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An evaluation of maternity care provided in three Sure Start Local Programmes in Islington

Final Report

September 2006

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Table of Contents

Chapter 1: Introduction	1
1.0 Description of Context.....	1
1.1 Holloway.....	3
1.2 Hillmarton.....	6
1.3 Copenhagen.....	6
Chapter 2: Aims and objectives.....	8
Chapter 3: Methods	11
3.1 Quantitative Methods.....	13
3.1.1 Data sources	13
3.1.2 Analysis	16
3.1.3 Limitations	18
3.2 Qualitative Methods.....	20
3.2.1 Professionals.....	20
3.2.2 Service Users	21
3.2.3 Data Collection and Analysis	23
3.2.4 Limitations and Issues in data collection.....	23
Chapter 4: Findings for Sure Start Targets	25
4.1 Smoking during pregnancy	25
4.2 Breastfeeding	35
4.3 Mental Health.....	47
4.4 Access to and provision of antenatal care.....	51
4.5 Low birthweight babies.....	58
4.6 Delivery methods and complications at birth	61
4.7 Summary	66
Chapter 5: Qualitative findings on users' experiences.....	69
5.0 Introduction.....	69
5.1 Sure Start engagement and satisfaction	70
5.2 Disadvantaged Groups	86
5.3 Groups with Special Needs.....	89
5.4 Summary	90
Chapter 6: Staff experiences of delivering services	92
6.0 Introduction.....	92
6.1 Communication between staff	92
6.2 Recruitment Difficulties in Hillmarton.....	97
6.3 Job Satisfaction/Retention	100
6.4 Staff experiences of data collection	104
6.5 Summary	107
Chapter 7: Bringing the findings together.....	108
7.1 Conclusion	110
7.2 Key Recommendations	111
7.2.1 Sure Start Targets	111
7.2.2 Organisational Recommendations.....	112
7.2.3 Data Recommendations	113
Appendices.....	115
Appendix 1: City proposal	115
Appendix 2: Data Sources for Quantitative Analysis.....	124
Appendix 3: Sample Information pack for recruitment of service users.....	133

Appendix 4: Qualitative Interview Schedules	138
Appendix 5: Table of service users recruited for qualitative interviews	146
References.....	151

List of Figures.....	iii
List of Tables	iii
Chapter 1: Introduction	1
1.0 Description of Context	1
1.1 Holloway	3
1.2 Hillmarton	6
1.3 Copenhagen.....	6
Chapter 2: Aims and objectives.....	8
Chapter 3: Methods	11
3.1 Quantitative Methods	13
3.1.1 <i>Data sources</i>	13
3.1.2 <i>Analysis</i>	16
3.1.3 <i>Limitations</i>	18
3.2 Qualitative Methods	20
3.2.1 <i>Professionals</i>	20
3.2.2 <i>Service Users</i>	21
3.2.3 <i>Data Collection and Analysis</i>	23
3.2.4 <i>Limitations and Issues in data collection</i>	23
Chapter 4: Findings for Sure Start Targets	25
4.1 Smoking during pregnancy	25
4.2 Breastfeeding	35
4.3 Mental Health.....	47
4.4 Access to and provision of antenatal care.....	51
4.5 Low birthweight babies.....	58
4.6 Delivery methods and complications at birth	61
4.7 Summary	66
Chapter 5: Qualitative findings on users' experiences.....	69
5.0 Introduction.....	69
5.1 Sure Start engagement and satisfaction	70
5.2 Disadvantaged Groups	86
5.3 Groups with Special Needs	89
5.4 Summary	90
Chapter 6: Staff experiences of delivering services	92
6.0 Introduction.....	92
6.1 Communication between staff	92
6.2 Recruitment Difficulties in Hillmarton.....	97
6.3 Job Satisfaction/Retention	100
6.4 Staff experiences of data collection	104
6.5 Summary	107
Chapter 7: Bringing the findings together.....	108
7.1 Conclusion	110
7.2 Key Recommendations	111
7.2.1 <i>Sure Start Targets</i>	111
7.2.2 <i>Organisational Recommendations</i>	112
7.2.3 <i>Data Recommendations</i>	113

Appendices.....	115
Appendix 1: City proposal	115
Appendix 2: Data Sources for Quantitative Analysis	124
Appendix 3: Sample Information pack for recruitment of service users	133
Appendix 4: Qualitative Interview Schedules	138
Appendix 5: Table of service users recruited for qualitative interviews	146
References.....	151

List of Figures

Figure 1.1 Timeline for services offered by Sure Start Local Programme areas.....	2
Figure 4.1.1 Smoking at delivery by Sure Start area of residence.....	27
Figure 4.1.2 Smoking status throughout pregnancy	29
Figure 4.1.3 Smoking during pregnancy by Sure Start area of residence: Women who smoked 12 months prior to booking only	30
Figure 4.2.1 Feeding method by Sure Start area of residence	37
Figure 4.2.2 Feeding types by year: All Islington	39
Figure 4.2.3 Breastfeeding at birth, by year and area of residence.....	40
Figure 4.5.1 Timing of booking visits by Sure Start area of residence	54
Figure 4.5.2 Per cent of deliveries where recommended number of antenatal appointments were attended by Sure Start area of residence and parity.....	56
Figure 4.6.1 Delivery method by Sure Start area of residence	63

List of Tables

Table 1.1 Approaches to maternity services within Sure Start areas operating during the quantitative and qualitative analysis periods	1
Table 1.2 Sure Start Group Activities.....	5
Table 1.3 Sure Start Services Offered.....	5
Table 3.1 Availability of data about Sure Start outcome areas of interest by local data collection system.....	15
Table 4.6.1 Deliveries with selected complications by method of onset of labour and by delivery, March 2003 to August 2005, All Whittington Deliveries	66
Table 5.1 Reduction in Sure Start Copenhagen new registrations after the Maternity Health Care Assistant and Nursery Nurse left post	72

Chapter 1: Introduction

1.0 Description of Context

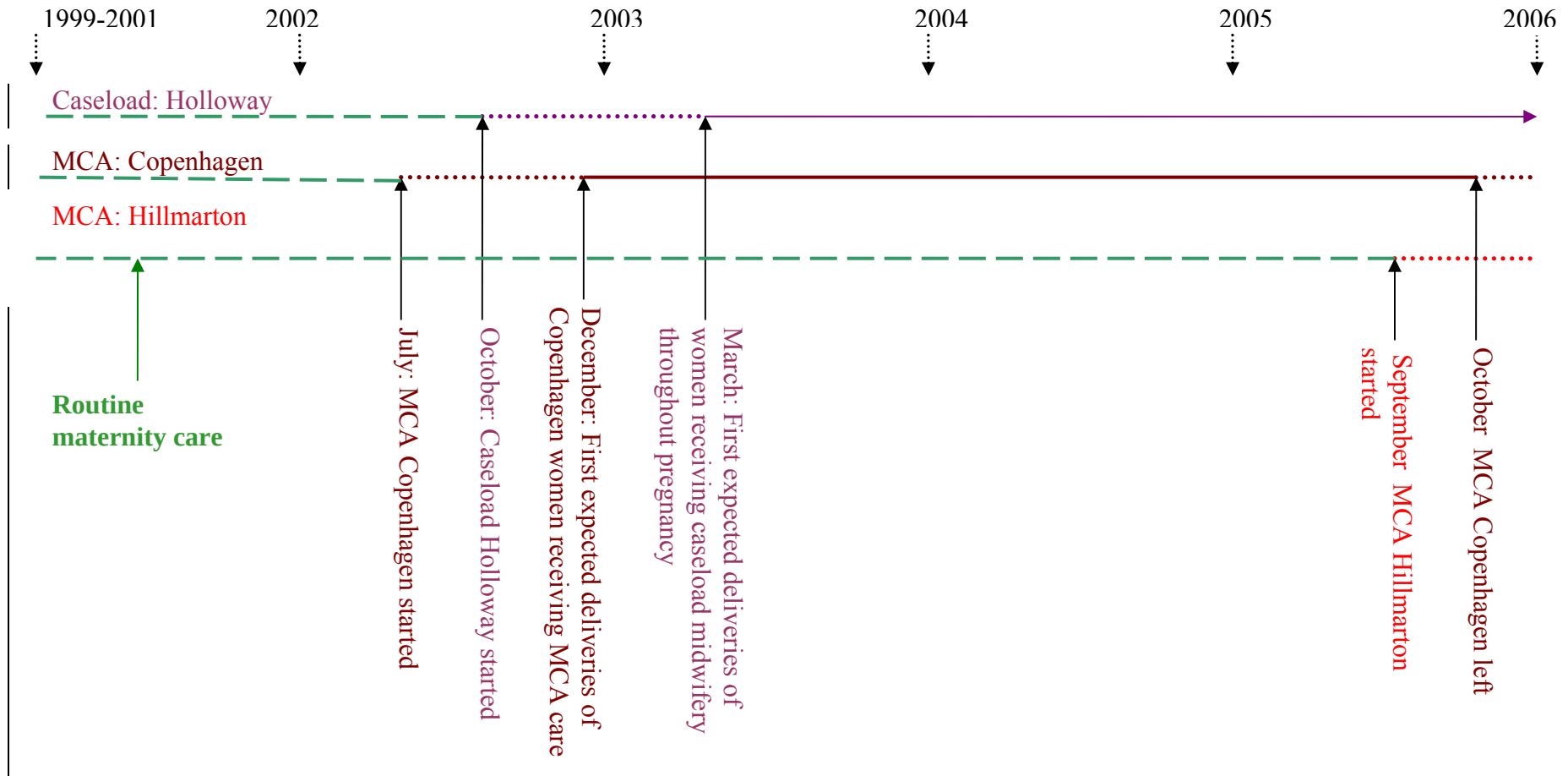
This project was commissioned to gain a better understanding about the impact of three different approaches to the provision of maternity services operating within three Sure Start areas in Islington. Initially, the first approach funded two additional midwives at a local hospital to provide caseload midwifery for women in one area. A second Sure Start Local Programme Area employed a maternity health care assistant and the third had no enhanced service for maternity care. Over time, the areas changed their approaches due to recruitment difficulties. These changes meant that for the evaluation a ‘time line approach’ was taken. Figure 1.1 outlines changes in service provision over the years 1999 to 2005.

For the quantitative component of the evaluation, routinely collected data relating to the period from 1 March 2003 to 31 August 2005 were analysed. During this period Copenhagen employed a maternity health care assistant and Hillmarton had no extra service. For the qualitative component, data were collected from women who had given birth between 1 September 2005 and 28 February 2006, at which time Hillmarton employed 1.5 maternity health care assistants and Copenhagen had no enhanced service. Throughout the evaluation period, Holloway had a caseload midwifery service. Table 1.1 shows the approaches to maternity services operating in the Sure Start areas during the quantitative and qualitative analysis periods.

Table 1.1. Approaches to maternity services in Sure Start areas during the time periods included in the quantitative and qualitative analyses

	Time period	Caseloading Model	Maternity Health Care Assistant Model	Standard Model
Quantitative Analysis	March 2003 – August 2005	HOLLOWAY	COPENHAGEN	HILLMARTON
Qualitative Analysis	September 2005 – March 2006	HOLLOWAY	HILLMARTON	COPENHAGEN

Figure 1.1: Timeline for services offered by Sure Start Local Programme areas



In addition, each Sure Start Local Programme area provided a diverse array of activities and services of use to women during their pregnancy and after. This is illustrated in Tables 1.2 and 1.3. A brief description of the services and activities in each area at the time of the evaluation are described briefly below.

1.1 Holloway

In Holloway, the employment of two extra midwives in the Whittington Hospital funded by Sure Start, meant that a caseload midwifery service could be provided. In this model each woman is allocated to a named midwife for the duration of her antenatal appointments, her labour and her postnatal care at home. Unlike standard care, the antenatal appointments are at home and organised at the convenience of both client and midwife. The exception to this is when a scan is needed or if the client is in need of an interpreter, in which case appointments can occur in the hospital. Furthermore, the period over which midwives continued to visit the woman at home postnatally was extended to 28 days after birth, twice the standard 14 days.

At the time of the interviews, each midwife was partnered with another midwife so that when she was off call she could be covered by her partner. In this way the client could get to know both midwives. The aim was to have one of the two attending her at birth but due to high caseloads, this was not always possible. Since the two extra midwives were appointed in a team from the Whittington Hospital, only women who gave birth in the Whittington could have a caseload midwife. Thus women who gave birth in other hospitals did not have a caseload midwife except for their postnatal care at home.

Like the other two Sure Start Local Programmes, Sure Start Holloway provided a range of groups and activities, such as a breastfeeding group and baby massage as Table 1.2 shows. Services relevant to the maternity targets were also available. Table 1.3 shows that these included links with smoking cessation services and a service level agreement with Child and Adolescent Mental Health Services. This involved health visitors being trained by this service to use the Edinburgh Postnatal Depression Scale and to undertake 'listening visits', a form of counselling. Once they had given six listening visits to a woman who was judged to be at risk of postnatal depression,

they used the Edinburgh Postnatal Depression Scale again and if the woman was still at risk, she could be referred on to a psychologist in the Child and Adolescent

Table 1.2 Sure Start Group Activities

Sure Start Local Programme Area	Groups or activities offered (September 2005 – February 2006)											
	Young Parents Group	Mother and baby exercise class	Adult Exercise Class	Childminder and Baby Group	Baby Massage	Breast feeding Group	Free Crèche	Fathers Group	Alternative Therapies	First Time Parents Group	Baby Play Group	Baby Yoga
Copenhagen	✓		✓	✓	✓	✓	✓	✓			✓	
Hillmarton (Maternity Health Care Assistant)	✓	✓			✓	✓	✓		✓	✓	✓	✓
Holloway (Caseloading)	✓		✓		✓	✓	✓		✓		✓	

Table 1.3 Sure Start Services Offered

Sure Start Local Programme Area	Services offered						
	Caseload Midwifery	Maternity Health Care Assistant	Smoking Cessation Counsellor	Smoking Cessation Services	CAMHS Psychologist Service for PND	Health Visitors trained in listening visit	Breastfeeding Group
Copenhagen		✓ (quantitative data analysis period)		✓	✓	✓	✓
Hillmarton (Maternity Health Care Assistant)		✓ (qualitative data analysis period)	✓	✓		✓	✓
Holloway (Caseloading)	✓			✓	✓	✓	✓

Mental Health Services.

1.2 Hillmarton

No enhanced midwifery services were available in Hillmarton during the quantitative data collection period, as Figure 1.1 shows, so Hillmarton was used as a control in the quantitative data analyses. During the qualitative data collection period Hillmarton employed 1.5 maternity health care assistants at the Whittington hospital. The maternity health care assistant was there to provide general administrative support for the midwifery team as well as support to the women through help with breastfeeding and advice on the care of the newborn. Maternity health care assistants also registered women to Sure Start and promoted Sure Start activities to them. At the time they were interviewed, the maternity health care assistants were not visiting the women until the postnatal period, usually a couple of weeks after they gave birth, although they had contact with some women in the postnatal ward.

Activities offered in Hillmarton included a breastfeeding group. This was supported by the maternity health care assistants and actively encouraged by them. There was also baby yoga, which was popular, and baby massage, as Table 1.2 shows.

Hillmarton was the only area which employed a smoking cessation counsellor and also the only area of the three which did not have a service level agreement with Child and Adolescent Mental Health Services as Table 1.3 shows. This meant that although the health visitors in the area were trained to do listening visits, they could not refer women to a psychologist in Child and Adolescent Mental Health Services. Adult mental health services were available, however, and one woman in our Hillmarton qualitative sample had been successfully referred to a psychologist there.

1.3 Copenhagen

Due to recruitment difficulties, Copenhagen had no enhanced service for maternity care during the qualitative data collection period and thus was used as for comparison in the qualitative evaluation. The Goodinge midwifery team at the Whittington hospital served both Copenhagen and Hillmarton. This meant that the same midwives received some administrative assistance from the maternity health care assistants in Hillmarton but they did not give any assistance to the women who live in the

Copenhagen area. This situation was reversed during the quantitative data collection period.

Unlike the Sure Start areas of Holloway and Hillmarton, where the majority of women accessed antenatal care and gave birth at the Whittington hospital, women from Copenhagen access care from a range of hospitals, with only about a fifth using the Whittington hospital. The primary reason for this appears to be the geographic location of hospitals in relation to the Copenhagen Sure Start area, with other hospitals notably University College London Hospital being closer than the Whittington.

Similar Sure Start activities such as a breastfeeding group and a 'play and stay' group were available in Copenhagen, as Table 1.2 shows, but Copenhagen was the only Sure Start Local Programme area to have a Fathers' Group and a 'Childminder and baby group'. It also had links with smoking cessation services and a service level agreement with Child and Adolescent Mental Health Services, as Table 1.3 shows.

Chapter 2: Aims and objectives

2.0 *Aims of the research*

To provide a clear understanding about the results achieved from different approaches to providing maternity services in three Sure Start areas in Islington and the ways in which Sure Start Local Programmes have worked with midwives to achieve this.

2.1 *Objectives*

1. To provide a clear understanding about similarities and differences in the needs being met and the aspects of care being improved by maternity service provision in the three Sure Start Local Programme areas in Islington
2. To identify how this relates to any differences in the population of the areas and location of hospitals and other service provision.
3. Have a clear understanding about how each approach to maternity service provision contributes to the following Sure Start targets
 - Reduction of smoking during pregnancy
 - Increases in breastfeeding at birth, six weeks and subsequently
 - Reduction in pre and postnatal depression
 - Reduction in the percentage of low birthweight babies, defined as weighing less than 2500g at birth
 - Provision of antenatal advice, support and information
4. Have a clear understanding about how each approach to maternity service provision contributes to:
 - Improvements in attendance rates for antenatal appointments
 - Reductions in complications at birth requiring medical intervention
 - Reduction in late bookings
 - Increase in spontaneous vaginal deliveries
 - Recruitment, retention and development of staff

5. Have a clear understanding about user satisfaction with different approaches to service provision and the impact of the different approaches on the choices available to women
6. Have a clear understanding about how each approach to maternity service provision contributes to better outcomes for women living in disadvantaged or minority groups and communities including teenage parents, women living in temporary accommodation and refugees and asylum seekers.
7. Have a clear understanding about how each approach to maternity service provision contributes to better outcomes for women with particular needs such as those with disabilities, HIV or sickle cell, women living with domestic violence, those who are not fluent in English and provision of contraceptive and sexual health advice to teenage parents.

2.2. Ethics

The Local Research Ethics Committee was informed of the study. It took the view that this was an audit of services and therefore did not require Local Research Ethics Committee approval. A letter to that effect was obtained. The local Research and Development offices of participating organisations were informed of this decision. Permission to use anonymised routine health data for quantitative analyses was granted by Caldicott Guardians of relevant organisations. Data collection procedures conformed to the standards normally expected of health services research. All manual data were securely stored in the University under lock and key and electronic data were held in a secure area of a server on the university system. For the qualitative aspects of research, individual named data were available only to named members of the research team. Only anonymised data were distributed outside the team although the three case study areas are clearly identified. Patient information letters for the qualitative research were distributed and informed consent obtained. The research was designed and analysed to ensure that the focus was on the outcomes listed above and that, in disseminating these findings, no participants were targeted for individual criticism or adversely affected personally by the public dissemination of the findings from the study.

2.3. *Project Management*

A project steering group was established in collaboration with Islington Sure Start.

This involved representatives from the Islington Sure Start Unit, the Sure Start Local Programmes of Copenhagen, Holloway and Hillmarton, the Whittington Hospital and the Islington Primary Care Trust.

Chapter 3: Methods

The methodology is grounded in a whole systems research model [1]. Whole systems approaches are becoming increasingly influential in health and social care policy [2-4]. Four principal perspectives on the whole system have been identified [5]:

1. The causal system is a “network of causal relationships which points towards trends and processes unfolding gradually over the long term” This focus fits with Islington’s need to identify how practice developed through Sure Start can inform discussions with the Primary Care Trust commissioning department about long term commissioning plans for maternity services in Islington.
2. For many of the most important areas of the whole system, we have very few data. The structure of explanation cannot be determined by the availability of systematic data. Where a particular explanatory factor is important, but precise data are lacking we must use every means at our disposal to do that factor justice. A review was undertaken of local data collection systems to identify data which were relevant to the outcomes and objectives. Few data had previously been available to Sure Start and part of this project aimed to identify alternative sources of data and information for use in monitoring.
3. The organisational whole system is by far the most common context in which whole systems are analysed. The emphasis is on making the various parts of the health and social care system function together as a single system rather than as parallel systems. The organisational perspective is relevant to this proposal in two ways. Firstly, there is a need to collate evidence of changes in outcomes for mothers, children and families arising from the different approaches to supporting maternity services that Sure Start has piloted in Islington. Secondly, the extent to which the health and social care system fails to function as a whole system may form part of the explanation about the level of contribution maternity programmes is able to make to Sure Start targets.

4. The patient or service user experience of the whole system recognises that the whole system comes together and is embodied in the experience of each individual user. The individual experience, therefore, provides a microcosm of the level of service integration achieved locally and provides evidence of model outcomes.

A strength of this evaluation lies in the fact that it is possible to compare findings from three midwifery services provided separately in three distinct geographic areas. This lends itself to multiple case study evaluation [6, 7]. For the purpose of the evaluation each midwifery approach has been treated as a case study. Case study design allows for the identification of complex contextual conditions, enabling the exploration of micro as well as macro variables and how this impacts on practice and service delivery outcomes. It also allows for comparison between cases to build a picture to inform the overall Islington Sure Start programme.

A distinction has been made between intrinsic case studies where the interest is in gaining a greater understanding of the particular case under study and instrumental case studies where a case is studied mainly to provide insight into an issue for the purpose of theorisation or generalisation [6]. This evaluation falls somewhere between the two. It will provide an analysis of the particular in each case. At the same time, it draws conclusions about what is important about each case in relation to the evaluation objectives set out previously, rather than in relation to theorisation. It does not attempt to redraw generalisations about Sure Start programmes per se.

In this study, evidence derived from both quantitative and qualitative data are drawn together. The aim was to identify as far as possible the extent to which the different approaches to supporting maternity service provision in Islington have contributed to the Sure Start targets set out by the Sure Start Unit and in the National Service Framework for Children, Young People and Maternity. In doing this, an attempt has been made to describe the achievements of the midwifery programmes and also the organisational context within which they are most able to benefit service users.

3.1 Quantitative Methods

The overall aim of this part of the project was to use quantitative data to describe the contribution of the three Sure Start programmes and the pre-existing maternity services to meeting Sure Start targets in the three programme areas in Islington. To achieve these aims, local routine systems were reviewed to assess the availability and quality of the data and relevant data were specified and requested. A descriptive analysis was then undertaken to compare maternity service provision and outcomes in the Holloway, Copenhagen and Hillmarton programme areas before and after the Sure Start programmes were established.

3.1.1 Data sources

The following data collection systems were identified as holding relevant data:

a) Maternity data in hospital-based data systems:

- (i) Whittington Hospital Patient Administration System (PAS)
- (ii) Manor Gardens Team Statistics database from the Whittington Hospital London
- (iii) University College London Hospital (UCLH) Patient Administration System (PAS) until June 2005 when a new IT system was installed.

b) Population-based data held by the Islington Primary Care Trust

- (i) Regional Interactive Child Health System (RICHS) until June 2005
- (ii) Child and Community Health Interim Application (CHIA) from July 2005 onwards
- (iii) Health visitors intention form data

c) Data from Sure Start programmes

- (i) Islington Sure Start Unit Central Monitoring Database
- (ii) Databases held by Holloway, Copenhagen and Hillmarton Sure Start Programmes

The availability and quality of data held in these systems was reviewed to identify data suitable for analysis. Substantial variation was found in the availability of data. Data could not be extracted from the CHIA system, which had superseded the RICHS

system in July 2005. It was known from the outset that up to date data could not be extracted from CHIA, but it was hoped that data downloaded from RICHs before its withdrawal could be accessed via CHIA. This also proved impossible. Data from University College London Hospital, which had also changed to a new computer system in July 2005, were not available within the timeframes of the evaluation or in subsequent months.

Within systems from which data could be extracted, the recording of data relevant to Sure Start targets and outcomes varied considerably, with no data being available to assess some outcome areas. The quality of data also varied within each system, further limiting the scope of the evaluation. Timeframes for the evaluation meant that some of the data were provided too late to be analysed. Table 3.1 below provides a summary of the relevant data items that were collected routinely. Entries with a tick in bold (✓) indicate data that were available for this evaluation; entries shaded in grey indicate data that were recorded but were not available for the evaluation. Entries with a cross (X) indicate systems where data were obtained but were unusable because of their poor quality.

As seen in Table 3.1, data from Islington Sure Start Unit and from individual Sure Start Local Programme databases could not be used for this evaluation. Problems with Islington Sure Start Unit's monitoring database stemmed largely from the fact that it relied on receiving data from child health systems but could not do so following the withdrawal of RICHs because of the problems with CHIA. A number of problems were encountered in analysing data from individual Sure Start Local Programmes. Some of the relevant information was missing. Difficulties were encountered in distinguishing between antenatal and postnatal contacts and this led to unexplained inconsistencies in data when standard reports were run retrospectively.

Table 3.1 Recording of data about Sure Start outcome areas of interest in local data collection systems

Outcome area	Data system							
	Islington Sure Start Unit	Individual Sure Start programmes	Islington PCT Intention form data	Islington PCT RICHs/CHIA data	University College London Hospital	Manor Gardens Team Statistics	Whittington Hospital PAS	
Reduction in smoking during pregnancy	X					✓	✓	
Increase in breastfeeding:								
at birth	X		✓			✓	✓	
at six weeks	X							
at four months	X							
Reduction in pre and postnatal depression	X							
Reduction in per cent of low birthweight babies	X					✓	✓	
Provision of antenatal advice support and information	X	X				✓		
Reduction in late bookings						✓	✓	
Improvement in attendance at antenatal appointments						✓	✓	
Increase in spontaneous vaginal deliveries						✓	✓	
Reductions in complications at birth requiring medical intervention						✓	✓	

■ Data were recorded but not accessible

X Data were available but unusable because of poor quality

Appendix 2 contains a summary of each of the local data collection systems reviewed, and the availability and quality of the data they contained. Further details of the review of local data collection systems and analyses of available data have been provided to the Sure Start Unit in a supplementary report.

3.1.2 Analysis

Analyses were undertaken to examine the following outcome areas

- Reduction of smoking during pregnancy
- Increases in breastfeeding at birth
- Reduction in the percentage of low birthweight babies
- Provision of antenatal advice, support and information
- Reduction in late bookings
- Increases in attendance rates for antenatal appointments
- Increases in spontaneous vaginal deliveries
- Reductions in complications at birth requiring medical intervention

Data were not available to assess the following areas:

- Increases in breastfeeding at six weeks and subsequently
- Reduction in pre and postnatal depression

Definitions of measures used to assess each of these areas are provided in the results section.

The analysis was undertaken for all or a portion of the time period 1 March 2003 to 31 August 2005, subject to the availability of data. This was a period when there were no major changes in service provision.

Initially, it was planned to use data for all or a portion of the period from 1 January 1999 to 31 June 2002 to describe the situation in the period prior to the introduction of caseload midwifery or maternity health care assistants. This would have provided a baseline for the Holloway, Copenhagen and Hillmarton areas. Data for the baseline

period were provided by the Whittington Hospital, but due to limited resources and time for evaluation, there was insufficient time to analyse these data.

For some outcome areas, all data available for the period from 1 April 2002 to 31 January 2006 were examined to maximise numbers within groups or to look at changes over time. This approach does not take into account the changes in service provision referred to in the preceding paragraphs.

Post codes were used to assign women and their babies to the Sure Start areas of Holloway, Hillmarton and Copenhagen. Where data were available for other Islington residents, these were assigned to the 'Other Islington' group, or in the case of the Whittington PAS data, 'Other Whittington'.

The Sure Start areas were used as a proxy for the three different approaches to maternity care. It was assumed that Holloway Sure Start would have access to the caseload midwifery approach, Copenhagen residents to the maternity health care assistant approach, and Hillmarton residents would have just standard maternity services and act as a control group.

This should be interpreted with caution as it is not known how many women and babies within each Sure Start area actually received the approach to midwifery care assigned to them. For example it was estimated that about two-thirds of women in Holloway received caseload services throughout pregnancy, and 20% received them for only part of their pregnancy. This was a particular issue for the Copenhagen area where the maternity health care assistant worked from the Whittington Hospital, but only around 18% of women from the Copenhagen area delivered there.

A comparison of baseline data with intervention data would have provided the most robust estimates of the contribution of the different Sure Start approaches to midwifery care and their impact on outcomes for mothers and babies. Without these comparisons it is difficult to attribute any observed differences between areas to the different approaches to midwifery care.

The scope of the analysis undertaken was restricted by the availability of data for each outcome and varied by source of data. Two approaches were used.

1. Percentages were calculated for groups for a specified time period and chi-square tests performed to compare differences between groups and assess their significance. To maximise the numbers of women or babies in any one group, and thus increase our ability to detect any significant differences, percentages were calculated based on grouping cases together over a period of time, for example all those in Holloway from March 2003 to August 2005.

2. Percentages were calculated on a calendar year basis, and confidence intervals constructed around percentages to provide an estimation of the reliability of the estimate.

The results of the descriptive analyses of quantitative data are given in Chapter 5. Additional details of analyses of data for each outcome area, including time periods examined, methods used and results, are given in a supplementary report to Islington Sure Start.

3.1.3 Limitations

The analysis of data available from routine local data collection systems was limited by a number of factors.

Population-based child health system data would have provided information for all women and babies in the three Sure Start areas, regardless of where they accessed maternity services. In its absence, there was a reliance on data from the Whittington Hospital, in which women from Copenhagen Sure Start are particularly poorly represented in these data. Overall, lack of child health system data impeded evaluation of services which were designed to be universal.

In the absence of population data, data from Whittington Hospital were used to assess most target areas. While these data provide reasonable coverage of births to women from the Holloway and Hillmarton areas, the coverage of births to women from

Copenhagen Sure Start was poor among these data and the small numbers on which they are based mean that they are not very stable estimates.

To compensate this, data were requested from University College London Hospital, where many women from the Copenhagen area received maternity care, but the data were not available within the timeframes of the project. In addition, some of the data provided by the Whittington Hospital could not be cleaned and analysed in the time available. Thus the short time frame for the quantitative evaluation restricted access to data and the extent to which, data could be analysed.

The second major limitation of the quantitative aspects of the evaluation is the lack of baseline data for target areas. As a result, where differences were found between Sure Start areas, the difference could not be attributed to the approach to midwifery as alternative explanations, such as pre-existing differences between areas could not be ruled out. While there were some start point data available from Sure Start programmes, the data were generally not sufficiently robust to be used for evaluation purposes.

Thirdly, small numbers in data about some outcomes made it difficult to obtain reliable estimates for the target area and there was inadequate statistical power to detect differences. This was a particular problem in the analysis of birthweight data, smoking during pregnancy, and selected complications at birth requiring medical interventions.

Finally, it was not possible to examine outcomes for particular groups of interest to Sure Start, such as women in disadvantaged or minority groups including teenage parents, women living in temporary accommodation and refugees and asylum seekers. Apart from the mother's age, this information was not routinely recorded in data collection systems and there were too few births to teenage parents to analyse data for this group separately.

3.2 Qualitative Methods

This section describes the data collection strategy used to collect the interview data from service users and professionals.

3.2.1 Professionals

In depth interviews were undertaken with five of the midwives involved in Sure Start programmes in Islington as well as the two maternity health care assistants employed in Hillmarton. Additional short (20 minute) telephone interviews were conducted with service providers in each of the three areas. These are listed below and include Sure Start, Whittington Hospital and Primary Care Trust staff. Unless there was only one person in the role, professionals were chosen at random from a contact sheet.

Sometimes, for convenience, other members took part instead. These interviews were used to ascertain the experience of colleagues in working with Sure Start maternity services and their view of the impact it has had on meeting Sure Start targets locally. Issues around job satisfaction and cross agency working were also elicited. With the permission of participants, all interviews were either tape recorded and transcribed or recorded via rigorous note taking. The interview schedule used with professionals is shown in Appendix 4.

Professionals interviewed:

Holloway midwives	3
Goodinge team midwives (Copenhagen and Hillmarton)	2
Maternity health care assistants	2
Health visitors	3
Sure Start local programme managers	2
Community team leader	1
Family support workers	3
Consultant midwife (Whittington)	1
Community midwife manager (Whittington)	1
Health visitor manager	1
Child and Adolescent Mental Health Services psychologist	1

Efforts to recruit general practitioners and smoking cessation staff were not successful.

3.2.2 Service Users

Sampling

In order to ensure that the sampling strategy for the service users was as objective as possible, we did not use a convenience sample. Where possible we avoided asking staff to identify service users. In order to facilitate this, and to maximise variability in the sample group, there were two phases of sampling. The first was through the local Sure Start databases and the second, which was more ‘targeted’ sampling, was done with the aid of health visitors.

Phase One

An anonymised database was obtained from each Sure Start Local Programme, containing information about each woman who had given birth in the selected time period. Typical information included ethnicity, language spoken, postcode and lone parent status. The data varied between programmes, with Holloway supplying the most detailed information. Using these different characteristics, a computer programme was used to select a sample with a representative distribution of women from the different categories, for example ethnic groups. Once the sample had been selected, the list of women selected, known to the researcher only by code, was sent back to the relevant Sure Start Local Programme.

An information pack, an example of which is shown in Appendix 3, was then sent out to each woman on the list, telling her about the evaluation and asking her if she was prepared to take part in the study. In cases where the participant could not speak English, a translated letter was used. The pack also contained a pre-paid reply envelope for her to send to the Sure Start programme if she wanted to opt out of the study. The contact details of all those who did not opt out after a two week period were passed on to the researcher who contacted the women by phone and obtained verbal agreement before arranging a convenient time and venue to conduct the

interview. All service users chose to have the interview in their homes. An interpreter or Language Line was used for participants who did not understand English.

From phase one of the sampling ten women were interviewed in Holloway and Hillmarton and eight in Copenhagen. Copenhagen had fewer women overall registered on its database and they were less diverse, tending to be well educated and from Britain or Europe. This can be seen in Appendix 5, which gives a breakdown of characteristics of all women sampled. Women sampled in phase one are identified by a numbered code of the form Cop05 and those sampled in phase two, have a lettered code of the form CopB.

Phase Two

Islington Sure Start was eager to have as wide a representation of women as possible and especially to ensure the inclusion of women who fell in to the following categories:

- Teenage parents
- Women living in temporary accommodation
- Refugees and asylum seekers
- Women with disabilities
- Women with HIV or sickle cell
- Women living with domestic violence
- Women not fluent in English

The Sure Start Local Programme databases that were used in the first phase of sampling did not have this level of detail about each woman. Therefore health visitors and family support workers from each area were contacted and asked to draw up a sample of all women who fulfilled one or more of these criteria and who had given birth within the selected time period. Very few women were identified and it was anticipated that these women in particular would be ‘hard to reach’. Thus rather than taking a sample from these lists, all women identified were sent an information pack as in phase one. In addition, health visitors and a family support worker were asked to encourage the women to take part if and when they saw them. Due to time constraints, and health visitors’ concerns about supplying such sensitive information about their clients, phase two was delayed considerably. To offset this, interviews were reduced

to a more manageable twenty minute targeted interview which was undertaken over the telephone.

Women who did not return an 'opt out' slip were contacted by the researcher, as in phase one, and asked to take part in a telephone interview. Since many women decided to have the interview immediately, they were given the researcher's contact details in case they wished to withdraw consent afterwards. Language line was used via a conference call for those participants who did not understand English.

In phase two, five women were interviewed from Copenhagen, three from Holloway and two from Hillmarton. Their characteristics are shown in Appendix five.

3.2.3 Data Collection and Analysis

All face to face interviews were recorded and transcribed with permission from participants except for one participant who preferred notes taken. Telephone interviews were recorded via notes. Participants from both phases received a £10 Tesco voucher as a thank you for taking part in the study. The interview schedule was semi-structured in style and was designed to elicit experiences from all stages of the pregnancy, birth and looking after the newborn. In particular information was gathered about experiences with health and Sure Start services and how these interactions affected their overall experience.

The patient or service user experience of the whole system was used to identify how services come together and are experienced at an individual level and to identify when, where and how integration is achieved at a local level. Combining this information with that gathered from professionals allowed a detailed picture of each Sure Start Local Programme area to be constructed. A constant comparison approach to analysis was used to encourage within case and between case analysis to test out the evolving findings.

3.2.4 Limitations and Issues in data collection

Women recruited through both phases one and two were accessed through Sure Start and PCT staff. Due to heavy workloads and high turnover of staff looking after the Sure Start database, and because some PCT staff felt uncomfortable with releasing

details of women for research even though this was all done in an ethical manner there was some delay in the recruitment phase. This meant that in phase two, interviews with women were short and focused and were undertaken over the telephone. For this reason the data gathered in phase two are not as rich. This also means that for Copenhagen where there was a less diverse group in phase one of recruitment, less information was gathered from 'disadvantaged women' in that area than in the other two Sure Start areas.

In recruiting of staff for interviews, we were unable to recruit general practitioners and the smoking cessation services for interviews into our sample. Several attempts were made to contact these people but busy schedules on both sides meant that ultimately contact was not possible.

Finally, interviews with staff were held in a time of change and some considerable stress. When staff were speaking to researchers, it should be kept in mind that they were doing so knowing that policy and practice of Sure Start, indeed the very existence of Sure Start was in a period of transition.

Chapter 4: Findings for Sure Start Targets

This section presents the results of the quantitative analyses of data, combined with selected analyses of qualitative data, for Sure Start targets and outcome areas. For each area, the Sure Start targets are defined, together with existing baseline data where available. The measure used to assess progress towards the target in this evaluation is then presented, followed by data for women and babies in the Sure Start areas of Holloway, Copenhagen, and Hillmarton. In most cases, Whittington Hospital PAS data have been used, so analyses are restricted to data for deliveries at the Whittington hospital. Where data from Islington Primary Care Trust were available at a population level, figures for all Islington residents are also included. Qualitative data are also included, where available, to give a fuller picture of the issues.

This information is then combined to describe the effectiveness of each approach to maternity services provision.

4.1 Smoking during pregnancy

Reducing smoking during pregnancy fits within the Sure Start objective of improving health. Targets for reducing smoking have been set both within the Government Public Service Agreements (PSAs) for 2001-2004 and 2003-2006, as well as within the Service Delivery Agreement (SDA) for individual Sure Start programmes. The targets are:

- To achieve by 2004 a 10 per cent reduction in the number of women who smoke in pregnancy in the Sure Start area (SDA target)
- In fully operational programmes, achieve by 2005-06 a 6 percentage point reduction in the proportion of mothers who continue to smoke during pregnancy (PSA target)

Support for women to stop smoking during pregnancy has been offered both through hospitals and through Sure Start local programmes.

Limited data were available to assess the percentage of women smoking during pregnancy. When Sure Start programmes were established, data on smoking during pregnancy were not routinely collected in hospital or community systems but Sure Start programmes worked with service providers to fill this gap. Information on smoking during pregnancy has been collected by the Whittington Hospital midwifery teams and recorded in the Patient Administration System since May 2004. Data are recorded for smoking status 12 months prior to booking, at the time of booking and at time of delivery. The Manor Gardens Midwifery Team also recorded information about smoking during pregnancy in a separate database, along with referrals to smoking cessation services.

Accurate local baseline data are therefore not available. The best estimate available was based on the *Infant Feeding Survey 1995* [8]. Data derived from this were used to suggest that an estimated 24% of mothers in the Camden and Islington boroughs smoked during pregnancy. The 2000 *Infant feeding survey* estimated that 35% of all women in England smoked in the year before or during their pregnancy, 46% of women who smoked gave up sometime prior to or during pregnancy, while 54% continued smoking [9]. Overall, 19% of women in England smoked throughout pregnancy, and smoking during pregnancy was more common among women in manual socio-economic groups and among younger women.

Information about smoking during pregnancy is not recorded in birth notification data supplied by hospitals to primary care trusts. Health visitors collect information about smoking among women and households at the time of visit following the birth, but do not collect information retrospectively on smoking during pregnancy.

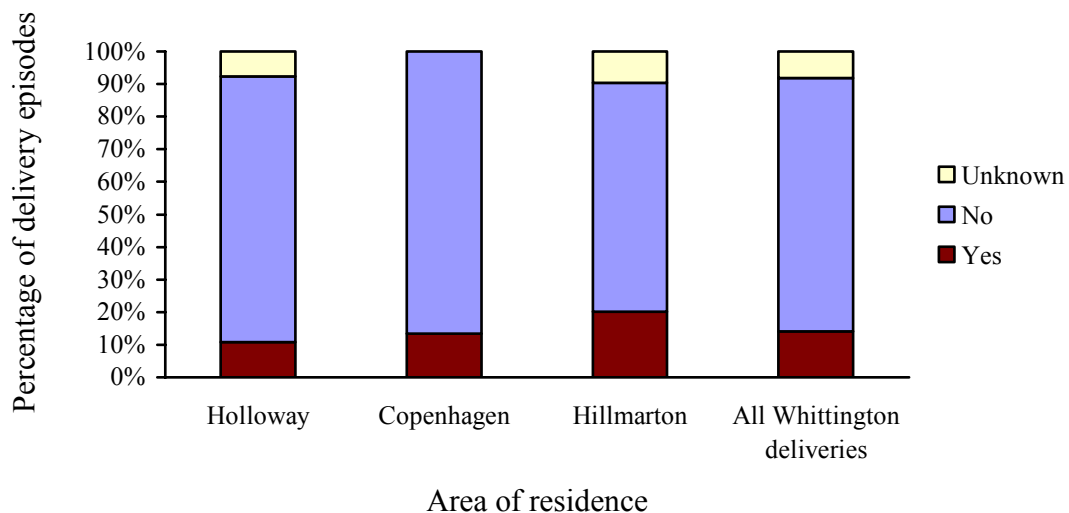
Each of the three Sure Start local programmes was required to collect information on smoking during pregnancy but none of the three programmes has been able to provide this information to Islington Sure Start Unit's Central Monitoring Database, within which no data source for providing information on smoking during pregnancy was identified.

4.1.2 Smoking at delivery

Data on smoking at time of delivery were used as a proxy measure of smoking during pregnancy as these data were the most complete. The time period examined was from May 2004, when this item was first recorded, to August 2005. Only women whose smoking status at delivery was known were included.

Figure 4.1.1 shows the percentage of women in the Holloway, Copenhagen and Hillmarton areas smoking at delivery, together with figures for all women delivering at the Whittington Hospital. Overall, 15.3% of all women delivering at the Whittington Hospital were recorded as smoking at delivery. Smoking was most prevalent among women living in the Hillmarton Sure Start area, 22.3% of whom smoked at delivery, and less prevalent among women residing in the other two areas, with 11.7% of women living in Holloway and 13.5% of those living in Copenhagen smoking at delivery. The differences between the prevalence of smoking were statistically significant ($\chi^2 = 11.302$, $df = 3$, $p = 0.01$).

Figure 4.1.1 Smoking at delivery by Sure Start area of residence, births in Whittington Hospital, May 2004-August 2005



Source: Whittington Hospital PAS data

For the Holloway Sure Start area, data from the Manor Gardens Team Statistics database indicated 10.3% of women smoked at time of delivery. This was similar to the data from the Whittington Hospital.

A number of factors are known to be associated with smoking, including social class and ethnicity. No measure of social class was available in the data to assess whether differences in smoking status reflected differences in the socio-economic status of the women living in the three areas. The Sure Start areas in Islington were known to be among the most deprived areas in the country, although it is also known as a borough where affluent and deprived people live in the same localities.

The Whittington Hospital used its own coding of ethnicity rather than the national coding classification used in the census. Among women delivering at the Whittington Hospital, 21.6% of women of white ethnic backgrounds smoked at delivery compared with only 3.8% of women in groups originating from the Indian sub-continent and 6.8% of women in African ethnic groups.

The significant differences between the rates of smoking in the Sure Start areas of Holloway and Hillmarton are likely to reflect differences in the ethnic mix of women living there. Among Holloway residents, there were lower proportions of women of white backgrounds and higher proportions of African women, who are less likely to smoke, compared with Hillmarton which had higher proportions of women from white backgrounds and fewer African women.

As mentioned above, baseline data were not available to assess whether the prevalence of smoking in Hillmarton and Holloway Sure Start areas had changed over time. This makes it impossible to assess the contribution of caseload midwifery to the lower level of smoking in Holloway.

4.1.3 Smoking during pregnancy

Data about women for whom data were recorded in the Whittington PAS on smoking at 12 months prior to booking, at time of booking, and at time of delivery data were examined to provide an overall picture of the pattern of women's smoking during pregnancy. To maximise the numbers of cases, all women with complete data who gave birth from May 2004 to January 2006 were included.

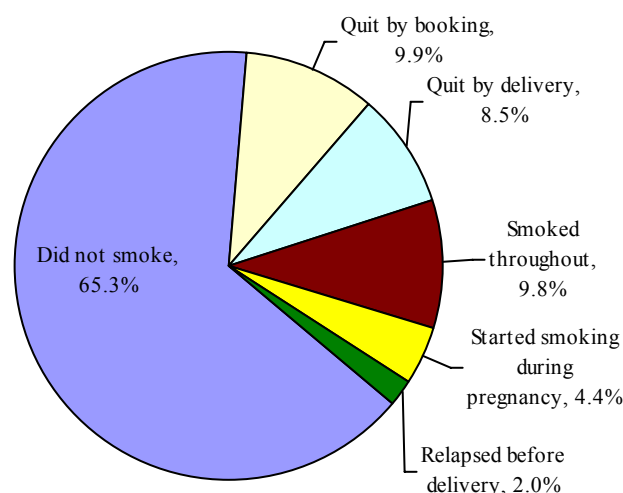
Among all these women, 30.2% smoked 12 months prior to booking, 18.4% were smoking at the time of booking and 16.2% were smoking at the time of delivery.

Almost two-thirds (65.3%) of all women did not smoke at any point in time during their pregnancy.

Of the women smoking 12 months prior to booking, 39.4% had stopped smoking at the time of booking. This is consistent with previous research which reports that around one-third of women stop smoking spontaneously when they find out they are pregnant.

The diagram below illustrates the pattern of women's smoking 12 months prior to booking, at the time of booking and at the time of delivery.

Figure 4.1.2 Smoking status throughout pregnancy, women delivering at the Whittington Hospital, May 2004-January 2006



Source: Whittington Hospital PAS data

Continuation of smoking during pregnancy by women living in the Holloway and Hillmarton Sure Start areas

The PSA target specifically relates to the percentage of women who continue to smoke during pregnancy. Data on smoking 12 months prior to booking, at booking and at delivery were compared to assess the percentage of women who continued to smoke. To maximise the numbers, 233 women from Holloway who delivered from May 2004 to January 2006 were included. For women from Hillmarton, only the 127 who delivered from May 2004 to August 2005 only were included to eliminate any

possible effects of the introduction of maternity health care assistants in September 2005.

When asked at booking about smoking at 12 months prior to booking, 40.9% (52) of women from Hillmarton and 26.2% (61) of women from Holloway had reported smoking. In both these areas, almost half of these women who smoked 12 months prior to booking continued to smoke throughout pregnancy.

Figure 4.1.3 shows the percentage of women in the Holloway and Hillmarton areas who smoked at 12 months prior to booking, by smoking status at booking and delivery.

Figure 4.1.3. Smoking during pregnancy by area of residence, women who smoked 12 months prior to booking only



Source: Whittington Hospital PAS data

In Hillmarton, of the 52 women who smoked 12 months prior to booking, 21.2% had stopped at the time of booking. A further 30.8% stopped by the time of delivery.

Almost half, 48.1%, of all women who smoked 12 months prior to booking, were still smoking at the time of booking and at the time of delivery.

In Holloway, of the 61 women who smoked 12 months prior to booking, 32.8% had stopped at the time of booking and a further 19.7% stopped by the time of delivery.

Almost half, 47.5%, of all women who smoked 12 months prior to booking, were still

smoking at time of booking and at delivery. Of the 40 women smoking at the time of booking, 70% were smoking at the time of delivery.

The Manor Gardens Team Statistics database provides an additional source of data on the continuation of smoking during pregnancy for women residing in Holloway and receiving caseload services. Among women for whom data were available about smoking at the times of booking and delivery, there were 41 women smoking at time of booking, of whom 14 were referred to smoking cessation services and four of whom were not smoking at delivery. Overall, 80.5% of women who smoked at the time of booking were smoking at time of delivery. The small numbers of women in each of these groups makes it difficult to draw clear inferences.

4.1.4 Qualitative data about smoking

There were few smokers in the sample overall, and similar patterns of experiences with smoking and smoking cessation were seen across all three areas. Findings are therefore examined for all three areas together.

Overall, about one-third of women or 13 of the 38 interviewed reported ever smoking. Most who had smoked, had given up some years previous to becoming pregnant. One or two mentioned that this was ‘part of the plan’, to give up some time before attempting to have a baby. Of the remaining women, most of them gave up immediately upon discovering their pregnancy. The majority of these women expressed relative ease in giving up, knowing it was best for the baby:

KT: And was it difficult to give up smoking?

I: No, ‘cause you know you’re doing it for a really valid reason, it’s like, yeah, you haven’t really got a choice in the matter, if you don’t stop smoking you could harm your baby, so stop.

Cop08

KT: Did you find it difficult to give up?

I: No, ‘cause as soon as I knew I was pregnant that’s it, I stopped.

Hlw16

Those who did not give up smoking, felt that they had reduced their smoking as much as possible within sometimes difficult circumstances such moving to a new country or having little family support or the general pressures and difficulties involved in being pregnant. None of them used any cessation services, nor did they express any desire to do so.

I don't know, I don't ... I don't want to give up. I really enjoy it. I think it's the only enjoyable part of my life at the moment, so ... I'll stick with it.

Hlw20

I smoke. I smoked, I used to smoke, and I still smoke. I smoke about five or six cigarettes a day. During the pregnancy I used to have maybe three cigarettes. I couldn't stop. I didn't try. <Laughs> It's just so many things happening, that to make an effort to stop it's like, with everything else on top ... it's difficult... I was hoping that ... I really wanted to stop and I was just hoping that it wouldn't harm the child. Of course it was difficult; I was far from my family, I was already making so much sacrifice in doing that, it was difficult, a bit too much.

Hil26

When asked about assistance, this woman said she had been given a number for a helpline by her GP but that she didn't want to use it. She did suggest that maybe nicotine patches would have been useful but it seemed overall she had a low motivation to stop smoking.

One other woman gave up when she discovered she was pregnant and started again after her child was born. She expressed similar sentiments of having already a lot to deal with.

Of the partners or close family members who lived in the same house and participated in childcare, fifteen had ever been smokers. Unlike the women, only two household members gave up smoking at the beginning of the pregnancy. Women reported that family members or partners that smoked were not keen to use smoking cessation services, although, in any case, none of them were ever offered services or advice.

The following woman explains why she thinks smoking cessation would not be of use to her partner:

I believe that if it's not in your head you won't appreciate it. I mean if, you know, it is the same, or if someone, a health visitor will tell you, or I tell you, which am your partner from ten years, and say look, stop smoking, and it's not in your head, if you don't appreciate it from me you don't appreciate from someone else either. So it has to come from you <laughs> you know? When you decide then you get help, don't get the help if you don't want to stop.

Cop05

The women tended to justify their partner's continued smoking by saying that their partner did not smoke around the baby and all of them were asked to smoke outside of the house. None of the women mentioned not smoking around the house during pregnancy. Furthermore, research has shown that having a partner that smokes makes it less likely that women will stay off cigarettes. As the following midwife explains:

Or if it's a teenager, she's in a house and she's got, her room's lovely and you know and away from the house but everyone in the house is smoking ...it's very hard when they're in an environment to just give up for themselves, even though it is beneficial for themselves and baby, just you have to be a very strong person to give up I think 'cause it's one of the hardest things to give up.

Goodinge midwife1

4.1.5 Evidence in context

The findings on smoking among pregnant women in Islington reflect the broader literature on smoking cessation which indicates that smoking is very strongly associated with deprivation and to ethnicity [9-11]. Box One gives the range of smoking cessation interventions identified in a recent Cochrane review of interventions to promote smoking cessation during pregnancy. The review concluded that "smoking cessation programs have been shown to increase smoking cessation, reduce preterm birth and low birthweight, and increase, mean birthweight, smoking

cessation programs need to be implemented in all maternity care settings. Attention to smoking behaviour together with support for smoking cessation and relapse prevention needs to be as routine a part of antenatal care as the measurement of blood pressure. In order to avoid 'victim-blaming', or the perception of 'victim-blaming', attention needs to be given to the existing evidence on barriers to implementation in antenatal care. Interventions involving additional group sessions during pregnancy have been reported as being poorly attended in most settings, though accepted in two trials in Scandinavia"[12].

Box One Types of smoking cessation interventions

- (1) Information about the harmful effects of smoking on the foetus and infant, the mother herself or other family members (verbal, written or both).
- (2) Advice by a health professional to 'stop smoking'.
- (3) Supplementation of advice by reinforcement at subsequent antenatal visits.
- (4) Supplementation of advice by group counselling.
- (5) Supplementation of advice by the provision of peer support.
- (6) Supplementation of advice by recording smoking status, or measuring by-products of smoking at other antenatal visits.
- (7) Supplementation of advice by feedback of the effects of smoking on the foetus (foetal movements, foetal breathing, foetal heart rate).
- (8) Supplementation of advice by positive information about the foetus and foetal development (for example, describing the ultrasound in detail).
- (9) Individualised advice and support for smoking cessation based on 'stages of change'.
- (10) Provision of pregnancy-specific self-help manual on strategies for quitting. Provision of the following as an adjunct to information and advice:
 - nicotine replacement therapy;
 - telephone follow up with reinforcement of advice and strategies and incentives for quitting;
 - rewards.
- (11) Strategies to change the attitudes, knowledge and behaviour of healthcare providers with respect to smoking cessation.

Taken from Lumley J, Oliver SS, Chamberlain C, Oakley L. Interventions to promote smoking cessation during pregnancy. The Cochrane Collaboration. The Cochrane Library 2006, Issue 3.

There was some evidence from the data that the smoking cessation counsellor was not well linked into Sure Start programmes. The findings, given above, reinforce the need to provide support for smoking cessation to pregnant women and their partners as an integral part of the obstetric and midwifery service rather than as a separate stand-alone service. As the Cochrane review reports, the approach to smoking cessation should recognise the social stressors associated with continued smoking that are well

documented in the literature [12] and which were found in this study. The evidence, both nationally and from this study, highlights the need to support these women on a broader level in order to facilitate their attempts to reduce and stop smoking.

4.2 Breastfeeding

Sure Start services work to “*promote breastfeeding, whilst supporting all women whatever their chosen method*” (Children’s NSF – Maternity Standard – Markers of Good Practice). The Service Delivery Agreement target between Sure Start Islington and individual Sure Start programmes is for “*All local programmes to give guidance on breastfeeding, nutrition, hygiene and safety*”.

Sure Start programmes do not have a specific target for increasing breastfeeding, but rather work to promote breastfeeding among women while also supporting women whatever their chosen feeding method. The programmes are required to report on the percentage of women breastfeeding at birth, six weeks and at four months. The Sure Start measure of breastfeeding is the percentage of babies either breast fed exclusively or receiving mixed feeding.

Data about the initiation of breastfeeding at birth were available on a population basis from the intention form data recorded by health visitors. Similar data were also available from the Whittington Hospital PAS for women who delivered there and from the Manor Gardens Team Database. Population-based data about feeding at birth and six weeks of age are recorded in child health systems but could not be accessed because of the problems with CHIA. No data were recorded about breastfeeding at four months.

Baseline data

Baseline data for the period before Sure Start began had been provided by Islington PCT for Copenhagen and Holloway but not for Hillmarton. These were based on Islington PCT Snapshot and RICHs data. It had been estimated that from 57% to 61% of babies in Holloway were breastfed at birth (Holloway M5 2001-2002 data; Holloway Delivery Plan 2001), as were 66% of babies in the Copenhagen area (Copenhagen M5 2001-2002). The national *Infant Feeding Survey* conducted in

2000, estimated that 71% of women in England and Wales and 81% of women in London and the South East Region initiated breastfeeding at birth [9].

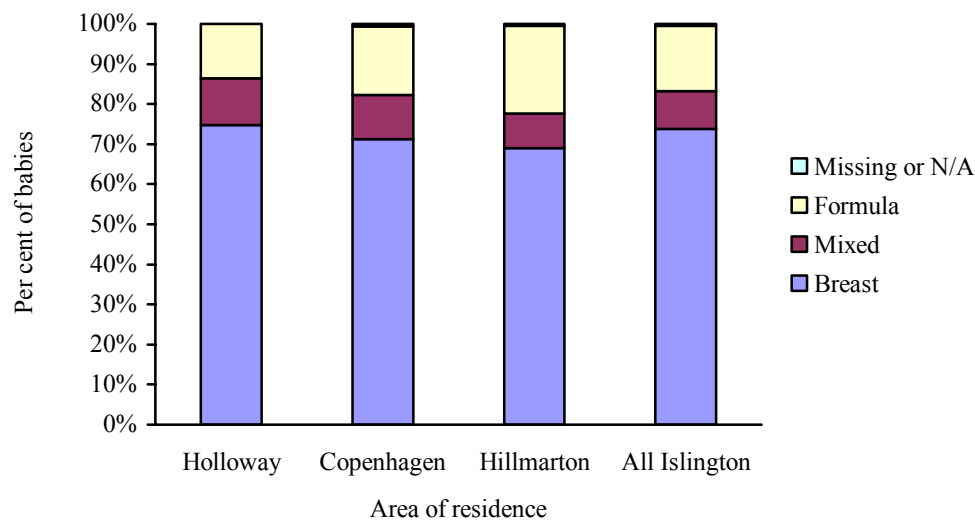
It had been estimated that between 34% and 48% of babies in the Holloway area were breastfed at six weeks (Holloway M5 2001-2002; and Holloway Delivery Plan 2001), as were 34% of babies in Copenhagen (Copenhagen M5 2001-2002). In comparison, 43% of mothers in England and Wales as a whole were breastfeeding six weeks after birth in 2000 [9]. The Central Sure Start Programme monitoring data, supplied by the PCT using data from RICHs, indicated that in the financial year 2003-2004, 71% of babies in Holloway were breastfed at six weeks, as were 56% of babies in Hillmarton. Some caution should be applied to these figures however, as by six weeks, data were missing for between 20-25% of babies.

4.2.1 Breastfeeding at birth

The percentage of babies breastfeeding at birth is first examined for babies born from 1 July 2003 (when data collection commenced) to 31 August 2005, to eliminate any effect of changes in midwifery services from September 2005 onwards, using data from the PCT intention forms. Data is also examined from July 2003 to December 2005 to assess any changes in breastfeeding over time.

Figure 4.2.1 shows the percentage of babies in the Copenhagen, Holloway and Hillmarton areas by feeding method at time of birth, together with figures for all Islington residents. It covers the period July 2003 to August 2005, to exclude possible effects of changes in services.

Figure 4.2.1 Feeding method by Sure Start area of residence



Source: Health visitors' intention forms

In Islington as a whole, 73.7% of babies were exclusively breastfed at birth; 16.3% were formula fed and 9.5% were mixed fed. Combining exclusive breastfeeding with mixed feeding showed that 83.6% of all babies in Islington were breastfed to some extent at birth.

In the three Sure Start areas, similar proportions of babies were exclusively breastfed at birth. This was the case for 74.8% of babies in Holloway, 71.3% of those in Copenhagen and 69.1% of those in Hillmarton. When babies who received mixed feeding at birth were added, in line with the measures used by Sure Start, wider differences were seen between the overall proportions of babies who were breastfed to some extent. Rates of breastfeeding were highest in the Holloway area where 86.5% of babies were breastfed, followed by Copenhagen with 82.8% and Hillmarton with 78.1%. No statistical difference was detected between rates of exclusive breastfeeding but differences in the overall rate were significant ($\chi^2 = 16.479$, $df = 3$, $p = 0.001$). Data provided from the Manor Gardens Team Statistics database indicated that 81% of women receiving caseload services initiated breastfeeding at birth, a figure slightly lower than that derived from population data for Holloway residents.

4.2.2 Factors associated with breastfeeding

Islington is an ethnically diverse area and feeding methods are known to vary with ethnicity. African women are more likely than others to practice mixed feeding. Within Islington, 10.8% (596) of babies were identified as African. Of these babies, 73.7% were exclusively breastfed at birth, and 18.6% had mixed feeding. The rate of mixed feeding among African babies was almost double the 9.5% for Islington as a whole.

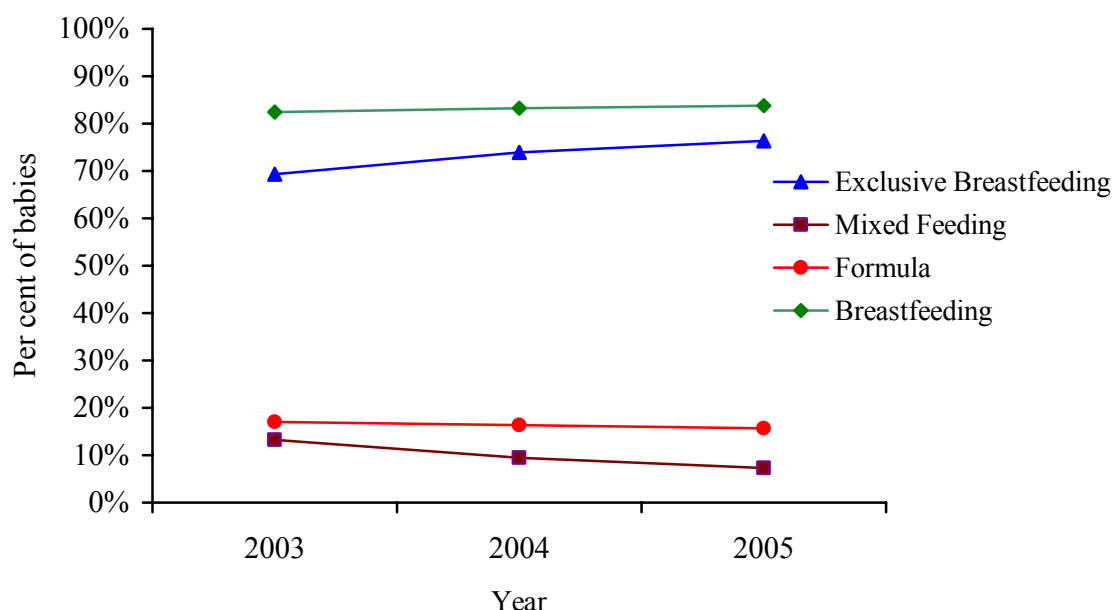
The proportions of African babies breastfed and having mixed feeding varied between Sure Start areas. Copenhagen had the highest rate of mixed feeding at birth among African babies, 29.6%, while 57.7% of African babies were exclusively breastfed. In contrast, Holloway and Hillmarton had higher rates of exclusive breastfeeding among African babies, 76.5% and 77.4% respectively. Rates of exclusive breastfeeding among African babies in Holloway and Hillmarton were similar or higher than rates of exclusive breastfeeding for all babies in these areas. The differences in feeding methods of African babies in the three Sure Start areas were statistically significant, with African babies in Copenhagen showing lower rates of exclusive breastfeeding and higher rates of mixed feeding.

It is likely that rates of breast and mixed feeding vary for women from different parts of Africa but no data were available about the countries of origin of African women in the three areas. Rates may also vary according to hospital of birth, reflecting the support given for breastfeeding, but it was not possible to investigate this because of limitations of time and data availability. Data on other factors known to be associated with breastfeeding, such as age, socio-economic status and parity, additional were not available for analysis.

4.2.3 Changes in breastfeeding over time

Data for the period from July 2003 to December 2005 showed an increase in the proportion of babies in Islington as a whole who were exclusively breastfed at birth, as Figure 4.2.2 shows. This rose from 69.3% in 2003 to 76.8% in 2005. A corresponding decrease 13.2% to 7.3% in mixed feeding at birth was also seen. The overall rate of breastfeeding varied little over this period.

Figure 4.2.2 Feeding types by year, all Islington residents, July 2003-December 2005



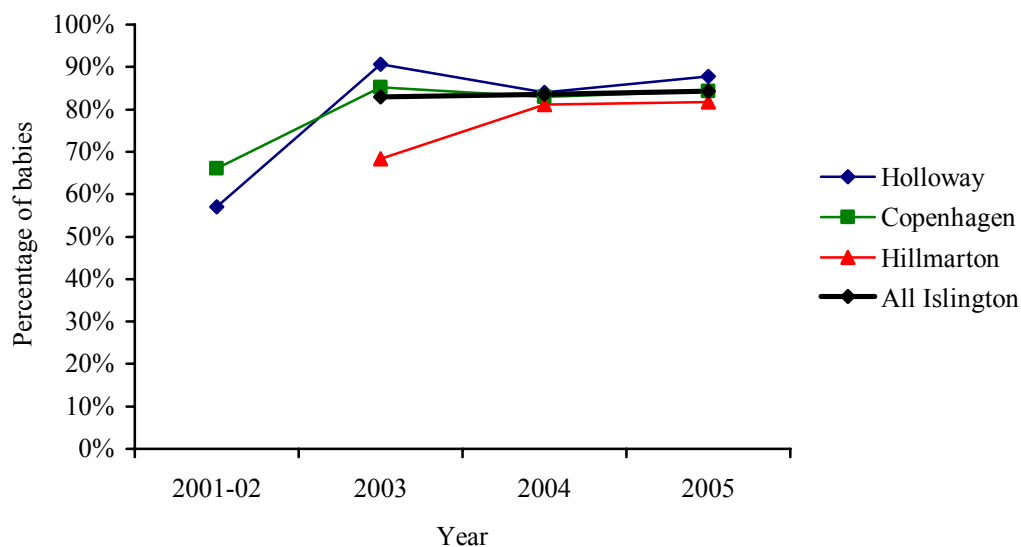
Source: Health visitor intention forms

To examine changes over time within Sure Start areas, Figure 4.2.3 shows the percentage of babies breastfed in each of the Sure Start areas for the years 2003, 2004, and 2005, with baseline data for 2001-2002 included where available.

Compared to start point data provided by Sure Start, there were large increases in breastfeeding at birth for both Holloway and Copenhagen babies from 2001-2002 to 2003. Between 2003 and 2005, a significant increase in babies breastfed at birth was seen in the Hillmarton Sure Start area. In the Holloway and Copenhagen area only small fluctuations in the percentage of babies breastfed at birth were seen over the years 2003 to 2005.

The increases seen in breastfeeding from 2001-2002 to 2003 in the Copenhagen and Holloway Sure Start areas roughly coincided with the introduction of Sure Start approaches to maternity services in these areas. Baseline data for Hillmarton and all of Islington were not available however, so the possibility that there was a general increase in breastfeeding across the area at this time cannot be ruled out.

Figure 4.2.3 Breastfeeding at birth, by year and area of residence



Source: Islington PCT baseline data and health visitor intention forms

4.2.4 Breastfeeding at 4 weeks following birth in Holloway

The only data available for the evaluation on breastfeeding subsequent to birth was from the Manor Gardens Team Statistics which recorded data on the percentage of women breastfeeding at four weeks. These data indicate that 88.3% of women were breastfeeding at four weeks, 67.3% exclusively and 21.0% as part of mixed feeding methods. Of the women who commenced breastfeeding at birth, 97.0% were breastfeeding at four weeks. Further, almost half of the women who did not initiate breastfeeding at birth were breastfeeding at four weeks. Some caution should be exercised in interpreting these data. They include only women who delivered with the Manor Gardens team midwives and maintained contact with them until four weeks later. As mentioned previously, this is likely to exclude approximately 20% of women from the Holloway area who moved out of the area prior to delivery.

4.2.5 Qualitative data about breastfeeding

Interviews in the three Sure Start areas reveal some common themes. Overall women had a good understanding of the benefits of breastfeeding and all women, except one discussed below, expressed a desire to do so. Breastfeeding was not considered easy

and in general any assistance and advice was appreciated by the women, particularly in the early stages after giving birth, which was the most difficult period:

KT: And did you find it difficult to breastfeed in the beginning?

I: God, it was hell, it was awful <laughs>. Really, really painful and bleeding and nasty, it was horrible, horrible, but after the first two weeks it got better, not completely better, but that made me think, right I'll keep going, you know, and now it's just really easy really...

Hil28

For some women it came as a surprise that breastfeeding was so difficult. Flagging this up during pregnancy might be a good idea so that women can be more prepared for difficulties and how to deal with them. The following woman describes how practical advice was particularly useful:

I wasn't sure if she was being fed and the midwives came round to see me at home, you know, they said, they showed me a certain way to have her stomach to stomach and that seemed to help actually and I found [daughter's name] was sucking a lot more and they said, yes she is feeding. So where I'd thought she wasn't feeding, they said, no she is, you can tell by the way her jaw's moving.

Hil20

How to recognise that the baby was feeding arose as an important issue for the women as many were apprehensive about not giving enough milk to their babies even when s/he was putting on a sufficient amount of weight. Not being able to provide enough milk was often cited as a reason to introduce bottle feeding.

He feeds only for 10, 15 minutes, well not every day but every other day, I get worried that maybe it's not enough and I know that he's gaining weight, so I know that actually it's enough for him because he's gaining weight, but I just get worried, oh maybe it's not enough, because you hear other people, like friends, they've got babies, and like this friend of mine

*and she was in the hospital at the same time and that's when I met her,
and her baby feeds for 45 minutes...*

Hil07

Previous research has shown that perception of inadequate milk supply is a common reason stated to introduce formula feed [8]. Medically this should be a rare occurrence [13, 14] and could be related to incorrect latching on, which can be avoided by appropriate professional assistance.

4.2.5.1 Hillmarton

In Hillmarton all women breastfed exclusively for over six weeks except for one young mother who never breastfed and one woman who stopped after a week.

In Hillmarton, the maternity health care assistant was on hand to give help and assistance in breastfeeding, but only two of the women explicitly mentioned the maternity health care assistant as having given help with breastfeeding. Of these two women, one, Hil18 expressed frustration at having received what she felt was conflicting advice from the maternity health care assistant and other information sources:

'cause the lady that came from Sure Start, I'm sure she was part of the breastfeeding group, and she said oh you should be breastfeeding ten minutes from each boob and I'm thinking, but then you've got a lot more to sort of make up and this, that and the next thing and it wasn't till I'd got a book, I said to (baby's father) I said I'm going to get this because I want to know for myself just a wee bit and it wasn't till he got that that the first lot of milk when they latch on is more thirst-quenching and then when they've been on you for about five, ten minutes, your milk thickens and that's the stuff that will fill them up. Now if you do ten minutes from each, they're not going to get that, they're only going to get the thirst-quenching stuff so they'll end up being hungry, so I thought I'm not going to be doing that then, I'll just do the way I'm doing it.

Hil18

Although few women mentioned the maternity health care assistant as specifically helping them, this may in part be because there is some confusion over the title and

role of the maternity health care assistant and many women talked about nurses, midwives and health visitors interchangeably. Also, many of the women who were visited by the maternity health care assistant were contacted a few weeks after the birth, by which stage the early difficulties with breastfeeding may have passed. Furthermore, the maternity health care assistants had yet to complete UNICEF breastfeeding training at the time of the interview.

Breastfeeding group

In terms of encouraging women to take part in the breastfeeding group, it appears that the maternity health care assistants were quite successful. About half of the women who had had contact with a maternity health care assistant were encouraged by her to join a breastfeeding support group and most of these decided to join it. All attendees expressed appreciation of the breastfeeding group, in particular the women enjoyed the peer support and opportunity to meet other new mums:

Yeah, no, so the breastfeeding groups really good because before I went there, most of the people I know were bottle feeding, so I was having sort of things where I'd think, God I wonder if anyone else is having this at this point, you know, and so in a way I wish I'd gone there earlier because then I would have been able to talk to people who were going through the same thing maybe. But now I know lots of people who are breastfeeding because of going there, so that's great, and you can say, what are you doing about that and it's really good, really nice.

Hill28

As this woman mentioned, it would be good to ensure that women are 'caught' early to attend the group in the initial weeks as well as later on. It appears the group helped with continued breastfeeding with all attendees continuing to exclusively breastfeed after six weeks.

Of the women who were not contacted by the maternity health care assistant, none joined the breastfeeding group. These women knew about the group from information leaflets or from midwives but felt they had no need or no interest. One woman who

had not met the maternity health care assistant said she would like to attend the group but was unable to do so since she had other young children to look after.

KT: And did you go to a breastfeeding group?

I: There is this but I didn't go.

KT: Why not?

I: Because I told you, you know I have two daughters, and they have not ...you know, chair push? I have not twin, I have just one. I can't take her. These breastfeeding parties and these breastfeeding days, yeah, I know, and I didn't go.

Hil09

Having more than one child at different ages as shown here was cited as a barrier by a few women who had not accessed Sure Start services.

4.2.5.2. Holloway

Seven of the thirteen women interviewed exclusively breastfed for longer than six weeks, while three breastfed for up to a month, two never breastfed and one mixed fed. None of them attended the breastfeeding group but they all mentioned receiving assistance in breastfeeding from midwives and health visitors. They appreciated this as the Hillmarton women did.

It was not clear that having an individual midwife necessarily made the women feel more confident about breastfeeding however, for those women who gave up at four weeks, they felt strongly that they had made a determined attempt to breastfeed but were unable to continue. These women appreciated the support from health care professionals who respected their decision.

Then when I'd decided to give up I rang L and I said 'L, I can't do it any more. I just can't do it any more!' And she went, 'Right. Stop.' She went, 'Stop'. But then I spoke to this other midwife and she was like, oh yes, I rang L and said I'd made the decision that I was going to stop. So I rang L and the phone got diverted to another woman who I'd never dealt with before. She was like, 'you mustn't stop. You mustn't just quit. You can't

just do that.’ And I was like, ‘you don’t know what I’ve been going through, and you don’t know how hard I’ve been trying.’ And she made me feel really guilty. And anyway, then I actually spoke to V, she rang me back, and she went ‘I know exactly, you know, I’ve seen you in tears at every feed and I’ve seen how hard you find it.’ She says, ‘it’s not for every woman. Everyone can’t do it. They make it sound like everyone can do it but not everyone can.’ And she said, ‘stop. Just stop’.

Hlw19

Reasons for giving up breastfeeding or not breastfeeding included soreness of the breasts and embarrassment at breastfeeding in public.

Two women never breastfed; One had a learning disability and said she didn’t feel confident enough to breastfeed and that nothing would induce her to do so, although she knew from her midwife the benefits. She told me “*No, no matter what they tell me, I’d say no.*” The other woman was 16 years old at the time of the interview and was also determined not to breastfeed although she knew the benefits. She said she would only breastfeed if she thought her baby was ill or had been born with a low birthweight. For both of these women, it seemed that having to breastfeed in public was a particular barrier to breastfeeding.

I just don’t like it, one of the main things I don’t like is like see if you’re out and I want to breastfeed and I can’t do it. I know you can use these pump things but my mate was doing that and it’s just so painful ... And that means you have to stay in doors if you want to breastfeed. If you don’t want to have your baby screaming you have to breastfeed indoors, that’s what I say.

HlwE

4.2.5.3. Copenhagen

As in Holloway, seven of the thirteen women interviewed exclusively breastfed for over six weeks, usually continuing or intending to continue for about 6 months. The other six women varied the duration of breastfeeding from one day to 5 weeks. Unlike the women who breastfed for over six weeks, most of these six women were recent

migrants from poorer socioeconomic backgrounds. They did not appear to have the same level of commitment to breastfeeding as described by the women in Holloway but this may have been an issue with language as they were all non-English speakers, talking through an interpreter. Most of them cited ‘not enough milk’ as their reason for introducing bottlefeeding, a reason identified by other women also.

Only one woman attended a breastfeeding group and this was a one off visit for specific information, although all mentioned receiving help from midwives and/or health visitors.

4.2.6 Evidence in context

Evidence from other research suggests that care received in postnatal wards is particularly important in establishing breast feeding [15] but women interviewed in this study felt that assistance to breastfeed in the postnatal wards was not sufficient. Furthermore, it appears that the wards are not conducive to rest and recovery after delivery and do not conform to the environment recommended in the NICE guidelines as an appropriate environment to initiate breast feeding [16]. In the light of this, there is a need to review postnatal care provided at all hospitals used by women in Islington. It is unlikely that breast feeding rates will improve substantially unless this is addressed.

Current postnatal midwifery practice at the Whittington hospital favours a ‘hands off’ approach to breast feeding support in the immediate post-partum period. The evidence on whether to provide women with ‘hands on’ or ‘hands off’ approach in the early postnatal period is inconclusive but a recent randomised controlled trial indicates that ‘hands off’ care is no more effective than routine care. It may be less effective than routine care which included some ‘hands on’ care in establishing and maintaining breast feeding [17].

In order to sustain breastfeeding and increase the length of time for which mothers choose to give breast milk rather than formula feed, peer support programmes and /or lay support have been shown to be effective. The former were particularly so with women on low incomes and those who have expressed a wish to breastfeed [15, 18].

4.3 Mental Health

The target set is for *“All Sure Start programmes to have agreed and implemented, in a culturally sensitive way, ways of identifying, caring for and supporting mothers with postnatal depression”*.

Progress towards this target was to be measured by Sure Start according to the percentage of mothers identified as having postnatal depression, and the percentage of mothers with postnatal depression receiving appropriate care. Data about postnatal depression were not recorded within routine data collection systems. When health visitors were trained to diagnose postnatal depression using the Edinburgh Postnatal Depression Scale, plans were made to record these activities on the Camden and Islington child health system. It does not appear this information was consistently recorded and the move from RICHs to CHIA made the data inaccessible. The information was also recorded on health visitors' activity sheets.

Referrals to mental health services were recorded but would not have been referred back to Sure Start because of confidentiality issues. Information about depression was also recorded by the Manor Gardens team but not in a way which could distinguish it from other mental health problems.

The net result was that no data about mental health were available for analysis. These issues are discussed more fully in the supplementary report.

4.3.1 Qualitative data about mental health

As discussed before, health visitors in all areas have been trained to use the Edinburgh Postnatal Depression Scale and to give 'listening visits.' Midwives and maternity health care assistants were also aware and keen to help with mental health issues and tended to assess the women based on their previous history of depression and their own intuition. Maternity health care assistants and midwives did mention referring women on to health visitors or a GP or psychologist. Maternity health care assistants also reported helping women who they recognised as potential sufferers by introducing them to Sure Start so that they could come out of the house more often. A

psychologist in the Child and Adolescent Mental Health Service was keen to have more professionals trained in dealing with postnatal depression so that more women can be 'caught' on time.

The women interviewed were not asked specifically whether they had mental health problems but they were probed on any health issues or difficulties experienced around the pregnancy and birth. Overall four women described experiencing symptoms of postnatal depression, one from Hillmarton, three from Holloway and none from Copenhagen. As noted before the women in the sample from phase one in Copenhagen were quite different from the sample from the other areas. This may account for the difference in findings, since these women tended to have better support from wider family ties in the area. Women from phase two in Copenhagen were talking through an interpreter on the telephone and this may have inhibited them from giving information about such a sensitive issue. Also extra attention that was given to women in the Hillmarton and Holloway areas could have made them more aware of postnatal depression and thus they may have been more likely to discuss it with a researcher.

4.3.1.1 Hillmarton

Only one woman in Hillmarton described suffering from symptoms of postnatal depression. This woman had recently broken up with her long term partner when she discovered she was pregnant. She didn't ask for help specifically from her midwife, but when the midwife saw how upset she was, she was referred to a psychologist, which she found very useful.

I: I was very depressed when I was pregnant, very depressed, I cry for everything, you know, but after the baby born, the first two weeks it was so terrible, but after that, after six weeks I really am fine, now six months, so I'm OK.

KT: So did you ask to see a psychologist or did the midwife suggest that you see one or how did it happen?

I: Yeah, I asked in, the midwife to, because I tell her, when, I went one day and she, I think I was so nervous that day and she asked me why I was crying and have I got any problem, so I tell her about my split with

his dad and the baby dad and she say maybe you need some help or do you want to speak to the psychologist, then you can speak with her and blah, blah, I say alright and I went...I was so tired and not sleeping in the evening, oh my God, it was so terrible <laughs> so tired, but now everything is better.

Hil02

From this woman's description of her referral, it seems that it was easier for her that the midwife brought up her state, rather than having to ask specifically for help herself. As discussed earlier, Hillmarton was the only area that did not have a service level agreement with Child and Adolescent Mental Health Services. This meant that a psychologist was not available there for referral, but it seems from this woman's experience that adult mental health services can still be accessed.

Another woman in Hillmarton briefly described how she found it useful to be able to recognise the symptoms of postnatal depression so that she would be aware herself if she was suffering from it. She said she had experienced mild baby blues from which she had recovered quickly.

4.3.1.2 Holloway

In Holloway, three women spoke about postnatal depression or feeling low. This was usually in conjunction with how understanding their midwife or health visitor was. This woman describes how she felt the health care professionals looking after her worked as a team and gave her extra attention.

I: <pause> I did, I did think that there were, after doing the survey that I scored high on, I did find that they [health visitors] were very, you know, they didn't just do a survey and leave and refer you, I did have a few phone calls just to see how I was and they did let my midwife know I was feeling very low and, yeah, I found that she used to stay a lot longer than she was supposed to 'cause she was always saying she was running late, you know, they weren't just rushing in and rushing out, they were <pause> I just found that the team that was visiting me was very nice and very caring and, yeah, that's nice to know that someone cares, especially

when you're feeling low and <pause> yeah, I found that I didn't have that before, as I said, with my previous kids, I didn't have that sort of care. It was nice this time, so I think they're doing a good job with that.

Hlw16

The extra attention and team work appeared to be more useful and meaningful for her than counselling which she attended once, referred by health visitors. She described this as “not very useful” as she didn’t “really like thinking about the past and going over things that make you more depressed.”

Hlw19 also talked about how her relationship with her midwife helped her when she was feeling down:

And then, so [midwife] came round and she was like, you know ‘you’re doing fine, you’re doing marvellously’ because on the third day they always say baby blues comes in on the third day, and you’re like on a high for the first and second day and then it all like falls off, and that’s what happened... I was ...I just felt like, oh, awful, I can’t do it any more. And [midwife] ... was just so reassuring and she said, ‘you wouldn’t believe the amount of women ...’

On the other hand, the Edinburgh Postnatal Depression Scale, which was used by the health visitor with this same woman, was not useful at all:

And then she gave me this questionnaire to see if I was depressed, to see if I was suicidal! She says ‘have you ever thought about cutting your wrists or harming yourself?’ And I was just like ‘WHAT is she going on about?’ I said no! <Laughs> I haven’t. And it was just a bit like, she didn’t really help much. And so she’s supposed to be my health visitor, but I’ve never seen her since.

In Hlw19’s interview, it was clear that a close relationship with her care providers was important for her to develop trust and feel ‘looked after.’ It seems also that she did not experience the same kind of team work as the previous woman had.

In all of the areas, women expressed a desire for continuity and to build a familial relationship with the people looking after them which aided communication and trust. In Holloway, relationships with health care professionals, in particular midwives, are marked by a close familiarity and individual care for which they expressed appreciation. In the light of how busy midwives are, this kind of relationship may be unrealistic across the board but an enhanced service may want to consider the kind of personal service that women appreciate.

4.3.2 Evidence in context

Guidelines on postnatal mental health recommend that routine assessment with tools such as the Edinburgh Postnatal Depression Scale is not undertaken [16]. Instead guidelines recommend that two questions are asked at postnatal contact (*“During the last month, have you often been bothered by feeling down, depressed or hopeless?”* and *“During the last month have you often been bothered by having little interest or pleasure in doing things?”*). Assessment is selective, depending on the answer given to each question, with an element of professional judgement to be included in the assessment. Mild to moderate problems should be treated with listening support and psychological treatments in preference to drug treatment. It is recommended that a health visitor undertakes up to five listening visits if mild to moderate mental health problems are identified. If women are not better after five visits they should be referred to a psychologist. It appears that current practice in Islington conforms to the recommendations in the guidelines provided that the Edinburgh Postnatal Depression Scale is not used routinely or in isolation. Furthermore, our data indicated that the maternity health care assistant has an important role in helping people with, or at risk of developing, mental health problems to access groups and other forms of social support.

4.4 Access to and provision of antenatal care

According to the Children’s National Service Framework for Children, Young People and Maternity Services, maternity services need to be *“proactive in engaging all women, particularly women from disadvantaged groups and communicating early in their pregnancy and maintain contact before and after birth”*. Maternity services are

to include “*routine antenatal and postnatal services*” (Maternity Standard – Markers of Good Practice).

The target set by Sure Start programmes is to have “*Antenatal advice, support and information available to all pregnant women and their families*”. This advice and support may be provided through midwives and other healthcare professionals, as well as through Sure Start services. The National Service Framework and National Institute for Clinical Excellence (NICE) guidelines both recommend that antenatal care commences early in pregnancy, preferably before 12 weeks of gestation, to give women time to plan their pregnancy effectively and consider early screening options. The NICE guidelines also recommend a minimum number of antenatal appointments for women, designed to allow all screening options to be offered, considered and undertaken if so desired. Improving attendance at antenatal appointments fits within the overall Sure Start objective of improving the health of young children by supporting parents and promoting health development before birth.

In Sure Start Islington’s Central Monitoring Database, the measure used to assess progress towards providing antenatal advice, support and information is the percentage of pregnant women contacted by the local Sure Start programme during pregnancy. There were problems in this form of monitoring, however. In reviewing annual outcomes data submitted by individual Sure Start programmes, only one programme had submitted data on the percentage of pregnant women contacted by the programme during pregnancy and this was for one year only. Individual Sure Start programmes had monitored contact with pregnant women on a monthly basis and reported this to Islington Sure Start through a monthly report. The frequency with which these reports had to be submitted, altered over time, making these data unsuitable for analysis. These reports also provided aggregated counts of the number of women the services saw each month and could be used to assess the total number of pregnant women seen. There was also some concern expressed by Sure Start workers as to the accuracy of the identification of women who were pregnant.

The databases from individual Sure Start programmes could not be used retrospectively to extract data about numbers of pregnant women visited per year. They were live databases in which information was continuously updated and they

were designed to monitor contacts and activity rather than services for individual women. In addition, they did not distinguish between antenatal and postnatal contacts. As the population-based data held in child health systems could not be accessed, the only data available were those from the Whittington Hospital and the Manor Gardens Team. The data about antenatal care provided by the Whittington Hospital were for women who attended a booking appointment and delivered babies there from March 2003 to August 2005.

4.5.1 *Health professionals involved in antenatal care*

The vast majority, 98.1%, of women who attended a booking appointment with the Whittington Hospital were referred by a general practitioner. At their booking visit, 96.0% of women were seen by a midwife. Among women from the three Sure Start areas, 76.0% of women from the Holloway area were seen by a midwife from the Manor Gardens team, while 19.7% saw a midwife from other teams. Among Hillmarton residents, 71.6% were seen by a midwife from the Goodinge Team, while 23.7% were seen by midwives from other teams. For Copenhagen residents, 42.6% were seen by a midwife from the Goodinge team, and 51.0% were seen by midwives from other teams.

Appointments with midwives accounted for 56.5% of all appointments attended by women at the Whittington Hospital. Appointments with consultants accounted for a further 25.1%. Women also received antenatal advice, support and information through attending parent craft classes, the African Well Women's Clinic, Antenatal Diabetic Clinics, combined HIV clinics and drop-in clinics, and the Maternity Day Unit.

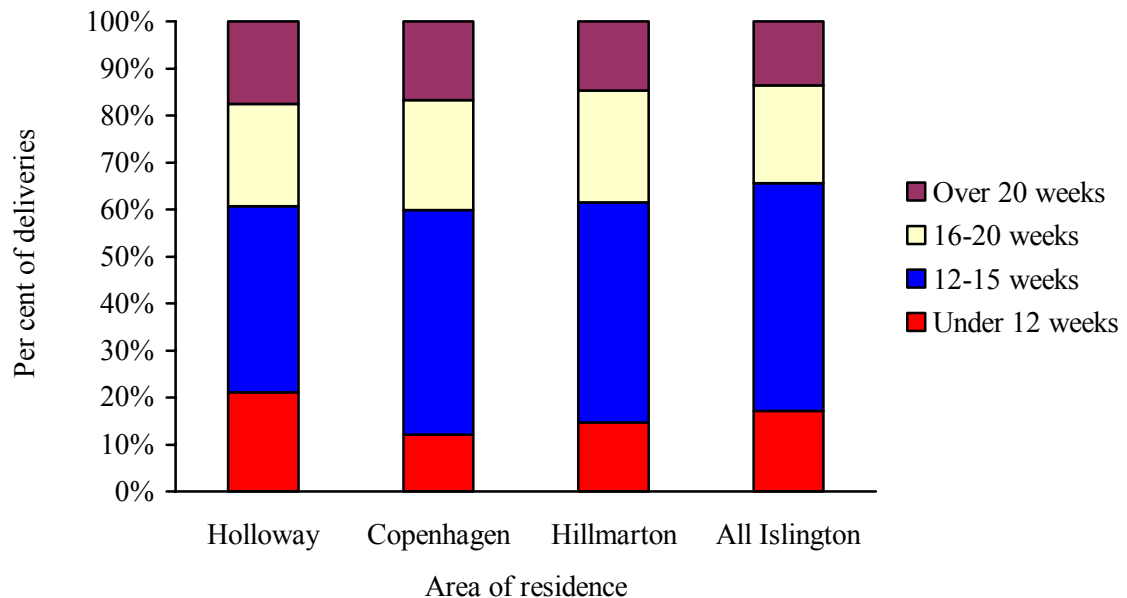
Of the appointments with midwives, 85.0% of those for women in the Holloway area were with a midwife from the Manor Gardens team. In the Hillmarton area, 76.0% of all women's midwifery appointments were with a midwife from the Goodinge team, as were 46.0% of all midwifery appointments for women in the Copenhagen area.

4.5.2 *Timing of booking visits*

As noted earlier, NICE guidelines recommend that women commence antenatal care before 12 weeks of pregnancy. Figure 4.5.1 shows the percentage of bookings

grouped by gestation at time of booking for women in the Copenhagen, Holloway and Hillmarton areas, together with figures for all deliveries at the Whittington Hospital.

Figure 4.5.1 Timing of booking visits by Sure Start area of residence



Source: Whittington Hospital PAS data

Overall, only 17.4% of all women attended their first antenatal appointment with the Whittington Hospital before 12 weeks of pregnancy, and significant differences were seen between the Sure Start areas of residence. The percentage of women attending their first antenatal appointment before 12 weeks of pregnancy was 21.0 in the Holloway area compared with 14.7 in Hillmarton and 12.1 in Copenhagen ($\chi^2 = 7.956$, $df = 2$, $p = 0.019$). It is important to note that that these figures cannot be generalised to all women residing in Copenhagen because of the low proportion who delivered at the Whittington Hospital.

By 16 weeks of gestation almost two-thirds (64.9%) of all women having care at the Whittington had attended their first antenatal appointment.

On the other hand, 13.8% of women (392) were noted to be 'late' bookers, not attending a booking appointment until after 20 weeks gestation. Late attendance limits

a woman's options for screening, and also means that important information, advice and support cannot be provided in the early stages of pregnancy. No significant difference was found in the percentages of deliveries associated with booking after 20 weeks gestation in each Sure Start area. This ranged from 14.7% to 17.6%. Compared with deliveries to women not residing in the three Sure Start areas, 12.6% of whom booked after 20 weeks, women from Holloway and Copenhagen showed higher proportions of late booking visits, 17.6% and 16.8% respectively ($\chi^2 = 8.810$, $df = 3$, $p = 0.032$). Again, findings for Copenhagen cannot be generalised due to low numbers. Manor Gardens Team Statistics estimate the percentage of women from Holloway with later bookings at 16.3%.

Figures from the Manor Gardens Team Statistics database provide a similar picture of attendance at booking appointment among women from the Holloway area. Here, 20.7% attended a booking appointment by 12 weeks, and 65.4% had attended by 16 weeks.

4.5.3 Attendance rates for antenatal appointments

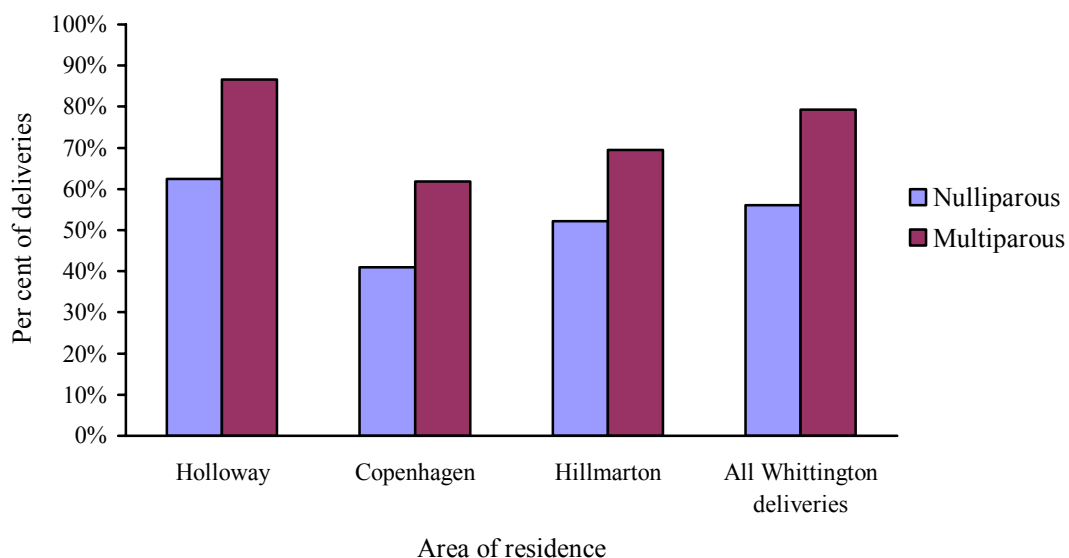
While Sure Start programmes do not have a set target for improving attendance rates for antenatal appointments, Service Level Agreement between Holloway Sure Start and the Whittington Hospital anticipated an improvement in attendance rates where caseload maternity services were available. This section examines women's attendance at antenatal appointments in line with recommendations from the National Institute for Clinical Excellence guidelines on antenatal care

The National Institute for Clinical Excellence guidelines recommend that nulliparous women with an uncomplicated pregnancy attend a schedule of 10 antenatal appointments, while for parous women with uncomplicated pregnancies, seven antenatal appointments is adequate. Additional appointments are recommended for complicated pregnancies, based on the individual women's presentation. Based on the recommended schedule of appointments for nulliparous and multiparous pregnancies, and taking into account gestational length at delivery, women were grouped according to whether they had attended an appropriate number of antenatal appointments. For the purposes of this analysis it was assumed that all pregnancies were uncomplicated. It is recognised that this will result in over-counting the number of cases where the

number of appointments is sufficient. The analysis also did not take into account the timing of the first antenatal appointment, which may impact on the total number of appointments attended. Details of methods used in examining antenatal attendance can be found in the supplementary report.

Figure 4.5.2 shows the percentage of deliveries where the recommended number of antenatal appointments were attended, by parity for women in the Copenhagen, Holloway and Hillmarton areas, together with data for all deliveries at the Whittington Hospital.

Figure 4.5.2 Percentage of deliveries where recommended number of antenatal appointments were attended, by Sure Start area of residence and parity.



Source, Whittington PAS

Overall, 67.9% of all Islington residents who booked and delivered at the Whittington attended the recommended number of antenatal appointments. There were significant differences between Sure Start areas in the percentage of women attending the recommended number of antenatal appointments. In the period studied, 75.1% of women in Holloway attended the recommended number of appointments, compared with 61.8% of women in Hillmarton and 54.2% of the women in Copenhagen who delivered at ($\chi^2 = 25.802$, $df = 3$, $p = 0.000$).

In all areas, multiparous women were more likely to attend the recommended number of antenatal appointments during their pregnancy. For both nulliparous and

multiparous pregnancies, women in the Holloway area were significantly more likely to attend the recommended number of appointments than women in the Copenhagen and Hillmarton areas (Nulliparous: $\chi^2 = 7.970$, $df = 2$, $p = 0.019$; Multiparous: $\chi^2 = 26.599$, $df = 2$, $p = 0.000$).

The Manor Gardens Team Statistics database provides a somewhat lower estimate for Holloway women, with 63.8% of women attending the recommended number of appointments. A similar pattern was seen by parity, with 72.7% of multiparous women attending the recommended number of appointments, compared to 50.9% of primiparous women.

One reason why multiparous women may be more likely to attend the recommended number of antenatal appointments is that only seven appointments are recommended for women with uncomplicated pregnancies compared with ten for parous women with uncomplicated pregnancies.

Women in the Holloway area were significantly more likely to attend a booking appointment before 12 weeks of pregnancy, although in all three Sure Start areas around 60% of women had attended a booking appointment by 16 weeks. Women in the Holloway area were also significantly more likely than women in the Hillmarton area to attend the recommended number of antenatal appointments.

The higher level of attendance at antenatal appointments in the Holloway area is likely to be associated with the caseload midwifery approach. This allows for antenatal appointments to be offered at a woman's place of choosing, which may include home visits. This flexibility in scheduling antenatal appointments is not available to women residing in other areas of Islington. Having a named midwife may also have played a role in improving women's attendance, particularly where good relationships were developed between women and their named midwife. Without baseline data other explanations for the increased attendance seen among Holloway women cannot be excluded, however.

4.5 Low birthweight babies

A baby born weighing less than 2.500g is defined as low birthweight. Sure Start does not have a specific target to reduce the percentage of low birthweight babies but it fits within its remit to improve health outcomes.

Data on birthweight are routinely recorded within hospital-based systems, and forwarded to Islington PCT as part of the birth notification form, which initiates the child's record in the child health system. Because of the problems with CHIA, only birthweight data from the Whittington Hospital PAS were available, however.

Some start point data were available about the percentage of low birthweight babies at the commencement of Sure Start programmes. For the Copenhagen area, it was estimated using the Office for National Statistics' birth registration data that 12.8% of babies born in 1998-2000 were of low birthweight (Office for National Statistics: Copenhagen M5c Start point data). Later estimates for Copenhagen based on birth notification place this figure at 11.9% for the period 1 April 1998 to 31 March 2002 (Islington PCT Child Health Systems data). For Holloway, it was estimated from RICHs birth notification data that 10.1% of babies born from April 2000 to March 2001 were of low birthweight (RICHs birth data from Holloway Delivery plan). Comparative information was not available for Hillmarton. In England and Wales as a whole, 7.6% of babies born alive in 2001 were of low birthweight [19].

Data from the Whittington Hospital about singleton babies born from March 2003 to August 2005 are described below. Babies from multiple births were excluded as they are known to have lower birthweights. A short description is then given of an extract of data on birthweight provided by Islington PCT for births during the period 1 January 1998 to 17 February 2004. Further details and results of the analysis of these data can be found in the supplementary report.

4.5.1 Low birthweight

The data about low birthweight babies weighing under 2,500g at birth presented below are restricted to singleton live births at the Whittington Hospital. Of the 204

singleton live births to Islington residents from March 2003 and August 2005 at the Whittington Hospital, 6.7% were of low birthweight. In the three Sure Start areas, 8.4% of babies born to Holloway residents were of low birthweight, compared to 5.6% of babies born to Hillmarton residents and 2.7% of babies born to Copenhagen residents. The figure for Copenhagen should be interpreted with caution as they are based on a small number of cases. The differences in the percentage of low birthweight babies in Holloway and Hillmarton was no greater than would be expected by chance but it could be that the numbers of babies were too small to detect a difference. ($\chi^2 = 2.757$, $df = 1$, $p = 0.097$).

Estimates from the Manor Gardens Team Statistics database suggest that 10.0% of babies born to mothers residing in the Holloway area were of low birthweight.

Factors associated with low birthweight

A number of factors are known to be associated with birthweight, including social class, smoking during pregnancy, ethnicity and mother's age.

Consistent with previous research, smoking at the time of delivery showed the strongest association with low birthweight. Among women smoking at time of delivery, 11.8% of deliveries resulted in babies of low birthweight compared with 5.2% of babies born to women who did not smoke at delivery. ($\chi^2 = 13.826$, $df = 1$, $p = 0.000$). Within the Hillmarton Sure Start area, a similar pattern of results was found, with 10.4% of babies born to women smoking at the time of delivery being of low birthweight compared to 3.0% among women not smoking at time of delivery ($\chi^2 = 4.681$, $df = 1$, $p = 0.030$). Small numbers of deliveries and the low prevalence of smoking restricted analysis of smoking and low birthweight within other Sure Start areas. No data were available about social class, which is correlated both with smoking and low birthweight, but it could have contributed to the differences observed.

Some African women have been reported to have a high prevalence of very low birthweight babies but very small numbers of babies have birthweights in this category, under 1,500g. Among births to African women at the Whittington Hospital

6.6% were of low birthweight compared to 6.7% for all babies. Numbers were too small to examine the rate of low birthweight by ethnic group within the Sure Start areas.

Teenage mothers, along with mothers aged 35 or over are more likely to give birth to low birthweight babies. Deliveries to mothers aged under 18 years accounted for only 1.1% or 54 of the deliveries at the Whittington Hospital. No differences were detected between the proportions of low birthweight babies in each age group, but the numbers in the oldest and youngest groups were probably too small to detect such differences, either overall or within individual Sure Start areas.

4.5.2 Trends over time in low birthweight

The small numbers of babies born each year meant that it was not possible to obtain reliable estimates of changes over time in the percentage of low birthweight babies from the Whittington PAS data. Three year rolling averages were used to estimate the overall percentage of low birthweight babies, which were 8.9% in 2003 and 8.1% in 2004. Confidence intervals around these estimates indicated that the percentage of low birthweight babies lay somewhere between 5% and 12%. Within the three Sure Start areas, the numbers of low birthweight babies were even smaller, so time trends could not be estimated.

4.5.3 Islington PCT child health system data

While Islington PCT was unable to extract data on low birthweight from the CHIA system for this evaluation, it supplied a file containing data on birthweight which had been downloaded from RICHs. The file included data on birthweight for babies born from 1 January 1998 to 17 February 2004. Births from 1 January 1999 to 31 June 2002 were selected to provide a baseline measure of low birthweight in the Sure Start areas. In Holloway, 17.5% of babies were low birthweight, as were 15.2% of babies in Hillmarton and 14.5% of babies in Copenhagen. In Islington as a whole, 14.7% of babies were born at low birthweight. It is important to note that all babies are included in this description of birthweight as data about multiplicity were not available to identify singleton live births.

These data were available for less than a 12 month period after the introduction of caseload midwifery and maternity health care assistants. Over the period March 2003 to 17 February 2004, the proportion of low birthweight babies was lowest in the Copenhagen Sure Start area, at 7.4%. In Holloway and Hillmarton the rate of low birthweight was 13.1% and 13.8% respectively. The small numbers of low birthweight babies born during this time mean that wide confidence intervals were seen around percentages calculated, indicating instability of these estimates.. The difference in the percentage of low birthweight babies between this time and the baseline period was significant for the Copenhagen area only ($\chi^2 = 8.055$, $df = 1$, $p = 0.005$). A significant decrease was also detected across the all births to Islington residents over this time ($\chi^2 = 17.795$, $df = 1$, $p = 0.000$). Instability in these estimates suggests, however, that these results should be interpreted with some caution.

4.6 Delivery methods and complications at birth

The marker of good practice for maternity services, as stated in the Children's National Service Framework, is that "*All services facilitate normal childbirth wherever possible, with medical interventions recommended only when they are of benefit to the woman and/or her baby*". Sure Start requested the evaluation team to examine the percentage of spontaneous vaginal deliveries and complications at birth requiring medical intervention. While Sure Start programmes do not have a specific target to reduce complications at birth requiring medical intervention, Sure Start Holloway did expect provision of a caseload midwifery service to produce a reduction in complications at birth requiring medical intervention.

Population-based data on delivery method, including spontaneous vaginal deliveries, are recorded in RICHs and CHIA as part of the Birth Notification Form data submitted by individual hospitals. As these data were not available for analysis, the possibility of obtaining data from the Maternity Hospital Episode Statistics maintained by the Information Centre for Health and Social Care was investigated, but organisational changes at the time of the project precluded this. Therefore data from the Whittington Hospital were used. Data were available from 1 January 1999 to 31 January 2006 but due to time restrictions, data have been analysed only for the period from 1 March 2003 to 31 August 2005.

Previous research indicates that the most common complications during pregnancy are abnormality of the pelvic organs, including uterine scarring from previous pregnancies, hypertension and oedema during pregnancy. The most common complications during labour and delivery are obstructed labour, long labour, perineal laceration, fetal stress, post partum haemorrhage, and prolonged pregnancy. Complications such as these can affect decisions about the onset of labour and delivery method, including decisions to induce labour, or to deliver babies using instrumental methods or by caesarean section.

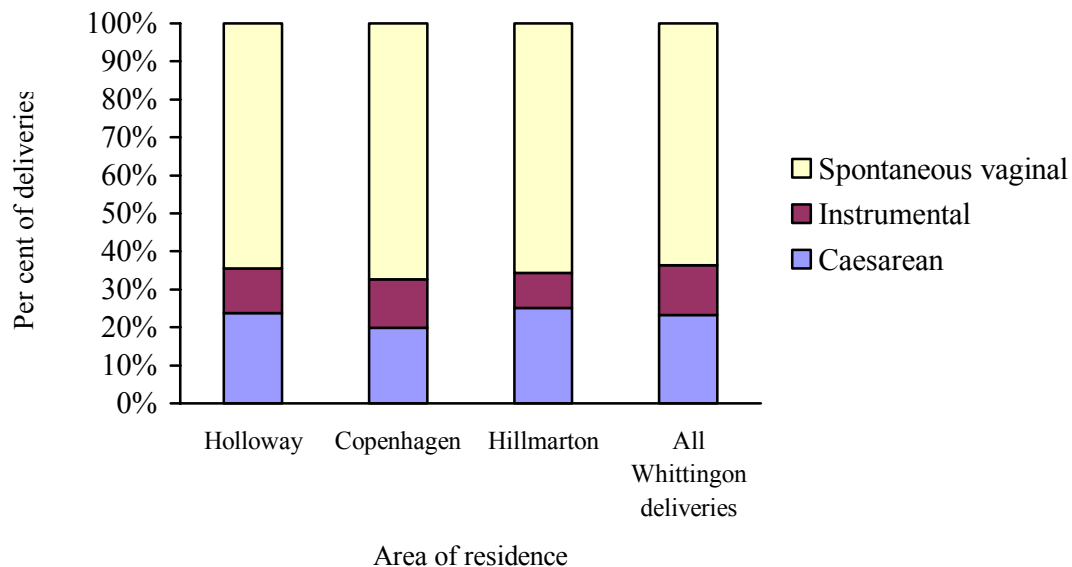
Information about complications at birth requiring medical intervention were extracted from both the Maternity module and the Inpatient module. The Inpatient module contains data on conditions recorded during pregnancy and labour, coded according to the International Classification of Diseases (ICD-10) while the Maternity module contains data about the onset of labour and method of delivery. The prevalence of the most common complications of pregnancy and labour, and medical interventions used at birth were examined. Further details of the analysis and results can be found in the supplementary report. Small numbers within each groups limited the scope for analysis of these.

4.6.1 *Delivery methods*

Spontaneous vaginal deliveries are recorded when there is no use of instruments or caesarean section. This section also examines the method of delivery by method of onset of labour, to report on the births where both the onset of labour and delivery were spontaneous. Further details of the analysis and results can be found in supplementary report.

Figure 4.6.1 shows the deliveries to women in the Copenhagen, Holloway and Hillmarton areas by method of delivery, together with data about all deliveries to Islington residents at the Whittington Hospital. Among all these deliveries at the Whittington Hospital, 63.5% were spontaneous vaginal deliveries; 23.2% were by caesarean section, and 13.2% were instrumental. The rate of spontaneous vaginal deliveries to women in the Sure Start areas varied between 64.4% in Holloway and 67.2% in Copenhagen and no significant difference was detected between the rates of spontaneous vaginal deliveries in the three areas.

Figure 4.6.1 Delivery method in the Whittington Hospital by Sure Start area of residence, March 2003-August 2005



Source: Whittington Hospital PAS

Rates of caesarean section in the three Sure Start areas ranged between 19.8% in Copenhagen to 25.1% in Hillmarton, with no significant differences found between the three areas. As seen in Figure 4.6.1, rates of caesarean section are higher in each of the three areas than instrumental deliveries which ranged from 9.3% to 12.9%. In the three Sure Start areas, rates of elective caesarean section varied between 6.2% and 10.3%. Again no significant difference was detected.

Data from the Manor Garden Team Statistics database provided roughly similar figures for women from the Holloway area in which 60.6% of women had a spontaneous vaginal delivery, and 27.4% of women had a caesarean section.

For all deliveries to Islington residents at the Whittington, the method of delivery varied according to the method of onset of labour. Where the onset of labour was spontaneous, 72.2% of deliveries were spontaneous compared to only 48.5% to 61.3% of deliveries where the method of onset was drug-induced, surgically induced or involved both drugs and surgery in induction. For women in whom the onset of labour was induced by drugs, surgery or both, caesarean rates ranged from 25.0% to 35.3%

much higher than the rate of 13.6% for deliveries following a spontaneous onset of labour.

Overall, 53.1% of women had a spontaneous onset of labour and delivery, in other words a labour and delivery without induction, the use of instruments or caesarean section. Within the three Sure Start areas, 54.9% of women from Holloway had a spontaneous onset of labour and delivery, as did 55.2% of women from Copenhagen and 51.8% of women from Hillmarton.

4.6.2 Complications during pregnancy and at birth

Selected complications of pregnancy, labour and delivery in Sure Start areas showed similar patterns to those seen among all deliveries. The most commonly cited category of complications seen during pregnancy or during labour at the Whittington Hospital were complications of labour and delivery, cited in 54.7% of deliveries. This broad category included perineal laceration, which was noted in 23.2% of all deliveries, fetal stress noted in 12.6% of all deliveries, and long labour noted in 11.6% of all deliveries. Abnormalities of the pelvic organs were recorded in 5.3% of all deliveries, most commonly being uterine scarring resulting from a previous caesarean section. Hypertensive disorders and oedema during pregnancy were recorded in 2.8% of all deliveries. These complications are likely to affect decisions about the onset of labour and method of delivery. Table 4.6.1 shows the method of onset of labour and method of delivery for women with selected complications.

Onset of labour

Medical intervention was seen at the time of labour onset most often among women with abnormality of the pelvic organs, those who experienced hypertension and oedema during pregnancy, and those who had a prolonged pregnancy. Where abnormality of the pelvic organs was recorded, generally due to scarring from a previous caesarean section, onset of labour was by caesarean section in 74.5% of cases. Labour was induced in 59.2% of cases where hypertension and oedema were recorded during pregnancy, with a caesarean section for a further 18.3% of these women. Labour was induced in 88.5% of women whose pregnancy was recorded as prolonged. Rates of medical intervention were lower for other complications. Labour was induced in 32.0% of women subsequently diagnosed as having a long labour,

23.4% of cases where fetal stress was observed, and 18.2% of cases where labour was diagnosed as obstructed. It may be that some of these women's labour was augmented rather than induced.

The patterns of intervention within Sure Start areas were generally similar to the pattern seen among all deliveries to Islington residents at the Whittington Hospital. Small numbers of women within each Sure Start area with these selected complications precluded statistical testing of differences.

Delivery method

Medical intervention during labour and delivery was common among women with diagnosed as having abnormalities of the pelvic organs, obstructed or long labour or fetal stress. Among deliveries to women with abnormalities of the pelvic organs, most commonly a uterine scar from a previous pregnancy, 92.8% of deliveries were by caesarean section. When labour was obstructed, 75.3% of deliveries were by caesarean section, and a further 18.5% were by instrumental delivery.

Among women where a long labour was recorded, medical intervention was noted in 95.2% of deliveries, with 52.1% of all deliveries with a long labour being instrumental and 43.1% by caesarean section. Where fetal stress was recorded 83.7% of all deliveries involved medical intervention, 42.1% being instrumental deliveries and 41.6% by caesarean section. Delivery by caesarean section was also undertaken in 39.5% of women diagnosed with hypertension and oedema during pregnancy.

Within Sure Start areas, delivery methods where complications were present appeared similar to those seen among all deliveries at the Whittington Hospital, but the numbers of women involved were very small.

Complications among all deliveries by elective and emergency caesarean section were analysed. Among deliveries by elective caesarean section, the most commonly recorded diagnosis was maternal care related to the fetus and amniotic cavity, seen in 82.0% of cases. Of these cases, uterine scars from previous pregnancies were recorded

for 60.5% of women. In 4.5% (11) of deliveries by elective caesarean section, no complications were recorded. For deliveries by emergency caesarean section, complications of labour and delivery were recorded in 81.2% of cases, including cases of long labour, fetal stress, and obstructed labour.

Table 4.6.1 Deliveries at the Whittington Hospital with selected complications by method of onset of labour and by delivery, March 2003 to August 2005

Selected complications	Method of labour onset Percentage ^a			Method of delivery Percentage ^a		
	Spontaneous	Induced	Caesarean	Spontaneous	Instrumental	Caesarean
Abnormality of pelvic organs (O34)	24.2	1.3	74.5	7.2	-	92.8
Hypertension and oedema during pregnancy (O10-O16)	22.5	59.2	18.3	54.3	6.2	39.5
Obstructed labour (O64-O66)	81.8	18.2	-	6.2	18.5	75.3
Long labour (O63)	68.0	32.0	-	4.8	52.1	43.1
Perineal laceration (O70)	96.4	3.6	-	99.5	-	-
Fetal stress (O68)	75.7	23.4	0.8	16.3	42.1	41.6
Postpartum haemorrhage (O72)	88.2	11.8	-	100.0	-	-
Prolonged pregnancy (O48)	10.3	88.5	1.1	88.8	4.5	6.7

Notes. ^a Percentage refers to the percentage of deliveries with the selected complication by method of labour onset and method of delivery

Source: Whittington Hospital PAS

4.7 Summary

Analysis of Sure Start targets and outcome areas of interest was undertaken using data available from routine local data collection systems. Where possible, a quantitative description of the outcome areas was provided for women and babies residing in the Holloway, Hillmarton and Copenhagen Sure Start areas. The conclusions that can be drawn from the results are limited by a lack of baseline data and population-based data.

Smoking

Among women delivering at the Whittington Hospital, smoking during pregnancy was most prevalent in the Hillmarton area, where 22.3% of women smoked at delivery. This is significantly higher than the rate of 11.7% in the Holloway area. The ethnic mix of women in the Hillmarton area may be one factor associated with the higher rate of smoking seen there. In both these areas, almost half the women who smoked 12 months prior to booking, continued to smoke throughout pregnancy. Robust baseline data were not available to assess whether there has been a decrease in smoking during pregnancy in the three Sure Start areas.

Breastfeeding

Breastfeeding at birth among all women in the Sure Start areas was most common in the Holloway Sure Start area where 86.5% of babies were breastfed at birth. This was significantly higher than the 78.1% of babies breastfed in Hillmarton. The rate of breastfeeding in Copenhagen was 82.8%. Baseline data available from Sure Start showed an increase in breastfeeding at birth in both the Holloway and Copenhagen areas but baseline data were not available for Hillmarton.

Data on breastfeeding at later points in time were limited. Among women receiving caseload services in the Holloway Sure Start area, rates of breastfeeding at 4 weeks remained high. Figures provided by Sure Start suggest there has been an increase in breastfeeding at six weeks among women residing in the Holloway Sure Start area but data were not available for the other areas.

Low birthweight

In Islington as a whole, there has been a decrease over time in the percentage of low birthweight babies. A significant decrease was also seen in the percentage of low birthweight babies born to mothers in Copenhagen, but was not detected in Holloway or Hillmarton Sure Start areas. The low numbers of low birthweight babies means that there was insufficient statistical power to detect a significant difference unless it was very large. Low birthweight is associated with a number of factors. The rate of low birthweight babies among women who lived in the Hillmarton area and smoked was twice that seen among women in the same area who did not smoke. Numbers of smokers in Holloway and Copenhagen were small. Associations between low birthweight and smoking should be interpreted with caution in the absence of data on social class as social class differences in smoking in pregnancy can contribute to the differences between smokers and non smokers.

Antenatal care

Among women who attend a booking appointment and delivered at the Whittington Hospital, women from the Holloway area were significantly more likely to do so before 12 weeks of pregnancy than women from Hillmarton and Copenhagen. Women from Holloway and Copenhagen were also more likely to present for a booking appointment after 20 weeks of pregnancy, compared to women from non-Sure Start areas. In each of the three Sure Start areas, approximately 60% of women had attended a booking appointment before 16 weeks. No baseline data were available for comparison.

Women from the Holloway area who received antenatal care through the Whittington Hospital and delivered there, were significantly more likely to attend the recommended number of antenatal appointments than women in Hillmarton and Copenhagen Sure Start areas. Again, baseline data were not available for comparison.

Data on the provision of antenatal advice, support and information were limited, as were data on antenatal and postnatal depression.

Method of delivery

Among deliveries occurring at the Whittington Hospital, there were no significant differences found between the Sure Start areas in delivery methods, with around two-

thirds of all women having a spontaneous vaginal delivery and just over half of women in each Sure Start area having a spontaneous onset of labour and delivery. Methods of delivery were similar to those for England as a whole, even though the Whittington Hospital has one of the highest caesarean section rates in the country. Baseline data specific to Sure Start areas were not available.

Complications of labour and delivery

Selected complications of pregnancy and labour and delivery were examined for deliveries occurring at the Whittington Hospital. Common complications of pregnancy and labour and delivery were evident, and these often were associated with obstetric intervention. Due to small numbers of selected complications, comparisons between Sure Start areas were not undertaken. Generally, the pattern of complications seen appeared similar to those seen in England as a whole, although perineal tearing may be less common among the deliveries at the Whittington.

Assessing the impact of Sure Start maternity programmes

The lack of baseline data for most outcome areas means that it is difficult to conclude what impact, if any, different approaches to maternity services have had. In the Holloway Sure Start area, where a caseload approach to midwifery services was introduced, some positive findings were reported during the period over which caseload midwifery has been active. For example, this area shows the highest rate of breastfeeding at birth, and most women continue breastfeeding to four weeks. Compared to baseline estimates of breastfeeding by Sure Start, there appears to have been an increase in breastfeeding at birth and at six weeks in this area. It is not known, however, whether this is due to the caseload approach to midwifery or a general increase in breastfeeding at birth and six weeks in Islington as a whole. The Holloway Sure Start area also shows a lower rate of smoking than other areas, although baseline data were not available for comparison. It is possible that the lower rate of smoking is a consequence of the ethnic mix of women in the area rather than of enhanced midwifery services.

Encouraging results were also found for antenatal care among women from the Holloway area who delivered at the Whittington Hospital. These women were more likely than women in other areas to attend a booking appointment before 12 weeks of pregnancy, and also to attend the recommended number of antenatal appointments. Without baseline data however, these differences between areas cannot be attributed to the caseload approach to midwifery. A limitation of these findings, in relation to the caseload approach to midwifery operating in the Holloway area, is that they include only women who booked and delivered at the Whittington hospital. With about a fifth of women known to transfer out of the area prior to delivery, these figures cannot be generalised to all women residing in the Holloway area.

Limited data were available about maternity care and outcomes for women residing in the Copenhagen Sure Start area. Compared to start point data provided by Sure Start, there appears to have been an increase in breastfeeding at birth among women in this area, with 82.8% of babies being breastfed at birth. Again however, it is not possible to say whether this is an effect of the provision of maternity services in this area or whether there was a general increase in breastfeeding during this time. Some data were available for the 18% of women from this area who delivered at the Whittington

Hospital, where a maternity health care assistant was employed, but the numbers were small and it is not known how typical these women were of those living in the area.

The Hillmarton Sure Start area was considered to be the control for the quantitative analysis. When compared to the Holloway Sure Start area, differences were observed in some outcome areas. Breastfeeding at birth was lower among Hillmarton women compared to Holloway, but increases were seen from 2003 to 2004 among Hillmarton women. Baseline data were not available for Hillmarton. Hillmarton showed a high rate of smoking during pregnancy, with 22.3% of women smoking at the time of delivery, higher than in Holloway. Baseline data were not available to assess any change in smoking during pregnancy in the Hillmarton area. One factor identified which may contribute to the high rate of smoking in this area is the ethnic mix of women. Compared to Holloway, Hillmarton has a higher proportion of women of white backgrounds who were more likely to smoke. An alternative explanation may be that there are more deprived women living in Hillmarton, with rates of smoking often reflecting underlying deprivation. While Hillmarton did not show higher levels of low birthweight babies than other areas, the high rate of smoking in Hillmarton was found to be associated with associated with low birthweight, but this may again reflect adverse social factors among its white population.

In summary, while the quantitative aspects of this evaluation have provided some useful information about Sure Start targets and outcome areas, this information generally relates only to the time period since the introduction of different approaches to maternity care. Without baseline data for all Sure Start areas, it is not possible to conclude with certainty what impact maternity services have had on Sure Start targets and outcomes of interest. Further, a lack of population data means that for most areas, figures apply to a select group of women, generally those delivering at the Whittington Hospital. As well as the possibility of selection bias, this provides particularly poor coverage of women from the Copenhagen area, as well as of the 20% of women from the Holloway area who were known to have moved out of the area prior to delivery.

Chapter 5: Qualitative findings on users' experiences

5.0 Introduction

This section presents the findings from the interviews with service users. It maps onto objectives 5, 6, and 7 outlined in the proposal for the evaluation (see Aims and Objectives, pg 8). Qualitative findings specific to Sure Start targets on breastfeeding, smoking, alcohol consumption and mental health were integrated with the quantitative findings given in the previous chapter. Findings relating to staff satisfaction and communication are given in Chapter 6.

5.1 Sure Start engagement and satisfaction

Most women understood Sure Start as the support groups and activities offered by the different Sure Start Local Programme areas (breastfeeding, tots, baby massage) rather than as caseload midwifery or a maternity health care assistant. Table 1.2 in Chapter 1 provides a breakdown of these groups and services as offered at the time of interviewing. According to staff, these groups are in constant fluctuation with some ending and more beginning. All women registered to Sure Start, including those that did not attend Sure Start on a regular basis, had a good knowledge of the services and activities on offer. Women were kept informed by the regular newsletter which they received and posters inside the Sure Start building. From the data, it appears that some groups are considered particularly useful in the different areas, this is discussed further below.

On the whole these groups were appreciated by a lot of the women and for those women using them they provided an important social function and support and information network. This was particularly the case in Hillmarton where women described the most engagement in activities, in particular with the breastfeeding group. Other women intended to use the services but were finding it difficult to get themselves sufficiently organised to attend. For example, one woman commented that most of the activities were in the morning and she was ‘not a morning person’ (Hil18). These women expressed interest in attending and said that perhaps in the future when they were a little more settled they would access Sure Start more.

There are things like ... er, there's a dance and movement class which I've sometimes thought I must try and go to that and never managed.

Cop18

I don't know, they're offering baby massage, which I really would like to take [son's name] to but I've just been so busy with all his appointments and everything, I haven't really had time.

Hil11

I haven't actually used that facility yet because she's quite clingy and I think she's a bit young, not that I wouldn't use it, I would.

Hlw16

I kind of <pause> you plan to do all these things, and then you know, on the day, like say Wednesdays was Baby Massage and sometimes you know, Tuesday night she'd be up all night so Wednesday you know, I can't possibly leave the house today.

Hlw19

Other women with more than one child were worried what to do about the extra child while accessing a group or session and a few felt their child was too young to attend any of the groups.

A third group of women did not respond to this type of service provision and are unlikely to engage with it. These women expressed no interest in attending or accessing the services, either saying that they did not feel they fit in to this kind of organised activity, or that they did not need the kind of service or networking that was on offer there.

It's just me really <laughs> I can't be bothered, I can't be bothered to go and have tea in the school <pause> no, that's just not me, I've got my mum and I've got my family and I've got loads of friends who have got little ones as well, so <pause> just do that instead.

Hlw33

KT: And why haven't you gone to anything [in Sure Start]?

I: ... I just ... I'm not really interested in going and meeting other people 'cause I've got loads of family round here, takes up my week just doing all of that kind of stuff. And I've got friends who've got children. So ... I wasn't out to go and meet other people with babies. So ... I don't know really.

Cop09

Cop09 also said that she might go later when her child is older but this would be for her child's benefit, to play with other children rather than so she can 'hold him and talk to other Mums.' On the whole, women who were not interested in participating in

Sure Start activities tended to have a good support base in the area or felt confident in their situation and therefore did not need the additional social support available through Sure Start

The use of Sure Start groups does not appear to be related to differences in the social circumstances of the women, but more related to choice and lifestyle. The maternity health care assistant had a role to play in helping women to get sufficiently organised to attend, as seen in the attendance of the breastfeeding group in Hillmarton.

Furthermore, in Copenhagen after the maternity health care assistant and a Sure Start sponsored nursery nurse left, attendance at groups went down dramatically (See Table 5.1). So the maternity health care assistant appears to give the women more motivation to get involved but also plays an important role in keeping the midwives up to date on the services offered. The following midwife explains:

I mean I really don't know a whole lot about Copenhagen... bits and pieces have not really been that advertised to us, if they're doing anything interesting or anything. So you know I know of a few things in the past because [ex-maternity health care assistant] has now left as well, so she used to kind of say, oh this is happening or that's happening, you know, and I know that they've moved their health centre up into the area more and that's about it really I know for Sure Start Copenhagen.

Goodinge midwife 1

Table 5.1 New registrations, Sure Start Copenhagen, July 2005 – March 2006

	Number of new registrations
July	50
August	50
September - Maternity health care assistant left	20
October	27
November	33
December	12
January - Nursery nurse left	26

February	8
March	7

Source: Sure Start Copenhagen database

In phase one of the sampling all women were selected randomly from the local Sure Start databases, since the majority of women were sampled in phase one, this means that almost all women interviewed were registered with Sure Start. All women were asked how they had heard about Sure Start and their level of involvement as well as their likes and dislikes of the organisation. On the whole there was good feedback about Sure Start from women who were actively involved. The following sections compare the individual areas to examine any differences in women's comments or experiences.

Hillmarton

In Hillmarton around half of the women were referred to Sure Start through a health visitor and the other half through a maternity health care assistant. They were all therefore picked up postnatally since at that time the maternity health care assistants were only contacting women after they gave birth. The only exception was if a woman was on her second or third child and so had been referred with her previous pregnancy. Some women who were signed up some weeks after their child was born expressed disappointment that they hadn't joined earlier. One had never heard of Sure Start (phase two sampling).

The 'active' members in Hillmarton came from a variety of backgrounds, of different ethnicities and ages. Activities most likely to be mentioned included the breastfeeding group, baby massage and playgroups.

KT: And you mentioned Sure Start a bit, what kind of services have you accessed from Sure Start?

I: Sure Start's got loads. They've had aerobics, the playgroups have been fantastic for me, like I was saying, to get my little girl out and about, 'cause you meet other parents as well... they give advice about transportations and things like that that are available to us for free, which I didn't know about.

Hil20

I mean, mostly now I use Tots, which is the baby group and what else do we do? We go to music, which is very good, but they run, you know they run very nice stay and plays and <pause> I don't know, they're offering baby massage, which I really would like to take [child's name] to.

Hil11

Regular users were on the whole very enthusiastic about Sure Start and its facilities. Here are some of the comments from women in Hillmarton:

KT: And do you, are you aware that you live in a Sure Start area?

I: Yes, I love it, it's great, really, really great <laughs> ...I've met, some really nice people through it, and we were having coffee and we were all saying how we really wanted to write letters to say how wonderful it is and, you know, because I think it's criticised sometimes for the wrong people making the most of it or, not the wrong people, but maybe not the main target people, but I have to say that I just wouldn't be able to do half the things I do through, because I get them through Sure Start, 'cause otherwise if I had to pay for them I just wouldn't be able to afford it, you know...

Hil28

It's so nice to go and you see all the other parents in the area and you're all sort of together and the really wonderful thing about Tops I think is, this playgroup, is it's so mixed from the local area, it's so nice that there's, we all are friends and know each other and there's a whole load of Turkish mummies and Somali mummies and white working class mummies and white middle class mummies and black English mummies and there's lots of daddies and there are special needs children and it's like really genuinely, genuinely mixed and it's such a nice atmosphere and everybody's friends and talks to each other and I do think that comes from the top, from the people who run it... I've often wished that Tops ran primary schools and secondary schools as well 'cause it's an absolute model of community child group, it's fabulous <pause>.

Hil11

The comments from these two women show how they appreciate the peer support and networking that Sure Start enables. The second woman has a child with a congenital abnormality and has had a very difficult experience in trying to access care and support for her baby. For her, Sure Start has made a big difference as an outlet for her and as a place to seek advice for the care of her child.

Holloway

Women in Holloway were referred to Sure Start through a variety of channels; by health visitors, midwives and Sure Start workers. One woman had never heard of Sure Start though she was registered. It seems her husband acted as a translator for her and had never told her about Sure Start and the letters they received from Sure Start. She expressed interest in taking part but since she could not speak English she was not sure that there was any point. This was reiterated by one other woman in Holloway.

Fewer women in Holloway were regularly involved in Sure Start activities. These women came from a variety of backgrounds again. As noted earlier, none of the Holloway women attended a breastfeeding group but they did mention playgroups and baby massage. Unlike the Hillmarton women, although Holloway women enjoyed the groups, they were less likely to describe networking or peer support as their motivation for joining or staying. A teenage mother who attended a young mothers group was an exception:

The baby groups is just like a bunch of teenage girls, they're all under 22 no under 21...and it's good cause, well, there was a girl there that was breastfeeding and she said she liked coming here cause she had to get out of the house at some point and she could breastfeed there cause other girls were doing it too. Well, I wasn't but other girls were, there was a few people that haven't.

I noticed that with the teenage mums, like a lot of them had the same views as me, a lot of them didn't breastfeed and a lot of them were like, well certain things that I do they like it as well.

HlwE

This woman had previously spoken about how in an antenatal class she had felt awkward as she was 18 years old and the youngest there. She enjoyed being with other young mothers and that made her feel more 'normal.' The last sentence shows that there is some danger of 'negative' peer support, however.

Copenhagen

In Copenhagen, all women were referred to Sure Start via a health visitor. This is consistent with the fact that Copenhagen did not have an enhanced service during the time of interviews, although midwives are aware and available to register women as well. Those registered with Sure Start in both Hillmarton and Holloway included a number of women who were in the 'hard to reach' or physically or socially disadvantaged groups targeted by Sure Start and these were then included in the 1st round of interviews. This was not the case in Copenhagen where there was a clear social distinction between those registered and those not registered with Sure Start. Given that Copenhagen did not have a maternity health care assistant during the period of qualitative data collection and Hillmarton did, while Holloway had caseload midwifery, this suggests these maternity roles were important in getting the full spectrum of women registered with Sure Start. While a high proportion of women in Copenhagen use University College Hospital this does not explain this finding as women in Hillmarton and Holloway were registered with Sure Start through health visitors and/or home visits by a maternity health care assistant or midwife.

However, of those interviewed, the majority attended Sure Start activities on a regular basis. Consistent with the other two areas, women were most likely to mention baby massage and playgroups but also baby yoga. Women said they appreciated active activities which they could partake in with their babies. On the whole there was very good feedback such as this lady below.

The Sure Start stuff is brilliant. Really good. I know Copenhagen was one of the first ones, so it's probably had a lot more experience and that's why it's very good, but we've done a weaning course, baby massage, baby yoga, lots of sessions where you go and there are mums with babies the same age so you get to know people. Lots of advice about returning to

work, really concise stuff that ... I just, well I couldn't fault that. That's been really good. We've had a really good six months. It's been really good fun. So that stuff has been really good.

Cop04

Two women, neither of whom had given birth in the Whittington, had never heard of Sure Start. A third woman said that her husband had been told about Sure Start but that she was not sure what it was about as English was her second language.

5.1.1 Service User Suggestions for Sure Start

All suggestions for Sure Start came from the Hillmarton area, this may have been because these women appeared to be the most actively involved out of the three areas. A few women mentioned that they would have liked to have heard about Sure Start a little earlier than they did and even to get involved with Sure Start during their pregnancy through for example antenatal classes.

So it would have been useful probably to have known about it at the hospital because then, you know, in the meantime you've got five days, you're in bed, there's not much you can do, so if someone comes round and explains all of this at that time then you've got time to actually think about what you want the baby to do and start straight away, so that would have been useful <pause> but now that I know, it's a great service so I'm definitely going to make use of it.

Hil07

This woman suggests the postnatal period in the hospital to be a good time to be approached about Sure Start. The maternity health care assistants in Hillmarton report picking up some women at this point.

Another suggestion was that Sure Start attempt to work outside work hours and during school holidays. This would be especially useful for partners who are working full time and would like to spend time with their babies.

KT: Yeah. Did any of, did your partner for example, was he ever offered support for anything in any way during your pregnancy?

I: No and actually that's something that he mentioned to me, that he would like to do something with the baby, because he feels a bit left out so when he comes back home and obviously I've been with the baby all day and he hasn't, ... he mentioned a few times that he would like to do something but the problem is that he's working most of the day anyway, so it would be over the weekend and Sure Start, for example, doesn't do anything over the weekend and anyway, as far as I know, there isn't anything really for fathers.

Hil07

Where women knew of fathers' groups, which were available only in Copenhagen at the time of interviewing, they said their partner was too shy or embarrassed to go to the group. A more outreaching approach may be needed to enlist men in the services of Sure Start similar to that which is more successful with the women. When women were asked about how their partners were included in or offered services, the majority of them said that their partner was never offered services and sometimes felt excluded in the meetings in particular with medical staff. One man said on the telephone during the interview that he thought that 'was about right' since having a child was more to do with the women.

Other suggestions included some day care for women to leave their children so that they could have some 'me time' and postnatal exercise classes to get women back into shape after giving birth, specifically Pilates which helps the back. A free crèche was offered in all of the areas for a couple of hours a week, so it might be beneficial to consider more times for flexibility.

5.1.3 User Satisfaction – Clinical Care

As described there was good feedback from women about the services offered from Sure Start – which women identified as the group activities rather than caseload midwifery or a maternity health care assistant. However, in all three areas and across a range of hospitals there were mixed reports of the clinical care received with many women remarking on an inconsistency in the standard of care.

The Whittington, both times, I'd say it's very mixed and ultimately it depends on who you get at the time. We've had some very good, we had some very good people and we had some people who were <pause> lacking I'd say.

Hlw04

Well, I think if you get one of the good midwives when you're giving birth and they're still on their shift for the whole time, then you're probably fine but they have a whole load of duff ones and I think they know that they have a whole load of duff ones, in fact I know that they know they do, but I guess they have to have staff.

Hil11

The women reported an element of 'luck' in the care they received, which many felt was corroborated by their friends' experiences in other hospitals – i.e. it was considered a problem endemic in all of London and possibly England. Like Hil11, women were across the board aware of the issues of staffing present in the hospital and many were sympathetic. However, there still appears to be 'mixed' experiences within the same care period which would point to differing standards within a hospital that is suffering from under recruitment.

In particular women were unhappy with care in the postnatal care wards, reporting lack of cleanliness, shortage of staff and insufficient attention or support. Some women were so upset with the care in the postnatal wards that they left early.

And then there's a real shock because you go from the fantastic care that you can't believe how good it is, to the postnatal ward ... which is ... I was out of there within twenty-six hours but they were querying giving me a blood transfusion, that was how much blood I'd lost, and I refused because I wanted to go home, because it was so appalling.

Cop04

When I was moved from there up to the main postnatal ward, it was just horrific, I just thought it was horrible, I just felt like I was in some refugee camp, it was just grim.

Cop06

KT: And then what was it like for that 24 hours staying in the hospital? What kind of things, did they go over anything with you?

I: Absolutely nothing.

Hil18

Previous research in England has also shown that postnatal care wards are often those where women are least likely to be satisfied [20]. Some women felt that the night staff were particularly bad and felt unsupported especially during these times.

I: I said afterwards to the sensible midwives about my blood test disappearing and they were like, oh yeah, you know, you might as well not bother taking the blood test, 'cause in the middle of the night nothing happens.

KT: So, your first birth was in the middle of the night?

I: Yeah. I mean, my general opinion, in terms of hospitals, is like never go at night at the weekend at the Bank Holiday because the sensible staff have gone home and you're left with these, kind of half-baked...

Hil11

KT: And then what was it like staying overnight in the hospital?

I: <pause> It was OK. I don't really think, I think that the midwives this time were not as helpful as I remembered them to be the last times, the night staff ones anyway, I thought they were a bit rude.

Hlw16

Part of the issue of staffing at night time, as recognised by some women, was that the women, having had their family or partner around them for the most of the day, are suddenly left on their own. This caused distress to quite a few women, particularly those that had just had a caesarean section and therefore found it difficult to move around and lift their newborn child. Furthermore, this had implications for women

attempting to breastfeed who found there was little assistance available to them in the postnatal ward which many women felt was a crucial time in establishing breastfeeding and getting the baby to 'latch on' correctly.

A few women were happy with the care they received on the postnatal ward, these women tended to have a room on their own or had had a caesarean section in the Whittington hospital, where it seems that post-caesarean care is particularly good.

Continuity of care

In all areas the majority of women expressed a preference for more continuity in the care they were receiving. This usually occurred in answer to a question about general improvements they would like to see in maternity care. The following woman from Latin America describes how she was expecting more continuity in her care provider here.

The doctor that sees me from the start is the doctor that's going to deliver my baby, [at home]. All the visits, consultations, I see him; I do all my exams with him. That's how it happens ... Here it's different. Here I go to see one doctor, then I get sent to a different midwife, and then to another one and all that, so there's changes. I felt a bit insecure.

Hil26

This woman was quite isolated in England as she had very little English and had just arrived over to the country. Although she was overall quite satisfied with her care, she did describe quite a lot of anxiety during and after the pregnancy.

A few women said that it was important that health care professionals understand you and your point of view such as the following woman who is a Jehovah's Witness.

KT: Oh, OK, and what difference did that make, when you think about your first pregnancy versus your second pregnancy, having one midwife?

I: Because they get used to you and they get use to, 'cause I'm quite, from a religious background, I'm a Jehovah's Witness, so that means I don't actually have blood, so it was good that I didn't have to

have to keep on having to explain the situation each time, so she was familiar with my situation, so she could <pause> <laughs>... then she could say, well have you done this basically or have you, you know...

Hil20

This increased understanding meant that the women felt more confident in their decisions and information received and avoided the necessity to repeatedly go over their decisions and circumstances. Furthermore, since quite a few women described feelings of powerlessness in labour and an inability to articulate their preferences, having the same midwife may help some women to have more confidence in following through their decisions during labour.

Despite not having one to one midwives, women in Copenhagen and Hillmarton did describe some continuity in their care - two women in Copenhagen described seeing the same health visitor and in Hillmarton four women repeatedly saw the same midwives. In general these women were enthusiastic about meeting the same health care professional more than once. However, a minority of women felt that there was no need to have the same health care professional, that it made little difference to your care, as long as the health care professional was kind and competent.

I: Oh no, no, I had loads of different, loads of different midwives, yeah.

KT: And how was that? Was it OK?

I: I found that fine actually because I read lots of books on what I needed to, so I didn't find ... I mean I'd ask them obviously what my urine was and what my blood pressure was and things like that, but I didn't find anything ... no I found that OK actually.

Hlw18

KT: That's super. And then when you came back home did someone come and visit you here at the house?

I: Yeah.

KT: And who was that?

I: Different midwives, but mostly those that I'd seen. One was one of my delivery midwives and the others were midwives that I'd seen here and up at Whittington, so it was people that I knew, so ...

KT: That made a difference?

I: Not really, because to me they're doing their job, so whether I know them or not ...whether they're students or not, it doesn't matter, they're doing their job, as long as they're not being rude or ...anything

Hil05

One woman even expressed concern on having only one midwife, in case they didn't get on well.

KT: Do you think that you would have liked that, [to have one midwife] or that would have made any difference to you or...?

I: I suppose it depends whether you can chose, because what if you, for some reason, you just don't gel with that person or ... I, it didn't matter to me at all that several different people were involved.

Cop18

Midwives from all three areas expressed a preference for some continuity in the care that they were giving, one midwife in the Goodinge team said that she had moved from an area quite far away in order to work at the Whittington where she knew she would be able to provide more continuity. Looking at overall satisfaction as expressed by the users in their clinical care, there were a few issues that arose in the different models.

Holloway

Considering that many women expressed a desire to have continuity in their care, it is perhaps not surprising that women in Holloway were the least likely to have complaints about their care and almost all of the women expressed a high satisfaction with their 'named midwife.'

I couldn't wish for a better midwife, you know, they were, and the carers in the hospital when I had him...I couldn't wish for more, you know.

Hlw25

Women were particularly glad to have visits made to their home at a time when they were available rather than having to wait at the clinic in the hospital.

I was quite happy with the fact the midwife visits you at home. That makes a huge difference, 'cause my mate's pregnant now and she has to go to the midwife and it's a nightmare.

Hlw20

This same woman said she had a 'personality clash' with her midwife and felt that her delivery had not been managed well; her baby was turned the wrong way in the womb and she was pushing for hours before a doctor was called who then said that she needed a caesarean section. However, despite this personality clash and the caesarean section which she thought was inevitable anyway, she was happy to have a named midwife that visited her at home and was anxious to have someone at the birth that she knew. She felt the care she received from her midwife was better than that she had previously received in the Royal London Hospital, which she had attended for the first six months.

One area where caseload midwifery does not have an impact and which appeared to be the most concerning for women, was the postnatal ward. The caseload team provides care for clients antenatally, during delivery and postnatally at the home of the client but does not provide postnatal ward care in the initial few days after birth. According to the women from all areas and hospitals, they received the worst or least care at this period in the postnatal ward. As mentioned before, this time appears to be crucial for establishing good breastfeeding practice with the women.

Hillmarton

Only a few women mentioned meeting the maternity health care assistant. Women explained that the maternity health care assistant registered them to Sure Start and told

them about the breastfeeding group. Only one woman appeared to have met a maternity health care assistant more than once and she described a close relationship with her which was aided by a shared language.

I: But the best thing was when a women came from Sure Start. It was a coincidence. I don't know how it happened. She came, and I explained that I didn't speak English and she said, 'what do you speak?' [speaks same language] ... she's become a good friend now, and she comes and she talks and she asks if we need some help.

KT: What kind of help?

I: She always asks if I'm well, if I'm depressed, and there are also the benefits that we have the right to, are entitled to. There is a benefit called Sure Start Maternity Grant and she helps with that, she makes it all clear to us.

Hil26

One woman described her anger at receiving conflicting advice from the maternity health care assistant and a book she was reading about breastfeeding. However, at the time of the interviews, the maternity health care assistants had not yet received full training for breastfeeding assistance, which may have led to some confusion over best practice.

It is clear from the interviews in Hillmarton and from some data collected in the Copenhagen area relating to the time when there was a maternity health care assistant there, that the maternity health care assistant plays a key role in encouraging women to attend the groups that are available in the Sure Start Local Programme. These group activities appeared to improve women's overall levels of satisfaction in Hillmarton.

5.1.4 Evidence in Context

Local evaluations of practices which offer caseload midwifery have found that the continuity of carer appears to improve maternity outcomes including fewer interventions in labour [21, 22]. Given the increased satisfaction of users and the

potential benefits for maternity outcomes, any move to reduce continuity in care should be avoided if possible.

Continuity of care is advocated both by the NICE guidelines on antenatal care, which recommend that women receive continuity of care throughout the antenatal period by a small group of carers, as well as in the National Service Framework for Maternity which advocates continuity of support during pregnancy, childbirth and the postnatal period [4, 23].

5.2 Disadvantaged Groups

In our sample of interviewees there were three teenage mothers, two women living in temporary accommodation, and one identified refugee. As women were not probed specifically on their immigration status there may have been other refugees sampled who did not bring this up in their interview. All these women, except one living in temporary accommodation, were sampled in phase two which meant that the interviews were shorter and less detailed.

For the women living in temporary accommodation it seems that housing difficulties during their pregnancy are a cause for stress and anxiety. Both of them were offered help in finding accommodation from health professionals which they appreciated greatly. However, in one case in particular it was apparent that the temporary nature of her accommodation was affecting her ability to access care and to maintain a healthy diet. The fact that she was moving around a lot and did not have a fixed address meant that she was changing GPs and hospitals and appeared to get somehow lost in the system, only managing to access care regularly once she was given a caseload midwife in Holloway.

I: When I went [to the hospital], didn't explain to me anything about the baby, the foetus, with the first scan, so I didn't know what was going on, I just had to read the books.

K So you went to this clinic and then did you go to the hospital or did you go to a GP or ...

I Urm, I didn't have a GP back then, I just changed GPs when I moved as well, so that was another hassle. Um ...the GP, the first GP I was at, when I first told them I was pregnant, they asked me if I wanted to do the, the scan for Down's Syndrome, to check if it's a possibility, and um ... I ended up never having that scan at all anyway, 'cause I moved GPs. Um ... <pause> yeah...All the documents, my antenatal records, I didn't get the yellow book 'til I was about six months pregnant or something.

Hlw20

On top of this she was studying at university and trying to hold down a job. This meant that home visits from a midwife made it a lot easier for her to make her appointments. Her busy and transitory lifestyle meant that her diet came second place. She said that in the first three months she had no time to cook and the communal kitchen in her hostel put her off cooking her own meals, so she ate a lot of food from KFC and McDonalds.

Although Hlw20 proved to be quite an extreme case of transience, in women who were living in non-temporary accommodation there were similar examples of late booking and/or gaps in antenatal care due to referral letters being misplaced and women moving house and therefore changing GPs. The following are two examples.

So I was supposed to have that actually from ten weeks and I went to my doctor and, you know, for the antenatal care, he filled out the form but apparently it got crossed in the post and lost, so I didn't receive my antenatal until quite late. I was waiting, I kept going to the doctors though, being checked on by the doctor, but the hospital didn't write to me till quite late, so I had my stitches put in at 19 weeks, which wasn't normal <pause>.

Hlw16

I was not quite happy because I've started there and when I had only two sessions left, they've asked me to go there [another health clinic] and I was like six, seven months pregnant and I had to take two buses and all stuff so it was too far... And then, I had problem with maternity certificate, so when I asked the midwife she said... I need to go to the GP.

Then they've said no, you have to take it from the midwife. So when I spoke to the midwife, she said no I have to take it to the GP...so I called and they've told me that I had to go to the GP to have it, then finally I had it from the GP, because I didn't understand... the relationship between the midwife and the GP about the maternity certificate.

Hil21

There appears to be quite a lot of confusion for Hil21, probably aided by the fact that she doesn't have good English.

Nonetheless women from all sections of society were quite mobile, in particular first time mothers were setting up home in response to the pregnancy mostly with partners, in or around the area and moving into and out of Sure Start areas as part of this process. This created a high level of transience and provoked difficulties in accessing healthcare services early in the pregnancy.

The three teenage mothers interviewed were a mixed group in terms of backgrounds and outcomes such as breastfeeding and smoking. However, two of them were in a teenage parents group which they really appreciated, having previously described how they felt uncomfortable with how they were judged as young mothers.

I'm involved in the Paradise Park, I go to Young Moms and baby bounce and other things there. I really like it there, I like meeting new mums, especially young mums. In the group it's all mums under 25, it's a nice environment, it makes you feel a bit more normal, sometimes people can look down at you, normally people think that you can't look after your baby but you can take just as good care as somebody else can.

HilD

The third woman who gave birth at the Whittington, had never been part of a group and did not know about Sure Start, however, she expressed a desire to have more contact with people as she felt very isolated. She said

Nobody here to help me, m all alone, I live just me and my baby...I feel very upset and no one help me... I'm happy with my baby [but] not happy with anything else.

HilC

This same woman is also a refugee, i.e. she entered the country as an unaccompanied minor. Unfortunately she had not managed to access much care, this led to her dropping her efforts to breastfeed as when she was in the hospital nobody helped her.

I ask I like to give my baby breast, nobody helping me, that's why I'm upset. I ask but nobody help me. Now I give the bottle, nothing of the breast, nobody help. It was difficult.

HilC

From such a short interview it was difficult to ascertain why she had such difficulties in accessing care.

5.3 Groups with Special Needs

It was anticipated there would be difficulties in reaching women with special needs as they are known typically to be difficult to engage in studies such as this. For that reason two phases of sampling were employed, as discussed previously. However, due to the sensitivity of the topics, women were not asked specifically about HIV or sickle cell status or whether they had suffered from domestic violence, and it was unlikely that women would bring these up spontaneously in the interview. In phase two one woman was identified by a health visitor to be HIV positive and another as having suffered from domestic violence; however these issues did not arise in their interviews.

Approximately thirteen women who were not fluent in English were interviewed. Predictably, issues around language and interpretation were most likely to come up with this group. Many women appreciated the presence of an interpreter and understood the difficulties that arose in having one there at all appointments. In Holloway women reported an interpreter present at all appointments except for one woman who preferred to have her husband translate. In Copenhagen women were least likely to have had an interpreter at all appointments. This could raise issues in relation to inaccuracies in translation as well as issues of privacy, however the women

did not express any problems with having their husband there for translation. In one or two cases women did not know about Sure Start as their husband had not passed on the information on to them. However, generally women were satisfied that they understood what was happening despite language barriers.

5.4 Summary

Most women understood Sure Start as the support groups (breastfeeding, tots, baby massage, etc.) rather than as caseload midwifery or maternity health care assistant - these groups were appreciated by a lot of the women particularly those in Hillmarton. Other women intended to use them but were finding it difficult to get themselves sufficiently organised to attend. A third group of women did not respond to this type of service provision and are unlikely to engage with it. Women with toddlers as well as a new born baby were less likely to attend these groups because they were unsure how the toddler would manage in the group and found it easier to stay home. The maternity health care assistant had a role to play in helping women to get sufficiently organised to attend. For those women reluctant to attend groups some suggested the timing was wrong, or it didn't suit their lifestyle, others would have valued groups at a different time when partners were around to look after toddlers or when partners were around to attend groups with them.

On the clinical side, feedback was more mixed. Women from Holloway appeared to have the highest levels of satisfaction, being particularly happy about receiving home visits. However, across the board women were unhappy with the postnatal wards in the hospitals and many women expressed a desire for more continuity in their care.

The evaluation found that 'hard to reach' and 'disadvantaged' groups had good access to Sure Start services despite being a highly transient population. In both Hillmarton and Holloway women designated as 'hard to reach' and 'disadvantaged' were accessed via the Sure Start data base and were included in the first round of interviews. Evidence from Copenhagen showed that, following the departure of first the maternity health care assistant and then the nursery nurse, access to Sure Start services declined rapidly. Copenhagen was the only area in which we were unable to access 'hard to reach' and 'disadvantaged' groups through the Sure Start database,

reinforcing the importance of the additional maternity roles in facilitating access for all women including ‘hard to reach’ and ‘disadvantaged’ women to these programmes. This provides evidence of the strength of the universal approach to service provision which characterises Sure Start programmes. It is important that in any future re-configuration of services such as the introduction of Children’s Centres that this access is not compromised.

Chapter 6: Staff experiences of delivering services

6.0 Introduction

This section presents the findings from the interviews with service users relating to communication between staff, recruitment difficulties, staff satisfaction, and experiences of data collection.

6.1 Communication between staff

As part of the evaluation we examined how communication between professionals both within agencies and between agencies works and how this is facilitated or inhibited by the different models of care.

6.1.1 Holloway

Inter-professional Communication in Holloway

In Holloway there are six caseload midwives; two groups of three share the same caseload so that each woman will see her own midwife or have one of the team of three if her midwife is on call/holiday etc. Inter-professional communication on the whole seems more likely to happen on an informal basis since groups work more closely together with regular contact. Holloway midwives are particularly reliant on this informal type of communication especially within the 'threesome' which takes on the same caseload. For them, this communication is vital for the functioning of the team and ensures flexible working hours for their workload. The team of three keep in regular phone contact with one another, keeping abreast of the clients they share and the hours they are available to work. All the midwives interviewed were satisfied that this system works well for them.

And as I said we always meet within our little threesome, we'll always meet our colleague's women at least once where possible so that when they do go into labour, if it's me that's on and not their named midwife, I won't be a complete stranger to them.

Holloway midwife2

The lack of a 'team space' means formal meetings are some what more difficult to arrange, nonetheless these appear to happen on a fairly regular basis. At these meetings new clients are distributed amongst the midwives and any arising client or professional issues are discussed.

Inter-Agency Communication in Holloway

Holloway midwives in particular stressed the importance of inter-agency communication and the benefits it has for mothers' welfare. They feel they have good relations with a range of other professionals which is enhanced by a thorough knowledge of their clients. This knowledge, they feel, promotes trust amongst other professional groups in the information that they are giving.

We get very positive feedback from our paediatricians, because when they walk into a room we can give a very concise history 'cause we know the woman very well, erm, and the obstetricians as well, we've managed to free up some of their busy clinics because again they know the women are being seen, so they know that perhaps they only need to see them maybe once or twice rather than keep having them come back, erm, because they know the quality of care that they're getting and that again is good for the service, it has a knock-on effect.

Holloway midwife1

This was reiterated by the Community midwife manager from Whittington and by a health visitor who said she had regular telephone contact with the midwives who she found shared information well about their common clients. The following is an example of the some of the ways the caseload midwives described sharing information with other professionals:

KT: So the communication then is through these slips of paper basically?

I: In the red book, but if there was a specific problem, for instance, yeah, if we had a woman who, their baby had a weight problem, the weight was a bit static and it wasn't gaining as much weight as we'd like, if it was something that we were worried about we'd refer them to the

paediatricians here at the hospital, which we've done, I've done, and usually they would say they'll keep an eye and they would then see the woman, maybe ask her to come back in a week or two. But also at that point that would be a good time for us to ring the health visitor and say, 'look, this is a lady, she's being followed up by the paediatrician but just so that you're aware so when the baby comes to the clinic,' 'cause it will be the health visitor that would be following the child up for the next five years or so, up until school age, so if this baby wasn't thriving and she would then be aware that there was an issue straight from the beginning. Usually mums would say, you know, baby wasn't growing very well so the midwife referred us to the hospital, but it's always nice for the health visitor.

Holloway midwife2

As seen from the other areas below, this kind of regular informal contact with other professionals about shared clients is less likely to happen in the other models. This may well be because of the more in-depth knowledge of the Holloway midwives as mentioned above but seems to also arise from an 'ownership' of clients, unlikely to happen in non one-to-one areas.

On the other hand, the Holloway midwives found it difficult to make the inter-agency formal meetings as set up in Holloway Sure Start. Like the midwives from other areas, these meetings are considered too time consuming in an already hectic schedule. However, this is a missed opportunity as other professionals consider these meetings to be valuable for integrated work and sharing of information. It was intended that a midwifery consultant should attend these meetings to feedback to the Holloway group but difficulties in staff changes have meant that this has rarely happened.

6.1.2 Hillmarton

Inter-professional Communication in Hillmarton

Maternity health care assistants work as part of the midwifery team and therefore considered in this section rather than in the inter-agency section. Maternity health

care assistants in the Hillmarton area report communicating informally on a daily basis with the midwives that they work with. This can be through opportunistic meetings or by ringing through to the team centre. They also report attending meetings on a monthly basis. However, it is not clear how much information sharing occurs at these meetings as the midwives report little of this. Furthermore, some midwives are unaware of the exact role of the maternity health care assistants, only identifying breastfeeding and Sure Start registration as their aims. One midwife confused the maternity health care assistant with a general Health Care Assistant. However, that same midwife said that working with a maternity health care assistant made a big difference to the level of knowledge she had had about the Sure Start services there. This meant she was more likely to refer her clients to specific Sure Start activities.

I mean I really don't know a whole lot about Copenhagen, so your answer is going to be very clear and bits and pieces have not really been that advertised to us, if they're doing anything interesting or anything. So you know I know of a few things in the past because [the maternity health care assistant] has now left... she used to kind of say, oh this is happening or that's happening, you know,

Goodinge midwife1

Since that particular maternity health care assistant has left, she has a much less idea of what is going on, even though she has seen leaflets and posters, so it seems that the personal contact and a shared role (since the maternity health care assistant is also part of Sure Start) is important for communication.

Communication between the midwives in Hillmarton seems to be less often than that in Holloway, this may be because they have less information about individual clients.

Inter-Agency Communication in Hillmarton

KT: OK. What about the other kinds of people that work with pregnant women, like health visitors for example? How much do you communicate with them?

I: *Erm ... <long pause> ... I think I've only maybe once or twice had contact...*

maternity health care assistant 1

Maternity health care assistants have little contact with professionals other than the midwives. Some contact was reported between maternity health care assistants and the Family Support Worker manager in Sure Start – mostly to communicate referrals. However, it does seem that maternity health care assistants have a lot of communication with their line manager who in turn communicates any issues that need to be followed up. This method may be used in order to optimise time which can then be spent with mothers.

A Community Team Leader from Sure Start Hillmarton, reflecting on communication, said that “*informal communication between service providers is very good*” but formal meetings rarely happen. However, the midwives in Hillmarton described little sharing of information with other professional groups.

6.1.3 Copenhagen

Inter-professional Communication in Copenhagen

Since midwives in Copenhagen and Hillmarton come from the same team, their inter-professional communication remains the same.

Inter-agency Communication in Copenhagen

In Copenhagen inter-agency communication, particularly between PCT staff and Sure Start works well. One staff member said:

At the weekly meeting we work on children who are on this common assessment framework and we're working together, actually talking in depth about cases and what we can all do for the family... We find it very helpful, just the sharing of information. Families will tell different people different pieces of their story, so they might choose to tell a Sure Start worker something that I don't know.

Health visitor Cope

Staff felt this was because Sure Start Copenhagen had been around longer and therefore had more time to develop good relations as well as the fact there had been a nursery nurse that shared her time between Sure Start and the PCT. In particular staff interviewed referred to the importance of building trust between agencies.

Furthermore, the Community Midwifery Manager for the Whittington sat on the board of the Copenhagen Sure Start and so could more easily relay information to the Copenhagen midwives about Sure Start Copenhagen, though whether this information trickles down is unclear. As in other areas, midwives themselves are unlikely to make these meetings on a regular basis.

6.2 Recruitment Difficulties in Hillmarton

As part of the evaluation, recruitment difficulties which had been experienced in the Hillmarton area were investigated. In Hillmarton, Sure Start had been attempting to recruit one to one midwifery service in order to start a caseload midwifery model similar to that used in Holloway. Once recruitment strategies were exhausted, two maternity health care assistants were employed instead. A number of factors arose which health care practitioners interviewed in this study felt contributed to the difficulties experienced.

6.2.1 Time Commitment

Many midwives felt that the time commitment involved in being a caseload midwife might make it unattractive to some midwives, in particular those that have families. Caseload midwives described the flexibility necessary when working with a case that works around the availability of the mother, rather than the shifts of the midwife. Furthermore, being on call was felt to be particularly off-putting for some midwives.

I love the way I work and I dread to think what's going to happen when the funding's pulled and if the hospital doesn't agree for us to work the way we're working. But I can also see why it's not as popular with other midwives. I think the main thing is the on call commitment, I think that's the only thing that would prevent midwives from working the way we

work. If they didn't have to be on call practically half the month then they would say, yeah, 'cause it's a great way of working.

Holloway midwife2

This caseload midwife explained how when she first decided to work on the Holloway team, her colleagues reacted to her in disbelief, telling her that she would have 'no life,' though as she reports here, she finds it very personally fulfilling. All midwives interviewed expressed a desire for more continuity in their work, and saw the benefits of working in a one to one manner, but both midwives from Copenhagen and Hillmarton, felt that they were not ready or in the right time of their lives (family-wise) to make that commitment.

6.2.2 'Negativity'

All of the caseload midwives interviewed (three) felt that there was a 'negativity' surrounding the recruitment for Hillmarton, which may have effected recruitment. Two in particular put this down to management preferences for a non-caseload team. Holloway midwife1 described how a student midwife attempted to join the Holloway team before but was blocked by the politics of the hospital.

There was a student who wanted to join our team and very competent, very keen and very willing and was told that she had to go to, through, she had to consolidate her training in the old service, in the fragmented service of running clinics, and we felt and she felt that she, because we'd had a newly qualified student before who just absolutely blossomed as a midwife and is very valued and she didn't need that. ...We felt ready to take her on as she was and what was being said to her behind a closed door by a manager was very detrimental about the team, erm, and very sort of, erm, off-putting and the negativity. She felt that the politics were too immense and that was then told there wasn't a position for her because we were backed into a corner and we had to reduce and go down to six, erm, and that happened, that's happened to two other midwives that I've known, that we are, we're saying one thing and trying to positively recruit and the management...

Holloway midwife1

This was partly felt to arise from a resources issue – i.e. midwifery managers were keen to spread resources across all the teams but the caseload team takes more than others having to have full capacity at all times. This is explained below by a midwifery manager from the Whittington Hospital.

The Caseload midwives need to be nurtured more. They have such tightly controlled numbers of women that they can look after. Once when a few midwives left and their caseload was increasing I had to step in and make an organisational change, i.e. that rather than look after all Manor Garden women, they would just look after the women in the Sure Start Holloway area. This of course meant those women had to be taken on by another team. They have to be nurtured; I have to make sure they always have a full team. If they have a vacancy they can't deal with it like the other teams.

Midwifery manager

This was recognised by the caseload midwives, however, one midwife felt that a caseload team is also challenging for management by the manner in which they work.

We work differently, I think we're probably quite a challenging team to manage because we're very vocal and we are, we will stand up for what we believe in and we are willing to go that extra mile and I don't think the managers have ever had a team of midwives like that and feel threatened and they have to manage us in a different way and it would be a lot easier if they could manage the whole maternity service in one way.

Holloway midwife1

This midwife felt that this lack of enthusiasm for caseloading in the hospital management meant that the positions in Hillmarton were probably 'not sold in a positive light' which led to difficulties in recruitment.

6.2.3 Low Grade Position

One midwife felt that Hillmarton had difficulties in recruiting a midwife as it was advertised at too low a grade.

I think, erm, they, the problem is that offering F Grade, which is now Band 6, which is, erm, I feel that it's not enough money for that role that that midwife is going to be because it's a very diverse area, we do have pockets of real affluence here and deprivation and just, as I said, a real cultural mix, so I felt, we all kind of felt that the band that they were offering wasn't, it wasn't enough money for what was expected and 'cause she was setting up it was going to be quite an autonomous kind of practitioner nurse.

Goodinge midwife1

6.3 Job Satisfaction/Retention

On the whole, Sure Start staff were satisfied with their job, with many having a strong commitment to the ideals and goals of Sure Start. Some issues needing work were recognised by staff, such as coordination across different agencies but on the whole staff felt that Sure Start and Sure Start staff members as individuals were having a positive impact on families, the benefits of which would be seen in the years to come. Not surprisingly, non-Sure Start staff appeared to have less of a 'connection' with Sure Start; many of them are aware of the services offered in Sure Start but they do not necessarily feel part of the team.

I'd like to be more involved, with more closer connections. Over the last year I've happened to have women who have used lots of the services, sometimes I've had women with few needs and then I have little to use Sure Start. It doesn't feel like we are closely connected as a team.

Holloway midwife3

Furthermore, the connection with Sure Start can be stressful for health care professionals. One health visitor in particular explained how her work had increased since Sure Start had begun working with the Primary Care Trust, even though their work overlapped.

I'm slightly confused, not I'm not, I mean, the two organisations, there's confusion, we have the same agenda in terms of outcomes of children, we're still working it out, how we can come together to them... They are different organisations with different management, not always tallying, you know?... We still run our independent clinics, we refer to Sure Start a lot, but we're dragged into doing things in the Children's Centre which takes a lot of time on top of what we already have. There's an overlap, there is time demanded for this new way of working but we're still doing the old way of working, time wise. Other services are involved; we're just working with Sure Start... The Children's Centre will be a whole new steering group! Who knows what then!

Health visitor Hlw

Across the board, many employees from both Sure Start and the health care agencies were anxious about the future of Sure Start, Children Centres and their jobs. Many of those interviewed commented on the 'period of uncertainty' within which the evaluation was happening. As one Sure Start local manager said 'It's a challenging time and there's not enough time to really make this transition.'

6.3.1 Hillmarton {and Copenhagen}

In Hillmarton, the maternity health care assistants expressed very high job satisfaction in their role and strong support from management. Both women were satisfied that they had received adequate training and were enthusiastic to continue expanding the remit of the maternity health care assistant role. They felt that they were contributing to the midwifery team and that they were making a difference to the women they saw.

KT: So, then from your perspective, we talked a bit about these targets or whatever, what makes you think that you yourself have done a good job? You personally?

I: Erm ... <pause> ...the attendance at my groups, the appreciation from women, the Christmas cards, just when I happen to see them they're so happy and smiling, and to see that they've increased their circle of friends, and not being isolated and to ... even to sit down and

have a chat with them and point out that they're doing a great job and 'do you remember yourself two or three months ago' or whatever, and it's 'oh god!' You know. And it's nice to point out to them how far they've come, and that makes me feel as if I've done a good job, because I can do that with them. And yeah, then from what the midwives tell me as well, you know, the efficiency and everything has gone up. So <pause> I'm delighted!

Maternity health care assistant 1

Furthermore, the midwives from Hillmarton are delighted to have the maternity health care assistants on board.

KT: Is it useful having maternity health care assistants working with you?

I: Very very useful! Very useful. A midwife, you are meant to be with the woman, but you are always writing, writing because of litigation. Yesterday I did a booking, do you know what I left the hospital to visit a woman? Nearly two o'clock, if the maternity health care assistant had been there she could have done the computer for me and I could have dashed out to do my visit! But she was not there. So it's really very helpful. The clerical side is most helpful... They are very helpful, I am telling you, they are good. They check in the book and make things ready for us, very helpful!

Goodinge midwife2

Having a maternity health care assistant gives the midwives a feeling of being supported by the management, which was lacking in the areas without a maternity health care assistant. The midwives in Goodinge (who are also part of Copenhagen) expressed satisfaction in their job, though they admitted that at times their workload can be stressful, due to some recruitment and retention issues. One midwife, however, expressed her concern about the planned move in the Whittington hospital away from integrated care to a model where midwives will either do community or hospital duty.

I think a lot of midwives aren't very happy about it, 'cause I originally travelled in very, very, far to come here so it was a big trek in every day, until I've moved more local, just so I could do this kind of care but now it's going to be taken away from us so I think it's going to, I think the women are going to lose out, I think we're going to lose out because it's for our skill, you're talking about skills, because I can do anything, I can do suturing, caesareans, delivering babies, home births where you provide, that lady there that you just seen, she's having a home birth.

Goodinge midwife1

Goodinge midwife1 was committed to the ideal of continuity in care although she did not want to work in a one to one team and she expressed concern that this change will have implications for the women using maternity services in the Whittington, reducing their chances to have any continuity in their care.

6.3.2 Holloway

In Holloway midwives expressed a strong commitment to the caseload model of working, explaining how they enjoyed the relationship they built with their clients and the confidence they had in the model as a means to deliver quality maternity care. In addition, the Holloway midwives described excellent working conditions within the team with high levels of support and a strong commitment to team work.

But in actual fact, the way that we work is great. It actually works well for me, yeah OK being called out at night is not the best and being on call is not the best because I can never go too far from home... But at the same time <pause> it's flexible in terms of if, for instance, I've got an appointment at my daughter's school, I can say to the girls, look I've got to switch off for an hour, I'm going to divert to you, I'm really sorry I've got a prior commitment and I've got to, and the girls are fine with that in the team and that's what it's all about. We have to be flexible, we have to work together because if we didn't it just wouldn't work, the team wouldn't work.

Holloway midwife2

However, all three Holloway midwives interviewed felt that there was little support on a management level for the caseload team. This coupled with the fact that the future of the caseload team is uncertain, appears to have caused a considerable amount of despondency for the midwives.

It's soul destroying because nobody's fighting for it anymore, we're kind of, we feel that the management have dined out on us for the last three years, if they use any statistics, they use ours because they glorify the unit.

Holloway midwife1

In addition, the midwives feel that the women will suffer from the loss of the caseload team, particularly those that have had a caseload midwife before.

They're finding it very difficult now because they're having a fragmented service and it's not what they're used to so I think we're seeing the backlash of a good model now and that's perhaps when a good model ceases to exist anymore it's not only detrimental to the staff, it's detrimental to women and that's been quite hard.

Holloway midwife1

6.4 Staff experiences of data collection

The review of Sure Start Local Programme databases, undertaken as part of the quantitative side of the evaluation, suggested that some of the data collected or entered into the three Sure Start Local Programme databases is incomplete. In particular, information which would allow the identification of particular subgroups of interest to Sure Start, such as teen or lone parent status, was frequently unreported. As part of the qualitative study, all staff interviewed were asked about targets and monitoring in order to ascertain where the gap in information flow may be occurring. While it is not possible to pinpoint this exactly, some issues around data collection were identified which might explain why data is not being collected more thoroughly.

6.4.1. Disconnection with data

Overall staff who were not working directly for Sure Start i.e. Whittington and Primary Care Trust staff, were less likely to have a clear understanding of Sure Start targets. In fact some of them, were not aware of any targets.

I don't know much about it... no, I don't think so.

Goodinge midwife2

No! We have set up a breastfeeding group at one of the children's centres, with Sure Start... But we've no targets.

Health visitor Cope

These professionals had ideas about the areas they needed to be working on – such as breastfeeding, but they were unaware of specific targets that they could work towards or where they would see an improvement over time. As one Sure Start worker explained, it's more about quality of work then meeting targets. Lack of awareness of specific targets, or indeed lack of them as in some cases the target was a general improvement, may mean some members of staff fail to see the relevance of collecting monitoring information.

KT: And how do you, or how do they monitor?

I: We have monitoring forms... It's all on a computer they have here.

KT: And is that useful for you, or ...

I: Erm ... <Pause> ...not really. Well yes, I mean it's nice to see how many women I've visited and subjects that we've covered, but ... <pause>, kind of just file it somewhere really. But I think it is useful for the manger of Sure Start and everything, to know what women want, what they've been asking, what their needs are really.

Maternity Health Care Assistant 1

I keep everything in my diary, at the end of the year, I submit it back to the hospital. I don't know where they take it! I just hand it in and take one then for the next year!

Goodinge midwife2

Feedback to staff about where the data they collect or record are going and how they are important for monitoring and evaluation of services could be beneficial.

6.4.2. Time

A second point is that clinicians have increasing demands on their time and resources. Having the maternity health care assistant to help with data entry and collection has helped the Goodinge team a great deal (Hillmarton and Copenhagen), however, the caseload midwives feel overloaded and unsupported in this area of their role.

The rest of the teams have like they use the clerical staff here and they say, you know, 'this is the list of people that attended clinic', then they would go on the computer with their hospital numbers and put attended, attended, attended, whereas we have to do all of that.

Holloway midwife2

A difficulty with data collection, it has been less than good recently, I think they have difficulty with data collection as they have no assistant. Sometimes the midwives register the women later than the first booking but they would still send in the information to Sure Start that they have seen a woman, but if she is not registered with Sure Start, we can't add that information into our data.

PMHlw

This last point came up a few times with discussions with data entry staff and needs flagging up with midwives to avoid loss of information.

6.5 Summary

Of the three models, it appears that caseload midwives share more information with other agency groups. However, there are few formal meetings held in this Sure Start area which would be useful for working together and not just sharing of information. In Copenhagen, it's 'working together' that works best, particularly between the PCT and the Sure Start Local Programme. This appears to be because of the age of the programme and the shared nursery nurse between the two agencies. The maternity health care assistant would therefore open an opportunity for increased dialogue between the Sure Start Local Programme and the hospital midwives if they had thorough information on the clients and if their time was also shared with Sure Start.

While recruitment and retention difficulties in midwifery are being experienced in many hospitals, the difficulties that arose in Hillmarton were felt to have been due to the heavy workload and low grade offered for the new positions, coupled with some perceived lack of support from management. In terms of retention of staff, it appears that although Holloway midwives have very high job satisfaction they also feel there is a lack of understanding about and support from management for their roles. Sure Start staff in all three Sure Start Local Programme areas were anxious about the future and what it holds for their jobs and their clients.

Gaps in data collection can be explained at least partly by lack of integration of monitoring with staff roles and targets along with a lack of resources to ensure sufficient time involved in this aspect of Sure Start.

Chapter 7: Bringing the findings together

The data analysis has revealed the usual disjuncture between qualitative and quantitative data with quantitative data able to supply population trends but an incomplete picture; and qualitative data able to describe experience but not generalise that experience to larger populations. This section attempts to integrate where possible findings from both sets of data and develop an explanatory model which could be used to inform future policy. This will be done using the whole system methodology described in the original tender document.

This methodology is comprised of four principle perspectives on the whole system:

- The causal system
- The data system
- The organisational system
- The patient/user experience

The causal system will be represented through an explanatory model which links data, organisation and user experience.

The Sure Start targets create data points (data system) which link individual experience and behaviour to population level information systems. The organisational system is structured to provide the support required to enable individual users to meet targets. User behaviour is partly shaped by access to the organisational system and policy is based on the assumption that their experience of this system will influence the extent to which their behaviour reflects the Sure Start targets.

The data on user experience indicate that most users were aware of the health behaviours associated with Sure Start targets i.e. most users recognised the need to stop smoking, reduce alcohol intake, eat a healthy diet and to breastfeed their child.

The organisational system offered a variety of services to help service users to realise these aims.

For the most part smoking behaviour, alcohol intake and diet were behaviours that were managed independently of the support services provided by Islington Sure Start. The exception was women in temporary accommodation who identified difficulties in eating a healthy diet because of lack of control over kitchen space. More access to affordable healthy eating venues for these women or more control over kitchen space are required if these women are to be supported to eat healthily during and after pregnancy.

The evidence from the literature indicates that smoking cessation is effective in helping pregnant women to reduce or stop smoking but it appears that it is particularly effective when integrated into existing antenatal care [12]. More integration of smoking cessation services with midwifery services could increase the effectiveness of these services in Islington. This means a more holistic approach to smoking cessation rather than isolated strategies to reduce smoking. In other words, it is important to look at the broader context of the woman's life and identify within that context what makes giving up or reducing smoking difficult and to address these difficulties.

The need to include fathers in Sure Start programmes was important. The data indicate that women attempting to give up smoking during pregnancy would be helped if their partner also stopped smoking. Currently services seem to focus exclusively on women. In the interviews women indicated that their partners wanted more opportunity to participate in Sure Start activities and more could be done to help them achieve this. Women who do not speak English often relied on their partners to translate. These women were often not informed of Sure Start activities by their partners. More could be done to help these fathers link into Sure Start activities and help these women to access Sure Start services.

Breastfeeding and the mental health of women following birth were supported by a variety of different groups. For those women accessing and using these groups the qualitative evidence suggests they did help women to adopt the behaviours required to meet Sure Start targets but the groups did not suit everyone. Some women were not attracted to the idea of support groups and others had difficulty accessing them. This

was particularly the case for women with toddlers as well as a new baby and for women who did not speak English who felt they would have difficulties communicating at the group or who were simply not informed about them by the person translating Sure Start information.

For some women choosing not to use these groups, social support was available through family and friends and therefore they did not require this type of service to maintain their well-being. These women did not, therefore, necessarily benefit from the support to maintain breastfeeding apparent among the Hillmarton women who attended a group there.

There was a major gap in service provision in meeting the breast feeding target in the postnatal care available to women both in hospital and in the community. Many women were not given information about the support groups until three or four weeks postnatally whereas support is needed most intensively in the first few days and weeks following birth.

7.1 Conclusion

The evidence from this evaluation indicates that both caseload midwifery and maternity health care assistant roles impacted positively in enabling Islington to meet Sure Start targets, but that they worked in different ways. Caseloading midwifery impacts through one-to-one support and continuity of care which women valued highly. Maternity health care assistant roles facilitated access to Sure Start groups and programmes which were also valued by those women who accessed them. The maternity health care assistant role seemed to increase overall access to these groups. However, not all women choose groups as a preferred method of support. Both caseload midwifery and the maternity health care assistant role also supported access to Sure Start services for women from 'hard to reach' and 'disadvantaged' groups.

Some gaps in provision were found in particular in the immediate postnatal period. These gaps indicated that the current organisation of maternity care, while providing high levels of user satisfaction and contributing to the effectiveness of Sure Start in Islington, was not optimising the capacity of the system to support women to adopt

behaviours which would further improve Sure Start targets. Informing women about Sure Start programmes earlier in their pregnancy, improving postnatal hospital care and facilitating access to Sure Start programmes for fathers could increase further the effectiveness of Sure Start programmes. Problems with the quantitative data prevented examination of the effectiveness of these programmes at a population level but even if the quantitative data had been available this would not have guaranteed the statistical power required to detect changes in the behaviour of small groups of women.

In moving to Children's Centres it is important that the provision of maternity services in Islington replicates the key features of these roles if the achievements of Islington Sure Start are to be maintained.

7.2 Key Recommendations

7.2.1 Sure Start Targets

Smoking Cessation

- From this study it appears that the ability to reduce or stop smoking arises from personal motivation and appropriate psychological and social circumstances. Greater integration of smoking cessation services with Maternity services in Islington, taking a more holistic approach to the women's needs, may improve outcomes.
- Partner/family members do not have the same motivation to reduce or stop smoking and should be included in attempts to reduce harm to the unborn and to aid the woman in giving up smoking.

Breastfeeding

- Support for breast feeding is needed in particular in the initial few hours and days in the postnatal care ward. The role of both caseload midwives and the maternity health care assistant in the provision of immediate postnatal care should be considered.
- The physical environment for hospital postnatal care should be reviewed and improved in line with NICE guidelines.

Mental health

The role of the maternity health care assistant in helping women with mild to moderate postnatal depression access a wider social support network should be supported and maintained.

Diet

Homeless women living in temporary accommodation need access to affordable healthy food outlets and/or more control over their kitchen space.

Disadvantaged women

- The partners of women who do not speak English need to be helped to understand their partners' needs and to support their partner in accessing services.
- Ways of increasing access to services for non English speaking women are required.

7.2.2 Organisational Recommendations

Sure Start Access

- Women with older children need provision of care for these children in order to increase their ability to access services in Sure Start.
- The maternity health care assistant role plays an important function in bringing women into services, this could be done ante as well as post-natally.
- Inclusion of partners in general into Sure Start activities needs attention.
Considering the outreach approach of maternity health care assistants' success in recruiting women, a similar role for partners could work to include more men.

Continuity of Care

Many women interviewed from all three Sure Start areas highly valued continuity in their care, moves to un-integrated care in any of the hospitals may lessen women's chances of getting this.

Allocation of Service Provision

Since over half of the women in Copenhagen use University College London Hospital whereas only one in five attend the Whittington Hospital, it is important for the registration and care of these women that any future enhanced services work with University College London Hospital.

Staff Communication

Multi-agency referral meetings are possible and are more likely to occur where there is shared staff such as existed between the Islington Primary Care Trust and Sure Start Copenhagen.

7.2.3 Data Recommendations

Working with Islington Primary Care Trust

Once Islington Primary Care Trust has returned to a situation in which it has a functioning child health system, possible enhancements should be investigated

- Investigation with Islington Primary Care Trust and local hospitals about the inclusion of information on smoking during pregnancy in the birth notification dataset forwarded to child health systems to provide data for monitoring at a population level.
- Investigation with Islington Primary Care Trust about the feasibility of collecting information on breastfeeding at the four month immunisation appointment.
- Investigation with Islington Primary Care Trust about the availability of mental health data collected by the health visitors and its integration or linkage into child health systems

Mental Health

Further consideration of how postnatal depression and support for women is monitored across the Islington area.

Staff Roles

Managers of Sure Start Local Programmes to promote the importance of databases used for monitoring to all staff, including the role of staff in collecting data and providing feedback to staff from data that is collected.

Sure Start Databases

A more comprehensive review of the SmartStart and E-Start databases used by Sure Start Local Programmes is required to address particular issues with these systems, including distinguishing between antenatal and postnatal contact and discrepancies in standard reports. This could form part of a wider review of the information systems needed by children's centres.

Baseline Data

In moving to Children's Centres in Islington, accurate baseline data should be collected for monitoring the impact of programmes on outcomes for women, children and families. Where data do not exist, a co-ordinated approach is needed in working with services across the area to develop data collection and systems for recording.

Appendices

Appendix 1: City proposal

Evaluation of three different approaches to Sure Start Local Programme involvement in maternity service provision

Applicants:

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Professor Susan Procter, Professor Ros Bryar, Sue Richards, Public Health and Primary Care Unit,

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Project Summary

This proposal set out in this tender document is divided into three parts.

Part One will be undertaken by Alison Macfarlane and Lisa Hilder. This will start by reviewing the availability and quality of data in local routine systems. These will include

1. The programmes' delivery plans and their programme monitoring data
2. Data from the child health system and other data held by the Primary Care Trust.
3. Data from the maternity and other systems in the Whittington NHS Trust.
4. Relevant data held by the local authority.

Based on this, relevant data from these sources will be requested and used to undertake a quantitative description of the contribution of the three Sure Start programmes and the pre-existing maternity services to meeting Sure Start targets in the three Sure Start areas in Islington specified in the Tender document

Part Two will be led by Susan Procter, Ros Bryar, Sue Richards, they will be supported by ppre Limited who are able to provide researchers who are able to work bilingually in a number of languages likely to be needed in Islington. This part of the evaluation will undertake a review of documents and protocols associated with each programme and qualitative in-depth interviews with service users who have accessed the Sure Start maternity services and those who have not. Short descriptive telephone interviews will be conducted with service providers to gain an understanding of their experience of working with the expanded maternity provision in the three Sure Start areas.

Parts One and Two form the basis of our submission. The two teams will work together to integrate their findings and to ensure that each part is informed by and tests out the findings from the other part. Nick Drey, Shamoly Ahmed and Alison Macfarlane have just been commissioned to undertake an evaluation of a midwifery project in Sure Start Collingwood and Stepney. Where feasible and relevant, comparisons will be made between this and the Islington programmes.

Aims of the research

To provide a clear understanding about the results achieved from different approaches to providing maternity services in three Sure Start areas in Islington and the ways in which Sure Start Local Programmes have worked with midwives to achieve this.

Objectives

1. To provide a clear understanding about similarities and differences in the needs being met and the aspects of care being improved by maternity service provision in the three Sure Start Local Programme areas in Islington
2. To identify how this relates to any differences in the population of the areas and location of hospitals and other service provision.
3. Have a clear understanding about how each approach to maternity service provision contributes to the following Sure Start targets
 - a. Reduction of smoking during pregnancy
 - b. Increases in breastfeeding at birth, six weeks and subsequently
 - c. Reduction in pre and postnatal depression
 - d. Reduction in percent of low birthweight babies (weighing less than 2500g) of total live births
 - e. Provision of antenatal advice, support and information
4. Have a clear understanding about how each approach to maternity service provision contributes to:
 - a. Improvements in attendance rates for antenatal appointments
 - b. Reductions in complications at birth requiring medical intervention
 - c. Reduction in late bookings
 - d. Increase in spontaneous vaginal deliveries
 - e. Recruitment, retention and development of staff
5. Have a clear understanding about user satisfaction with different approaches to service provision and the impact of the different approaches on the choices available to women
6. Have a clear understanding about user satisfaction with different approaches to service provision and the impact of the different approaches on the choices available to women
7. Have a clear understanding about how each approach to maternity service provision contributes to better outcomes for women living in disadvantaged or minority groups and communities including teenage parents, women living in temporary accommodation and refugees and asylum seekers.
8. Have a clear understanding about how each approach to maternity service provision contributes to better outcomes for women with particular needs such as those with disabilities, HIV or sickle cell, women living with domestic violence, those who are not fluent in English and provision of contraceptive and sexual health advice to teenage parents.

Background

Although there is some evidence that developments in maternity care and other interventions will improve maternity and postnatal care for disadvantaged women, it is very patchy and inconclusive. Recent reviews covering both maternity care in general and interventions aiming to achieve the Sure Start targets in particular have highlighted the need for further research.¹⁻⁸ For example, although strong associations between low birthweight and smoking and nutrition during pregnancy have been identified, further research is still needed to identify specific interventions which can prevent low birthweight.⁷ In other cases, interventions have been found to have no impact, as was the case in a randomised trial of two forms of postnatal social support for mothers in Camden and Islington.⁹

Similarly a Cochrane review identified benefits of continuity of caregivers during pregnancy and childbirth compared with conventional care, but this was published as long ago as 1998 and was based on only two trials.¹⁰ More recent evaluations have focussed on caseload midwifery. In general such schemes have been found to have beneficial outcomes, but the outcomes do not necessarily relate to the Sure Start targets.^{11,12} A systematic review of midwifery-led care, including caseload midwifery, compared with other models of care for childbearing women has been registered with the Cochrane Collaboration but the results are not yet available.¹³ We are also aware of a literature review which will be conducted as part of the evaluation of a caseload midwifery scheme being established at Guy's and St Thomas' Trust.

Even if there was clear cut evidence of causal relationships between maternity care interventions and Sure Start and NSF targets, the numbers of pregnancies in births in the small areas included in individual Sure Start programmes are too low for there to be sufficient statistical power to detect effects. This makes the requirements in the tender for clear understandings of the impact of Sure Start programmes very challenging. The absence of unambiguous evidence about effectiveness means it is possible only to produce a limited analysis of costs rather than a full analysis cost effectiveness at a local level.

In preparing this tender, we have responded to these challenges by offering an approach which brings together the use of routine data for descriptive purposes and the collection of qualitative information through documentary analysis and interviews. This will be informed by our knowledge of existing literature reviews and other work we know to be in progress. Ros Bryar, Alison Macfarlane and other colleagues are involved the public health collaboration for Maternal And Child Nutrition supported by the National Institute for Health and Clinical Excellence. Alison Macfarlane was a member of the Advisory Group for a study of maternity services undertaken as part of the National Evaluation of Sure Start.

Methodology

The methodology will be grounded in a whole systems research mode¹⁴ Whole systems approaches are becoming increasingly influential in health and social care policy.¹⁵⁻¹⁷ Kendrick and Conway¹⁸ have identified 4 principal perspectives on the whole system:

5. The causal system is a “network of causal relationships which points towards trends and processes unfolding gradually over the long term” This focus fits with Islington’s need to identify how practice developed through Sure Start can inform discussions with the PCT commissioning department about long term commissioning plans for maternity services in Islington.
6. For many of the most important areas of the whole system we have very few data. The structure of explanation cannot be determined by the availability of systematic data. Where a particular explanatory factor is important, but precise data are lacking we must use every means at our disposal to do that factor justice. Part one of this application will provide a descriptive analysis of existing routine maternity and child health data to address the concerns raised in the Tender document.
7. The organisational whole system is by far the most common context in which whole systems are analysed. The emphasis is on making the various parts of the health and social care system function together as a single system rather than as parallel systems. The organisational perspective is relevant to this proposal in two ways. Firstly, as identified in the Tender document there is a need to collate evidence of changes in outcomes for mothers, children and families arising from the different approaches to supporting maternity services that Sure Start has piloted in Islington. Secondly, the extent to which the health and social care system fails to function as a whole system may form part of the explanation about the level of contribution midwives are able to make to Sure Start targets.
8. The patient or service user experience of the whole system recognises that the whole system comes together and is embodied in the experience of each individual user. The individual experience, therefore, provides a microcosm of the level of service integration achieved locally and provides evidence of model outcomes.

In this proposal we will draw together the evidence from both quantitative and qualitative data to identify as far as possible the extent to which the different approaches to supporting maternity service provision in Islington have contributed to the Sure Start targets set out in the Tender document and in the NSF. In doing this we will describe the achievements of the midwifery programmes and the organisational context within which they are most able to benefit service users. We will also attempt to identify the problems encountered in developing the service in Hillmarton and assess whether the factors behind the recruitment problems are largely local or stem from wider concerns.

Part One (objectives 1,2,3,4)

The overall objective in Part 1 is to assess the data available in the borough about childbearing women and babies and about the care available generally in the three Sure Start areas with maternity programmes. It will start by describing the plans for care and interventions provided by the maternity health care assistant in Copenhagen and the caseload midwives in Holloway as well as ascertaining the extent to which

services have been provided in Hillmarton. These will be described in relation to the evidence which does exist about their effectiveness or otherwise and the information which will be collected using qualitative methods in Part Two.

At the outset of the project, the availability and quality of data in local routine systems will be reviewed.^{19,20} These will include:

1. The programmes' delivery plans and their programme monitoring data
2. Data from the child health system and other data held by the Primary Care Trust.
3. Data from the maternity and other systems in the Whittington NHS Trust.
4. Relevant data held by the local authority and others.

This review will focus on the availability and quality of data relevant to Sure Start and NSF targets. For example, Sure Start programmes, child health systems and hospital maternity systems are all likely to hold some data about smoking in pregnancy and the baby's birthweight, but these are likely to vary in their coverage, completeness and scope.

This information will be used as a basis for requesting anonymised data extracts from the child health system and from the Whittington maternity system. Either extracts or aggregated data will be requested from other sources. These data will be used to compare the characteristics of the population of women giving birth, the outcome of their pregnancies, the use of services and the Sure Start indicators in the three Sure Start areas with those in the rest of the borough. Trends over time will be documented in relation to the beginning of Sure Start schemes, but because of the small numbers of births in the Sure Start areas, there will not be sufficient statistical power to detect changes unless they are unexpectedly large. Despite this, this descriptive information will be invaluable for describing the areas and for use in conjunction with the qualitative information.

Part Two (objectives 5,6,7,8)

A strength of this evaluation lies in the fact that it is possible to compare findings from three separate midwifery services provided in three distinct geographic areas. This lends itself to multiple case study evaluation. For the purpose of the evaluation each midwifery approach will be treated as a case study. Case study design allows for the identification of complex contextual conditions, enabling the exploration of micro as well as macro variables and how this impacts on practice and service delivery outcomes. It also allows for comparison between cases to build a picture to inform the overall Islington Sure Start programme.

Sampling strategy for qualitative study: Islington Sure Start are keen to ensure that the sampling strategy for the qualitative aspect of the data collection is as objective as possible. They are not keen to use a convenience sample or to have staff identify service users for the study.

The Islington Sure Start data base will be used as a sampling frame for this research. All the patients who registered on the data base in the three months prior to the start of the study will be anonymised using a code and entered into the sampling frame along with all the information about each woman entered on the data base. The evaluation

team will purposively sample from the list provided to cover as wide a range of service users as possible including:

- Teenage parents
- Women living in temporary accommodation
- Refugees and asylum seekers
- Women with disabilities
- Women with HIV or sickle cell
- Women living with domestic violence
- Women not fluent in English

Exclusion criteria:

- Still birth
- Baby born with congenital abnormality
- Premature baby

Approximately 60 women are registered on this database over a three month period. As new women are entered on the data base during the data collection phase of the study, they will be coded and their information passed to researchers who will include them if they are required as their circumstances offer the possibility of new and additional information and recruitment has not exceeded the specified sample size.

After 30 interviews the data collected will be reviewed and analysed and any gaps in the sample or missing themes will be identified. Health visitor birth books which contain more detailed information on women using the service will then be reviewed to identify up to 15 additional women whose needs, circumstances and experiences may not have been covered in the original 30 interviews.

Recruitment process: Once the woman has been identified by the researchers as fitting the sampling criteria a letter will be sent to her about the evaluation and asking her if she is prepared to take part in the study. In cases where the participant cannot speak English, a translated letter will be used. This will include a pre-paid reply to the Sure Start programme for use if she wants to opt out of the study. If she does not opt out her contact details will be passed onto the researchers who will contact her by phone and obtain verbal agreement before arranging a convenient time and venue to conduct the interview. An interpreter or language line will be used for the interview for those participants who do not understand English. Informed consent will also be taken at the time of the interview.

In-depth interviews will be undertaken with each of the midwives involved in Sure Start programmes in Islington. Additionally short (20 minute) telephone interviews will be conducted with service providers in each of the three areas. This will include GPs, health visitors, midwives, service managers, health promotion service providers. These will ascertain experience of colleagues in working with these services and their view of the impact it has had on meeting Sure Start targets locally. All interviews (including telephone interviews) will be tape recorded with the permission of the participant and transcribed.

Qualitative data will be analysed to build up a picture of what is important about each case within its own world and the process by which each approach:

- Promotes user satisfaction and the impact of the different approaches on the choices available to women
- Contributes to better outcomes for women living in disadvantaged or minority groups and communities or with particular needs
- Contributes to specific NSF concerns to improve choice, the uptake and effectiveness of services, quality of service user engagement and outcomes, particularly for women and their babies from disadvantaged or minority communities
- Contributes to extending the Sure Start principles across other services.
- Enables families to access Sure Start and other services for parents to be, parents and young children. Enables midwives to work effectively with professionals from other agencies and the implications this has for meeting needs and achieving better outcomes

The patient or service user experience of the whole system will be used to identify how services come together and are experienced at an individual level and to identify when, where and how integration is achieved at a local level.

For many of the most important areas of the whole system we have very few data. Part one of this application will provide a descriptive analysis of existing routine maternity and child health data to address the concerns raised in the Tender document.

A comparative analysis of each case will also be undertaken to identify the particular strengths of each approach and the particular populations whose health outcomes and choices have been positively influenced by each approach. The qualitative and quantitative data will be combined to provide a model of the relationships between midwifery practices under evaluation and trends and processes unfolding in the analysis of the objectives.

Additionally the costs of providing each service will be identified and discussed in the context of the above findings.

Ethical permission will be obtained from the relevant Local Research Ethics Committee and the research governance procedures of any participating organisation will be adhered to. All data will be securely stored in the University under lock and key if manual data and password protected on the main university server if electronic data. Individual data will only be available to named members of the research team. Only anonymised data will be distributed outside the team although the three case study areas will be clearly identified. The research will be designed and analysed to ensure that the focus is on the outcomes listed above and that in distributing these findings no participants are targeted for individual criticism or adversely affected personally by the public dissemination of the findings from the study.

Project Management

A project steering group will be established in collaboration with Islington Sure Start programme. Ethical approval and research governance procedures will be adhered to.

Adherence to the timetable proposed in the Tender document will be monitored. Intellectual property will be reviewed and agreed.

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Appendix 2: Data Sources for Quantitative Analysis

1. Hospital-based systems

1.1 Whittington Hospital Patient Administration System

The Patient Administration System contains information on care provided by the Whittington Hospital to women and their babies. Most women living in the Sure Start communities of Holloway and Hillmarton choose to have their babies at the Whittington, 83% and 74% respectively. Within the Copenhagen area an estimated 18% of women also have their babies at the Whittington. For all the two to three per cent of women who elect to have a home birth in these areas, antenatal and postnatal care is provided by midwives from the Whittington Hospital. This dataset therefore provides reasonable coverage of maternity care for women from Holloway and Hillmarton Sure Start areas, but limited coverage of maternity care in the Copenhagen area. Given the geographic location of the Whittington Hospital in relation to the Copenhagen Sure Start area, this finding was expected, although to a lesser extent.

Data were extracted from three modules within the Patient Administration System. Data about deliveries were extracted from the Maternity module, data on antenatal and postnatal visits from the Outpatient module and data on diagnoses for admissions from the Inpatient module.

Data from the Maternity module of the Patient Administration System provided data on the following outcome areas:

- Smoking during pregnancy from May 2004 onwards
- Initiation of breastfeeding
- Birthweight
- Method of delivery

Patient Administration System Maternity module data also includes demographic information, such as mother's age and ethnicity and information about obstetric history, including number of previous pregnancies and gestation at delivery. Women were assigned to Sure Start areas based on their postcode of residence at the time of delivery.

Data from the Maternity module were linked with data from the Outpatient module, providing data on the following activities:

- Booking appointments
- Attendance at antenatal appointments
- Antenatal care, support and information

As not all women who deliver babies at the Whittington Hospital access antenatal care through the hospital, the coverage of women from Sure Start communities is slightly lower for data on antenatal care compared to delivery data from the maternity module.

Combining Inpatient data with Maternity module data provides information about the following outcomes

- Complications at birth leading to obstetric intervention

Data were available from January 1999 to January 2006, and provided in two extractions. Data from April 2002 to January 2006 were provided first, followed by data from January 1999 to March 2002. All data from April 2002 to January 2006 was examined. Due to the short time period of the evaluation, data from 1999 to March 2002 could not be cleaned and analysed.

Data within the Patient Administration System were generally robust, with most variables of interest showing small proportions of missing information. Data were not available to assess outcomes for particular sub-groups, such as refugees, women living with HIV, or women living in temporary accommodation. While data were available to identify teenage mothers, the small numbers of teenage mothers did not allow for meaningful analysis of this group. Further information about the Whittington Patient Administration System and data available is included in the supplementary report.

Permission to access data was granted by Whittington Hospital's Caldicott Guardian.

1.2 Whittington Hospital midwives: Manor Gardens Team data collection

The midwives in the Manor Gardens team at Whittington Hospital, which provided caseload midwifery services to women in the Holloway Sure Start area, collected data on mothers and babies in their caseload. These data are stored in a stand-alone database, and allow the midwives to record more detailed information about mothers and babies than is possible within the Maternity module of the Patient Administration System. The database was used by the Manor Gardens team to produce annual statistics for internal purposes. Data were available from January 2004 to December 2005.

This dataset was analysed to supplement information available about outcomes for women and babies receiving caseload midwifery. It provides an alternative source of data about the following outcome areas:

- smoking during pregnancy;
- breastfeeding at birth and breastfeeding at 4 weeks;
- birthweight;
- booking times;
- antenatal appointments;
- type of delivery;
- complications at birth requiring medical intervention.

Limited demographic information was available, with maternal age and ethnicity not included. There were some data about social issues, although this was not sufficiently robust to comprehensively identify particular subgroups of women such as those with postnatal depression, or asylum seekers. Additional information relevant to maternity but not recorded in the Whittington Hospital Patient Administration System was identified in the Manor Gardens Team Statistics database. This included referrals for smoking cessation and feeding at 28 days. Additional variables were also present such

as skin-to-skin contact at birth, and body mass index, but these were outside the scope of this evaluation.

The Manor Gardens Team Statistics database was unique in that it provided information on women from the Holloway Sure Start area known to have received caseload midwifery. The majority of women, 76.0%, received care from the Manor Gardens Team throughout their pregnancy and delivered at the Whittington or at home. The dataset provided a useful description of Sure Start target areas and outcomes for these women. Data were less complete however for the approximately one fifth of women who transferred out or into the Holloway area during pregnancy. About a fifth, 19.0%, of women who attended a booking appointment with the Manor Gardens midwives and received some antenatal care, transferred out of the area before delivery. A small number, 1.5%, of women transferred into the area having commenced antenatal care elsewhere.

Comparison of data from the Manor Gardens Team Statistics dataset with Whittington Hospital Patient Administration System data and Islington Primary Care Trust Intention form data, suggested that the Manor Gardens Team midwives delivered continuous caseload midwifery, from booking through to delivery, to 66.0% of all women residing in the Holloway Sure Start area, and had some contact with a further 20.8% of women. Among Holloway residents who delivered at the Whittington hospital, the Manor Gardens Team midwives provided care for 69.3% of women.

As noted previously, Sure Start is designed to be offered as a universal service for all women in a specified area. For women in the Holloway area, the data available indicate that not all women were receiving a caseload midwifery service. Around two-thirds of women did receive continuous one-to-one care, but about a fifth of women moved out or into the area, and the remaining 10-15% did not appear to come into contact with midwifery services offered through the Whittington.

For several reasons, data from the Manor Gardens Team Statistics database has been used only to supplement findings from other data sources in this evaluation. Firstly, there is no comparative dataset available for women receiving standard maternity services or maternity health care assistant care. Secondly, while the Manor Gardens Team Statistics database provides the most accurate information about women who received caseload midwifery throughout pregnancy in the Holloway area, it does not provide the best coverage of all maternities to women in the Holloway Sure Start area.

Detailed information about the data available in this dataset and its quality, together with the results of analyses of these data, can be found in the supplementary report.

Permission to access the data was granted by Whittington Hospital's Caldicott Guardian.

1.3 University College London Hospital Patient Administration System

The Patient Administration System contains information on care provided by the University College London Hospital to women and their babies. While the majority of women from Islington give birth at the Whittington, it is estimated that around 55% of

women from the Copenhagen area give birth at University College London Hospital, due to its close proximity.

University College London Hospital operated the Patient Administration System up until June 2005, when it was replaced by a new system as part of the NHS National Programme for IT, Connecting for Health. The Patient Administration System operated by University College London Hospital was similar to that operated by Whittington Hospital, and provided data on similar outcome areas.

Permission to access Patient Administration System data for the period January 1999 to June 2005 was granted by the hospitals Caldicott Guardian. Due to the timeframe of the evaluation, these data could not be provided. This has resulted in limited information being available about maternity care for women in the Copenhagen Sure Start area.

2. Population-based data held by Islington Primary Care Trust

2.1 Regional Interactive Child Health System (RICHS) and Child and Community Health Interim Application (CHIA)

The RICHS dataset recorded child health data for Islington residents from late 1988 to June 2005. The RICHS dataset contains information from birth notifications and health visitor records, including information collected by health visitors from their first visit to a mother and baby shortly after birth. Information was also recorded for all check-ups, including that performed at six weeks after birth, and for subsequent health contact up until children are 16 years of age. The CHIA system which replaced RICHS in July 2005 contains similar information.

The RICHS and CHIA datasets are population based, that is they contain information about all babies and their mothers residing in the borough of Islington. Unlike hospital based data systems, these datasets include information on all women and babies residing in the Sure Start communities of interest together with information on all women and babies in Islington.

Based on a review of documentation available about the RICHS system and discussion with staff familiar with RICHS, it was found that the dataset contained information at a population level about the following outcome areas:

- Birthweight
- Booking appointment dates
- Delivery method
- Breastfeeding at birth
- Breastfeeding at six weeks
- Post-natal depression (based on contact with health services)

A review of documentation available about the CHIA system indicated that similar data should be held in the system.

Islington PCT was not able to provide child health data from RICHS or CHIA for this evaluation. The RICHS system was decommissioned at the end of June 2005, and data

were downloaded for transfer to the CHIA system which succeeded it. At the time of the evaluation, staff were experiencing major problems with the new system CHIA, including difficulties uploading the RICHs download and extracting any data from CHIA. Islington PCT could therefore provide no child health system data for this evaluation.

CHIA was designed as an interim system only, while a new child health information system is being developed. It was seen largely as an administrative system and was not designed for clinical or data collection purposes. Information is presently not accessible from it. In August and September 2006, Connecting for Health is now worked with the nine PCTs with CHIA to conduct an option appraisal and recommend a way forward. Meanwhile, due to their inaccessibility, the data contained in RICHs and CHIA could not be used.

The review of CHIA identified possibilities for the routine recording of information about the following outcome areas currently not available at a population level:

- (iii) Smoking during pregnancy
- (iv) Breastfeeding at four months

Smoking during pregnancy is currently not recorded in CHIA. The routine collection of data on smoking during pregnancy, and inclusion of this in the birth notification form, together with changes to CHIA or an alternative system to allow recording of this field, is one way this information could be made available at a population level.

There is currently the option for General Practitioners or Community Nurses to record feeding at the third immunisation given at four months of age in the baby's personal child health record, known as 'the red book'. A copy of the immunisation record is forwarded to Islington PCT, but CHIA currently does not have the capacity to routinely record feeding at this visit along with immunisation data. It is also not known currently whether health professionals complete this information on feeding at the time of visit. Again, modification to the child health system would be required, and work with immunisations providers is likely to be required to encourage collection and recording of this information.

Discussion with staff from the Islington PCT revealed that the detection and recording of information about postnatal depression remains problematic and is not easily resolved. The use of separate systems for monitoring contact with children and adults was identified as one issue complicating the monitoring of postnatal depression. Information to identify women who have completed the Edinburgh Postnatal Depression Scale is recorded by health visitors as part of the monitoring of their activity levels, together with a flag identifying women as depressed by scoring above 12, and women receiving 'Listening visits'. This information is not however linked in with the CHIA system currently and it is not clear whether it will be in future.

The lack of availability of RICHs and CHIA data has limited the scope of this evaluation. The value of these datasets is they provide population based data enabling the examination of at least some outcomes for all women and babies residing in Islington, regardless of where they access maternity services. Without population based data it is difficult to assess the impact of the different approaches to maternity services across the Sure Start areas of interest.

Detailed information about the review of RICHs and CHIA systems can be found in supplementary report.

2.2 Health visitors' intention forms

Intention forms are completed by health visitors when they first visit a woman and her baby, generally between 10 and 21 days following birth. This information is entered by the PCT into a spreadsheet, to monitor health visitor activity and outcomes. It was envisaged that, this information would be recorded in CHIA, when functional. Data were available from April 2003 to December 2005.

This dataset provides information about all babies and their mothers residing in the borough of Islington. As such, it provides information about women and babies from Sure Start communities who received different types of maternity care, together with information on all other women in Islington. This allows comparison of outcomes for women in Sure Start communities receiving caseload services, additional services or standard maternity services, with outcomes for all women residing in Islington.

Data were available to assess the following outcomes:

- Initiation of breastfeeding

Additional data are available from health visitor Intention Forms, including feeding at time of visit, mother's smoking at time of visit and other people in the household smoking at time of visit. As time of visit varies, this information could not be used to assess breastfeeding at either six weeks or four months following birth.

The quality of data recorded from Intention forms was high overall. Data were available on ethnicity, but no items were available to identify other sub-groups of interest such as refugees, teenage parents, people living in temporary accommodation or women living with HIV.

Detailed information about data extracted from Intention forms is included in the summary report.

3. Data collected by Islington Sure Start Programmes

3.1 Islington Sure Start Unit Central Monitoring database

Islington Sure Start Unit maintained a data system to monitor each Sure Start programme's progress towards targets. The data were collected from a number of sources including individual Sure Start programmes, Islington Primary Care Trust child health systems, as well as Census data. The system was designed to record information relating to the following outcomes for each programme on a financial year basis:

- Reduction of smoking during pregnancy
- Increases in breastfeeding at birth, six weeks and subsequently
- Reduction in postnatal depression

- Reduction in percent of low birthweight babies
- Provision of antenatal advice, support and information

The majority of data was supplied by Islington Primary Care Trust from its child health systems. These include data on breastfeeding at birth and at six weeks, postnatal depression, and low birthweight, as well as population data. Individual Sure Start programmes are expected to provide data on provision of antenatal advice, support and information. No specific source of data was identified for monitoring reduction of smoking in pregnancy.

The review of data contained within this system indicated that for most target areas data were missing or were not reliable. Data for the years 2001-2002 and 2003-2004 had been submitted. Data for 2002-2003 were not available, and data for 2004-2005 had not been submitted by any individual programme at the time of the evaluation.

For the financial years where data were available, Islington Primary Care Trust provided valid data for low birthweight and breastfeeding at birth. Data were also available from Islington Primary Care Trust for breastfeeding at six weeks, although some areas showed a high per cent of cases with missing information, thus compromising the validity of these data.

Limited data were recorded for pre and postnatal depression, and data recorded were of questionable validity. Data were recorded for one year only based on RICHs data, with extremely low numbers of women with postnatal depression identified. The extremely low numbers recorded are thought to undercount the prevalence of postnatal depression in the Islington population, and suggest problems may exist either in the use of the Edinburgh Postnatal Depression Scale and identification of postnatal depression, or in the recording of this information routinely. It was anticipated that this information would be collected by health visitors who may use this scale with women as an initial assessment of postnatal depression. The issue of collection of data relating to postnatal depression is discussed in the results section.

No data were recorded on smoking during pregnancy, reflecting in part the limited routine collection of these data. While the Whittington Hospital has incorporated collection of data on smoking during pregnancy in its Patient Administration System, these data have not been incorporated into birth notification form data available within the CHIA child health system.

Limited data were recorded on the provision of antenatal advice and support. Only one Sure Start area provided data on women contacted during the antenatal period. It appears that the two other Sure Start programmes have difficulties in collating this information due to problems with the data systems they use for monitoring contact with women.

As well as monitoring annual outcomes, the Sure Start Unit's Central Monitoring database contains Start Point data, designed to provide a snapshot picture at the commencement of programs. Data within these forms were also found to be of variable quality, and were generally neither sufficiently robust nor precise enough to be used as baseline measures in the evaluation.

Due to the irregular reporting of information and issues relating to data quality and coverage, information from this system was generally not included in the analysis for this report. The lack of information available from a system designed to monitor targets in outcome areas annually was disappointing, and reflects the general lack of availability of data for monitoring the Sure Start targets.

It is anticipated that data for monitoring some targets and outcomes, including breastfeeding at birth and at six weeks, and low birthweight will become available when the issues with Islington Primary Care Trust's child health systems are resolved. Additional action is needed however to develop the routine collection and recording of data on smoking during pregnancy, postnatal depression, breastfeeding at four months and antenatal support.

Further information about the review of this system and a summary of data available is provided in the supplementary report.

3.2 Individual Sure Start Programme data

The individual Sure Start programmes maintain databases to monitor their contact with families who are registered to their programmes. Copenhagen and Holloway Sure Start run the SmartStart system, while Hillmarton Sure Start uses the E-Smart data system. These systems include demographic information about individuals and their contact with Sure Start services, including maternity services, contact with women and babies, as well as attendance at other Sure Start activities. The systems were designed largely as administrative and reporting systems, rather than as research tools.

Individual programmes provided standard summary reports extracted from their systems, as well as anonymised case-level data for individuals contact with maternity services. Limited case-level data were available from the Hillmarton Sure Start programme.

Within standard reports extracted from systems, the validity of data identifying particular subgroups, such as lone parents, teenage parents, and pregnant women could not always be established, limiting the usefulness of these data. Issues concerning the SmartStart systems management of data relating to pregnancy also meant when examined retrospectively, data from Holloway Sure Start and Copenhagen Sure Start on contact with pregnant women across the Sure Start program were not valid.

Extracts of data on contact of women with specific services, such as midwives or maternity health care assistants, were also provided. Data were available from Copenhagen Sure Start for the period October 2002 to July 2005 inclusive. For Holloway Sure Start data were available from July 2002 to December 2005 inclusive, while for Hillmarton Sure Start data were available for September 2005 to January 2006.

It was anticipated that case-level data from contact with midwifery services could be used to assess the provision of antenatal advice, care and support in each of the three programmes. It was not possible, however, to distinguish in a systematic way contact

occurring antenatally from that occurring postnatally, thereby limiting the usefulness of the data for this purpose. It was also not possible to accurately assess contact with specific groups, such as teenage parents and those living in temporary accommodation due to the data systems management of this information. For example, date of birth for parents was not always complete, and information on people's place of residence was updated when they moved, making it difficult to know whether people were in temporary accommodation at the time of contact. Nonetheless, the data do provide a useful source of information about the activity level of midwives and maternity health care assistants in the Sure Start areas.

The extraction of data from the SmartStart and E-Start databases for this evaluation was performed by Sure Start employees within each of the three programmes. The levels of knowledge and experience of users of the systems varied across programmes, and this affected their capacity to be able to comment on irregularities in the data. While a number of issues were identified in the recording of data in these systems, this project did not attempt to fully evaluate the IT systems employed by individual programmes. A comprehensive review of these systems may be required in order to identify and resolve issues with the systems so that individual Sure Start programmes can generate accurate data to monitor the provision of antenatal advice, support and information

The review of databases used by each Sure Start programme is included in supplementary report, together with information about the data extraction methods used and results of descriptive analysis of available data.

Appendix 3: Sample Information pack for recruitment of service users



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www.city.ac.uk/barts

SAMPLE LETTER

Dear Madam,

Re: A Survey of Women's Views and Experiences of giving birth in the area of Islington.

I am writing to you from City University to invite you to take part in a research project on women's views of maternity care in Islington.

We would like to find out about your experience of giving birth and looking after your young child in Islington. This will include your stories about being pregnant and giving birth as well as your views on the maternity and childcare services provided in Islington. This information will help us to find out which primary care services are most useful and effective. Your participation would involve one interview lasting approximately one hour. As a thank you for giving your time, each participant will receive a £10 voucher from Tesco.

The information you give to us will remain completely confidential. .

- We will not share this information with any of the health care staff looking after you.
- Whatever you say will not affect the service provided to you.

There is more information about this study in the sheet entitled '**Participant Information Sheet**' that you will find with this letter. Please take some time to read this information.

If you decide you do NOT wish to take part, please fill in and return the opt out slip in the prepaid envelope provided before the date shown. If you do not return this slip, our researcher Katherine will call you to arrange an interview time and venue.

In the mean time if you would like to know more about the study or have any questions, please call Katherine on 020 – 7040 5314.

Sincerely,

Katherine Twamley
Research Officer
Department of Midwifery
City University

Dr Susan Procter
Professor of Primary Health Care Research
Public Health and Primary Care Unit
City University

SAMPLE LETTER

20th April 2006

Dear ...

Re: A Survey of Women's Views and Experiences of giving birth in the area of Islington.

We are writing to you about a research study we are doing with City University on maternity needs and experiences in the Islington area. We would like to know what you think about the maternity health care that you have recently received and how you think it can be improved. With this letter you will find information from them about the study. Please read this carefully. If you would like to take part in the study, your contact details will be passed on to City University. If you do not wish to take part please follow the instructions carefully and we assure you your details will not be passed on to any researchers.

In the meanwhile, if you have any questions about this study or would just like to know more about it, you can contact me or one of the researchers from City University. We look forward to hearing your views.

Thanking you in advance,

Fiona Horigan
Sure Start Manager Holloway

Information Sheet for Participants

A Survey of Women's Views and Experiences of giving birth in the area of Islington

We would like you to help us with a research study. This sheet will give you basic information about the study. Thank you for taking the time to read it.

Q. What is the purpose of the study?

A. To find out about your views and experiences of giving birth and looking after a young child in Islington, including the support and care you received from various health care services.

The information received will be used to evaluate the current services provided and to assess the best means of delivery of midwifery care. This will give invaluable feedback to staff and contribute to future service developments.

Q. Why have I been chosen?

A. You were selected randomly from a database of all women living in Islington who have recently given birth.

Q. What would I have to do?

A. If you choose to take part you will be asked to attend an interview with a researcher lasting approximately one hour. This interview will be about your experiences of pregnancy, giving birth and looking after your new born child.

The interview will be arranged at a convenient time and location for you. If you are uncomfortable talking in English, a translator will be provided.

During interviews we shall record and take notes, however, everything you say will be kept confidential - see below.

Q. Will my taking part be kept confidential?

A. Yes. Recordings and notes taken during interviews will only be made available to members of the research team. This information will then be anonymised so that no individual person's views will be identified in our reports.

Health care staff will not be aware of what you have said and participation will not affect the care you receive.

Q. Will I be paid for taking part?

A. Participants will not be paid however they will receive a £10 voucher for Boots as a thank you for taking part.

Q. Is anyone else being interviewed?

A. Yes. Approximately 40 new mothers will be interviewed in the Islington area. Some health care staff members will also be interviewed.

Q. Who is conducting the study?

A. The study is being conducted by City University in conjunction with Islington Sure Start.

Q. What happens next?

A. If you have decided that you would like to take part, you do not need to do anything as your contact details will be automatically passed on to Katherine, our researcher. She will contact you via telephone to arrange a convenient time and venue for an interview.

If you have decided that you would NOT like to take part, please fill in and return the opt out slip in the prepaid envelope provided before the date shown. Your details will not be passed on to the researcher and no one will get in touch with you about the study.

Q. What will happen to the results of the study?

A. A report of the findings of the study will be produced in about 8 months time. This will be available from your local Sure Start centre and will also be published on the City University and Sure Start websites: www.city.ac.uk and www.surestart.gov.uk.

This report will be used by staff to improve and develop the delivery of services.

For more information about the project please contact:

Katherine Twamley
City University
Tel. 020 7040 5314
katherine.twamley.1@city.ac.uk

Opt Out Slip

*If you do NOT want to take part in this study, please fill in the details below and return this slip in the prepaid envelope provided before **May 12th 2006**.*

*If we receive this slip before the **22nd February** your details will not be passed on to the research team and no one will get in touch with you about the study.*

Name:

Address:

I confirm that I do not wish to take part in this study, please do not pass my details on to anybody.

Signed:

Date:

Appendix 4: Qualitative Interview Schedules

4.1 Service User

General introductions, explain purpose of the interview, confidentiality and anonymity.

1. Could you tell me a little about your family, who you live with, what they do etc.?

- Number/type of family (extended/nuclear)
- Where come from
- Employment status etc.

2. Could you describe to me your recent experience of giving birth, starting from when you discovered you were pregnant?

- Expectations pre birth
- Whether first pregnancy

(This question may give rise to answers for the next few questions...)

3. During pregnancy what kinds of services did you access or support did you receive from midwives or other health care workers?

- Antenatal Classes and check-ups attended
- Difficulties in access
- Support that was appreciated or missing
- Relationship with and perception of staff
- Difficulties or health problems during pregnancy

4. Tell me about the birth itself, how did that go for you?

- Who attended i.e. midwife
- Type of birth and why
- Decision-making
- Complications
- Satisfaction
- Support (Family etc.)

5. After the birth, what kind of support and care did you receive from the midwives or other support workers? Did you find it useful?

- Satisfaction
- Support that was appreciated or missing
- Confidence in looking after baby
- Relationship with midwife/HCW

6. What about now, are you still in contact with these people or are there other health workers that you see such as health visitors?

What kind of services or support do they offer you and do you find them useful?

Describe other services that you use.

Elicit details such as:

- knowledge of services
- difficulties in access such as location/cost
- one to one or group
- information sources
- knowledge received
- Satisfaction

7. Was your partner or other family members offered support? Did they take it? How did they find it?

Now we'll talk just a little more generally about your health during and since pregnancy.

8. During your pregnancy did you think about your diet? What did you do to try and maintain a healthy diet and did you find it easy? What kind of a diet do you keep now?

Did you receive any support or advice? Was it useful?

- Perception of a healthy/unhealthy diet
- Support received
- Difficulties eg. financial

9. Have you/your partner ever smoked? Did you/your partner smoke during your pregnancy/now?

If yes, how often?

When do you / your partner normally smoke?

Have you/your partner tried to give up? Did you receive any support in doing so?

- Risk awareness i.e. smoking near baby
- Support received
- Partner influence
- Recommendations

10. How have you been feeding your baby? Why have you chosen this?

- Decision making
- Support
- Advice received

11. Have you been given any information about contraception? Who was this from and did you find it useful or relevant?

Were you able to use this information?

12. Do you or did you have any health/sexual health concerns? Have you been able to discuss this with someone and where they able to help you? How?

13. During your pregnancy or since, do you feel there were any special needs or particular issues that you had? Were these issues addressed adequately?

This could refer to any of the following:

- Disability
- HIV/Sickle cell
- Domestic Violence
- Postnatal depression

14. Overall, would you say there are any improvements that you would like to see in the care you received from the different services and health care staff?

More specific questions about Sure Start:

- Are you aware that you live in a Sure Start area?
- Do you know what Sure Start is and the kinds of services they provide?
- Did/do you use/attend any of their services?
- What did you particularly appreciate about Sure Start services or are there improvements that you would like to see in the services they offer?

Holloway – One to one midwifery

- During your pregnancy and birth who was your midwife?
- Did you exclusively see this midwife or did other midwives also attend you?
- Do you feel that the midwives worked well together?
- Did you enjoy receiving this one to one care? What about it did you appreciate or needs improvement?

Hillmarton – Maternity health care assistant (MCA)

- Were you ever in touch with a maternity health care assistant?
- What was her role?
- Did you find her helpful/ what did you learn from her?

Copenhagen has nothing extra therefore no specific questions.

4.2 Midwife Interview Schedule

1) Thinking about your own professional development...

Could you tell me a little about your career as a midwife, why you joined the profession, how long you have been caseloading / working in Whittington etc.?

- Experience
- Views of midwifery role

What kinds of skills do you think a midwife needs in your position? Could you give me some examples of when you have used these skills recently?

- Different roles
- Difficulties

For caseloading: How do you manage your time and the caseloads that you have?

- Time management
- Team work
- Autonomy

➤ if mentions difficulties ask for examples!

2) Thinking about Sure Start...

What is Sure Start to you?

What kinds of targets or objectives do you have from Sure Start and how are these monitored?

What strategies do you use to meet these targets?

- Hard to reach groups

Do think these kinds of targets are useful? Why? If not, what do you think would work better?

If not mentioned:

Do you think that Sure Start reaches the mothers who are most socially disadvantaged such as refugees, asylum seekers, homeless women etc.? Why?

- Geographical targeting

From your own perspective, what would make you think that you have ‘done a good job’?

- Ideals of the job
- Expectations of role
- Care needs

- Job satisfaction

Can you think of a case when you worked with a

- An asylum seeker
- A teenage mother
- A women in temporary accommodation

and take me through how you worked with her and how it worked out. These can either be ‘effective interventions’ or engagements and also ones which you think exemplify the difficulties that are experienced.

For the latter, how might things have been done differently?

3) Communication

What other services does Sure Start offer that you link up with when taking care of a woman and her child?

How do you communicate with one another? Could you give me some examples?

- Health visitors
- Sure Start Outreach
- Family Support Workers
- **Family members?**

Do you think you work together effectively? Why?

Overall, how effective do you think Sure Start is and what improvements would you like to see?

4) Specific Questions

For Case Loading:

It seems there have been difficulties in recruiting for caseload midwifery in some Sure Start areas, why do you think that is?

What do you think could be done to increase recruitment in caseloading?

For midwives that work with a maternity health care assistant:

What is the role of the maternity health care assistant?

How much do you work with them?

Do you think it is a useful role and where do you see its future?

4.3 Maternity health care assistant interview schedule

1) Thinking about your own professional development...

Could you tell me a little about your self before you became a maternity health care assistant and how you came into the role of maternity health care assistant?

- Experience
- Views of maternity health care assistant role

What kinds of skills do you think a maternity health care assistant needs? Could you give me some examples of when you have used these skills recently?

- Role of maternity health care assistant
- Difficulties
- Limits of role

What is a typical day of a maternity health care assistant like?

2) Communication

How do you find out if a woman is pregnant or in need of your attention?
Do you know of any women who have been missed by this system?

How does a woman come onto a Sure Start database or list?

How often would you say you meet with the midwives? Could you give me an example of how you have worked together?

What about other Sure Start services that you can refer to, how does that work?

In general how does communication work between the different professionals and groups that are working with a pregnant woman?

- Health visitors
- Sure Start Outreach
- Family Support Workers
- Family members?

How do you link up with these other services?

3) Thinking about Sure Start...

What is Sure Start to you ?

What kinds of targets or objectives do you have from Sure Start and how are these monitored?

What strategies do you use to meet these targets?

- ‘Hard to reach groups’

Do think these kinds of targets are useful? Why? If not, what do you think would work better?

If not mentioned:

Do you think that Sure Start reaches the mothers who are most socially disadvantaged such as refugees, asylum seekers, homeless women etc.? Why?

- Geographical targeting

From your own perspective, what would make you think that you have ‘done a good job’?

- Ideals of the job
- Expectations of role
- Care needs
- Job satisfaction

Can you think of a case when you worked with a

- An asylum seeker
- A teenage mother
- A women in temporary accommodation

and take me through how you worked with her and how it worked out. These can either be ‘effective interventions’ or engagements and also ones which you think exemplify the difficulties that are experienced.

For the latter, how might things have been done differently?

How would you like to see the role of the maternity health care assistant develop in the future?

4.4 Twenty minute service provider interview schedule

1) Sure Start direct staff e.g. Family Support Worker

Could you tell me a little about your work with Sure Start?

What kinds of targets or objectives do you have from Sure Start and how are these monitored?

- Data keeping

What strategies do you use to meet these targets? Could you give me examples?

- Hard to reach groups

Do you think these kinds of targets are useful? Why? If not, what do you think would work better?

If not addressed:

Do you think that you / Sure Start reaches the most vulnerable (Teenage Moms, Refugees...)? Why?

- Geographical targeting

What kind of strategies do you use to reach these groups?

From your perspective, how would you judge your own effectiveness overall, what would make you think that you have ‘done a good job’?

- Ideals of the job
- Expectations of role

What other kinds of services are offered by Sure Start? How often do you refer to these services or do you think they refer to you?

In terms of service provider coordination generally, how does communication work between the different professionals and groups that are working with a pregnant woman?

2) Questions for those who work ‘outside’ of Sure Start e.g. health visitors

What would you say Sure Start is about?

How do you work with Sure Start?

Are you given objectives or targets to meet by Sure Start and if so, how do you try to meet them?

Are they monitored? How?

- Data keeping

From your experience, what impact do you think Sure Start is making with the more vulnerable groups such as teenage mothers, refugees etc.? Can you give me some examples?

Are there any improvements they could make?

What other kinds of services are offered by Sure Start? How often do you refer to these services or do you think they refer to you?

In terms of service provider coordination generally, how does communication work between the different professionals and groups that are working with a pregnant woman?

Appendix 5: Table of service users recruited for qualitative interviews

ID	Age	P.O.B.	Ethnicity	Language	Fluency	Marital Status	Education	Disability	Partner disability	Home	Employment	Partner's employment
Cop04	30-39	UK	White British	English	Yes	Married	Above degree	No	No	Rent	FT	FT
Cop05	30-39	Italy	Italian	English and Italian	Yes	Cohabiting	Dip	No	No	Owner	PT	FT
Cop06	30-39	UK	White British	English	Yes	Married	Above degree	No	No	Owner	FT	FT
Cop07	30-39	Australia	White Australian	English	Yes	Married	Degree	No	No	Rent	Carer	FT
Cop08	20-29	UK	White British	English	Yes	Married	Degree	No	No	Owner	PT	FT
Cop09	30-39	UK	White British	English	Yes	Married	Degree	No	No	Housing Assoc	Carer	FT
Cop10	30-39	Australia	Australian	English	Yes	Married	Above degree	No	No	Rent	FT	FT
Cop18	30-39	Spain	British-Spanish	English	Yes	Married	Above degree	No	No	Owner	FT	FT
CopC	20-29	Iraq	Kurdish	Kurdish	No	Cohabiting	-	No	No	Council	Unemployed	Unempl oyed
CopD	20-29	Bangladesh	Bengali	Bengali	No	Married	-	No	No	Council	Carer	-
CopL	30-39	Somalia	Black African	Somalian	No	Married	-	No	No	Housing Assoc	Unemployed	Unempl oyed
CopN	20-29	Poland	Eastern European	Polish Dialect	No	Married	-	No	No	Council	Unemployed	Unempl oyed

ID	Age	P.O.B.	Ethnicity	Language	Fluency	Marital Status	Education	Disability	Partner disability	Home	Employment	Partner's employment
CopR	20-29	Bangladesh	Bengali	Bengali	No	Married	-	No	No	Council	Carer	FT
Hil02	30-39	UK	Latin American	English and Spanish	Little	Single	Less than GCSE	No	N/A	Council	Carer	N/A
Hil05	40+	UK	Caribbean	English	Yes	Single	Degree	Little	N/A	Council	FT	N/A
Hil07	30-39	Italy	Italian	English and Italian	Yes	Married	Above degree	No	No	Owner	FT	PT x 2
Hil09	30-39	Algeria	Algerian	French and Arabic	Little	Married	A-level	No	No	Council	Carer	Unemployed
Hil11	40+	UK	White British	English	Yes	Married	Degree	No	No	Owner	Carer	FT
Hil18	30-39	UK	White British	English	Yes	Cohabiting	GCSE	No	No	Owner	FT	FT
Hil20	30-39	UK	Black British	English	Yes	Married	A-level	No	No	Housing Assoc	Carer	FT
Hil21	20-29	Morocco	Moroccan	French and Arabic	Little	Married	Degree	Yes	No	Council	Carer	FT
Hil26	20-29	Brazil	Latin American	Portuguese	Little	Married	Above degree	No	No	Owner	Unemployed	FT
Hil28	30-39	UK	White British	English	Yes	Cohabiting	Degree	No	No	Owner	FT	FT
HilC	<20	-	-	-	Little	Single	-	Mental Health	N/A	Council/HA ?	Carer	N/A
HilD	<20	UK	British Asian	English	Yes	Single	-	No	N/A	-	-	-
Hilw03	40+	Tanzania	Black African	English and	Yes	Married	A-level	No	No	Owner	PT	FT

ID	Age	P.O.B.	Ethnicity	Language	Fluency	Marital Status	Education	Disability	Partner disability	Home	Employment	Partner's employment	
				Swahili									
Hlw04	30-39	UK	White British	English	Yes	Married	Above degree	No	No	Owner	PT	FT	
Hlw09	20-29	Somalia	Black African	Somalian	Little	Married	Primary GCSE and Childcare	No	Yes	Council	Unemployed	Unempl oyed	
Hlw16	20-29	UK	Mixed Race	English	Yes	Cohabiting		No	No	Housing Assoc	Carer	FT	
Hlw18	20-29	Ireland	White Irish	English	Yes	Married	Degree	No	No	Owner	FT	FT	
Hlw19	20-29	UK	White British	English	Yes	Cohabiting	Degree	No	No	Rent	Unemployed	FT	
Hlw20	20-29	China	White Other	English	Yes	Single	A-level	Little	N/A	Temporary	Student	N/A	
Hlw25	20-29	UK	White Irish	English	Yes	Single	Below GCSE	Little	N/A	Council	Unemployed	N/A	
Hlw33	20-29	UK	Caribbean	English	Yes	Single	Degree	No	N/A	Council	Carer	N/A	
Hlw43	20-29	Albania	White Albanian	Albanian	Little	Married	A-level	No	No	Rent Private	Unemployed	PT	
HlwA	30-39	UK	-	English	Yes	Seperated	-	No	N/A	-	PT	N/A	
HlwD	30-39	Portugal	Portugese	Portugese/ Spanish	No	Cohabiting	-	HIV	-	Temporary	Carer	PT	
HlwE	<20	UK	White British	English	Yes	Single	-	No	No	-	-	-	No

Table Cont.

ID	Hospital	Caesarean section MCA/CL	Smoker	Smoker Family member	Breastfeeding Time	Breastfeeding Group	
Cop04	UCH		No	No	5 weeks	No	
Cop05	Whittington	Yes	No	Yes, Out	After 6 wk	No	
Cop06	UCH	Yes	Never	Never	After 6 wk	No	
Cop07	UCH		No	No	After 6 wk	No	
Cop08	UCH	Yes	Stopped	Stopped, P	After 6 wk	No	
Cop09	UCH		Never	Never	After 6 wk	No	
Cop10	UCH		Never	Never	After 6 wk	Yes	
Cop18	Whittington		Never	Never	After 6 wk	No	
CopC	UCH	Yes	Never	Never	1 week	No	
CopD	UCH		Never	Yes, Out	1 day	No	
CopL	UCH		Never	Never	Mixing	No	
CopN	Homerton	Yes	Never	Never	1 day	No	
CopR	UCH		Never	Yes, Out	4 weeks	No	
Hil02	Whittington	Y	Yes	Never	No	After 6 wk	Yes
Hil05	Whittington	N		Stopped	Yes, Out	After 6 wk	No
Hil07	Whittington	N	Yes	Never	Never	After 6 wk	No
Hil09	Whittington	Y		Never	Yes, Out	After 6 wk	No
Hil11	St MarysH	N	Yes	Never	No	After 6 wk	No

ID	Hospital	Caesarean section MCA/CL	Smoker	Smoker Family member	Breastfeedin g Time	Breastfeedin g Group
Hil18	UCH	Y	No	Yes, Out	1 week	No
Hil20	UCH	CL!	Never	Never	After 6 wk	No
Hil21	Whittington	Y	Never	Never	After 6 wk	Yes
Hil26	Whittington	Y	Yes	Yes, Out	After 6 wk	Yes
Hil28	Whittington	Y	Never	Stopped, P	After 6 wk	Yes
HilC	Whittington	N	Never	N/A	No	No
HilD	Whittington	N	Never	N/A	After 6 wk	Yes
Hlw03	Whittington	Y Yes	Never	Never	After 6 wk	No
Hlw04	Whittington	N	Never	Never	After 6 wk	No
Hlw09	Whittington	Y	?	?	4 weeks	No
Hlw16	Whittington	Y	Stopped	Yes, Out	4 weeks	No
Hlw18	Royal Free	N Yes	Stopped	Never	After 6 wk	No
Hlw19	Whittington	Y	Stopped		4 weeks	
Hlw20	Whittington	Y Yes	Yes	-	After 6 wk	No
Hlw25	Whittington	Y Yes	Never	Yes, Out	No	No
Hlw33	Royal Free	N	Never	Never	After 6 wk	No
Hlw43	Whittington	Y	Never	Never	After 6 wk	No
HlwA	UCH	N Yes	No	N/A	After 6 wk	No
HlwD	Whittington	Y	Never	Never	Mixing	No
HlwE	Whittington	Y Yes	Yes	-	No	No

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