Early Years: Building A Sustainable Implementation

Early intervention

The evidence for investing in early intervention in the early years of a child's life is overwhelming. There is a large body of research evidence showing that environmental influences from conception to three years of age impact significantly on a child's academic, language, social and emotional development. Poor early life experiences can permanently impair the healthy growth of very young children's brains; whilst positive experiences can have the opposite effect, promoting healthy brain development. The central tenet of early intervention is that by preventing problems arising in the first place, and/or remedying problems as early as possible, families can be supported to help their children develop to their full potential. There is long standing research evidence that parent interventions can be highly effective in the prevention and treatment of emotional and behavioural difficulties in young children (Brestan and Eyberg 1998; Gardner et al. 2015).

Alongside the scientific case to be made for early intervention and the significant potential to improve outcomes for children, economists and politicians are increasingly recognising the financial case for early intervention (Allen 2011a). There are effective, evidence based interventions suitable for preschool children and their families which not only provide good outcomes but also have positive cost-benefit analyses. Investing funds in these interventions saves on wider public expenditure. It is therefore interesting that so few services implement these interventions robustly enough to have major impact on improving the psychological outcomes for children (Timimi 2015; Wolpert et al. 2017) and reducing the financial burden on the public purse (Scott et al. 2001).

In this chapter, a model for successful delivery, and sustainable implementation, of effective evidence based interventions, in the early years, will be discussed. This will include exploration of the role of national and local policy, of front line and strategic managers, training and supervision of staff, cultural beliefs and values; in addition, the barriers and obstacles commissioners, managers and workers face will be discussed.

Early child development

As discussed in the previous chapter, the very earliest experiences, from conception, shape a baby's brain development and have a lifelong impact on their mental and emotional health. From birth to 18 months, connections in the brain are created at a rate of one million per second. If these connections are not repeated many, many times the brain cells themselves will disappear; and it requires sensitive and responsive parenting from caregivers in order to establish critical brain mass. By 3 years of age a child's brain is 85% of its full development.

Yet babies are also at their most vulnerable to abuse and neglect in these early months. Most deaths of children occur in the perinatal period with babies being disproportionately vulnerable to abuse and neglect (Leadsom et al. 2014). In England, they are 7 times more likely to be killed than an older child; and 36% of serious case reviews involve a baby under one year of age. Perinatal mental health, domestic violence and substance abuse are frequently highlighted in such cases and it is estimated that approximately 26% of babies in the UK are living within complex family situations. There is now good medical evidence that when a foetus or baby is exposed to such toxic stressors it can permanently raise their cortisol levels leading to a distorted stress response in later life. Research consistently shows that these early difficulties are often the precursor to preschool behaviour problems, followed by conduct disorder in later life, alcohol and drug misuse, mental health problems and,

potentially, a life of social exclusion (Broidy et al. 2003; Fergusson, Horwood and Riddler 2005; Scott et al. 2001).

In order to support optimal brain development, it is imperative that babies have the best possible start in life; and there is longstanding research evidence that a strong attachment between a baby and the caregiver provides the basis for positive outcomes in terms of academic, social and emotional development. There is good evidence that effective interventions are available for babies, preschoolers and their caregivers to reduce these risks and provide a more stable foundation for child development.

National policy

Over the past decade there has been a wealth of national policy and cross-party collaborations highlighting the importance of early intervention in the early years. The basic premise being that identification of problems early in life will not only be the most effective in terms of child outcomes, but also the most cost-effective in terms of public expenditure.

One of the most influential was the publication of 'Early Intervention: Good Parents, Great Kids, Better Citizens' (Allen and Duncan-Smith 2008). This cross-party document concluded that, having looked at previous approaches to tackling antisocial behaviour, successive governments with multiple policies have failed to improve outcomes. It presented the case for intervening early and suggested that the major political parties put their differing views aside to tackle the intergenerational cycle of underachievement and social disorder. A follow up report, 'Early Intervention: The Next Steps' (Allen 2011b), proposed a radical new social policy of Early Intervention to deliver effective, evidence based interventions, to develop an Early Intervention Foundation (EIF), and to support the development of research in

innovative areas. It highlighted that child public expenditure was at its lowest when the child's development is most rapid and has the greatest capacity to change; with high levels of expenditure much later in life tackling mental health problems, antisocial behaviour and drug and alcohol addiction. A compelling case was made for preventative strategies, noting that the economic returns of intervening early were well documented.

A range of policy documents have been produced, all reinforcing the same message regarding the enormous significance of the early years. In 'The Marmot Review: Fair society, healthy lives' (Marmot 2010) it asserts that 'the foundations of virtually every aspect of human development are laid in early childhood. What happens during these early years (starting in the womb) has lifelong effects on many aspects of health and well-being.' 'The Foundation Years: Preventing poor children becoming poor adults' (Field 2010) and 'The Early Years: Foundations for life, health and learning' (Tickell 2011) both state the same important principles for better outcomes.

The Department for Education outlined in their service reform paper for 0-5 year olds that "The foundation years are vitally important both in their own right and for promoting future life chances. The moral argument is clear and the economic cost to society of failing children in the foundation years is becoming increasingly well understood" (Department for Education 2011). It emphasised the need to:

- focus on child development
- recognise that families are the most important influence on children in the foundation years
- promote effective and evidence based early intervention
- improve the quality of the workforce

Most recently the EIF published two documents (Asmussen et al. 2016; Axford et al. 2015) outlining that the strongest evidenced interventions targeted the early signals of risk:

- child behaviour problems
- insecure attachment
- delayed speech development
- lack of maternal sensitivity

They also highlighted the importance of the parent or primary caregiver as being best placed to support the child's optimal development. The Department of Health's 'Future in Mind' (NHS England 2015) restates the vital importance of early intervention and the need for effective evidence based parenting interventions.

With approximately 27% (and rising) of children living in poverty (Axford 2015), and all the risks associated with child poverty, it seems clearer than ever that tackling these issues from the point of conception is essential. The real question is, why do so few services provide the kinds of high quality care and interventions that all of these documents recommend and highlight as being of crucial importance; especially when the financial argument for early intervention is as strong as for child outcomes?

Implementation science

One of the biggest criticisms of evidence based interventions is that they don't transport well from research trials into 'real world' services. Implementation science is still relatively new and studies the process of implementing evidence based programmes into real settings. Increasingly there are models for implementation being developed and many programme

developers of existing evidence based programmes have their own research and strategies to support successful implementation. However, the evidence for successful, effective and sustainable implementations is still very limited despite these frameworks and redesign of the workforce. For example, children's services across England have, for eight years, had access to funded, accredited training and, managerial support and training, for service transformation of services to deliver evidence based interventions via Children and Young People's – Improving Access to Psychological Therapies (CYP-IAPT). Despite the success of workers trained in one year post-graduate diplomas in interventions, such as parenting interventions, there are still few robust examples of sustainable implementations of this evidence based intervention (Timimi 2015).

Another example is highlighted when taking a look at the National Institute for Health and Care Excellence (NICE) guidance for the treatment and prevention of behaviour problems (including conduct disorder, attention deficit hyperactivity disorder) and the promotion of social and emotional wellbeing in early years. Unsurprisingly, evidence based, group parent training is highlighted as a model of best practice (National Institute of Health and Care Excellence 2012, 2016, 2017). However, very few Child and Adolescent Mental Health Services (CAMHS) even take referrals of under five year olds, where we know intervention is most effective, cost-effective and preventative; and many CAMHS services do not provide group based parent training as part of their care pathways for older children with these difficulties either. Equally, very few early years' front line workers such as health visitors, nursery nurses, and family support workers have any remit in their job roles to deliver such evidence based interventions. There is no doubt these professionals work extremely hard and play a vital role in safeguarding children and supporting families. However, it does leave the

question about the evidence for their effectiveness in terms of measurable child outcomes and is this the best way to invest public funds?

Despite its relative infancy, implementation science tells us some important principles regarding the effective mechanisms involved in developing services to deliver successful evidence based interventions. Unfortunately, the least effective strategies are the most common (Fixsen 2005) and these include information dissemination alone and staff training in isolation. Fixsen (2005) states the key components for successful and sustainable implementation are:

- having a longer term and multi-level approach
- careful practitioner selection for training
- skills based training
- practice based coaching
- using fidelity measures
- practitioner evaluation
- programme evaluation
- facilitative administration
- being programme driven, not practitioner driven
- policy makers understanding the implementation themselves

Interestingly, most implementation models also highlight these themes, and the CYP-IAPT programme shares the same principles and methods too; and yet there are still very few examples of sustained, evidence based implementations. It appears there is a parallel process taking place, whereby the evidence we have for successful implementation is as difficult to implement as the intervention itself!

Children And Parents Service (CAPS), Manchester: A successful model of sustainable evidence based implementation in Early Years

Maybe there is something to be learnt by taking a look in some detail at models of best practice, where effective, evidence based interventions have been embedded successfully and have achieved and maintained positive outcomes for children and families over time. CAPS has consistently demonstrated impressive results using standardised, reliable and valid outcome measures; with significant improvements in child behaviour problems, and parental depression and stress. These results have been maintained over time, and data has shown that children are more ready for school and parents are more likely to get a job or go back to college as a direct result of the parenting intervention. These impacts are substantial and lifelong; so why are there not more services achieving this standard? It is possible, that whilst guiding principles are helpful, the actual details of applying them are worthy of more scrutiny.

The Children And Parents Service (CAPS) in Manchester is a citywide, jointly commissioned, multi-agency early intervention service that delivers effective, evidence based interventions to preschool children and their families. It was established in 1998 following a successful bid to identify behaviour problems in young children and to deliver evidence based parent groups in community settings across Manchester. The service has delivered the same evidence based intervention for almost 20 years and has been highlighted as a model of best practice by NICE for ‘Early Years: Social and Emotional Wellbeing’ (National Institute of Health and Care Excellence 2012).

CAPS initiated as a partnership between three organisations, Health (CAMHS), the Local Authority (Manchester City Council) and a third sector agency (Family Action; formerly Family Service Unit and Family Welfare Association). The CAMHS-led team consisted of a clinical psychologist and two family support workers to deliver the interventions, with the provision of funding for child care available as part of the bid. In addition, an assistant psychologist was appointed to support the evaluation of the project. The service was fairly innovative at the time and followed many of the principles that were later implemented by Sure Start.

The initial funding was for three years and was commissioned by the CAMHS commissioner as part of the NHS Modernisation Fund. The service's main aims were to identify early child behaviour problems, to deliver effective evidence based parent programmes and to provide a seamless referral process to other services where necessary. There is an enormous range of parent interventions available and understanding the research thoroughly in order to choose the most effective and cost effective is not an easy task. This chapter will not present the wealth of research regarding the many parenting interventions as this is already well documented in other texts (Brestan and Eyberg 1998; Furlong et al. 2012).

The evidence based parent intervention commissioned was the Incredible Years® Parent Programme due to its highly robust evidence base (Brestan and Eyberg 1998; Webster-Stratton 1990; Webster-Stratton 1997; Webster-Stratton 1998; Webster-Stratton 2000; Webster-Stratton and Reid 2012), including multiple randomised controlled trials by independent researchers, who were not the programme developer, across different settings and populations (Gardner 2015; Hutchings et al. 2009; McGilloway et al. 2014; Møerch et al. 2004; Scott et al. 2001).

The detail behind this initial phase reveals important factors about the implementation. Whilst most implementation models talk about the importance of a 'champion' within the service, this alone is not enough. It is also critical that the 'champion' has relevant knowledge and expertise in the evidence based programme chosen, has a thorough understanding of what it entails for model fidelity and crucially, has some authority for shaping the service delivery model.

It was also essential that this information and intelligence was shared and disseminated to commissioners and strategic leads so there was mutual understanding of the details. This process was established over a long period of time, via several face-to-face meetings with a collaborative approach. This included an understanding of the programme, its effectiveness, its cost-effectiveness and the enormous commitment required to deliver it to model fidelity (i.e. in exactly the same way it was delivered in the original research), in order to achieve the same positive outcomes. There are far too many examples of services with experienced, well-meaning practitioners delivering evidence based programmes poorly which simply doesn't work and wastes public money.

The Incredible Years® Parent Programme

The Incredible Years® Parent Programme is a series of evidence based interventions which focus on strengthening parenting competencies to improve the parent-child relationship, promote children's academic, emotional and social skills and reduce conduct problems. The research evidence for the programmes' effectiveness and cost-effectiveness is extensive and the findings have been replicated in many countries, across diverse populations over many years (Gardner 2015). There has also been much research on which components of parent

programmes make them effective (Webster-Stratton 2004; Webster-Stratton 2016). These include:

- group based
- based on social learning theory
- manualised programme
- videotaped modelling
- role play and rehearsal
- removing barriers to access
- highly skilled workforce with ongoing accredited video supervision

A glance down this list will highlight immediately that the majority of parent and family support currently provided would not meet many of these criteria, and with just a little further examination the many obstacles to implementation become clearer.

Time

In relation to setting up CAPS, this knowledge and expertise of the Incredible Years® programme allowed the bid to be realistic in terms of time frames, outputs and outcomes. It ensured that staff were allocated the appropriate amount of time to deliver parent courses; for Incredible Years® a minimum of 1.5 days per week is recommended for both group leaders for every group delivered. As a new project, with newly appointed staff, it was realistic to expect that it would take even longer to acquire new skills, to set up new referral pathways, to establish good working relationships with children's centres and to design a thorough system for data analysis.

Manchester is a culturally diverse city with a high need, complex population of vulnerable families who may be seen as ‘hard to reach’. CAPS’ approach was to acknowledge that it is often services that are ‘hard to reach’ and an assertive outreach model was adopted for parental engagement, which is inevitably time consuming requiring high degrees of skill acquisition. As a result, 2.5 days per week was actually allocated in the bid for group leaders to ensure enough time to do all of these elements effectively. Many implementations fail due to the absence of protected staff time in the job plan to deliver evidence based programmes to model fidelity and they often under-estimate the challenges of a totally new set up.

Access

The stigma attached to attending a parenting course is a huge barrier, and the term ‘parent training’ is often perceived as ‘parent blaming’. The art of engaging 10-12 potentially resistant parents, often with their own clinically significant mental health problems, into a minimum 14 week intervention for two hours per week is a truly challenging task. An enormous amount of time, effort and service redesign needs to be invested for services to break down barriers to engagement; these include providing high quality child care and interpreters.

CAPS parent courses were delivered in children’s centres but not all centres were Ofsted registered for a crèche and links were developed with other child care providers locally to resolve this. Some parents had never separated from their children so additional support was required, prior to the course, to settle children, requiring highly skilled crèche staff. CAPS psychologists provided one day training to frontline, multi-agency staff across early years in attachment and parenting strategies covered by the course. This ensured the wider workforce were consistent in supporting parents and also improved communication and referral

pathways. In the original bid, funding was set aside for crèche provision, for interpreters and for refreshments for parents. Without this budget, most services are unable to provide the necessary infrastructure to enable parental access to courses.

Even when funds are available, some organisations find it difficult to change their cultural norm. For example, senior managers demanded why parents should get refreshments on the parent courses when other interventions didn't provide that, and biscuits were banned from buildings as it didn't promote healthy eating. These factors may seem petty but parents won't come to a 14 week course, for two hours per week if you don't meet their basic needs, nurture them and provide high quality child care. These tiny obstacles soon become insurmountable and, without the organisational support from strategic and operational managers, it fails.

Materials and equipment

One of the early steps to implementing an evidence based programme is to purchase the materials required to deliver. For Incredible Years® this comprises a manual, DVDs and tip sheets costing approximately $2000, and each parent requires a book (or downloaded version) and photocopies of the tip sheets. This should be one of the simplest steps but unfortunately can cause chaos within organisations. The materials must be purchased in U.S. dollars and this can lead to an investigation about why materials are being purchased from another country, followed by a pointless tendering process to find the cheapest possible solution, despite materials only being available from the programme developer in the U.S. This can simply take months to resolve.

It is also common for managers to question the perceived ‘enormous’ cost of this intervention. Research consistently tells us that it costs approximately £1,500 per family and has a positive cost-benefit analysis (i.e. investing money in it, saves more money). There seems an excessive desire to only use or develop ‘home grown’ (U.K.) interventions. This seems inexplicable when the evidence base is so strong across countries and cultures and has over 30 years of research (Gardner 2015). There are several national implementations across Europe; why is England any different? There appears a cultural bias towards external models despite contradictory evidence that the programme works cross culturally. Would we have the same approach if another country had developed the cure for cancer?

Other equipment is also required for delivery: a large television or projector and good quality speakers. In community settings it is important to establish that equipment is available for all 14 weeks, that it works, that remote controls are available, that batteries are charged and that someone knows how to use the equipment. It is the minutiae that can make all of the difference; but reports of schools needing to use televisions for assembly one week, lost remote controls between sessions and no-one knowing how to get sound out of the projector are all too common. The solution CAPS adopted was to purchase their own equipment, with bespoke carriers for safe transportation and protection.

All practitioners are dependent on good organisational support for letter and report writing, photocopying, access to equipment etc. Each of these time-consuming tasks is aided massively by a single place for equipment storage and administrative support to complete all paperwork in advance.

Model fidelity

Model fidelity is the termed used to describe the process of facilitators delivering an evidence based programme as closely as possible to the developer's intentions to ensure the same outcomes as were obtained in the original research. This is key to the success of the programme.

It is useful here to compare the implementation approach to medical treatments with those for psychological interventions. In parent programmes, all too frequently, the number of sessions is reduced from 14 weeks to as few as 6-8 sessions. Courses are sometimes run with one group leader instead of two and many without ever having any supervision on their practice. In some instances they do receive supervision, but from someone without any training or experience of the programme themselves. Now imagine this same 'dilution' of intervention if it were for radiotherapy treatment for cancer. If the research states 14 sessions is required for efficacy then this is given; and the practitioner giving the radiotherapy most certainly would have been supervised many times and had their practice supervised by someone with the qualifications to do so.

Furthermore, with the cancer analogy, if this were a pharmaceutical intervention model fidelity refers to the 'active ingredients' which makes the intervention effective. Incredible Years® has many checklists, protocols and evaluation tools to help practitioners follow the programme to model fidelity by using these 'active ingredients'. Two of the main ingredients include use of video modelling to promote discussion in the groups; and role play and rehearsal to allow parents experiential learning and practice the strategies.

The video clips are of parent-child interaction in American families, and some are quite dated and even unintentionally humorous. New group leaders often feel uncomfortable using the

videos, feeling embarrassed by the age of the material and also assuming the American accents aren't relevant to a U.K. audience. Parents complete weekly evaluations and new group leaders frequently report that parents rate the videos negatively. Sometimes group leaders then abandon the video clips hence, leaving out a crucial active ingredient.

Role play and rehearsal is another barrier with the majority of practitioners having a strong dislike and/or fear of participating in role play; and the same is almost universally true for parents too. It is therefore easy to understand why some new group leaders avoid doing role plays, for fear of parental drop out. This again often leads to the removal of a key ingredient for success.

However, accredited, experienced group leaders don't experience the same resistance to the videos or to integrating several role plays at every session. This tells us something about the high level of skills required to deliver the programme collaboratively, a vital active ingredient for effective delivery. Protocols and checklists are important tools but the only way to ensure model fidelity is by accessing accredited, video supervision from a certified Incredible Years® mentor and to have all practitioners work towards their own accreditation.

Most organisations don't consider the role of ongoing supervision for practitioners following the three day initial training. There exists a belief that psychological interventions can be tampered with and endlessly adapted, and with parent training in particular there is a professional snobbery that it is not an especially skilled intervention. Within many CAMHS organisations, parenting interventions have disappeared from provision altogether being outsourced to local authorities and the third sector; despite the fact that NICE guidance recommends evidence based group parent training as the first line of treatment for conduct

disorder and attention deficit hyperactivity disorder - the majority of CAMHS referrals. The challenge of attaining long term, sustainable change in 10-12 often anxious and depressed parents, resistant to advice due to previous failures, requires complex collaborative and group processes skills taking years to master. Would you want your cancer specialist to have only had a three day training before administering your intervention?

CAPS benefited hugely from an individual desire by the lead psychologist to access accredited supervision and attain accreditation to ensure model fidelity. At the time this was only possible via direct contact with the programme developer in Seattle. It was, however, also understood that this was not a sustainable model for supervision going forward. As a result, discussions took place with the programme developer to develop an infrastructure for providing more accredited training and supervision in the U.K. This structure now exists internationally making it much more accessible.

Supervision and accreditation

The Incredible Years® has a well-established training/accreditation process with four levels:

- group leader
- peer coach
- mentor
- trainer

Each level has specific requirements involving months of training, shadowing, video submissions and delivery with strict criteria to be achieved. To put into context, there are currently only eight trainers in the world, 50-60 mentors and nearly one hundred peer

coaches. Mentors are required to attend an international meeting each year in either the U.S./Canada or Europe, supported by their agency.

Ideally, to build a sustainable intervention, a plan to develop accredited group leaders, peer coaches and a mentor should be considered from the start. The sooner this process begins, the sooner the organisation reduces costs and becomes more self-sustainable in providing supervision. Realistically, it takes about two years for a group leader to become accredited, another two years to become a peer coach and perhaps another two years to become a mentor. As the majority of public funding is increasingly short term, this makes forward planning challenging. A further barrier occurs when, as during austerity, organisations indiscriminately ban professional development to reduce expenditure. This is short sighted as developing sustainable supervision within the organisation saves money.

CAPS' initial funding was for three years and the staff were employed on fixed term contracts. For the service to survive, it had to demonstrate positive outcomes for children and developed a proactive strategy to develop the lead psychologist to become a mentor. This enabled the service to develop the workforce and maintain the high standards of model fidelity required for success.

All parent group leaders require video supervision to shape the collaboration skills needed to be effective and achieve accreditation. This required all parent group sessions to be recorded, requiring video equipment for every session and staff needed training to use this equipment alongside editing software. Clinical governance policies also required this sensitive and confidential data to be handled safely and appropriately; something made even more complex

when working in multi-agency settings. The technical skill and policy guidance required cannot be underestimated and requires organisational and managerial support at every level.

Part of this process involved written parental, informed consent. Many practitioners feel threatened by the prospect of video supervision and parents can be suspicious of video cameras in the room. However, well informed parents rarely refuse consent and once an ethos of reflective practice is established these initial fears from practitioners can be overcome. It does however, require strong leadership, organisational support and an expectation of best practice for effective implementation.

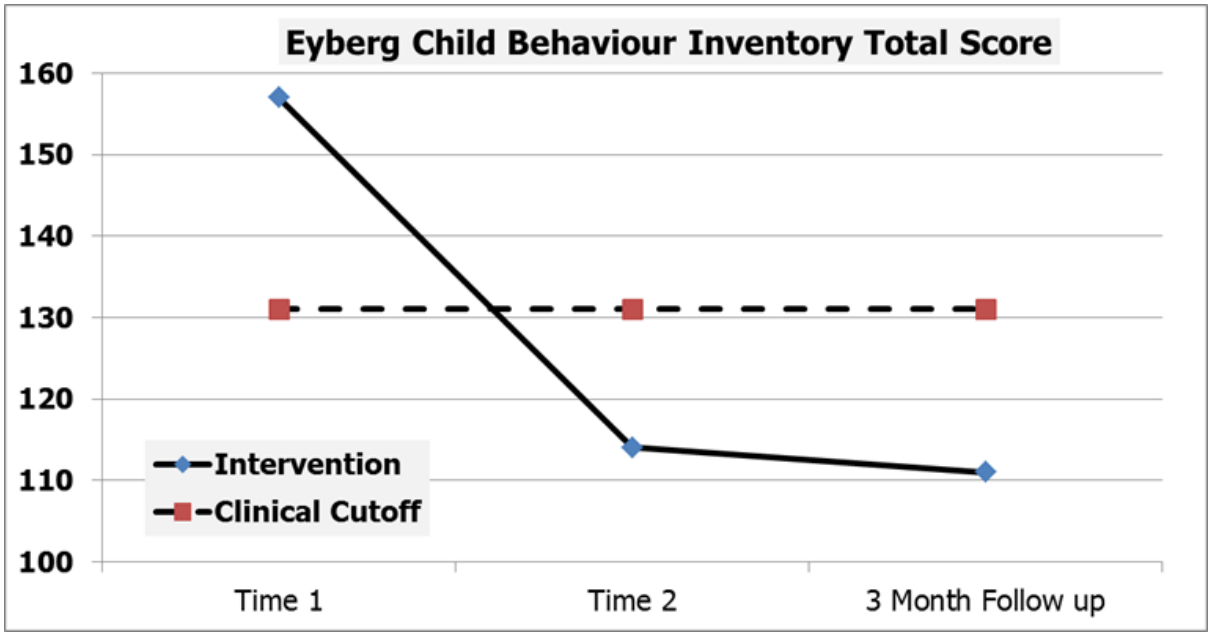
Data and evaluation

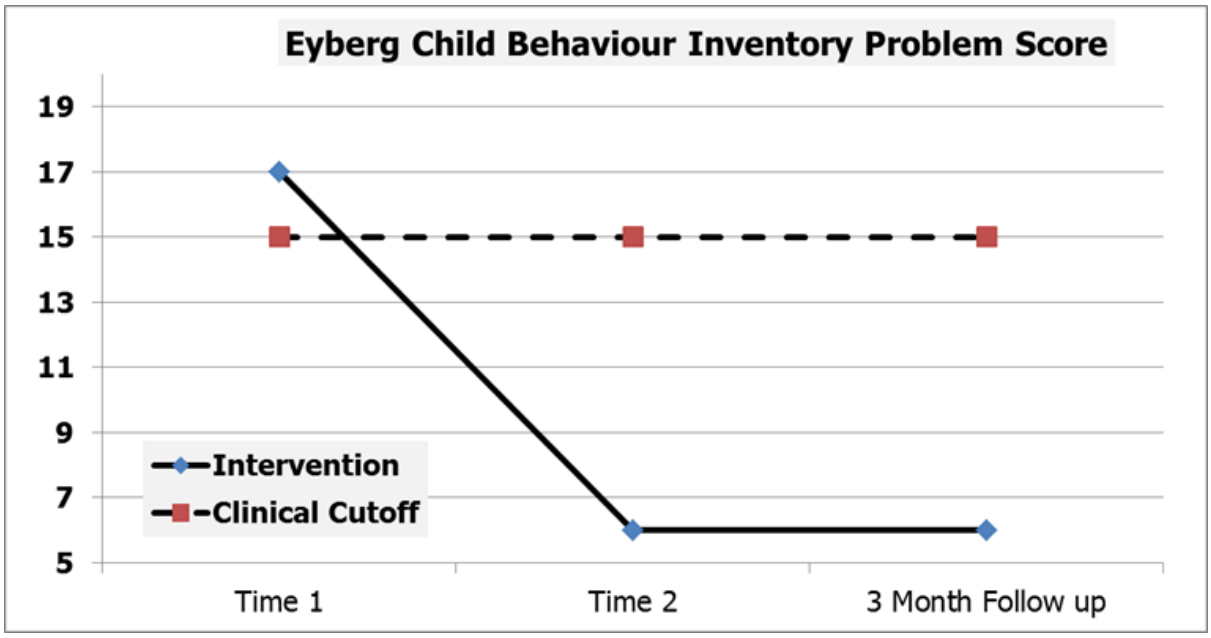
Outputs and outcomes are increasingly important for services to demonstrate, with a culture of key performance indicators and payment by results. In England, IAPT has had some impact on transforming services to develop systems to analyse data and a shift in the workforce to collect routine outcome measures. This is a good example of the influence a national driver, such as IAPT, can have in shaping organisational change long-term and challenging long standing practices. It takes a whole organisational restructure to ensure it happens effectively. The workforce need to collect, input and analyse data whilst the database develops in line with service requirements. Managers need to operationally manage the timeliness of each action and ensure data is accurate and complete.

For future funding it seemed imperative that CAPS was able to demonstrate positive outcomes for preschool children and families in Manchester. Standardised, valid and reliable outcome measures were used (i.e. Beck Depression Inventory; Beck 1961), Child Behaviour Inventory (Eyberg 1978) and Parenting Stress Index (Abidin 1995) to evaluate the impact of

interventions and an annual report was published demonstrating the intervention's effectiveness; with multiple demographics, highlighting risk factors and complexity of cases.

The routine collection, analysis and reporting of CAPS' outcome data, such as the graphs here, has been pivotal in the continued success of the service. With demonstrable improvements in child behaviour problems and parental mental health reported annually, and sometimes more frequently, commissioners were able to make informed decisions about funding and service developments. Furthermore, these data provided a platform for dialogue with strategic leads regarding needs analysis and targets, including reach rates, and uptake and retention, of service users. The importance of high quality data using the most robust outcome measures available cannot be overstated. In addition, the clear reporting and interpretation of these data is essential to make the information as accessible and transparent as possible. Explanation of the measures and clinical cut-offs to readers has proven to be more helpful than reporting statistical significance, as would be used in the research literature.




Eyberg Child Behaviour Inventory Problem Score
19
17
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13
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9
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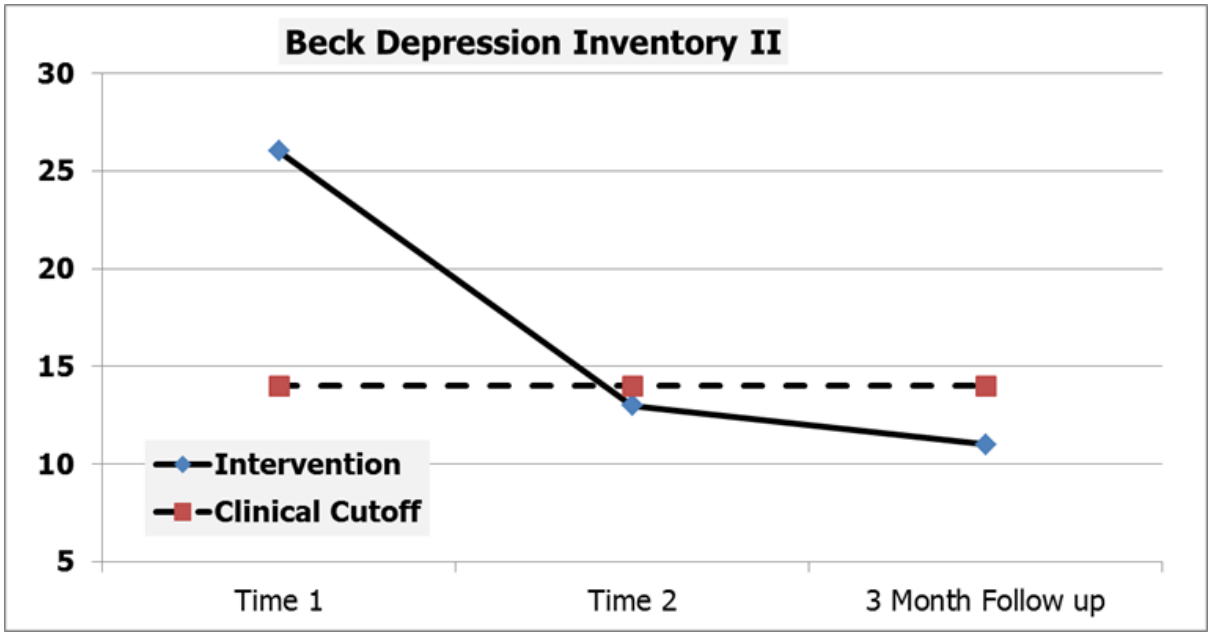
Intervention
Clinical Cutoff
Time 1
Time 2
3 Month Follow up


Beck Depression Inventory II
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25
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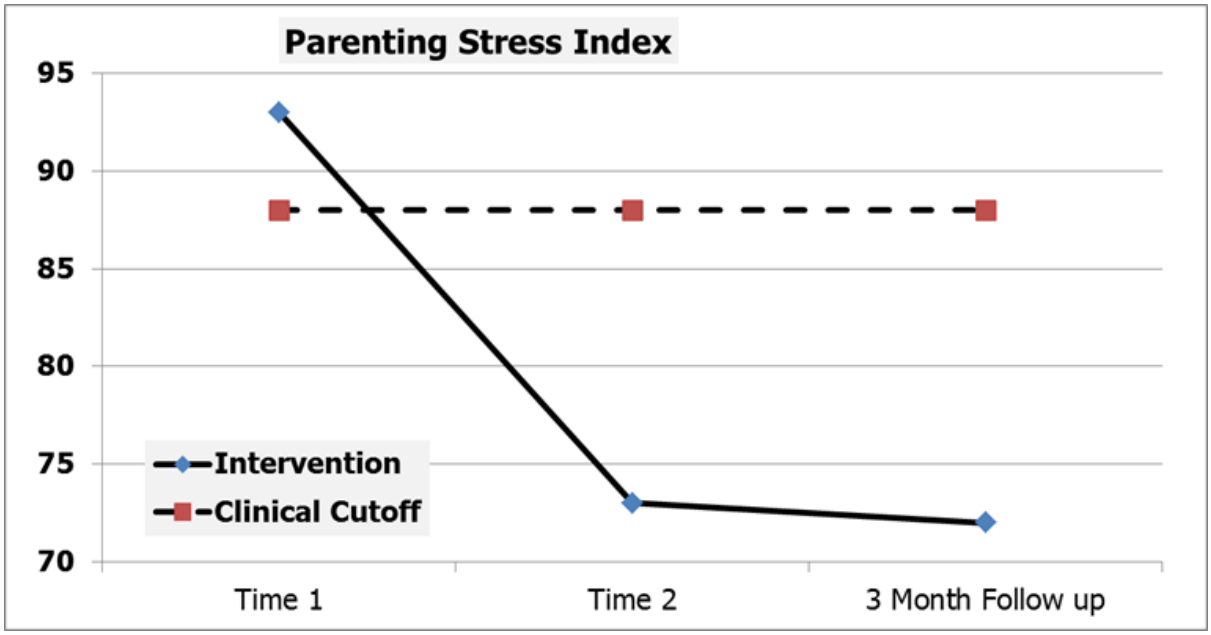
Intervention
Clinical Cutoff
Time 1
Time 2
3 Month Follow up



At a time when routine outcome measures were not used and computers were not on every clinician's desk, the creation and management of a database was seen as high priority. The original bid included the appointment of an assistant psychologist to set up the database and input data. In many implementations, these 'gold' standard measures are not used simply because they cost money. Whilst free measures are available they're not always appropriate for measuring the desired outcomes; and it can look like the interventions had only minor impact. This is disastrous in terms of bidding for future funding, and investment in the most appropriate measures is very important.

Local strategy and funding

CAPS was accountable to a multi-agency steering group consisting of both strategic and operational managers from each partner agency plus the commissioner. This group met monthly initially, later moving to quarterly to ensure progress was made, targets were met and data was reported directly from the service lead. This created a collaborative forum where issues were discussed and problems resolved; and it was crucial that all partners

agreed jointly with transparency. Annual reports were published, jointly owned and distributed widely to highlight the excellent outcomes achieved. These data formed the basis of all future bids and were imperative in strengthening the case for further funding and expansion.

Over the following two decades a series of national drivers and policies highlighted the importance of early years and early intervention as the foundation for life; and CAPS funding was increased with its strong track record of positive outcomes. The service lead was invited to participate in Manchester's Parent Board, Health and Wellbeing Board and Parenting Strategy. Many times there was uncertainty about funding, constant organisational change and shifts in policy. This was enormously challenging to manage and incredibly unsettling for the workforce, and yet staff turnover remained low and positive outcomes were, not only maintained, but improved upon.

In 2011, with huge austerity measures, Manchester announced its largest cuts to public funding in history, with 2000 job losses (17% of the workforce) and a 26% reduction of the budget for children's services. Over the following few years the Early Years budget was cut from 29 million pounds to just seven million and the number of children's centres reduced from approximately 50 to 12. This impacted enormously on the entire workforce across children's services. Despite this, CAPS received a significant increase in funding from the local authority, taking its total budget to two million pounds; on the premise that with so little funding left, it had to be targeted, and demonstrably effective. CAPS currently consists of 20 whole time equivalent (w.t.e) clinical psychologists, 21 w.t.e. parent group leaders and 6 administrative staff (including one information officer); with new partners, Big Life (Third sector) and Barnardo's (Voluntary sector).

During the same period, Greater Manchester (GM), made up of Manchester local authority and nine others, was granted a devolved budget and an elected Mayor. With this in mind, the ten boroughs were invited to participate in writing an Early Years pathway for all 0-5 year olds across GM. Early Years representatives from GM completed a needs assessment and a review of all interventions delivered. A staggering number of different, largely non-evidence based interventions were identified. It took over two years, looking at models of best practice but eventually the GM Start Well Strategy (Start Well: Early Years 2016) was agreed. The main aims were for health visitors to complete developmental checks and implement the Healthy Child Programme, and for outreach workers to engage families' unknown to services and to deliver evidence based interventions to those in need; the priorities being group parent training and specialist speech and language therapy. Many services were decommissioned and the remaining workforce were trained in evidence based assessments and interventions. Calculating the long-term cost-benefits were integral and it was demonstrated that after approximately seven years, authorities would see a return for their investment. This was, and still is, a hugely ambitious goal and each authority is at different stages of its development.

Manchester currently has a preschool population of approximately 33,000 and estimated that approximately 20% (6,600) of those families needed a targeted intervention. CAPS already had a proven track record of delivering effective evidence based parent programmes and the additional funding was to facilitate this scale up. The service had also learnt much about implementation and shared knowledge has benefitted other boroughs' developments. It is noteworthy that other local authorities have adopted different models of delivery but success has come from the application of the principles and details outlined in this chapter.

Scaling up with sustainability

CAPS has experienced two episodes of large scale up, a challenge for most successful implementations. Usually an area trials a small-scale model and once they achieve positive results aim to roll it out broadly and quickly; but training a new workforce, managing operational and administrative systems, whilst handling the natural response to the uncertainty of change, is difficult. The infrastructure of the organisation has to be sound, with good lines of accountability, excellent communication, and organisational resilience consisting of effective systems and processes to ensure the maintenance of model fidelity.

As part of CAPS' development, over several years, the psychologist workforce has also been trained in Video Interaction Guidance (VIG), another effective programme, with a strong, emerging evidence base to improve maternal sensitivity; and is recommended in early years guidance (National Institute of Health and Care Excellence 2012). This is not part of any current commission but this is an important implementation phase for effective delivery. The same principles have been applied as for Incredible Years® by developing a skilled workforce of accredited practitioners, supervisors and trainers, identifying the most accurate outcome measures and educating strategic leads and commissioners.

Change is inevitable in any organisation, let alone a large, citywide multi-agency service. What happens when your only mentor leaves for another job when it takes six years of training to replace them? How do you manage maternity leave and long term sick leave when the locum workforce doesn't have the skills in the evidence based programmes you deliver? How do you ensure staff collect crucial, follow up data consistently and accurately when it's a boring part of the job and parents are difficult to contact? How do you keep staff motivated when funding is uncertain and policy forever changing? The list of potential threats to the

implementation is endless. Over the years, CAPS has developed a number of systems and processes to adapt to the ever-changing environment and to minimise inevitable challenges.

The first principle, adopted early on in CAPS, was to plan for the long-term, regardless of unknown future budgets as this was essential for forward planning. To protect staff time, CAPS developed clear job plans for each role ensuring everyone had appropriate amounts of time to do all tasks. Also, each position's job description was reviewed and when necessary modified according to the requirements of the service (e.g. data collection was added to highlight its importance). As the operational lead, this was done by the service lead in conjunction with the manager from each agency. An audit group was set up with representatives from each staff group, and regular audits completed (e.g. parental uptake and retention rates, referral patterns, outcome standards). At the end of each parent course group leaders received summaries of outcomes and retention rates which was motivating and made the data meaningful. Collected data was handed in at weekly team meetings and minuted so there was transparency about missing data and an action plan made to rectify it. Group leaders collected data, and assistant psychologists inputted data. Scaling up created much more data management, and commissioners became much more demanding regarding demonstrating impact. As a result, a full-time Information Officer post was created with responsibility for creating, developing and modifying a database, specific to the needs of the service. This was absolutely crucial for long-term success as funding was dependent on demonstrable outcomes. Finally, proactive management of staff and application of performance management policies when necessary instilled an ethos of high quality.

Often when scaling up some associated costs get easily forgotten; and failure to include those costs into the budget can be fatal. CAPS consistently built in relevant additional funds for

crèche, interpreters, staff equipment (including replacement of dated/broken equipment), administrative support, outcome questionnaires and refreshments and books for parents, accreditation fees and supervision.

A systematic approach was adopted to develop the service's capacity to provide supervision. All group leaders were expected to become accredited and this formed part of their annual appraisal to ensure progress; and once accredited, all were trained and supported to become peer coaches. Two further mentors were also developed to remove reliance on one individual for future training and supervision. Most psychologists had a career path for pay progression, however this was not true for family support workers; with increased funding, opportunities were taken to restructure the service allowing those workers to achieve an increased pay grading once they became accredited peer coaches. This has contributed to low staff turnover and a feeling of being valued in the workforce.

To achieve model fidelity supervision and accreditation was imperative and it was hugely beneficial that the service lead became a mentor (and eventually a trainer) in the evidence based programme being delivered. It was very advantageous for the person responsible for the implementation to know in great detail every element of the programme and what was needed for delivery. In addition, it meant that accredited supervision was consistently available for all staff 'in house' and annual requirements for attendance were set at every level. It is no coincidence that CAPS delivers the highest amount of accredited supervision of any implementation of Incredible Years in the world and also has possibly the highest retention rates of parents (approximately 82% complete), whilst also working with the most vulnerable, complex and high risk families.

CAPS maintains a commitment to model fidelity despite huge cultural pressure, especially during austerity, to deliver interventions quicker, faster, shorter, cheaper. Despite the service's established track record of success there is a constant need to exhaustively educate and disseminate to strategic leads and commissioners regarding model fidelity, why it is important and what it takes to achieve it; and this continues.

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