Evaluation of the use of health care assistants to support disadvantaged women breastfeeding in the community

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1. Introduction

This report describes the initial evaluation of a small-scale project using a Health Care Assistant (HCA) in the community to support women in infant feeding. The project was set up in 2001 as a collaboration between a local Sure Start programme and a maternity service that was part of the local NHS Trust. It was funded by Sure Start Coningham for a pilot period of fifteen months to meet the Sure Start national targets regarding guidance on breastfeeding. The evaluation was funded as part of the Department of Health's Infant Feeding Initiative.

The project had a number of aims. In particular to

- Increase rates of women making an informed choice to breastfeed in a diverse area with pockets of deprivation
- To enhance general levels of support to new mothers
- To develop more communication and inter-disciplinary work between agencies such as Sure Start, the health visiting and the midwifery services
- To explore how far the role of a Health Care Assistant in maternity could be shifted from a hospital to a community base

In addition, the research team aimed to explore and develop further the evidence on the forms of support likely to be effective in helping women to breastfeed.

Both the pilot project and the evaluation were planned to take place over a one-year period. However, delays in appointment of the Health Care Assistant meant that the evaluation was only able to track the very early stages of implementation. This is reflected in the focus of this report. Additionally, this and the small scale of the project placed limitations on the numbers of women included in the study. As a result the data, outcome figures in particular, should be interpreted with caution. We plan to continue to follow progress and outcomes for a longer period.

The evaluation gathered qualitative and quantitative data on the planning and implementation of the project, the views and experiences of the different stakeholders involved and on the rates of breast, mixed and formula feeding in the project area. Both primary and routine data were included. In this report we outline briefly the background to the project, the research methods used, key issues arising in the process, the role of the Health Care Assistant in practice, the experiences of local mothers and the early evidence of potential impact on rates of breastfeeding.

2. Background

Background to the project

This project was developed in an area of London that had recently been identified as part of the government's Sure Start scheme. Although very diverse, it included a high level of temporary (B&B type) accommodation, a high number of refugees and high levels of relevant indicators including teenage pregnancy, low birthweight, childhood accidents and health problems, and poor parental literacy and numeracy. Key Sure Start targets include reducing infant emergency hospital admissions and giving guidance on breastfeeding. Data for breastfeeding rates were not available locally. However, an earlier maternity services research project in the local area that included this ward found that in 1994/5, at 6 weeks, only 39% of mothers receiving caseload midwifery care were fully breastfeeding and 26% partly. By 3 months this had fallen to 19% and 24% respectively. In 1997/8, at 2 weeks, 41% were breastfeeding fully and 21% partly (McCourt & Page 1996, Beake et al. 2001), suggesting a slight improvement in the period leading up to this study.

Initial Sure Start documentation indicated around 174 births per year in the area. Local women generally booked for maternity care with the nearby NHS Trust that was the main partner in this project. This was a large, obstetrically-led teaching hospital but midwifery care locally was provided by caseload midwives working in group practices, with a high level of continuity of carer and community-based care. Care is midwifery-led where appropriate and the named midwife provides continuity for women on her caseload, working closely with a midwife partner and collaboratively with other relevant professionals. Most women received postnatal care from midwives who had provided care antenatally and for labour/birth. The midwives were able to operate a selective visiting policy, enabling them to vary the pattern of visits and time given, to focus care where needed. Earlier research had shown that the visit time was longer and more varied than in the conventional community midwifery service. Nonetheless, a need for more support to new mothers was perceived. These visits were intended to supplement rather than substitute for existing levels of midwife and health visitor support.

Relevant literature

Existing research and service audit has identified gaps and problems in the support women receive for breastfeeding, as well as for other aspects of care postnatally (Ball 1994, Audit Commission 1997, Garcia et al. 1998, McCourt et al. 1998). The value of practical and social support for adjustment to parenthood and for breastfeeding is well established in the research literature. However, there is little evidence that additional professional midwife support is necessary or superior to other possible arrangements for additional support, for example, from peers or community members (Schafer et al. 1998). Much of the literature on lay

support is based in the US, however, where there is no community-based midwifery and postnatal home visiting is not the norm.

A literature search found little research into the effects of non-professional support for breastfeeding in the community in the UK. A recent in-depth study found that practical, role-modelling forms of support were most likely to have a positive impact on socially disadvantaged mothers' intentions and success in breastfeeding (Hodinott 1999). A recent trial of peer counsellor support also found that women valued non-judgmental listening, reassurance and encouragement to keep going. However, it did not show evidence of effect on breastfeeding rates (Taylor personal communication). A further UK evaluation of breastfeeding support workers, although only a small project, suggested that the use of support workers in an area of social deprivation had been of benefit in promoting and encouraging mothers to breastfeed (Battersby & Sabin 2002). As lengths of hospital stay decrease in the UK, it is anticipated that many women will need additional support at home and this is likely to have particular implications for disadvantaged women.

A prospective, randomised controlled trial of the effectiveness of community postnatal support workers in the UK, although much valued by the women concluded that there were no health improvements in the study group (Morell & Stapleton 2000). However this study did not focus on infant feeding or target women living in an area of deprivation or lacking social support.

Although there has been very little experience of use of Health Care Assistants in the community to support breastfeeding in the UK, there are some other models of community- or home-based practice that might be drawn on. These include the maternity aides established as a service in the Netherlands – where home birth has remained relatively high – and use of trained nursery nurses as assistants to health visitors. However, the support provided by Dutch maternity aides is more general and takes place within a very different system of maternity care. Similarly, the work of health visitors is somewhat different in that the assistants have greater formal training and they work in a more tightly planned way, with the health visitor. There was little evidence therefore, apart from the Glasgow CMSW study, of how such a role, with a high level of independence and a relatively open remit, might work in practice (McInnes & Stone 2001).

3. Evaluation methods

The evaluation aimed to examine breastfeeding rates as well as monitoring how the scheme was implemented and the reactions of both professionals and women involved. It used a comparative, longitudinal design, comparing levels of care and breastfeeding rates before and during the first year of the Project. The research methods included audit of activities and outcome data and qualitative analysis of the implementation of and responses to the scheme.

The main outcome measures were rates of full breastfeeding or mixed feeding at birth and at 6 weeks and 4 months postnatally. Secondary outcomes included women's satisfaction with the support given and whether it was perceived as helpful in other ways - such as for self or baby care, postnatal symptoms or confidence.

This evaluation took place very early in the life of the project – and this was added to by bureaucratic delays to implementation, and a prolonged wait for police checks. Additionally, since this was an innovative scheme, with little prior experience of the workings of such roles in the UK, the evaluation needed to monitor and document the nature of the intervention, and to develop a good, analytical description of the implementation of the project.

The specific methods of data gathering were as follows:

1. Baseline data

This was intended to provide a profile of feeding patterns and support offered to postnatal women before the project was implemented. In addition to figures on feeding and postnatal support, women's reports on the problems experienced and need for support were also obtained.

- Collation of routine records on pre-project breastfeeding rates for women giving birth with this Trust and living locally

- Audit of Midwives' records of postnatal visiting and support for feeding (appendix 1)

- Women's self-reports of infant feeding in pre-implementation questionnaires (appendix 2)

The pre-implementation period was also used to pilot all data collection tools, including the women's questionnaires.

Initially this period was expected to be 3 months. Due to delays in the Health Care Assistant appointment, baseline data were collected for a six-month period.

2. Process data

The intention was to document the nature and process of the support intervention to provide a descriptive analysis of the implementation and conduct of the Project.

- Unstructured interviews with the members of the working group.
  All members were interviewed to obtain their reflections on the implementation and early impact of the project.

- Analysis of Health Care Assistant record forms
  A form was developed to record all support activities and the feeding patterns of all women included (see appendix 3).

- Women's comments about care and self-reports of feeding on a postnatal self-completion questionnaire (see appendix 2).
  This was sent at 6 weeks postnatally to all women identified for involvement in the project, with a reply paid envelope for return to the University and contact details for queries. Reminders were given to non-responders, by telephone when possible.

- Focus groups with midwives and interviews with the HCA on their perceptions and experiences of the scheme.
  Initially this was planned to take place early in and again towards end of pilot. Due to project delays only the initial interviews were conducted.

- Individual semi-structured interviews with women who had been offered Health Care Assistant support, conducted at about six weeks postnatally.
  These were planned to avoid loss of data due to skewed and poor questionnaire response rates in areas of social deprivation and to obtain greater depth of understanding of what women find helpful in supporting feeding. All women who had received Health Care Assistant support in the period mid May to June (i.e. the first to receive support) were invited to participate and six interviews were conducted.

- Audit of midwifery postnatal support during the scheme to compare with baseline levels of support.

Midwife record forms developed for the scheme and piloted during the baseline period were used to assess levels and types of midwifery support given (appendix 1). The plan had been for a before and after comparison, however of the 23 charts completed only 2 were during the period when the health care assistant was in place.

During the period of the project, the community services were completely overhauled with caseload midwifery extended to the whole community service, approximately doubling the number of caseload midwives. With such a major

reorganisation of the community midwifery services, the priorities of the midwives were with settling into a new way of working.

3. Outcome data

Data on breastfeeding rates following implementation were collected from three sources as described above (and see table 1-3 below)

- Routine hospital records
- Health Care Assistant record forms
- Women's self-reports on questionnaires

Design of Tools (see appendices for copies)

Record forms – These were intended to be simple forms for midwives and health care assistants to be integrated with routine record keeping and continued in use at the end of the formal evaluation period.

Questionnaires – The aim was to develop brief questionnaires that do not depend on very high levels of literacy, to focus on women's perceptions of the support provided and recollections of what was done as well as their infant feeding since birth.

Focus group and individual interviews – an open approach was taken using a semi-structured topic guide. All were tape-recorded for detail and accuracy of recording.

Response

Total number of women recruited: 84 (December 01 – August 02)

Women's questionnaires and interviews

Number of questionnaires returned: 44/84 (52%)
Number of questionnaires returned **before** HCA input: 33/59 (56%)
Number of questionnaires returned **having** HCA input: 11/25 (44%)

Note: the number of women receiving HCA input was 28/84, however 3 were recruited after the baby was 4 weeks of age and as such excluded form the total of women returning questionnaires having had HCA input. It is also worth noting that during the period of HCA input telephone reminders to participants were reduced as this coincided with the summer holiday period.

In total 6 interviews with women were conducted of 9 women approached.

Midwives and HCAs record forms

Midwives record forms returned for each woman recruited 23/84
Note of the 23 completed forms from midwives only 2 were for women having HCA input.

HCA record forms were completed for all women having HCA input.

Professionals Interviews/focus group

The midwives focus group was attended by 14 midwives.

Interviews were conducted with the two Health Care Assistants, the midwifery manager, the Sure Start representative and the Sure Start health visitor.

Ethics

All data were treated as confidential and stored securely. Women's questionnaires were coded to ensure confidentiality and all participants were assured that their personal views will not be fed back into or affect their work or care on a personal level. Ethics permission was obtained from Hammersmith Hospitals NHS Trust.

Analysis

Audit and outcome data were analysed using descriptive statistics. Very small numbers included due to the short time run of the project precluded the use of inferential statistics. Qualitative data were analysed by open coding to identify themes, using principles of case-oriented data analysis. Open comments on forms and questionnaires were analysed using content analysis.

4. The process of implementation

Aims and Intentions

The aims and intentions for the post have been described above. However, key objectives can be summarised as

- To offer support to women around infant feeding
- To improve breastfeeding rates, in line with Sure Start health improvement targets
- To develop inter-agency and inter-disciplinary work

The Health Care Assistant post was funded for a pilot 15 month period by Sure Start and the evaluation funded by the Department of Health Infant Feeding Initiative. The Sure Start programme for this area had been developed without earlier midwifery involvement and this project was seen as a chance to re-establish communication and collaboration between hospital- and community-based services and between midwives and health visitors, that had been undermined by the way services were organised from the 1970s to 1990s. The Health Care Assistant would be part of the Sure Start muti-disciplinary team but employed by the NHS Trust maternity service and would work across such boundaries.

Despite the lack of prior collaboration, the philosophy and understanding of the qualities sought for the post were shared and there was a strong commitment to working together around the needs of women and families. The Health Care Assistant role was seen as additional to and different from those of professionals: midwife or health visitor. Qualities sought in the post-holder were:

- Ability to listen
- Able to understand and work with women and families needs
- Interpersonal and communication skills
- Maturity and life experience
- Ability to manage autonomy and boundaries
- Ability to ‘engage’ rather than ‘teach’

Specific expertise on breastfeeding or infant feeding was not required since the job was not intended to substitute for professional support and full training would be given. However, a candidate with personal experience of breastfeeding and some relevant experience – such as working with community groups, working with mothers/babies - was sought (see appendix 4 for details of job specification and description).

The workload and activities could not be planned in fine detail since the proportion of women likely to need or request support was not known. Also, since this was an innovative project, with limited prior experience of such roles, much

would need to be developed in practice. Initially, it was agreed that eligibility for support would be determined by midwives, using clear and simple written guidelines. After further discussion this plan was amended, and the period of involvement extended to commence antenatally, from 32 weeks, and to continue, if needed, through to 4 months postnatally. The cut off point was agreed partly in line with health improvement targets set for Sure Start programmes – to increase rates of women initiating breastfeeding and still breastfeeding at 4 months. Antenatal contact was considered important since many women make decisions about feeding before birth. In practice the Health Care Assistant assessed each woman's needs and arranged her visits accordingly.

Details of the role as it worked in practice and from the perspectives of women and service providers are given below.

Project Planning and Management

A project working group was established that included the Sure Start manager and Health Visitor, the relevant Midwifery Manager, the midwife nominated to act as the Health Care Assistant supervisor, researchers and a consumer representative. The group met at regular intervals first to develop and then to co-ordinate and monitor the project.

The Health Care Assistant was employed by the NHS trust maternity service with day-to-day management provided by a midwife co-ordinator with a specific interest and expertise in breastfeeding. Overall line management and supervision was provided by the Midwifery Manager (community/caseload midwifery and birth centre). Although clinical supervision was by midwives, the Health Care Assistant was expected to liase closely with the Sure Start health visitors, as part of the Sure Start team and using the Sure Start programme as a work base.

These arrangements were formally planned but also required refinement in practice once the project started. This kind of inter-agency and inter-disciplinary work was not well established in the area and the Health Care Assistant needed to work across two quite different organisations with different structures and traditions. She would need to work closely with Sure Start community-based multi-disciplinary team such as health visitors as well as midwives, where traditionally women had been passed on from midwifery to health visiting, with little contact or overlap, except around specific problems. Clear lines of referral and consultation, as well as management, were needed.

Once a clear job description, specification and criteria had been developed (see appendix 4), the next important step was to refine and review supervision and management arrangements, role definition and boundaries.

The appointment was delayed by a number of bureaucratic problems. Key aspects were job grading – although the hospital had established use of Health Care Assistants, these were hospital ward based and carried less autonomy and

responsibility – and police checks which were subject to severe delays at the time. As a result, an existing member of staff in a Health Care Assistant post was seconded to the project for a short period. This was useful since it allowed a person with experience of working with midwives locally to establish the position, and also provided researchers with two individual perspectives on the role (interviews were conducted with both).

Key areas to be worked on were

- Further definition of the role including boundaries
- Lines of referral to and from the Health Care Assistant in a multi-agency and multi-disciplinary setting
- Support, supervision and management arrangements

Defining the role

The role carried a high level of autonomy and responsibility since the Health Care Assistant was visiting women independently at home and planning support with the woman. Additionally, although clearly focused on infant feeding, the support was intended to be different from that offered traditionally by professionals and likely to be somewhat broader. It was important for all those involved to define what forms of support would be included and what the limits to this were. Similarly, when the Health Care Assistant should provide that support and when it was appropriate to refer on to other professionals.

In the early weeks of the project, with busy midwives unfamiliar with this way of working, there were few referrals. Therefore, an introductory visit was made to all new mothers in the area where the Sure Start facilities were introduced and the mother's needs around feeding assessed informally. If the woman wanted additional support, further visits would be arranged, taking the woman's desire for support as the cue. At this point, the Health Care Assistant reported that women had a number of general problems or support needs that were not directly about breastfeeding but likely to impact on it – such as problems with older children, dependent relatives and other health problems. At this stage, she offered very general social support. As the project developed and the numbers of women identified needing support increased, the work became more tightly focused around infant feeding and the Health Care Assistant used her base within the Sure Start project to ensure women had access to the other support services available locally. These included drop-ins for new parents, parenting groups, and support from a Sure Start health visitor able to provide home visits.

Lines of referral

Referrals to the Health Care Assistant

As noted, the original planning for the project had been for midwives to refer women to the Health Care Assistant. This was quickly changed in the light of early experience. In the early weeks of the project there were very few referrals

from midwives. As a result the Health Care Assistant developed informal methods of identifying women in the area, including consulting the hospital delivery registers and this proved to be effective.

As the project became established and with the appointment of a new midwife co-ordinator, lines of communication and awareness of the project improved and numbers of referrals increased steadily. However, the Health Care Assistants also developed an effective way of working that did not depend on formal referral, with a short introductory letter and visit to contact those women who wanted additional support. In effect, this meant the project was highly centred on the women's own definition of need, but did not depend on women having the confidence or knowledge to seek this out independently.

Discussion with all those involved indicated that a number of factors were at play:

1. Midwives' awareness of the project was not high, beyond the few midwives who cared for many of the women in the immediate area.

Although information had been provided, this was an extremely busy period with midwives having recently undergone a number of major service changes – a move of hospital site, development of a birth centre and extension of caseload midwifery - and they were just settling into new roles and arrangements. Additionally, staff changes meant the midwifery co-ordinator was not in place in the immediate implementation period. Once a new co-ordinator was appointed she was able to establish very effective communication systems.

Midwives also pointed out that the area involved did not gel well with the boundaries of their own service. They were caring for women in a wider local area that they saw as equally deprived and felt unclear on a day to day basis about who could be referred, and about why some 'local' women could receive support but not others.

2. Midwives' had a number of concerns about the use of a Health Care Assistant in the community to support breastfeeding

Concerns were particularly around competence, training and support and knowing the limits of the role. For example:

- The type and amount of training offered and background experience
- Whether inconsistent advice would be given
- Whether inappropriate or 'out of date' advice would be given
- Whether another role would interfere with existing patterns of care
- Whether, when and how the Health Care Assistant would refer problems, and to whom (midwife, breastfeeding advisor or health visitor)
- Whether the Health Care Assistant would offer advice in other areas not trained for

It was clear that midwives would not refer women without information and reassurance on such issues and some expressed the need to know the Health Care Assistant first – once confidence was established they would feel more able to work with her.

3. Midwives had some concerns around role boundaries and the likely impact on their practice

In addition to issues such as training and competence, some midwives were concerned about the impact of such developments on their roles. For example, would Health Care Assistants be used to substitute for their roles? However, they valued the idea of working with someone who would have additional time to spend with women, for observing feeding, talking to them and providing the more general support that they perceived to be important.

Referrals from the Health Care Assistant to other professionals

This was an area where both midwives and health visitors had expressed concerns early in the project. They needed confidence that women would be referred back to them appropriately and that the Health Care Assistant would not attempt to work alone, or extend the boundaries of their role. This was challenging since, in a new model of practice, and one aiming to offer general support, the boundaries had been left deliberately broad at the outset. Initial concerns were allayed however as the Health Care Assistant developed ways of working across organisational and professional boundaries, communicating with the appropriate professional when concerned – for example, where women may be depressed or need other types of support.

Support, supervision and management

The planned arrangements with day-to-day supervision by the midwifery co-ordinator, overall management by the midwifery manager, a base within the Sure Start team and liaison with health visitors was new and complex, leaving potential for confusion or gaps to develop. However, they proved to be effective and the link role of the midwifery co-ordinator was seen as crucial in this respect. Despite differences in organisational base, a shared philosophy of woman and family-centred care was also valuable in supporting such arrangements.

A two-week induction program was planned, with one week spent at Sure Start and one in the hospital. This included the usual employee training (such as health and safety) plus specialist breastfeeding training, participating in workshops (two days) with midwives as part of the ongoing Baby Friendly programme. The post was graded at Health Care Assistant level iii (a higher level than when working on hospital wards) and in a continuing post, the Health Care Assistant would be expected to participate in NVQ training established within the unit.

5. Perspectives and reflections on the work

Role and activities of the Health Care Assistant (HCA)

The HCA was expected to provide additional support to women, focused around but not limited to infant feeding. The nature of this support would lie somewhere between professional – as provided by midwives and health visitors – and 'lay' or peer support. Research evidence on breastfeeding promotion suggested that non-professional support may be particularly effective, but such schemes may be difficult to develop in practice on a large-scale. This was an attempt to provide non-professional support within the public services, and to experiment with extending the established role of Health Care Assistants into a community base.

This section outlines the roles and activities of the HCA as understood by women receiving support, by midwives and health visitors and by the HCA herself.

Health Care Assistant's views

Activities

The Health Care Assistant's role started antenatally if a woman was referred by a midwife. This might be due to concerns and questions expressed by the woman – for example, about difficulties with a previous baby or uncertainty about whether to breastfeed. These referrals were only beginning to be established at the end of the study period, however, and it was not possible to form any view on the potential benefits of antenatal contact. The possibility of the Health Care Assistant participating in Sure Start antenatal parent groups was also being discussed. However, she felt it was beneficial to have made contact with women before birth. Women also noted the value of having met someone previously who they could call on if problems arose.

To contact women postnatally, the Health Care Assistant checked the birth register regularly, although it was hoped that this time consuming approach would be replaced by regular listings from the hospitals computer records. She then made a brief visit to women in hospital, or at home, in the early postnatal period. If women wanted more support, further visits would then be arranged. In the initial visit she introduced the Sure Start services and generally enquired about how the woman was 'getting on' before discussing feeding – partly to avoid feelings of defensiveness in women who might otherwise feel pressured about breastfeeding.

In general she saw the need to listen to women, sit with them and encourage them as central to the role. She also noted that many women had broader problems that related to or impacted on their ability to breastfeed: if the woman was stressed or anxious for other reasons, feeding would become more difficult. This was taken into account in her approach, but more complex general needs for support were referred to the Sure Start health visitor.

Within this broad remit, she found some specific forms of support were commonly needed. Some key examples include:

- *making yourself comfortable*
- *Confidence about sufficiency of milk*
- *Not expecting life to go "by the book"*
- *Reinforcing knowledge*
- *Establishing feeding*
- *More general help for women lacking social support*
- *Referral to others*

- *Making yourself comfortable*

Many women were attempting to feed in an un-relaxed position and with poor posture that could cause pain and fatigue. She experimented with women in use of seats and cushions, and advised women to take a little more time to ensure they were comfortable before feeding. Trying different things out helped women to see the advantages through direct experience. She then focused on positioning the baby and the importance of 'bringing the baby to the breast' rather than bending forwards to the baby. This approach would include measures such as 'making sure you have a drink by your side' or sitting a potentially fretful toddler beside you with a book to share and a drink.

- *Confidence about sufficiency of milk*

Many mothers, especially with first babies, expressed anxieties about whether the baby was getting enough milk – since they can't measure or see breastmilk as with bottled milk. She discussed other ways that women could 'see' or 'know' the baby was getting enough milk that would increase the mother's confidence. For example, looking at the baby's thighs to see how it was 'filling out', observing the baby's behaviour and when contented, learning to distinguish between different types of cries, feeling the let-down reflex and observing the way the baby fed.

- *Not expecting life to go "by the book"*

She observed that many women were anxious and disappointed because their experiences seemed to differ from what was presented in books and magazines. She encouraged women to feel reassured that all experiences were different, not conforming to an ideal and that they would gain confidence with experience and practice.

- *Reinforcing knowledge*

Although most women were aware of key benefits of breastfeeding, she felt able to keep them informed about less well-known benefits. She kept a file of magazine and paper cuttings to share with women. She also informed women about the underlying workings of aspects of feeding they were less familiar with. This included the importance of latching on effectively, different qualities of breastmilk during the feed, the relationship between suckling and supply and how

'top-ups' with formula could interfere with this, reinforcing problems with sufficiency of milk.

- *Establishing feeding*

She noted that as many women leave hospital very early, the initial few days of establishing are usually undertaken at home, at a time when women may previously have been in hospital with staff constantly present, even if very busy. She was also aware from women's reports that many found care in hospital in the early period inadequate, confusing or unhelpful.

- *More general help for women lacking social support*

She noted that many local women do not have family around to help and that many have no, or very limited, experience of young babies. Consequently they often lacked basic knowledge such as how to change a nappy or bath a baby. This was increasingly important with very early hospital discharge. However, rather than trying to provide all support herself, after the very early days she encouraged women to attend community groups and took opportunities to put women in touch with others, for mutual support.

- *Referral to others*

Where she felt women might be depressed or have more long-term or complex needs she put them in touch with health visitors or other appropriate local services (e.g. Babytalk, Weaning Group, Parents To Be Group). This might include referral back to midwives, a breastfeeding specialist or GP where the breastfeeding problems might require this, for example, mastitis or suspected infections.

Midwives and Health Visitors' views

Midwives and health visitors welcomed the opportunity to provide additional support to women with infant feeding and generally regarded the project as having been positive.

Both shared initial concerns around role boundaries that have been discussed above, under implementation. The potential diffuseness of the role – offering more general support – and the issue of appropriate referral were of concern to both. However, they welcomed the way the role worked in practice. Both felt the role should be clearly focused on infant feeding, rather than extended into other, more general forms of support and that women with more complex needs or problems should be referred to midwife or health visitor. Health visitors also emphasised the value of accessing other forms of community-based support outside the home – such as drop-ins and parent groups – in addition to visiting at home and noted that the project had been helpful in ensuring that new mothers were informed about such facilities and invited to them in an encouraging way.

Particular aspects of value included:

- giving reassurance and confidence- they suggested that if there is a problem just having someone around can make women feel more confident
- able to visit women still needing feeding support after discharge from midwifery care
- having the time and flexibility to stay with a woman to observe feeds where there is a problem
- being able to identify when a woman is isolated and put her in touch with other mothers for mutual support

All these aspects echoed closely what women themselves emphasised.

Women's views

From the women's accounts, the HCA's role can be divided into three main areas:

- *Practical/technical support*
- *Information*
- *General and social support*

All were key aspects of the role but the latter was more highly valued and emphasised by the women, particularly during interviews. This may reflect a greater focus on the former by professionals: women's accounts of midwives' roles in supporting feeding tended to describe mainly technical/practical support and information.

- *Practical/technical support*

Practical/technical support involved activities such as help with 'positioning' and 'latching on'. The fact that the HCA had time to sit with women and observe them was seen as particularly valuable in this respect. For example:

'She offered me very practical advice, she was watching me do the breastfeeding and trying to give me pointers on how to improve. She was encouraging, positive and supportive. She said it was fine to do what you are doing but try it this way and try that' (*Miranda*)

' home visit from person specialising in breastfeeding and with time just for that would have been really welcome, and beyond the initial two weeks' (pre-implementation questionnaire – open question)

- *Information*

Information giving was linked to such support, and fell into two main types

- ‘tips’ – suggestions on how to prevent and deal with problems such as soreness etc.
- underpinning information – on the mechanisms of breastfeeding, sufficiency of milk etc.

It was apparent from all the women’s accounts that the type of information needed was quite different from that sometimes found in health promotional literature and antenatal visits or classes. All were aware of the health benefits of breastfeeding but their knowledge of the practical aspects and their underlying physiology – such as the relationship between frequency of suckling and supply of milk – was less full. (Different forms of knowledge- theoretical and experiential are discussed further below.)

- *General and social support*

General, social support was discussed in great depth in the interviews and was clearly highly valued by the women. They emphasised the importance of general encouragement, gaining confidence, and knowing there was someone available to help and to talk to.

> ‘but there is a thing in your mind thinking OK there is support already there and I’m not on my own’ (Miranda – talking about the value of meeting the HCA antenatally)

> ‘she’s like colic baby, she has always got wind and all that and she would always come and find out how she’s doing and how she is feeding and how she is getting on, you know, it’s encouraging’ (Femi)

The importance of the HCA’s approach – friendly, encouraging, non-dogmatic and non-didactic - was evident from the women’s accounts. For example:

> ‘because she’s a friendly person I found it useful. Let me say that because I enjoy her coming round because she’s nice, you know, when she comes round she feels at home and you’re comfortable around her kind of thing, so I love her coming round’ (Ola)

Similarly, the continuity of ante and postnatal visits by one person and the relationship that could be formed was valued. This woman continued:

> ‘that made a big difference because you don’t often see, when people come round like that they just do what they need to do and go. There’s no relationship or anything, but her coming round is also relationship-based, She’s not coming round just to do her duty, she comes to build a relationship and that actually makes you feel comfortable around her, to actually talk to her and open up to her’ (Ola)

This woman had longer-term questions and concerns but she had not contacted the HCA since the changeover of staff (see project implementation above) meant she did not have a number to call. She explained that she would not generally approach someone else for help without an established relationship:

'I wouldn't have had that liberty to call somebody else if they were not as friendly as she was to me because I would have thought they might think I was bothering them'.

This was sometimes contrasted with that of professionals, who were seen by some women as too dogmatic, trying to persuade women to breastfeed, or unrealistic:

'it's all very well saying you must breastfeed, yes, you must do this, but they don't know, they haven't done it' (Miranda - twins)

'my gut feeling is that sadly the vast majority of professionals offering advice to new mothers on breastfeeding have no experience of breastfeeding themselves and this creates a confusing discrepancy between advice offered and the realities of the experience. I put the reason why so many people stop breastfeeding relatively early on down to this fact' (pre-implementation questionnaire, open question)

'feel that pressure to breastfeed exclusively of "NCT style" breastfeeding Nazis approach actually puts lots of women off – surely some feeding is better than none.' (pre-implementation questionnaire – open question) referring to midwives.

Issues in breastfeeding support – themes emerging from the women's accounts

This discussion is based on two key sources

- interviews with six women who received HCA input
- responses to open questions in questionnaires before and after the implementation

It looks at the main areas of concern women expressed about infant feeding and the ways in which they discussed the nature and value of the support given. The themes also explore general issues that are likely to be pertinent to women's infant feeding patterns. The key themes identified were as follows:

- *Support*
- *Concepts of breastfeeding*
- *Knowledge about feeding (different forms and sources)*
- *Problems: Reasons for introducing formula/bottles*

- *Support*

This was the main theme arising in the women's accounts and has already been discussed under the heading 'role of the HCA'. The main types of support women perceived were noted above - *practical/technical support, information and general and social support.* With or without difficulties, all the women valued the idea of a support person being available, and several noted that just knowing about such a person, even if not called on, would be reassuring. The general social support was particularly valued and emphasised and a number of women

commented positively on the time available, especially being able to sit with women, talk about things and observe feeding, and the continuity or regularity of visits available over a period of time. For example:

'I would have like someone to come and spend time with me observing how I was feeding my baby and offer advice in the context of my baby's demands' (pre-implementation questionnaire)

- *Concepts of breastfeeding*

By *concepts,* we mean the understandings and attitudes that tend to make up different women's basic views and disposition towards breastfeeding. The women interviewed could be grouped to some degree into two basic dispositions. With such small numbers, this is merely suggestive, and could not reasonably be generalised, but it may be worthy of further exploration and research.

- Breastfeeding as normal, natural, everyday and essentially easy, even if after some initial problems
- Breastfeeding as ideal but difficult, hard work, uncomfortable, a struggle

The first disposition was found in women who were breastfeeding fully, sometimes for extended periods, although some introduced mixed feeding, and who did not see themselves as having problems needing support. In this very small sample, all the women from minority ethnic groups shared this disposition. Such women described breastfeeding as more convenient and less trouble than using bottles. For example:

'it's easier when you go out, you don't have to carry all those bottles and everything, so it's easier and also it brings a bond to life' (Ola)

'breastfeeding is easy for me – just take out breast and give it to baby. Bottle, go to kitchen, wash bottle, sterilise, don't know what, warm the water, mm, sometimes milk too hot, wait until coming cold, baby cry too much' (laughs) (Fatima – *1st baby weaned early due to lack of help with problems, hopes to feed this baby much longer*)

'I think it's more the convenience of it. I don't have to get up in the night or make bottles. And I've got so much breastmilk I do not need to worry' (Femi)

The second was found in women who had expected to breastfeed and viewed it as ideal for babies, but experienced the reality as very different from their expectations, including those conveyed by professionals. For example:

'I said, will I produce enough and they said, oh yes, of course you will. Now I realise that they don't have twins…. I was trying to breastfeed. L was particularly bad at latching on. He would hit me and thrash around and they didn't latch on really at all' (Miranda – twins)

‘Breastfeeding isn’t easy and I would have loved it to be and still be able to breastfeed my second child. I hope if I have another child more help will be available.’ (pre-implementation questionnaire)

One aspect of concepts of breastfeeding that emerged from women’s accounts was the issue of measurement. Several women expressed concerns about or a focus on measurement, and these tended to be women who had introduced feeding by bottle. It appeared that for some women, the ability to visualise and formally measure the amount of milk taken was important and reassuring. This was accompanied by concerns about sufficiency of milk, babies’ weight, fluid intake, babies’ bowels and so on. Those women who expected to breastfeed without introducing formula for an extended period did not mention such issues. While all women were concerned about contented babies, some appeared to need external reassurance in addition to their own observation and embodied knowledge.

One woman – who had particular reasons for feeling anxiety with twins born prematurely – illustrated the degree to which such a focus on measurement was set in train by hospital neonatal care, but could give her a sense of control and reassurance:

‘ initially I had enough because I’d do about a litre a day but now they take 800 or 900 each there’s no way…

..all I need to do is look and see and then if they are really bad in the evening I can, like yesterday I said, well they haven’t had enough in the day and that is probably why they are bad now’ (Miranda - explaining the need to introduce formula and the calming effect of keeping feeding charts)

- *Knowledge about feeding*

In the interview analysis, we noted two key forms of knowledge that were drawn on by the women in differing degrees:

- Theoretical (or formal) knowledge
- Experiential (or tacit) knowledge

Women who had previously breastfed children were more likely to draw on and have confidence in experiential knowledge, but this was not necessarily or always so. Confidence in experiential knowledge also tended to be higher where breastfeeding was regarded as ‘normal’. One woman, for example, who expected to breastfeed her baby for a year or more, as with her older children, could not say where her knowledge came from, but appeared to rely very little on professional input or advice. This was reflected in the more personal and general way she spoke about the benefits of breastfeeding:

‘I find that it’s bonding, they’re more comfortable, they’re generally happy’ (Maria)

Several women spoke of advice and encouragement from family members to continue with breastfeeding, although most were geographically isolated from family support.

Some women relied more strongly on formal or theoretical knowledge – such as information and advice from midwives – and this was reflected in the language used around breastfeeding. All were well aware of the health benefits, whatever their basic attitude towards breastfeeding. One woman was very critical of the theoretical knowledge of professionals – viewing it as unrealistic – and valued the HCA's personal experience and 'down to earth' approach and 'practical advice' strongly, yet found her own approach to feeding and baby care was very led by her hospital postnatal experience:

'I think they think you've been trained because you have had the month or how many weeks, but you're not, you are brainwashed into thinking that hospital is normal and it's not at all, is it' (Miranda)

In contrast, one woman relied mainly on experiential knowledge and felt she didn't need professional support but nonetheless, she valued the information that the health care assistant and health visitor had given to add to this and would have liked more advice with her first baby. For example:

'she told me one thing about breastfeeding, when you breastfeeding its alright to continue, you know, continue, no stop the baby and change another breast because first milk, second milk, third milk, you know what I mean?' (Fatima)

Similarly, this woman was confident in her own knowledge and experience, but still really valued information on the physiology of feeding:

'more explanation about brest feeding beforehand. Ex – I did not knew that the actual milk coms after couple of days. So simple but I did not knew and no-one told me.' (post-implementation questionnaire)

Discussion: Is there a need for such additional support?

Women's perspectives

None of the women interviewed had not intended to breastfeed to some degree and similarly, most women returning questionnaires hoped to breastfeed. However, intention to 'mixed feed' either initially, or quite quickly, was common and additionally some women introduced formula due to early difficulties. There was some evidence from the interviews of such women being more likely to avoid or delay introduction of formula with the additional support.

'I think it would have been helpful to be able to call for help from a Health Care Assitant. If I had more support I may have struggled to get over my difficulties and may have continued breastfeeding for longer' (pre-implementation questionnaire)

‘it just encouraged me, because I was planning to mixed feed as well…so it just encouraged me really to just keep it on the breast and it was just nice for me to see that, you know, you have people that comes round to talk to about things like that because that has never been.’ (Ola)

Some of the women did not feel they had a particular need for support. Of those who returned questionnaires after the implementation, 5/11 stated that they did not need any help/support. This was consistent with the responses given in interviews, where 2/6 did not feel they needed support and 1/6 felt she did not have *problems* needing support. Nonetheless, all felt the availability – and knowing that support was available – was valuable, and those who did not stated that they would have valued this with their first baby. One also gave an example of a relative who she felt should have had such support, who had now given up trying to breastfeed. It was also clear that support could be valuable in the absence of specific problems – for general encouragement, reassurance etc.

The responses of those women who did not identify themselves as needing any feeding support showed that support, when not sought or needed could have the potential to be negative. Two seemed somewhat confused by the numbers of people who had visited them postnatally. However one – who was isolated from her family – emphasised how nice it was to have women visiting and offering help. Another noted how the HCA recognised her as an experienced mother who knew a lot about breastfeeding and didn’t have problems, but still described the visits as having made a difference, due to the encouragement given. This is in line with the existing literature on social support for new mothers: those schemes that have been most carefully targeted at women without the usual ‘informal’ sources of social support, have shown the most positive effects (McCourt & Percival 2001). One recent trial, conversely, suggested that additional postnatal support offered to women who do not lack informal sources of support might be counter-productive by discouraging women from developing their own, personal resources (Morrell et al. 2000, Barlow et al. 2000).

Our very small sample of six women interviewed reflected the profile of the area selected for a Sure Start programme: although very diverse, socially and ethnically, women tended not to have ready access to maternal or family support or a network of friends, either because they are recent migrants (including refugees) or because they have only recently stopped full time work and families are not local. It was notable that several respondents likened the support of the HCA to the support that a mother might give: as one women said, a ‘mother figure for the mother’, while others emphasised the importance of the relationship.

Although some women were clearly very critical of professional support a number had received good support from midwife or health visitor that they clearly valued highly. This included information, technical/practical advice and in some cases (particularly with caseload midwives or health visitors that the women knew) more general support and encouragement. One woman noted, for example, that

her midwife stayed with her for hours when she was having difficulty. Nonetheless, the women's accounts did suggest there was some qualitative difference in the nature of the support offered by the Health Care Assistant and the midwife or health visitor. The emphasis was more squarely on being with the woman, listening, observing and giving general encouragement, tips and ideas rather than expert advice.

Existing Services

We have noted that although this was an area identified as having particular needs, warranting Sure Start funding, the provision of midwifery care in this area was by caseload midwives who, although undoubtedly very busy and stretched, were able to apply selective postnatal visiting and vary length of visits to suit womens' needs. The data we were able to collect from midwives was very limited, partly because they were so busy and concerned with wider service developments. The limited data collected (forms for 21 women) showed that the mean number of midwifery postnatal home visits before the health care assistant was in place was 5 visits per woman (range 1 to 9). The mean length of visit was 45 minutes (range 15 mins to 2hrs 30mins). This confirmed earlier research indicating that the average length of visit was longer than with those midwives not practising caseload midwifery. This implies that such a post may be *more* rather than less effective in other settings where caseload midwifery is not available.

The activities they described were mainly giving advice and practical assistance with aspects such as latching on, positioning and cup feeding. This included some observation of women feeding. More general advice around infant feeding was given, for example, feeding patterns, weight gain, breast massage, colic, diet and rest and stopping the use of dummies. Some women were also referred to the hospital's infant feeding specialist for advice.

These activities appear similar to those of the Health Care Assistant in many ways, particularly in the area of technical/practical advice. However, the findings from women's questionnaires and interviews, discussed above, suggest that there were differences in approach and what could be offered that are subtle and not easily captured in checklists of activities. What might have made a difference was the additional time available and the more general, less focused, offer of support and encouragement. Some women's comments also suggest that fewer barriers were perceived, with women feeling less defensive about their feeding practices and more comfortable in sharing problems with a 'non professional'.

6. Outcomes

Findings on rates of breastfeeding, mixed or formula feeding are based on the following sources

- Women's self-reported feeding patterns
- Feeding patterns from project records
- Feeding patterns from routine maternity data

Each has clear limitations, but we were re-assured by the degree of consistency between the different data sources. Nonetheless, any figures produced at this very preliminary stage in a small-scale project and with only historical comparisons should be viewed with great caution. It is entirely possible that any changes noted could be attributed simply to seasonal variation, random variation or other unidentified changes taking place. Also, with a 52% response rate to questionnaires, women's reports were likely to be skewed by a selective response.

Women's self-reported feeding patterns

Of the women who returned questionnaires (44/84) self reported feeding patterns at the time of completion (mean 6-8 weeks postnatally) were as follows:

	Before HCA input (%)	With HCA (%)
Exclusive breastfeeding	18 (55%)	7 (64%)
Mixed – breast/formula	8 (24%)	4 (36%)
Formula	7 (21%)	0

Feeding patterns from Health Care Assistant project records

	At birth (%)	**At six weeks (%)**	**At four months**
Exclusive breastfeeding	20 (71%)	19 (69%)	14 (50%)
Mixed – breast/formula	3 (11%)	5 (18%)	6 (21%)
Formula	3 (11%)	2 (7%)	2 (07%)
Missing	2 (7%)	2 (7%)	6 (21%)

Note: – post implementation only & only forms completed at 4 months 'discharge' included.

Feeding patterns from routine maternity data

Figures from the routine hospital maternity data system were as follows:

Feeding at birth	**Before HCA input** Sept 01-April 02 (%)	**With HCA** May 02-August 02 (%)
Exclusive breastfeeding	60 (59%)	43 (67%)
Mixed – breast/formula	0	0
Standard Formula	4 (4%)	3 (5%)
Special formula	9 (9%)	3 (5%)
Missing	29 (28%)	15 (23%)

(maternity data system – feeding intention recorded on delivery suite)

The outcome data suggest that rates of initiation and continuation of breastfeeding may be increasing in association with the implementation of the project. This was very early in the life of the project and the figures at this stage should not be considered reliable, nonetheless the initial findings are encouraging.

7. Initial conclusions and implications for policy, practice and research

This was a very small study of a small-scale project in its early stages of implementation. Nonetheless, it has shown some encouraging evidence that a role of this type has the potential to make a difference to women in feeding their babies.

The experience of those involved in the project was generally positive. The women receiving the extra input from the Health Care Assistants valued the support and encouragement they offered. The midwives and health visitor were in general supportive of the role. It was also very clear from our interviews and from informal contact within the working group that the health care assistants really enjoyed the role and wanted to continue working in this way. This was important, since the role was new and carried greater responsibility and independence than is usual for Health Care Assistants. Indeed, they appeared to thrive on such responsibility.

In the course of the implementation, effective inter-agency and interdisciplinary work was established. This was seen as important to underpin the role and ensure it was properly supported. It was also seen as an additional positive outcome, enabling better working between hospital and community, midwifery and health visiting.

Here we summarise key lessons from experience of the project, and recommendations for future work:

- **Features of the role and qualities required**

    - Increased responsibility, as compared to working on a hospital ward
    - Ability to have time to sit and observe women in order to offer practical support; just having someone present can make women feel more confident
    - The ability to offer general support to women
    - Knowing someone was available to give support highly valued by women
    - Making contact with women antenatally was seen as important by the health care assistant
    - Ability to work autonomously
    - Good interpersonal and communication skills
    - Being able to listen to women seen as central to the role
    - Flexibility, being able to adapt and respond to women's different needs
    - Knowing your boundaries

    - Knowing how to offer information without appearing authoritative
- Ability to ‘facilitate’ or ‘engage’ rather than ‘teach’ in a formal sense
- Ability to reassure the woman’s reality that what they are going through is normal
- Maturity and life experience
- Able to be proactive but without setting up barriers/defensiveness

- **Organisational considerations**

    - Lines of referral and communication in a multi-agency and multi-disciplinary setting needed to be clearly addressed
    - Formal lines of referral of women to the health care assistant were less effective than direct approaches to the women, with informal assessment by the woman and health care assistant together
    - It was important to establish clear but flexible boundaries of work to ensure appropriate referral from the health care assistant to the relevant health professionals
    - However, a key aspect of effectiveness was an open, responsive and flexible approach
    - Clear management arrangements were important to ensure she received appropriate support

- **Outcomes**

    - Improved breastfeeding rates at birth, six weeks and four months postnatally; however the figures should be treated with caution
    - Better working links and communication between Sure Start and maternity services locally. This had also prompted midwives to become involved in plans for other local Sure Start schemes

- **Recommendations**

    - With changes in midwifery roles and the shortage of midwives and changes in patterns of maternity care (eg. earlier discharge from hospital, selective visiting by midwives at home) there may be more need for such supporting roles

    - continue to evaluate this project as it becomes more established and with larger numbers of women seen, for assessment of feeding outcomes

    - Pilot in other areas; in particular similar areas without the additional benefits of being included in a Sure Start programme or caseload

midwives. Future research should include a focus on antenatal input, especially with women who are undecided about breastfeeding.

- Once the key features of the role are clearly described in a range of settings, consider a multi-site randomised controlled trial to test the outcomes

References:

Audit Commission. First class delivery: improving maternity services in England and Wales. London: Audit Commission, 1997.

Ball J. Reactions to motherhood: the role of postnatal care. Cambridge: Cambridge University Press, 1994.

Barlow J, Stewart-Brown S. Costs and effectiveness of community postnatal support workers. British Medical Journal 322 (7281), 301, 2001.

Battersby S, Sabin K. Breastfeeding peer support – 'The Worldly Wise Project' MIDIRS Midwifery Digest

Beake S, McCourt C, & Page L. Evaluation of One-to-One midwifery: Second cohort study. Centre for Midwifery Practice, 2001.

Crowther S, Spiby H, MorrellJ. Community midwifery support workers. British Journal of Midwifery 9, 754-757, 2001.

Garcia J, Redshaw M, Fitzsimons B, Keene J. First Class Delivery: A national Survey of women's views of maternity care. Abingdon, Oxon: Audit Commission/National Perinatal Epidemiology Unit, 1998.

Hodinott P Why don't some women want to breastfeed and how might we change their attitudes? A qualitative study. M.Phil. Department of General Practice, University of Wales College of Medicine, 1999.

Hoddinott P, Pill R. Qualitative study of decisions about infant feeding among women in east end of London. British Medical Journal 318(7175), 30-34, 1999.

McCourt C, & Percival P. Social support. In The new midwifery: science and sensitivity in practice (ed.) L. Page. Edinburgh: Churchill Livingstone, 2000.

McCourt C, & Page L. Report on the evaluation of One-to-One midwifery. Centre for Midwifery Practice, 1996.

McCourt C, Page L, Hewison J, Vail A. Evaluation of One-to-One Midwifery: Women's Responses to Care. Birth 25 (2): 73-80, 1998.

McInnes R.J & Stone DH. The process of implementing a community-based peer breast-feeding support programme: the Glasgow experience. Midwifery 17, 65-73, 2001.

Morrell CJ, H. Spiby P, Stewart S, Walters, Morgan A.. Costs of effeciveness of community and postnatal support workers: randomised controlled trial. British Medical Journal 321, 593-598, 2000.

MorrellJ. & Stappleton H. Supporting postnatal women: views from community support workers. MIDIRS Midwifery Digest 10, 362-366, 2000.

Schafer E, Vogel M, Viegas S, Hausafus C. Volunteer Peer Counselors Increase Breastfeeding Duration Among Rural Low-Income Women. Birth 25 (2): 101-106, 1998.

Taylor J and Graffy J. Unpublished comments on a recently completed trial of interventions to support breastfeeding in the community.

Appendices

Coningham / Sure Start Breastfeeding Project

Midwife's record form

Woman's name, address and hospital number: Woman's telephone number:

Date of baby's birth:

Mother's initial feeding method (at birth): Full breastfeeding ☐ Formula/baby milk only ☐ Mixed ☐

Please complete on each visit:

Date	Time arrived	Time left	A brief outline of all care and support offered (including feeding support)	Feeding pattern today

Date of midwife discharge: Mother's feeding pattern on discharge: Full breastfeeding ☐ Formula only ☐ Mixed ☐

- Review (please comment on how you feel the support has gone)

Please return to Sarah Beake (Ex 35071) in the boxes provided on the Birth Centre or Community

Midwives' Information sheet

Coningham/Sure Start breastfeeding Project

If you care for any **postnatal** women in **Coningham ward** could you please collect a pack for each women:

- new packs can be found either on the Birth Centre or the Community/1to1 office
- give each woman a copy of the information sheet and a brief description of the pilot
- complete the midwife's record form each time you visit the woman in the community postnatally
- leave the midwife's record form in the woman's hand held notes, so if a different midwife visits she can add to it
- when you discharge the woman please return the form to either the Birth Centre or the Community/1to1 office in the box provided
- identify if a woman lives in Conningham ward her postcode will be W12 8- - or W12 9- - (see map provided)
- for this pilot only, please do **not** include women who would need an interpreter

If you have any comments on the data collection sheet or ways of improving their distribution or collection, please either write them on the forms you complete or contact Sarah Beake Ex.35071 direct.

Ref:

Coningham/Sure Start Breastfeeding Project Questionnaire

Thank you for helping us to review your maternity care in the community. All information that you give us will be completely confidential.
We would be grateful if you could *complete this form 6 weeks after having your baby* and return it to us in the prepaid envelope provided.
If you have any queries please contact Sarah Beake on 020 280 5287.

1. What is today's date / /

2. How old is your baby today ?…….weeks

3. How are you feeding your baby now? (please tick one box only)

   Full breastfeeding π (including expressed breast milk)

   Formula/baby milk only π

   Mixed breast and formula/baby milk π

4. If you stopped breastfeeding, how old was your baby when you stopped?

   ……. days

   What were your main reasons for stopping?

5. If you introduced formula baby milk, how old was your baby at the time?

   ……. days

   What were your main reasons for introducing formula baby milk?

6. If you stopped using formula baby milk and returned to full breastfeeding, how old was your baby at the time?

   ……. days

   What were your main reasons for stopping using formula baby milk?

7. How often did the health care assistant visit?

   a. before your baby was born……

   b. after your baby was born……

8. What help, with feeding your baby, were you offered by the health care assistant?

9 Did you find the help offered by the health care assistant useful?

yes π
no π
unsure π

Please explain why:

10. What help, with feeding your baby, were you offered by the midwife(ves)?

11. Did you find the help offered by midwives useful?

yes π
no π
unsure π

Please explain why:

12. Was there any help you would have liked but did not receive?

13. Have you any other comments to make which might help with our study?

14. Please tell us anything else you feel is important.

Thank you very much for your time. Please could you return the completed questionnaire in the envelope provided.

Evaluating the role of health care assistants in the community to support breastfeeding

Study information sheet for parents

We are carrying out a study looking at the use of Health Care Assistants helping with breastfeeding in the community.

In order to do this, when your baby is about six weeks old, we will be sending you a short questionnaire to fill out, giving your views on the care you received at home and what you found helpful or unhelpful with feeding your baby. We will also be contacting you to see if you would be happy to talk to us about your experience.

It is important that you feel able to give your views freely so all information you provide will be treated as confidential and will be available only to the research midwife and her research team. You are not obliged to take part in the study and your routine care will not be affected by your decision whether or not you take part. The research is being carried out by the Centre for Midwifery Practice, Thames Valley University.

If the scheme is found to be helpful for women, the Trust may be able to offer such support as part of the maternity service in the future.

If you have any questions about the study or would like to talk to the research midwife, Sarah Beake, please contact her at the Centre for Midwifery Practice on 020 8280 5287.

Thames Valley University
Wolfson Institute of Health Sciences
Centre for Midwifery Practice
Thames Valley University
32-38 Uxbridge Road
Ealing
London W5 2BS

date

name
address

Dear

Coningham/Sure Start breastfeeding Project

We will soon be carrying out a study looking at the use of Health Care Assistants helping with breastfeeding in the community. Before we do this we need to collect some information so that we will have something to compare the main study with.

In order to do this we are sending you a short questionnaire to fill out, giving your views on the care you received at home and what you found helpful or unhelpful with feeding your baby. We would also like you to tell us what you thought about filling in the questionnaire, so that we can make changes if need be before the scheme starts.

It is important that you feel able to give your views freely so all information you provide will be treated as confidential and will be available only to the research midwife and her research team. You are not obliged to take part in the study and your routine care will not be affected by your decision whether or not you take part. The research is being carried out by the Centre for Midwifery Practice, Thames Valley University.

If the scheme is found to be helpful for women, the local hospital may be able to offer such support as part of the maternity service in the future.

If you have any questions about the study, please contact Sarah Beake at the Centre for Midwifery Practice on 020 8280 5287.

Yours sincerely

Sarah Beake
Research Midwife

Thames Valley University
Wolfson Institute of Health Sciences
Centre for Midwifery Practice
Thames Valley University
32-38 Uxbridge Road
Ealing
London W5 2BS

date

name
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Coningham/Sure Start breastfeeding Project

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If the scheme is found to be helpful for women, the local hospital may be able to offer such support as part of the maternity service in the future.

If you have any questions about the study, please contact Sarah Beake at the Centre for Midwifery Practice on 020 8280 5287.

Yours sincerely

Sarah Beake
Research Midwife

Enc. Questionnaire
Prepaid envelope

Coningham/Sure Start Breastfeeding Project

Referral for health care assistant support

Woman's name, address and hospital number:

Woman's tel. no:

Date of baby's birth: Date of hospital discharge:

Reason for health care assistant support:

Support advised by midwife/health visitor:

Name of referring midwife/health visitor:

Signature:

Contact telephone number:

Please leave this form with the woman and contact the health care assistant (Joy) on her mobile ---------- or leave a message at the Sure Start office----------.

Coningham/Sure Start Breastfeeding Project

Health care assistant's record form

(please complete at each visit):

Date	Time spent at each visit	Support given	Signature