November 2005

National evaluation report

# Maternity Services Provision in Sure Start Local Programmes

SureStart

Report 12

Evidence & research

**Research Report**
**NESS/2005/FR/012**

# *Maternity Services Provision in Sure Start Local Programmes*


**ISBN 1 84478 579 3**

# Maternity Service Provision in the First Four Rounds of Sure Start Local Programmes

## National Evaluation of Sure Start (NESS)

**Dr Zarrina Kurtz, NESS Investigator**
**Jenny McLeish, Maternity Alliance, Researcher**
**Anita Arora, NESS Researcher**
**Mog Ball, NESS Investigator**
**Members of the NESS Implementation Study team**

**The National Evaluation of Sure Start Team is based at the Institute for the Study of Children, Families and Social Issues, Birkbeck, University of London, 7 Bedford Square, London WC1B 3RA**

### Core Team -

Professor Edward Melhuish, Institute for the Study of Children, Families and Social Issues, Birkbeck (Executive Director);
Professor Jay Belsky, Institute for the Study of Children, Families and Social Issues, Birkbeck (Research Director)
Dr. Alastair Leyland, MRC Social and Public Health Sciences Unit, University of Glasgow (Statistician);

### Impact Module -

Professor Edward Melhuish, Institute for the Study of Children, Families and Social Issues. Birkbeck (Director);
Professor Angela Anning, department of Education, University of Leeds (Investigator)
Dr Zarrina Kurtz (Investigator)

### Implementation Module -

Professor Jane Tunstill, Department of Health and Social Care, Royal Holloway, University of London (Director)
Mog Ball (Investigator)
Pam Meadows, National Institute of Economic and Social Research (Investigator)

### Cost Effectiveness Module -

Pamela Meadows, National Institute of Economic and Social Research (Director)

### Local Context Analysis Module –

Dr Jacqueline Barnes, Institute for the Study of Children, Families and Social Issues, Birkbeck (Director)
Dr. Martin Frost, Birkbeck (Investigator)
Dr Beverley Botting, Office of National Statistics (Investigator)

### Support to Local Programmes on Local Evaluation Module

Professor Jacqueline Barnes, Institute for the Study of Children, Families and Social Issues, Birkbeck (Director)

**ACKNOWLEDGEMENTS**

The NESS team would like to acknowledge the enthusiasm for this study shown by all staff in the SSLPs with whom we worked. And we would like to thank these and all other staff and the mothers upon whose knowledge, experience and opinions the study is based, for giving so generously of their time and attention. We would also like to thank the members of the Advisory Group for this study who have given us valuable advice and guidance in its conduct.

**MATERNITY SERVICES PROVISION in the FIRST FOUR ROUNDS of SURE START LOCAL PROGRAMMES**

**CONTENTS** **Page**

# EXECUTIVE SUMMARY

## Introduction

This study is one of several which are being carried out by the National Evaluation of Sure Start (NESS) to examine how Sure Start Local Programmes (SSLPs) are implemented. It addressed the factors which have led to the establishment of effective maternity services in SSLP areas, the relationships between SSLPs and mainstream maternity services, and the impact of Sure Start maternity services on users and professional staff. Several other aspects of implementation are addressed by this series of studies, which are designed to "investigate local policy and practice issues within a purposive sample of programmes" (NESS Methodology, 2000) and to highlight examples of good practice developed by SSLPs.

## Methodology

The research had four components:

- a **literature review**, which is available separately on the NESS website www.ness.bbk.ac.uk
- a **close analysis of NESS data** from the Implementation module of the evaluation, particularly the National Survey of the first four rounds of SSLPs
- **telephone interviews** with 73 SSLPs, the majority identified as 'most active' in the maternity field, but also 8 which had undertaken 'innovative' projects and 10 which had done little to enhance maternity services
- **in-depth** studies of 13 SSLPs.

## Context

Maternity services are universally available in the NHS to care for women and their babies before, during and after birth. They are delivered by a range of professional staff, but the key figures are **midwives**, employed by acute NHS trusts, and **health visitors,** based in Primary Care Trusts (PCTs). Over the past 15 years there has been a shift from the medical model of maternity care towards a 'woman-centred' model, led by the evidence that the emotional and psychological aspects of maternity care affect outcomes for mothers and babies. There is also strong evidence that health inequalities are associated with social disadvantage and that the key to overcoming them is early intervention. The NHS plan sets targets for reducing smoking in pregnancy, addressing post natal depression and encouraging breast-feeding. An important element of the context is the national shortage of midwives and health visitors.

## Evidence on What Works

While there is good evidence on inequalities in outcomes for disadvantaged mothers and babies, the evidence on what works is less robust. The babies of women living in poverty, women from some minority ethnic groups (especially if the mother was born abroad), women without partners, and teenagers, are at an increased risk of a range of poor outcomes. Other risk factors are behavioural:

smoking, poor diet, substance misuse, and not breast-feeding. Lack of social support, mental health problems and domestic violence add to the risk.

These problems are tackled by maternity services by concentrating on getting high risk groups to access antenatal care, by providing continuity of care, and by tackling smoking, substance misuse and diet and promoting breast-feeding. Intensive programmes of social support for women at risk, particularly those from minority ethnic groups, have led to reductions in the numbers of low birth-weight babies, pre-term babies and babies with other health problems. Post-natal depression in mothers has an impact on the health and development of babies, and there are various examples of effective screening for, and management of PND. Interventions have also been effective in promoting emotional attachment between mother and child.

Domestic violence during pregnancy can be associated with serious outcomes for mother and child, but though effective screening, acceptable to women, has been developed, there is no evidence yet about the impact this may have had on the health of mothers and babies in this situation.

All effective interventions:

- identify women and children at risk at the antenatal stage
- make sure that the services offered to women are appropriate to their needs
- establish trusting relationships between a woman and the practitioners who help her
- offer sustained, responsive support, with continuity of care
- empower women, so that they will want to change behaviours , and continue and develop the changes.

## Findings

The analysis of the National Survey data suggested that around one third of the 186 SSLPs for which information was available had enhanced existing maternity services and created new services. Where SSLPs did not report significant activity, this may mean that existing mainstream provision was good. The ‘active’ SSLPs were representative of all SSLPs in their types and geographic spread.

Effective development of maternity services depended on:

- **new resources:** dedicated time from midwives and health visitors, new services, new venues, new equipment;
- **involvement of mainstream stakeholders**: especially if represented on the Sure Start Partnership board, or if an individual had a personal commitment to developing work in disadvantaged areas; consultation about plans with local midwives and health visitors.
- **community consultation**
- **support within the SSLP** for maternity services as a gateway for Sure Start.

Obstacles to service development included poor relationships with mainstream services, where managers might have reservations about the Sure Start approach, and poor understanding within the programme of the significance and working of maternity services. However, services evolved over time, with Sure Start offering an opportunity for new approaches to be tried and tested.

**Delivering Services**

Maternity services are universally available but not necessarily able to meet the needs of Sure Start communities. SSLPs funded midwives and health visitors, who were usually seconded, though sometimes part of an integrated team. The commissioning of further services and extra time from individual maternity staff also occurs. Within SSLPs two approaches are found:

- **additional services -** supplementing the care of mainstream staff
- **caseload services -** providing full antenatal and postnatal care to all or some of the women in the Sure Start area.

Sure Start has brought the following changes to the *way* maternity services are delivered:

- a **public health** approach to target the most disadvantaged;
- working **geographically;**
- **multi-disciplinary working**: between midwives and health visitors;
  between maternity staff and the wider Sure Start team
  with para- professionals

The co-location of workers in Sure Start centres, training opportunities and strong leadership encouraged multi-disciplinary work, lack of leadership and poor integration with mainstream services hindered it.

In some areas **multi-agency partnerships** were leading to new kinds of referral systems, services and joint work on specific issues, including with voluntary organisations. The relationship between the SSLP and mainstream midwifery and health visiting services was crucial – it affected information sharing (which was often problematic), and referrals in particular. There are complaints about professional boundaries being maintained on both sides, about the difficulties of balancing and prioritising work and about obstruction to development.

The key factors which improved relationships were:

- maternity staff working for both the SSLP and mainstream services
- relationships being established over time
- SSLPs lightening the workload of mainstream staff
- good communication
- SSLPs were funding extra training and materials for mainstream services

- involving GPs

In many cases mainstream services have taken over Sure Start approaches and used them across the whole area. A few SSLPs had built capacity into the mainstream from the outset, but in other areas there could be frustration that mainstream staff were not taking on the Sure Start approach themselves.

**Improving Access to Services**
This occurred on three levels:

- identifying and **making contact** with pregnant women
- creating **accessible and flexible** local services
- providing support for women to **access existing mainstream services.**

Almost all SSLPs offered ante-natal visits where direct contact was made with pregnant women and they were invited to groups, and all produced written materials about services. Using new venues for services, including Sure Start centres, and familiar places in the community, like libraries, and mobile clinics in rural areas were ways of reaching out to women. And services were made easier to use, especially by having drop-in clinics rather than appointments, by home visits to provide care and by the informal availability of staff, especially on mobile phones. Groups could be run in the evenings and at weekends, and such services were supported with childcare and transport, interpreters where necessary and following up on attendance. There were examples of poor practice in some areas, where family members had been used as interpreters.

**New Maternity Services**
Although some SSLPs reported that they had created new services based on research evidence, this was not universal and in many areas there were activities that went against the evidence of successful practice – smoking cessation groups, for example. Sure Start does offer great scope and resources for innovation however. Examples of innovation included:

- **antenatal groups** which take a holistic approach, sometimes entirely planned by users, and offering sessions like free classes at local swimming pools;

- enabling an **ongoing relationship** over time **between a user and one primary carer.** A minority of SSLPs were offering one-to-one midwifery care, though Sure Start midwives rarely delivered the babies. Continuity was the aim of most SSLPs.

- **intensive, one-to-one postnatal support.** For example, the use of a model of care based on the Birmingham IMPaCT study and offering an extra screening visit at 28 days.

- **smoking cessation**, usually by referring women to specialist services, but also using trained SSLP staff for one-to-one support. Innovative approaches included

a multi-agency service, coordinated by an SSLP, which explored with women the barriers they saw to quitting. Some SSLPs concentrated on smoking reduction.

- **healthy eating**: increasing access to healthy food, cooking sessions, having a dietician attached to the Sure Start team.

- **support for breastfeeding:** was widely available and included the development of imaginative peer support.

- **social support:** a central focus of group work in most SSLPs

- identification of **mental health issues antenatally,** screening for PND and supporting mothers with on-to-one listening, cognitive therapy and counselling. Areas also developed good partnerships with mainstream services to improve coordination and develop local pathways of care for women with mental health needs.

- **promoting attachment** between parent and child, with preparation for parenthood, courses on parenting and encouraging bonding with baby massage, for example.

- tackling **social issues** (housing and debt, for example) and **domestic violence.**

- **targeted services for women with particular needs**, like teenage mothers, mothers from minority ethnic groups, asylum seekers and immigrants, homeless women, travellers, substance misusers and mothers with disabilities.

## Impact of Sure Start Maternity Provision

Evidence for impact is almost entirely qualitative.

**On Users** Women reported that they had made new friendships and gained confidence from the contacts they had made through SSLPs. They appreciated the easier access to Sure Start services and had developed a new trust in professional staff, and easier access to support through the multi-agency approach. Many women had gained training and experience by acting as peer supporters for breast feeding or baby massage. Sure Start childcare enabled women to take these opportunities. There was some doubt as to whether services were reaching the most 'hard-to-reach' mothers, though it was clear that many SSLPs were trying hard to do so.

**On Staff** Staff report high levels of job satisfaction, enjoyed the chance to build close relationships with users and to be creative and innovative, with a sense of control over their work, though a few found this way of working difficult. The professional development offered by increased training was appreciated..

Statistical evidence, though very limited, showed increases in breast-feeding rates in some areas, and some reductions in the caesarean section rate in others.

**CONCLUSIONS**

• It was not clear to early SSLPs that maternity services were central to programme design and mainstream maternity services were slow to realise the opportunities Sure Start offered.

• Sure Start resources have funded additional midwifery and health visitor time which allows practitioners to spent time with individuals, especially vulnerable individuals.

• Many SSLPs have not reached some of the most excluded families, but some, through outreach services, have contacted women not previously known to mainstream services.

• The neighbourhood model has improved practitioners' contacts, underpinned public health approaches, and led to services that promote peer and social support.

• Non-professionals and para-professionals can support families and deliver services – but it takes time to create, develop and manage them.

• Efficient referral links have been created between Sure Start maternity services and other services, and Sure Start maternity services have been a gateway to other services for families.

• Co-location of staff within maternity services, and between maternity and other services, assists the care and follow-up of women during and after pregnancy.

• SSLPs have improved access to services. A lot of work has been done to create services for marginal groups.

• SSLPs have provided a setting for experimentation and innovation in maternity service, and evaluation of this work has contributed to the evidence base on good practice.

• Sure Start has provided professional and informal training which has enabled positive aspects of maternity practice to be shared.

• Skills shortages have caused some tensions between SSLPs and mainstream managers, and raise questions about whether Sure Start levels of service can be sustained.

• Sure Start has changed the way practitioners are working, and both staff and users are enthusiastic about these changes. Opportunities for 'joined-up'

working have occurred at strategic and operation levels, but the strongest development has been in individual relationships between practitioners.

# CHAPTER 1. INTRODUCTION

## 1.1 The Sure Start programme

The national Sure Start programme is a central component of the Government's efforts to tackle social exclusion. Its overall aim, set out in the Public Service Agreement 2001-2004, is to work with parents-to-be, parents and children to promote the physical, intellectual and social development of babies and young children – particularly those who are disadvantaged – so that they flourish at home and in school, and thereby break the cycle of disadvantage for the current generation of children. The first 'trailblazer' round of Sure Start local programmes (SSLPs) was established in mid-2000. Since then others have followed in six Rounds and by mid-2004 there were 524 SSLPs throughout England.

## 1.2 Sure Start local programmes (SSLPs)

SSLPs work in the most socio-economically disadvantaged communities (Barnes, 2003), where there is a high prevalence of factors known to be associated with poor outcomes for mother and baby, including poor nutrition, poor reproductive health, high rates of smoking, communicable disease and maternal mental illness. Some groups of women living in these communities are particularly likely to experience many of these factors together, as well as having serious difficulties in accessing appropriate services. The Sure Start ethos emphasises a preventative approach, including intervention as early as possible.

## 1.3 Sure Start maternity targets

SSLPs were commissioned in a series of 'waves' or 'rounds' of about 60 programmes each, beginning in 1999. Guidance for the first round of 'trailblazer' local programmes noted that SSLPs would need to develop arrangements with providers of antenatal services – GPs, midwives, hospital staff and voluntary providers were specified – to make sure that parents-to-be received introductory information about the programme and services available. *"Local programmes may also encourage better take-up of antenatal care."* (DfES, 1999) All parents with a new baby were to be visited and offered support within two months of the birth. Among the outcome measures these programmes were asked to consider were an increase in breastfeeding rates and reductions in postnatal depression.

In Guidance for subsequent rounds of Sure Start local programmes, specific aims, objectives and targets, set out in a Public Service Agreement (PSA), were laid out. Among the objectives and targets relevant to maternity services were: *"All Sure Start programmes to have agreed and implemented, in a culturally sensitive way, ways of identifying, caring for and supporting mothers with postnatal depression."*

Under the objective of improving health, SSLPs were told to do so *"in particular, by supporting parents in caring for their children to promote healthy development before and after birth."* Targets included reductions in the proportion of low birth weight babies, in the numbers of mothers who smoked during pregnancy, and in

the guidance given to mothers on breastfeeding, hygiene and safety. Small changes were made in these targets over time.

Sure Start local programmes have responded to the targets by providing enhanced maternity services targeted at the risk factors particular to their local communities. Enhanced provision may include: additional resources; improved access to services; new services to meet particular needs; new ways of working that improve effective delivery; closer collaboration with other services; and staff development and training.

### 1.4 About this study

This is a descriptive study of the maternity services provided by a proportion of Sure Start local programmes. It is a 'themed' study carried out as part of the Implementation module of the National Evaluation of Sure Start (NESS). NESS examines the first four rounds of SSLPs (260 programmes) in an integrated study with five elements:

- looking at the ***Impact*** of Sure Start in children and families living in Sure Start areas;
- examining how SSLPs have been developed and delivered and how they work in the ***Implementation*** module;
- collecting information about the ***Local Context*** in which SSLPs are operating and examining change at the community level; over time;
- analysing the ***Cost Effectiveness*** of the programme;
- providing ***Support*** to SSLPs in conducting their own evaluations.

'Themed' studies are designed to investigate specific policy and practice issues in order to explore key themes. Advice on the selection of themes is given to NESS by an Advisory Group of academic experts and a Steering Group of representatives from Government departments and voluntary organisations.

This study describes the ways in which some Sure Start local programmes have created and enhanced maternity services to ensure appropriate and effective provision for pregnant women, their partners and their babies, where some groups are recognised to be hard to reach and to be at particular risk of poor outcomes. It considers the factors that support or hinder the development of effective services, the relationships between the SSLPs and the mainstream maternity services, and the impact of Sure Start maternity services on both users and professionals. The term Maternity Services includes services offered before conception, during pregnancy and for the first few months after birth.

# CHAPTER 2. RESEARCH METHOD

## 2.1 Components of the study

The study had four main components:

1. A literature review.
2. Identification of the SSLPs that were 'most active' in developing maternity services.
3. Telephone interviews with the SSLPs identified as 'most active', and with a contrasting sample of inactive SSLPs.
4. In-depth studies of a sample of SSLPs.

## 2.2 Literature review

The literature review aimed to identify:

a) what is known about the particular maternity care needs of disadvantaged women and babies; and
b) what is known about the effectiveness of interventions in maternity care to meet these needs.

The literature review was based largely on relevant reviews carried out for other purposes, such as the Cochrane Systematic Reviews (www.nelh.nhs.uk/cochrane.asp) and the *Report of the Independent Inquiry into Health Inequalities* (Department of Health 1998) and an active search of more recent literature, including the grey literature. A summary of the literature review is given in Chapter 4. The full review is published separately at www.ness.bbk.ac.uk

## 2.3 Identification of the 'most active' SSLPs

The SSLPs that were 'most active' in developing maternity services were identified in two ways:

a) systematically, by analysing data from national surveys of SSLPs carried out by the NESS in 2001 and 2003 and
b) informally, by gathering information about which SSLPs were actively developing maternity services in innovative ways, from the NESS team that supports the SSLPs' own local evaluations, and from Sure Start Unit staff in the Regional teams which supported the development of SSLPs .

*Information from the NESS Implementation Study*

The national surveys of SSLPs national surveys collected information about local services that were 'inherited' at the time the SSLP was set up. Further questions asked whether SSLPs had 'enhanced' (i.e. added to) existing services or developed new services

Five service areas were selected to describe maternity provision: community midwives, health visiting, antenatal clinics, breastfeeding, and postnatal depression. SSLPs that had both enhanced *and* developed new services in at least three of the five maternity service areas were categorised as the 'most active' in maternity provision. However, it should be noted that some programmes listed the same activities under the categories of 'new' and 'enhanced'.

### 2.3 Telephone survey

A semi-structured telephone interview was carried out with a key informant, usually the Programme Manager in a total of 73 SSLPs. These included:

- all 55 SSLPs identified as 'most active' in maternity provision from the national surveys;
- 8 SSLPs identified as doing innovative work from the informal additional information; and
- 10 SSLPs that had, in the national surveys, reported very little enhancement or new development of maternity provision.

The telephone interview sought comprehensive and detailed information about the full range of maternity services provided for the local Sure Start community; staffing; resources; ways of working; relationships with other local services and agencies; understanding of needs and unmet needs; evidence of effectiveness; and difficulties encountered and overcome.

### 2.5 In-depth studies

From information obtained by the telephone interviews, a sample of thirteen SSLPs was selected for in-depth study. These SSLPs were chosen to include different models of maternity provision and different types of community, including inner city and rural communities, and those with a high prevalence of minority ethnic groups and teenage mothers. The in-depth studies were designed to explore the more innovative and creative approaches, and the factors that supported or undermined their success.

In each SSLP selected for in-depth study, interviews were carried out with a range of staff working with pregnant women, new parents and babies, both within Sure Start and in the local mainstream services. Some mothers who had had a baby within the previous six months and were using Sure Start services were also interviewed individually or in focus groups.

### 2.6 Description of findings

This report describes the maternity services developed or enhanced by those 73 SSLPs that were part of the telephone survey (including those studied in-depth). These represent about 15% of all the SSLPs that now exist. Because the sample was limited, it is not possible to generalise with certainty about 'Sure Start maternity services' across all programmes. However, we hope that by including both SSLPs with 'most active' or innovative maternity services and those which were comparatively inactive, we will have captured the full range of different approaches to developing and delivering 'Sure Start maternity services'.

# CHAPTER 3: CONTEXT - MAINSTREAM MATERNITY SERVICES

All SSLPs develop their maternity services in the context of existing local mainstream provision. This chapter gives an outline of core mainstream maternity services and the trends influencing their current development, while recognising that in practice there is substantial local variation, according to local needs, priorities and resources.

## 3.1 Scope of maternity services

Maternity services are universally available under the NHS, and provide care for women in pregnancy, during labour and childbirth and for mothers and babies postnatally. These services aim to:

- identify mothers and babies at risk of poor outcomes;
- provide appropriate interventions for problems that arise;
- provide relevant education and health promotion for the health of the mother and baby, and to prepare for labour and new parenthood; and
- (to a limited extent) provide social and emotional support to increase maternal confidence and parenting competence.

## 3.2 Professionals involved in maternity services

Maternity services are delivered by a range of professionals in primary, community and secondary care – principally midwives, obstetricians, health visitors and general practitioners, but also others including dieticians, mental health specialists and health promotion experts. The key community professionals are midwives and health visitors.

Midwives are usually employed by an acute (secondary care) NHS trust while health visiting services are provided by a primary care trust (PCT). In most areas, some midwives work exclusively in the hospital, and some in community teams usually attached to GP practices. Health visitors are also usually linked to GP practices. The caseload of GP-attached community midwives and health visitors consists of families who are registered with their GPs, and who may live scattered over a large area.

## 3.3 Antenatal care

Antenatal (pregnancy) care includes assessment of the health of the mother and the developing foetus; management of any problems; screening for foetal anomalies and maternal conditions such as anaemia; health promotion on issues such as diet, smoking and infant feeding; and general advice on pregnancy, including preparation for labour. The clinical guideline *Routine antenatal care for the healthy woman for use in the NHS in England and Wales*, (NICE, 2003) published by the National Institute of Clinical Excellence (NICE), gives evidence-based guidance for the care of women with uncomplicated singleton pregnancies.

A pregnant woman is ‘booked’ under the care of a consultant obstetrician, but most routine antenatal care is provided by midwives, either community-based or in the hospital, or less commonly by a GP. The first and longest antenatal

checkup is known as the 'booking visit', when the midwife or doctor takes a detailed medical and social history at around 8-12 weeks of pregnancy. Regular checkups continue throughout pregnancy.

### 3.3 Childbirth

The overwhelming majority (96%) of babies are born in hospital consultant units. (House of Commons Health Committee, 2002) About 2% of babies are born at home, but there is wide geographical variation, ranging from 0.3% to 6.1%.(ONS, 2002) The remainder are born in birth centres, midwifery-led units or GP units.

### 3.4 Postnatal care

Postnatal care is usually provided by midwives until 10-14 days after birth, when care is transferred to the health visitor. Postnatal care has traditionally included the management of any birth-related health problems in the mother, and advice and support on the physical well-being of the baby. Wider aspects of the health of the mother have more recently become included, for example identifying postnatal depression.

### 3.5 Trends affecting mainstream service development

#### *3.5.1 'Woman-centred' care*

Maternity services differ from other health services in that the women who use them are generally well. Over the last 15 years there has been a shift in policy away from a narrowly medical model of maternity care, towards a more 'woman-centred' model based on evidence that the emotional and psychological aspects of maternity care affect outcomes for both mothers and infants. (Kitzinger, 1992) As a result of the efforts of campaigning consumer groups and the Expert Maternity Group's report, *Changing Childbirth* (Department of Health 1993) women have in many respects gained more control over their care, more information about the options available to them and more choice.

#### *3.5.2 Recognition of health inequalities*

Alongside this trend to woman-centred care there has been a broad recognition that the health inequalities affecting mothers and babies are strongly associated with social disadvantage, and that early intervention is key to overcoming the inequalities in outcomes for disadvantaged mothers and babies. The strong evidence for this was summarised in the *Report of the Independent Inquiry into Inequalities in Health*, (Acheson, 1998) which recommended that *"a high priority is given to policies aimed at improving health and reducing health inequalities in women of childbearing age, expectant mothers and young children"*. The report presented the growing evidence for the importance of antenatal and postnatal services in overcoming health inequalities and the kinds of developments that would promote more effective services, such as adjusting the role of health visitors to provide social and emotional support to new and expectant parents.

#### *3.5.3 NHS targets for action on inequalities*

The *NHS Plan* (Department of Health, 2000) described the health of the mother and baby at the very beginning of the baby's life as being the foundation for

lifelong health. It set targets for reducing smoking in pregnancy and recommended that services be set up to address women's mental health problems sensitively. The implications for maternity services were stated: *"This means knowing where pregnant women are and how they want and need their care delivered and configured. It means understanding the local patterns of disadvantage and exclusion; and designing services that reach out to ensure those most in need have prompt access to the support they need".*

As part of the government's *Cross-cutting spending review into health inequalities* (Department of Health, 2002A) the targets set by the NHS Plan were combined into a single Public Service Agreement (PSA) target: by 2010 to reduce inequalities in health outcomes by 10% as measured by infant mortality and life expectancy at birth.

Progress towards this PSA target is supported by two maternity service targets set in the *Priorities and Planning Framework for the NHS, 2003-2006*: (Department of Health 2002B)

- to deliver a one percentage point reduction per year in the proportion of women continuing to smoke throughout pregnancy, focusing especially on smokers from disadvantaged groups; and
- to deliver an increase of two percentage points per year in the breastfeeding initiation rate, focusing especially on women from disadvantaged groups.

### *3.5.4 The National Service Framework (NSF)*

In 2004, the Department of Health published the *National Service Framework for Children, Young People and Maternity Service,* (Department of Health, 2004) a ten year strategy. The maternity standard of the NSF sets out a vision of *"flexible individualised services designed to fit around the woman and her baby's journey through pregnancy and motherhood, with emphasis on the needs of vulnerable and disadvantaged women."* It emphasises woman-focused care, inclusive services that are truly accessible to disadvantaged women, and co-ordinated multi-disciplinary and multi-agency partnerships ('managed maternity networks'). It directs all NHS maternity care providers and Primary Care Trusts (PCTs) to improve uptake of community maternity services and support for all pregnant women and new parents by *"extending Sure Start principles across other services".*

### *3.5.5 The pressure on maternity services*

There is an ongoing shortage of midwives. In recent research (Curtis, 2003) into the retention of midwives, Heads of Midwifery identified their 'establishments' – the numbers of midwives who should be available in their units, without taking account of staff shortages – as completely insufficient to meet the demands of the new policy imperatives. On top of that, most units experience regular, sometimes chronic, shortages of midwives and some rely heavily on agency staff. There are similar problems for health visitors.

# CHAPTER 4. WHAT WORKS? EVIDENCE FROM THE LITERATURE REVIEW

This chapter summarises what is known about maternal and infant health inequalities, and what maternity services can do to reduce inequalities in both access to services and outcomes for mother and baby. Evaluated interventions fall into two main categories:

- interventions to **improve access to existing services** for women who do not currently make full use of them; and
- **extra services** for women who need additional support (for example to stop smoking, or to because of mental health problems).

Unfortunately, while there is good evidence on inequalities in outcomes for disadvantaged mothers and babies, the **evidence on "what works"** is often less robust. Many studies that show positive results are small and it is unclear what effect the personal qualities of the people delivering the intervention may have had.

The full Literature Review on which this summary is based can be found at www.ness.bbk.ac.uk

## 4.1 Health inequalities for babies

The life chances of a child are affected by the circumstances, health and choices of his/her mother before, during and after pregnancy. The babies of women living in poverty, women from some ethnic minorities (especially if the mother was born abroad), women without partners, and teenagers, are at increased risk of a range of poor outcomes. They are more likely to be born at a low birth weight (below 2500g – a key indicator for poor future health), to be born before term, with congenital abnormalities, stillborn or to die in the first year of life.

Apart from poverty, ethnicity and age, the main risk factors for poor outcomes are behaviours such as smoking, poor diet, substance misuse and not breastfeeding; lack of social support; mental health problems; and domestic violence.

Babies born to women in certain situations are particularly vulnerable because they may experience high levels of these risk factors, usually in combination. They include women who are homeless and/or living in temporary accommodation, asylum seekers and other women who are recently arrived in the UK, especially if they do not speak English, Travellers and women with physical and/or learning disabilities.

## 4.2 Health inequalities for mothers

Mothers from the most disadvantaged groups are more likely to die during or soon after pregnancy than women in social classes I and II. Women from non-White ethnic groups are twice as likely to die in pregnancy as White women, with over-representation of those who do not speak English.

### 4.3 Inter-related factors

The maternal factors associated with poor outcomes for mother and baby tend to be closely inter-related. For example:

- Teenagers are particularly likely to be smokers before pregnancy and least likely to give up; they are also particularly likely to have a poor diet.
- Pregnant women living in poverty are unlikely to have an adequate diet. Some Asian women are vulnerable to vitamin D deficiency.
- Depression during pregnancy has been associated with smoking in pregnancy and with substance misuse.
- Two key risk factors for postnatal depression are lack of a confiding relationship and low income; teenagers are particularly at risk.
- Domestic violence is more likely to occur where relationships are under social or financial strain. Key indicators include young age, marital separation, financial pressure, drug/alcohol abuse, and disability/ill health.

### 4.4 How maternity services help tackle inequalities - access to services

#### *4.4.1 Antenatal care*

Around 98-99% of pregnant women receive antenatal care. Women are at greater risk of poor outcomes if they do not receive any care, or begin their care late in pregnancy or miss more than a few antenatal appointments. Women are likely to start care later and to have fewer antenatal visits if they are young or unsupported, from ethnic minorities, unemployed, in temporary housing, or live in deprived areas .Examples of good practice in relation to antenatal care for all women, but particularly those who experience one or more risk factors include:

- Advocates, linkworkers and bilingual workers for women who do not speak English.
- Written, audio and video information in English (accessible for women with disabilities and women with low literacy skills) and in minority languages.
- Following up women who do not attend an appointment.
- A flexible care plan to suit a woman's particular circumstances, which may include providing individual care at home.
- Liaison between all the relevant professionals: GP, midwife and health visitor.
- A midwife and/or health visitor taking specific responsibility for a particularly disadvantaged group (e.g. homeless women, asylum seekers) can improve services with a multi-agency approach.
- A physically accessible environment for women with disabilities.

#### *4.4.2 Antenatal classes*

Around two-thirds of first-time mothers attend antenatal classes, usually provided by midwives and offering information on personal care during pregnancy, and preparation for birth and early parenthood. Attendance increases women's confidence and significantly reduces the use of pain-relieving medication in labour. Women and men who are aged under 20, from manual social classes or from ethnic minorities are less likely to attend classes, often because they believe they will not fit in. Good practice includes:

- Separate antenatal classes for vulnerable groups such as minority ethnic groups or teenagers.

### 4.5 How maternity services help tackle inequalities - extra services

#### *4.5.1 Continuity of carer*

Models of midwifery care that offer a high degree of continuity - that is, where one practitioner provides the care through pregnancy to the birth - appear to improve outcomes, particularly for disadvantaged women. Women appear more confident and prepared for birth, and expect to have more control because they have a relationship with the midwife who will support them. They tend to have a lower induction rate, higher vaginal delivery rate, lower use of pethidine and epidural analgesia, higher initiation of breastfeeding, and a high home birth rate. In normal 'team' midwifery there is little continuity as a woman may see any one of the midwives in the community team for any antenatal appointment. Good practice includes:

- In "one-to-one" midwifery, each woman is cared for throughout pregnancy and labour by a single midwife, backed up by a partner or a small team. This allows a relationship of trust to develop and enables the midwife to understand the woman's needs, and to signpost effectively to other services.

#### *4.5.2 Smoking*

Smoking during pregnancy is the leading cause of low birth weight, and a key risk factor for stillbirth, neonatal death and SIDS (cot death). It may also increase the risk of attention deficit disorder, deficits in motor skills and perception, and reduced educational achievement. Postnatal exposure to household smoke independently increases the risk of SIDS and appears to be a cause of acute chest infection in young children.

Interventions designed to motivate or assist women in giving up smoking have fairly low rates of success (average 6.4% , Lumley et al. 2002), and there is no review-level evidence of effective interventions for pregnant women in lower socio-economic groups who are the most likely to smoke and the least likely to quit. Generally, the majority of women who quit during pregnancy do so spontaneously. There are examples of good practice.

- One-to-one sessions are more effective than group sessions, which are very poorly accepted.
- Cognitive-behavioural self-help approaches aimed at changing attitudes and providing support for people as they take up positive habits are more effective than advice and feedback (Arblaster et al. 1998).
- Providing information on the risks (to foetus and baby) of smoking, the benefits of quitting, and the growth and development of the foetus.
- Brief cessation counselling, using the "ask, advise, assess, assist and arrange" steps (North American Agency for Health Care Policy and Research), delivered by a trained provider in conjunction with the provision of pregnancy-specific self-help materials.
- Nicotine Replacement Therapy (NRT) for resistant pregnant smokers in the first trimester.

- Interventions for disadvantaged women need to take account of their feelings about smoking and the role it plays in their lives, since many reports show that they use it to cope with stress. (Graham, 1987)

### *4.5.3 Substance misuse*

Use of illegal drugs during pregnancy can lead to premature birth, low birth weight, brain damage, neonatal death and SIDS (cot death). Illegal drug use is also associated with an increase in all categories of child abuse. Heavy drinking can cause Foetal Alcohol Syndrome, which is the biggest cause of non genetic mental disability and can also lead to other harm, including low birthweight and unusual facial features. Good practice in this area includes the following examples:

- A drugs liaison midwife ensures good communication between all agencies working with women who are alcohol or drug dependent and enables their early access to maternity services, thus giving time to work on their dependencies and any economic, housing and childcare concerns.
- A multi-disciplinary clinic, providing holistic and non-judgmental care for pregnant drug users through weekly or fortnightly visits, reduces or stabilizes drug use, and increases contact with other services.

### *4.5.4 Mother's diet in pregnancy*

Inadequate diet is the second most important cause of low birth weight after smoking. A 'healthy' diet in pregnancy may also have long term benefits in reducing the baby's later risk of cardiovascular disease, and of non-insulin-dependent diabetes.

There is a lot of evidence that it is easier to improve a woman's nutritional knowledge (for example through nutrition classes or leaflets) than to affect her dietary intake. There is no good evidence on the effectiveness of interventions to promote healthy eating in pregnant women in order to affect pregnancy outcome, including birth weight. Examples of effective practice to improve diet:

- Intensive, one-to-one counselling over many weeks, including individualised dietary intake assessment, nutrition education and counselling.
- Behavioural counselling by nurses (two 15 minute sessions) was twice as effective in increasing fruit and vegetable consumption as ordinary nutritional counselling. (NB this study did not include pregnant women).
- Facilitating access to cheap healthy foods (for example by providing vouchers, or linking with food co-ops or community cafes), and teaching cooking skills to those who lack them, may enable women to follow dietary advice.

### *4.5.5 Breastfeeding*

Breastfeeding reduces the incidence and severity of many infections of infancy, such as gastro-intestinal, respiratory, urinary tract, and ear infections. It also protects against insulin-dependent diabetes and allergic disease and is

associated with better cognitive development. Breastfeeding reduces the mother's risk of breast cancer, ovarian cancer and hip fractures.

Interventions to promote breastfeeding aim to increase the number of women who start breastfeeding (initiation), and/or to increase the length of time for which they breastfeed (duration) Examples of good practice include

- Professional antenatal and postnatal support can be effective for women on low incomes and ethnic minority women.
- Informal, small group health education, delivered during the antenatal period.
- One-to-one health education can be effective for women on low incomes.
- Peer support programmes can be effective for women on low incomes, particularly those who have expressed a wish to breastfeed.
- Breastfeeding groups or drop-ins.
- Help with the practicalities of breastfeeding, for example from a trained healthcare assistant, decreased early feeding problems in a disadvantaged community. However, such support did not work well in an ethnic minority community.

### *4.5.6 Social support*

Targeted social support, which may be offered by telephone or home visiting during pregnancy has positive social and behavioural outcomes including self-confidence and parenting skills. An example of such a scheme is the link workers who visited Pakistani women who had already had one low birthweight baby. Although evidence of the impact on health is mixed, individual intensive support programmes have led to reductions in low birth weight, preterm births, and other health problems for particularly vulnerable groups (notably ethnic minority women and those who have already had a low birth weight baby). Examples of good practice:

- Professional social support from nurses or linkworkers, delivered by regular one-to-one visits and/or telephone contact.
- In the Community Mothers programme, experienced mothers from the same community visit once a month during the first year. However, non-professional support interventions have very poor uptake in some communities.

### *4.5.7 Mental health and postnatal depression*

Stress and anxiety during pregnancy are associated with an increased risk of premature birth and low birth weight, and severe anxiety during pregnancy is also associated with emotional and behavioural problems in the child at age four. Postnatal depression in mothers may have a significant impact on the future health and development of their babies, and an association has been found between maternal mood disorder and impaired cognitive functioning in the child. Psychiatric conditions (including suicide, drug overdose and alcohol abuse) are the leading cause of maternal mortality.

The following are examples of good practice:

- Women who have a history of psychiatric illness should be identified early in pregnancy and referred for antenatal psychiatric assessment.
- Women with mental health problems benefit from a strong network of appropriately skilled support, offering continuity of carer and 24-hour access during pregnancy, labour and the early postnatal period.
- Women without existing mental health problems should not be offered routine antenatal screening to predict the development of postnatal depression.
- Appropriately trained health visitors can detect and manage postnatal depression, either through "listening visits" or through a series of counselling sessions, but the most vulnerable women may be least likely to accept these interventions.
- Professional and lay social support may help in the treatment of postnatal depression, including activities such as groups for new mothers, swimming, and baby massage.
- The Edinburgh Postnatal Depression Scale (EPDS) is valid for screening for postnatal depression, but is not valid for non-English-speaking women.

Antenatal education interventions are not effective in reducing prenatal and postnatal depression (NICE, 2003).

### *4.5.8 Infant mental health*

Development of the bond between parent and child, known as attachment, is very significant for the future development of the child. Where such bonds are insecure there is an association with future antisocial and violent behaviour and adult mental health problems. There are examples of effective practice to promote the mother's sensitivity to her baby's needs and her own capacity to respond to these needs.

- The Brazelton Neonatal Behavioural Assessment Scale (Brazelton, 1973) is used to improve parents' responsiveness to their newborn by highlighting the baby's abilities.
- In the Sunderland Infant Programme (Maher, 2002) a video of the mother playing with her baby is used for assessment and developmental guidance from a health visitor.
- Intensive home visiting from the last trimester until the baby is one year old, from visitors trained in parent counselling and promoting mother/child interaction.
- Parenting groups e.g. Mellow Parenting, PIPPIN, which help parents whose relationships with their children are under stress with some 'expert' guidance and mutual support.
- Baby massage, especially for women with postnatal depression.

### *4.5.9 Domestic violence*

Violence during pregnancy is associated with premature birth, low birth weight, foetal injuries, damage to the placenta, and premature rupture of the membranes leading to complications such as infection. It is also associated with death of the

mother and/or baby, miscarriage of the foetus, severe morbidity, depression in the mother, attempted suicide, alcohol and drug abuse.

Although there are effective screening tools for domestic violence in pregnancy, and screening for domestic violence has been shown to be acceptable to women, there is insufficient evidence for the effectiveness of interventions in improving health outcomes for women who have been identified.

### 4.6 Common Elements of Effective and Good Practice

Effective approaches to intervention maximise women's engagement with services, empower them to seek further appropriate help and enable them to take greater responsibility for their own well-being and that of their families. The common elements across effective interventions are:

- Antenatal identification of women and mothers and babies at risk of poor outcomes.
- Ensuring access for women and mothers and babies at risk to a service appropriate for their particular needs.
- Establishment of a trusting relationship between the woman and the caregiver.
- Sustained and potentially intensive support, with continuity of carer.
- Empowerment to promote self-motivation, pro-active change, and the maintenance of healthy behaviours.
- Timely and co-ordinated multi-disciplinary input to addressing the multi-faceted aspects of each family's needs.

# FINDINGS

## Chapter 5. DEVELOPMENT AND STRUCTURE OF MATERNITY SERVICES IN SSLPs

### 5.1 What type of Sure Start programmes were 'most active' in developing maternity services?

Analysis of the national surveys carried out in 2001 and 2003 for the NESS Implementation Study found that of the 186 SSLPs for which information was available, 30% fitted our definition of 'most active' in developing maternity services (i.e. they had both enhanced existing services and created new services in at least three of the five 'maternity' areas). By contrast, 13% of programmes surveyed had provided no new maternity services and 12% had not enhanced any existing maternity services.

Detailed statistical analysis is not meaningful because some programmes listed the same activities under the categories 'new' and 'enhanced', and therefore identification of which programmes were 'most active' was to some extent an artefact of the way the survey form had been filled out. It should also be noted that lack of 'new' or 'enhanced' services did not necessarily mean that the community was deprived of maternity services – it might, on the contrary, mean that existing mainstream maternity provision was good.

Overall, the SSLPs that we characterised as 'most active' appeared broadly representative of all the SSLPs. For example, whether or not a programme was in the 'most active' category was not affected by whether it was urban or rural, by the type of lead agency or by the general level of parent involvement with the programme. The 'most active' programmes were found in roughly equal proportions in the eight Government Office Regions of the country, except that a higher proportion of the SSLPs in the North East and East Midlands were 'most active'. There was also a slight under-representation of SSLPs with high (more than 10%) ethnic minority populations among the earlier (rounds 1&2) 'most active' programmes, but not the later (rounds 3&4) programmes.

The findings reported in the remainder of this report are based on the telephone survey and case studies, including the SSLPs which were 'most active', but also others identified as having interesting maternity provision and some which had very little maternity provision (see section 2.3).

### 5.2 Key factors in the establishment of robust Sure Start maternity services

Maternity services rarely figured in the original delivery plans of the early (round 1&2) SSLPs, because there was no specific focus on maternity in the guidance available to those programmes (see section 1.3), but many of these programmes had subsequently added maternity services. Later (round 3 & 4) SSLPs usually included maternity services from the outset, reflecting the altered guidance from the Sure Start Unit.

### *5.2.1 New resources*

Effective development of Sure Start maternity services depended fundamentally on additional resources. The most important new resource was **dedicated time from midwives and health visitors** to work with Sure Start communities, usually providing extra antenatal and postnatal services, and sometimes replacing a substantial portion of the clinical care provided by the mainstream services. SSLPs also funded **new venues** for maternity care, **new services** provided by professionals, paraprofessionals and volunteers, and **new practical resources** (e.g. props to describe baby care or breastfeeding).

Designated midwifery time to work with the SSLP community varied between 7 hours a week to 2.5 FTEs ('full time equivalents'). The majority of SSLPs had between 0.5 and 1 FTE midwife, although two programmes had none at all. An unusual example was found in one SSLP where the mainstream services resourced and managed 6 FTE midwives to work in the SSLP area (although not exclusively with Sure Start women).

Dedicated health visitor time was comparable, but a fifth of the SSLPs did not fund dedicated health visitor time for their communities. Instead, some programmes 'worked with' the mainstream health visitors, and some used staff such as home visitors and outreach workers to perform similar functions.

With the establishment of several SSLPs in an area, these resources of designated midwifery and health visiting time had sometimes been developed to form a specialist team that supported a group of SSLPs. In many cases, the extra staff funded by Sure Start had become a specialist referral resource for community midwives and local health visitors working with disadvantaged families outside the SSLP.

### *5.2.2 Involvement of mainstream stakeholders*

There was a strong focus on maternity in SSLPs where a **member of the Sure Start partnership board** had a special interest in maternity, and in particular, where the heads of area health visiting and/or of midwifery services were on the partnership board. In some cases, even if they were not on the board, the **personal commitment** of influential mainstream maternity postholders to Sure Start goals supported the development of Sure Start maternity provision. For example, in one area, the local health authority was reviewing community midwifery when Sure Start began and the SSLP was seen as an opportunity to pilot new ways of working. *"It was really the case that the two agendas were in the right place at the right time*" (programme manager).

Even where there were no links at a strategic level, maternity services also tended to be strong in SSLPs that had fully **consulted local community midwives or health visitors** and designed services accordingly.

### *5.2.3 Community consultation*

Maternity issues often had not come up in the original community consultation. Where they had, the most common issues raised by parents were the need for

accessible local clinics, for improved postnatal support, and for better preparation for parenthood. Many SSLPs had generally responded by providing services to meet exactly these needs.

### *5.2.4 Support within the SSLP*

Many SSLPs saw their maternity services (particularly the midwifery) as an ideal opportunity to get families engaged with Sure Start services generally. Midwifery - as a truly universal service - was generally acceptable to families who might reject or mistrust other professionals, either because there was stigma in their involvement, or because they were believed to have a hostile agenda (e.g. health visitors were perceived in some communities as the eyes and ears of social services). *"The considerable strength that midwives have as a delivery mechanism, to get people into services, is based on the trust which parents have in them. They can act as an entry to other services, and that is the strategy we have here, building on that relationship and the trust that comes from it to integrate the services"* (programme manager).

## 5.3 Key obstacles to the development of Sure Start maternity services

About a dozen of the SSLPs had experienced significant difficulties in developing appropriate maternity provision for the Sure Start community.

### *5.3.1 Poor strategic relationships with mainstream maternity services*

The development of maternity services in some SSLPs had been profoundly influenced by a lack of commitment from senior managers in the mainstream services, and in a couple of cases, this resulted in failure to establish even basic provision. There had often been tensions over programme development because of a clash between the Sure Start agenda - driven by concerns over social exclusion and inequalities - and the priorities of overstretched mainstream services with different professional agendas and staff shortages. The key issues were that some mainstream managers:

- had **limited understanding of the needs** of the Sure Start community;
- believed the intensive support delivered by Sure Start was **not sustainable**;
- did not support geographical **targeting,** feeling that this was unfair to non-Sure Start women;
- were concerned that Sure Start professionals who did not carry a caseload had **'cushy' jobs** and might lose their clinical competence;
- were constrained by **resource shortages** from responding fully to Sure Start. For example, in one SSLP that commissioned all of its services, the programme manager noted: *"The major difficulties have been around the lack of capacity in the statutory organisations to work with me to develop these services…It's taken longer than I think is reasonable";*
- were concerned that far from adding resources to the service, SSLPs were **'poaching' their staff**. One programme manager described *"the reluctance of the midwifery service to work alongside us at the strategic level not at the ground level. The shortage of midwives in the country is a major problem everywhere. Rather than seeing us as an opportunity we are seen as a threat taking their midwives – it's sad because it's the one*

*statutory agency that we've really struggled with."* In another SSLP where the Sure Start midwife had resigned, the mainstream midwifery manager refused to allow the programme to advertise for a replacement because the mainstream service was itself so overstretched that she feared 'losing' a staff member to the SSLP.

On the other hand, one head of community midwifery, who was supportive of her local SSLPs, explained that SSLPs expected a great deal from mainstream managers: "*All involvement in Sure Start is hugely time consuming, especially data collection, supervising staff, and partnership meetings – you've got to motivate yourself."*

### *5.3.2 Other key obstacles*

The other main problems for the development of the maternity services were:

- where the SSLP originally saw itself as a **service for children** and therefore, as working with parents only from the time the baby was born;
- where the **programme manager had poor knowledge** of maternity services;
- where the SSLP had an **extended catchment area and no Sure Start centre**, causing difficulties in reaching families, building relationships and engaging them in maternity services: *"My role is a continual struggle; it is much harder than I expected. We are still trying to get over the threshold"* (Sure Start midwife);
- where **leadership within the SSLP was weak**, and resources were not effectively managed. For example, one SSLP had expanded its catchment area but the management had failed to apply for additional resources, so the maternity provision had to be stretched more thinly;
- where - in a few SSLPs - there had been **high turnover of maternity staff**, usually linked to the other areas of difficulty. For example, in one SSLP that commissioned all its services, the linkworker and midwife had resigned because the programme manager had been unable to establish clear lines of responsibility;
- where **programmes in later rounds** had not been supported by their colleagues in earlier programmes;
- where (in one case) **members of the partnership board**, who were all parents or community members, had not supported a key aspect of the SSLP's maternity provision – breastfeeding- *"because of personal baggage"* (Sure Start midwife).

## 5.4 The evolution of services

Sure Start maternity services often evolved over time and in response to local conditions. Some SSLPs reported improving maternity provision, with recruitment of more staff, extra services and closer integration with the mainstream. But sometimes movement was in the opposite direction and SSLPs which had built apparently robust maternity services encountered difficulties as resources and relationships changed.

### *5.4.1 Learning from experience*

At the simplest level, Sure Start gave practitioners the scope to take risks, and many SSLPs reported trying out particular approaches, activities or staffing arrangements that turned out not to work in that particular community. They learned from experience and went on to develop different activities. One programme manager described how the approach to providing services changed over the lifecycle of the SSLP: *"At the beginning of the project you have a lot of ideas and take a lot of risks, but now three years later, after some evaluation, we're in a position to judge what works and what doesn't. We can concentrate our resources on fewer, more effective services, picking winners."*

### *5.4.2 Changing relationships with mainstream services*

Changes in key staff and/or staff shortages in the mainstream services often strongly affected the evolution of Sure Start maternity services. Typical mainstream difficulties that led to a 'thinning' of services are explored more fully in sections 5.3.1 and 6.9.

### *5.4.3 Impact of external policy developments*

Several SSLPs were in areas where a new Children's Centre would soon be taking the lead on child health and social care, and staff expected this to impact significantly on the future of the Sure Start maternity services. In one SSLP, staff were concerned that the Sure Start model of multi-disciplinary maternity care would be disrupted if child health services were removed from the Sure Start centre to a new building; in another SSLP, staff welcomed the new Children's Centre as a force for integration because their whole staff team, which had no Sure Start centre, was moving there.

# CHAPTER 6. HOW SURE START MATERNITY SERVICES ARE DELIVERED

The maternity services provided in SSLPs were designed in the context of local mainstream maternity services which are 'universal' but, in practice, not necessarily able to meet the needs of the Sure Start communities. Because the existing mainstream provision varied, so did the extent of Sure Start supplementary provision, particularly for antenatal services. At one extreme, a few SSLPs funded midwives to provide full clinical care and antenatal support services for their community. At the other extreme, in a couple of SSLPs where the mainstream services already provided excellent one-to-one midwifery care, the programmes had minimal input in the antenatal period and were unable to integrate maternity provision into the rest of the programme.

## 6.1 Staffing arrangements

Although there were many professionals involved in providing different aspects of maternity services, this section concentrates on midwives and health visitors who were the lead professionals in the antenatal and postnatal periods respectively.

### *6.1.1 Secondment and commissioning*

The most common arrangement was for the SSLP to fund a "Sure Start midwife" and "Sure Start health visitor," who were usually **seconded from the mainstream** services. The mainstream services retained their professional (clinical) management while the SSLP had their day-to-day line management. In a few SSLPs, Sure Start posts had been created as part of an **integrated Sure Start/ mainstream team.**

An alternative, in a minority of SSLPs, was to **commission maternity services** from mainstream providers under a service level agreement. Sometimes there was little difference in practice between this arrangement and secondment: a midwife or health visitor might work full time providing Sure Start services, be based at a Sure Start building and be referred to by Sure Start colleagues as a "Sure Start midwife/health visitor". In other SSLPs where relatively little maternity staff time had been commissioned, they tended to be identified more as mainstream practitioners. Another model was for the SSLP to **commission time from each health visitor** to offer a slightly enhanced service to the Sure Start community; some SSLPs described this as *"incorporating"* the existing local health visiting team into the programme. Only two SSLPs had tried this with midwifery, but it had not been a success.

A small number of SSLPs that did not fund any health visiting time instead employed a **health co-ordinator** who worked with the local health visitors to develop their practice. Other programmes relied on staff such as **home visitors and outreach workers** to perform the functions sometimes carried out by Sure Start health visitors, and a few took a **'whole team' approach** where all members of the Sure Start health team - midwives, health visitors, perhaps a CPN or a speech and language specialist - shared responsibility for maternity care.

### *6.1.2 Advantages and disadvantages of different staffing arrangements*

Many SSLPs reported that funding a designated individual 'Sure Start' midwife or health visitor helped to **'ring fence' her time** for the Sure Start community, but was less effective in **influencing the mainstream services**. In contrast, commissioning some time for Sure Start from each member of the mainstream community teams (and usually funding an additional staff member to increase capacity) was felt to be very positive for integration, but the arrangement was vulnerable to mainstream staff shortages when the Sure Start services were always the first to be cut: "*With the health visiting, where we've funded everyone to do a bit of additional work, whenever there's a staff shortage, which there is constantly, they fall back on their core duties"* (programme manager). Several SSLPs had initially commissioned time from a whole mainstream team but had cancelled the arrangement and gone over to secondment of an individual because of this problem.

In addition, a couple of SSLPs cautioned that commissioning extra time from the whole mainstream team was only worthwhile if those practitioners were prepared to work in a 'Sure Start' way, which was not always the case. These SSLPs believed that to influence the mainstream services, they needed to **function as a beacon of good practice** outside them: *"The acute sector that manages both maternity delivery and community midwifery services are very traditional in their approaches and by investing directly into their services we would not have had any impact"*(programme manager).

## 6.2 'Additionality' and 'caseload' services

There were two significantly different approaches to providing maternity services within SSLPs: 'additionality' and 'caseload' services.

### *6.2.1'Additionality'*

In the majority of programmes, the Sure Start midwife and/or health visitor did not provide clinical maternity care for Sure Start women. Instead, the mainstream maternity services provided the clinical care and the Sure Start staff **organised and provided additional services** suitable for the community, for example local antenatal and postnatal groups and activities, and extra support on specific issues such as smoking cessation, breastfeeding, and postnatal depression (a description of the type of 'additional' services found in the SSLPs is in chapter 8). They also helped women to **access mainstream services**. Three quarters of the SSLPs with a designated Sure Start midwife used her to provide 'additionality'. In a few of these SSLPs the midwife provided some limited clinical care (for example booking appointments), but then referred the women on to mainstream colleagues for the rest.

### *6.2.2 Carrying a Sure Start caseload*

In a minority of SSLPs (all of which had either seconded maternity staff or commissioned individuals), the Sure Start midwife and/or health visitor not only provided additional services for the Sure Start community, but also had a 'caseload' of women for whom she **provided full antenatal or postnatal clinical**

**care**. In the case of midwifery, the midwife usually had a **small caseload of especially vulnerable women**, for example teenagers, drug users or homeless women. She would generally provide very **intensive and personalised one-to-one care** for these women, being available to them on a 24-hour, 7-day a week basis. However, she would not normally deliver their babies unless a birth happened to coincide with the (usually) limited time she spent working in the hospital. Where the Sure Start health visitor held a caseload of Sure Start women, it was more often a **generic caseload** rather than a targeted one. A few practitioners mentioned that carrying a caseload sometimes limited the amount of 'additionality' they could offer.

In a third of the SSLPs, the 'Sure Start' midwife worked part-time for Sure Start and part-time for the mainstream services, and many of these midwives had their own **mainstream caseload of non-Sure Start women**. The same applied to part-time health visitors.

### 6.3 New ways of working in Sure Start maternity services

Sure Start has brought about dramatic changes in the working arrangements and working style of maternity professionals in many SSLPs, including:

- adopting a public health remit ;
- the type of catchment for which they are responsible; and
- multi-disciplinary working.

#### 6.3.1 Public health approach

Whereas traditional maternity services have operated on a clinical model of care, focused on risk assessment and intervention, more recent national policy developments have emphasised a 'public health' approach. This highlights reducing health inequalities by **targeting services** on the most vulnerable families and **meeting their social and psychological needs**. It also involves fundamental changes in ways of working, particularly to **engage the most disadvantaged**. Mainstream maternity professionals are to some extent taking on a public health approach in delivering their services, but in most areas this is severely constrained by resource shortages, as well as some professionals' resistance to change.

Using a public health approach was a defining feature of Sure Start maternity provision. Sure Start midwives and health visitors aimed to identify and to meet each family's wider needs. They made access to healthcare easier and less formal, working flexibly to offer choice in the type and delivery of services. Methods of improving access and the new services offered are explored in chapters 7 and 8.

#### 6.3.2 Working geographically

Health visiting and community midwifery services have traditionally been attached to GP practices and therefore clients may have been scattered over a wide area. By contrast, the additional maternity services provided by SSLPs were primarily focused on families resident in the SSLP area. This had a number of advantages:

- the maternity staff got to know the important **local background**: *"It is going back to the old-fashioned midwife who knew everyone, who knew women's husbands' type of work. We'll be on bicycles next…"* (midwifery manager);
- group sessions encouraged and enabled women to make **local friendships** and build networks that could be sustained outside the groups. *"They've made friends where they were first time mothers and didn't know anyone, and they've gone for a coffee, for a girls' night out"*(healthcare assistant); and
- maternity services could be delivered to families that were **not registered with a GP** (which is often an issue for asylum seeking and homeless families).

On the other hand, many SSLPs **described their boundaries as "fuzzy"** or "porous", and most regularly allowed families from the surrounding non-Sure Start area to make use of their group services. Sometimes this was seen as a positive advantage because the groups functioned better with more people in them, although Sure Start families would always get priority if the service was too popular. Occasionally the Sure Start maternity practitioners provided clinical care for women with particularly complex needs from outside the SSLP area, on referral from mainstream colleagues.

### 6.3.3 Multi-disciplinary and multi-agency working

A co-ordinated input from many professional disciplines and agencies is needed to meet the multi-faceted needs of pregnant women, mothers and babies effectively. Many programmes reported a significant change in the way their midwives and health visitors worked in this respect.

## 6.4 Multi-disciplinary working within the SSLP team

### *6.4.1 Midwives and health visitors*

There is traditionally a certain element of rivalry, and relatively little contact, between the midwifery service (which is managed by an acute trust and cares for women during pregnancy, labour, and 10-14 days after birth), and the health visiting service (which is managed by a community trust and takes over from 10-14 days after birth). One head of community midwifery described this situation as a *"chasm between professionals".* Many SSLPs reported a great increase in co-working between midwives and health visitors, working for the first time as part of an integrated team. This collaboration had resulted in significant improvements in continuity of care between the antenatal and postnatal periods, with joint visits, efficient handovers and follow-up.

### *6.4.2 Co-working with the wider Sure Start team*

SSLPs also enabled their midwives and health visitors to co-work with other staff in the wider Sure Start team, including nursery nurses, family support workers, outreach workers, healthcare assistants, home visitors, bilingual linkworkers, community dieticians and community psychiatric nurses.

Examples of other Sure Start practitioners contributing to maternity services included:

- **nursery nurses** trained to carry out the 6-week postnatal depression check, to advise on smoking cessation or breastfeeding, or running postnatal groups;
- **family support workers** visiting women at home to offer services including breastfeeding support, baby massage, and respite care for older children; supporting shy parents in coming to groups; also helping pregnant women and new mothers to resolve housing, welfare and debt problems;
- a **healthcare assistant** providing specialist breastfeeding support by visiting all Sure Start mothers antenatally or just after delivery; running groups; and offering one-to-one support for feeding problems;
- **dieticians** leading sessions on healthy eating for pregnancy; and
- **community psychiatric nurses** leading sessions on postnatal depression and bonding for antenatal groups, and running groups and counselling sessions for women who developed postnatal depression.

### *6.4.3 Working with paraprofessionals*

An important development in some SSLPs was the use of unqualified but trained paraprofessionals, working as **healthcare assistants** or **maternity care assistants**, to provide specific elements of the maternity services, such as breastfeeding support. This freed up midwifery or health visitor time to concentrate on other elements of the service, or might be used to create a completely new service, for example one SSLP used maternity care assistants to provide practical and social support at home (cleaning and befriending) to women for six weeks after birth, following a Dutch model.

There were occasional indications that some professional staff had difficulties adjusting to paraprofessionals. For example, some midwives expressed concern that their role was being eroded by the maternity care assistants – and in one SSLP there was some justification for this view, as the SSLP had recruited a maternity care assistant *instead* of a midwife. This tension reflects a debate going on more widely in the professions.

### *6.4.4 Enablers of effective multi-disciplinary working within SSLPs*

*Using the Sure Start centre*

There were clear advantages when maternity services worked out of the same centre as the wider Sure Start team, because staff had informal opportunities to **share knowledge and refer to each other**. Working out of a collective setting had the most impact on Sure Start midwives, because opportunities for multi-disciplinary working are uncommon in traditional midwifery. Some described how much they appreciated the **'on the job' training** they received from colleagues, such as family support workers and health visitors. They valued the ready availability of support from other members of the Sure Start team and visiting specialists.

*Joint clinics*

Not all the SSLPs had a Sure Start centre, and sometimes it was not the best venue to offer maternity services for particular groups (see section 7.2.2). Some

SSLPs which offered maternity services at other venues nonetheless maintained a multi-disciplinary approach by having other members of the Sure Start team **informally attend the clinics or groups**, **co-facilitate groups** or **lead particular sessions**.

*Leadership and strong team ethos/networking*
A few SSLPs that relied heavily on outreach, or on commissioning services from mainstream organisations, sustained a multi-disciplinary approach by very strong leadership that embedded maternity services in a clear team ethos. Even where the professionals did not share a base, these SSLPs were characterised by **good communication**, especially regular 'staff'meetings. Several SSLPs held weekly meetings of the entire multi-disciplinary team where the needs of families newly enrolled in Sure Start were discussed.

### *6.4.5 Obstacles to effective multidisciplinary working within SSLPs*

*Lack of leadership and lack of role clarity*
There were some SSLPs in which a lack of leadership and lack of clarity about roles had undermined the Start Start 'team' approach. Where co-working was not managed sensitively, staff could become demoralised. For example, in one SSLP, the strategy was for the whole health team to have responsibility for the entire maternity period. The SSLP provided holistic support for transition to parenthood and the maternity services it offered were popular and successful. However, one of the two midwives job-sharing a full time post was leaving because she was dissatisfied with the lack of boundaries to her role: *"We thought we were employed to do the midwifery component of Sure Start, but we learned we were not allowed to do that – what they wanted us to do was to be more of a generic worker – signing up people with children under four, assess their needs as a family unit and refer to whoever appropriate. It meant we couldn't focus on the midwifery components…As midwives we are losing our professional identity because we are being told the health visitor has equal responsibility for antenatal and postnatal care…Sure Start is very good about crossing boundaries, but this generic working is going too far."*

*Lack of integration*
In a few of the SSLPs where the midwives working for Sure Start also spent a substantial amount of their time working within the mainstream service, there were indications that the midwives sometimes **identified more with the mainstream service** than with the Sure Start team. This was exacerbated where the midwife spent less than half of her time working for Sure Start (in two cases as little as one day a week), or where the organisation of the mainstream service on a 24 hour on-call model meant the midwife's Sure Start time was fragmented and irregular.

In one SSLP, the mainstream maternity services had invested heavily in the SSLP area by fully funding and managing six midwives to deliver one-to-one maternity care. Although this meant that Sure Start women received excellent antenatal care, other staff felt that the midwives were not well integrated into the rest of the programme because all the emphasis was on their personal

relationships with the mothers: "*They (the midwives) are very strong women. Which sometimes makes it a bit of a challenge to be part of teams."*

### 6.5 Multi-agency working

To provide comprehensive maternity care, most SSLPs also brought in expertise from a range of local statutory and voluntary agencies outside the Sure Start team and developed good referral links. Some went further and brought together multi-agency partnerships on particular issues that had catalysed change for the whole surrounding area – to tackle postnatal depression, for example.

#### *6.5.1 Delivering sessions and services*

In many SSLPs that ran antenatal or postnatal groups, the organisers invited statutory or voluntary sector experts to offer women information and support on topics such as healthy eating, welfare benefits, maternal mental health, the emotional aspects of having a baby and relationships. Some SSLPs funded voluntary organisations to provide a specific service for Sure Start women, such as befriending or breastfeeding counselling.

#### *6.5.2 Arranging referrals*

Another very common practice was for the SSLP maternity staff to work with city- or county-wide services to arrange clear and efficient referrals to mainstream services for Sure Start women who needed additional support, especially on issues such as smoking cessation, domestic violence and support for women with postnatal depression.

#### *6.5.3 Joint work on specific issues*

Several SSLPs had developed strong collaborative relationships on specific topics, for example some Sure Start midwives and health visitors worked with schools on sexual health. There were also examples of SSLPs taking the lead on a particular maternity issue, particularly breastfeeding or postnatal depression, and **building comprehensive partnerships** with all the relevant stakeholders to transform the services in a wider area.

For example, one SSLP created a partnership with the PCT, mental health services, social services, the acute trust, the health visiting service, and local parents to develop an 'Integrated Care Pathway' on postnatal depression that included training for staff, screening of women, listening visits, support groups and clearer referral paths. The SSLP had funded a postnatal co-ordinator: *"What Sure Start allowed was the time – midwives and health visitors had to fit it in to existing workloads; (whereas) our posts allowed us to put time into training, producing reports, facilitating meetings."* The programme manager reported: *"We have been a real catalyst for change, co-ordinating things, pulling different teams together, getting people talking to each other, and working with parents."*

#### *6.5.4 Joint work 'across the board'*

Some SSLPs have achieved strong collaboration with a range of local services from the voluntary and statutory sectors. One programme manager reported that the SSLP acted as a hub, drawing together local services: *"There was always*

*good working within the voluntary sector, there was always good partnership working within the statutory sector, but I think Sure Start has brought the voluntary and the statutory sector together"*.

This type of collaboration was **particularly likely in programmes which commissioned most of their services**, where there was a thriving voluntary sector, and where the SSLP's philosophy was to build capacity in sustainable organisations. For example, one SSLP in a very transient and ethnically diverse area focused its resources on networking between the statutory and voluntary sector, funding training for professionals, and funding voluntary sector groups to provide services such as baby massage because "*voluntary groups can often reach hard to reach groups which the statutory sector has difficulty reaching"* (programme manager). However, because this programme had no midwife of its own, it had weak links with the mainstream midwifery and its maternity provision was apparently ad hoc according to what local groups were interested in providing. In another SSLP with a comparable population and structure, a midwife had recently been recruited and based with the community midwifery team to overcome the same problems.

### *6.5.5 Working with voluntary organisations*

Sure Start relationships with local and national voluntary organisations working in the maternity field were strong, partly because the voluntary sector was the source of many aspects of the Sure Start approach, but also because many SSLPs **funded workers** at voluntary organisations to deliver Sure Start services, as noted in section 6.5.1. One SSLP noted that even though the programme had expanded voluntary sector capacity by funding some staff in local voluntary organisations, at the same time the creation of the Sure Start core team might have had an adverse impact: *"We have recruited the cream of the staff from the other voluntary organisations. I was conscious we were poaching all the best staff"* (programme manager).

Where the SSLP commissioned most of its services and had no Sure Start centre, SSLPs sometimes **refurbished existing community buildings which they shared with the voluntary organisations that ran them**. However, several SSLPs had experienced problems with investing in or using community venues and cautioned that it was essential to have absolute clarity about what the SSLP expected in return.

Many Sure Start practitioners commented that Sure Start had given them unprecedented opportunities to work with voluntary community groups to the benefit of clients, both **referring and receiving referrals**, and **holding joint groups**. For example, one health visitor found that community groups from the very diverse cultures in her SSLP were often better placed to support women than Sure Start was: *"I've made huge links and I just wish that I had worked that way before. The mainstream health visitors had never heard of these groups – even if they were right behind the health centre."* She explained that the SSLP's attitude to community groups had evolved away from an initial possessiveness of clients: *"In the first year, there was a lot of pressure to register and keep*

*everyone in Sure Start, but now they're happy to dip into community groups and cross refer."*

**6.6 Working with mainstream midwifery and health visiting services**
The relationship of the SSLP with its local mainstream services fundamentally affected the way in which maternity services were provided to the Sure Start community: the level and type of resources deployed and the kind of work that was done. These relationships could differ at different levels of the organisations involved, and they evolved in response to policy changes and staff changes and shortages. Strategic relationships have been explored in sections 5.2.2 and 5.3.1.

**6.7 Operational relationships**
Good operational relationships with mainstream colleagues were crucial for an SSLP to function most effectively. There were examples both of excellent collaborative working, and of obstructive relationships where the mainstream midwives and/or health visitors had not 'bought into' Sure Start.

***6.7.1 Information sharing***
The nature of the relationship between the SSLP and mainstream services was often epitomised by the sharing of information about pregnant women who had booked for maternity care. Some SSLPs had established **straightforward ways of sharing information.** For example, in one SSLP, the community midwives supplied the names and addresses of pregnant women booking for care in the area to the SSLP midwife, who recorded the details of delivery dates for SSLP residents and checked their access to services on a monthly basis, following up those who were not attending appointments.

However, **problems with information sharing** were very widely reported. There appeared to be considerable confusion about the extent to which it was legitimate for the mainstream midwifery services to release women's names and addresses to Sure Start without their written consent. Consequently there were many cases where this information about pregnant women was not forthcoming.

Even where the mainstream services did not perceive data protection or confidentiality issues as an obstacle to information sharing, there were sometimes problems on an operational level. Information was sometimes incomplete because it was an **additional burden on those staff** to have to identify women eligible for Sure Start by checking their postcodes, and generally meant more paperwork. Other obstacles included the **uncertain or negative attitude** of some community midwifery teams towards Sure Start. This could make them, in the words of one Sure Start midwife, *"a bit precious"* about even passing on information about Sure Start to women.

In the light of these obstacles, a number of SSLPs used **informal methods** to gain access to the relevant data. For example, in one SSLP staff used the time-consuming method of attending the local clinics every day to check whether any women from the Sure Start area had booked in. In one third of SSLPs the Sure

Start midwife worked part-time for the mainstream service and in that capacity had access to the details of all local women booking for care. In some cases the SSLP saw this as a specific justification for the creation of the Sure Start midwife post.

Sometimes the information flow was in the other direction, for example many Sure Start midwives made a point of actively following up women who did not attend for their mainstream appointments, and **keeping the community team informed**. In one SSLP the mainstream services reported that the SSLP was better than they were at finding the hard-to-reach women.

### *6.7.2 Referrals*

Irrespective of their stance on the release of contact information, some SSLPs had **good referral links** to and from the local maternity services. This was true of many SSLPs where the Sure Start midwife or health visitor carried a clinical caseload of the most vulnerable women, who would often be referred to her by the mainstream. However, in some SSLPs, community midwives appeared to feel threatened or implicitly criticised by Sure Start, and were **reluctant to refer** women to the SSLP.

For example, in one SSLP the community midwives refused to refer Sure Start women to the Sure Start midwife (who provided 'additionality'), claiming that they could provide *"everything women need"*. In another, the **community midwives acted as gatekeepers**, only referring the 5% of women who they had identified as needing extra services. In a third SSLP, the mainstream midwives did not promote a breastfeeding helpline run by the Sure Start midwife and health visitor, resulting in low take up of the service. There were similar examples of mainstream health visitors failing to refer Sure Start women to Sure Start health visitors who offered 'additionality'.

### *6.7.3 Concern with professional boundaries*

Some mainstream midwives and health visitors appeared to be **highly protective of their caseloads**. For example, in one SSLP, the mainstream midwifery service did not allow the Sure Start midwife to provide any clinical care for Sure Start women, even when they were known not to be attending mainstream antenatal care. In another SSLP, families got two 'new birth' visits (from the mainstream health visitor and from Sure Start), and the Sure Start health visitor believed the mainstream health visitors were reluctant to hand over their new birth visit to her in case it *"disturbed the flow"* of their caseload.

On the other side, some mainstream maternity professionals expressed **frustration at the way that the SSLP maintained its boundaries**. For example community midwives providing a specialist service for pregnant teenagers had on several occasions asked one SSLP for permission to use a Sure Start venue to hold a drop-in for teenagers, because there were no other community venues that they could book. The SSLP management had refused permission because many of the teenagers were from outside the SSLP. (There were, however, many

examples in other SSLPs of exactly this type of 'joint' service where large numbers of non-Sure Start women also benefited).

In complete contrast, there were also examples of partnership work so well integrated that the **professional boundaries had effectively disappeared**. For example, in one SSLP, the mainstream health visitor took advantage of the popular Sure Start antenatal/postnatal drop-in to hold her own clinic there, and the local community midwives covered the antenatal drop-in if the Sure Start midwife was away.

### *6.7.4 Balancing Sure Start and non-Sure Start work*

Where maternity professionals took part in both Sure Start and non-Sure Start work, there was frequently a reported tension between the sometimes conflicting needs of the two services. This centred on **which work got priority** when there were staff shortages. In terms of midwifery, Sure Start midwives might get 'pulled onto the labour ward' to cover staff gaps at the hospital; in terms of health visiting, it could lead to a loss of 'additionality' if there were not enough local health visitors to carry out core contacts and Sure Start health visitors had to take on more of this work.

In a few SSLPs maternity professionals felt that the mainstream services were **exploiting the presence of Sure Start** by failing to invest adequately in their own services. For example, in one SSLP, Sure Start funded two health visitors and the PCT had reduced its funding to only one part-time health visitor, which the programme manager felt to be the wrong balance. In another SSLP, the midwife felt that Sure Start was not getting *"value for money"* from her services as the mainstream service relied on her to work extra shifts at the hospital (unrelated to her Sure Start work.)

Some midwives and one head of midwifery felt that non-midwives in Sure Start did not always understand the nature of midwifery, and therefore had **unrealistic expectations of red-circling** 'Sure Start' midwifery time: *"I think one criticism of Sure Start is that people forget that midwifery is a 24 hour, 7 day a week service and we have to provide that…It is an emergency service and they (the midwives) cannot predict their work"(head of midwifery).*

### *6.7.5 Obstructing innovation*

Occasionally SSLPs encountered what one midwife described as *"Jurassic opposition"* to new ways of working. For example, in an area with more than 80% Asian families, the midwifery manager had refused permission for Sure Start midwives in the five local SSLPs to work in a less traditional way, insisting that they wear the uniforms which were known to be off-putting to the ethnic minority families.

## 6.8 Key enablers to successful operational relationships

### *6.8.1 Working within the community team*

Where the "Sure Start" midwife or health visitor worked part-time for the SSLP and part- time for the mainstream services, there were usually considerable

advantages in terms of good working relationships: *"because we are working with them (the community midwives) two or three days a week they are not suspicious"* (Sure Start midwife). One Sure Start midwife noted that building and maintaining these relationships of trust and good communication was a big part of her split role and she would have liked to have had more development time for this aspect of her job.

### *6.8.2 Building and consolidating relationships*

Where the SSLP recruited a midwife or health visitor who had worked in the area for a long time, there were often warm existing relationships that were maintained even if the professional now worked full time for the SSLP. Some practitioners who came from 'outside' worked hard to build relationships. One SSLP had arranged facilitated sessions to break down the feeling of competitiveness; in another, the Sure Start midwife tried to involve the community midwives in events such as a celebration of National Breastfeeding Week, when she invited them all to a restaurant meal.

### *6.8.3 Lightening the workload*

Some SSLPs made a specific effort to lighten the workloads of overstretched mainstream practitioners by creating posts to provide clinical care for a caseload of local women, sometimes including some non-Sure Start women. In many SSLPs this was a targeted caseload of the most disadvantaged and potentially most time-consuming women with the most complex needs, such as teenagers or drug users. One Sure Start midwife described her role as the *"trouble-shooter and specialist"* for the mainstream midwives.

### *6.8.4 Good communication*

In some SSLPs there was a clear understanding of the importance of good communication in maintaining relationships. For example, the Sure Start midwife would **attend the community midwifery team meetings**, or there were regular health and social care meetings that included both Sure Start and mainstream practitioners. In some areas there were regular **regional network meetings** of mainstream and Sure Start midwives, or **regular strategic meetings**, for example between the programme managers from seven SSLPs and mainstream maternity services managers.

Many Sure Start midwives noted that they were careful to **communicate any relevant information about clients back to mainstream colleagues**, for example in one SSLP, the Sure Start midwife would telephone the community midwives after a visit but also sent a printed sheet that described the input Sure Start was planning with that client and any referrals that had been made. In a few SSLPs, good communication was achieved by basing the mainstream midwives or health visitors at the **Sure Start centre.**

### *6.8.5 Adding value*

Relationships tended to be good in areas where the mainstream services could see SSLP resources directly benefiting their own practice. For example, many SSLPs had **funded extra training for mainstream midwives and health**

**visitors** on issues such as breastfeeding, postnatal depression, aquanatal teaching, and baby massage. Some SSLPs had **funded extra materials** for the community midwives' regular antenatal classes: *"Sure Start has given the community midwives a lot of support*" (community midwifery co-ordinator). One SSLP had led a successful bid to the Neighbourhood Renewal Fund to **move the mainstream health visitor clinic** to a better location.

### *6.8.6 Involving GPs*

In some areas positive efforts had been made to engage GPs who are often the gatekeepers to mainstream maternity services. For example in one SSLP, Sure Start staff were specifically introduced to GPs; in another, GPs had been involved in the development of protocols for referrals to and from Sure Start. However, it was more common to find that GPs had been absent from both planning and implementation stages of SSLPs, even though they had been invited to participate. In the handful of local programmes where they were active, GPs could be very active, with Sure Start buildings being extensions of medical surgeries, for example. Such GPs had a track record of community involvement which pre-dated Sure Start.

### *6.8.9 Proving itself*

It was quite commonly reported by the SSLPs that relations with the mainstream services had originally been poor, but that they had improved following a concerted effort. The most common explanation given was that over time, **the programme had proved its worth** and the mainstream practitioners came to appreciate its successes. This applied to changing attitudes of both community midwives and health visitors. *"Now they realise that we weren't trying to take over from them, the fact that we're complementary to them, but it's taken a long time. The other key turning point was all the work we've done around postnatal depression, because they've benefited"* (programme manager).

## 6.9 Barriers to successful relationships

Many Sure Start interviewees, when describing their mainstream colleagues' negative attitudes, identified a feeling of **defensiveness** about the mainstream service, and a **lack of understanding** of what Sure Start was trying to achieve. They believed that some saw Sure Start, with its greater resources, as calling into question the work the mainstream professionals did day in and day out (*"they feel Sure Start is treading on their toes")* rather than as an opportunity to add value for disadvantaged communities that could most benefit from targeted help: *"Some of the health visitors' attitudes were really old fashioned; I think they felt collectively threatened by Sure Start because they felt they were doing it already*" (programme manager); *"the local midwifery team has been very suspicious: why is there a need for other services?"* (programme manager).

Some Sure Start interviewees also believed that mainstream colleagues felt a degree of **jealousy** at the scope Sure Start gave practitioners to work in innovative ways. One Sure Start midwife was told by the mainstream midwives: "*You're a Rolls Royce with all the money; we're a Mini*". Practitioners in some SSLPs recognised that **resource shortages** in the mainstream services

influenced their ability to respond to Sure Start: *"At the moment we have quite good links with the local midwife but her time is very restricted: good will but not necessarily a lot of time"* (programme manager).

### 6.10 Mainstreaming Sure Start maternity services

The SSLPs included in this study were at varying stages of their development in terms of maternity provision. Some newer programmes were still in the process of setting up their services and were not considering mainstreaming at all. Other, better established programmes were considering succession planning for when the Sure Start funding ended. In some cases, the mainstream services had picked up a particularly successful element of the Sure Start maternity services and rolled it out over a wider area. In a few programmes, Sure Start maternity services were organised with a mainstreaming vision from the outset.

#### *6.10.1 Rolling out successful services*

In many cases, the mainstream maternity services had **responded to the success of a particular Sure Start activity by taking it over** and rolling it out across the whole area. For example, in one SSLP, the part-time Sure Start midwife also worked as the area breastfeeding co-ordinator, and was able to persuade the mainstream services to roll out the comprehensive breastfeeding support developed in the SSLP across the county. There were also several examples of Sure Start innovations *"rolling out spontaneously"* where mainstream midwives and health visitors, impressed with the Sure Start parent support groups, incorporated the emphasis on emotional and psychological adjustment to parenthood into their own practice.

In some areas where strategic relationships with the mainstream were good, the mainstream services collaborated with the SSLPs from the outset to run a particular service expressly as a **pilot scheme**, with the intention of mainstreaming it across the area once the benefits had been demonstrated: *"Sure Start allowed us the opportunity to pilot the way we wanted to work and then roll out best practice county-wide"* (Head of Maternity Services). A key example of this piloting was the move to a geographical model of health visiting (see section 6.3.2). In some areas this development was happening independently of Sure Start, but there were several examples in this study of PCTs using SSLPs to test the model for their area. In one interesting case the trial had led to the decision *not* to mainstream the model because of opposition from local GPs. Other examples of deliberate piloting included the development of a multi-agency strategy for teenage pregnancy, antenatal/postnatal mental health care pathways, and one-to-one midwifery care.

However, it was sometimes noted that when a specific Sure Start service was selected to be rolled out, this led to the service being **stretched more thinly** over a wider area. It appeared that in doing so, the mainstream services might have lost the very thing that had led the activity to succeed within the SSLP. For example, in one SSLP, a nursery nurse promoted breastfeeding by visiting antenatally, contacting women on the postnatal ward, running groups and providing one-to-one support for problems. Following mainstreaming the same

post holder had to cover a much larger area, and she could no longer make antenatal visits. In another SSLP, where all the local health visitors were being realigned to work geographically and mainstream health visiting duties were being transferred to the SSLP, the Sure Start health visitor feared losing the 'additionality' that she had successfully provided, because mainstream health visiting targets were not the same as Sure Start targets.

### *6.10.2 Building 'Sure Start' capacity into the mainstream*

A handful of SSLPs focused their resources on building capacity in the mainstream services to incorporate more 'Sure Start' ways of working, with the explicit intention that this would be **more sustainable**. For example, one programme manager, who had capitalised on good local organisational infrastructure, explained: *"If a worker funded through Sure Start was a member of their wider professional team, as opposed to being everyone under one roof, there would be more ownership from that partner organisation to sustain that post beyond Sure Start"*. This approach was, however, vulnerable to staff shortages in the mainstream services (see section 6.1.2).

### *6.10.3 Close integration from the outset*

There were a few SSLPs in which the Sure Start and mainstream maternity services were closely integrated from the outset, usually by **working in joint teams**. For example, in one SSLP, the decision was made to engage fully with deprived pregnant women by offering one-to-one midwifery care. The SSLP worked in partnership with the mainstream midwifery service to create an integrated team of two Sure Start and three community midwives, based at the Sure Start centre. This team gave intensive one-to-one maternity care to Sure Start women, and to non-Sure Start women (referred by the community midwives) who were unsupported teenagers, had mental health problems, were HIV+, abused alcohol or drugs, or were survivors of abuse. In another SSLP, an unusual degree of integration was achieved by basing the community midwifery team at the Sure Start centre, led and supported by the Sure Start midwife who was responsible for developing additional innovative services.

### *6.10.4 Mainstream dependency on Sure Start*

There were several SSLPs where the Sure Start midwives or health visitors expressed **frustration that their mainstream colleagues would not take on more of the Sure Start approach for themselves**, at the very basic level of multi-agency referrals. Even where the Sure Start practitioner had compiled referral resources and made them available to colleagues, the mainstream practitioners tended to take the easy option of just referring difficult issues directly to the Sure Start practitioner. *"Midwives are ringing me up to help them out with housing problems they have with their clients and I have to pass them on to more specialist advice. I feel they can do this for themselves"* (Sure Start midwife).

# CHAPTER 7. IMPROVING ACCESS TO MATERNITY SERVICES

This chapter describes the ways in which SSLPs were improving *access* to maternity care and antenatal classes, including new ways of reaching particularly vulnerable women. The evidence on inequalities in access to care, and the limited evidence on good practice in overcoming those inequalities, are summarised in chapter 4.

Improving access to services was a defining goal of the maternity provision by SSLPs. It operated on three levels:

- identifying and **making contact** with pregnant women;
- creating **local services** that were more **accessible and flexible**; and
- providing support for women to **access existing mainstream services**.

## 7.1 Making contact with pregnant women

Because many women in Sure Start communities were at risk of poor outcomes, SSLPs used various approaches to try to make contact early in the pregnancy. At the same time, most of the SSLPs explicitly saw making contact during pregnancy as an opportunity to draw families in to Sure Start services more generally. This in itself was a reason to offer user-friendly antenatal services : *"If parents have a good experience with the midwives, then the numbers for all the other activities go up too"* (programme manager). In most cases SSLPs actively searched for pregnant women to offer antenatal care and classes, and to introduce the Sure Start programme generally. There were, however, a few SSLPs where there was no midwife and no routine antenatal contact by Sure Start staff.

### *7.1.1 Personal contact*

Almost all SSLPs had some method of trying to contact pregnant women directly, often by **offering an antenatal visit** from one of the programme workers, and/or **inviting them to groups or to clinical services** if appropriate. Over half of the programmes offered an early home visit from the midwife or other members of staff including the community outreach team, family support workers, community mothers and healthcare assistants. Sure Start midwives rarely visited all pregnant women, usually targeting their visits on particularly vulnerable women, such as pregnant teenagers or those abusing drugs and alcohol. **Practical assistance** was sometimes offered at the first contact to build trust; for example, one Sure Start midwife commented that young women did not welcome her visits when they were about promoting Sure Start, but when she became well informed about benefits and housing and offered that information instead, her visits immediately became very popular and she was able to bolt on the Sure Start information.

The SSLPs' success in contacting women depended to a large extent on the mainstream services' **willingness to share information** on women booking for maternity care, which was often problematic (see section 6.8.1). In general, SSLPs reported that they almost certainly did not know of all the pregnant women in the Sure Start area. Some described using **informal methods** to

supplement data from the hospital, for example inviting word-of-mouth referrals from within the community, or *"bumping into"* pregnant women who were accessing another Sure Start service with an older child. In areas with effective partnership between the SSLP and mainstream services, mainstream health and social care professionals often **'referred' pregnant women into Sure Start**.

### *7.1.2 Publicising services*

All the SSLPs produced **printed materials** about Sure Start activities, including antenatal and postnatal groups, listing times and venues. Some SSLPs had leaflets specifically for expectant and new parents, and a few produced materials in community languages. Some SSLPs used **innovative ways of publicising their maternity services**, for example, one Sure Start health visitor held a drop-in once a month in the local market and joined other local health professionals on a regular day in the main shopping centre, offering breastfeeding support.

Nevertheless, **the Sure Start 'brand' was not necessarily readily understood**. For example, women in one Sure Start antenatal group described how they found out about the group through a lengthy process of ringing a generic parentcraft number for the city, leaving their details and then waiting weeks for someone to phone back to tell them which classes they could go to. *"You don't know what Sure Start is - they say that you're in the Sure Start area, but what does that mean? You think, why can't I just go to antenatal classes like normal?"* (mother). One midwife commented that families might be *"hard-to-reach for Sure Start"* but that did not necessarily mean they were not accessing mainstream services.

## 7.2 Creating more flexible and accessible local services

Almost all the SSLPs arranged local antenatal clinics and/or classes for pregnant Sure Start women. In most cases, the mainstream services already provided antenatal clinics and classes, but these were not accessible to the Sure Start community for various reasons, including:

- the services were sometimes physically inaccessible, where care was based at a distant maternity hospital and public transport was poor;
- women did not like the system of fixed appointments and long waiting times;
- women did not feel comfortable in mainstream antenatal classes where most of the people were not like them, e.g. older, different cultural background;
- some women were not confident enough to make use of any group setting.

SSLPs tackled these obstacles in a number of ways. The underlying philosophy was one of **outreach** – on a geographical level, by **taking the services into the community**, and on a personal level, by **taking the services to the individual**, to acceptable venues including her own home, and offering those services in new, more flexible ways that engaged women more successfully.

### *7.2.1 Using local venues*

Most of the SSLPs improved access by delivering maternity services inside the Sure Start area, meeting a need often identified in parent consultation. About half the programmes surveyed had a Sure Start Centre and in a few others, centres were still being built. The remaining SSLPs used a variety of existing community venues to deliver their services or created a new Sure Start 'shop' in the main shopping centre. One SSLP had responded to a specific community request for local access to an obstetric consultant by arranging this and providing an ultrasound scanner.

### *7.2.2 Using the Sure Start Centre*

Where the SSLP had a Sure Start Centre, maternity clinics and/or groups were usually held there. This allowed a **'one stop shop'** approach, encouraging expectant parents into other Sure Start services: *"The feeling in the Sure Start Centre is absolutely key to this way of working. It belongs to the people. There is a lot going on all the time: play and educational activities; the midwifery is absorbed into the whole pattern of activities"*(Sure Start midwife). Co-locating 'non-stigmatising' maternity services with more specialist support services also helped to normalise the specialist support.

Some SSLPs had made real efforts to make women feel at home in the Sure Start centre, for example by avoiding uniforms and using first names. They had also shown sensitivity to the potential stigma of using more specialist services, by modifying job titles so that a community psychiatric nurse became a 'support nurse', and a domestic violence worker became a 'women's development worker'.

The only disadvantage of locating Sure Start maternity services in the Sure Start centre – reported by a tiny number of the SSLPs – was where there were substantial minority communities and the local **perception was that Sure Start was only for people of a particular ethnicity**, which then deterred people from other communities from using the centre. For example, in one SSLP with significant Asian and African Caribbean populations, the Sure Start building had a reputation as a 'white' environment. The programme had tackled the issue not by challenging this perception, but by targeting outreach services on those communities – the Sure Start midwife set up an alternative early pregnancy group in a community location, working in partnership with an established voluntary group. In another SSLP, there was a perception that Sure Start was for ethnic minorities, and white working class families were the hardest to reach.

### *7.2.3 Using familiar and acceptable settings*

Some SSLPs had tried to improve uptake by setting up antenatal and postnatal services in community venues that were not only easy to reach, but were already **familiar to the client group**. Sometimes these were already established as baby clinics or family centres, while others were being put to new use. In one SSLP, for example, the Sure Start midwife ran evening antenatal classes at the library.

Some SSLPs took the opportunity to **work in partnership with another service** that already had a local reputation. For example, in one SSLP, this was an established Young Woman's Project, where the Sure Start midwife ran antenatal and postnatal groups for teenagers. Embedding the Sure Start maternity service in this trusted setting had brought clear benefits in the popularity of the groups and the strength of the relationships created : *"Asking for help still has a label – a girl who was very depressed said she wasn't going to tell the health visitor, because the health visitor would remove the baby, but she'd tell me because she knew me from the project"* (midwife).

For SSLPs that included **distinct communities** which did not collaborate with each other, this way of working was used to advantage, because the programme could offer separate services that were appropriate to those communities' particular needs. For example, one SSLP used two venues, one of which was located in a predominantly Asian area and had interpreters on site. The midwife in another SSLP with a wide catchment area split by a main road, reported : "*Everything is done by outreach. Although it is one Sure Start area we are providing some things in more than one way for two patches. The positive thing is that we are not stuck in a building and expecting the community to come to us".*

The disadvantage of using community venues was that Sure Start maternity services could become **isolated from the rest of the programme**, creating difficulties in offering mothers the linked provision that would give them maximum benefit. Some SSLPs also reported considerable difficulties in booking venues where sessions could be held.

### *7.2.4 Delivering services in rural areas*

In rural communities, Sure Start antenatal sessions were often delivered by a **travelling team**, sometimes using a specially fitted bus as a **mobile clinic**. In one SSLP, the clinic/bus was first set up in the car park of the Leisure Centre in order to attract attention in an appealing manner. In another SSLP, where the nearest hospital was 20 miles away, Sure Start had capitalised on the willingness of parents to hold **groups in their own homes**. Rural SSLPs also did a lot of **support work by telephone**, including peer support for breastfeeding. Mobile crèches were regularly used.

### *7.2.5 Increasing flexibility*

Almost all the SSLPs had identified a need to provide maternity services which were more flexible than those traditionally offered by the mainstream. They organised drop-in clinics instead of appointment-based ones, delivered both clinical care and antenatal education in women's own homes, and made their staff more available to women on an informal basis.

#### *7.2.5.1 Arranging drop-in facilities*

Drop-in facilities were generally much better used than traditional services for which an appointment was necessary, because the approach was informal, and women did not like the lengthy waits and set visiting timetable at regular clinics.

They were of particular value to women with chaotic lifestyles as they could not 'fail' by missing an appointment. Drop-ins were used for both clinical care and other support. For example, in one SSLP, the Sure Start health visitor (who did not have a clinical caseload) ran a weekly drop-in 'health lounge' at a community venue where mothers could come informally for a private chat about any concerns. About 15 women used the health lounge each week, and the health visitor made many referrals for issues that had not been picked up by mainstream services.

Another SSLP had a very well developed programme of drop-ins that ran in the three main Sure Start venues, including an integrated antenatal/postnatal clinic with antenatal education, play facilities and many members of the wider Sure Start team in attendance. Pregnant women could choose regular antenatal care, or care at the Sure Start drop-in clinics; most preferred the drop-in because as well as quick and flexible access to a midwife and other professionals, there was the opportunity to socialise, and older children could be looked after by a family support worker while the mother was with the midwife. Women were enthusiastic about the atmosphere and the service: *" The midwives have time for everybody. It's a nice place to come and meet people"* (mother).

*7.2.5.2 Providing care at home*

Home visiting is a fundamental part of the Sure Start way of working, but apart from the fortnight immediately after birth it does not form part of traditional maternity care. Many SSLPs invested a good deal of their extra maternity staff time in delivering antenatal and postnatal services at home. In most cases this was **targeted** at women who had complex needs, or who lacked the confidence to attend groups or who for cultural reasons found it difficult to leave the home. Typically, either the Sure Start midwife would identify women who could particularly benefit from the service, or mainstream midwives would refer women who had not attended the generic service or who they had assessed as especially vulnerable. In some SSLPs, pregnant teenagers received all their antenatal care at home. Home visiting had also made a major impact on access for families in **rural communities**.

As well as being highly convenient for the women, providing care at home was used as the **foundation of building a relationship** with women, and gaining insight into their social circumstances that might impact on pregnancy and their ability to follow advice on self-care (for example their cooking facilities, or relationship with a partner).

In most of the SSLPs, women also had the benefit of **other home visitors** from the Sure Start team, including outreach workers, healthcare assistants, family support workers, bilingual linkworkers and community parents. These staff provided a variety of services at home: they might introduce Sure Start, provide social support, offer help resolving practical problems with housing or benefits, signpost women to other services, or deliver specific interventions such as breastfeeding support or 'listening visits' for women with postnatal depression.

*7.2.5.3 Informal availability of staff*
As well as offering drop-ins and home visits, many Sure Start midwives (particularly if they were offering clinical care), and some health visitors, could be contacted via mobile 'phones and email, and encouraged calls to discuss worries promptly. One health visitor described how she tried to **be available to mothers on their own terms**: *"I've done visits in the market, in McDonalds, sitting on the wall, because people won't come in. It's not a matter of me accessing them, but them accessing me where they feel comfortable."*

Where the SSLP was a compact area, the midwives and health visitors often commented on how they had become a **well known face in the community** and were therefore able to be available to women in an informal way : "*You get to know not only the girls you look after but their friends, their families, their sisters. I can go out and about and recognize all of them and they recognize me*"*(Sure Start midwife).*

*7.2.5.4 Flexible timing*
Whereas mainstream antenatal classes were usually run during the working day, a small number of SSLPs set up sessions in the evenings or at weekends, to accommodate women with many children, those who worked or studied, or to include or cater exclusively for fathers. A couple offered out-of-hours home visits to include working fathers in their services.

**7.3 Supporting parents in using services**
***7.3.1 Practical support***
Another key goal of SSLPs was to support parents in accessing existing services, or their own Sure Start services. This support often took the form of providing **crèche** facilities or **child-minder** places, or **transport to the services** (this was found in both rural and inner city SSLPs).

***7.3.2 Following up non-attendance***
In SSLPs where there was a high incidence of women failing to attend scheduled mainstream maternity appointments (known as 'DNA' for 'Did Not Attend'), it was usually a core activity of Sure Start midwives or health visitors to follow up the DNAs with personal contact. They would gain an understanding of the reasons why the woman did not attend, and either mobilise Sure Start resources to help her **overcome those obstacles** (such as transport, childcare or a companion), or provide her with alternative **care at home**. In one SSLP, all the Sure Start families were registered on a database that enabled staff to identify families who were not attending any Sure Start activities, and these families were then visited to ask whether they needed any support to access the services, or whether there were other services they would like.

***7.3.3 Interpreters***
Many SSLPs reported the use of interpreters, but this varied from extensive to minimal. In some programmes with a high population prevalence of minority ethnic groups, SSLPs had **funded interpreter services, or bilingual linkworkers**, sometimes with a specific remit to work with the maternity services.

This was a significant development as the mainstream community maternity services usually have very limited access to interpreters. For example, in an SSLP where at least 20 major different languages were spoken, the programme employed a bilingual co-ordinator and used over 30 interpreters/translators, committing 9% of its baseline budget to this service, 80% of which was used by the maternity service.

By contrast, there were **examples of poor practice** in some SSLPs where there was an apparent need for language support. In one SSLP where more than 120 languages were spoken, interpreters were used when working with families therapeutically, but not to support the Sure Start healthcare assistant who visited all new mothers, specifically to encourage breastfeeding. She said that to explain breastfeeding issues *"I use a lot of mime"*, and she explained Sure Start services by pointing at pictures in the programme leaflets. In another SSLP, the bilingual family support worker interpreted where she could, and otherwise the programme relied on family members to interpret: *"It's very hard to find interpreters, but we don't have problems because there is always family around, although that is not always very helpful, for example Pakistani ladies don't want to open so much in front of their husbands."* Using relatives to interpret has been very strongly condemned in the context of the maternity services,(Lewis, 2003) in relation to accuracy, confidentiality and domestic violence.

### *7.3.4 Targeting services to reach particular groups*

Some SSLPs had identified particular subsections of their population as being less likely to make use of some maternity services, and had devised separate services to meet their needs. Very often this was in the form of separate groups (for antenatal and postnatal education and support), or developing peer support networks from within that group. The targeted services are covered in more detail in section 8.14.

# CHAPTER 8. NEW MATERNITY SERVICES TO TACKLE HEALTH INEQUALITIES

This chapter examines the specific types of maternity services that had been extended or created by the SSLPs in this study. There was great variety in the number and type of antenatal and postnatal services offered. Most SSLPs offered a range of services addressing the key factors affecting maternal and infant health, at a greater or lower level depending on the amount of dedicated maternity practitioner time available. Many programmes were particularly strong in one or two areas (for example, breastfeeding or mental health) where the maternity practitioner or programme manager had a special interest.

## 8.1 Evidence-based services

As outlined in chapter 4, evidence for good practice in overcoming health inequalities is in many respects limited and evolving. Some SSLPs specifically reported that they had based their services on the literature on good practice. In other cases, far from being evidence-based, the activities the SSLP had first unsuccessfully tried were directly contrary to the limited evidence that exists (e.g. smoking cessation groups, which had been tried in many SSLPs and almost invariably abandoned). Some stated that they would have preferred to have more comprehensive evidence-based guidance on good practice in maternity from the Sure Start Unit.

Although this chapter draws attention to SSLP services that follow or ignore the evidence on good practice, it must be remembered that one of the most significant contributions Sure Start has made to the maternity services is providing the scope for innovation. The extra resources deployed by SSLPs have enabled new approaches to be tested and piloted. Sure Start is itself creating the evidence and generating examples of good practice for the future. This is a descriptive study which does not assess the merits of these new approaches, but records them. Several SSLPs have evaluated their maternity services as part of their local evaluation. The reports of local evaluation can be accessed on the NESS website. www.ness.bbk.ac.uk.

## 8.2 Preparation for parenthood

Mainstream maternity services offer most first time mothers a few classes ('antenatal' or 'parentcraft' classes) in late pregnancy, usually focused on coping physically with labour and birth, and some basic advice on baby care. A major unmet need identified in many SSLPs was for an **antenatal group** that was not only local and accessible, but took a much more **holistic approach** to preparing for parenthood. Many SSLPs therefore established groups that began earlier in pregnancy and which covered the emotional and relationship impact of having a baby, as well as topics associated with improved outcomes, such as nutrition advice and breastfeeding. Most of these groups actively tried to build supportive relationships among the women attending.

In some groups, the **agenda** was entirely determined by the participants; in others, 'information' sessions were mixed with 'pampering' sessions (for example

head massage, aromatherapy, reflexology). One very popular approach was to run free **'aquanatal' pregnancy/postnatal exercise** (and healthy lifestyle) classes at a local swimming pool, with Sure Start providing transport and a crèche, and in one case swimsuits and towels as well. These were usually very well attended and opened up new opportunities for women, for example, in one SSLP half the women at the classes were Asian Muslims who had never been swimming before.

### 8.3 Continuity of carer

Models of maternity care based on a strong, continuing relationship with one primary carer appear to improve outcomes for disadvantaged women. The extra Sure Start resources were very often invested in giving practitioners the time to build precisely this sort of relationship of trust, especially with the most vulnerable women: *"Sure Start gives you time to be persistent"* (Sure Start midwife).

Having the time to gather comprehensive in-depth information about a family was regarded by Sure Start practitioners as the best foundation for planning effective intervention among women who were often reluctant to use formal services and to disclose sensitive aspects of their needs**.** Where the Sure Start midwife provided clinical care, this usually began with a long 'booking' visit, often carried out at the woman's home, allowing much more detailed assessment of the family background and circumstances than would be possible in a rushed mainstream clinic. Building up an **ongoing relationship over time** also encouraged disclosure and enabled identification of issues such as domestic violence, HIV status, and mental illness.

As outlined in section 6.2.2, a minority of SSLPs offered women with the most complex needs the 'gold standard' of midwifery care, **one-to-one midwifery** with 24/7 availability. There was, however, a crucial difference in the Sure Start version of this, which was that Sure Start midwives giving one-to-one care very rarely delivered the babies. Instead, the benefits of the relationship were invested in building women's confidence and drawing mothers into appropriate services. In many SSLPs, the midwife who had built up this relationship of trust remained involved with the family for an extended period after birth – up to 28 days, compared with 10-14 days normally.

In other SSLPs, the **philosophy of continuity** underpinned the wider design of services, even where one-to-one clinical care was not provided. A degree of continuity was provided by:

- health visitors being involved in antenatal work;
- midwives being involved in postnatal work;
- using the same interpreter when working with a family over time;
- pregnant women being encouraged to attend postnatal sessions, such as breastfeeding support groups;
- holding antenatal and postnatal events at the same venue and time;
- family support workers or home visitors making contact with the pregnant woman and maintaining contact after the baby was born.

Despite these efforts to sustain relationships with familiar professionals, a number of SSLPs commented that mothers tended to get 'lost' 6 months after the birth. This may be explained in part by the high mobility of families in some Sure Start areas, or by women returning to work or feeling more confident and no longer needing Sure Start input.

### 8.4 Postnatal support

Mainstream postnatal support is usually provided by community midwives home visiting during the first 10-14 days, a health visitor home visiting at approximately 10-14 days, and weekly health visitor-run baby clinics that mothers can attend to discuss any concerns and have the baby weighed. Health visitors may also continue to visit families with complex needs in their home.

These services usually continued in the SSLPs, although the Sure Start midwife might replace the community midwives if the woman was part of her caseload. The SSLPs usually used their postnatal resources to deliver either more **intensive one-to-one support** generally, or on particular issues (e.g. breastfeeding, postnatal depression), and/or to develop new groups. Sure Start has a target to visit all new mothers within two months of the birth, and these home visits were carried out by health visitors, outreach workers, family support workers and community parents (peer supporters). It was unclear how many met the target, but many clearly recognised the crucial importance of early contact and support. For example, in one SSLP where the mainstream health visitors had been 'incorporated' into the SSLP, they visited weekly for the first six weeks: "*Our philosophy is we have a lot of isolated women, a lot of first time parents, that early support is important to them but also builds relationships, so you can lead them on to other Sure Start services later."*

Almost all the SSLPs ran **postnatal groups** with an emphasis on peer support, social activities, the promotion of mothers' self esteem and parenting competence. As with antenatal groups, complementary therapies were sometimes used for relaxation, and baby massage was widely used to promote bonding (an evidence based intervention). Shy or hesitant women were sometimes accompanied to a group by a Sure Start worker. There was evidence that the friendliness and informality of groups run by Sure Start could change women's negative assumptions about service providers. For example, one health visitor reported that seeing her in informal group settings had enabled women to be honest with her. She had been told: "*You're not like a health visitor"* and "*We'd never tell the health visitor, but…"*.

In one SSLP the midwife had greatly improved identification of postnatal problems by using an evidence-based **postnatal model of care,** with an extra screening visit at 28 days. Physical and psychological problems were systematically identified and managed according to a standardised checklist, and the midwife could refer women to an obstetrician-led postnatal clinic including midwifery and physiotherapy staff, set up by Sure Start in partnership with the mainstream service.

### 8.5 Smoking cessation

Mainstream maternity services typically aim to ask pregnant women and new parents about smoking at antenatal and postnatal contacts, to provide information on the risks, and to refer people who express an intention to quit to specialist services such as the NHS helpline or an area-based smoking cessation specialist. Almost all the SSLPs offered some kind of smoking cessation service, although in some cases it amounted to little more than this mainstream model. Even where the programme was actively pursuing smoking cessation, most found the results disappointing.

About half of the SSLPs **referred clients onto external specialist services**, whether or not they also offered additional services of their own. In some cases the SSLP had helped to fund the external smoking cessation post. In half of the SSLPs, staff had received specific **training** in smoking cessation, and this often included midwives and health visitors, and sometimes home visitors. The SSLPs used these trained staff as a resource to provide **one-to-one sessions** for pregnant women, new mothers and fathers – several particularly noted the importance of involving partners and other family members in smoking cessation work. In some cases, these Sure Start specialists also took referrals of non-Sure Start women from the community midwifery team.

A third of the SSLPs had tried offering **group sessions**, and with one exception (a group for teenagers) they were universally reported not to work, due to poor uptake. It is perhaps surprising that so many programmes had attempted an intervention that has been proven to be ineffective. In 15% of SSLPs it was reported that GPs (or occasionally consultants or a health visitor) prescribed **nicotine replacement therapy** (NRT) for pregnant women as appropriate. NRT during pregnancy is controversial and some SSLPs reported that GPs would not prescribe it. A small number of SSLPs had tried other ideas (with no greater success), such as regular CO2 monitoring of smokers, incentives to quit, and props such as a “lung jar”, a model foetus, or a man dressed as a giant cigarette.

A promising approach in one SSLP was a **holistic multi-agency service** that engaged pregnant women in **self-directed assessment** to explore the barriers they perceived to quitting (e.g. weight gain and increased stress), and then offered practical services to overcome these barriers (e.g. a fitness group, and anti-stress activities such as benefits advice and a ‘time out’ group – not specifically about smoking - with a crèche.) Sure Start co-ordinated this interdisciplinary service, which included the hospital smoking cessation worker, the Sure Start midwife, community midwives and local health visitors, a community dietician and the local Healthy Living Programme. This approach had not shown ‘hard’ results in numbers successfully quitting, but the practitioners believed it was changing attitudes.

In quite a number of SSLPs, smoking cessation was **not a prominent part of the programme.** Occasionally this was because the SSLP had a high prevalence of certain minority ethnic groups in whom smoking rates are very low.

In other cases where smoking rates were very high, and smoking was entrenched in the local culture, it was because staff felt a sense of hopelessness about trying to achieve change: *"You know that you're just hitting your head against a brick wall"* (programme manager)

Some Sure Start midwives said that they were not assertive about smoking cessation because this might compromise their carefully-built supportive relationship with the women. For example, one Sure Start midwife described how she allowed a 'fag break' in her antenatal sessions for teenagers, because otherwise the young women would not attend: *"There's no point in saying 'You're pregnant and you can't smoke' because the reality is they're pregnant and they will smoke".* Another pragmatic approach was to concentrate on **smoking reduction** with women who did not give priority to quitting. Other midwives, however, reported that for women who were keen to quit, a close relationship was an invaluable basis from which to offer support.

### 8.6 Healthy eating in pregnancy

Mainstream midwives usually give brief advice on foods to eat and foods to avoid during pregnancy, backed up by written information, but these methods are known to be generally ineffective in changing behaviour. Although some SSLPs gave only this basic advice, many of the SSLPs offered more practical support, in accordance with known good practice.

Many SSLPs aimed to increase women's confidence in following dietary advice by holding **'cook and taste' sessions** to develop their cooking skills and demonstrate 'healthy eating' on a budget. Some SSLPs provided individual support showing women **how to buy food** within their tight budget, and worked with the local shops or food co-ops to **increase access** to affordable healthy food. For example, one SSLP commissioned a food co-op to deliver a box of fresh vegetables at cost price to pregnant women every week. SSLPs in areas with high proportions of minority ethnic groups and/or asylum seekers usually offered sessions focused on traditional diets, and one rural SSLP had a 'mobile kitchen' in a bus to bring healthy cooking demonstrations out to the community.

Midwives in some SSLPs provided **healthy snacks** at their antenatal groups to reinforce 'healthy eating' messages, sometimes encouraging women to choose and discuss the food. A few SSLPs had a **dietician** as part of the Sure Start team, who led healthy eating sessions and gave pregnant women individual dietary counselling. Others worked closely with community dieticians from the mainstream services.

### 8.7 Breastfeeding Support

Support for breastfeeding was the most widespread intervention offered in Sure Start maternity provision. Mainstream midwives encourage women to breastfeed by stressing the benefits for the baby, but do not usually have the resources to provide timely practical support if a breastfeeding woman encounters problems, which is one of the key reasons why many women give up breastfeeding within the first few days. SSLPs provided this support in a range of evidence-based

ways, and many programmes reported considerable improvement in breastfeeding rates.

Various Sure Start staff were involved in breastfeeding support, including midwives, health visitors, maternity care assistants, nursery nurses and occasionally trained volunteer breastfeeding counsellors from an external organisation. The level and type of support varied considerably, from basic advice from the Sure Start midwife to a whole menu of activities, including establishing **breastfeeding support groups and drop-ins**, providing **one-to-one support** for women experiencing difficulties, running **telephone help lines**, arranging **training for local women** to become breastfeeding peer supporters, and giving out **incentives** (such as pampering packs) or **practical equipment** (breast pumps and nursing bras).

### *8.7.1. Support Groups*

Nearly half of the SSLPs had established **breastfeeding support groups, drop-ins or 'baby cafes'**. These were sometimes run by Sure Start professionals and sometimes by trained peer supporters, and in some cases they served a wider (non-Sure Start) population as well. For example, one SSLP organised an open breastfeeding group in a Tesco's coffee shop.

Some SSLPs also **encouraged women to try breastfeeding** by inviting pregnant women to postnatal breastfeeding support groups, or offering an antenatal visit or workshops to women who were undecided. For example, in one SSLP, the Sure Start midwife gave **antenatal breastfeeding workshops** (one-to-one or in small groups) on the benefits and practicalities of breastfeeding; she also ran a postnatal 'Breast is Best (BIB)' group jointly with a mainstream midwife, open to non-Sure Start women. In this programme, in two years the breastfeeding rate at four weeks had risen from 7.8% to 34.7%, and the rate at four months had risen from 12.5% to 23.6%.

### *8.7.2. Peer Support*

**Peer (mother-to-mother) support** from trained volunteers in the Sure Start community was a major feature of the SSLPs' breastfeeding work, found in over half the programmes. SSLPs used various forms of peer support training for mothers, most commonly that developed by La Leche League, a breastfeeding voluntary organisation. Peer breastfeeding supporters worked in various ways: attending groups and running drop-ins, visiting breastfeeding mothers at home, visiting mainstream antenatal clinics or hospital wards, giving advice by telephone, and 'spreading the word' at the school gates. The SSLPs paid their volunteers' childcare expenses.

Sure Start practitioners were generally very pleased with the results of their peer support programmes, and felt that they were contributing to normalising breastfeeding in communities where there had previously been very low breastfeeding rates. In a few areas the successful programme had been **rolled out** by mainstream services. There were, however, some **problems** reported. Several SSLPs found that many of their trained peer supporters moved on into

other training or work and were not available for peer support. One SSLP reported that the peer supporters found home visiting and providing telephone support too daunting and planned instead to open a baby café instead.

Practitioners were sensitive to the need to recruit genuine 'peers' for breastfeeding support. This meant not just women from the SSLP area, but women of the **same ethnicity or age group**. There were examples of both success and failure in recruiting ethnic minority women. In one SSLP the Sure Start midwife worked intensively with pregnant teenagers at a local Young Women's Project, and succeeded in giving breastfeeding a "cool" image. She capitalised on this by introducing a ten-week training programme for breastfeeding "baby buddies" to support other teenagers by home visits, visits to the postnatal ward, involvement in the antenatal and postnatal groups, and the production of a breastfeeding video and leaflets. The breastfeeding rate among the young women rose from 30% to 82%, with most still feeding at 10 to 12 months.

### *8.7.3. Other Strategies to Encourage Breast Feeding*

One SSLP had trained the whole staff team to meet the rigorous assessment criteria for a **UNICEF Baby Friendly award**. This SSLP was one of just seven community healthcare facilities in the country to achieve full Baby Friendly accreditation, which requires that all healthcare staff be trained to support breastfeeding, that facilities are welcoming to breastfeeding families, and that links are made with breastfeeding support groups. Several other SSLPs were working towards Baby Friendly status, in one case leading this work across the PCT.

In a few programmes, a culture of **bottle-feeding** had proved difficult to shift, and there was little take up of breastfeeding support offered. There was one reported instance of a woman who felt she had been 'bullied' into trying breastfeeding by staff trying to meet targets. A few SSLPs did not exclude bottle-feeding mothers from postnatal breastfeeding groups, and one programme had developed a laminated card on 'Feeding Baby Safely' which included bottle-feeding.

A handful of SSLPs did minimal or **no work at all on breastfeeding**. In all of these there was no midwife in post or no midwifery time commissioned.

## 8.8 Befriending and Social support

The provision of social support to pregnant women and new mothers was one of the most significant new services made available in the SSLPs, and the aspect of Sure Start most often commented on by the parents. It is almost entirely absent from mainstream services, except in the form of **professional-to-mother support** in the small minority of areas that offer one-to-one midwifery. A third of the SSLPs provided this type of midwifery care to at least some of the Sure Start women, and all offered social support through home visiting by other Sure Start professionals or paraprofessionals, such as family support workers, bilingual linkworkers or maternity care assistants. For example, one SSLP with a large Somali population developed a service of health and social care support in the

home, delivered by maternity care assistants visiting either daily or weekly for up to six weeks postnatally to befriend and offer practical help such as cleaning. This was based on a 'home help' model that some of the parents had experienced when they previously lived in Holland.

Peer (mother-to-mother) social support **was a fundamental part of the Sure Start maternity services.** It was the **central focus of group work** in all the SSLPs, especially in postnatal groups. Groups were run on the philosophy of *"everyone should walk out with a friend",* which was especially relevant to socially isolated women, but also to women becoming a mother for the first time who benefited from meeting others in the same situation. Group peer support was specifically used to promote self-esteem, to support mothers with postnatal depression, and to support breastfeeding, and separate groups were often established for teenagers and women from ethnic minorities. These are covered in more detail under the relevant sections.

In a minority of SSLPs, local volunteers, often known as **'community mothers'**, were trained to offer emotional support to vulnerable mothers, visiting them at home and befriending them. In some SSLPs they also offered health promotion on topics such as postnatal depression, parenting and relationships. Recruiting community mothers from individual minority ethnic groups was important, for example, in the SSLP with the large Somali population mentioned above, mothers preferred help from their own community and in their own language, so the programme was recruiting community mothers to undertake the 'home help' role.

Several SSLPs had experienced difficulties in recruiting community mothers from their Sure Start community, for example the community parents scheme in one SSLP had collapsed, despite the enthusiasm of the mothers supported: *"All local areas are not the same, you think because something works really well elsewhere it must work, but here you've got lots of women going back to work, lots of part time work in hotels, shop work, there weren't lots of volunteers*" (health visitor). Occasionally SSLPs mentioned that their local community did not accept volunteer support and preferred professional visitors.

### 8.9 Mental health and postnatal depression (PND)

In some areas, the mainstream maternity services screen women for postnatal depression (PND) using a validated questionnaire, the Edinburgh Postnatal Depression Scale (EPDS). Where depression is diagnosed, follow up services are very variable, and often limited or oversubscribed. SSLPs in this study reported that there was usually a long waiting list for access to mainstream mental health services, which were in practice often only available for mothers who were seriously unwell. For women from minority ethnic backgrounds, the EPDS is unsuitable as a screening tool and there are very few culturally appropriate follow up services.

There is a Sure Start target to identify and support mothers with Post Natal Depression, and most SSLPs had extensively developed mental health support.

In many SSLPs, Sure Start resources had been used to **train key staff** (primarily health visitors but also midwives and family support workers) in the detection and management of PND. In a few SSLPs the entire staff team had been trained.

### *8.9.1 Identification of mental health issues*

About a quarter of the SSLPs **assessed mothers' mental health antenatally**, and several others were trying out methods to implement this, often as a joint research project with the local mainstream specialist service. The booking visit was used as an opportunity to assess mental health problems and the risk of PND. Antenatal screening to predict PND is contrary to research evidence. However, antenatal assessment of mental health was often used appropriately to identify women who might particularly benefit from more intensive antenatal support, for example one-to-one midwifery care.

About half of the SSLPs reported that mainstream health visitors in their area **screened postnatally for PND** but almost all of the SSLPs carried out screening. Often the EPDS was used during postnatal home visits. Several SSLPs had developed methods for identifying PND in ethnic minority women. For example, one health visitor, funded by Sure Start for her Master's degree, piloted a visual tool to identify perinatal depression in Asian women and also other women who did not speak English or read or write.

Some Sure Start health visitors attempted to identify postnatal depression without a structured instrument. There was one SSLP where mental health was a dominant theme, and all team members were trained to do **'informal' screening** constantly and report any 'feelings of concern' to the programme's two clinical psychologists. Staff in this SSLP and others observed that through building a relationship with the mothers, they "*tend to pick up when a mother is not coping"* (healthcare assistant).

### *8.9.2 Supporting mothers with PND*

In many SSLPs, health visitors, family support workers or members of the outreach team were trained to do **one-to-one 'listening visits'** and less commonly **cognitive behavioural therapy** for women with PND, an evidence-based intervention. For women who needed more intensive support, many SSLPs overcame the problem of long waiting lists for mainstream mental health services by **commissioning counselling services** specifically for the Sure Start community. At least half of the SSLPs had dedicated sessions from a mental health worker, mostly clinical psychologists but sometimes community psychiatric nurses or primary mental health workers. Sometimes mental health professionals were part of the core Sure Start team. A considerable number of SSLPs also worked with the voluntary organisation Home-Start in promoting mothers' mental health.

Most SSLPs actively tried to promote mothers' mental health by enhancing their self esteem, and most ran popular **general postnatal support groups** to promote mothers' well being through relaxation, activities (e.g. swimming) and guidance on coping with stress. Many also ran specific **targeted PND groups** for

women who were clinically depressed or particularly isolated and vulnerable. Care was taken to avoid a PND 'label' and the groups were often given a neutral name such as 'Time Out'. Many of these groups were based around activities (for example art, mother and baby swimming, baby massage, holistic therapies) and emphasised peer support. In some cases Sure Start provided childcare.

Many of the SSLPs worked in **partnership with mainstream services** to improve the detection and management of PND. In some cases, Sure Start services such as support groups were available to non-Sure Start women who could be referred in by mainstream professionals; in other cases the SSLP could refer out to existing specialists, for example a PND/ domestic violence specialist midwife, funded by the Urban Renewal Fund to work across the whole county.

A number of SSLPs participated in area-wide initiatives to devise a **local pathway of care** or to **improve co-ordination of local services**. For example, one SSLP brought together a multi-agency partnership on PND and funded a postnatal co-ordinator, a process which had transformed PND services in the whole town. The SSLP funded five workers – a community psychiatric nurse, 2 health visitors, a midwife, and a clinical psychologist, to do training-for-trainers on PND, and those staff were training professional colleagues and would offer ongoing multi-agency training.

### 8.10 Parenting and attachment

A secure bond between baby and parents is fundamental to the child's future well-being, but mainstream antenatal education and postnatal services do little to help women adjust to the realities of motherhood or encourage sensitivity to the baby's emotional needs. Almost all SSLPs used their antenatal sessions to try to give **realistic preparation for the transition to parenthood**. For example, in one SSLP all staff were trained on the emotional needs of mothers and in mother and baby interaction, and a family therapist attended antenatal classes to talk about the emotional side of having a baby.

Some SSLPs provided specific services to **promote secure attachment**. **Baby massage** was very widely used to support bonding between mother and baby. Other SSLPs used evidence-based **PIPPIN parenting group**s. The full PIPPIN (Parents in Partnership – Parent Infant Network) programme consists of 35 hours of education and support for families. Between 6 and 8 group sessions take place before the birth, followed by a home visit from the course leader shortly after the birth and 8 post-natal sessions with mothers, fathers and babies. A second delivery model is offered by an NHS midwife and PIPPIN facilitator together. But **courses on parenting skills**, while often requested by parents, were not generally used by parents of young babies. In one SSLP, mothers were screened for anxiety and negative feelings at 18-20 weeks antenatally and midwives could refer them directly to a psychologist for support. At 8 weeks after the birth (following known good practice) a video was made of the mother and baby at play and used to identify problems and as a basis for discussions with the mother. A similar service was under development in some other SSLPs.

### 8.11 Social issues and domestic violence

Social circumstances have a significant impact on maternal and child health, but few mainstream maternity practitioners have the time to build comprehensive referral links to other agencies that could assist with social problems. This was an area in which most SSLPs were extremely strong. Most SSLPs tried to obtain a **full picture of the woman's social circumstances** at the initial antenatal visit, or by building a good relationship with her antenatally. They were then able to **refer effectively** through their established multi-agency networks, for example to the Citizen's Advice Bureau, housing department, Jobcentre, women's refuge, or homeless hostel. Some programmes invited **welfare experts to give sessions** at their antenatal groups, or to hold regular advice surgeries at the Sure Start centre. Staff in some SSLPs also accompanied women to external agencies, or wrote letters to support housing applications. Mainstream community midwifery teams often referred non-Sure Start women with significant social problems to the Sure Start midwife for signposting to other services.

One SSLP had a very effective mode in which all pregnant women notified from the hospital were offered an antenatal visit by the midwife, at which she carried out **systematic screening** for social problems using a standardised 'evaluation care programme tool'. If this identified the need for specific input she would offer ongoing one-to-one support (but not clinical care) while also mobilising Sure Start's multi-disciplinary and multi-agency networks to devise a **care plan** for the family and baby.

**Screening for domestic violence** is a routine part of booking for mainstream maternity care in some areas, but not in others. Many SSLPs asked about domestic violence during the antenatal visit or 'booking' session, but others considered it a difficult issue, and a number of programmes were planning **training** for all their staff, or working on **joint policies with other local agencies**. A **relationship of trust** built up over time was considered to make disclosure more likely. Some had identified the importance of seeing each woman without her partner at least once during her pregnancy, which could be challenging in SSLPs where most of the contact took place at women's own homes. One SSLP used an creative method to enable **confidential communication** with the midwife for women whose controlling partner was present at all clinic visits: the woman would be asked to provide a urine specimen in the ladies' toilet, where a notice asked her to put a sticky label dot on the specimen bottle, with one colour if domestic violence was a problem and another if it was not.

Where domestic violence was identified, many Sure Start practitioners (like mainstream colleagues) were faced with the problem of being unsure what to do next. Some SSLPs had established **good referral pathways**. One SSLP had its own Women's Development Worker for domestic violence who worked closely with the programme's community psychiatric nurse because many women diagnosed with postnatal depression or using general postnatal support groups were found to be experiencing domestic violence.

### 8.12 Special needs babies

Very few of the SSLPs in this study added anything to the mainstream provision for babies with special needs, although they would generally **support the family** of a special needs baby in **accessing the mainstream services**. A few SSLPs were making particular efforts to encourage the **earliest possible identification** of special needs in the baby. One had developed a structured postnatal assessment tool for use by all health visitors, aimed at early identification of special needs. In another, a speech therapist took part in postnatal sessions to observe and educate mothers in the signs of developmental delay. A third employed a pre-school teacher specialising in special needs and her presence in the integrated team assisted early identification of babies with special needs.

### 8.13 Working with fathers

The maternity services in most SSLPs (as in the mainstream) were overwhelmingly focused on women, not men. Although most SSLPs included fathers-to-be in their **antenatal groups**, only a minority reported significant take up of this service. In particular, there was very low take up by Black and ethnic minority fathers, and one SSLP reported that even when sessions were delivered in the home, Asian men tended to leave the room. On the other hand, a couple of SSLPs held antenatal sessions in the evening specifically to accommodate working fathers. One midwife advertised the fact that she would bring a crate of beer to her antenatal session and had an excellent response from fathers-to-be. A few SSLPs employed a father's worker and ran a 'dads group,' but these were usually attended by fathers of older children.

### 8.14 Targeted services for women with particular needs

#### *8.14.1 Teenagers*

Over half of the SSLPs reported a high teenage pregnancy rate. It was commonly found that pregnant teenagers were *"uncomfortable accessing maternity services, citing boredom with the routine of the services, feeling embarrassed and judged by older mums and staff because of their age"* (Head of Midwifery). The SSLPs had responded creatively by developing their own targeted services for young women, and/or by devising a teenage pregnancy strategy in conjunction with existing organisations.

Engaging teenagers in services was generally one of the **key tasks of the Sure Start midwife**, who often **visited** all the young women at home, and in many cases set up a teenage pregnancy and parenting group. If the midwife carried any caseload of Sure Start women, teenagers were the mostly likely group to be included, as they were seen to benefit particularly from **one-to-one care**.

Many SSLPs had established **antenatal and/or postnatal groups** specifically for pregnant teenagers and young mothers where these had not previously existed, sometimes **in partnership with an existing service** for young people. It was found that the young women were much more comfortable attending groups where they felt accepted: *"If I didn't come here I'd be sitting there with just four walls, I was getting really depressed…When I've had problems with my partner,*

*so many times I've just come here and everyone has helped me and talked about it…And they're not all old biddies either – just girls, and that's really nice"* (teenager with three month old baby). Separate groups enabled the young women to make new friends from their own peer group, which was particularly important because often their old friends continued in education or work and lost interest in the young mother who could no longer go out socially. One SSLP with very successful teenagers' groups had also trained **breastfeeding peer supporters** from among the teenage mothers.

Some SSLPs operated in areas where there was already **considerable mainstream activity** around preventing teenage pregnancy and supporting pregnant teenagers. These SSLPs tended to concentrate on establishing an **effective referral pathway** for pregnant teenagers into mainstream services. Alternatively in some areas, the SSLP **worked in partnership** with other SSLPs and mainstream specialist services for teenage sexual health and teenage pregnancy, to create an integrated service that emphasised both prevention and support. Prevention work usually took the form of **outreach at local schools**, for example Sure Start midwives or health visitors holding regular sessions at the school, or making an educational video about a young mother. This work also established early links with those young women who did go on to become pregnant. In one area where the SSLP was part of a local strategy that included educational sessions at the local secondary school on pregnancy and parenting, with a special video and teaching pack, and training for all community midwives and school health nurses, there was a 14% decrease in teenage conception rates in the whole area, and a 22% decrease in the SSLP.

### *8.14.2 Ethnic minority families*

The ethnic composition of the SSLPs varied enormously, and their approaches to meeting need varied according to the type of ethnic minority population they served. Although most had a White majority population, there were some SSLPs where the majority of the population was from Black and ethnic minority communities. A few had almost no ethnic minorities at all. The ethnic minority population in some SSLPs was from one or two principal minority communities and sometimes the ethnically distinct populations had very little contact with one another; in other programmes it was extremely diverse, with over a hundred languages spoken in some SSLPs.

Many SSLPs reported on difficulties in reaching and engaging women and families who did not speak English well and had different cultural expectations and constraints in using the available maternity services. **Poor take-up of regular groups** by minority families was widely reported.

SSLPs tried to overcome these difficulties through a variety of strategies to engage both the community and the individuals. As well as **providing interpreters for services**, as outlined in section 7.3.3, these strategies included:

- Offering **group sessions specifically for the community**, with language support, for example, one SSLP ran antenatal classes jointly with the

mainstream bilingual health advocate. Where appropriate, members of the extended family (especially mothers-in-law) were often included. Some SSLPs offered sessions on healthy eating and cooking targeted at families with a range of different diets, and one Sure Start midwife in an African/Caribbean community included sensitive discussion of HIV. In some SSLPs this strategy had succeeded; in others take-up had remained disappointing.

- Where there were two or more distinct communities, the SSLPs usually established **separate, parallel services** for each community. For example, in one SSLP 75% of the families were Orthodox Jewish and 15% were Muslim, and the SSLP commissioned services from a range of groups in each community (for example, parenting advice sessions at an Orthodox mother and baby home, and at an Islamic women's centre). In another SSLP there were separate antenatal groups for the White, Bangladeshi and Somali communities.
- Creating a library of **bilingual resources** such as videos, in SSLPs where there was minimal uptake of group education.
- Employing **bilingual outreach workers** from the local ethnic minority communities as part of the Sure Start home visiting team. Their role included giving information and social and emotional support; signposting and referring for specialist help; accompanying people to appointments; and providing advice and assistance on welfare issues such as debt and housing.
- Recruiting Asian mothers to offer **breastfeeding peer support** to others from their own community.
- Using picture-based screening tools to identify depression in women who did not speak English.
- Working in partnership with **existing community groups**.

### *8.14.3 Asylum seekers and illegal migrants*

A minority of SSLPs had a population of asylum seekers, and a few were in contact with pregnant migrants without legal status in the UK. Sometimes the Sure Start midwife tried to build confidence in these vulnerable groups by offering **practical assistance**, for example personal support in applying for grants and finding cheap or donated baby clothes. One SSLP encouraged over-stayers (who were excluded from other services) to make use of its services without legal problems. One SSLP had tried to start a separate **antenatal/ postnatal** group for asylum seekers but with little take up.

**Partnership working** with existing asylum support organisations was very successful in several SSLPs. For example, in one SSLP where the Sure Start midwife provided clinical care for clients with complex needs, she had become the first point of contact whenever the local asylum support service identified a pregnant asylum seeker; she offered antenatal care to asylum seekers living in the SSLP, and for non-Sure Start asylum seekers she organised an appointment at the local specialist GP for homeless families. Another SSLP did not provide special services for asylum seekers but had made good referral links to a local refugee agency which ran a women's group and ESOL classes.

### *8.14.4 Homeless women*

Some SSLPs had a high proportion of their clients who were homeless or in temporary accommodation, and were often not registered with a GP. In these programmes the Sure Start maternity services usually tried to offer **practical support** (for example, providing baby equipment or supporting applications for rehousing) and **referrals** (for example to welfare rights advisers or the local housing departments). Homeless women were also likely to be particularly isolated and practitioners tried specifically to **encourage them to make use of groups**. Where the midwife carried a **targeted clinical caseload**, homelessness was often one of the criteria.

Midwives and health visitors sometimes made a **particular effort to make contact** with pregnant women in hostels, who might not otherwise be in contact with maternity services at all. In some SSLPs this was done by knocking on doors; in others through good links with accommodation providers. For example, in one SSLP the local housing trust gave Sure Start monthly registers of pregnant women and families with young children in the bed and breakfast hotels.

### *8.14.5 Travellers*

A small number of the SSLPs had a Traveller site nearby, and their responses varied. For example, in one SSLP, the health visitor did outreach work to the site as the Travellers tended not to access mainstream services, but in another, the SSLP did no extra work because it was felt that mainstream provision was meeting their needs.

### *8.14.6 Substance misusers*

A few SSLPs with a high prevalence of substance misuse had developed specific services. Sometimes drug users were included in the **clinical caseload** of a Sure Start midwife if she had one; some SSLPs had **trained their staff** on alcohol and substance misuse or employed a **substance misuse worker** who worked closely with the midwives; other SSLPs had made **strong links with local substance misuse voluntary agencies** which sent workers to attend Sure Start drop-ins; and sometimes Sure Start had funded these workers. One SSLP had a well developed model in which the local substance misuse service referred pregnant drug users to the Sure Start midwife, who worked individually with the client to create trust in the maternity services before **referring her on to the mainstream** hospital-based multidisciplinary substance misuse clinic. She also liaised with that clinic over Sure Start women who were already receiving services there, and visited them at home.

### *8.14.7 Mothers with disabilities*

A few of the SSLPs reported that the Sure Start midwife or health visitor would **support parents with learning disabilities in using appropriate services**, and some Sure Start midwives gave individual women (or couples) with learning disabilities **intensive one-to-one support tailored to their needs**, for example personalised antenatal education. None of the SSLPs in this study reported any

new services for women with physical disabilities, although one had used a British Sign Language interpreter from mainstream services to communicate with a deaf couple. There was some evidence that, where pregnant women needed **specialist medical care** because of conditions such as diabetes or epilepsy, mainstream and Sure Start midwives withdrew from support, leaving these mothers – who still needed help in other areas - to the care of the obstetrician.

# CHAPTER 9. IMPACT OF SURE START MATERNITY PROVISION

The evidence of the impact of Sure Start maternity services on women and families, and on staff, is almost entirely qualitative. Statistical assessment of impact is, as yet, very limited, though evidence about outcomes for children is expected to emerge from the Impact module of NESS, which is measuring a random sample of children from 150 Sure Start areas, using a range of indicators. Overall, both the women receiving Sure Start maternity services and the staff delivering them were very enthusiastic about the Sure Start way of working.

## 9.1 Impact on Women and Families

### *9.1.1 Making new friendships*

One of the most popular aspects of Sure Start services was the opportunity to get out of the house and meet other women at groups and drop-in sessions. Groups provided a much-needed source of social contact for isolated women: "*Before I came here I didn't know anybody, I had nobody, I felt lost, but now people come to me as well"* (young mother expecting fourth child). Teenagers in particular valued the chance to form new friendships with young women in a similar situation, as their old friends tended to melt away: *"I was a bit depressed at first, and that just helped me get through, having new friends. I broke up from school and all my friends went on and did their own little thing. And I just found loads of new friends"* (teenager expecting second child).

On the other hand, the busy environment of a drop-in session could be rather isolating for women who lacked the self-confidence to start chatting to others: *"To be honest, nobody really talks to me. I just sit in the corner quiet, then I see the midwife and then I'm gone again"* (young mother expecting second child.*).* Professionals recognised that the most vulnerable families, and in some places Black and minority ethnic families, simply did not make use of groups: *"You try as hard as you can to invite everyone, but you know the people who will come to groups are less disadvantaged"* (health visitor).

### *9.1.2 Accessible services*

Women were enthusiastic about Sure Start clinics and groups held locally, that had previously only been available at a distant hospital: *"It's five minutes away from where I live so it's much easier to come here than to go to the hospital"* (pregnant mother of one).

Even where other antenatal groups existed in the local area, the Sure Start sessions were felt to be more relevant and inclusive. For example, one woman described how she had tried attending a voluntary organisation's antenatal group but much preferred the Sure Start group because it was professional, not middle class, and not prescriptive (about natural childbirth, for example).

### *9.1.3 New relationship with professionals*

Many mothers spoke warmly about the confidence they felt in health professionals working for Sure Start because of their non-judgmental attitudes and the relationship of trust that had been built over time. They sometimes

contrasted this with their experiences of non-Sure Start professionals: *"They wanted me to have obstetrician-led care because I'm having twins, but I chose to have the Sure Start midwife because I know where I am with her, she's brilliant. She's not one of these midwives that's all strict and you can't speak to her, I feel she's more like a friend and she understands you"* (pregnant teenager with one child).

Women often commented on how Sure Start professionals always seemed to have time for women and their problems*: "They (the mainstream midwives) are so busy and they're hardly ever there, they say 'Have you got any questions?' but you don't feel you can say really because there's 200 pregnant women at the surgery and you can see them all waiting. Whereas here (at the Sure Start antenatal group) you've got time to think of questions, you never feel it's a silly question"* (pregnant woman).

### *9.1.4 Benefiting from multi-agency working*

Women who needed help with specific problems found that Sure Start maternity services provided a gateway to access the help they needed. Many women mentioned how pleased they were with the ready access to professionals and the opportunity to be referred quickly to other members of the Sure Start team where necessary: *"There's always experts on hand. You don't have to put yourself out if you're a bit concerned about something – there are all sorts of professionals on hand to chat to"* (mother of one). *"Before, I stayed in the house – I said where will I go? My neighbours always shut their doors…but at Sure Start you can talk about your problems, they advise you. There is nice support, everything supports me"* (mother of baby with special needs).

One single mother who had been hospitalised with puerperal psychosis (extreme postnatal depression) after the births of her two elder children, who had consequently been removed from her care, described how Sure Start had mobilised a multi-agency team to look after her: *"The Sure Start midwife helped me get in touch with the obstetrician, she found out who specialised in depression so I got the right person…The obstetrician and Sure Start midwife got together, with the Sure Start family worker, the housing support worker from the housing association, my mental health worker and the head of midwifery, and they set up this thing so everybody was talking to each other and trying to set up a room in the hospital where I could go with the baby if I did get postnatal depression…so I knew all the things that were scaring me were taken care of. That's the biggest difference this time – I knew there were people behind me. It's made a huge difference to my well-being – my mental health has been fine since I had her."*

### *9.1.5 Building confidence and self-esteem*

Some Sure Start groups, especially those targeting younger women or men, explicitly aimed to build the self-esteem of those using them. Sure Start also provided the resources for staff to work one-to-one with vulnerable people. Some mothers described how this support had changed the way they felt about

themselves: *"From the help I've had, I'm more confident, my self-esteem has grown hugely*"(mother of three).

### *9.1.6 Dependence on Sure Start staff*

The high quality of some Sure Start support carried the inherent risk of creating dependency among the families who benefited from it, and some professionals were aware of this risk and actively tried to manage it: *"Sometimes it feels like they depend on me, so I encourage them to depend on themselves. I have organised a welcome pack, to give them the power back – it has all the main services"* (bilingual family support worker). A number of practitioners commented on the need to 'move women on' from support groups as their babies grew older, for example, in one SSLP health visitors encouraged new parents to progress to a drop-in with toys after six sessions in a postnatal support group. Where mothers were strongly attached to the group format, sometimes staff supported the development of a new support group for parents of older babies.

Leaving a Sure Start area could be traumatic for a family with high support needs, but some staff were sensitive to this: *"I'm going to be moving, unfortunately – I've just been nominated for permanent housing and it's out of the Sure Start area, so that's worrying me a bit, because I think Sure Start should be everywhere. My family support worker has said she won't just drop me, she'll come and see me for a couple of months ad set me up going to a mother and baby group, and they'll keep an eye on me. You get used to such good support – they're so invaluable"* (mother of three).

### *9.1.7 Training and employment opportunities*

In many SSLPs, a number of women gained experience and training by acting as peer supporters, and gained qualifications (NVQs) in areas such as breastfeeding support and baby massage, which could lead to further training and employment opportunities. Over half of the SSLPs offered women training in breastfeeding peer support. In one SSLP where the large midwifery team was highly visible, midwives had become role models for the young women in the area: *"We have quite a few mums who now want to become midwives because they have had such a positive experience"* (programme manager).

One mother of two who had started going to Sure Start groups, went on to train as a volunteer community parent and then got a Sure Start-funded job at a local voluntary organisation as a bilingual family support worker. She described how Sure Start had transformed her life: *"After I had my first child I was very depressed, I thought I was going crazy, and I didn't know about any of the services. I didn't find out about them (Sure Start)- they found me. I was splitting up with my husband, I was pregnant with my second child, I didn't have any friends or family, I was in a world of my own. I remember I was sitting at home, sitting around the sink half the day peeling vegetables and half the day wiping my son's bum, ironing my husband's shirts, and then the Sure Start worker came, she told me about the services, she was very pleasant…From that day the world changed."* She was very enthusiastic about her job supporting other families: *"I'm so lucky to be doing work which is in my heart."*

On the other hand, schemes involving community parents and peer support were not always successful and in some cases had to be discontinued after a great deal of training and effort: *"It was soul-destroying, particularly for volunteer parents. They would go around and the families just weren't in. People just don't want people visiting them at home"*(programme manager).

### *9.1.8 Childcare*

SSLPs provided childcare to enable mothers to access services, to enable volunteers to train, and to take the pressure off families in need. New mothers suffering from postnatal depression described having a support group with a crèche as providing them with a vital breathing space: *"I can relax here when I've not relaxed all week"; "It's somewhere to escape to."* Pregnant women struggling to cope with a young family welcomed the option of nursery sessions to get a break from their children. Mothers at one drop-in antenatal/postnatal clinic praised the relaxed atmosphere where their children could play and be looked after while the mothers saw the health professionals: *"When I come here I can see my midwife, my health visitor, my community parent. I can ask my community parent to keep an eye on my son while I nip down to see my midwife"* (pregnant mother of one).

## 9.2 Reaching the 'hard-to-reach'

Most SSLPs believed that their flexible, well-resourced, multi-disciplinary maternity services had **enormously improved access to care**, and a few SSLPs were proud of their record in making personal contact with 100% of Sure Start families. Some SSLPs, especially where a Sure Start midwife offered one-to-one care to the most disadvantaged women, felt that these services were effective in reaching the 'hard-to-reach'. Many Sure Start midwives made a specific effort to contact women who were not engaged with mainstream services, or who did not keep their appointments, using skill and persistence to find them and gain their trust. For example, in one SSLP with a very transient population there were eight GP attached community midwives and *"no one knew how many pregnant women were in the Sure Start area…People missing out on services weren't being accessed. One community midwife might have had a homeless client in the same hostel as two other midwives with clients in that hostel, and there was not a lot of good communication."* The SSLP had created a midwife post expressly to connect up the existing services for vulnerable women, as well as providing new ones.

However, many SSLPs, especially those that relied heavily on group work, felt that they had not generally succeeded in truly engaging the most marginalized pregnant women and new mothers, particularly where their data on pregnant women were incomplete in the first place. For example, one member of staff described Sure Start maternity services as ***"skimming the surface."***

On the other hand, there were many instances of Sure Start maternity services having an **enormous impact on very vulnerable individual women**, and in some cases transforming their lives. For example, one pregnant client was

homeless, living on the street, and had had three older children removed into care when Sure Start outreach workers made contact with her. The midwife gave her one-to-one care, and with Sure Start support she was rehoused and was successfully parenting her fourth child: *"Complex cases that everyone has given up on have done really well under Sure Start"* (midwife).

## 9.3 Impact on Staff

### *9.3.1 Positive views*

At their best, SSLPs offered unprecedented opportunities for motivated maternity practitioners to devise and deliver services within a public health framework. Most staff working in Sure Start maternity services reported **very high levels of job satisfaction**, despite the frequent difficulties in managing relationships with professional colleagues. In contrast to the mainstream services, most SSLPs reported **few recruitment and retention problems**. Some reported that while staff may be *"dragged down"* in the NHS, Sure Start was very affirming of the people who work in the programme.

Both Sure Start midwives and health visitors greatly valued what they had gained from the changes in their working practice, which some described as being able to practise in the way they had always wanted. They enjoyed the opportunities to **build real relationships** with mothers and the community, to provide a holistic service that set maternity care in the context of **social needs**, and to **tailor services** to meet women's individual needs. They also welcomed the potential for **creativity and innovation**, taking risks, **team working**, and a greater **sense of control** over their work. A nursery nurse expressed what was heard from many staff: *"I really, really enjoy my job. Every day is different, you're given responsibility for planning your own work, and that's exciting. I feel I'm growing in knowledge and confidence, and you learn all the time from your different colleagues"*.

### *9.3.2 Negative views*

There were a handful of SSLPs where staff expressed very different views. In some cases, potential for creativity and innovation had been experienced as a **lack of management support or guidance**; there was unhappiness over the **fluidity of boundaries** between staff roles, and staff referred to *"burning out"* through **overwork**. Some had become highly **frustrated** with the lack of support for Sure Start in some mainstream services. These negative views were expressed both in a few SSLPs where the whole maternity side of the programme appeared to be struggling, and occasionally where the services themselves appeared to be flourishing.

### *9.3.3 Training*

Sure Start had brought significant training opportunities for staff, who greatly valued the **professional development** of a kind and on a scale that was not open to them in the mainstream services. Much of this training was formal, but some was informally gained by working alongside other professionals in multidisciplinary teams. Partnership working structures also enabled Sure Start

practitioners to **develop as trainers**, by cascading their professional knowledge to Sure Start and mainstream colleagues.

Professionals and paraprofessionals alike **took on new roles** within the Sure Start maternity services and therefore had **specific training needs**, which appeared always to be met by the SSLPs. The two most commonly reported areas of training were on breastfeeding support and postnatal depression (identification and listening visits). Breastfeeding training was usually provided by one of the breastfeeding voluntary organisations, and postnatal depression training by a mental health professional. Staff were also trained to lead activities such as aquanatal groups and baby massage.

As well as offering training to increase staff awareness and competence on specific issues, some SSLPs had given staff training in the **skills required to deliver services in non-traditional ways**. For example, in one SSLP where there was low attendance at the antenatal group, staff were trained in group work skills and the attendance rose from an average of 4-8 to 20 at each session. It was sometimes noted, however, that it was difficult to judge the appropriateness and effectiveness of the wide variety of types of training on offer, particularly in relation to working with disadvantaged communities and families with multiple difficulties. Some Sure Start maternity practitioners had therefore **developed their own training**.

#### *9.3.4 Supervision*

A number of SSLPs reported paying close attention to professional supervision, especially on issues where staff might lack experience such as child protection, domestic violence or postnatal depression. Although Sure Start midwives and health visitors were usually professionally managed by the mainstream services, SSLPs had in some cases arranged clinical supervision groups on specific issues, or in-house support from an expert such as a clinical psychologist.

### 9.4 Statistical Evidence

#### *9.4.1 Problems with the evidence*

The statistical evidence available from the SSLPs in this study was disappointing. In general, baseline data for the assessment of change were **not available**, usually because they had not been routinely collected by the mainstream services, or the data on Sure Start families had not been separated from the rest. In addition, routine statistics that might demonstrate the effectiveness of SSLPs in improving breastfeeding and smoking cessation rates were often **unreliable**, because:

- denominators tended to be inaccurate, due to difficulties in identifying all the women who were pregnant within the SSLP locality;
- information had to be collected from a number of professionals and was often not available from all sources;
- there were issues around definition, for example, whether a woman who had given up smoking had relapsed, and whether breastfeeding rates captured exclusive breastfeeding or mixed feeding; and

- the fact that many pregnant smokers are reluctant to tell the truth about smoking.

In many of the SSLPs, at least some of the services were open to non-Sure Start women, and that added a further complication to data collection as those women had to be edited out of statistics. There were also examples of Sure Start practitioners believing they had statistical evidence where the figures involved were, in fact, based on so few women that they were not statistically significant. For example, one SSLP claimed to have a pregnancy smoking cessation rate of 39% based on just five women using its service.

### *9.4.2 Good practice in data collection*

A number of SSLPs were working hard to improve the quality of the data collected. For example, in one SSLP, the midwife and health visitor recorded data on breastfeeding, smoking in pregnancy, client visits, and all activities. Data collection forms were redesigned and updated to reflect Sure Start targets, and county-wide data collection was being improved under the guidance of a joint working group with the local trust.

### *9.4.3 Trends in breastfeeding and smoking cessation*

Although the data generated by most programmes were weak, practitioners were generally clear about the trends that they saw in daily practice. Almost all SSLPs reporting on smoking cessation noted that they knew of very few pregnant women who had quit as a result of using their services. In contrast, some SSLPs reported marked increases in the numbers of women breastfeeding.

There was a general feeling in SSLPs that monitoring figures did not necessarily reflect the impact that the programmes were having. For example, breastfeeding rates in one SSLP had risen from 24% to 52% but dipped at the next half-yearly audit, and the midwifery manager commented *"It is disheartening to give the impression of failing when the hard work is being maintained."* In another SSLP with a very entrenched smoking culture, the health co-ordinator felt it would be more appropriate to develop indicators of success falling short of actual numbers quitting, for example measuring the change in a woman's attitude to accept the health risks of smoking. She felt this would help staff to remain motivated in the face of failure to meet the *"hard number"* targets.

### *9.4.4 Trends in caesarean section and home birth*

A very small number of SSLPs had statistics showing a reduction in the caesarean section rate and an increase in the home birth rate. In two SSLPs, mothers in the SSLP had a caesarean rate of 10-15% compared with 23-25% average rate for the local hospital. These SSLPs reported home birth rates which had risen to about 33% in the Sure Start area. In each case the Sure Start women were receiving intensive one-to-one midwifery care (in one case, provided by the mainstream trust not the SSLP), which is known to reduce the risk of caesarean section and increase home birth.

### *9.4.4 Uptake of services*

Some SSLPs had figures showing uptake of various Sure Start activities, including attendance at antenatal and postnatal sessions. These data were used by the SSLPs to assess the acceptability of their services. For example, in one SSLP detailed attendance records were collected at every group activity and entered in a computer programme that measured overall uptake of services and generated a list of Sure Start residents not using the services. Some of these figures showed dramatic upward trends; where uptake was found to be low, the service was replaced. Other SSLPs made unsystematic assessments of trends: *"People are coming along and they're smiling"* (midwife).

## CHAPTER 10. CONCLUSIONS

The following conclusions have been drawn with the future development of services for women, babies and families in mind:

10.1 Sure Start Local Programmes have provided an opportunity to implement resource-intensive good practice, as well as a setting for experimentation and innovation in maternity services. Although some SSLPs were not aware of the evidence base for improving maternity services, and made mistakes in early service provision, in other cases positive evaluations of innovative Sure Start maternity services have themselves added to the good practice evidence base.

10.2 Sure Start Local Programmes have improved access to maternity services, by delivering them in new places and acceptable ways. A lot of work has been done to create targeted services for marginalized groups and to address their specific needs.

10.3 Sure Start has invested in maternity services so that practitioners have more time to spend with clients, especially the more vulnerable women. Because the mainstream maternity services often do not have enough midwives and health visitors to offer disadvantaged women and families comprehensive support, the transforming effects of SSLPs has been felt most clearly where resources have funded additional midwifery or health visitor time and enabled practitioners to develop trusting personal relationships with women.

10.4 The delivery of maternity services on a neighbourhood basis has increased practitioners' ability to build up relationships with individuals and communities and to create services that promote social support.

10.5 Clear and efficient referral links have been created between Sure Start maternity services and other Sure Start and mainstream services, and this has improved women's access to a range of appropriate support services. Sure Start maternity services can function as a gateway to other services, particularly for marginalized families.

10.6 Skill shortages in midwifery has created tension between SSLPs and mainstream managers where there has been competition for staff. These shortages raise questions about the sustainability of enhanced maternity services, however much they are valued and effective.

10.7 Most Sure Start maternity practitioners report high levels of job satisfaction. As well as having more time to spend with clients and the stimulation and support they gain from working in a multidisciplinary setting, practitioners particularly value the unprecedented flexibility to work holistically and to tailor services that meet women's individual needs, including

psychosocial needs. Service users are equally enthusiastic about these new and profoundly woman-centred ways of working.

10.8 Co-location of health visitors and midwives helps to overcome the division between the professions and assists the smooth handover and follow-up of women between the antenatal and postnatal periods. Co-location of maternity practitioners with other health and social care staff - for example community psychiatric nurses and family support workers – is a key enabler of effective multidisciplinary working.

10.9 Trained para-professionals and volunteers can make a valuable contribution both in supporting families individually and in delivering specific maternity services, such as breastfeeding support. But an investment of time is needed to create, develop, manage and sustain such a service: it is not just a cheap alternative.

10.10 Sure Start has provided enormous scope for professional development through formal and informal training, which has benefited Sure Start and mainstream maternity practitioners and has enabled positive aspects of maternity practice to be shared with colleagues. Multi-agency training adds particular value to the investment.

10.11 Many early Sure Start local partnerships did not acknowledge that maternity services were central to the Sure Start approach, and mainstream maternity services themselves were often slow in realising the opportunities Sure Start offered. Guidance from the Sure Start Unit evolved, and in later rounds of SSLPs maternity services were more likely to be embedded from the outset.

10.12 Many SSLPs recognise that their maternity services have not managed to reach some of the most socially excluded families. This is connected in some cases with the absence of reliable information from mainstream maternity services about Sure Start women booking for care. On the other hand some SSLPs have been able, through outreach, to make contact with women who were not previously known to mainstream services.

10.13 Sure Start Local Programmes have provided opportunities for ‘joined-up’ working around maternity issues at both strategic and operational levels. However, it is individual relationships that have determined whether joined-up working flourishes or founders. Successful joined-up working is underpinned by strong leadership, commitment to a shared vision and adequate resources in each service to be able to deliver to their commitment.

**APPENDIX I**

**REFERENCES**


Abraham R, Campbell-Brown M, North W, McFadyen R (1987). Diets of Asian pregnant women in Harrrow: iron and vitamins. *Hum Nutr: Appl Nutr* **41 A**: 164-173

(cited by) Abrams 1993. *Annals of the New York Academy of Sciences* **678**

Adams C & Sobowale A (2003). Peri-natal mental health: promoting the mental health of non-English speaking women. *Community Practitioner*

Ahmed S & Macfarlane A (2003). *Evaluation of Sure Start on the Ocean bilingual breastfeeding support work.* London: City University

Alison L (2000) What are the risks to children of parental substance misuse? In Harbin F, Murphy M eds. Substance misuse and child care: how to understand assist and intervene when drugs affect parenting, Russell House Publishing, Lyme Regis

Anderson AS et al (1995). The influence of dietary advice on nutrient intake during pregnancy. *British Journal of Nutrition* **73(2)** : 63-177

Anderson HR, Cook DG (1997). Passive smoking and sudden infant death syndrome: review of the epidemiological evidence. *Thorax* **52**:1003-9

Anderson JW et al (1999). Breastfeeding and cognitive development: a meta-analysis. *Am J Clin Nutr* **70**: 525-35

Arblaster L, Entwhistle V, Fullerton D et al (1998). *A review of the effectiveness of health promotion interventions aimed at reducing inequalities in health.* York: NHS Centre for Reviews and Dissemination.

ASH Scotland (2002). *Executive Summary* 17th July 2002 www.ashscotland.org.uk/inequalities/bmereport.html

Attride-Stirling J, Davis H, Markless G, Sclare I, Day C (2001). 'Someone to Talk to Who'll Listen': Addressing the Psychosocial Needs of Children and Families. *Journal of Community & Applied Social Psychology*. 11: 179-191.

Audit Commission (1997). First Class Delivery: Improving Maternity Services in England and Wales. London: Audit Commission

Bambeng S, Spencer NJ, Logan S, Gill L (2000). Cause-specific perinatal death rates, birth weight and deprivation in the West Midlands, 1991-93. *Child Health Care Dev* **26**(1): 73-82.

Barker DJP (1998). *Mothers, Babies and Health in Later Life.* Edinburgh: Churchill Livingstone

Barnes J, Broomfield, K, Frost M et al (2003) *Characteristics of Sure Start Local Programme Areas: Rounds 1-4* London: DfES

Batten L (1997). *Low income, smoking, pregnancy and the transtheoretical model*. Southampton: University of Southampton, Department of Psychology.

Beake S, McCourt C (2002). *Evaluation of the use of health care assistants to support disadvantaged women breastfeeding in the community*. London: Thames Valley University.

Beckman C, Demilew J (2001). *Audit of "unbooked women" in maternity services, 2000.* London: King's College Hospital.

Bewley S, Friend J, Mezey G, eds (1997). *Violence Against Women*. London: RCOG Press.

Bickman L (1996). A continuum of care: More is not always better. *American Psychologist*, **51**: 689-701.

Blair P, Fleming P, Bensley D, et al (1996). Smoking and the sudden infant death syndrome: results from 1993-5 case-control study for Confidential Enquiry into Stillbirths and Deaths in Infancy. *British Medical Journal* **313**: 195-198

British Medical Association (1999). *Growing Up in Britain: Ensuring a healthy future for our children.* London: *BMJ* Books

Botting B, Rosato M and Wood R (1998). Teenage mothers and the health of their children. *Population Trends* 93.

Brazelton TB (1973). *Neonatal Behavioral Assessment Scale*. London: William Heineman Ltd.

Buescher PA et al (1993). Prenatal WIC participation can reduce low birth weight and newborn medical costs: A cost-benefit analysis of WIC participation in North Carolina. *J Am Diet Assoc* **93**:163-166.

Bull J, Mulvihill C and Quigley R (2003). *Prevention of low birth weight: assessing the effectiveness of smoking cessation and nutritional interventions. Evidence briefing.* London: Health Development Agency.

Bullock L et al (2002). Telephone Social Support for Low-Income Pregnant Women. *JOGNN* Nov/Dec:523-529.

Burnett A, Peel M (2001a). What brings asylum seekers to the UK? *BMJ* **322**:485-488

Burnett A, Peel M (2001b). Health needs of asylum seekers and refugees, *BMJ* **322**:544-547

Burchett B, Seeley A (2003) Good Enough to Eat? The diets of pregnant teenagers. London: Maternity Alliance & Food Commission.

Caan B et al (1987). Benefits associated with WIC supplemental feeding during the interpregnancy interval. *American Journal of Clinical Nutrition* **45**:29-41

Campbell D, Hall M, Barker D, Cross J, Shiell A, Godfrey K (1996). Diet in pregnancy and the offspring's blood pressure 40 years later. *British Journal of Obstetrics and Gynaecology* **103**: 273-280.

Campbell R, Macfarlane AJ (1994). Where to be born? The debate and the evidence. 2nd edition. Oxford: National Perinatal Epidemiology Unit.

Carroll H (2001*).* Working with homeless families. In: *Midwives in Action: a resource.* ENB 2001.

Carson C (2001). Infant Feeding*.* In: *Midwives in Action: a resource*. ENB 2001

CESDI (1997). Confidential Enquiry into Stillbirths and Deaths in Infancy. *4th Annual Report for 1 January to 31 December 1995.* London: Maternal and Child Health Consortium.

Chalmers I, Enkin MW, Keirse MJNC (eds) (1989). *Effective Care in Pregnancy and Childbirth*. Oxford: OUP

Chappell T, Schafer J, Stewart Brown S (2003). Rose Hill – Littlemore Sure Start; the First Two Years. A summary of the local evaluation August 2000-May2002.
http://www.hsru.ox.ac.uk/surestartrep.pdf

Charmaz K (2003). Grounded theory. pp 81-110, In: Smith JA (ed). Qualitative Psychology: a Practical Guide to Research Methods. London, Thousand Oaks, New Delhi: Sage Publications

Chilaka VN, Konje JC et al (2001). Knowledge of Down syndrome in pregnant women from different ethnic groups. *Prenatal Diagnosis* **21(3)**: 123-127.

Child Accident Prevention Trust (1991) *Accidents and the safety of children in temporary accommodation.*

Child Psychotherapy Trust (1993). *Reducing risks: relationship-based services for babies and parents.* London: Child Psychotherapy Trust / AIMH (UK).

Cnattingus S et al (1988) Cigarette smoking as a risk factor for late fetal and early neonatal death. *BMJ* **297**:258-61

Coghill S, Caplan H, Alexandra H, Robson K, Kumar. R (1986). "Impact of postnatal depression on the cognitive development of young children." *BMJ* **292**:1165-7

Collaborative Group on Hormonal Factors in Breast Cancer (2002). Breast cancer and breastfeeding: collaborative reanalysis of individual data from 47 epidemiological studies in 20 countries, including 50302 women with breast cancer and 96973 women without the disease. *Lancet* **360**: 187-95.

COMA (1999). Committee on Medical Aspects of Food and Nutrition Policy Panel on Child and Maternal Nutrition *Scientific Review of the Welfare Food Scheme Report to the Welfare Food Scheme Review Group. 7th draft 1/11/99*

Confidential Enquiries into Maternal Deaths in the United Kingdom (2001). Why Mothers Die 1997-1999. RCOG Press

Cooper PJ, Murray L (1987). *The impact of psychological treatments of postpartum depression on maternal mood and infant development*. In: Murray L & Cooper PJ (eds), Postpartum Depression and Child Development. Guilford: New York.

Cumming RG & Klineberg RJ (1993). Breastfeeding and other reproductive factors and the risk of hip fractures in elderly women. *Int J Epidemiol* **22**: 684-691.

Curtis C, Ball L, Kirkham (2003) *Why do Midwives Leave? Talking to Managers* Women's Informed Childbearing and Health Research Group

Dallison J, Lobstein T (1995). Poor Expectations: poverty and undernourishment in pregnancy. London: NCH Action for Children and The Maternity Alliance.

Dance J (1987). *A social intervention by link workers to Pakistani women and pregnancy outcome.* MA dissertation, School of Sociology, University of Warwick. Cited by Richens (2003).

Day C, Davis H, Hind R (1998). The development of a community child and family mental health service. *Child: Care, Health and Development,* **24(6)**: 487-500.

Davis H, Spurr P (1998). Parent Counselling: An Evaluation of a Community Child Mental Health Service. *Journal of Child Psychology and Psychiatry*, **39(3)**: 365-376.

Department of Health (1993). *Changing Childbirth Part I : Report of the Expert Maternity Group.* London: HMSO.

Department of Health (1998). Independent Inquiry into Inequalities in Health (chairman: Sir Donald Acheson). London: TSO

Department of Health (2000). The NHS Plan: A plan for investment, a plan for reform.

Department of Health (2001). *Valuing People. A New Strategy for Learning Disability for the 21st century.* The Stationery Office.

Department of Health (2002A) Cross-cutting Spending Review into Health Inequalities

Department of Health (2002B) Priorities and Planning Framework for the NHS, 2003-2006

Department of Health (2003). *Delivering the Best: Midwives Contribution to the NHS Plan*. London: DH.

Department of Health (2004) *Maternity Standard, National Service Framework for Childre, Young People and Maternity Service*

DETR 1998. *Local authority activities under the homeless legislation, England, fourth quarter 1997.*

Doll R et al (1994) Tobacco related diseases. *Journal of Smoking Related Diseases* **1**:3-13

Dobson B, Beardsworth A, Keil T, Walker R (1994). *Diet, choice and poverty: social, cultural and nutritional aspects of food consumption among low income families*. Loughborough: Loughborough University of Technology, Centre for Research in Social Policy.

Doering SG, Entwistle DR (1975). Preparation during pregnancy and ability to cope with labor and delivery. *Am J Orthopsychiatry* **45(5):**825-837

Dorsett R, Marsh A (1998). *The health trap: poverty, smoking and lone parenthood*. London: Policy Studies Institute.

Dowler E, Calvert C (1995). *Nutrition and diet in lone-parent families in London.* London: Family Policy Studies Centre.

Draper E, Abrams K, Clarke M (1995). Fall in birth weight of third generation Asian infants (letter). *BMJ* **311:** 876

Drife J, Lewis G, eds (1998). *Why Mothers Die. Report of the Confidential Enquiries into Maternal Deaths in the United Kingdom 1993-96.* London, TSO.

D'Souza L (2003). *Evidence of what works in terms of the way services are organised for disadvantaged women in the perinatal period.* National Perinatal Epidemiological Unit.

D'Souza L, Garcia J (2003). *Limiting the impact of poverty and disadvantage on the health and well-being of low-income pregnant women, new mothers and their babies: results of a mapping exercise.* Oxford: National Perinatal Epidemiology Unit.

Duncan B et al (1993). Exclusive breastfeeding for at least 4 months protects against otitis media. *Paediatrics* **5**:867-872

East London and City Health Authority (1997). *Refugees in Hackney: A Study of Health and Welfare.*

Eaton PM, Wharton PA, Wharton BA (1984). Nutrient intake of pregnant Asian women in Sorrento Maternity Hospital, Birmingham. *Br J Nutr* **52**: 457-468

Elbourne D, Oakley A, Chalmers I (1989). Social and psychological support during pregnancy. In: Chalmers I, Enkin M, Keirse M, eds. *Effective Care in Pregnancy and Childbirth*, vol 1. Oxford: Oxford University Press.

Enkin MW, Keirse MJNC, Renfrew MJ, Neilson JP (1993). Cochrane database of systematic reviews. Pregnancy and childbirth module. Oxford: Update Software.

Enkin MW, Smith SL, Dermer SW, Emmett JO (1972). *An adequately controlled study of the effectiveness of PPM training.* In: Psychosomatic Medicine in Obstetrics and Gynecology. Morris N(ed). Basel: Karger

Eds Erns B, Primatesta P, Prior G (2001). *Health survey for England: the health of ethnic minority groups 1999.* London: The Stationery Office

Evans J et al. Cohort study of depressed mood during pregnancy and after childbirth. *BMJ* **323:**257-260

Fairbank L et al (2000). "A systematic review to evaluate the effectiveness of interventions to promote the initiation of breastfeeding." *Health Technology Assessment* Vol 4: No. 25

Fall CHD, Stein CE, Kumaran K et al (1987?CHECK). Size at birth, maternal weight, and non-insulin dependent diabetes in South India. *Diabetic Medicine* **15**:220-7

Farrell C (1999). Free fresh fruit and vegetables with your milk token? *Maternity Action no 83.*

Fleming P, Blair P, Bacon C & Berry J (eds) (2000). *Sudden unexpected deaths in infancy: the CESDI SUDI Studies 1993-96.* London: The Stationery Office.

Fogelman K, Manor O (1988). Smoking in pregnancy and development into early adulthood. *British Medical Journal* **297**:1233-1236

Fonagy P (1998). Prevention, the appropriate target of infant psychotherapy. *Infant Mental Health Journal* **19(2)**: 124-150

Forsen T, Eriksson JG, Tuomilheto J (1997). Mother's weight in pregnancy and coronary heart disease in a cohort of Finnish men: follow-up study. *British Medical Journal* **315**:837-40

Gaaserud M (2001). *Maternity Services for Newly-arrived Refugee and Asylum-seeking women in the City and Hackney Boroughs of London*. City and Hackney Primary Care Trust.

Gerrard et al (19930. A trainer's perspective of an innovative programme teaching health visitors about the detection, treatment and prevention of postnatal depression. *Journal of Advanced Nursing* **18**: 1825-1832.

Gerstein HC (1994).Cow's milk exposure and type 1 diabetes mellitus. *Diabetes Care* **17**: 13-19

Godfrey KM, Forrester T, Barker DJP et al (1994). The relation of maternal nutritional status during pregnancy to blood pressure in childhood. *British Journal of Obstetrics and Gynaecology* **101**:398-403

Goodman M (1994). *Mothers' pride and others' prejudice: A survey of disabled mothers' experiences of maternity.* London: Maternity Alliance.

Goodwin S (1992). Community nursing and the new public health. *Health visitor*, 65(3): 78-80

Gortmaker SL (1979). The effect of prenatal care upon the health of the newborn. *Am J Public Health*. **69**:653-60

Graham H (1987) Women's smoking and family health. *Social Science and Medicine* **25(1)**: 47-56

Graham H (1993). *When life's a drag: women, smoking and disadvantage*. London: HMSO.

Haslam C, Draper E (2000). Stage of change is associated with assessment of the health risks of maternal smoking among pregnant women. *Soc Sci Med* **51(8):**1189-96

Hamlyn B, Brooker B, Oleinikova K, Wands S. *Infant Feeding 2000*. London, TSO 2002.

Hart J, Davidson A, Clarke C, Gibb C (2003). Health visitor run baby massage classes: investigating the effects. *Community Practitioner* **76(4):** 138-142

Health Education Authority (1994) *Smoking in pregnancy: guide for purchasers and providers*. London: Health Education Authority.

Hedegaard M et al (1993). Psychological distress in pregnancy and preterm delivery. *British Medical Journal* **307**:234-239

Hemingway H, Saunders D, Parsons L (1997). Social class, spoken language and pattern of care as determinants of continuity of carer in maternity services in east London. *Journal of Public Health Medicine* **19(2):**156-61

Henderson L, Gregory J, Swan G (2002). *The National Diet and Nutrition Survey: Adults aged 19-64 years.* London:TSO

Hodnett ED (2002a). *Continuity of caregivers for care during pregnancy and childbirth* (Cochrane Review). In: The Cochrane Library, Issue 4, 2002. Oxford: Update Software.

Hodnett ED (2002b). *Caregiver support for women during childbirth* (Cochrane Review). In: The Cochrane Library, Issue 4, 2002. Oxford: Update Software.

Hodnett ED (2002c). *Support during pregnancy for women at increased risk of low birthweight babies* (Cochrane Review). In: The Cochrane Library, Issue 4, 2002. Oxford: Update Software.

Hoddinott P & Pill R, (1999). Qualitative study of decisions about infant feeding among women in the east end of London. *British Medical Journal* **318**:30-4

Holden J, Sagovsky R, Cox J (1989). Counselling in a general practice setting: a controlled study of health visitor intervention in the treatment of postnatal depression. *British Medical Journal* **298**: 223-226

Holmes V (2001). Partner involvement in smoking cessation. *British Journal of Midwifery* **9(6)** Jun 2001

Home Office (1999). *Domestic violence: Findings from a new British Crime Survey Self-completion Questionnaire.*

House of Commons Health Committee (chairman: NW Winterton) (1992). *Maternity services*. Vol I, report. HC 29-I. London: HMSO

House of Commons Health Committee (2003). Reports of Inquiries carried out for the Maternity Services Sub-committee: Provision of Maternity Services (Fourth Report); Inequalities in Access to Maternity Services (Eighth Report); Choice in Maternity Services (Ninth Report). London: TSO

Howie PW et al (1990). Protective effects of breastfeeding against infection. *BMJ* **300**: 11-16

Ineichen B (1993). *Homes and Health: How Housing and Health Interact.* London. E and FN Spon.

Johnson Z, Howell F, Molloy B (1993). Community mothers' programme: randomised controlled trial of non-professional intervention in parenting. *British Medical Journal* **306**; 1449-52.

Johnson Z, Molloy B, Scallan E, Fitzpatrick P, Rooney B, Keegan T, Byrne P (2000). Community Mothers Programme – seven year follow-up of a randomized controlled trial of non-professional intervention in parenting. *Journal of Public Health Medicine* **22(3)**: 337-342

Kandall S, Gaines J, Habal L et al (1993).Relationship of maternal substance abuse to subsequent sudden infant death syndrome in offspring. *Journal of Paediatrics* **123**:120-126

Kehrer B, Wolin V (1979). Impact of income maintenance on low birthweight, evidence from the Gary experiment. *Journal of Human Resources* **14**: 434-462

Kempley et al (1995). Birthweight and special educational needs. *Journal of Epidemiology and Community Health* **49**:33-7

Kingswell S & Fogarty B (2001). *Pals in pregnancy. Social support for vulnerable pregnant women: a luxury or a lifeline?* Coventry Health Authority

Kitzinger S, (1992). Chapter 3 in: Enkin M, (eds). A Guide to Effective Care in Pregnancy and Childbirth. Oxford: OUP

Kowalski J & Roberts A (2000). Postnatal depression: involving partners in promoting recovery. *Professional Care of Mother and Child* **10(3)**

Kurtz Z (2004) What works in promoting children's mental health. http://www.surestart.gov.uk/ensuringquality/research/earlyyears/

Kramer MS (2003). Balenced protein/energy supplementation in pregnancy. (Cochrane Review). In: *the Cochrane Library,* Issue 2. Oxford: Update software

Lancaster T, Staed LF (2003). Self-help interventions for smoking cessation (Cochrane Review). In: *The Cochrane Library,* Issue 1 2003. Oxford: Update Software

Landgren M et al, (1998) Attention deficit disorder with developmental co-ordination disorders. *Archives of Disease in Childhood* **78**:207-12

Leger J, Levy-Marchal C, Bloch J et al (1997). Reduced final height and indication for insulin resistance in 20 year olds born small for gestational age: regional cohort study. *British Medical Journal* **315**:341-7

Lewis G (2003) *Why Mothers Dies (2002-02): The Sixth Report of the Confidential Enquiries into Maternal Deaths in the United Kingdom*. London. RCOG Press

Lumley J (1995) Strategies for reducing smoking in pregnancy. In: The Cochrane Database of Systematic Reviews, ed. *The Cochrane Library*, Issue 2, 1995. Oxford: Update Software, 1995

Lumley J, Oliver S, Waters E (2002). Interventions for promoting smoking cessation during pregnancy (Cochrane Review). In: *The Cochrane Library*, Issue 4 2002. Oxford: Update Software

Lumley J (2003). Personal communication. Cited by D'Souza L, Garcia J (2003). *Limiting the impact of poverty and disadvantage on the health and well-being of low-income pregnant women, new mothers and their babies: results of a mapping exercise.* Oxford: National Perinatal Epidemiology Unit

Macrory F (2001). Sexual health for women with complex problems. In: *Midwives in Action: a resource.* English National Board for Nursing, Midwifery and Health Visiting

McCourt C, Page L, eds (1996). *Report on the Evaluation of One-to-One Midwifery.* London: Hammersmith Hospitals NHS Trust & TVU

McFarlane A et al (2000). *Birth Counts* table A8.3.1 (pub details)

McInnes RJ (1998). The Glasgow Infant Feeding Action Research Project: an evaluation of a community based intervention designed to increase the prevalence of breastfeeding in a socially disadvantaged area. (Summary). Research undertaken at the Paediatric Epidemiology and Community Health Unit, Department of Child Health, University of Glasgow

McLeish J (2002*). Mothers in exile: Maternity experiences of asylum seekers in England.* London: Maternity Alliance

Maher T (2002) Talking babies: securing early attachment. *Young Minds Magazine* **60**: 18-19

Margetts BM et al (2002). Persistence of lower birthweight in second generation South Asian babies born in the United Kingdom. *Journal of Epidemiology and Community Health* **56**: 684-687

Maternity Alliance (1999). *Maternity Services for Women with Learning Difficulties. A report of a partnership of midwives, community nurse and parents.* London: Maternity Alliance

Mitchell E, Hall J, Campbell D, van Teijlingen E (2003). Specialist care for drug using pregnant women. *British Journal of Midwifery* **11(1):** 7-11

Moore et al (1998). A randomised trial of nurse intervention to reduce preterm and low birthweight births. *Obstet Gynecol* **91(5 pt1)**: 656-61

Moore L et al (2002). Self help smoking cessation in pregnancy: cluster randomised controlled trial *BMJ* **325**:1383

Morrell CJ (2000). Costs and benefits of community postnatal support workers: a randomised controlled trial. *Health Technol Assess* 4(6):1-100

Morton R, Sharma V, Nicholson J, Broderick M, Poyser J (2002). Disability in children from different ethnic populations. *Child: Care, Health & Development* **28(1)**: 87-93

Murray L (1997). Postpartum depression and child development. *Psychological Medicine* 27: 253-260.

Murray L, Cooper PJ (1997). Effects of Postnatal depression on infant development. *Archives of Disability in Childhood* **77**:99-101

Murray L, Woolgar M, Murray J, Cooper P (2003). Self-exclusion from health care in women at high risk for postpartum depression. *Journal of Public Health Medicine* **25(2)**: 131-137

Murray I, Fiori-Cowley A, Hooper R, Cooper PJ (1996). The impact of postnatal depression and associated adversity on early mother infant interactions and later infant outcome. *Child Development* **67**:2512-26

Murray L (1992). The impact of postnatal depression on child development. *Journal of Child Psychology and Psychiatry* **33**:543-61

Narang I & Murphy S. (1994) Assessment of the antenatal care for Asian women. *British Journal of Midwifery* **2(4)**:169-73, cited in Schott J & Henley A (1996) *Culture, Religion and Childbearing in a Multiracial Society*. Oxford: Butterworth-Heinemann

Nathanielz PW (1996). *Life Before Birth; the challenges of fetal development.* New York: WH Freeman

NHS Centre (1998). *Smoking cessation: What the Health Service can do*. NHS centre for Reviews and Dissemination, The University of York vol 3, Issue 1

NICE (2003). *Antenatal care: routine antenatal care. NICE guideline. 2nd draft for consultation, June 2003.* National Institute for Clinical Excellence

Norbeck et al (1996). A randomised trial of an empirically-derived social support intervention to prevent low birthweight among African-American women. *Soc Sci Med* **43(6):** 947-54

NPEU authors 2003 Social class, ethnicity and attendance for antenatal care in the United Kingdom: a systematic review and secondary analysis

Oakley A, Hickey O, Rajan L, Hickey A (1996). Social support in pregnancy: does it have long term effects? *Journal of Reproductive Infant Psychology* **14**: 7-22.

O'Connor T et al (2002). Maternal antenatal anxiety and children's behavioural / emotional problems at 4 years. *Br J Psychiatry* **180**: 502-8

ONS (2002) *Mortality statistics. Child, infant and perinatal.* Series DH3 no 33. London: Office for National Statistics

ONS (2002) *Birth Statistics, England and Wales*. Series FM1 No 30. London: Office for National Statistics

Olds D, Eckenrode J, Henderson C, et al (1997). Long-term effects of home visitation on maternal life course and child abuse and neglect. Fifteen-year follow up of a randomized trial. *Journal of the American Medical Association* **278**: 637-643

Onozawa K, Glover V, Kumer C, Potts J, Adams D, Dore C (2000). Infant massage improves mother-infant interaction for mothers with postnatal depression. *Journal of Affective Disorders* **63:**201-207

Pagel et al (1990). Psychosocial influences on newborn outcome: a controlled prospective study. *Soc Sci Med* **30**:597-604

ParentAbility 1991. *Accessible Birth: A ParentAbility Report on Physical Access to Maternity Units by Parents with Disabilities*. London: National Childbirth Trust.

Parke EW, Schultz JK, Tudiver F, Campbell T & Becker L (2002) *Partner support in smoking cessation.* (Cochrane Review). In: *The Cochrane Library*, Issue 2. Oxford: Update software

Parsons L (1991). Homeless Families in Hackney. *Public Health* 105:287-296

Parsons L, Day S (1992). Improving obstetric outcomes in ethnic minorities: an evaluation of health advocacy in Hackney. *Journal of Public Health Medicine* **14(2):** 83-191

Pearce L. (2001) Special delivery: work of a midwife creating a service to support disabled women during and after delivery. *Nursing Standard* **15(23)**: 14-15

Perkin MR et al (1993). "The effect of anxiety and depression during pregnancy on obstetric complications" *Br J Obstet Gynaaecol* **100**: 629-634

Piscane A, Graziano L & Zona G (1992). Breastfeeding and urinary tract infection. *J Pediatr* **120**: 87-89

Pleace N, Quilgars D (1996). *Health and Homelessness in London: A Review*. London: The King's Fund.

Rajgopal R, Cox RH, Lambur M & Lewis EC (2002). Cost-benefit analysis indicates the positive economic benefits of the EFNEP related to chronic disease prevention. *Journal of Nutrition Education and Behaviour* **34:** 26-37.

Ravelli A, van der Meulen J, Michels R et al (1998). Glucose tolerance in adults after prenatal exposure to the Dutch famine. *Lancet* **351**: 173-177.

Ray KL & Hodnett ED (2002). Caregiver support for postpartum depression. (Cochrane review). In: *The Cochrane Library,* Issue 1 2002. Oxford: Update software.

Reid M (2002). A two-centered pragmatic randomised controlled trial of two interventions of postnatal support. *BJOG* **109(10):** 1164-70

Richens Y (2003) *An Exploration of Women of Pakistani Origin's Experiences of UK Maternity Services* (final draft)

Roberts H (2000). *What works in reducing inequalities in child health?* London: Barnardo's.

Rogers I, Emmett P, Baker D, Golding J & the ALSPAC Study Team (1998). Financial difficulties, smoking habits, composition of the diet and birthweight in a population of pregnant women in the South West of England. *Eur J Clin Nutr* **52**:251-260

Rosenblatt KA et al (1993). Lactation and the risk of epithelial ovarian cancer – The WHO Collaborative Study of Neoplasia and Steroid Contraceptives. *International Journal of Epidemiology* **22**: 499-503

Rowe et al (2003). *Social and ethnic inequalities in access to prenatal screening and diagnosis in the UK: a systematic review*. Oxford: NPEU.

Royal College of Midwives (2000a). *Vision 2000*. London: The Royal College of Midwives

Royal College of Midwives (2000b). *Midwives and the new NHS. Paper Four: Public Health*. London: The Royal College of Midwives

Royal College of Midwives (2000c). *Midwifery Practice in the Postnatal Period*. London: The Royal College of Midwives

Royal College of Physicians (1995). *Alcohol and the Young*. London:RCP

Ryan G, Sweeney P, Soala A (1980). Prenatal care and pregnancy outcome. *Am J Obstet Gynecol* **137**:876-81

Saarinen UM & Kajosaari M (1995). Breastfeeding as prophylaxis against atopic disease: prospective follow up study until 17 years old. *Lancet* **346**: 1065-1069

Sandall J et al (2001). *Evaluation of the Albany Midwife Practice, Final Report*. London: King's College.

Saunders M (2001?). *As good as your word: a guide to community interpreting and translation in public services*. London: Maternity Alliance.

Sawtell M (2001). *Lives on hold: homeless families*. London: Maternity Alliance.

Schott J & Henley A (1996). *Culture, Religion and Childbearing in a Multiracial Society.* Oxford: Butterworth-Heinemann

Scobie J and McGuire M (1999). The silent enemy: domestic violence in pregnancy. *British Journal of Midwifery* **4(7)**

The Scottish low birth weight study (1992) II. Language attainment, cognitive status, and behavioral problems. *Arch Dis Child* **67**:672-6

Seeley S, Murray L, Cooper P (1996). The outcome for mothers and babies of health visitor intervention. *Health Visitor* **69**: 135-138.

Sen DM , Holmes C (1996). Newcastle Bangladeshi Midwifery Project. *MIDIRS Midwifery Digest* 6(2): 225-229

Sikorski J, Renfrew MJ, Pindoria S, Wade A (2002). *Support for breastfeeding mothers.* Cochrane Database Syst Rev 2002; (1): CD001141

Simkin P & Murray Enkin (1989) Antenatal classes. In: Chalmers I et al, eds, *Effective Care in Pregnancy and Childbirth.* Oxford: OUP

Siney C (2001) Drug misuse. In: *Midwives in Action: a resource.* English National Board for Nursing, Midwifery and Health Visiting.

Singh D & Newburn M, eds (2000a). *Access to Maternity Information and Support: The experiences and needs of women before or after giving birth.* London: National Childbirth Trust.

Singh D & Newburn M (2000b). *Becoming a Father: Men's access to information and support about pregnancy, birth and life with a new baby*. London: National Childbirth Trust.

Southall Black Sisters (2002). *Domestic abuse quarterly* Summer 2002.

Sparey C, Walkinshaw S (1993). *Obstetric problems for drug users*, in Siney C ed Pregnancy and drug misusers 2nd ed Books for Midwives Press, hale pp55-68

Spencer N, Logan S (1998). Smoking, socio-economic status and child health outcomes: the ongoing controversy. In: Spencer N ed, *Progress in Community Child Health 2.* Edinburgh: Churchill Livingstone.

Stein A. et al (1989). " Social adversity and perinatal complications: their relation to postnatal depression" *BMJ* **298**:1073-1074.

Stein CE, Fall CHD, Kumaran K et al (1996). Fetal growth and coronary heart disease in South India. *Lancet*1269-73.

Steptoe A, Perkins-Porras L, McKay C, Rink E, Hilton H, Cappuccio F (2003). Behavioural counselling to increase consumption of fruit and vegetables in low income adults: randomised trial. *BMJ* **326**:855-8

Strauss RS (1997). Effects of interuterine environment on childhood growth. In: Marmot ME, Wadsworth MEJ, eds. *Fetal and early childhood environment: long-term health implications. British Medical Bulletin* **53(i):**81-96.

Street C & Smith L (2003). *Positive beginnings: exploring UK provision for the social and emotional development of babies.* London: Child Psychotherapy Trust.

Thomas J, Paranjothy S (2001). *The National Sentinel Caesarean Section Audit Report.* London: RCOG Press.

Tinsley V (2003). An audit of midwives' attitudes and management of women who fail to attend routine antenatal care. *MIDIRS Midwifery Digest* **13(2)**

Tudor-Hart J (1971). *'The inverse care law'*. The Lancet, 405-412

Villar J, Bergsjo P (1997). Scientific basis for the content of routine antenatal care I. Philosophy, recent studies and power to eliminate or alleviate adverse maternal outcomes. *Acta Obstet Gynaecol Scand* **76(1):**1-14

Villar J, Caroli G, Khan-Neelogur D, Piaggio G, Gulmezoglu M (2002). *Patterns of routine antenatal care for low-risk pregnancy (Cochrane Review).* In: The Cochrane Library, Issue 2, 2002. Oxford: Update Software.

Wadwa PD et al (1993). "The association between prenatal stress and infant birthweight and gestational age at birth" *Am J Obstet Gynaecol* **169**:858-865.

Walson et al (1984). Psychiatric disorder in pregnancy and the first postnatal year. *Br J Psychiatry* **144:**453-462.

Whitehead M (1995). Tackling inequalities: a review of policy initiatives. In: Benzeval M, Judge K, Whitehead M, eds. *Tackling inequalitties in health: an agenda for action*. London: King's Fund.

WHO (1992). *Low Birth Weight. A tabulation of available information.* Geneva: World Health Organisation/UNICEF

Widga AC, Lewis NM (1999) *Defined, in-home, prenatal nutrition intervention for low-income women*. *J Am Diet Assoc* **99(9):** 1058-62

Widmayer SM, Field TM (1981). *Effects of Brazelton demonstrations for mothers on the development of preterm infants*. Pediatrics **67**; 711-714.

Wilkinson A (1995). All Aboard in Bradford. *MIDIRS Midwifery Digest* **5(3):** 302-303

Wilkinson J, Phillips S, Jackson J, Walker K (2003). "Mad for Fitness"; an exercise group to combat a high incidence of postnatal depression. *The Journal of Family Healthcare* **12(2)**:44-48

Williams J (2003). The Baby Café: a fresh idea for supporting breastfeeding mothers. *Community Practitioner***76(5):**161-162

Wilson J (1995). Maternity Policy. Caroline: a case of a pregnant teenager. *Professional care of mother and child* **5(5):**139-142

Wilyman-Bugter (2003) Substance misuse and pregnant women: a study of a sure start early antenatal support programme. *MIDIRS Midwifery Digest* **13(2):**262-265

Wright J (1996). Breastfeeding and deprivation – the Nottingham peer counsellor programme. *MIDIRS Midwifery Digest* **6**(2).

Wynn M et al (1994). The association of maternal social class with maternal diet and the dimensions of babies in a population of London women. *Nutrition and Health* **9**:303-315.

Zhu and Valbo (2002) Depression and smoking during pregnancy. *Addict Behav* **27**(4): 649-58

**APPENDIX II**

from *Getting the right start: The National Service Framework for Children, Young People and Maternity Services – Emerging Findings*. April 2003, London: Department of Health.

**MATERNITY** (pp.26-27)

**Aim: To define the standards that will enable childbearing women and babies to achieve optimum health and wellbeing.**

1. To promote the best outcomes for women, babies and their families, maternity services need to be woman-focused; involving service users in all aspects of care and service provision. It is important to promote normality throughout pregnancy and childbirth, while balancing this with early identification and management of relevant social, medical and psychiatric problems. A key theme of the maternity workstrand is reducing inequalities in health and in access to services. Services will need to meet agreed standards of care for all women and babies. Achieving this will involve developing the workforce's skills and competencies and enhancing communication and teamwork between heath care professionals, with social care professionals and with women. Collecting high quality maternity information is necessary for effective audit and planning. Services also need to focus on how best to involve the father in the process of supporting his partner and his child.

2. To ensure that women and babies get the best possible care, individualised care plans based on informed choice need to be agreed by the woman and health care professionals throughout pregnancy, childbirth and into the post-birth period. Taking into account the needs and preferences of the woman and her family, a good antenatal/birth care plan offers appropriate and realistic options for place of birth, appropriate care and support in labour and is backed up by coordinated emergency care provision for both the woman and the baby.

3. In the post-birth period, the main aims are to give the newborn baby the best possible start and help the mother recover fully from the birth both physically and mentally. Postnatal services include building on the support and information to the woman and her family already given in the antenatal period; supplemented as necessary, by tailor-made plans to meet the individual needs of women and babies. Diagnosing and treating postnatal depression is key since this is known to have a long term impact on the child and the family. Services should include appropriate care for:

    - Healthy babies;
    - Babies with specific needs (for example, resulting from prematurity or disability);

- Vulnerable women with physical and mental healthcare needs, including postnatal depression and teenage parents; and
- Families experiencing pregnancy loss or bereavement.

4. From pre-conception to post-birth, all women need to have appropriate access to community, hospital and/or specialist services, including women with:
   - Healthy and uncomplicated pregnancies;
   - Complicated pregnancies due to medical, psychological or social reasons; and
   - Ethnicity, poverty or social exclusion issues, eg. prisoners, women with enduring mental health problems, women with disabilities, and women from transient populations.

5. This can be helped by: setting standards of care to reduce health inequalities; recognising cultural diversity and providing appropriate communication and support; and by providing flexible services, for instance considering innovative approaches for women who have difficulty accessing services.

***Improvement, Expansion and Reform*** **sets out the following objectives, targets and capacity assumptions:**

<u>Reducing health inequalities:</u>

- To reduce inequalities in health outcomes across different groups and areas in the country. Initially the focus is on reducing the gap in infant mortality and life expectancy at birth.
- Deliver a one percentage point reduction per year in the proportion of women continuing to smoke throughout pregnancy, focusing especially on smokers from disadvantaged groups as a contribution to the national target to reduce by at least 10% the gap in mortality between “routine and manual” groups and the population as a whole by 2010, starting with children under one year.

Improved access to services for disadvantaged groups and areas, particularly antenatal services.

## APPENDIX III

## METHODOLOGY

The methodology for this study comprised:

i) analysis of information from the national surveys of the NESS Implementation Study;
ii) telephone interviews with SSLPs identified as being particularly active in developing enhanced or new maternity provision;
iii) in-depth studies in selected SSLPs
iv) a literature review as a basis for identifying the extent to which provision in SSLPs is in line with the evidence of good practice in meeting needs

### Analysis of information from the Implementation Study

A 'map' of maternity services provision in SSLPs was made from the responses to questions asked in the NESS Implementation Study national surveys about local services that were 'inherited' at the time the SSLP was set up. For Rounds 1&2, the responses to the second national survey were used (carried out in the fourth quarter of 2001), as the information yielded from the first survey (a year earlier) had proved disappointing. Questions were redesigned for the second survey. These questions were included in the first national survey of Rounds 3&4 local programmes, completed in the early summer of 2003.

A large number of health services were asked about, including five which we used to describe maternity provision: community midwives, health visiting, antenatal clinics, breast-feeding, and postnatal depression. Further questions in the national surveys sought to identify whether SSLPs had enhanced or developed new services in these service areas. Thus we were able to identify the SSLPs with enhanced and/or new service development in the five areas of maternity provision. Information was also obtained about smoking cessation services and its inclusion in maternity provision.

#### *Enhanced and/or new maternity services*

National survey information was available for 104 of the 128 SSLPs in Rounds 1&2 and of 82 of the 132 SSLPs in Rounds 3&4. The following number of programmes reported having enhanced or developed new services in each of the five 'maternity' service areas:

| | **Rounds 1&2 SSLPS** | **Rounds 3&4** |
|---|---|---|
| Community midwives | 33 | 43 |
| Health visiting | 33 | 58 |
| Antenatal clinics | 14 | 24 |
| Breast-feeding | 26 | 33 |
| Postnatal depression | 20 | 28 |

Programmes had enhanced services in a variable number of the five 'maternity' service areas, as follows:

| | Rounds 1&2 SSLPs | Rounds 3&4 |
|---|---|---|
| No enhancement | 9 | 14 |
| One area | 14 | 9 |
| Two areas | 27 | 14 |
| Three areas | 15 | 23 |
| Four areas | 18 | 15 |
| All five areas | 20 | 4 |

Programmes had developed new services in a variable number of the five areas of maternity services provision, as follows:

| | Rounds 1&2 | Rounds 3&4 |
|---|---|---|
| No new services | 14 | 10 |
| One area | 13 | 9 |
| Two areas | 15 | 15 |
| Three areas | 18 | 15 |
| Four areas | 22 | 25 |
| All five areas | 20 | 7 |

***The most active SSLPs in developing maternity provision***

We categorised SSLPs which had both enhanced *and* developed new services in 3, 4 or 5 of the 'maternity' service areas as the 'most active' in maternity services provision. This applied to 32 SSLPs in Rounds 1&2 (33.3%) and 23 in Rounds 3&4 (18.9%), These SSLPs constitute the sample from which we sought further details in mapping the provision and identifying innovative and good practice.

To this sample we added a few SSLPs, identified as having innovative approaches from information that we obtained from Sure Start regional staff and the NESS Support for Local Evaluation team.

**Telephone survey**

A specifically designed telephone interview was carried out with a key informant in all the SSLPs identified as 'most active' in maternity provision. In addition, we sought information from SSLPs which had reported very little or no enhancement or new development of maternity provision. Only one SSLP (with no reported enhancement of services) failed to respond, and telephone interviews were carried out with 73 SSLPs in all.

The key informant in well over half the interviews was the Sure Start midwife; in about a quarter, the interview was with the programme manager. For other programmes, information was most usually obtained from a health visitor and, otherwise, from others such as a clinical psychologist or health co-ordinator. In

several instances, interviews for a single programme were carried out with more than one informant.

The telephone interview sought comprehensive and detailed information about the full range of maternity services provided for the local Sure Start community; staffing; resources; ways of working; relationships with other local services and agencies; understanding of needs and unmet needs; evidence of effectiveness; and difficulties encountered and overcome. A copy of the Telephone Interview schedule is given at Appendix IV).

**In-depth studies**

From information obtained from the telephone interviews, a sample of SSLPs was selected for in-depth study – programmes from which we were likely to learn most about differing models of maternity services provision. Seven SSLPs were selected from Rounds 1&2 and 6 from Rounds 3&4, spread across the country, and chosen to include different approaches in their delivery of maternity provision and different types of community, including inner city and rural communities and those with a high prevalence of minority ethnic groups and teenage mothers.

Certain types of local programme were excluded from the in-depth study. In order to avoid research over-load, we excluded any being studied in depth for the Sure Start Plus evaluation or as part of evaluation of the Teenage Pregnancy Strategy. However, we specifically included one local programme within a larger Sure Start Plus area. In addition, for Rounds 1&2 programmes, we avoided working where the Implementation Study Case Studies were carried out, but we included a Round 3&4 programme to coincide with a Case Study so as to work together in this SSLP. We also included a SSLP that is linked to one of the Whole Systems Demonstration Sites that have developed new models of health visiting as part of the NHS Health Visitor and School Nurse Development Programme.

***Characteristics* of the programmes studied in depth***

<u>Rounds 1&2</u> – 7 programmes

- 3 in Round 1 and 4 in Round 2
- Rural – 1, London – 1, Inner city (other than London) – 3, other urban – 2
- 2 have large ethnic minority populations, one predominantly Black and one South Asian; another programme has a homeless population and many asylum seekers
- Large – 1; Medium-sized – 5; Small – 1
- 2 programmes are in the SE Government Office Region; 1 in EE; 1 in London; 2 in NE; 1 in EM

<u>Rounds 3&4</u> - 6 programmes

- 5 in Round 3 and 1 in Round 4

- Rural – 2; London – 1; new town – 1; city – 1; small town – 1
- 1 programme has a large minority ethnic population;
- 5 medium-sized programmes; 1 small programme
- 1 programme is in the SE Government Office Region; 1 in London; 1 in the NE; 1 in the NW; 1 in the SW; 1 in EM

**Definitions*
- Government Regions: East of England (EE), East Midlands (EM), London (L), North East (NE), North West (NW), South East (SE), South West (SW), West Midlands (WM), Yorkshire and Humber (YH)
- Rural/urban – self-declared by Programmes/SSU. Others are arguably rural but they do not consider themselves so
- Population – the estimate is taken from the Index of Multiple Deprivation 2000 (figures from 1998)
- Children aged 0-3 years – from the Child Benefit records at the DWP 2001
- Ethnic group – from the 1991 Census

The in-depth studies were designed to elucidate the more innovative and creative approaches, and the factors that support or undermine their success. In each SSLP selected for in-depth study, interviews were carried out with a range of staff working with pregnant women and parents and infants, and staff with similar responsibilities in the local mainstream services, including the voluntary sector. A copy of the Staff Interview schedule is given at Appendix V. An average of 10 (range 5 to 15) staff interviews were carried out in each SSLP.

Information was also obtained directly from mothers who had had a baby within the previous six months, via focus groups and individual interviews (Interview schedule at Appendix VI), and on average, 8 mothers were seen (range 3 to 12) in each of the in-depth study SSLPs. In two programmes, a father was interviewed.

## Literature review

The literature review is based largely on relevant reviews carried out for other purposes, eg. the Inquiry into Health Inequalities (DoH, 1998), and an active search of more recent literature, published up to the end of April 2004. A summary of the literature review is given in Chapter 6, with the full review and references at Appendix III.

## Analysis

### *'Map' of enhanced maternity services*

All the interview material was coded by hand by the lead researcher, with detailed systematic recording, collation and analysis of the data according to grounded theory methods (Charmaz, 2003). The amount and quality of the information we obtained from each programme varies to some extent, depending upon the particular members of staff and the mothers we interviewed and their knowledge and background experience. This means that we have rich information on certain aspects of maternity services from some programmes and similarly detailed information on other aspects from other programmes. The study was not designed to provide an epidemiological description of all maternity provision within SSLPS but, above all, to identify innovative and good practice.

The data come from SSLPs selected as those most active in the provision of maternity services, and from which it was most likely that we could learn about good and innovative practice; we specifically sought details to this end. And although selected according to a range of background characteristics, the in-depth study sites are not representative of all SSLPs. Neither denominators nor numerators can be stated with confidence. For these reasons, exact numbers and proportions are not given in the findings, although, where possible, an approximate figure is given to indicate the extent to which a particular type of characteristic or activity is found. However, when information from all the programmes studied in-depth is examined along with that from all the telephone interviews, we can report with a good deal of confidence on the models of maternity services in Rounds 1, 2, 3 7 4 Sure Start local programmes, the range of services that they provide, and their strengths and weaknesses.

***Description of good practice***

This is based upon the ways in which our findings on maternity services provision in SSLPs matches the evidence for good practice from the research literature, including indicative evidence. The term ‘effective’ is used for approaches that have been shown to be so in rigorous studies; ‘good practice’ for approaches that have been welcomed and liked by staff and/or mothers and reported to be of benefit, and that have positive process outcomes such as increased take-up of services; and ‘promising’, where an approach is clearly along the lines indicated by what is known of effective and good practice but has not yet shown benefit.

Copies of this publication can be obtained from:

DfES Publications, PO Box 5050, Sherwood Park, Annesley,
Nottingham, NG15 0DJ; Tel 0845 6022260; Fax 0845 6033360;
Textphone 0845 6055560; E-mail mailto:dfes@prolog.uk.com

Please quote reference: NESS/2005/FR/012



ISBN 1 84478 579 3