

Women, Babies and their Families (WOMB)

West Howe Midwifery Evaluation: The WiTH ME Study

**An evaluation of the impact of midwifery care
provided to women and their families within the Sure
Start Bournemouth Scheme at the Kinson and West
Howe Children's Centre**

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February 2007

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My pregnancy was stressful anyway and they helped take the edge off of it and sometimes I just used to sit and sob and she (SSMW) would just sit and listen and having somebody listen as well and having no time limit on things, she was here sometimes two or three hours. At one point I had a really bad day, just after she was born and I just couldn't stop crying and she always intently listened. I never felt that she didn't want to be here. I never felt like I was taking up her time or anything. It was unconditional support you just can't get that anywhere. (Parent)

Acknowledgements

We would like to thank all the parents, centre staff and Bournemouth and Poole Midwifery Staff who participated in this evaluation.

Within the report we have used the following categories to identify respondents:

Parents:	Mothers and fathers
SSMW:	Sure Start Midwives
Centre Staff:	West Howe & Kinson Sure Start and Children's Centre
BMCM:	Bournemouth and Christchurch Community Midwives
Stakeholders:	Managerial and supervisory professionals
The Centre:	Kinson and West Howe Children's Centre

All quotes from participants are in italics and [...] indicates a break in that respondent's story.

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EXECUTIVE SUMMARY

This report considers the contextual situation in which the Sure Start midwives work, including the national and local socio-political situation. The aim of this evaluation was to discover the impact of the midwifery care provided by the Sure Start midwives to the women within the local community.

This study used a qualitative approach with quantitative demographic data. The qualitative data was collected via interviews with stakeholders and parents, and focus groups with parents, the Sure Start midwives, Centre staff and Bournemouth community midwives (BCM).

The findings show high satisfaction for all the activities within the Centre and for the services and care provided by the midwives. The Centre and its associated activities were viewed as being of positive significance to the daily lives of the local families who access services.

The services and care provided by the midwives was noted to be effectively integrated within the Centre's activities. This enabled the midwives to participate effectively in collaborative planning and review of Centre activities.

The Centre staff, inclusive of the SSMWs, share a collaborative approach to the planning and provision of care and services to the local community. This partnership approach enabled parents in their daily activities and in their personal planning for the future.

The Sure Start midwives were noted to be accessible due to their location and pattern of working. Their accessibility was enhanced by their highly developed interpersonal communication skills and their personal commitment to be responsive to and enabling of women and families in their care.

The provision of maternity care by the Sure Start midwives is in accordance with the targets initially identified when they took up post and with emergent care needs and targets. The SSMWs provide holistic midwifery care that meets the needs of the individuals within the community. Women and their families viewed the midwives as their 'professional friends' and valued their 'unconditional support'.

There was an understanding that the midwives' role was not seen as a 'policing role' however, it promoted access to the Centre's services for

hard to reach families, although where children were considered to be at risk, referrals were made to the Social Services, generally working alongside parents.

The continuity of provision of a flexible women and family centred service over the last few years from the SSMWs was creating what appeared to be an increasing demand for their services. These services included:

- Physical, emotional and psychological wellbeing assessment, review and provision of care to women, their babies and families in pregnancy and post birth;
- Involvement in parent education, support and development for individuals, group activities and via signposting individuals to other relevant services;
- Promotion of and involvement in client advocacy work, maintenance of client safety and child protection;
- Public health development work via promotion of healthy lifestyles;
- Supporting women's sexual health via advice, provision of some family planning care, pregnancy testing and support following miscarriage.

Recommendations

These recommendations relate in part to the local context of the West Howe and Kinson Children's Centre and also offer the individuals involved in the future development of maternity services within Children's Centres and in areas of social disadvantage a resource for future consideration based on the evaluative evidence.

West Howe and Kinson Sure Start Children's Centre

- Explore further ways of celebrating the multiple successes of the Centre's activities as a means to continue partnership working within the local community. Such activity could also be used strategically to communicate with other agencies and commissioning bodies etc. For example, Sure Start in Brighton & Hove has produced a CD of women's views of the service.
- The process of women and their families being referred to the Centre has operational frailties that a more strategic approach between health centres/surgeries and the newly formed Children's Centre could address.
- To review the current process of how information and statistics regarding women's access to the SSMW maternity service are collected. Alongside this a way of recording women's emergent care needs is required to quantify the existing and changing use and needs of the SSMW service.

Future developments

- Consider the integration of the Bosom Buddies with Bumps and Babies as this second group has good support and attendance. This would include the transfer of the breastfeeding counsellors and may be a cost effective way to retain their valuable service whilst providing support to a wider audience.
- Continued collaboration with Bournemouth and Poole Trusts regarding the future maternity service provision via Children's Centres; incorporated within this we advocate learning from the SSMW experience at West Howe and Kinson. There is evidence of collaborative working and planning and a willingness to think dynamically about the future provision of care to childbearing women and their families in areas identified as being socially disadvantaged.
- In recognition of the difficulty surrounding the future funding of the existing service alongside the future development of the services, a mixed approach to the provision of maternity care should be considered. This would involve midwives, maternity care assistants and or community workers who support the midwives to provide continuity of woman centred care in the antenatal and postnatal periods.
- There is a tension between the primary and secondary care settings relating to assessment of care needs and identification of risk factors. Consideration of an integrated care and risk assessment tool developed from the evaluation data may provide a holistic, woman centred approach to care.
- Whilst not part of this evaluation study, the process of documenting one-to-one care undertaken by SSMWs is consistent with current standards laid down by the NMC (2005).
- Interprofessional planning, implementation, and documentation of care should be considered in line with the developments of community based midwifery care as an integral part of the Centre's activities in order to maintain the principle of holistic care.
- The education and training needs of the SSMWs are recognised by the current post holders and they have received support from both the Centre and Seconding Trust in meeting them alongside personal commitment to their own development. The supervisory practice needs of the SSMWs are met primarily on a day-to-day basis by their peers and by the informal management support within the Centre, also available to all staff working in the Centre. There was little

evidence of the SSMWs seeking support from their supervisor of midwives. The system of integrated education, training and supervision requires consideration in the future planning of integrated Bournemouth and Poole maternity services.

BACKGROUND

National Context

Sure Start was a programme announced in July 1998 (Department of Health 1998). The Government agreed to provide £542 million (£452 million in England) between 1999-2000 and 2001-02 to set up and develop more than 250 programmes across the country (Department of Health 1999b; Roberts 2000). This Government initiative came into effect as a result of many Department of Health (DOH) reports which identified that aspects of public health were not being fully addressed by health professionals (Acheson 1998; Department of Health 1999d). In the wider context, there are recognised problems relating to health which are more prominent within disadvantaged areas (Acheson 1998). Specific public health needs focus on smoking, low breastfeeding initiation rates and continuation of breastfeeding and teenage pregnancy. Monies were thus made available for areas with specific need due to their location or their disadvantage and projects were set up locally (National Evaluation of Sure Start Programmes 2005). Significant benefits of Sure Start programmes are to facilitate health, education and welfare services to work together effectively (Roberts 2000; National Evaluation of Sure Start Programmes 2005).

The Government has an agenda to evaluate the Sure Start projects. This commenced in 2000 and the Government's rationale for this is as follows:

- a) "At a developmental level, to contribute to the successful establishment and operation of the Sure Start strategy;
 - b) To evaluate how well Sure Start is delivering its aim and key objective;
 - c) To contribute to the knowledge base on the effectiveness of early intervention in improving the social, emotional, physical and cognitive development of children in disadvantaged areas."
- (Department of Health 2000a)

The Department of Health (2000) suggested that data should be collected using a range of both quantitative and qualitative approaches. They confirmed the need to collect local data as well as national information in order that objectives could be met (Department of Health 2000a).

National Evaluation of Sure Start Programmes (2005) has evaluated 260 programmes of local provision. This includes aquanatal classes where women receive transport to take them to classes and crèche facilities are

provided. Within the report, the needs of fathers were highlighted and demonstrated that provision was variable locally but appeared to be more focused on networking and fun activities than on parenting or childcare skills. It was also shown that activities for fathers were often “gendered” such as a DIY tools and book borrowing services (National Evaluation of Sure Start programmes 2005:46). However, other areas reported employing “men’s workers” or “father involvement workers” who visit fathers at home to engage the men in developing parenting skills (National Evaluation of Sure Start programmes 2005:47).

Maternity service provision varies throughout local Sure Start areas (National Evaluation of Sure Start Programmes 2005). For example, joint drop-in sessions are run with midwives and Sure Start staff; additional support is provided to SS families by Sure Start midwives; new babies are registered with Sure Start so their families have support and information about additional services available (National Evaluation of Sure Start Programmes 2005). There is evidence that Sure Start is providing financial support for midwives in other areas with training and support provision for maternity support workers and peer supporters in breastfeeding (National Evaluation of Sure Start Programmes 2005). A well attended ‘Bumps and Babies’ group has expanded attendance, involves fathers and encourages support from a range of specialists, with an average of 25 users each month (National Evaluation of Sure Start Programmes 2005). Specific support programmes have been evaluated for smoking cessation and breastfeeding (National Evaluation of Sure Start Programmes 2005).

Local Context

While national projects have been underway, locally an evaluation of the WHSS local programme has recently been published (Sharples et al 2005). This evaluated, by a range of methods, the different services in operation since Sure Start began operating in the area in 2001. A variety of opportunities exist in West Howe under the Sure Start umbrella. These include a toy library, educational classes, speech therapy and smoke stop support groups. The midwifery service was set up to support these initiatives in April 2002 and was extended in 2003 (Sharples et al 2005). The development of the midwifery and breastfeeding support (Bosom Buddies) service encouraged more children between birth and one year to benefit from Sure Start support. It is reported that from 2003, when the breastfeeding peer support group was set up, that new contacts in the age range up to one year showed continual growth (Sharples et al 2005). Involvement of fathers within the Sure Start initiatives has been minimal; the National Evaluation of Sure Start programmes are keen to encourage

this (Sharples et al 2005). It is considered that further involvement would support children by giving them positive role models and enhancing their development (Sharples et al 2005).

In February 2005 a report was published relating to the West Howe Sure Start midwifery service (Viccars 2005). A questionnaire developed by the SS midwives was sent out by them to 100 women who had received care during the past 12 months. This report provided an analysis of 19 completed questionnaires returned in order to audit practice in the area, which aimed to determine if the service provided met the needs of local women. Following on from this report, discussions have demonstrated a need for a more thorough evaluation of the West Howe Sure Start Midwifery Service.

The manager of the Sure Start Children's Centre identified that to meet Government targets, such as reducing smoking in pregnancy, supporting women to breastfeed, reducing hospital admissions of babies with gastroenteritis for example, the best person to address these issues would be a midwife. The manager put in a bid to gain funding for three days a week at the end of 2001. A service-level agreement was set up between the local trust and the SSCC. This identified the clear aims which they needed to meet.

The first Sure Start midwife was employed part-time, on two days a week commencing in May 2002. Her remit was, as she states:

What I was to focus on was reducing smoking with families in the area, increasing breastfeeding, what was the other target? Oh, reducing postnatal depression, you know, all single handily, um {laughs} working with young teenage parents...and anything else besides. So that was the core of the original aim...and it's mushroomed from that basis really. (SSMW)

By the end of 2002, it was apparent that one midwife could not address all of the required targets. There were some surplus monies available and it was agreed with the Trust that a full time post could be created. This facilitated the employment of another midwife to support the midwife currently in post. Having midwives in the SSCC encouraged parents' attendance at the centre earlier than if they had not received care during pregnancy or post birth:

The kind of role she [SSMW] had was very valuable to what we were doing, we wanted to increase the number of hours because we could see the potential, because to really get

involved with the parents at pregnancy stage means they're gonna be involved later as well and we missed out on that at the very beginning 'cos we were going out looking for people to start participating and if we can actually start at the very beginning and get people's trust and get to them to trust in what we are doing and realising what we've got to offer that's much better than with a child that's aged two or three trying to learn the parenting and we've now got that system going which is now very effective. (Stakeholder)

The women and their families who have been attended by the SS midwives have shown many benefits:

But there are some parents who can benefit a great deal who had babies who had built up a good and positive relationship with the midwives and who now are doing things that they would never have done, like building self esteem, getting parents in the mainstream. (Stakeholder)

This demonstrates that midwifery care is only the beginning of a lifestyle change for the local community. It is borne out by the women who have identified similar changes to the health professionals.

Role of the Midwife

The role of the midwife has always been clearly defined within the context of normal childbirth (including pregnancy and postnatal care) (Nursing and Midwifery Council 2004a). Midwives have also had a role in the provision of postnatal care up to and including 28 days. Current NMC documentation (Nursing and Midwifery Council 2004a) does not, however, identify a time limit on postnatal visiting thereby making the role of the midwife more flexible and adaptive to meet the needs of the individual woman. Furthermore, the NMC (2004a:19) states that there are times when developments in midwifery care become an integral part of the midwife's role but this may not always be the case; it is therefore important that the midwife's employer has a "locally agreed guideline, which meets the NMC standards".

Social support has been a role which midwives have taken on to a greater or lesser extent depending on the areas in which they practise. Oakley et al.'s work (Oakley, Rajan et al. 1990; Oakley, Ribvy et al. 1998) with midwives demonstrated how they provided social support to women. Social support by midwives has been evaluated to demonstrate that outcomes for women and their babies improve in both the short and long-

term (Oakley, Rajan et al. 1990; Oakley, Ribvy et al. 1998). Oakley, Rajan et al. (1990) randomised a total of 509 women to either a control group where they received standard antenatal care or an intervention group where they received social support. Women in the study were mainly working class (77%); 41% were smoking at booking and 18% had unemployed partners. Four research midwives offered 24 hour telephone contact and a programme of home visits, gave practical information and advice and worked with other health care professionals when necessary. Outcomes from this study paved the way for the SS midwifery service.

In the control group, findings showed more admissions to hospital in pregnancy, greater use of epidural anaesthesia, more invasive resuscitative methods needed for the babies and more intensive and special neonatal care provision compared with the intervention group (Oakley, Rajan et al. 1990). In the early weeks the mothers and babies were significantly healthier than the control group. Women also gave positive reports of the support they had received. What is interesting to note that at both one year and seven years later when these families were followed up, the findings showed that the physical and psychosocial health of the women had continued to improve and health and development outcomes for the children were significantly better compared to the control group (Oakley, Rajan et al. 1990; Oakley, Ribvy et al. 1998). However, this study only looked at the provision of social support, in addition to midwifery services during pregnancy; it does not appear to have provided this additional support postnatally or after that time (Oakley, Rajan et al. 1990; Oakley, Ribvy et al. 1998). Had this been provided, the differences between the groups may have been more obvious.

Hildingsson and Haggstrom (1999) from Sweden demonstrated in a phenomenological study that midwives advocated for women and their babies. They found that midwives provided social support that was in addition to the maternity service normally provided. The authors considered that the additional support for women who needed it was founded on a “willingness and on an experienced ethical demand to do good for the woman/the family” (p88). Support offered by the midwives included listening, and offering time to talk, motivating the family and directing them to other agencies who could help them (Hildingsson and Haggstrom 1999).

Direction from Government

The extension of the midwifery role into Sure Start has moved the boundaries beyond where midwifery has been practised in the past. The Sure Start midwife role encompasses a wide public health agenda and can provide women and their families with lifestyle information,

knowledge and understanding to take them far beyond the pregnancy and postnatal periods. This can give women the confidence to improve their physical, social and psychological health across a range of areas in their life. Government agendas have always included a need to address inequalities in health and improve the environment and care provision for those in areas of high deprivation (Townsend and Davidson 1990; Acheson 1998; Department of Health 1999c).

More recent documents have led to maternity care being led by consumers, as demand for the care chosen by the individual has come more to the fore (Department of Health 2004). In the early 1990s the issues of choice, continuity of carer and control were identified as important aspects of care for women throughout their birth experience (Department of Health 1993a). Women were widely questioned about the service they receive in subsequent documents and similar needs for care were again identified (Department of Health 1998). Being able to respond in an individualised way to women makes a difference to them and facilitates them to receive the care they want (Department of Health 1993a; Page 2000; Campbell, Thompson et al. 2002; National Institute for Clinical Excellence 2003; Department of Health 2004). The National Institute for Clinical Effectiveness (2003) suggested that care should be centred on the needs of the woman, with effective communication, information-giving and support.

The National Service Framework (NSF) for children, their families and the maternity service identified that women should have care individualised to their own requirements and expect good social support frameworks to be in place to support particularly those from disadvantaged areas or groups (Department of Health 2004). Other aspects of the National Service Framework identify the social support required for women who have issues of public health concern, such as teenagers who are pregnant, women who smoke or women who are disabled (Department of Health 2004). Furthermore, the Government has been proactive in looking to support the development of children in terms of the physical, psychological and social wellbeing (Department for Education and Skills 2004). These two publications, National Service Framework for children, young people and the maternity services (Department of Health 2004) and *Every Child Matters: Change for Children* (Department for Education and Skills 2004), articulate objectives for service providers to work towards and have been used in the study evaluation plans.

Benefits of offering social support to women in childbirth

The Confidential Enquiry into Maternal and Child Health (Confidential enquiry into maternal and child health 2004) has been influential in identifying that women in families where both partners are unemployed with characteristics of social exclusion are 20 times more likely to die than those from more advantaged groups. Furthermore, women who are single are three times more likely to die than women in married or stable partnerships (Confidential enquiry into maternal and child health 2004). If social support can alleviate or prevent just one of these deaths then it is imperative that the health profession work towards a solution. Women from the most deprived areas of England had a 45% higher death rate than women from more affluent areas (Confidential Enquiry into Maternal and Child Health (2004); areas such as this are likely to be those covered by Sure Start initiatives.

A variety of Sure Start initiatives are in place across the country and these offer support to families until the children start school. While work has been published which specifically explores Sure Start initiatives, other published work supports the concept of social support in pregnancy. A study in Canada by Seguin (1995) established that there is an increase in depression in women of low socioeconomic status compared with women of higher status; the women in their study presented with symptoms of depression more often and more severely than women who were in a higher socioeconomic group. Seguin (1995) used the validated Beck Depression Inventory score, and identified that social circumstances, such as inadequate housing and financial problems were very strongly associated with higher scores. They also considered that women who could not access social support when they wanted to meant that they would exhibit more mental health problems (Seguin, Potvin et al. 1995).

The support offered by Sure Start midwives is also evident in Great Yarmouth where young pregnant women meet and decide their own agenda for antenatal education (Lovett 2003). Sure Start midwives offer drop-in sessions with one-to-one midwifery consultations alongside other projects such as swimming, massage and arts and crafts (Lovett 2003). In addition, Attree (2004) evaluated a Sure Start project that was described as a 'capacity building initiative' (p156) in a deprived area of the North East of England. The project considered the provision of support for families by community support workers who were themselves parents and members of the local community (Attree 2004). Using qualitative interviews and focus groups, the community support workers in training, who provide direct contact with users and those managing and providing family services, explored their experiences of working within the project. The findings showed that the community support

workers felt more able to support families because they did not have a professional agenda or the responsibilities attached to this. Nonetheless, the community support workers suggested that clarity around roles and responsibilities was important in terms of flexibility and trying to fit the roles (e.g. parenting skills and breastfeeding support) to the most appropriate person. These examples of multiple agency working between lay and professional groups is a strategy to meet the needs of the community (Kenny 2002).

Exploring the public health role of the midwife

Tyler (2005) discusses the issues surrounding public health and how gaining equity for everyone irrespective of class, income, educational achievements and ethnicity are significant issues for the public and the maternity service. Tyler (2005) discusses the key factors in maternal and child health which have considered short and long impacts on both. These include women in social class IV and V, teenagers who become parents, women on an inadequate diet, those with disability, the homeless or those who do not have social support networks which meet their needs (Tyler 2005). The role of the midwife has broadened to allow scope for the provision of care beyond foundational pregnancy, birth and postnatal care. Midwives frequently find themselves providing a facilitative role for women who are requiring help with housing, support for drug misuse and domestic violence. Women who are refugees or asylum seekers often live in Sure Start areas and the local services work together to reduce inequalities in health (Tyler 2005).

Smoking is still a significant public issue and not only has individual effects but also impacts on partners, other family members and children. Stead (2001) suggest that where people live is an important factor in whether they are willing or able to consider cutting down or giving up smoking. These factors often lead to continued patterns of smoking. It is estimated that there are 5 million deaths each year worldwide due to smoking related illnesses. It is currently estimated that 120,000 deaths each year in this country are smoking related. The concern is that if current smoking rates continue, this will cause 10 million deaths yearly by 2020 (World Health Organization 2005). There is evidence that in the UK figures for the general adult population figures for 2001 still show that 25% of women smoke and 28% of men (Department of Health 2005). Furthermore, 39% of women under 20 years of age smoke throughout pregnancy compared with 12% of those over 25 years (Department of Health 2005). However, there is evidence that the younger women find it easier to give up smoking that those who are over 35 years.

The literature is clear that women often feel motivated to cut down or reduce smoking when they are pregnant because it is a time when they

are contemplating change (Prochaska and Diclemente 1986; Lumley, Oliver et al. 1998; Lumley, Oliver et al. 2001; Okene, Yunsheng et al. 2002). Women's health is improved by reducing smoking during pregnancy, in addition to the benefits for the family of keeping the environment free of smoke (Horta, Victoria et al. 1977; Ershoff, Quinn et al. 1990; Li, Windsor et al. 1993). Because many women may begin smoking again once the baby is born, this is a challenging time for the midwife (Secker-Walker, Solomon et al. 1995; Lumley, Oliver et al. 1998; Lumley, Oliver et al. 2001). Health professionals' support is especially important beyond the puerperium to facilitate the process of cutting down, giving up and maintaining smoke-free environments. Although it remains controversial, the use of nicotine replacement therapy for women who smoke heavily is an option for women who are pregnant or breastfeeding, but only under medical supervision (National Institute for Clinical Excellence 2002).

In the UK, 79% of first time mothers choose to breastfeed or combine feed compared with 76% for those with two or more babies (DOH 2005). Although midwives tend to advocate breastfeeding for women and their babies, women's individual preferences and feelings must always be considered (Page 2000). In the Sure Start area of Great Yarmouth, breastfeeding training and support is offered to develop peer support, which has had a significant impact on local short and long-term breastfeeding rates (Lovett 2003). A support group for women who breastfeed in Salisbury was evaluated in 2003; this was shown to be highly effective in the support of women to continue breastfeeding beyond six weeks following the birth of their baby (Alexander, Anderson et al. 2003). Nationally in 2005 it was noted that an increase in breastfeeding rates across disadvantaged groups, mothers in manual jobs or who had never worked rose from 60% to 67% in 2000 and 54 to 57% respectively (DOH 2005). It can be questioned if some of this increase could be due to Sure Start support for women who are breastfeeding as found in other areas, such as Bosum Buddies in Dorset (Alexander, Anderson et al. 2003). Other initiatives support this work such as the antenatal intervention for grandmothers and partners carried out in an area of high social deprivation in Bristol (Ingram and Johnson 2004).

Role of the Father

The role of the father has been less well explored than many other aspects of childbirth. Recent work, however, by Locock and Alexander (2006) effectively demonstrates, following in-depth interviews, how men play a variety of roles during pregnancy. The roles include that of parent,

bystander, protector or supporter, gatherer and guardian of fact (Locock and Alexander 2006:1349). Depending on what is happening to the woman, the man plays a role as described above, but there are times when they feel that they cannot be a parent to their child, for example during an ultrasound scan, because they feel that they must be there to support their partner. At other times, they must seek out information so that both parents can make informed choices about the care they wish to receive, and not necessarily at that time be able to adopt another role more suited to how they are feeling (Locock and Alexander 2006). In this article some fathers were noted to use their educational ability, for example analysing the information about a condition they were seeking out on the internet. For other fathers, this type of activity may not be so straightforward if they are unable to fully understand and analyse information retrieved.

Summary

To conclude this background to the study, the practice of Sure Start midwifery has stretched the boundaries of midwifery practice. It can be said to encompass the customary midwifery role but evidence illustrates that Sure Start midwives often have an enhanced role as public health advisor and social supporter for the family. The opportunity to provide social and emotional support appears to be highly valued by women, given the limited information we have so far, and may ultimately make a difference to the long-term health and wellbeing of the whole family. Thus, there is national evidence that such work is supportive as positively contributing towards the Government's long term objective of eradicating poverty by 2020 (Department of Health 2001a). This study will explore and seek to provide evidence relating to the local impact of the Sure Start midwives practice on the health and wellbeing of the local families.

EVALUATION OF SURE START MIDWIFERY SERVICES

Study Aims

- To identify contextual demographic information relating to the Bournemouth area;
- Listen and attend to the experiences of individuals and groups, both lay and professional, who have insight into the activities of the SSMWs;
- To identify strategies for the future of midwifery care in the SSCC.

Study Objectives

- To produce a report that presented the findings below and considered issues of discussion and possible recommendations for practice;
- To describe the demographics of the SSCC area from public data sources;
- To qualitatively produce a narrative of the women's experience of midwifery care from the SSCC midwives with reference to the outcomes of the KSF and ECM;
- To qualitatively produce a narrative of women's partners experience of midwifery care from the SSCC midwives with reference to the outcomes of the KSF and ECM;
- Production of thematic analysis that highlights issues of significant to stakeholders involved in the study.

Evaluation Strategy

Having analysed the national context and the evaluation evidence to date that SSCC has participated in generating, we propose the following strategy for further enquiry. The aim of Sure Start projects has been identified to be the development of healthier lives for children under five (National Evaluation of Sure Start Programmes 2005). Since this time further government policy of significance has been published, namely the National Service Framework for Children Young People and Maternity Services Department of Health (2004) and *Every Child Matters* (Department for Education and Skills 2004).

In developing a proposal for evaluation there is an analysis and cross referencing of key aspects of the NSF and ECM reports (presented in

Appendix 1). Alongside this analysis, we have generated questions in need of addressing in relation to SSCC. In the right hand column of Table 1 we have positioned together issues into three themes of evaluation focus. In Appendix 2, the three themes of evaluation provide a route to identify the relevant individuals or groups who can provide answers and offer insights into the issues in need of addressing. This table provides further information and detail about how we propose to collect the data and the mode of analysis and presentation of findings.

METHODOLOGY

The research approach to this evaluation project is qualitative. The rationale of this choice is a pragmatic response to the study objectives. Creswell (2003) indicates that a pragmatic stance seeks to utilise the respective strengths of quantitative and qualitative methods. This strategy is informed by the researchers adopting the philosophical foundation that the research problem needs to be placed in the foreground rather than the research methods (Creswell 2003). Such a pragmatic approach draws on the historical work of Dewey and the more recent work of Rorty (1990). These philosophers sought to develop ways of working that were a 'best fit' to a given situation or problem (Creswell 2003). Such an approach calls for plurality of perspectives and flexibility of the researchers alongside a knowledge base of the respective methods used for effective evaluation to occur (Department of Health 2001b).

Via the collection of data using different approaches, triangulation is achieved. Creswell (2003) indicates how this can be sequential or concurrent in organisation. The gathering of the data is in two phases.

Phase 1: Quantitative Data Collection

Demographic information

The demographic data is sought from public resources. The first data set relates to the total population of women and their families who live within the sample area as identified by post code. This data will be sourced from publicly available sources such as population statistics from national and local sources (Bournemouth Borough Council 2006; Office for National Statistics 2006; Bournemouth Borough Council 2007) and web based resource sites such as UPMYSTREET (A Classification of Residential Neighbourhoods profile (ACORN) 2007). The data sought will include:

- Family make up, number per household, employment, education, smoking;
- Trends, teenage pregnancy, health care provision: number/location of GPs;
- Health centres/surgeries: if possible mortality/morbidity rates and trends.

Phase 2: Qualitative Data Collection

The qualitative approach to gathering and analysing data was taken from the subjective context. This naturalistic approach is a feature of

Qualitative interviews with individuals

qualitative work that does not seek to manipulate or control the participants or their activities but to understand events and experiences from their perspective. This phase of the study focused on the gathering of data about people's experience of the Sure Start midwives' activities. This included gathering the perspectives of individuals who had a stakeholder role in their activities and groups who shared the experience of having received care or having worked at SSCC with the midwives.

The individual interviews were purposeful in nature and involved face-to-face recorded conversations. The stakeholders were identified as individuals who were significant to the study by virtue of their role, associated links to the activities of the Sure Start midwives or the needs of the women they cared for. To recruit these individuals, letters inviting participation with a research information sheet were sent along with contact details of the researchers. On agreement to participate, the researchers negotiated consent. The interviews with these individuals were semi-structured and tape recorded. The semi-structured questions were created with reference to the individual's role and its association to the Sure Start area.

Creswell (2003) indicates six broad steps that qualitative research follow in the data analysis process; these are:

- Organisation and preparation of the data for analysis. As part of this process the recorded interviews were transcribed verbatim with nuances noted;
- To obtain a general sense of the information and reflect on its overall meaning;
- Detailed analysis with a coding process. The coding process will be developed with reference to the study aims and outcomes;
- Using the coding process, descriptive themes were developed;
- Via the process of creative themes, the stakeholder roles will have their identity protected. This step is associated with the selection of data that represents the descriptive themes;
- Concerned with the reflective process of interpretation.

The commissioning body proposed that capacity was made within the study to have individual interviews with a small number of women who were users of Sure Start maternity care and were unable or unwilling to join a focus group but wished to have their experience heard. Recruitment of these women was via referral gatekeepers within the Sure Start centre; staff at the Centre were proactive in offering their support for recruitment. The information and consent process for these individuals is comparable to that described in the focus groups below.

Qualitative focus groups

The selection of the focus group approach to data collection was chosen as an appropriate method to enable individuals to share experience of their care alongside that of others. In this way a large amount of data was gathered in a comparatively short time. Comments and stories of experiences were generated via the interactive process of the group (Barbour and Kitizinger 1999). The bringing together of individuals to share their experiences in a focus group, Berg (1995) suggests has its routes in the anthropological tradition of collecting data around tribal campfires. Significant factors for individuals attending focus groups are the setting and environment of safety that is created by the facilitators (Williams and Katz 2001). The setting was the SSCC during times when crèche facilities were available or when women and their partners may have attended other activities. Support from the Volunteer staff at the Centre facilitated the distribution of refreshments and the provision of crèche facilities were made available. The focus groups had one researcher acting as the facilitator of the process and the other being an observer/moderator (Bryman 2001). The skills required for these roles are being a good listener, observer and reflector (Krueger and Casey 2000) and are comparable to those used within educational practice by both researchers.

The following focus groups were set up:

- Three with women who had experienced midwifery care in the last year;
- Two with partners of women who had received midwifery care;
- Two individual interviews with women;
- Two groups with mixed lay and professionals working at the SSCC;
- Two individual interviews with stakeholders;
- One group with community midwives working in the associated geographical area employed by Bournemouth NHS Trust;
- One with the SSMWs.

The women and their partners were recruited via the lay and professional staff at the SSCC in particular the health visitor. The midwives working for Bournemouth NHS Trust were approached via the community midwifery manager. Flyers were posted in and around the SSCS centre to raise awareness about the study. Information sheets about the study were distributed by SSCC staff. The information prepared is in two formats, one which follows traditional ethical principles of practice as identified by COREC (Central Office for Research Ethics Committees 2007) and the second which uses language and images that seek to meet the needs of a wider audience as recommended by EdComs (Dartnell, Gamguly et al. 2005). Written consent was obtained prior to commencement of the focus group or interview. The numbers of

participants in a focus group were decided according to MacIntosh (1981) to have between six and eight people and the intention was for the women's focus groups to achieve 'saturation' of issues (Bryman 2001).

Following the focus groups the researchers recorded field notes and reflections surrounding issues that stood out within the interaction. As with the individual interviews they were transcribed verbatim and the analysis was via the identification of themes significant to the study. The focus group analysis was informed by the work of Krueger and Casey (2000) who offer a structure that promotes directed analytical enquiry. The qualitative analysis is presented using several different formats. A summary of the thematic findings is presented alongside the NSF and ECM outcomes to enable evaluative comparison to be made with national expectation. This qualitative data when considered with the quantitative findings will enable the reader to gain insight to the contextual social world of individuals receiving midwifery care in the Sure Start area. The analysis of the women's/focus group activity will also be with reference to the storied experience. Via the multiple storied accounts of individual women a blended narrative can be created to form an illustration of a woman's journey through the maternity care system at SSCC. Such an approach is congruent with the research aims, Government agenda: Department of Health (2004) and Elliott (2005) indicates how the narrative approach can provide a reflexive bridge between qualitative and qualitative methods. The presentation of the individual's journeys in health care is being used as an approach to develop care pathways that are integrated, Campbell (2004) and will draw on the work of Ely (1977), Polkinghorne (2005) and Leamon (2001).

Ethical Considerations of the Evaluation

Holloway (1997) asserts that attention to ethics ensures the maintenance of "moral standards" within research. Much consideration has been given to the ethical issues which surround this study. The study was approved by Dorset NHS Research Ethics Committee in May 2005. The significance of ethics in any study is to ensure the safety and wellbeing of its participants throughout the process (Holloway 1997). Informed consent is now part of the daily life of a health professional as no care is provided to women without information and consent (Department of Health 1993a; Department of Health 1995; Department of Health 2004). The importance of choice and thus consent in maternity care has been widely discussed in the literature (Kirkham and Stapleton 2004).

Signed consent was obtained from all participants. Participants were able to opt out of the study, without the reason needing to be explained, at any

point before or after they had given consent. It is recognised that discussing experience can provoke emotions. If individuals had become distressed when sharing or after sharing their experiences, the SSCC had volunteers available for immediate support and information regarding Trust based contacts who were able to provide further discussion or counselling opportunities alongside local Health Centre services. This was not required. No issues regarding the quality of midwifery practice were raised and no participants wished to pursue making contact with the local supervisor of midwives.

No midwives interviewed wished to discuss further issues touched on in the interview/focus group; support was not therefore required by the observing researcher and details of the Royal College of Midwives Counselling Service did not need to be provided. Midwives were aware that they could contact a supervisor of midwives for supportive discussion and further reflection on issues relating to their/others' professional practice (Nursing and Midwifery Council 2004a).

Had any interviews raised concerns about the women's physical or psychological health, the researcher would have worked within the NMC Code of Conduct with regard to confidentiality. The researcher would have discussed with the women their options including the seeking of appropriate medical/health care. To ensure personal safety, the researchers ensured records were kept: personnel were informed of their location and attending interviews/focus groups and associated time frames and conclusion of the interview.

To ensure confidentiality all data is stored on password protected computers and no records of individuals' real names have been logged. Recorded qualitative data is securely stored and accessible to the researchers. Individuals involved were provided with a pseudonym to protect their identity without removing a sense of individuality. Information shared by those who hold a stakeholder role had their identity protected via the thematic analysis and reporting process. All individuals involved in the study, their consent forms and tapes will be retained and stored in line with the University standards for post graduate students.

FINDINGS

Demographic Data of the Centre's Local Community

The SSCC is situated in BH11. Neighbourhoods are categorized by ACORN: 'A Classification of Residential Neighbourhoods.' There are approximately 2 million postcodes in the U.K. (the average postcode being shared by around 14/15 addresses). The marketing-data firm CACI produced this classification to include every street in England, Scotland and Wales, fitting them into 17 distinct groups, which, contain 56 'typical' ACORN neighbourhood categories. Streets of similar people are grouped together and a postcode is assigned to the type which is the best match with the unique characteristics of the street. This postcode is known for its low income earners, older people who often reside in a semidetached property (A Classification of Residential Neighbourhoods profile (ACORN) 2007). These are known as type 45 in the ACORN classification. Only 3.03% of the UK's population fit into this category (A Classification of Residential Neighbourhoods profile (ACORN) 2006). Population figures are in appendix 3.

Whilst many of the neighbourhoods which fit into these categories are in the North East or the West Midlands, the profile for BH11 from Upmystreet (2006) is as follows:

Family income:	Low
Interest in current affairs:	Very low
Housing – with mortgage:	Low
Educated – to degree:	Very low
Couples with children:	Medium
Have satellite TV:	Medium

Homes are typically council properties, many of its older clientele having serious health problems. Retired men and women are likely to live on the state pension alone (A Classification of Residential Neighbourhoods profile (ACORN) 2006). The local population are usually working in routine jobs in shops, on the factory floor or in other manual occupations thereby on low incomes (Upmystreet 2007). Although the cause has not been identified, there is an association with age or previous work, a number of people suffer from chronic ill health (A Classification of Residential Neighbourhoods profile (ACORN) 2006).

Local properties are small, usually one or two bedrooms, and many people rent their homes from the council or housing association; less than 50% of the households own a car (A Classification of Residential Neighbourhoods profile (ACORN) 2006).

The population has little spare money, and so expenditure is often at local shops with other purchases made via catalogues through mail order; other spending activities are playing bingo and the lottery, betting and going to the pub; few leisure activities are undertaken (A Classification of Residential Neighbourhoods profile (ACORN) 2006). However, within a mile there a one-stop-shop, butcher, baker, off licence, greengrocer, newsagent, post office and a supermarket (A Classification of Residential Neighbourhoods profile (ACORN) 2006)

Crime figures for 2004/2005

Crime in the West Howe area is higher than that in other areas of the town. Crime is tackled locally by Crime & Disorder Reduction Partnerships (CDRPs). These are a partnership of the police, local authorities and other organizations whose aim is to tackle crime and disorder locally. Bournemouth Borough Council (BoBC) shows an increase in violence against the person (25 incidents per 1000 of the population against the national average of 16.4). Sexual offences in BoBC are double the national average (Bournemouth Borough Council 2006).

There is only one pub within half a mile of BH11 and all others are nearly two miles away. There is a cinema just under two miles away and a few local restaurants and takeaways. Schooling is also challenging within the BH11 area. The primary school less than a quarter of a mile away has English and science results 10% below the national average and maths results 16% below the national average according to 2004 statistics. The school has 663 on the role, which is larger than most primary schools, it has 40% of its role made up with children who have additional educational needs (The Office for Standards in Education Children Services and Skills (Ofsted) 2002). The population is very mobile making up to 20% of children moving in or out at different times, causing difficulty for children to settle into learning (The Office for Standards in Education Children Services and Skills (Ofsted) 2002). The nearest secondary school demonstrates GCSE results of 34%, nearly 20% below national average figures (The Office for Standards in Education Children Services and Skills (Ofsted) 2005). More than a quarter of all pupils attending this school have additional educational needs, The Office for Standards in Education Children Services and Skills (Ofsted) (2005) with many students entering their secondary education with below average grades.

Approaching the Centre for the First Time

The West Howe Sure Start Centre and play ground has been positioned well in what was a disused open area that had been allowed to become run down. When you approach the Centre you pass by the colourful play area that has activities for the young and older children, where the swings hang intact, the slide is in full working order as is the other play equipment and there is no graffiti. The Centre is a single story building in the middle of the open space. It has an external children's play area with safety fencing; some of the Centre's windows have children's artwork on them and others offer a glimpse of the space within. Having buzzed to gain entrance into the Centre you open the doors and are immediately greeted by someone with a welcoming smile. The entrance is designed with sufficient space for a number of people to gather, for parents with their prams or toddlers to linger with a member of staff and catch up. The following demonstrates a father's response to entering the building for the first time:

I mean, this is the first time I have been over with the baby, yesterday I came across to see a careers person and today I was made to feel very welcome, you always are made to feel welcome here. It's wonderful. (Dad)

Off in one direction are several offices, a meeting room and the computer room and to the other a large café/meeting area that is filled with natural light. Adjoining this is the kitchen where food and beverages are produced and where classes are held in supporting clients to develop their cooking skills. In another direction is the nursery, a room full of colour, images, stimuli, and warmth leading off from the children's area are smaller rooms for quiet time or private conversations.

There is evidence of the Centre's activities everywhere in displays, posters and leaflets that are strategically placed throughout. To describe it in such detail seeks to provide the reader with an opportunity to walk in the shoes of the local parents who access it to attend the activities facilitated by the staff.

I feel more safe now this is here. I let my kids go on that park more than I ever did. I wouldn't let my kids go up there, I wouldn't, I hate it, there was always kids, you know, older kids doing whatever they liked over here. They put the centre here, now they done that I have no problem; my kids could stay up there all day if they want to. (Parent)

Another parent commented on how proud she felt of the outside area and if she saw a child in the play area not using the equipment appropriately she now felt able to say something to them about respecting it as it belonged to everyone. The locality of the centre in this open space surrounded by housing enables easy access;

Here we are meant to be easy to access, within easy walking distance so they can and do access things. (Centre Staff)

Centre staff and their activities

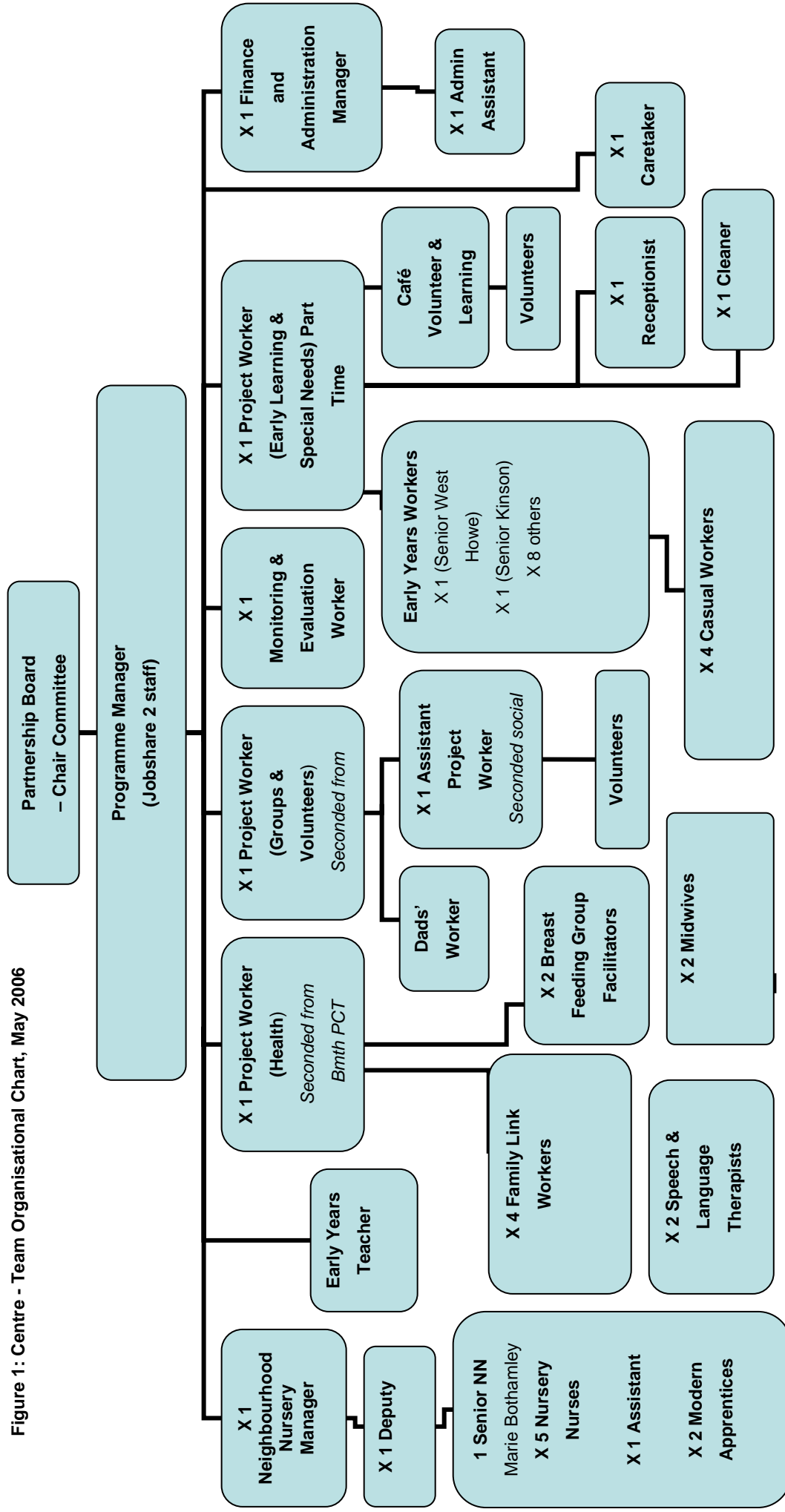
The Centre employs, directly or via secondment, and is supported by a number of volunteers who cover a range of health, social, administrative and lay personnel who collectively and in partnership with the community provide numerous services and facilities. The Team Organisational chart (Figure 1) illustrates the range and number of staff, the vast majority of whom are part time in nature. The activities of the individuals listed here are those in addition to the role identified with the health or social carer's professional remit; they focus on the Centre's activities of engaging with parents and children in the area.

Table 1. Centre staff and their associated activities

Staff	Activity
Midwife	Bumps and Babies, Bosom Buddies
Family link worker	Bumps and Babies
Early years manager & workers	Let's Play, Messy Play, Toy Library, Sure Tots
Health visitor	Bumps and Babies
Receptionist/administrative staff	Welcoming clients, general administration and support work
Social worker	Case conferences, complex family review meetings, staff support
Crèche manager	Overseeing all crèche activities
Project worker/initiates courses on different issues involving other Centre staff and relevant external people.	Cookery, Computer, Employment workshops, Self esteem, Art courses for parents and children, Infant massage course, Confident parenting, Developing maths or English, First aid and home safety, Smoke stop, Sure Can, Parents Forum.
Volunteers – buddies	How to be a volunteer/buddy
Speech therapist	Speech and Language support, Tips4Twos

Centre staff are funded by different streams of monies that change over time. The core funding for the project came initially from the Government and subsequently changed so monies came from the local authority. As it can be seen from the organisational chart some staff are seconded into their posts, this may be informed by the need to maintain a funding stream for the post and role that they fulfil.

Figure 1: Centre - Team Organisational Chart, May 2006



Lived Philosophy of the Centre, its Clients and its Staff

The Centre's service philosophy is in accord with the Government initiative of providing children living in a disadvantaged area with a 'Better start in life' (Department of Health 1998). The Centre and the staff within it share a philosophy founded on working with and enabling the local community to enhance their lives. The relationship is a collaborative one based on principles of partnership, the need and desire for social justice for all individuals. There is an overriding philosophy of a centre which is there for the family; staff will try to support members of that family whatever their age.

The Centre staff communicate their respect for individuals and their right to choice and control over their lives alongside their professional responsibility to move between being an advocate, a protector of individuals both young and adult and being a friendly accessible local service and resource centre. When services additional to those offered by the staff or the resources available at the centre are required the effective links that exist with other agencies, both lay and professional, are used to meet individual and local requirements.

This area wasn't chosen for a Sure Start area for no reason at all, were talking about an area of disadvantage, we're talking about results if you like in terms of children's welfare, how well they do at school and all these things (Centre staff)

The Centre, its staff and activities are valued by clients and staff alike:

I think it is the atmosphere isn't it? The environment and the people who work here who create that environment, really and the continuity of staff. (Parent)

It's not only for your children it's a place for us as well, to meet up with other people. You know its good for the kids but it's also good for the parents as well, I think. (Parent)

I think it is also about building up relationships with people so they feel able to ask questions and they are able to build trust and have their worries and concerns listened to. (Centre Staff)

It's quite a pleasant atmosphere isn't it? I mean, you can go into some places and people are a bit anxious and stuff aren't they, and it can put you off a little bit, and you can sense when people

are like that, and so far I have not come across anybody like that here. Obviously I don't think I will here, either. (Parent)

It's clean here as well. You know you get some establishments where there's a lot of children involved and they can be a bit, you know you, go in the toilets and there are soiled nappies. But personally I think here is a very clean establishment, and I walked in there this morning, it smells clean and that is important as well. (Parent)

A while back they did 'Father's day' [...] they had pictures done of their dads and that was quite nice. [...] He (her husband) says they all come up to me, and start speaking to me. I'm like; 'well that's the whole idea'!(Parent)

I've lived here for two years and all my family live miles away so I have no one up here. My partner works so if it wasn't for this place I'd be, I wouldn't have no one, to talk to. (Parent)

This quote sums up the ethos of the SSCC and how it is perceived by those who use it.

Well it's the people isn't it? They are all friendly, nice; nothing is too much trouble (Parent)

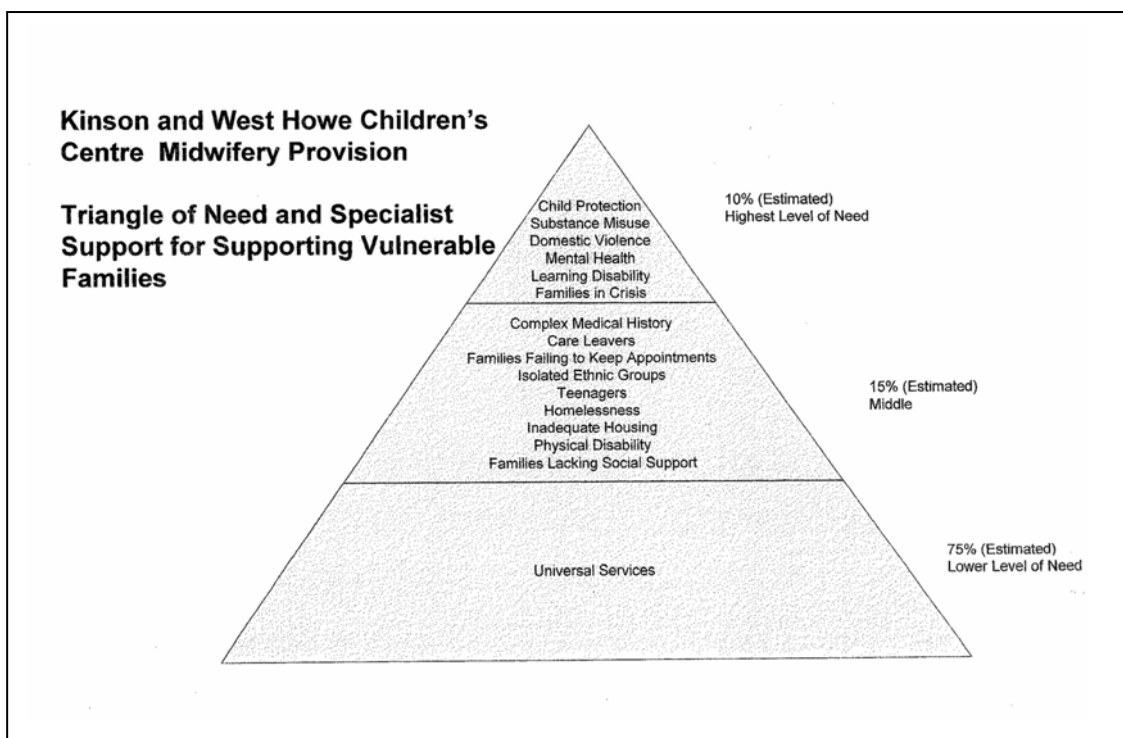
In addition, two parents in Group 1 having a discussion said:

*Parent : 'Cos the midwives and helpers, if you're just sitting there talking, they'll just say, do you want us to check your baby, then take your baby from you as well, and play with them and...
Parent: [Interrupts] so you just feel like, so relaxed, you know, it's lovely.*

Working in partnership

Within the Centre it is acknowledged that individuals have a range of different needs. The diagram below developed by centre staff illustrates the different levels of need and how social issues can be prioritised.

Figure 2



The care of families with a high or middle level of need is estimated here to be 25% of the client group; what is not estimated alongside this is the representation of how much time staff need to support these families. Families with such complex needs are provided with support from relevant centre staff who do recognise that when working in partnership with parents there are elements of overlap between professionals at times:

I think we do overlap but we discuss things as there are some families where there is a lot of input and therefore possible overlap and we need to say "OK, what is the most pressing issue of this family and who is the most appropriate worker to be involved?" (Centre Staff)

In relation to the Centre staff working with the SSMWs it was highlighted that the overlap was not duplication of care but a responsive to address the complex needs of some clients.

There have been some cases where they (SSMW) would recognise that the women would need additional support so would introduce someone else to ensure the women knew different people who could help them, if and when needed. We would try and do this in a relaxed way. (Centre Staff)

Enabling parents

Other clients within the community required help and support that draws on the many talents of the centre staff and their network of colleagues and their collaborative ability to provide regular or ad hoc sessions, groups or workshops. These activities and their facilitation focused on three broad groups:

- The parents: cooking course, computer courses, self esteem workshops, volunteer scheme, training;
- The parents and their children: open days, special events i.e. Father's/Mother's Day, Bumps and Babies, Bosom Buddies;
- The children: crèche, multiple play activities.

The provision of the crèche enabled the parents to attend groups, courses, workshops and training sessions at the centre.

If you look at the projects now it is very heavily weighted towards providing services to enable parents to do things so it might enable them to do a computer course or a parenting course or might enable them to go on a self-esteem course but the facility that enables them to do that is the crèche, it's quality of staff able to give quality of services through the crèche and 'stay and plays'. (Centre Staff)

The significance of the Centre's programme of activities on the individual should not be underestimated as this woman indicates:

I was just coming here, doing courses and that, so I'm here every day. [...] The cookery one at the moment, and an art one soon, so quite a lot. I used to be quite shy before I come here and, now I'm getting out of my shell. (Parent)

For this parent 'getting out of her shell' was enhanced by being asked and trained to become a volunteer or buddy, a process a member of Centre staff describes:

Well it's usually through a member of staff; someone would have been identified as confident to welcome new parents. Then every now and then we would put on a buddy training and this would include such things as confidentiality, so they understand not to share anything that has been shared with them at any of the sessions and if there could be some historical conflict as this is quite a close knit community so there could be historical grievances that come to light and we talk about what the role of a buddy is. How it is a bridge between staff and parents umm...we would talk about what qualities they

may have, smiley, chatty, non judgemental, the list is endless and then at the end of that if they want to, and, if, when they come along it is a good day and they are quite up for talking to new parents then they wear their badge and they will help meet and greet a new parents. If they have had a particularly disturbed or bad night or don't want to be a buddy then they just don't put their badge on. (Centre Staff)

The mother who went through this preparation shares how she is now part of the Centre team facilitating others:

Um, if there's like someone new comes into playgroup, and they're shy, they don't wanna speak to anyone, then I've gotta go, approach them, and speak to them, and say about how long I've been coming, things like this. I ask how many kids they've got and stuff like that. [...] I used to be shy and now it's like, I've come out of my shell.

Here a Stakeholder reflects on how they noted a change in another individual:

We have a self-esteem building course which is quite scary really. It's several hours long over a number of days and it's really getting people to look at the things in their lives that's held them back from achieving [...] There was one parent in particular I can think of that, who I don't think would have gone anywhere near something like that but not that long ago did do it and who's come on in leaps and bounds in terms of attending other courses. I was here on a Saturday dropping some stuff off [...] and she shouted out across to me over the road and this was someone who wouldn't have said 'boo to a goose' in the past. It was remarkable, the change, the confidence in her and that I'm sure will reflect in the parenting. (Stakeholder)

Personal development is difficult to measure in terms of health and social care. It is not quantifiably measured but the overriding messages from the SSCC demonstrated how individuals were developing in terms of confidence and skills and how this could potentially impact positively on their lives and that of their families.

Maternity Care

Within the NHS, change at strategic and local level has been a feature for several decades. In 2006 the reorganisation of primary care in the

Bournemouth and Poole area led to the formation of the Bournemouth and Poole Primary Care Trust. A change in the provision of maternity care in the area was planned for 2007 with the current provision from the Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust and Poole Hospital NHS Trust becoming united under one management. This planned amalgamation has now been postponed until 2008. The public knowledge of these plans informed the research and evaluation of the midwives' role at West Howe.

Maternity services are offered from two maternity units: Poole Hospital is situated on Longfleet Road, the A348 which is half a mile from Poole town centre. Access to the hospital from BH11 using public transport is by bus, the Wiltshire and Dorset Bus Company has buses which stop at the main entrance on Longfleet Road. The Royal Bournemouth Hospital is located in Castle Lane East, Bournemouth, BH7 7DW to the East of West Howe.

At Poole the care is shared between midwifery and medical staff. There are services in places for women seeking normal birth and those women whose general health or health in pregnancy is identified as higher risk than normal and that they need additional medical or midwifery services or support. By implication of their wider remit of care the services cover a broad area with some women from the Bournemouth area attending Poole for specialist care. There is provision of a 'low tech' birth unit at Bournemouth staffed primarily by community midwives.

The Royal Bournemouth Hospital provides care to women living in the Bournemouth, Christchurch, Poole and the surrounding New Forest areas. Care is facilitated by community midwifery based teams which supports a 15% home birth rate; this is higher than the national average. The normal birth rate for England (2004-5) was 2.53% (BBC 2006) although figures are increasing throughout England and Wales (BBC 2006). Normal birth is promoted in Bournemouth and provision for this is through a 'low tech' birth centre within the main hospital.

Bournemouth community midwifery interface with the Sure Start midwives

The midwives who provide midwifery care in the area which surrounds the Centre work within Rainbow team based at and managed by Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust (Bournemouth). These midwives carry a caseload of women within the community that the Centre serves. Women who are identified as not needing any medical care during the pregnancy or labour, can book with these midwives to give birth at home or in the low risk Bournemouth Maternity Unit. Women from the area identified as having additional medical or obstetric needs will be cared for during their pregnancy by the

Bournemouth midwives in conjunction with midwifery and obstetric staff at Poole NHS Trust. These women will be booked to give birth at Poole and then receive follow up care by the Bournemouth midwives in the community once they have been discharged home.

It is recognised that the midwives working in the community may adopt a partnership approach to working with women and their families as advocated by Pairman (2000), Page (2000) and McCourt and Page (1996) which facilitate holistic care:

Midwives who work on the community...I think see themselves as guests in peoples' houses and there to support and advise them and to a certain extent do as the SSMWs do, point women in a certain direction, help them with this, help them with that. (Stakeholder)

The ability to provide holistic care is informed by the current context of co-ordination and distribution of workload, staffing and other issues within the Bournemouth and Poole area:

They can't (provide a holistic service for all the women in the SSCC area) (Community MW) as they have case loads of 120 women and these women need quite extensive extra input at times. (Stakeholder)

When they come to an antenatal (check up during pregnancy) they come in to a GPs surgery and there's a desk and a computer and a table, and a bed and things and you have 15 minutes. A lot of women find that quite threatening, opening up their hearts knowing that there are lots of women in the waiting room as well, waiting for your time. (BMCM)

We're still doing the physical checking and they're (SSMW) giving them the emotional support, we're rushing off and seeing 20 women a day. (BMCM)

From our point of view it's really quite handy with the more difficult cases, people that need a lot more input, you know, its quite nice that you can talk to a SSMW and they'll sort of take it on and they've got time. (BMCM)

Parents were aware of the pressure placed on midwives and acknowledged how it impacted on their care:

The other MW (community midwife from Royal Bournemouth Hospital) is nice but she has umpteen people to see and she is on call and if that phone went off she may have to go, she may have to cut short our visit for an emergency. [...] It's really, really hard for them they have a big list of who to see and it's really hard for them when they are based from the hospital.
(Parent)

I found that the difference was that the midwives at the doctor's would be solely about the child and your health.
(Parent)

The size of the caseload carried by the usual community midwives was reflected in the quotes from women whereby they felt that the midwives had many more women to see compared to the SSMWs:

I didn't have any relationship with any of my midwives as I was just, they were all friendly enough and everything, but I just didn't feel like I built a relationship with any of them. [...] You'd go in there, and there was always someone different.
(Parents)

They were friendly enough and everything but again you don't feel like you can have this long discussion. (Parent)

You're more of a person up here, it's almost like they'd remember, whereas if you go to your own midwife they'd have to look back in the notes, you know, they didn't even know who you were. (Parent)

The current organisation of services from two hospitals and community midwives alongside SSMWs leads to individuals with medical problems relating to their pregnancy, experiencing care from a range of different health professionals all working from a different place.

We were under Bournemouth for scans but Poole for the delivery. (Parent)

I have to give birth at Poole. I have no choice, I have a condition called Strep' B which I didn't know I had with my first. [...] I have to have antibiotics as soon as I go into labour and have a drip put in. I hate it, but I know that if I don't have it my baby is gonna die so I have to put up with it. [...] I'm having all my checks now at Bournemouth because I wanna find out the sex of my baby and if you go to Bournemouth you can find out the

sex. [...] So I'm going there for my checks, but I've gotta have my baby at Poole. (Parent)

Some of the parents in the study sample indicated that they sought out their midwifery care from the SSMWs as they had 'more time' for them. In having the SSMWs provide this level of social support the fragmentation of care was not talked of as a problem. The provision of care to women with additional needs by SSMWs will be returned to later in the report.

One woman was seeing a different (Bournemouth) midwife at every visit, this woman had a history of depression and obviously it was affecting her, so SSMWs took over her care basically, but they kept us informed at all stages about what was happening. (BMCM)

The understanding gained by listening to the respective groups is that, whilst a desire to provide holistic care was present, the organisational framework of maternity and obstetric services led to the privileging of medical and obstetric needs over psychosocial needs.

One of the issues and problems of having a service based in a hospital that it's kind of separate from the community and what else is going on in other agencies. There is an argument almost for multi agency team work. (Centre staff)

Drugs and Child protection are no less important than the clinical needs that have been identified by the hospital. (Centre staff)

The split was reinforced further by the hospital based medical care being prioritised above the psychosocial care that was more community based. The significance of this for the parents and their children who reside in the catchment area of the Centre is that having been identified as living in a disadvantaged area, they are at greater risk of morbidity and mortality compared with families from more affluent areas (Confidential enquiry into maternal and child health 2004; Department of Health Social Services and Public Safety 2005).

System of referral by Bournemouth midwives to Sure Start midwives

When the SSMWs started at the Centre a communication system was set up so the SSMWs would receive notification of women residing in the BH11 postcode who were pregnant. This system is an explicit as one community midwife explains:

When we see the women at our referral, we've got a list of postcodes and things that are in the Sure start, children's centre

area now isn't it? We do an extra copy of the referral form and then either we send it to them [SSMWs] or quite often we'll meet with them and give them a load of referrals that we have. (BCM)

This process, when followed, worked however it was commented on as having a number of frailties:

- Women who lived within the catchment area of the Centre attended a number of health centres/surgeries;
- Referral was prompted by the effective use of the postcode crib sheet;
- The community midwife was required to complete additional paperwork;
- The system of information exchange between health centres and the Centre was informal.

This situation prompted one of the Centre staff to present the view that:

We are disadvantaged really in that it's the same when we register a new baby here, we do not actually know how many new babies or pregnant women are out there, we are not automatically given that information due to data protection. So, we rely on midwives and Health Visitors to pass on, refer women and families who are living in the area. The Health Visitor or Midwife's frustration is that they have to remember the post code stuff and who it is. (Centre staff)

The SSMWs were aware that they were not receiving notification regarding all women in the Centres' area and sought to highlight this to their community midwifery colleagues. One way of knowing who is pregnant that seems to be growing is self referral. Women are now finding out about the SSMWs and attending the centre to ask the midwives to care for them. These women have been told through a word of mouth system through friends and family about the SSMW service.

One of the health professionals also stated that:

There are often families missed; we may find out about a woman attending here because of her going to some group we run but the midwife has not necessarily heard from the community midwife about her. So it can be a bit hit and miss. (Centre staff)

Sure Start Midwives Scope of Midwifery Practice

The Sure Start midwives have in the four years they have been at the Centre developed their scope of practice and service provision. This has been alongside their professional development which has included studying varied topics relating to public health, midwifery care, child protection, sexual health, and advancing care for vulnerable groups. The learning focus and drive has been led by the midwives and has been funded in part by different sources. What this activity illustrates is a life long approach to learning as endorsed by the NMC (Nursing and Midwifery Council 2004; Nursing and Midwifery Council 2004a).

A requirement of the professional body, the Nursing and Midwifery Council is the Notification of Practice which is completed on a three year cycle and the Notification of intention to practice as a midwife which is completed on an annual cycle in association with the individual's Supervisor of Midwives (NMC 2004a). This process seeks to ensure that the midwife is meeting national standards of practice performance and the Midwifery Supervision process is in place to support midwives' personal and professional development (NMC 2004a). The SSMWs indicated that they met with their supervisors of midwives and that their professional development was informed by their role and the developing services. The process of Midwifery supervision is also there for midwives as a source of support and guidance relating to practice experiences. The SSMWs reflected on how and why their need for support in relation to this was often provided, at least in part, by the Centre staff:

But I don't talk to my SOM [Supervisor of Midwives] about the families and my role here about the complexity about the cases and I know here that in Social work that supervision is totally different they have almost weekly or two weekly supervision and its case supervision and its OK what is going on for that family and what you are doing and that seems like a really useful structure. (SSMW)

When the midwives first took up post, agreements were made surrounding the prioritisation of their activities:

It was very specific what areas they were going to work in and what targets were going to be. (Stakeholder)

Initial Sure Start midwifery targets

- Care that could be described as 'add on' to the midwifery care provided by the community midwives;
- The provision of support to the breastfeeding group;
- The promotion of smoking cessation in pregnancy;
- The facilitation of antenatal and postnatal education;
- A reduction in numbers of children admitted to hospital with gastroenteritis;
- The promotion of contact and provision of support for hard to reach or vulnerable women, including teenage mothers and drug users.

By integrating the SSMWs within the Centre, families can receive care appropriate and responsive to their needs:

There are a couple of families that I can think of where there was known drug use in the families. One couple were hesitant about using the services here, fine about having the SSMW round but the services here were seen as official, but hesitant about the centre. (Centre staff)

The initial targets were drawn up prior to the NSF and ECM national agenda (Department of Health 1993a; Department of Health 1999a; Department for Education and Skills 2004). With the SSMWs' increased knowledge of the needs of their local community, the targets and scope of practice has increased from that originally envisaged.

Sometimes I would be with them an hour because I was not there as far as they could see in any specific role other than just a friendly midwife and sitting with them. They would just start telling their stories and then I would find there were far more things they need support and guidance with than those original aims. (SSMW)

One woman expecting her third baby whilst hesitant about sharing it with family had shared it with someone else who advised her to see the SSMW:

Look, you're pregnant, come and see the midwives at Sure Start. They know we'll "sort it out". (SSMW)

Emergent care and target needs

- Providing antenatal and postnatal care to individuals who found it difficult to access midwifery care and with complex needs;
- Involvement in child protection cases;
- Pregnancy testing and family planning;
- Supporting families with babies up to one year;

- Focused activities related to national focus i.e. child safety week;
- Taking women in their cars to appointments, group activities and events.

The SSMWs are, in principle, line managed by Bournemouth maternity unit. In practice, however, they and others recognised the need and their ability to self manage their work and to draw on the management and professional support resources of the Centre staff.

We have always kind of involved them in things going on in the centre and to come to team meetings because that's somewhere that a lot of information sharing and ideas and creativity comes from. (Centre Staff)

Their emersion within the Centres' team enabled them access to other members of the team, tapping into their professional knowledge base.

Lived Experience of the SSMW Philosophy of Care

The SSMW focus of care was described as 'add on care' to women within the catchment area of the Centre. This placed in the foreground the social nature of the midwives' role and the significance of the development and maintenance of relationships.

They give me confidence as a parent [...] its almost like they're your mums, aren't they, as they're older and you just phone up and say, I've got this and you talk about any personal problems you've got with your body as well, your periods or anything like that you can talk to them about that as well. (Parent)

The SSMWs acknowledged their personal interest in the social model of midwifery and their educational updating clearly illustrated their commitment to develop further their knowledge for practice. A stakeholder notes the importance of wanting to be involved with local communities:

There are some midwives who are quite comfortable and able to work with difficult families, hard to reach families and difficult circumstances but I think as with health visitors there are those workers who do find it more difficult who are more likely to feel comfortable with the norm. Someone like themselves (Stakeholder)

For women, their experiences of care from the SSMWs is summed up thus:

She knows me, so she can give me reassurance, she's honest with me and I need that sort of up front approach. (Parent)

This parent had a number of additional needs and the SSMWs acted as an advocate in communicating with other individuals to resolve the anxiety for the women in being expected to share her whole story each time she met someone new. The SSMWs also provided information so she was a partner in her care leaving her feeling enabled.

But she didn't talk me into it, she gave me the information I needed to feel safe and make a rational decision. Because I got so low I wasn't thinking rationally anymore and you know the smiling face and a kind word means a lot (Parent)

I think if you're vulnerable, any vulnerable person whatever makes you vulnerable by having somebody that you know having somebody knowing that they're always going to be there. Having somebody that can do things on your level, I don't know. I come in here where I feel safe. (Parent)

What we sought to understand from this woman and other respondents was not only what the SSMWs did but how they practised.

My pregnancy was stressful anyway and they helped take the edge off of it and sometimes I just used to sit and sob and she (SSMW) would just sit and listen and having somebody listen as well and having no time limit on things, she was here sometimes two or three hours. At one point I had a really bad day just after she was born and I just couldn't stop crying and she always intently listened. I never felt that she didn't want to be here. I never felt like I was taking up her time or anything. It was unconditional support you just can't get that anywhere. (Parent)

The phrase 'unconditional support' was communicated to us in many other ways from other respondents and it was inherent within the reflections from their colleagues at the Centre.

They have a very relaxed manner which is not one where I am all powerful and you know nothing, it is an equal relationship. (Centre staff)

I think the key word is consistency it's the knowing that that person is going to be there and if it was somebody different each time they would or could be expected to tell their story over and over again. (Centre Staff)

Yes they are non judgemental aren't they?[general agreement from focus group] It could be that a woman has a really basic query and it could have been the same query coming up again and again but they don't present or hear it as a pain, they have the time as if it's the first time they have been asked. (Centre staff)

They are flexible, adaptable. It might be, well I can't see you right now but when can I see you that is good for you? They will try and see the person straight away but if they can't it will be as soon as they can. (Centre staff)

I think they are like ambassadors really. (Centre Staff)

They are lovely, approachable, enthusiastic, flexible, friendly, a listening ear, it's the warmth and it's their knowledge as well. (Centre Staff)

They share knowledge with them (parents) and don't talk at them. (Centre Staff)

It's just about that willingness to accept things slowly. I think sometimes that the difficulty when working with people who maybe don't change in quite the way that you feel they need to is you can feel quite frustrated when they don't take up the offers that are there. (Centre Staff)

With the SSMWs being located within the Centre team and having continuity with individuals and families, being supported in making positive change, the visibility of the change can be noted in a way it may not be if these factors were not present. In summary:

I think it's also about having somewhere to come where they will be listened to. (Centre staff)

Supporting partnership working

SSMWs are integrated into the Centre team therefore they are very familiar with the services on offer. This knowledge was used to signpost women, their partners and other family members, towards Centre activities or to enable contact with other relevant agencies/individuals.

The evidence surrounding this midwifery activity reasserted the Centre's activity and their connection and partnership with the local community.

There are some parents who can benefit a great deal, who had babies, who had built up a good and positive relationship with the midwives and who now are doing things that they would never have done, like building self esteem, getting parents in the mainstream. (Centre Staff)

Well a lot of it is talking with the parents and chatting to them, it is really important to have that expertise there to be able to sign post women to other people or places of support. (Centre Staff)

The midwifery literature demonstrates the importance to women of partnership working (Pairman 2000). It supports the notion of holistic midwifery care as advocated by Page (2000). The next two quotes indicate how the SSMWs not only cared for the woman and the baby but showed interest in the whole family:

She has kept an eye on us throughout the pregnancy and whatever and helped us out with our older boy, getting him in to college and stuff. (Parent)

The 'stuff' this father was referring to involved supporting the family to make contact with the Connections service for young people. Once this contact was made the teenage boy was provided with support and guidance regarding interview techniques which led to employment experience necessary for his college application.

When she came over Monday I mentioned that I was looking for work and she noted it down and a few hours later I had a phone call saying you would be hearing from Career Finder. So I came over to meet him yesterday and I will see him again next Monday. Now she is a midwife and she does not have to do that, you know it's not up to her to respond like that when someone says we are looking for work. [...] That is going over the mark and the call of duty. I mean she came over to see my wife and daughter and not to try and find work for me. It's bloody good. (Parent)

This next quote indicated how the SSMWs phoned a woman about one issue and used the contact to share details of relevant activities:

If there's any events coming up she'll give us a ring and say, don't forget this and we have a good gossip when we're at the

events [...] we had Winton carnival last week. [...] and what was it the other day, 999 streetwise thing and the SSMW told us about that. Any events that she thinks will occupy the young, the little children. It's just to keep the stress off us really. (Parent)
She tries her best to, you know, to keep as much stress off us by finding them something to do if she can really. They've been really good, she tends to find us something to do with the children so it's not as stressed as we would be if we stay at home. (Parent)

This style of working is illustrative of the flexible and dynamic approach that is inherent within the centre. Staff showed respect for the different professional backgrounds and drew on the resources of the individual and how they could provide other opportunities for different families.

The midwife was happy to work outside her role a bit, she then used to go and talk to them (local women) after the day. (Centre staff)

I think this is the really important bit. I was talking to someone about partnership and I think it is critical that we recognise who has the relationship with that parent and I think that sometimes when problems arise can be where a good relationship is established and then because another service is needed they are 'well I can't deal with that' and the parent is passed on and the same thing starts again as the parent has to develop a new relationship. What they do here is they gauge, they are flexible in their boundary of what they will and won't do dependent on the needs and requirements of each woman. So if it is a woman who is very fearful of other agencies they may seek to provide a lot of other services by being adaptable. (Stakeholder)

In such situations, which may include child protection issues, Centre staff were not only working with the clients, but they were also providing peer support and guidance to the SSMWs.

We've got social workers and health visitors here, whom perhaps have more experience of child protection and everything and dealing with parents who have learning difficulties and drug using parents and stuff like that. (Centre Staff)

If there is a social worker involved I would try and get a bit more of a handle on what the plan is and I may have more knowledge

of the system and how it functions so I can clarify things sometimes. This could be working with the parents or the SSMW. It could be we come out of a meeting and we have a plan and they need to understand it better so I can sort of add a bit to it about what things mean and if a parent says what will happen, I can explain. (Stakeholder)

The SSMWs here indicated how the parents who attended the Centre, and those they would like to develop contact with needed not only a flexible practitioner but also a flexible service:

I see them as being people who find it more difficult to access (mainstream) services; they need a little bit more help to get there. Mainstream care has very rigid structures, there's a clinic at a certain time, and you have an appointment at a certain time. There's an expectation that you're able to attend and that you will attend. When, actually for a lot of these people, given everything else that's going on, that's just not gonna work for them and the systems just not flexible enough. So, it's about finding ways around that. (SSMW)

Sometimes the attitude of the professionals can provoke a reaction in women and then, communication doesn't progress any further. But we found that it's almost like being a friend to the women. By not being judgemental, they will, they do open up and we have to maintain that professional edge but I think the way we are, they feel safe with us and able to reveal more to us, and we've got the time for them. (Centre staff)

For this parent the attitude communicated by one member of Trust staff was difficult to bear:

Me and my partner were on benefits and I didn't have the bus fare to get down to the appointment (at the hospital). I phoned them up and said look, I can't make it and that may sound funny to you, but I haven't got the bus fare. And she said, basically, she said to me if I can't afford to get down there on the bus then how, why the hell am I having a child? I shouldn't be able to have a child, that's what they said to me. (Parent)

A further example of flexible working that has been developed to meet the needs of local women and their families was the ability of the SSMWs to transport women in their cars to attend classes, appointments and hospital.

After I had my first child she picked me up from the hospital and because [...] I couldn't imagine the midwife at the doctors being able to do that. So, I mean that was amazing for her to do that, and to pick me up from hospital afterwards when I was coming home. My partner, he doesn't drive, I drive but we haven't got a car and my family are elsewhere, so she did that for me. It was really nice. (Parent)

The next three quotes from Centre staff indicated how they placed value on the SSMWs collaborating with them:

Our remit is quite clear, it's 0–5 so we are not covering a huge age group, it's 0–5 families with children. If we have not got the midwife right there at the beginning of it, at the foundation of it then we are really reliant on family care workers referring people or on people just coming in, we would not know about them. Before the midwives came into post we would get some people through via a referral system but no way near the numbers we get now. (Centre staff)

I think that the service we offer now would not be the same service without the midwives they play a massive part in it. If we did not have midwives I think that we just be like other services offering early years care and activities like crèche and we would not be any different. I think it would affect how many parents would use it. (Centre staff)

I think that for a lot of parents the SSMWs are the first representatives of the Centre that they see and the fact that they go so far to build up families' trust, and most people are quite happy that they are having a baby and so its quite a nice thing that they can come in with that to access other services. (Centre staff)

Accessibility of the Sure Start midwives

The accessibility of the SSMWs was informed by a combination of factors:

- The strategic system of referrals from community midwives (although this did not include all eligible women and their families);
- Their approach to working with women and their families in the community and with the Centre staff;
- Their location and provision of private space to see women and their families within the Centre building;
- Operating groups for pregnant and post-natal women in the Centre and nearby;

- The part time SSMWs working together to ensure where possible one of them is working Monday to Friday;
- That, over time, the continuity of their presence has built up their reputation within the local community and had a positive effect in accessing hard to reach and vulnerable families;
- That the organisation of their workload included some commitment to regular events and group activities leaving time to be accessible to women on an ad hoc basis.

Accessibility to the SSMWs was not just a physical issue of how much time they spent where and when doing different activities. The respondents indicated it is also about how they made themselves accessible. As indicated in the Supporting Partnership Working section, the midwives recognised that formal structures may not enable access therefore they developed more flexible ways in response to clients' needs. In doing this they recognised that they were giving something of themselves:

I think there's also an element of giving a little bit of your-self as well. You, know you have to kind of maintain a little bit of that professional edge if you like but also that you know. But when they know that you're a parent, a mother or that you've had other experiences, sometimes that's really helpful when you're talking to them about other stuff, like I think you have to be able to give a little bit of that away. (SSMW)

Women involved in the study valued this and indicated how their relationship felt:

Parent 1: It's more like friendship really, than you know...

Parent 2: But on a professional level.

[Both agree.]

Researcher: So, that's quite interesting, it's a friendship but on a professional level. Can you say more about that?

Parent 2: Yeah, because it's like getting on, on that personal level as you don't feel like it's all clinical or all professional... You know the profession that they're in but you can almost speak to them on, like, a friendly basis. (Parent.)

The SSMWs were asked for an example of how their approach enabled clients.

There was a young mum who was 14 or 15 and I knew she was pregnant [...] I went to visit her and I could hardly talk to her as

she wouldn't look me in the eye but she, I don't know [...] maybe I was different to other professionals, I don't know anyway this young mum did start coming back into the centre to look for me and then gradually she started to trust me more. (SSMW)

Within this situation the SSMW recognised the need to work at gaining the involvement of other family members who were reticent at first about accessing the services in the Centre.

At first she (family member) was, oh no I'm not err, not going there. But because her daughter had come through the door, [...] it was you know, like pride, don't want charity or some people used to think it was a social services place where we "do things to them", you know, put them on the child protection register and take their children away. Other ones were just scared because it's was new. (SSMW)

By facilitating a flexible women centred service the midwives were meeting a fundamental principle of the *Every Child Matters* document (Department for Education and Skills 2004). At a local level this accessibility was described in the following ways:

I think the midwives are often the first point of contact. They are certainly the main way of gaining access to the families. (Centre Staff)

They are first point of call and along with the family link worker get to know the families. (Centre Staff)

Knowing 'they were there' was mentioned by a number of parents. Here one mother indicated how the SSMWs appeared to her to be more accessible than her community midwives;

If you haven't heard the baby, or felt move for a while, rather than making an appointment at the doctors to get in to see the midwives, just once a week, you just give them a ring and they are always here. (Parent)

You are listened to in a flexible way as there are not appointment times, its women led like, 'Oh I can pop down as I am not feeling too good today'. (Centre Staff)

If I need anything, if I'm worried about anything at all I just ring them up and they come out or they say can you come up and they do whatever they can do to help us. (Parent)

We can phone at any time. [...] if they're not in the office or whatever and if we are really that panicky, like I said to (SSMW) yesterday, she said you know all you've got to do is phone and I'll come round. It's just the fact of knowing that they're there.
(Parent)

The access to midwifery care from the SSMWs was not originally perceived as being part of their role however the provision of midwifery care helped parents to access antenatal and postnatal care and to have their holistic needs advocated for. Their ability to provide midwifery care was recognised as possible in part as they did not carry a case load of women from the local area.

I think we are enabled to do that because we don't have the commitment to do the case load and the core work of the other midwives that is what enables us to have the time to do it.
(SSMW)

Some people choose to kind of have that sort of care from them and they must negotiate that with their colleagues in the community but they don't carry a case load in the same way their colleagues in the community do. So they are free to be developing other ways of working and to be responsive to women and to engage and reach families and that's the area where the impact has been made. (Stakeholder)

By facilitating access to midwifery care, the SSMWs were aware that they were:

Promoting inclusiveness to enable equal access to services. Women we know speak to other women, they act as advocates to other women and promote the activities of the centre and our services. (SSMW)

The inclusiveness of families sometimes described as 'difficult to access' was explored and Centre staff felt that pregnant women did access the midwives as they:

Are a safe way of inviting and engaging with the families.
(Centre Staff)

In addition, talking about the SSMWs, one woman said:

They would say, 'would you like to come over, or would you like us to come round and see you and that. If you did they'd be there. (Woman)

But equally the way in which the service was used by women remained flexible and women knew that they could access it at a time of their choice:

They leave it as an open door...[...]...You don't feel like you have to have them round.

This member of Centre staff linked the engagement with families to the midwives clinically defined role and that the mother midwife relationship was not so linked with the role of 'policing' as with other professionals.

Providing Midwifery Care

Women accessing midwifery care is reported under the headings of:

- Initial targeted care;
- Emergent care needs;
- Group activities;
 - Lunch Club for teenagers;
 - Bumps and Babies;
 - Bosom Buddies.

Antenatal care: initial targets

This woman illustrated her clear concept of the role the SSMW had in midwifery care:

I'd always go to my initial midwife first at the doctors, and if they weren't available, then I would speak to the SSMW. So, it wasn't like I always went to them, but I knew they were there, you know. You knew that they were there if you needed them. (Parent)

Some women who sought midwifery care were within the initial targeted groups. This quote indicates how the SSMWs were recognised by their midwifery colleagues as being an appropriate source of continuity of care and recognised that they were not in a position to provide a level of service equivalent to full case loading.

One or two (the community midwives) have been really grateful to us for looking after the women that they know will need more care and some of the substance users, the women from the homeless families unit. [...] in fairness to them they do know

they're not being, got the time to give really good care to these women so they are glad that we can give that extra input. (SSMW)

The 'extra input' was identified for each woman and her family:

It depends on the client that we've seen regularly for antenatal care because for whatever reason, it just wasn't working out at the surgery. They weren't able to access it because of their lifestyle for example. Then there have been others who have been quite happy to attend ante-natal at the surgery and it hasn't been a problem for them but they will sometimes come to us for advice as they needed it. So, it very much depends on the client. (SSMW)

One of the issues for the women who have additional care needs was identified by a member of the Centre staff:

It's the knowing that that person is going to be there and if it was somebody different each time they would or could be expected to tell their story over and over again. (Centre Staff)

This quote indicates how when communication between the women, community midwives and the SSMWs is not transparent misunderstandings can arise and this can be stressful. This mother identified she missed appointments with the community midwives but was seeing the SSMW; however, this information was not exchanged initially so the community midwives became concerned:

They phoned up and checked that I was coming here. But when they found out that I was coming here they were fine about it but at first because I wasn't going to the appointments, because I found it easier to come up here. They said to me that they didn't think I was seeing anyone and they were saying it was classed as neglect. But, um once they found out obviously that I was, then it was a different story. (Parent)

This last quote highlights a transition to the emergent needs of care identified by women. Other aspects of antenatal care will be considered within the sections about groups.

Antenatal care:
emergent needs

For women their emergent care needs to receive midwifery care from the SSMWs focus on:

Continuity of care

I've seen a different midwife every single month or every week, so with the SSMW you have that personal basis going on as well as them being a midwife. (Parent)

She's been an absolute diamond she really has. With it being my first pregnancy as well, I don't know what to expect or what I've got to do or and she's just basically talked me through the whole thing. (Woman)

Time to talk, be heard

When I went to my own doctor, its like you've got a five minute appointment, you've got to rush through everything and that's it, out the door. You don't get time. (Parent)

She just sits and listens. (Woman)

Their need for social support and information

Women 1: With them (SSMW) you could talk about anything, you could talk about personal problems, the social side how to get money or how to apply for the grants and they would sign the forms so you could get milk tokens.

Women 2: It was all more personal. Whereas at the Doctors it was just more about the health wise, is the baby growing OK? They'd go 'is everything OK?'

Women 3: Which was nice, it is good to know all that but it's more the clinical side, you need it sort of personally as well.

Women 2: Yeah. They would ask about how you're doing, [...] You could say things like, things are not doing too well with my partner. It was more, it was really good. (Parents)

Another women commented:

It was about the child but its also other things, like help with money. If you're on social benefits they would always help you with information about that. (Parent)

Involving other family members and helping them to feel part of the process was a significant aspect of the SSMW's role:

The moment she puts the heart monitor on, the kids are there all four of them, they just stand there, she will interact with them and you know, she'll make them part of it. (Woman)

SSMWs identified psychological wellbeing as an emergent area of need:

We are noticing it more and more, a history of depression, on medication, or a history of self harm and then nothing is followed up. I had this situation where a young woman, already booked by the midwife, had it written on her notes. She had come here to register with Sure Start and as I talked with her I asked 'oh what is this about self harm?' and out came the whole story. [...] I said I have noticed the marks on your arm and I kind of know when it is OK to ask and I said 'Oh do you harm your self' and she said 'yes' so I said ' Oh what makes you do that' and out it came the whole story. She came in three times after that first week, just walked in. She looked terrible, she said I need to talk to you so we went into the office and she said I have had a terrible row with my boyfriend my emotions are all bubbling up I need to see a doctor now I can feel things going wrong. So we got her a doctor's appointment. Her solution is to get medication, it is a quick fix. But at least she had come here and if...she had gone somewhere where that had not happened I don't know what she would have done. [...] If she had gone into a surgery into an antenatal clinic, how 'safe' and able would you (as a midwife) feel to ask those questions? Especially when you know you are probably 15 – 20 minutes behind on your clinic anyway. So what are you going to do with all these answers when she comes out with them? So I can see it from both sides. (SSMW)

It was recognised by the SSMWs that when you do engage in this kind of conversation you do not know where it may lead. The SSMWs however were clear about how having heard a women's story they were in a position to do something in addition to the valuable service of listening:

Because we know that we have some of the, we can help and we have access to other people to help so it is not as if you are on your own with these women with all these problems. You have the support from the rest of the team and each other. (SSMW)

The SSMWs being known, flexible and accessible to the women was demonstrated by their response to women in crisis. Here one woman is

reassured as she could be seen by the SSMW in immediate response to her need.

My baby stopped moving, and it was like, you know, I was panicking and then I saw the SSMW and she heard it and it started moving it around so that was quite good. (Parent)

The next emergent need identified is that of preparation of women for their labour and birth experience. It could be argued that this would have been part of the antenatal education identified in the initial targets, if so this emphasis was not given.

Within the discussion it was clearly understood by all respondent groups that the SSMWs did not provide continuity of care to women during labour and birth. Women recognised that if the SSMWs did provide care in labour they would be less accessible and available for both antenatal and postnatal care. What became apparent is that the SSMWs, via their individual and groups contacts with women, facilitated their preparation for birth. This preparation was summed up in the following way by a member of the centre staff:

They (the women) feel quite safe in their knowledge of what is going to happen, if you like they have had this nine month journey with someone holding their hand, and how even though they have to cross the bridge themselves and they know that the SSMW are on the other side I think, it comforts them and they feel quite safe. (Centre staff)

Here a mother shared her insight into her choices regarding place of birth choice:

I had to go to Poole (due to higher obstetric risk). I did want to have the baby in Bournemouth. Anyway I wanted a family room, at Poole. That was quite nice, all your family could come in. [...] when you're in the family room, you're not allowed drugs and that lot; you're only allowed gas and air. (Parent)

This mother illustrated in her comment her knowledge of how to help the physiological process of labour and birth:

I think it's worse giving birth laying down. I was stood up for the second one.

A second women in the focus group agreed with her and indicated how:

You need to be a bit forward, when I, what I found when I went into Poole, I needed to be a bit sort of, I had to say because with my first child, it was like basically lie on the bed, you know, the bed's there and you don't. I didn't really feel like I could say anything first time, but with my second I had a bit more confidence. I said, no I don't wanna lie down (Parent)

These acts of self assertion within these women were communicated quite rightly with pride. Another aspect of pride spoken about from women was the need to return to the Centre to 'show off' their new babies; this issue will be considered in the postnatal care section.

In summary, the value of antenatal care cannot be underestimated, as suggested by staff at the Centre:

I have seen the SSMWs persuade some women that they do need to go and have antenatal checks, bloods done. I think the midwives have a 'waves' effect: the wave here isn't just a little ripple. It comes and it goes such a long way that we are probably not aware how far it is felt. It touches so many peoples' lives... (Centre Staff)

Postnatal care: initial targets

Postnatal care is a time of adaptation for the woman and her family, with many new and often challenging demands being made on them. Women who had accessed SSMW care antenatally continued to access the Centre. For some postnatal care was seen as a way to gain reassurance that the baby was growing well. The convenience of the centre was significant along with the flexibility of the centre staff.

We get him weighed every week and checked, length you know bit like you would get done up the doctors but it's easier getting it done here. The Health Visitor at the doctors are obviously not always there, they only have certain times in the day that they are there. (Parent)

A number of women highlighted the significance of being asked how they were:

With the SSMW it would be about you as well. Are you feeling OK? Do you want us to get you anything, do you want just a chat. (Parent)

The mothers valued the SSMWs contact and the relationship that had built up. In the next quote this women is responding to being asked about postnatal visiting at home and how this was planned:

It's almost, like they leave it as an open door, would you like us to pop round, if you do you can always ring us. (Parent)

Another women in the focus group later commented that:

You don't feel like you have to have them round. (Parent)

Other aspects of postnatal care will be considered within the sections about groups.

Postnatal care: emergent needs

Women demonstrated their excitement at returning to the Centre with their new baby in order to receive the attention of Centre staff inclusive of the SSMWs.

I didn't come here for about three weeks [...] I was itching to get back to see everybody, you know, show the baby off, chat to everyone and obviously they know what's been happening and stuff, so I really missed it that first few weeks, but they did phone to see how I got on. (Parent)

When I came out of the hospital, I come straight up here. [...] when I went in, they phoned to see if everything was alright, they said oh, you'll be going in soon and they were like, you know wishing me good luck, and things like that, and then the SSMW looked up and said when you've had your baby, come up and show us. (Parent)

It's almost like you want to anyway. Like part of the family, you know, I had to come up and show them, the reception and that lot the baby. (Parent)

Here a member of Centre staff reflected on her observation of the SSMW signposting during an informal conversation:

When the new mums come in so proudly with their new babies in the prams SSMW are so good at coming along and cooing and everything else but they are also so good that when a member of staff is passing by they will say 'Oh, this is Jan she is the health visitor' or what ever and if ever you have any problems like that they are good ambassadors in that situation where they very discreetly signpost parents to different things even when that new baby is very tiny. (Centre Staff)

When, after I had my first child, a SSMW picked me up from the hospital and because I was gonna breastfeed with my first, I didn't in the end, and I came out of hospital and I had no milk, no powder milk at all and um, none of the, because I had milk tokens, none of the clinics were open to be able to get any, so the SSMW came up and she come round my house with the milk, and the following day she picked me up and took me round the clinic to get some milk as well. I couldn't imagine the midwife at the doctors being able to do that. So, I mean that was amazing for her to do that, and to pick me up from hospital afterwards when I was coming home. My partner, he doesn't drive, I drive but we haven't got a car and my family are elsewhere, so she did that for me. It was really nice. (Parent)

As with antenatal care, issues of crisis emerged as significant and having the SSMWs enabled women to retain a sense of control in difficult situations. This women shared her experience of having a haemorrhage a number of days after the birth and how:

I was straight on the phone then to the SSMW. (Parent)

When asked why the SSMW she indicated how it was easier to talk with the SSMW and how she lived close and knew they would come across as soon as they could, which they did. Here she recalls how the SSMWs stayed with her at home, she acknowledged how she didn't want to go into hospital but in time recognised she needed to:

It was the Tuesday afternoon I was in a right state and she came over to me at half past three and she was still there when I was taken into hospital at half past seven I think it was. [...] They were both sat there with me the whole time. They were trying, 'cos I didn't want to go into hospital but then they got on the phone to the doctors and they were trying to encourage me to say, look you really need to go in and err, then I was home again in a few days anyway. (Parent)

Here this same mother speaks of how when she came out of hospital the midwives visited:

They'd just sit and chat and ask me how I feel, and like, basically they're telling me like, I bet you feel scared and sort of stuff like this, so they're knowing how I feel already and that's why I say its easy to talk to them about it. (Parent)

The significance of being sensitively listened to was recognised and discussed with Centre staff:

There are a lot of women out there who have loads of issues going on and they want and need to have someone to talk to in relation to the context of their pregnancy. The community midwives do not necessarily have the time to do that. (Centre Staff)

They were then asked: What would happen to the women who did not have a midwife who had time?

I think they would be left trying to struggle through. I think things would build up in the pregnancy and when they have the baby they would go down hill. (Centre Staff)

From the woman's perspective:

It's good as I think when you do have children if you're on your own or you haven't got your family around you your self esteem can hit rock bottom so you need something to pick you up other wise you just get withdrawn don't you? So it's good to have something like this that you can build your self up again. (Parent)

Furthermore, women found that there was a lack of continuity of midwifery care once they had been discharged home from hospital:

They had to send different people [...] every single day it was somebody different and you know, it was just, didn't feel comfortable.

Evidence from research literature demonstrates that women feel they benefit from continuity of midwife during the postnatal period and seeing someone they know on a regular basis (McCourt and Page 1996).

It could be argued that there is some role overlap between the SSMWs and health visitors who in many areas provide care for women at 10-14 days following the birth of their babies. The health visitors, however, did not consider that this was detrimental in any way, and this view was reinforced by women:

Researcher: Postnatally would you when you come here, once you've been seeing the midwives for a while, do you then start

seeing health visitors as well?

Woman 1: You can see the health visitor as well if you like.

Woman 2: I don't, they always pick, pick.

Woman 1: No, Jan (Name of health visitor at SSCC has been changed) is perfect...[...] she don't say nothing [...] My health visitor was really good, she only come out the first few weeks, then left it for me to come and see her.

The interprofessional working between midwives and health visitors supported the women and an empowering, non judgemental attitude from the professionals meant that they were well received.

Midwifery Groups

The provision of group activities was an integral part of the SSMW role when they took up post and local provision of services remained a priority in order to promote attendance. The provision of maternity care groups such as parent education was offered by Bournemouth and Poole Trusts however parents commented that these were sometimes difficult to attend as they were run in the evening, the distance to travel put them off and the travel costs were prohibitive for some.

What quickly became evident to the SSMWs was the need for careful consideration of how the groups would function, be communicated to families and facilitated in order to promote active engagement and partnership working. The SSMW reflected how for some of the local community the concept of attending a group was in itself off putting.

We'd say come to a group and they'd like... group just sounds terrifying and I'm quite wary about using that word group now because actually it's quite a middle class concept. (SSMW)

Via the process of gaining feedback, the SSMWs learnt to use language that was more inclusive of the community.

It's only the feedback I've had from them, so I just say, we just get together on this day and sit round and have a chat and it's actually what we call a group, but I'm very wary of calling it a group now. (SSMW)

Within the review three activities were encountered.

- Targeted workshops for teenagers;
- Breastfeeding support; Bosom Buddies;
- Antenatal and postnatal support and education: Bumps and Babies.

Teenage pregnancy workshop

The Centre provides care to an area where the level of teenage pregnancy is known to be higher than the national average. However to date exact statistics are difficult to define. At times the SSMWs were aware that the numbers of teenagers known to be pregnant swelled. When this occurred the SSMW:

We targeted the teenagers, in fact we had some really successful, they felt successful pregnancy workshops where we got, pregnant teenagers to come in. (SSMW)

On one occasion there were eight pregnant young women who they wanted to get together to offer supportive educational input. With the support of the Centre management the SSMW said:

We managed to get them vouchers for a free lunch in the café. So we said why don't you come, come to the café for a free lunch, pregnancy lunch group. So they sat in the café which feels OK. You know it's not a room where's there something gonna go on. So we sat around the tables, all ate together, err, then we had the youth worker from the young mums group came over and I think one of our err, family link workers dropped by, the breastfeeding counsellor dropped by and all kind of asked things quite casually. And again, like the other group, 'cos we were sitting there, they all started talking. So we were able to get out some of our pregnancy posters and said look this is what happened in you, this is what the baby looks like, we had some models of a baby in the uterus it got them going, the conversation going. (SSMW)

The SSMWs reflected on how they planned educational activities that promoted their involvement and drew out existing knowledge or preconceptions:

Then one time they came in, we had a quiz about breastfeeding, and the lads joined in. It was kind of tailored to them, you know, how soon can you have a drink when you're breastfeeding? things like that but it was relevant and they remembered so much of it. They did remember the health benefits as well. They had a lot of knowledge. The perception is that they don't know, but they do. It just needed a bit of bringing out, but it was there. The same when I did it, when I went to Open East School and did a teaching session, there about breastfeeding, the same: the knowledge was there. (SSMW)

One strategy that the SSMWs employed to make possible the attendance of the pregnant teenagers was to go and collect them in their car.

I have seen the SSMW go and pick very young mums up and bring them to the group week after week, if she didn't they would not turn up. One young woman she did that with is now going to another group and I am sure she would not have done that if she hadn't been helped. (Centre staff)

Here a fellow Centre staff member indicated how accessing and involving the young women of teenage years was difficult but is improving:

They (SSMWs) have got so many young mums in here. It is a group that we have found very difficult to get into the centre here, they are a consistent group and they have done like a 'coffee morning' for them when they are pregnant and they have achieved that well. They have had little groups and things.

As with other people who accessed one aspect of the Centres services the teenage parents may go on to access others:

Yes some have, so have some of the Dads. We have had difficulty in getting them involved as they often see this as a woman's environment. (Centre staff)

Bosom Buddies

One group in existence before the SSMWs took up post was the Bosom Buddies. This group was facilitated by a breastfeeding co-ordinator whose service was bought by the Centre as it was recognised that the breastfeeding rates within the area were lower than the national average therefore this was an explicit target to address. The Bosom Buddies group was evaluated in 2004, it was found to be a service that provided "a much needed support service to many mothers and their partners in the community and it has been shown that the group is instrumental in promoting and increasing breastfeeding rates in the area" (Alexander et al 2004:5).

One of the difficulties experienced by the SSMWs was that initially the provision of support to women breastfeeding in the community was sparse and this led to women travelling some miles to attend the group. Added to this the facilitator came from outside the area and was perceived by local women as different to themselves and this (the SSMWs felt) inhibited their active involvement according to the SSMWs:

The women who came were generally middle class women and so its almost that you need to start a core group and the core of

the group needs to be started with dedicated enthusiastic women but then how do you involve the families from the areas that are less likely to attend?

This dilemma was resolved over time as more breastfeeding groups developed elsewhere, the facilitators changed and more local women became involved in their local group.

But now we're getting local women coming and they're bringing their friends so it's really snowballing. (SSMW)

We now have two people, one is a breastfeeding counsellor and the other one's training to be a breastfeeding counsellor. At the moment they're employed by Sure Start. (SSMW)

Women's feedback from going to the Bosom Buddies group indicated it not only provided support and promotion of breastfeeding but also facilitated women to get to know each other.

I come to the first bosom buddies before I had the baby and got the dolls out and they got another young mum in and just showed us what to do and everything really. Only, 'cos I've built up friendships as well, that's another good reason to come. Also I have got to use the breast pumps as well, which I've been borrowing one for the last couple of months. (Parent)

The use of this equipment was free and enabled the women to maintain breastfeeding as did the provision of information and support provided by the breastfeeding counsellors and the SSMWs. The other feature that enabled women at this group to interact with each other and the Centre staff were the crèche facilities.

They were brilliant. They were very knowledgeable they had a lady who came in who had breast fed all her babies, one woman who had breast fed her baby who was now two or three They were very knowledgeable and the session was very, very good. (Parent)

Well a lot of it is talking with the parents and chatting to them but it is really important to have that expertise there to be able to sign post women to other people or places of support. (Centre Staff)

At the one I go to they also have a monitor so they can listen to the babies heart beats, which the mums find really comforting as

they find it hard to get up to the doctors or to the hospital. So with the midwives there they get reassured. (Centre Staff)

The presence of the SSMWs and counsellors at this group was questioned. However, it was evident that women valued having access to the midwives at this group as it provided another impromptu way to access advice, information and reassurance relating to an issue other than breastfeeding.

You always have one midwife and then you have the bosom buddy counsellors as well, and midwives float in and out as and when. If I need to speak to a midwife about things then I can it's very helpful. (Parent)

Just support as midwives. So, as Sure Start midwives. And encouraging the antenatal referrals then isn't it? Supporting the training workshops that they do for bosom buddies, we do part of the teaching for that and encouraging the antenatal women to come [...] to the workshops. (SSMW)

When enquiring about the Bosom Buddies rates or recorded attendance and change in local breastfeeding statistics over time it was acknowledged that improvements could be made:

The data collection, not by us, but generally has been pretty diabolical. Quite frankly, hasn't it? It's really hard to get figures. (SSMW)

What was known from observation was that:

I think from what you see from women in the group, there are more local women in there, there are more local women breastfeeding, and coming. It feels like it's making a difference but as with anything hard facts on paper, as for anything else we're doing, it's very hard to get those figures. (SSMW)

The sustainability of the Bosom Buddies group was bought up in relation to the future funding arrangements of the breastfeeding counsellor. Here the SSMWs indicated how future funds for the service may have to be generated from non traditional sources.

It's got to go voluntary, to get money of its own to keep itself going after the Sure Start funding runs out. It's a bit of a problem. They're looking at funding from various charities. But...they're vulnerable. (SSMW)

The SSMWs were aware that this was a time of transition: whilst women were still going to the Bosom Buddies group women who were breastfeeding were also accessing support from the Bumps and Babies group.

At the bumps and babies group there are quite a few breastfeeding mums in those. Not all of those mums choose to access the breastfeeding group. When you ask them they say, 'oh no, I didn't want to go to that'. They know it's quite a nice group, but they perceive the bumps and babies to have less of an agenda as it's a lot more general. So women might be sitting breastfeeding which is lovely, but it's not an agenda, it's not direct, not specific, whereas to come to a breastfeeding group and it is. (SSMW)

You know, I walked into bumps and babies recently, there were five women sat on the floor breastfeeding, I thought oh my God! Fantastic! (SSMW)

Bumps and Babies

This group was set up in two venues, both within walking distance to the Centre: Heathlands and Pelhams. This group was created for pregnant women and for those with a baby up to one year of age. The groups had an unstructured approach being responsive to the parents needs on the day. Occasionally there were structured activities run in response to request and in association with a national public health or safety agenda. The Bumps and Babies groups was facilitated by midwives and other Centre workers such as early years workers, health visitors, nursery nurses, and family link workers. This combined approach continued to expose the parents to different members of the Centre team and offered them an opportunity to become familiar with and access other services.

In preparing the environment of the Bumps and Babies consideration was given to the need to provide a space that promoted conversation, interactive play and also have space for private consultations when requested. The SSMWs responded to their early observations of how the parents used the space and facilitated positive changes.

We make a conscious decision to take away most of the adult chairs in the room so we've got child size chairs in there, we've got bean bags on the floor. So, actually, everyone has to get down. The other thing was, a lot of them would leave their child in the car seat or push chair and not really engage with them so again that's another reason to get them all down. So because they're on the floor they have to sit and talk to the person sitting

next to them or step over somebody to get where they're going so actually its a lot more suited to the communication, so that works. (SSMW)

We had noticed Mums would be sat in their chairs, backs to the children often and you know, they would be having their conversation and the children were just over there somewhere. When we started it we needed to encourage them to be playing and talking to their children. We were helped by having the early year's workers there, and some of them are really brilliant. They work in the same way as us, so we talk together before about how we want to run it and talk about how we want it low level so they can play with the older children. Some of the early years workers are very good at enabling the group to get going and drawing people in as well. So, it's not just us, it's not fixated on midwives. It doesn't feel too precious really. (SSMW)

The target group was for pregnant women, their partners and babies up to one year. Some parents chose to remain in this group beyond that time rather than moving on to be engaged in another Centre activity, here a member of the Centre Staff indicated how, with time, this changed:

I think we now better at getting the parents moved on into the other stay and playtime groups that we have. (Centre Staff)

One of the reasons to maintain this contact was that:

The idea of the midwives remaining involved for a longer period of time as many of these parents go on to have children again. (Centre Staff)

So, we decided it was going to be pregnant mums and mothers with children up to a year and then because there were early years workers there who would be working more with the follow on groups, and because there were families that come to the Sure Start building, they'd already be feeling safe within the building, they'd have got to know some of the other staff so the move on stage would be less painful. And, that has worked. (SSMW)

One of the women interviewed demonstrated how attendance at this group made a difference to her life:

My partner, well, ex partner anyway, when I found out I was pregnant, his sister was also pregnant at the same time and his

sister said to me, She said to me, come to Bumps and Babies with me. I was like that, quarter past nine, gotta be there for, and I've gotta get him dressed (older child), got to walk up there. I was like, OK then, I went up there and it was fantastic, I loved it and we got to see, speak to the SSMW and all the workers up there, they were fantastic. I mean my son is a bit of rebel at the minute, but they're fantastic with him. (Parent)

The empowering nature of the group for women is demonstrated here:

...and the SSMWs are very good at facilitating discussion, and helping Mums to share their experience by saying oh, you could tell so and so about your experience of that, or promoting intermingling and this Mum can get across the point the SSMW wants to get across without having to do it herself which is brilliant. (Centre Staff)

There are a number of issues from the collective data which identified the functions of the Bumps and Babies group:

- Antenatal and postnatal education;
- Antenatal and postnatal professional support;
- Peer support and the development of friendships;
- Promotion of positive parenting skills via role modelling;
- Enabling of parents to develop self confidence and esteem;
- Provision of a safe place to be with other people near to where they live.

The provision of education within the Bumps and Babies group was planned as informal activity to assist women and their partners to interact, to share and learn from each other and to observe the centre workers in their interaction with the babies and other children. This conscious unstructured approach privileged the needs of those who attended on the day. For them it was responsive and acknowledging of their existing parenting knowledge and skills and offered a way for the midwives to introduce parents to one another so they could learn from another's experience with the support and input of the midwives and other centre staff.

These parents indicated how the group tended not to have anything formal but it promoted communication:

You could either get talking in a group or you...on a one-to-one, nothing formal. (Parent)

When I walked in there first of all, the SSMW usually say hello and talk...and then they introduce you to other people. Then they just let you do what you feel you want to, you can go at your own pace. (Parent)

We would sit around and chat. Basically what they've got here, your (older) children in the crèche. Then you, you could have an initial chat with the midwives about your pregnancy and they would listen to the baby every week as well. (Parent)

Women valued this access to the midwife and the reassurance they offered:

Well when my wife was getting towards the end of the pregnancy the SSMW was coming round quite a lot just to check on stuff and again at Bumps and Babies they would always be there to listen to the heart beat etcetera. (Parent)

The provision of professional care continued once the baby was born.

'Cause the midwives and helpers, if you're just sitting there talking, they'll just say, do you want us to check your baby, so then they look after your baby for you as well, and play with them as well. (Parent)

They can weigh your baby there and they do all the check things you know, after like when your child has a five month contact or two month contact you can take your child up there and they weigh the baby, measure the head and say you've got the reassurance and all that. (Parent)

Well we welcome and chat with the mums and show them in to the health visitor as we have a weigh in as well there so they can chat to the health visitor as well and we lead a little group that does singing as well with the other children, provide coffee and most importantly we talk and the mums get to know each other. (Centre staff)

The issue of peer support and the development of friendships enabled parents to get together not only whilst at Bumps and Babies but outside of this.

Like I say you get out and are not staring at the TV all day and can go out you meet other people and we have got their numbers and you talk in the week and that. (Parent)

To speak to each other, and how we would talk about the birth, didn't we? Or how was your birth, and ...stuff like that.

(Parent)

It's nice you get to meet people and then you've got the crèche there for the others. (Parent)

Here a SSMW reflected on how the development of friendships, positive parenting and professional support are interlinked.

They make friends; a lot of them haven't made friends before. They do see, they learn about playing with the child because a lot of the mums haven't realised that little babies can learn to play you can stimulate them you can enjoy it, so they have learnt that and that's just by the early years workers are great at modelling behaviour: they just get on and do that. So, apart from teach them we do a lot of modelling behaviour here and it does, it slowly, slowly it does work. (SSMW)

For these parents, the fact that the parents attending were from a similar context helped and aided the sharing of information with the support of the SSMWs:

It was worth it; you could sit and talk to other people in the same sort of situation as what you were. You'd say, 'what did you do?' in that situation, and then you got a bit of information back.

(Parent)

People who are having their first child they can say things like oh, 'my baby's not been eating you know, what can I do?' and you can say something and then the SSMW would be there to talk through things with you so, it was good. (Parent)

Supporting parents in this way had the positive effect of supporting some of them to access other Centre courses and activities such as Buddy preparation, self esteem courses and more.

But there are some parents who can benefit a great deal who had babies who had built up a good and positive relationship with the midwives and who now are doing things that they would never have done, like building self esteem. (Centre staff)

For some parents attending Bumps and Babies was a focused activity in itself. Attending this group left some wondering what else they could achieve for themselves and their children.

So now its sort of right, we're doing that on a Monday morning and now we get up, 'cause I mean, I'm quite lazy I got quite tired before I had my son they thought I had a sleep problem 'cos I could just sit here and go to sleep and so I was quite lazy, I would sleep the day round before I had my son. And when I was pregnant with my son and now it's like, we get up at like, half past seven, eight O'clock and we're ready to go by about nine
(Parent)

The significance of a local venue was very important to ensure it was accessible by families living in a socially deprived area. For this parent the option of attending antenatal or postnatal groups further a field was not an option due to the cost of bus fares.

Well you get out of your house for a bit and socialise and you are not looking at the same walls all the time. None of us can drive and obviously we have the babe and two younger ones it's all bus fares and stuff isn't it, it just ends up costing a fortune.
(Parent)

Here one of the SSMWs reflected, with excitement, how the safe environment at Bumps and Babies enabled sharing:

When they're relaxed and OK, its just amazing what women will start talking about. (SSMW)

The Bumps and Babies group was significant in meeting initial and emergent targets and care needs. What was less explicit, in the quotes, was the facilitation skills of the midwives and other centre staff in organising and facilitating these sessions. This process could be further reflected on by those involved as a means to identify the core elements identified as supporting the groups' success. This information would enable further local development and could be shared with other groups seeking to set up such a service.

Recent Centre Developments Involving the SSMWs

The SSMWs have within the emergent care needs and targets developed their knowledge in order to progress their responsive service for women and their families. One example of this was their involvement in the care of women requesting family planning information and services and pregnancy testing. The provision of this service was not advertised but local knowledge of it grew through word of mouth.

I was four weeks late and I thought, she's only six months, I thought oh dear, so I come and spoke to SSMW and um, she took me in the little office and she goes 'what's your problem then? I said, oh, you know, I'm late, four weeks, you know. She said save you paying out all that money we'll do you a pregnancy test. So, it's better off 'cos she's saving you money and you're talking to someone about your problems. (Parent)

To date no statistics, we understand, have been collected regarding the level of demand for this service and the provision of family planning.

They (SSMW) can dispense contraceptives and stuff like now. Some of the work they do is around that. Some people choose to kind of have that sort of care from them. (Centre Staff)

As both services involve ongoing cost implications, the demands for the service, in our view, need evaluating in order that a case can be made to effectively support and meet the needs of the local community.

A different form of activity that the SSMWs have been associated with was the development of a group for pregnant women working with an artist exploring their experiences of pregnancy and childbirth through art. This project was funded by an Arts Council grant and the SSMWs approached a number of women who they thought would be interested and benefit from the opportunity to participate. The idea for this was developed by parents on the Parents Forum.

Several members of Centre staff were involved in obtaining the grant for the art group and in setting up the group.

The SSMW found a group of women who were pregnant and we are linking with a young artist who has recently had a baby herself [...] The midwives were around for the first session as that was quite important in terms of knowing the women getting them here and some were anxious about coming here doing something a bit different. (Centre Staff)

This demonstrated how the community were influential in getting the service they needed from the centre and subsequently how members of the Sure Start team worked together to meet their needs.

Implications for Future Developments

The context of this evaluation has occurred at a time of transition for the midwives at the Centre as not only with the future changes of Bournemouth and Poole maternity units seeking to join in 2008 but also in the funding arrangement that support the continuation of their existing commitment to the local community via their centre services. As the midwives have become so integrated within the services of the centre the possibility that this may change was met with concern from all respondent groups:

Parents

I think I'd be lost if they weren't here. Without them I wouldn't know what to do.

'Cos they know you personally as well, so when you come in if you haven't seen them for a couple of weeks, they know two weeks ago that you had this or that issue, so they remember that and its almost like you can carry on from there even though there's been a space of time.

With here you know you can just come in, they see you and then you can just go back out. You can sit in the café and have a chat with them and have a drink. With a proper midwife or doctor you can't really do that. Like one that works in a surgery. 'Cos they're just always busy.

Keep Sure Start going forever, PLEASE.

If we don't have Sure Start what would we have?

Coming here gives me confidence as a parent, because I've got the confidence its been such a long time since I had that and I haven't got any family around me, I've got friends that I've built relationships, so its like knowing that they're there. [...] you just phone up and say, I've got this and you talk about any personal problems you've got [...]

For the centre staff:

Well everything they do is so important.

I mean they do draw in families in the first instance don't they? Women have a particular reason to see them and that leads on to more.

I think people or some people have forgotten what this area was like.

I think it's because they are here and people can drop in and they are trusting.

From the stakeholders;

If you've got your skilled workers engaging parents then you've got a better chance of breaking the cycle of disadvantage and improved future outcomes.

That all the knowledge experience and skills that they have including extra stuff that they have done with children with disability, parents who have disabilities, child protection, drug using parents. That will all be lost and there will be nothing to show for it if they go.

One of the challenges for the continued funding of the Centre services and midwifery care in particular is that the benefit to the local women, their babies and families is not necessarily a measurable outcome within the maternity care episode. The cost benefit to health and social care may therefore not be felt during the maternity episode.

Projects elsewhere have been able to evaluate the midwifery input in relation to measurable outcomes such as place of birth, amount of analgesia in labour, mode of birth, mode of feeding and neonatal admissions. In this evaluation, this has not been possible for ethical and logistical reasons. Without such data we present the words of the respondents communicating the significance.

Within this next quote the Stakeholder indicated how change, such as that proposed by Sure Start projects takes time to be effective:

From a situation from where you have little going on there isn't a GP that on the estate, GP's were around the edge of the estate to one where you've got a range of services [...] That has made a very significant change and the tendency now is well there sorted now lets move onto the next one. Things have happened, things are much better here now. The community is much more gelled there is loads of things that have happened. But its still very early days, you need twenty years to bed it down and then you might say well actually its instilled into the community now and then it becomes integrated. (Stakeholder)

The concern is that with a reduction in the level of service from the SSMWs, women in need of additional support may, on contacting the centre, not get the support and the enabling experiences currently available.

No one leaves this building who comes in with a need and leaves with nothing. (Centre Staff)

With the development of Children Centres and the need for the Maternity services to illustrate their achievement of the NSF standards (Department of Health 2004) what is recognised by the respondents is that future developments necessitate consideration of the organisation of midwifery care including the attributes and characteristics the midwives need.

You've got to have the right people, I mean its like if you were gonna give tougher work to people, if you were going to give it to the midwives here, whose attitude to work and parents is appropriate and empathic and very professional. (Stakeholder)

Well unless you have a system whereby you had some midwives who were seen as the specialists at working with more difficult disadvantaged families working with the child protection, drug use etc... which to me would make a lot of sense as they begin to specialise and in terms of their work load, there would be an allowance or recognition that actually you need to work in other ways with some of these parents as they may not be able to access hospital so they maybe issue on how they get there which needs to be taken into account. (Stakeholder)

We need midwives who are interested in looking after women who are in different circumstances, because there is no good trying to force midwives who don't want to do what to do and if the midwife can't see her way to doing that...then she is not going to do a good job of it and she will come across as patronising and all the other stuff that goes with that. (Stakeholder)

The difficulty from some other Sure Start midwives we have spoken to is that where you carry a case load (antenatal, intrapartum and postnatal care) as a community midwife does and are attached to a Children's Centre, when the caseload stuff gets busy the Sure Start stuff has to go because its seen as a non essential extra. (SSMW)

Integrated health and social care needs assessment

The evaluators have in the process of this study developed understanding of the national and local context that the Centre and the SSMW currently work within. What is evident from the data from all respondent groups is how the working of the SSMWs is valued both in terms of what is done and also in terms of how it is facilitated. Within the analysis of the data a series of themes have emerged and been presented. What became evident was the holistic vision and practice of the SSMWs and how this met the psychosocial aspects of parents' needs and requirements because they were prioritised with the biological/obstetric needs. On the contrary, the women's biological/obstetric needs are prioritised over psychosocial needs by the mainstream maternity care organisations. The SSMWs have developed skills that bridge these different priorities while retaining the women and their families at the centre of care. Via our analysis of the data, a tool to represent this way of working has been developed.

The Integrated Health and Social Care Needs Assessment tool seeks to provide a way of acknowledging that all women who are experiencing the childbirth process have needs in relation to health and social care in pregnancy and post birth. Their care will be covered by the provision of care available to all women provided by mainstream services.

The women with additional health and social care needs will require more focused care that will involve personnel relevant to the individuals needs. Such provision of care does involve resources that are additional to the universal provision and this has an impact on resources such as staffing, time and costs.

The SSMWs were initially targeted with providing the 'add on' care that was of a psychosocial nature. Over time they have responded to emergent needs that has necessitated they move between the universal and additional provision of care with the recognition that women needed continuity of care in the antenatal and postnatal periods. The non provision of labour care was not within this evaluation a problem for women and it enables the SSMWs to be as flexible and accessible as they are.

Figure 3: Integrated Health and Social Care Needs and Risk Assessment

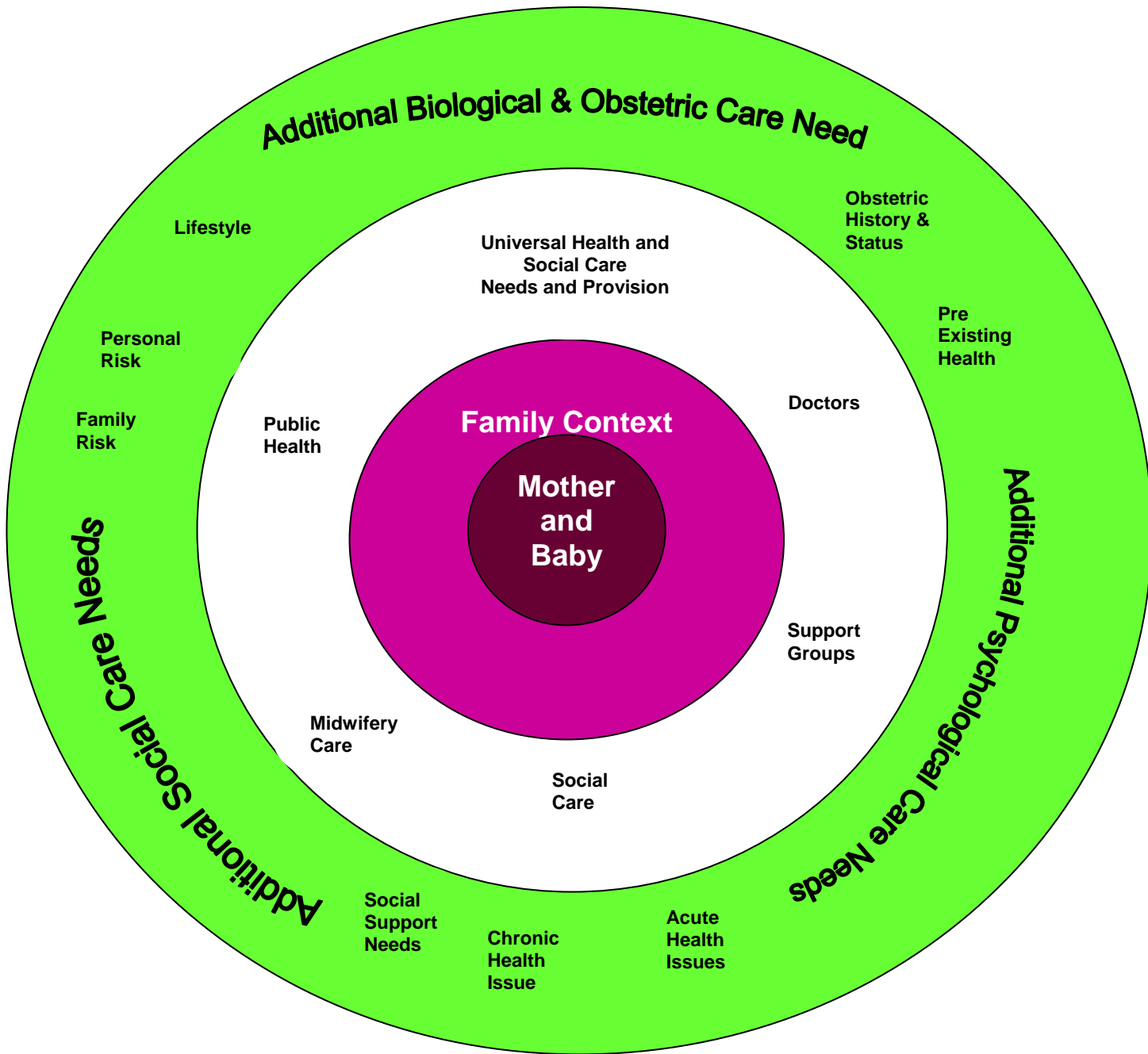


Figure 4: Risk Assessment Tool

Social Risk Factors

Date identified	Issue, action and contacts	Signature	Date Review and outcome	Signature

Psychological Risk Factors

Date identified	Issue, action and contacts	Signature	Date Review and outcome	Signature

Obstetric Risk

Date identified	Issue, action and contacts	Signature	Date Review and outcome	Signature

RECOMMENDATIONS

These recommendations relate in part to the local context of the West Howe and Kinson Children Centre and also offer the individuals involved in the future development of Maternity Services within Children's Centres and in areas of social disadvantage a resource for future consideration based on the this evaluative evidence.

The Centre

Explore further ways of celebrating the multiple successes of the Centre's activities as a means to continue partnership working within the local community. Such activity could also be used strategically to communicate with other agencies and commissioning bodies etc., such as a CD as completed by Sure Start in Brighton & Hove.

The process of women and their families being referred to the Centre has operational frailties that a more strategic approach set up between health centres/surgeries and the newly formed Children's Centres could address.

To review the current process of how information and statistics regarding women's access to the SSMW maternity service are collected. Alongside this would need to be a way of recording women's emergent care needs in order to quantify the existing and changing use and needs of SSMWs.

Consider the integration of the Bosom Buddies with Bumps and Babies as this second group has good support and attendance. This would include the transfer of the breastfeeding counsellors and may be a cost-effective way to retain their valuable service whilst providing support to a wider audience.

Future Developments

Continued collaboration with Bournemouth and Poole Trusts regarding the future maternity service provision via Children's Centres and incorporated within this we advocate learning from the SSMW experience at West Howe and Kinson. There is evidence of collaborative working and planning and a willingness to think dynamically about the future provision of care to childbearing women and their families in areas identified as being socially disadvantaged.

In recognition of the difficulty surrounding the future funding of the existing service alongside the future development of the services, consideration should be given to a mixed approach to provision of maternity care that would involve midwives and the integration of maternity care assistants who support the midwives to provide continuity of woman centred care in the antenatal and postnatal periods.

There is a tension between the primary and secondary care settings relating to assessment of care needs and identification of risk factors. Consideration of an integrated care and risk assessment tool, developed from the evaluation data, may provide a woman centred approach to holistic care.

Whilst not part of this evaluation, the need for and process of documenting one-to-one care undertaken by the SSMWs and any interprofessional planning should be reflected on in line with the developments of community based midwifery care being integrated within the Children's Centres.

The educational and training needs of the SSMWs are recognised by the current post holders and they have received support from both the Centre and Secoding Trust in meeting them alongside personal commitment to their own development. The supervisory practice needs of the SSMWs are met primarily on a day-to-day basis by their peers and by the management support within the Centre. There was little evidence of the SSMWs seeking support from their supervisor of midwives. The system of integrated educational, training and supervision requires consideration in the future planning of integrated Bournemouth and Poole Maternity services.

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APPENDIX 1

The project frame of reference linking local issues to the national context

Issue from NSF	Issue ECM	Questions / issues to explore and evaluate	Theme
Develop Primary care staff interagency working	Integrated service professionals who are enabled and encourage to work together via integrated services responsive to the needs of children and young people	Why and How did they set up this model of Sure Start. What is the midwives: Scope of practice in relation to care up to one year. Education, training access, provision Process of midwifery supervision and support	Structure and organisation of work done by Sure Start midwives
Use of children's centres Improved communication	Make positive contribution: decision making and support in community/developing positive relationships/ developing self confidence	How do different agencies link and work together to achieve this? How is care documented across agencies? Ask WHSS centre stakeholders about care provided by midwives How is smoking cessation support provided?	
People with different needs? No of people compared to other areas of Poole/Bournemouth population. Issues of language, teenage pregnancy etc.? statistics	Integrated care Access targeted, support where needed Local needs analysis: demographic info	What is the provision/publicity about SS? Physical location in relation to community. What number of people have specific needs regarding language, culture etc? Educational level and employment Consider rates of smokers	Contextual data analysis of the needs of the WHSS population
Women need to be involved in planning care and services	Stay safe from maltreatment, neglect and discrimination, security and stability and safe homes	How do women know that WHSS exists? How do they know about the midwives at WHSS? How do women access help?	
Reduce pre-pregnancy risks, regarding life style choices and experience (DV issues)		Contacts and provision of place of safety, Professional / self referral	

<p>Antenatal advice and preparation for birth: Engage fathers</p>	<p>Be healthy Physically, emotionally and sexually</p>	<p>What is the take up of this service What are the links with police liaison and other agencies/refugee/child protection use etc</p>	<p>Outcome data encompassing pregnancy, birth and up to one year of the babies life.</p>
<p>Engage fathers</p>	<p>Be healthy Physically, emotionally and sexually</p>	<p>What educational support is offered by the WHSS midwife to women and their partners? What financial, social, physical support is offered and provided? How do women and their families find out about local services?</p>	<p>Outcome data encompassing pregnancy, birth and up to one year of the babies life.</p>
<p>Issues surrounding breastfeeding, hygiene and nutrition aim to reduce under 3 hospital admissions</p>	<p>Be healthy</p>	<p>What are the birth outcomes compared to non Sure Start women? Consider place of birth, length of stay?</p>	<p>Outcome data encompassing pregnancy, birth and up to one year of the babies life.</p>
<p>Home visits for families within the first 2 months for SS families</p>	<p>Stay safe: reduce accidents</p>	<p>Postnatal outcome: Breastfeeding rates at intervals through the first year What BF support is available accessed? Who runs the BF groups (Health Professionals or women?) Who visits and how often in the first 2 months? Hospital admissions up to one year</p>	<p>Outcome data encompassing pregnancy, birth and up to one year of the babies life.</p>

APPENDIX 2

Project themes and process evaluative enquiry

Theme	Data from	Data collection via	Analysis	Dissemination / Presentation Of findings
Structure and organisation of work done by Sure Start midwives	Sure Start midwives	Interviews	Thematic analysis	Midwives journey of care for women alongside the woman's journey of care parallel to the NSF & ECM objectives
	Trust Midwives			
	Sure Start area Manager	Focus Group		Integrated into thematic analysis
	Sure Start staff: Professional Health visitor Social Workers			
	Sure Start staff: Lay Professional HCAs Bosom Buddies			
	Affiliated professional / lay Parent educators, NCT Teenage pregnancy liaison Police, Child protection GP, Practice nurses Counsellors, Smoking Cessation			

Contextual data analysis of the needs of the WHSS population	OPCS WHSS data Maternity services data	Retrieve data from data sources that are 'public' not personal records. Via post code / birth register.	Descriptive statistics Documentary analysis of descriptive data	Tables with annotated commentary
Outcome data encompassing pregnancy, birth and up to one year of the babies life.	WHSS Midwives records of AN activity; ANC, Parent education, Continuity of care AN, IP, PN	Interview supported by data records. Data collection from stats/evidence locally. Via post code / birth register	Thematic analysis of qualitative data and descriptive statistics of hard data.	Integrated into thematic analysis Tables with annotated commentary
	Maternity services data Place of birth, mode of birth, analgesia, weight of baby, gestation, length of hospital stay, MW care till day?	Data collection from stats/evidence locally. Via post code / birth register		
	WHSS data Attendance to which WHSS services	Data collection from stats/evidence locally.		
	Women and their families	Focus groups with women, Focus group with partners	Thematic analysis	The woman's journey presented alongside NSF and ECM objectives

APPENDIX 3

Population of Bournemouth by age

Bournemouth Borough Council
(Bournemouth Borough Council 2006) Average

These figures are from the first release of the 2001 Census data, released in September 2002.

Total Population:	163,441	49,138,831
Aged 0-4	8,183 (5.0067%)	2,926,460 (5.9555%)
Aged 5-9	8,665 (5.3016%)	3,122,646 (6.3547%)
Aged 10-14	8,755 (5.3567%)	3,229,098 (6.5714%)
Aged 15-19	9,216 (5.6387%)	3,032,714 (6.1717%)
Aged 20-24	12,910 (7.8989%)	2,952,885 (6.0093%)
Aged 25-29	11,789 (7.2130%)	3,268,760 (6.6521%)
Aged 30-34	11,837 (7.2424%)	3,785,676 (7.7040%)
Aged 35-39	11,488 (7.0288%)	3,881,043 (7.8981%)
Aged 40-44	10,221 (6.2536%)	3,460,849 (7.0430%)
Aged 45-49	9,150 (5.5984%)	3,111,538 (6.3321%)
Aged 50-54	10,350 (6.3326%)	3,382,567 (6.8837%)
Aged 55-59	8,892 (5.4405%)	2,785,286 (5.6682%)
Aged 60-64	7,705 (4.7142%)	2,391,708 (4.8672%)
Aged 65-69	7,553 (4.6212%)	2,153,925 (4.3833%)
Aged 70-74	7,864 (4.8115%)	1,948,731 (3.9658%)
Aged 75-79	7,594 (4.6463%)	1,645,033 (3.3477%)
Aged 80+	11,269 (6.8948%)	2,059,912 (4.1920%)

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