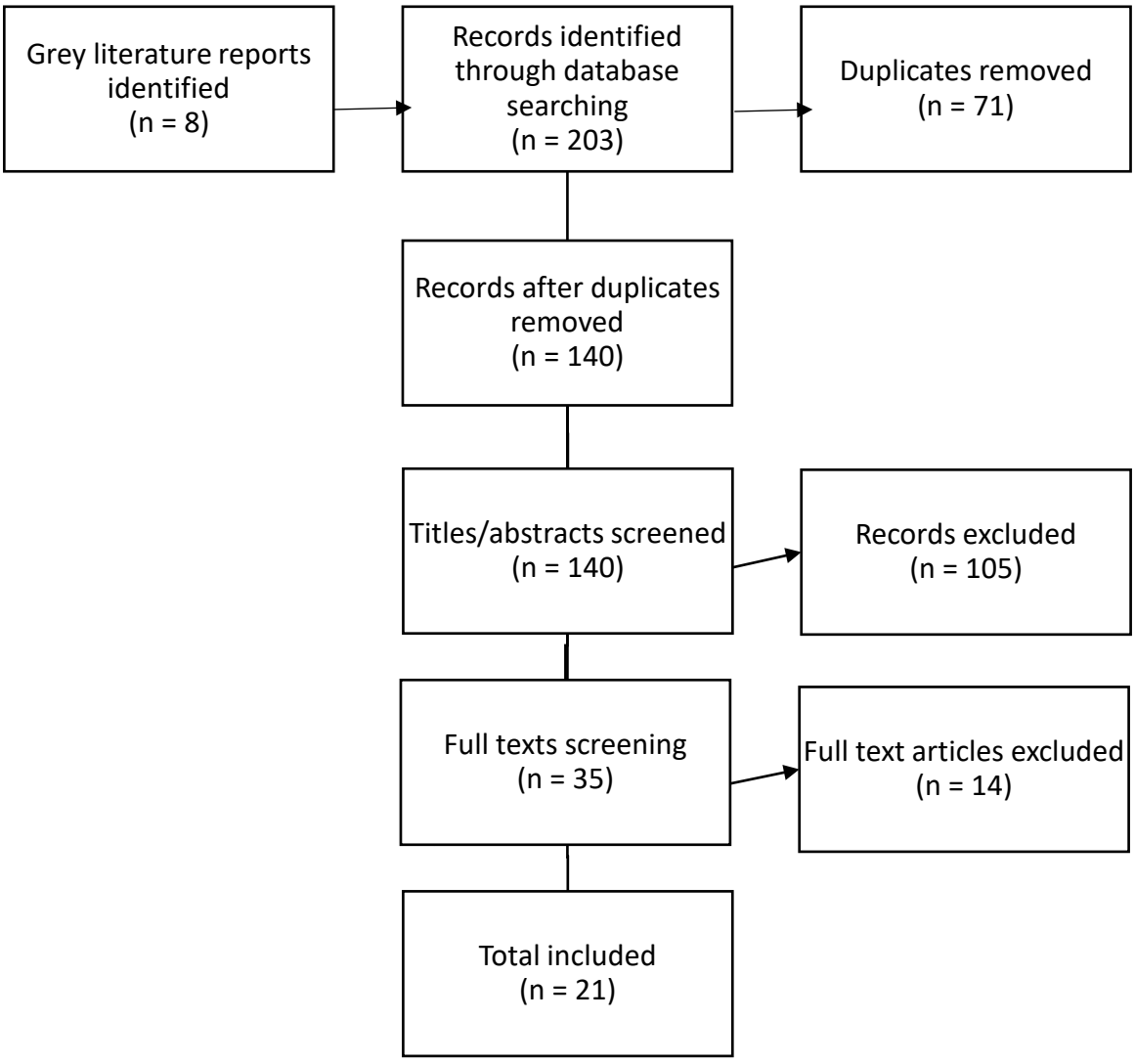
Parameter	Inclusion Criteria	Exclusion Criteria
Origin of study	UK or comparable countries including other European countries, the US, Canada, Australia and New Zealand.	Other international papers
Population of focus	Families living in temporary accommodation or experiencing homelessness (e.g., living in bed & breakfasts, hotels, refuges/hostels, short-term tenancy accommodations).	Families not living in temporary accommodation or experiencing homelessness.
Intervention of focus	Studies that focused on family's uptake of and experiences of accessing and engaging with services to support families that are delivered in community settings(e.g., peer support, advice services, laundry resources).	Papers that explored uptake of support not offered in community settings.
Full-text	Free full-text articles	Abstract only
Publication language	English	Written in other languages

Sheffield City Council:

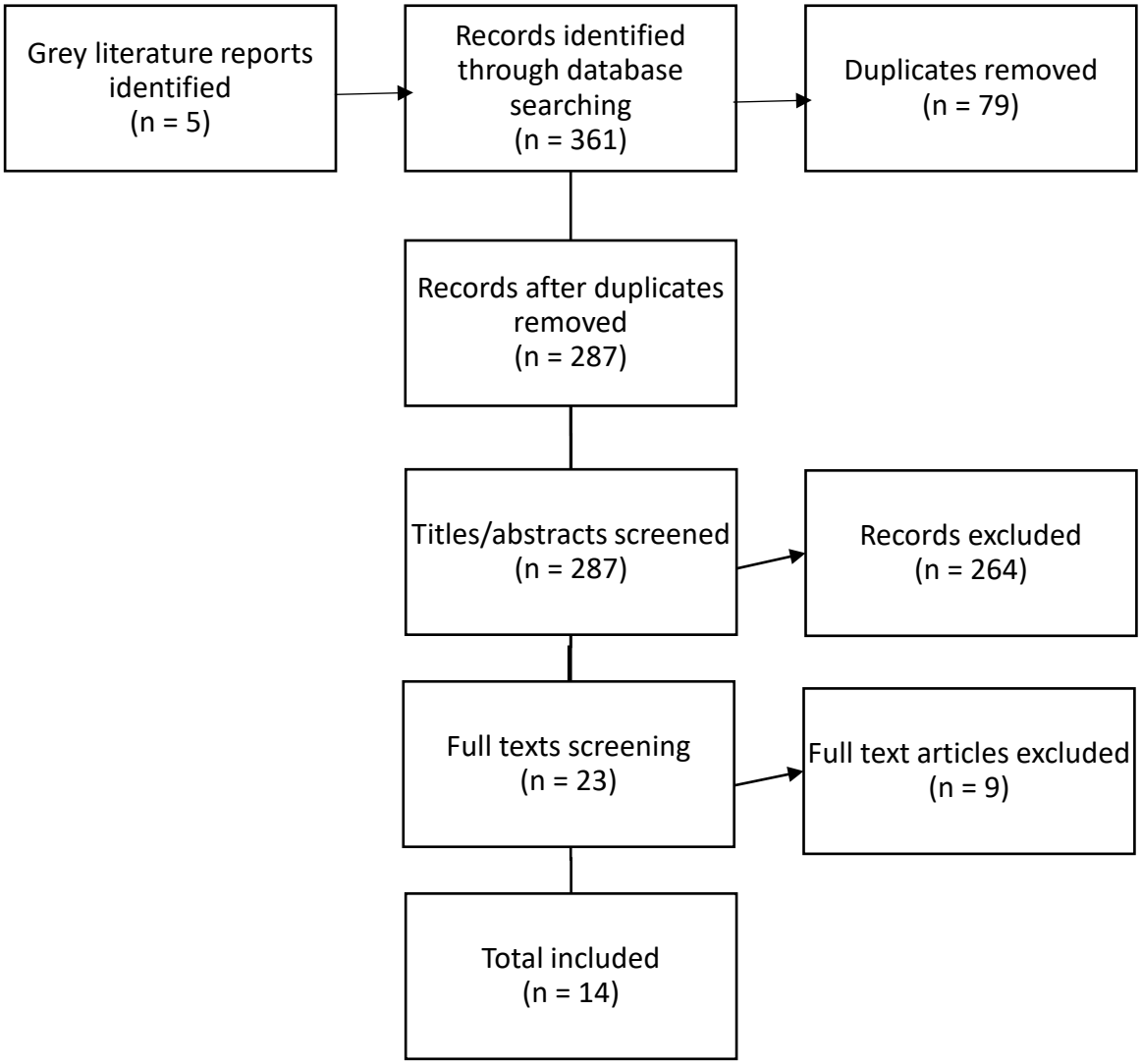
Parameter	Inclusion Criteria	Exclusion Criteria
Origin of study	UK or in comparable countries. Including other European countries, the US, Canada and Australia, and New Zealand.	Other international papers
Population of focus	Young mothers, including adolescent mothers (aged 14-18 years) and mothers aged 18-25 years living in disadvantaged or deprived areas.	Mothers aged above 25 years
Intervention of focus	Papers that focused on engagement or uptake of infant feeding support programmes or interventions that are delivered in community settings.	Papers that explored uptake of other services or similar services not offered in community settings.
Full-text	Free full-text articles	Abstract only
Publication language	English	Written in other languages

Appendix 4: PRISMA diagram for each evidence review

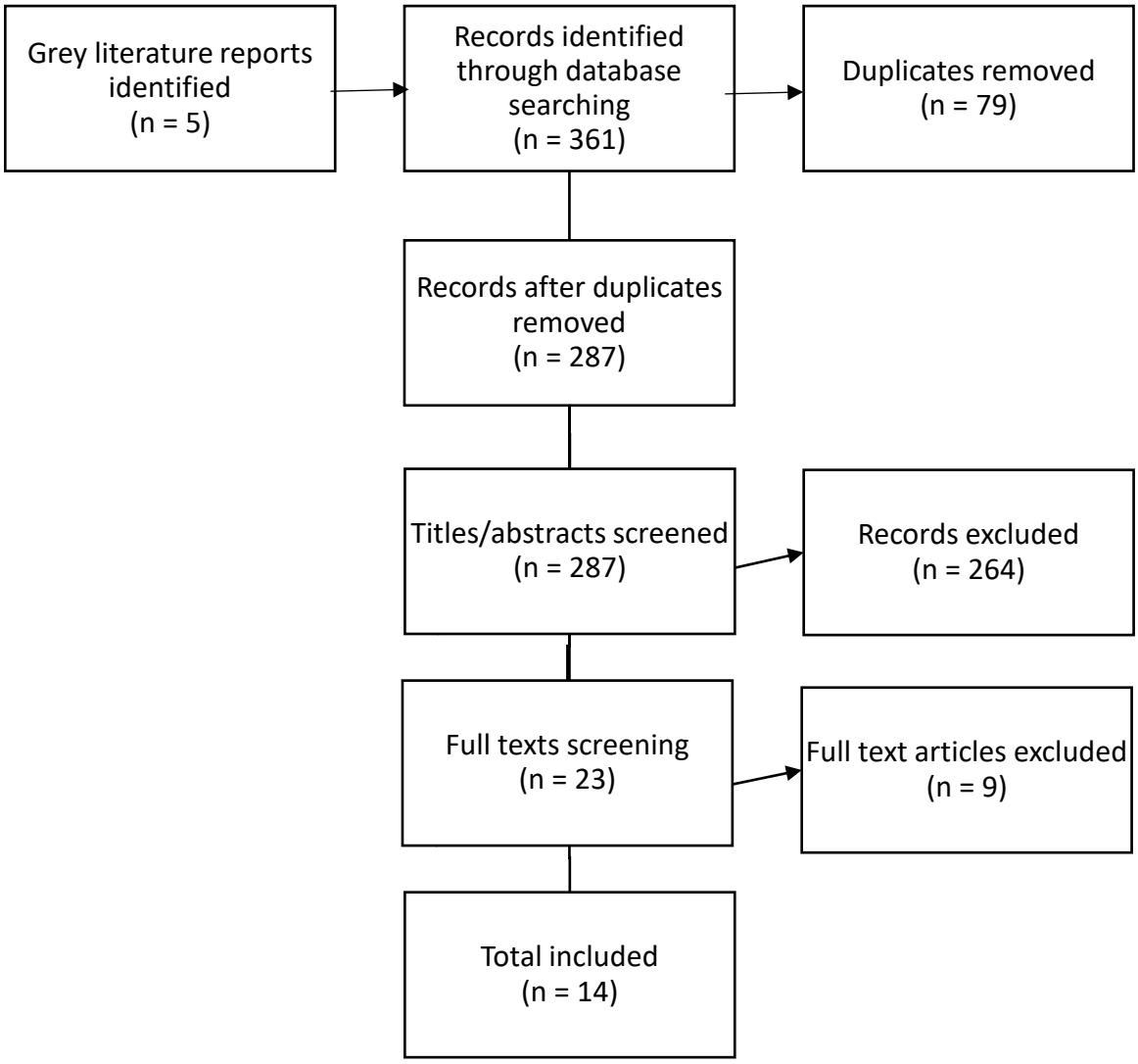
London Borough of Redbridge:



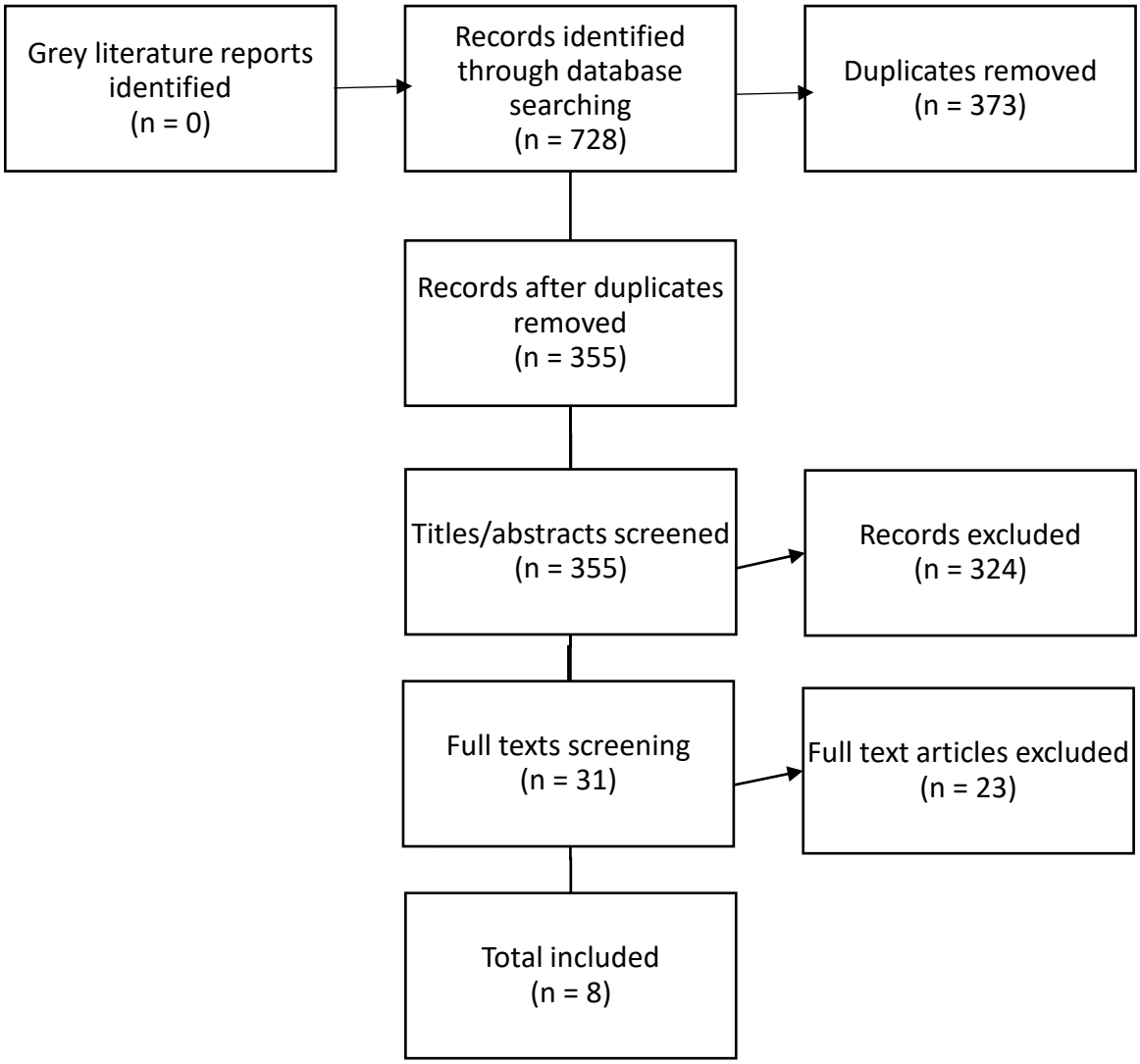
London Borough of Merton:



Fellowship of St Nicholas:



Sheffield City Council:



Appendix 5: Methodology and sample information for London Borough of Redbridge evidence review

Author	Date	Location	Study design	Aims	Sample
Almond & Lathlean	2011	UK	Qualitative (case study)	To investigate equity in the provision of a public health nursing postnatal depression service	Health visitors (particularly those with current or past Bangladeshi clients;' *n* = 16) Health visiting managers (*n* = 6) Subsidiary workers who worked with health visitors (*n* = 3). Health visitor clients (*n* = 21): English (*n* = 12); and Bangladeshi (*n* = 9)
Barboza et al.	2021	Sweden	Qualitative (included analysis of documentation, interviews with parental advisors, and observation of home visits).	To explore the practice and contributions of parental advisors from the preventive social services in a home visiting collaboration with CHC in a socioeconomically disadvantaged area of Sweden	Documentation of 481 home visits from 2013-2016 written by the three parental advisors who were then working in the program. Seven parental advisors (all female) from the Rinkeby extended home visiting program (interviews,1.5-2hrs)

Author	Date	Location	Study design	Aims	Sample
Brook & Salmon	2017	UK (South West)	Qualitative (semi-structured interviews and focus groups)	To explore the extent to which a new service policy aimed to increase the health visitor workforce by 4200 additional practitioners between 2011 and 2015, in parallel with introducing a new service model to provide comprehensive and accessible support for parents with children 0–5 years met parental expectation and need	Parents (n = 22; 21 mothers, 1 father) Three focus groups with parents, comprising of five, four and three parents, respectively, and 10 face-to-face interviews were held in four Children's Centres in the region on five separate occasions between March 2013 and March 2014
Conti & Dow	2020	England	Grey literature	This report provides evidence on the impacts of COVID-19 lockdown restrictions and redeployment on the ability of health visitors to deliver a service to children and families.	Individuals working in the health visiting profession in England (n = 663) - 98% are female - 88% White British or Irish - Average age is 50 - 55% have worked as a HV for 10 years or more
Cowley et al.	2018 (1)	UK	Scoping study / narrative review & Qualitative (interviews)	To remedy the gap in evidence about service models for achieving universal service provision.	44 parents (42 mothers, 2 fathers) 53 participants from early implementor sites: students, health visitors, managers, lecturers, strategic health authority leads

Author	Date	Location	Study design	Aims	Sample
Cowley et al.	2018 (2)	UK	Scoping study / narrative review & Qualitative (interviews)	To describe the essential features of a successful health visiting service, drawing on a programme of research commissioned as part of the Implementation Programme (DH, 2011)	44 parents (42 mothers, 2 fathers) 53 participants from early implementor sites: students, health visitors, managers, lecturers, strategic health authority leads
Donetto et al.	2013	UK	Grey literature	To briefly review the academic literature on service users' views of health visiting and to provide an in-depth analysis of service users' accounts of their experiences of engaging with health visiting services, with a particular focus on the 'Universal Plus' level of the family offer	-
Drennan & Joseph	2005	UK (inner London)	Qualitative (semi-structured interviews)	Reports on an exploratory study of health visitors' strategies in addressing the health needs of women asylum seekers and refugees living in Inner London	13 health visitors experienced in working with women and families who are refugees
Edge	2011	UK (Northwest England)	Qualitative (focus group interviews)	To examine stakeholder perspectives on what might account for low levels of consultation for perinatal depression among a group of women who are, theoretically, vulnerable (black Caribbean women).	Black Caribbean women (n = 42) NB the study also captured healthcare professionals (n = 42) - but these were reported in a separate paper

Author	Date	Location	Study design	Aims	Sample
Government Report: The Best Start for Life	2021	UK	Grey literature	This was a review into improving health and development outcomes for babies in England – aims to inform longer term work in this area.	Review is made up of consulting an advisory board of government ministers, civil servants, academics and practitioners. Also conducted a questionnaire (n = 3614 respondents): - 2633 parents and carers - 266 organisations or charities - 715 academics or healthcare professionals
Hogg & Mayes	2022	UK	Grey literature	This report describes the ongoing impact on babies, young children and their families, and the services that support them.	It sets out the results of a review of relevant reports, research and national data, and a new survey of 555 professionals and volunteers who work with babies and their families in health visiting and other services.
Hogg et al.	2015	UK (Scotland)	Qualitative (semi-structured interviews and focus groups)	To explore (1) Pakistani and Chinese women's experience of parenthood and the health visiting service, and (2) health visitors' experience of working with Pakistani and Chinese families.	Mothers (n= 31; 16 Pakistani mothers, 15 Chinese mothers) participated in individual interviews Mothers were recruited (mainly via HVs). Bilingual RAs assisted in recruitment and conducting the interviews for those mothers who did not speak fluent English. ½ of participants from each ethnic group had fluent English & the other ½ had little or not English. Health visitors (n=8; 7 White, 1 African), took part in one or two focus groups

Author	Date	Location	Study design	Aims	Sample
Local Government Association	2017	England	Grey literature	To report on case studies from local authorities of implementing health visiting services	-
Longfield et al.	2020	UK	Grey literature	This report details a blueprint for an early year's system which gives every child the right start in life.	-
Morton & Adams	2022	UK (England)	Focused scoping review (focused sample of data was drawn from a range of published evidence sources).	To consider the impact of the pandemic response on the health visiting service supporting families with children under 5 years in England in 2020	Sample varied: - Data was extracted from eight national survey studies (included data from 2585 HV's, 141 employers, and 36,000 parents/families.
Roche et al.	2005	UK (London)	Qualitative (interviews and focus groups)	To examine parents' views of child health surveillance and health promotion programmes offered during the first year of their child's life	35 participants (34 mothers; 1 father) participated in either one of 5 focus groups (n=18), an individual interview (n=12) or a brief interview in a clinical setting (n=5). No specific demographic details recorded but authors do say that participants represented a wide range of socio-economic backgrounds reflecting local diversity.
Russell & Drennan	2007	UK	Web-based survey (mixed methods)	To explore mothers' views about sources of support and experiences accessing the health visiting service	Mothers (n = 4665) responded to the survey of nine questions. Over half of mothers (54%) had a child aged under two years. No other demographic detail reported except for geographical spread of respondents.

Author	Date	Location	Study design	Aims	Sample
Saunders & Hogg	2020	UK	Grey literature	To gain insights into the impact of COVID-19 on babies and their parents of all backgrounds from across the UK.	Survey had 5474 respondents: - 91 fathers and/or other co-parents - 1480 pregnant women - 800 mothers who had given birth during the lockdown - 373 parents from Black, Asian and minority ethnic communities - 390 parents had a household income of less that 16k - 3903 were parents of a baby 24 months or under
Shribman & Billingham	2009	UK	Grey literature	To provide an overview of the Healthy Child Programme that is delivered across the UK.	-

Appendix 6: Original Theory of Change submitted by London, Redbridge

Why is intervention needed?	Who are the target group?	Which service is the intervention aiming to increase uptake of?	How will uptake be increased?	What is the intended outcome?
Uptake of the 2-2½ year universal developmental review is low. Therefore, a significant proportion of children with increased need for support are not identified until they start school.	Asian- British families living in the Loxford area. .	Improved uptake to the 2-2½ year review.	Through improving awareness and promoting the benefits of the 2-2½ year review using communication materials.	Improved uptake to the 2-2½ year review Increase referrals into universal and targeted provision Improved rates of children that are 'school ready'/ready to learn at reception

Appendix 7: Methodology and sample information for London Borough of Merton evidence review

Author	Date	Location	Study design	Aims	Sample
Action for Children	2021	UK	Grey literature	This briefing details the expansion and development of Action for Children's online parenting support service, Parent Talk.	-
Action for Children	2021	UK	Grey literature	This briefing reports on statistics and figures to show the difficulties faced by parents through the pandemic.	-
Asmussen et al.	2016	UK	Grey literature	This review aims to assess and identify the best evidenced interventions within the UK to provide advice for policy makers and commissioners about how to help parents improve how they live and play with their children up to age 5.	-
Axford et al.	2015	England	Grey literature: Rapid Review	The purpose of this rapid review is to update the evidence since the previous review in 2009. The review aimed to synthesise relevant systematic review level evidence about 'what works' in key areas.	-
Barrett, Hanna, and Fitzpatrick	2018	Australia	Qualitative	To explore first-time mothers' perspectives on the barriers to parental participation in first-time parents' groups which seek to facilitate a positive transition to parenthood by enhancing parental well-being, child-parent interaction, social networking, and parental confidence in child rearing.	8 first-time mothers • Mean age (31 years), range 26 – 34. • 75% (n=6) were married. • 63% (n=5) were working full or part-time. • 63% (n=5) had received education at undergraduate level or higher • 100% (n=8) English was the language spoken at home • 63% (n=5) reported Australia as their place of birth

Author	Date	Location	Study design	Aims	Sample
Clarke et al*	1995	Australia	Survey	To evaluate the first-time mothers' group programme which was conducted in Victoria, Australia	639 mothers
Cox and Docherty	2008	UK	Survey	To evaluate a five-session health visitor-led first-time parent group, which aims to develop parents' knowledge and skills and promote the well-being of both parents and infants.	56 parents attended a first session of the group and completed the pre-group questionnaire, and 38/56 completed a post-group evaluation. • 55/56 were first-time mothers, 1 first-time dad. • The average age of the babies whose parents attended the group was 16.09 weeks.
Government Report: The Best Start for Life	2021	UK	Grey literature	This was a review into improving health and development outcomes for babies in England – aims to inform longer term work in this area.	Review is made up of consulting an advisory board of government ministers, civil servants, academics and practitioners. Also conducted a questionnaire (n = 3614 respondents): • 2633 parents and carers • 266 organisations or charities • 715 academics or healthcare professionals
Hanna, Edgecombe, Jackson, and Newman	2002	Worldwide	Review/commentary article	This review/commentary article explores the benefits of first-time parent groups.	-

Author	Date	Location	Study design	Aims	Sample
Hickey, McGilloway, Leckey, Stokes, Bywater and Donnelly	2021	Ireland	Mixed-methods	To explore the processes and factors that influence the implementation of the Parent and Infant (PIN) programme (a group-based early parenting intervention), including factors influencing programme adoption and acceptability.	*Programme facilitators:* Participants in the one-to-one or small group interviews included community-based service managers (n = 4), PHNs and Nurse Managers (n = 6), family support workers, and community-based practitioners/volunteers (n = 12). Focus group participants included programme facilitators and implementers, most of whom were PHNs (n = 10). *Parents:* Parents who took part in interviews included 22 mothers who were aged, on average, 32 years (SD = 6.2), over half of whom (55%; 12/22) were first-time mothers and came from low-income families. Focus group participants included 5 mothers and 1 father.
Leckey, Hickey, Stokes, and McGilloway	2019	Ireland	Qualitative	To (1) assess the initial experiences of parenthood amongst mainly disadvantaged mothers (data not extracted); (2) explore their views on the extent to which they felt they had benefitted (or not) from participating in a newly developed, intensive mother and baby support programme in the community (which seeks to promote positive attachment, as well as strategies to enhance baby's physical, socio-emotional and language development); and (3) explore the perspectives of those who delivered the programme (i.e., facilitators), most of whom were Public Health Nurses (PHNs).	22 mothers and 25 facilitators • 77% (n=17) were first-time mothers • Mean age of mothers (30 years), range 18 – 41 years • Mean age of infants (16.9 months, range 3 – 30 months • 55% (n=12) were working full-time, prior to becoming pregnant • 77% (n=17) were married or cohabiting • 55% (n=12) held a degree or professional qualification. • 74% (n=14) were considered disadvantaged, based on the presence of two or more factors (lone parent, unemployment, large family of >3 children, early school leaver, anti-social environment/criminal activity)

Author	Date	Location	Study design	Aims	Sample
Sourander, Laakso, and Kalland	2021	Finland	Survey	The study investigated (i) the benefits reported by first-time parents after attending a Families First mentalization-based group intervention and (ii) looked for indicators of mentalization (data not extracted).	367 mothers and 183 fathers • Most of the mothers were aged 30 years or under and most of the fathers were aged from 31 to 35 years. • Most had either a high-school diploma, vocational training or a bachelor's degree
Taket and Crisp	2021	Australia	Mixed-methods	To evaluate a region-wide brief relationship education programme (which seeks to prevent violence by promoting respect and equality between couples), for first-time parents implemented in the maternal and child health setting	• 40 interviews with parents (26 female) • 4 interviews with parents who attended antenatal sessions (3 female) • 10 interviews with programme facilitators (6 males) • 10 interviews with maternal and child health staff and other stakeholders (9 females) • Survey with 342 parent's to explore their views immediately post-program (185 females) • Survey with 87 facilitators
Underdown and Barlow *(Study sample same as Underdown, Norwood, Barlow)*	2011	UK	Mixed-methods	To examine what factors influence the uptake, delivery, and outcomes of eight infant massage programmes delivered on a weekly basis to mother-infant dyads in Sure Start children's centres, located in areas of socio-economic disadvantage.	39 mother-infant dyads and 10 infant massage programme facilitators.

Author	Date	Location	Study design	Aims	Sample
Underdown, Norwood, and Barlow *(Study sample same as Underdown and Barlow)*	2013	UK	Mixed-methods	To identify the content, mechanism, and outcome patterns across a sample of 39 mother-infant dyads attending eight infant massage programmes in Sure Start children's centres, located in areas of socio-economic disadvantage.	39 mother-infant dyads • 72% (n=28) White British; 28% (n=11) other ethnicity. • 51% (n=20) female. • 54% (21) aged 16 – 30 years. • 48% (n=19) had received education beyond the age of 16 years, with 28% (n=11) achieving degree-level education. • 77% (n=30) living with partner. • 56% (n=22) of infants were firstborn. • All infants were between 5 and 26 weeks of age.

Appendix 8: Original Theory of Change submitted by London Borough of Merton

Why is intervention needed?	Who are the target group?	Which service is the intervention aiming to increase uptake of?	How will uptake be increased?	What is the intended outcome?
Data shows a lack of representation from families living in deprivation taking up a place on the Early Learning Together (ELT) Baby programme	New, first-time parents living in the borough of Merton, with a focus on those living in <30% IDACI areas.	ELT Baby is a five-week programme to support new parents.	Targeted promotion and outreach activities delivered in partnership with local community, voluntary and faith groups and through development of parent champion roles.	Increase in overall uptake of programme, with additional increase in uptake from those living in <30% IDACI areas.

Appendix 9: Methodology and sample information for FSN evidence review

Author	Date	Location	Study design	Aims	Sample
Bradley et al.	2020	UK	Formative mixed methods evaluation – pre/post questionnaires; semi-structured IVs	Evaluation of Empowering Parents, Empowering Communities-Temporary Accommodation (EPEC-TA), a parenting intervention based on the existing EPEC peer-led model with specific adaptations for a temporary accommodation setting.	15 parents (mean age=29.21years; 1 male and 14 females). 13 participants (87%) were full-time carers for their children, with the remaining parents working p/t or f/t. 9 parents (60%) did not have English as a first language and 12 parents (80%) were from ethnic minority communities. Number of children per family ranged from 1 to 4 (M=2); age range 2–9 years.
Bradley et al.	2018	-	Systematic Critical Review and Thematic Synthesis	How Does Homelessness Affect Parenting Behaviour? A Systematic Critical Review and Thematic Synthesis of Qualitative Research	-
Brott et al.	2020	US	Mixed methods – surveys and interviews	Exploring hardships and supportive factors for unhoused families led by single mothers who have successfully graduated from two transitional housing programs, one rural and one urban.	Rural program: Mothers ranged in age from 18 to 44 years (M = 30.34, SD = 5.81). Sample was predominately white (68.7%) and commensurate with county-level homeless population data (72.1% white). Average education level was high school diploma or equivalent, with over half (57%) of the participants having completed some college/trade school. Urban program: Participants ranged in age from 21 to 59 years old (M = 35.26, SD = 7.35). Most of the sample identified as Black/African American (38.1%), White (31.7%), or Hispanic (20.1%). Average education level was less than a high school diploma, with only 42.4% having successfully completed high school.

Author	Date	Location	Study design	Aims	Sample
Carson et al.	2016	UK	Descriptive summary article	Exploring risk factors for homelessness, what works for service provision, pathways and early years support – based on “Cardiff Early Years Family Team”. The team evolved from successful experiences of multidisciplinary working within Sure Start – now Flying Start in Wales – and lessons learned from earlier unsuccessful attempts to reach and engage families living in TA.	-
CHAMPIONS Project	2021	UK	National 18-month project (mixed methods)	To explore the impact of the COVID-19 pandemic and living through the lockdown on children under 5 who are living in temporary accommodation.	-
Cooper	2023	UK	Grey literature	This report takes a closer look at how this national crisis has affected children, families and young people using Barnardo’s services during winter 2022/23.	The report includes YouGov polling of a representative group of 1000 parents in Great Britain and findings from a survey of 316 children and young people supported by Barnardo’s, aged 11 to 25. A focus group of young people and case studies from Barnados services across the UK.
Crasnow et al.	2020	UK	Descriptive summary article	Reflections on delivery of a drop-in parent–toddler group in a homeless hostel. Theoretical background, context for the group, challenges encountered and interventions developed to meet them.	-

Author	Date	Location	Study design	Aims	Sample
Gewirtz et al.	2013	-	Book chapter	Research on programs designed to support positive parenting – In: Supporting families experiencing homelessness: Current practices and future directions	-
Harris-McKoy et al.	2015	US	Qualitative (diaries)	Family therapists reflections on delivery of parenting education programme for parents in transitional housing programme	5 x family therapists
Haskett et al.	2014	-	Qualitative systematic review	Parenting interventions in shelter settings: a qualitative systematic review of the literature	-
Haynes & Parsons	2009	UK	Descriptive summary article	Describing experiences of working with families in temporary accommodation	-
Holtrop & Holcomb	2018	US	Mixed methods	The purpose of this study was to adapt and pilot test a parenting intervention for homeless families in transitional housing.	12 parents. Nine parents (75%) were female and three (25%) were male. Parents reported an average age of 34.2 years (SD = 4.5). 75% Black and 25% White. Two parents (16.7%) reported a Hispanic/Latino identity. Participants had an average of three children (M = 3.18; SD = 1.66). Participants living in transitional housing for a median of 3–4 months. Majority of participants had at least high school diploma or GED (90.9%).

Author	Date	Location	Study design	Aims	Sample
Holtrop et al.	2015	US	Qualitative (semi-structured interviews)	To identify relevant components to include in a parenting intervention for homeless families in transitional housing. Data were gathered from 40 homeless parents through semistructured individual interviews and were analyzed using qualitative content analysis.	1 biological mothers, eight biological fathers, and one nonbiological male caregiver from a total of 33 families. Average age of 35.0 years (SD 7.58). 50.0% White and 47.5% African American (with one additional participant self-identifying as “other”). (72.5%) of participants had been living at the transitional housing community for 2 months or less, 17.5% had been there 3– 4 months, and the remaining 10% had been there at least 5 months. Average of three children (M 3.15; R 1–9), and 1-2 children (M 1.63; SD 0.87) typically resided with the parent at the transitional housing community.
Jenkins & Parylo	2011	UK	Survey	This paper reports on a survey of homeless families in 11 hostels in Leicester that aimed to inform improved services for them.	49 responses were received out of 167 hostel residents who were approached to take part (29%). Of the respondents, 90% (n=44) were female, chiefly aged under 30 years (85%, n=42) and most (65%, n=32) had been homeless or in temporary accommodation for less than a year. 43% (n=21) of respondents were aged under 20 years.
Kilmer et al.	2012	US	Descriptive summary article	Conceptual and empirical arguments for service systems, providers, and community supports to address the circumstances of children and families experiencing homelessness and, more specifically, to better attend to their ecologies and the diverse factors that can affect their well-being.	-

Author	Date	Location	Study design	Aims	Sample
McCoy et al.	2015	Merseyside	Grey literature	An evaluation to build on findings from a previous evaluation which illustrated positive outcomes in preventing homelessness for the whole family. This evaluation looks specifically at how supporting families achieves outcomes for CYP who are at risk of becoming NEET (not in education, employment or training).	12 in-depth interviews with 10 families (10 parents & 11 children aged 8-21). Interviews and a workshop with 18 Shelter staff and other professional partners involved in service delivery in Knowsley.
NEF Consulting	2015	London	Grey literature	This report sets out the evaluation of Shelter's Hackney Family support service.	-
Sheller et al.	2018	US	-	This article describes the development and implementation of the Family Care Curriculum (FCC) train-the-trainer parenting support program specifically designed to support positive parenting in families experiencing homelessness.	-
Shelter	2023	UK	Grey literature	To explore households' experiences of living in temporary accommodation	Conducted research with 1112 people living in temporary accommodation. The sample reached across England and was broadly representative of all households in temporary accommodation.
Swick	2009	US	-	Strengthening Homeless Parents with Young Children Through Meaningful Parent Education and Support	-

Author	Date	Location	Study design	Aims	Sample
Tischler et al.	2004	UK	Mixed methods – questionnaires and interviews	The objective of the present study was to establish the psychosocial characteristics and perspectives of 49 consecutive homeless families who received input from a new designated family support worker (FSW) post at a large statutory hostel for homeless parents and children.	The majority of families consisted of mother and children (n = 33, 67%), with the remainder being couples with children (n = 14, 29%), and father and children (n = 2, or 4%). Families had a mean number of three children (range = 1–7). White British (n = 30, 61%), Asian (n = 7, 14%), White Irish (n = 5, 10%), Black African (n = 4, 8%) and Middle Eastern (n = 1, 2%); ethnicity was not recorded in two cases. Carers' mean age 32.3 years [range = 19– 46 years; 95% confidence interval (CI) = 30.4–34.3] and the children's mean age was 7.6 years (range = 2–17).
Wilson & Barton	2023	England	Grey literature	This report explores the current situation of temporary accommodation across England, including figures and recommendations	-

Appendix 10: Original Theory of Change submitted by FSN

Why is intervention needed?	Who are the target group?	Which service is the intervention aiming to increase uptake of?	How will uptake be increased?	What is the intended outcome?
Families living in temporary accommodation are on the increase but these families still remain marginalised through a lack of knowledge of the services available and under representation in local statistics i.e. service use.	Research will target families who are currently living in temporary accommodation i.e. B&Bs, hotels, refuge/Hostels, short-term tenancy accommodation who have little or no interaction with local services	Activities in the hub which facilitate peer support e.g. laundry resources, cooking hot meals, IT resources, space for homework.	Widening outreach activities/promotion, going out to where families are placed	Families engage with the outreach activity. Families feel more included and, have better understanding of support services available to them and routes into housing. Local services/agencies gain improved knowledge of marginalised families living in temporary accommodation Families feel more resilient, motivated, confident to seek help and participate in local services. Families engage with activities in the centre

Appendix 11: Methodology and sample information for Sheffield evidence review

Author	Date	Location	Study design	Aims	Sample
Andrews et al.	2015	UK (Scotland)	Qualitative (semi-structured interviews)	To determine current infant-feeding practice and any changes in practice following attendance at workshops, mothers' knowledge of appropriate infant-feeding practices and mothers' opinions of current infant-feeding advice	15 interviews: • 11 primiparous; 4 multiparous • 5 mothers aged between 18-25 years; 8 aged 25-34 years; 2 aged 35-44 years. • 3 mothers had an infant aged 10-15 weeks at time of first workshop; 7 mothers had an infant aged 16-21 weeks; 5 mothers had an infant aged 22-27 weeks • 4 mothers were categorised as being most deprived (using the SIMD deciles scoring 1-2); 7 mothers scored 3-4 on the SMID; 4 scored 5-6. • SMID, Scottish Index of Multiple Deprivation

Author	Date	Location	Study design	Aims	Sample
Bengough et al.	2022	Worldwide	Systematic review	A systematic review of qualitative research that has explored women's experiences and perceptions regarding breastfeeding support programmes – both formal breastfeeding support in hospitals by healthcare providers and informal support from community support groups	22 qualitative studies • Of the 22 studies, 3 reported research in LMICs: South Africa (N= 1), Brazil (N= 1), Malawi (N= 1), 19 took place in HICs: the United Kingdom (N= 6), Sweden (N= 2), the United States (N= 7), Australia (N= 3) and Ireland (N= 1). • Most studies (n=13) focused on first-time mothers. • Eight studies focused on support programmes in a hospital or health care setting. • Eight studies focused on support programmes in more than one setting. • Of these, six focused on routine support from the hospital staff rather than a specific support programme • Two studies focused exclusively on support implemented in the home setting. • One study focused on support in a group setting. • One study focused on a virtual setting. • Two studies did not report the setting.

Author	Date	Location	Study design	Aims	Sample
Buckland et al.	2020	USA & Chile	Systematic review and meta analysis	A systematic review and meta-analysis to examine the range and effectiveness of interventions which have been designed to increase rates of exclusive breastfeeding among young mothers in high income countries.	Focusing on study's that were randomised controlled trails and quasi-experimental designs. Nine studies were included in the systematic review, and four of these were included in a meta analysis: Eight studies were conducted in the USA and one in Chile. Seven studies were RCTS, and two were quasi-experimental. Mothers' age ranged from 17-24 years Interventions/strategies implemented in the studies included pre-natal breastfeeding education (n=2), peer support (n=5), professional support (n=4), financial incentives (n=1), gift pack (n=1), telephone support (n=5) and massage (n=1). Five studies also included a peer counselling component and four using a combination of peer counselling and telephone support. Of the 4 studies included in the meta-analysis 3 were peer counselling interventions, and 1 involved education and telephone support. Overall, there was modest to no effect on rates of exclusive breastfeeding in 5 studies (this included interventions such as telephone support, peer counselling, massage, prenatal education and financial incentives). Three studies found a positive effect (interventions included a combination of peer counselling & telephone support). Two studies which used a combination of education and peer counselling & financial incentives found a statistically significant positive effect on breastfeeding duration and/or breastfeeding rates but not exclusive breastfeeding. Meta-analysis did not detect a difference in rate of exclusive breastfeeding to 3 months postpartum. Overall, peer counselling seemed the most promising strategy with higher rates of exclusive breastfeeding.

Author	Date	Location	Study design	Aims	Sample
Fox et al.	2015	UK	Qualitative (interviews & focus groups)	To explore women's experiences of breastfeeding in contemporary Britain, support from health professionals, friends and family and the experience of accessing support through the Baby Café initiative (i.e., a network of community-based breastfeeding support services – this is based upon the social model of support).	Interviews and focus groups were conducted across 8 sites. These sites were selected to represent a range of locations, settings, type of facilitator (e.g., health professional, breastfeeding counsellor) and length of time they had been running. Two sites were located in inner London, 2 in outer London 1 in rural Southeast England, 1 in a city and 2 in towns in Northern England. 47 qualitative interviews and 5 focus groups: • 33 primiparous and 18 multiparous women aged between 23 and 44 (extracted data focusing on young mothers)

Author	Date	Location	Study design	Aims	Sample
Hunt et al.	2021	UK	Systematic review and meta-ethnography	To explore existing qualitative research to determine how UK national non-profit breastfeeding organisations practice breastfeeding peer support services in areas of deprivation	16 qualitative studies • Studies include the views of 1033 mothers, 62 peer supporters and 113 health professionals. • Mothers ages ranged from 16 to 47 years. • All studies included took part in areas of deprivation, but only one reported participant's socio-economic characteristic. • Studies focused on qualitative accounts of UK non-profit breastfeeding organisations' practices in areas of deprivation.

Author	Date	Location	Study design	Aims	Sample
Hunt et al.	2021	UK	Case study	To explore and build theory about how UK non-profit breastfeeding organisations developed breastfeeding peer support services for areas of deprivation	Employed a case study method to explore the 'real life' context of a UK non-profit breastfeeding organisations approach to developing and delivering breastfeeding peer support services for areas of deprivation within the UK. Case study on two organisations: • Organisation A/Site 1: an urban post-industrial part of Northern England – an established black and minority ethnic community makes up 10-20% of population. In 2016, organisation A were commissioned to deliver universal postnatal peer support targeting mothers living in quintile 1 (most deprived) areas and young mothers (<20 years). Hospital hosted peer supporters and all women discharged who were BF received telephone call at 48h. Three peer supporters offered a proactive service which included home visits and ongoing text, phone, and home visit support as needed for 6 weeks, with invitation to ongoing virtual resources and community groups. • Organisation B/Site 2: affluent area in southern England with a small black and minority ethnic population and mix of urban/rural communities each with pockets of deprivation. In 2017, organisation B was commissioned to proved a universal peer support service with targeted support for women living in specific areas of deprivation with low BF rates. All women could call or text peer supporters for support, access online forums, or visit community support groups. Women living in target areas could sign up for proactive text and telephone support for first 6 weeks. • At each site a range of stakeholders (mothers who had/had not engaged with peer support, peer supporters, breastfeeding Peer Support Managers, health professionals and commissioners) to capture experiences from different standpoints. Forty interviews – 20 from site 1 20 from Site 2 (peer supporters = 9; mothers who had engaged = 10; mothers who had not engaged = 9; peer support service manager = 3; community midwives = 1; health visitors = 4; infant feeding co-ordinator = 2; commissioner = 2).

Author	Date	Location	Study design	Aims	Sample
Thomson et al.	2012	UK	Qualitative (interviews & focus groups) and quantitative outcomes	To explore the meanings and experiences attributed to receiving and giving incentives from the perspectives of women and peer supporters.	26 qualitative interviews • Women in the study were aged between 21 and 42 years • 14 had 1 child, 7 had 2 children, 4 had 3 children and 1 had 5. • 1 woman was Asian, and the remaining women were White-British Focus group: • 4 breastfeeding peer supporters who delivered the incentives and who had been working for as Star Buddies for 18-22 months – Star Buddies commissioned by the Breastfeeding Network (BfN) which is a registered charity to offer an extra tier of breastfeeding peer support to mothers before and after birth with the aim of increasing breastfeeding initiation rates and prevalence of breastfeeding at 6-8 weeks.
Watson et al.	2014	UK	Mixed methods	To explore infant feeding and breastfeeding peer support services in Middlesborough and Redcar & Cleveland	22 interviews and 10 focus groups. • Individual interview participants (n= 22) included service providers within the Foundation Trust (n=3), Community Health (n=6), the local authority (n=7), the voluntary sector (n=1), breastfeeding education (n=1) and peer supporters (n=1). A small number of interviews (n=3) were also carried out with mothers from the ethnic minority community. Individual participants (n=58) who attended one of 10 focus groups included representation from breastfeeding support groups (n=10), peer support groups (n=16), infant feeding groups, which included breast- and bottle-feeding mothers (n=18), drop-in health clinic (n=5), teenage pregnancy (n=3), fathers group (n=3), ethnic minority community (n=3)

Appendix 12: SCC Theory of Change

Why is intervention needed?	Who are the target group?	Which service is the intervention aiming to increase uptake of?	How will uptake be increased?	What is the intended outcome?
Young mothers, especially those living in deprived areas, are less likely to breastfeed. Uptake of infant feeding support services among young mothers is low, especially among young mothers living in deprived areas.	Young mothers aged 25 years and younger, living in Sheffield, who are pregnant or have recently had a baby. Particularly those from deprived areas in Sheffield.	Improved uptake of infant feeding support services delivered by Sheffield Family Hubs. Increased uptake of other Family Hub services.	Sheffield Family Hubs will develop and deliver a new antenatal and postnatal service for those aged 25 years and younger, providing infant feeding support, alongside other types of support, in an accessible city centre location. Sheffield Hallam University will advise on new behavioural-science informed messages to increase awareness and promote the value and benefit of this new service.	Increased uptake of infant feeding support services among young mothers aged 25 years and younger. Increased number of young mothers who breastfeed or intend to breastfeed. Increased awareness and intentions to use other Family Hubs services among young mothers.

Department for Education

Reference: RR1404

ISBN: 978-1-83870-533-6

For any enquiries regarding this publication, contact us at: FamilyHubs.RESEARCHANDANALYSIS@education.gov.uk or www.education.gov.uk/contactus

This document is available for download at www.gov.uk/government/publications