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Sure Start Collingwood and Stepney Local Programme Midwifery Project Evaluation

Report November 2006

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Executive Summary

Background

This report forms the basis of an evaluation of Sure Start Collingwood and Stepney (SSC&S) Local Programme Midwifery Project. The midwifery project had been running for 15 months with a part-time midwife (0.6 FTE) and a full-time bilingual (English Sylheti) support worker. The project was designed to offer one to one antenatal and postnatal support to all women within the area. The project, along with all other Sure Start Programmes in the London Borough of Tower Hamlets (LBTH) has now finished as the new focus of Sure Start is with the Children's Centres.

Sure Start Collingwood and Stepney is located in one of the most socially deprived boroughs in the country which has a high level of health inequality, high unemployment, extremely over crowded housing and a large minority ethnic population, many of whom do not speak English as a first language.

Progress towards Sure Start targets

The midwifery project had seen 183 women at the time of the study. Due to the small numbers (183 mothers and a total population of 11.5 thousand) it is difficult to show any trends in the various maternity/perinatal indicators laid down for Sure Start projects. However, some findings have emerged from the routine data.

Sure Start Collingwood and Stepney has a high percentage of low birthweight babies (11.74%, 2001) which is higher than Tower Hamlets and much higher than England as a whole (7.9%, 2001). Whilst there does not appear to be any trend in increasing or for that matter decreasing birthweight, the overall level for the last 4 years (2001-02 to 2004-5) of 13% is very high, not only when compared to England as a whole (6%) but also high when compared to the rest of Tower Hamlets (10%).

Antenatal and postnatal support increased quite clearly over the period of the project with the level of antenatal visits increasing as well as postnatal family visits where a dramatic increase from 60% of families to 71% of families is shown. The level of breast feeding has also increased and is remaining steady at a high level.

Service users' views

Thirty-two mothers agreed to take part in interviews, the majority of whom (58%) were Bangladeshi, but the sample also included White British, Pakistani, White Irish and Black/Caribbean mothers. Twelve percent described their ethnicity as other. Nearly half the women were born in Bangladesh (49%) and 39% were born in the UK. Only 30% of the mothers spoke English at home, but 67% felt there were able to communicate effectively in English. Three quarters of women reported that their health was good but a quarter also reported that they had a longstanding illness that limited their activities. Only 18% of the mothers smoked, with only one mother smoking during pregnancy, and 15% chewed Paan, a tobacco containing product.

Although 70% of women were aware of antenatal classes but only 30% attended them. The main reasons for this were being unaware of the classes or being too busy. The majority of women breast-fed their babies (82%) and the Bangladeshi mothers breast fed for the longest time.

Thirty percent of women received some antenatal contact from the Sure Start Collingwood and Stepney Midwifery Project, mostly by telephone and 93% of women had had postnatal contact with the project again most contact was by telephone (48%). The project was also an important source of referral to other "non-health" services locally.

An overwhelming majority of women (94%) found the bilingual support worker useful and she was highly valued for her own personal attributes.

Mothers found the service to be very approachable and warm and friendly, and a useful point of contact for information and advice. They said they felt passionately about the service to the point, where some women said they didn't know what they would do without it and only wished hospital services were as good.

On a less positive note, some women felt that the service could have made more contact with them and that they sometimes got different messages from different individuals within Sure Start Collingwood and Stepney. Several women also felt that the project could have made more effort to probe for problems women were experiencing though they did feel once the problem had been identified they were well supported. There was also a feeling, particularly from women from minority ethnic communities other

than Bangladeshi that the service did not cater for them very well and was “too” focused on the Bangladeshi community.

In terms of what women would like to see more follow up contacts was high on the list of priorities as was desire to have more information about what was available and what was going on. Some women also wanted the information to be more culturally specific in an Asian context and an Islamic one. Women also felt that there could be more involvement of fathers, especially in discussions about smoking.

Stakeholders' views

The stakeholders valued the project, in particular the role of the bilingual support worker and the ability of the project to go that extra step that mainstream services are unable to do. It was felt that the project had had a positive effect on mainstream midwifery services and was a valuable link to other services in both health and social care. Respondents felt that it has had a significant impact on breast feeding rates but were unsure about the effect it had had on smoking and emergency admissions. One of the principal features identified as a source of the projects success were the personal qualities of the staff involved, particularly the midwife and the bilingual support worker.

The biggest fear of respondents was that the move to Children's Centres would disadvantage the client group as universal coverage would no longer be provided. Universal coverage was felt to be key to delivering services to the most disadvantaged as these people are not always on the “radar” of mainstream services. The Midwifery project had the time and resources to uncover hidden problems that mothers, children and families were experiencing.

Observations and recommendations

The personal qualities of both the midwife and the bilingual support worker were identified by both the mothers and the stakeholders as key to the success of the project, particularly having good interpersonal skills and a broad professional knowledge together with an ability to work proactively and on their own initiative. It should also be borne in mind that the success of future projects might be quite person specific.

The bilingual support worker has been identified as a particularly crucial role in the project and the role's absence from the new

Children's Centres is a cause for concern. Careful monitoring of the bilingual co-workers work activities and style of work should be used when planning similar future services.

Organisationally communication both with external organisations and within midwifery services is an issue, both in terms of retaining existing expertise and personal contacts and developing the Children's Centres as a presence so that they are on the "radar" of other local health and non-health agencies.

It is also important to ensure that antagonism does not arise between mainstream services and those provided in Children's Centres.

Women also had a number of specific recommendations for the services. The configuration of antenatal classes and antenatal contact needs to be re-evaluated so that a much greater proportion of women are in contact with the new Children's Centres before the birth of the baby. Smoking cessation work should be undertaken with fathers and other family members as this was an issue identified by both women and stakeholders.

Lastly whilst the provision of services was good for the Bangladeshi community, other minority ethnic communities felt excluded. A needs assessment should be carried out in these communities.

Introduction

The midwifery project operated for 19 months from September 2004 to March 2006, when the local Sure Start programmes were reorganised into Children's Centres. The project had a part-time midwife (0.6 fte) and a full-time bilingual English and Sylheti support worker. The project was designed to offer one to one antenatal and postnatal support to all women within the Sure Start Collingwood and Stepney area. The project also developed a programme of antenatal classes. It worked in close partnership with the breastfeeding project and was designed to maximise the use of existing resources and avoid duplication of effort of professional input with women and their families.

Background

The Sure Start Collingwood and Stepney Local Programme Midwifery Project operated within one of the most deprived areas of London.⁽¹⁾ The area covered by the project is in the middle of London Borough of Tower Hamlets (LBTH) and is located around Stepney Green and the Collingwood estate, bisected by the Whitechapel Road/Mile End Road.

It had a population of 11,525 according to the 2001 census (personal communication SS S&C, May 2005). Further demographic and socio-economic data are shown in **Table 1**.

The population structure is skewed towards younger people, both when compared to Tower Hamlets and particularly when compared to England as a whole. Sure Start Collingwood and Stepney has a high ethnic minority population compared to the borough as a whole and especially to the English average. In particular the Bangladeshi community comprise half of all those people living in the Sure Start Collingwood and Stepney area (personal communication SS S&C, May 2005).

In terms of housing tenure, the percentage of people housed by the council, housing associations or in private rented accommodation is high at 71% even when compared to the borough average of 68%, but is considerably out of proportion to the English average of 28%. There is also a very high level of over crowding, 37% of households

Table 1: Sure Start Collingwood and Stepney, Tower Hamlets and England Selective Socio-economic and Socio-Demographic Comparisons

	SSC&S		LBTH		England	
	number	%	Number	%	number	%
Population						
Aged 0-15	2,933	25.4	44,934	22.9	9,901,581	20.2
Aged 16-24	8,131	70.6	143,450	73.1	35,532,091	72.3
Aged 75 and over	399	3.5	6,513	3.3	3,705,157	7.5
Ethnicity						
White British	3,745	32.5	84,151	42.9	42,747,136	87.0
Bangladeshi	5,688	49.3	65,549	33.4	275,394	0.6
Other	2,092	18.2	46,406	23.7	6,116,241	12.4
Tenure						
Council, Housing Association and Private Rented	3,093	70.9	42,460	68.1	5,739,592	28.1
Overcrowded households	1,598	36.7	22,984	29.3	1,457,512	7.1

Source: Personal Communication SS S&C May 2005 and 2001 Census Key Statistics Tables

in Sure Start Collingwood and Stepney, 29% for the borough and only 7% nationally. (personal communication SS S&C, May 2005).

Unemployment in the Sure Start Collingwood and Stepney area is 13.5%, higher than the average for the borough (11.2%) and much higher than the average of England (5.0%).(personal communication SS S&C, May 2005) Using ONS neighbourhood statistics, Tower Hamlets is ranked the fourth (98th percentile) most deprived borough in the UK out of 354 local authorities, on the Index of Multiple Deprivation (2004) which includes information relation to income, employment, education, health, skills, training, barriers to housing and services and crime. The Lower Layer Output Area that corresponds roughly with Sure Start Collingwood and Stepney Local programme is ranked the 4,639th (86th percentile) most deprived in Britain of 32,482. (2)

The population is quite mobile with 10% of existing residents changing their address each year. There is a high annual turnover on GP lists as well at 26% (1997 figures) (1)

Tower Hamlets has a high birth rate, 82.6 per 1000 women aged 15-44 in 2002, compared to a national average of 57.7. The

stillbirth rate is high, 8.3 per 1000 total births in 2002 compared to 5.3 nationally. The south west locality of the borough which includes Sure Start Collingwood and Stepney had the highest rate at 9.7 per 1000 total births. (1)

Sure Start Collingwood and Stepney has approximately 900 children aged under 4 years old in its area. There are 225 births per year of which approximately 70% were to Bangladeshi mothers. (personal communication SS S&C, May 2005)

Tower Hamlets suffers from high levels of health inequalities. Life expectancy for men is 3.2 years shorter than the average for England and that of women is 1.5 years shorter (2002). The death rate for cancer is 70% higher than the national average and the death rate from cardio-vascular disease is 50% above the national average. Approximately 6% of the population registered with a GP are living with long-term conditions such as chronic obstructive airways disease and diabetes. (1)

Whilst increasing, Tower Hamlets PCT has the lowest rate of access to GPs and other primary care professionals in London(3).

Aim and Objectives

Aim

To evaluate the effectiveness of the Sure Start Collingwood and Stepney Local Programme Midwifery Project.

Objectives

To evaluate:

- How pregnant women experience the services provided;

- How the project works within the existing statutory midwifery services / health visiting service;

- How the project adds value to existing statutory midwifery services and contributes to Midwifery Service targets;

- The role of the bilingual co-worker;

- How the project helps the local programme contribute to meeting its targets;

- The extent to which the project identifies and signposts families in relation to non-health needs;

And to make recommendations for:

- the development of the Midwifery Project;

- the potential lessons that mainstream midwifery services can learn;

- and how midwifery support might be delivered in children's centres.

Methods

The project met the aims and objectives of the evaluation primarily through a series of interviews with users, staff and other stakeholders within the local health economy, supplemented with a review of locally available, routine and semi-routine data and project documentation.

The project took place in two phases. The first was an initial collection of background data, drafting of questionnaires and seeking ethics approval. Phase 2 focused on service user and stakeholder interviews and the analysis of the data.

Phase 1 included a review of documentation, the project's history and the routine data that it collected. Initial discussions were held with key workers and other stakeholders both within Sure Start and the local health economy in order to identify who should be approached for the evaluation and to devise and refine concepts for the in depth interviews.

Background information on Tower Hamlets was collected, including the configuration of Sure Start and community and secondary health services, the socio-demographic and socio-economic profile of the borough and routine NHS data covering, amongst other things, midwifery and health visitor contacts. This provided a context and bench mark for the evaluation of the midwifery programme.

Phase 1 concentrated on reviewing previous Sure Start Local Programme health initiative evaluations, in order that a semi-structured interview schedule, including both qualitative and quantitative elements, could be developed for use with service users and other stakeholders. We also used our existing expertise in designing structured and semi-structured questionnaires in the evaluation of health services generally and more specifically in a previous evaluation of a Sure Start breastfeeding initiative in an area with a large Bangladeshi population. Service user and stakeholder questionnaires and details of the interviews are in Appendices 1 and 2.

Phase 2 involved the recruitment and interview of service users and stakeholders. The majority of service users were from the Bangladeshi community with Sylheti being the most widely spoken dialect. Our extensive expertise in Sylheti and in interviewing Bangladeshi women in East London proved invaluable in conducting the user interviews. After obtaining consent telephone interviews were conducted by a native Sylheti speaker using the semi structured interview devised in Phase 1 and shown in Appendix 1.

Concurrently, the qualitative stakeholder interviews were conducted face to face with eight individuals identified as being closely involved with the project in various capacities. Details are in Appendix 2.

Ethics approval

Once the questionnaires and interview schedules had been designed, approval was sought in June 2005 from East London and The City Local Research Ethics Committee 1. Due to the scheduling of committees and some minor amendments there was a significant delay to the project and final approval was not granted until 12th October 2005 (REC Ref 05/Q0603/133) This delayed the start of the project by five months.

User survey

The Sure Start Collingwood and Stepney Midwifery Programme team was consulted in order to identify all women receiving services offered by the team since it started in September 2004.

Sample size calculation

One hundred and eight-three women who had used the Sure Start Collingwood and Stepney Midwifery Project were identified, as Table 2 shows. It was decided to take a quota sample of 80 mothers designed to represent all ethnic groups and younger and older mothers as well. Eighty mothers were chosen as a trade off between universal coverage of the population and the time and resource constraints of the study. We hoped to recruit about 50 mothers to the study to reflect all groups within the sample.

As many of the black and minority ethnic groups were quite small we decided to complete a 100% sample of all 48 non-Bangladeshis so that we could ensure we captured some of their experiences. Well also decided to recruit all eight young mothers under 20 years of age and older mothers, 40 years and over, but these individuals were already included in the first part of the selection and the sample of Bangladeshi mothers. All five Bangladeshi mothers in age bands less than 20 and greater than 39 and a sample of 27 Bangladeshi mothers in age bands 20-29 and 30-39 were selected giving a total of 32 Bangladeshi women, 24% of all Bangladeshi

Table 2: Numbers of women in sample by Ethnic group and Age group

Ethnicity	Under 20 years	20-29 years	30-39 years	40 and over	Age not known	Total
White	0	6	11	2	2	21
Black	1	4	2	0	0	7
Other Asian	0	3	1	0	1	5
Bangladeshi	2	89	36	3	5	135
Indian	0	2	0	0	0	2
Pakistani	0	3	3	0	0	6
Other	0	1	1	0	0	2
Unknown	0	4	0	0	1	5
Total	3	112	54	5	9	183

Source: Personal Communication SS S&C May 2005

mothers. Thus, a grand total of **80** mothers was invited to take part in the study.

Recruitment

The initial approach to women was made by the bilingual support worker. Women were contacted and asked if they would like to take part in the study. The details of those women who agreed were passed on to the study team, where a bilingual (English/Sylheti) researcher (SA) contacted the users in order to explain the study, what was required answer any questions, obtain consent and arrange for a mutually convenient time for interview.

Development of a questionnaire for service users

A fairly short survey with open-ended and closed questions was devised to capture women's experiences of the midwifery services provided as well as background and demographic data. The questionnaire was based on our previous experience of these types of surveys and utilised standardised questions where possible, for example using the census classifications for ethnicity and questions from the omnibus survey of factors such as long-term limiting illness. The questionnaire was also informed by other questionnaires used to evaluate Sure Start midwifery projects, the need to gather

information on specific Sure Start targets and the need to address specific questions raised in the project brief, in particular the role of the bilingual support worker.

There were specific questions on smoking and breastfeeding reflecting the public health importance of these two issues and their direct relevance to the work of Sure Start midwives. We did not anticipate many Bangladeshi women (the majority of service users) to be smokers, though a question regarding smoking was asked of all women. In addition to this, we also asked a question regarding chewing of Paan or betel nut and “Darza”, a product believed to be contain tobacco. This is thought to be more prevalent amongst Bangladeshi women than smoking, and may have implications for the uptake of breastfeeding and the women’s and babies’ health. Recent research in Tower Hamlets indicates that the prevalence of Paan chewing amongst Bangladeshi women of 48.5% compared to a smoking prevalence of 4% amongst the same women(4).

Before piloting the survey, we discussed the questionnaire with the bilingual support worker and bilingual advocate/link workers working within the maternity services. This was to ensure we had used appropriate concepts, in particular midwifery terminology, in the survey and that these were equivalent and consistent within both English and Sylheti. The schedule of questions asked during in the survey of users can be found in Appendix 1.

Piloting the survey of users

The questionnaire was initially piloted amongst the first three women recruited to the study. The pilot included interviews with women in English and Sylheti. This helped us to clarify the questions used and to get the timing of the administration of the questionnaire right. We also used this as an opportunity to assess the validity and adequacy of the variables and scale constructions were planned to use in both languages. A few minor changes were made as a result, including the rephrasing of some questions, the addition of categories to select from, some additional questions and a re-ordering of the questions.

Analysis of the survey of users

Quantitative data from the Sure Start survey were entered into SPSS. Basic descriptive analyses and cross-tabulations were carried

out to explore the associations between age, ethnicity and parity and the women's responses.

Qualitative analyses on the free text were manually conducted using an inductive approach. The responses were collated into these and sub-themes identified. Where appropriate the frequency of themes from amongst the responses has been reported.

Stakeholder survey

After identifying key stakeholders, including Sure Start staff, midwives, midwives from neighbouring projects and mainstream midwifery managers, they were approached by letter and follow-up telephone call to invite them to take part in the study. A total of eight people were approached and interviews were arranged and completed with seven of them.

Structured in-depth interviews, shown in Appendix 2, were conducted with these stakeholders to explore what the midwifery project offered, how it contributed to meeting local programme targets and how it added value to existing statutory midwifery services. This one-to-one interviewing allowed us to explore the issues in detail. On average the interviews lasted for 30 to 40 minutes.

The questionnaire was developed in line with the project brief and on the basis of informal consultation with those involved with the project and individuals knowledgeable about Sure Start.

The interviews were taped and the tapes were transcribed anonymously, by an experienced transcriber who had had previous experience of transcribing interviews in a health services research context.

The transcribed interviews were entered into NVIVO software to facilitate the qualitative analysis. A straight forward inductive approach was adopted to the identification of themes from interviews as the interviews were relatively well structured thanks to the interview schedule and the topic was very focused. Emerging themes were refined and grouped iteratively, working with all the scripts simultaneously. The results of the qualitative analysis are presented according to the broad themes that emerged. Selective quotation has been used to illustrate these themes, however, some "censoring" was required in order not to identify individuals and break their confidentiality.

Results

Progress toward Sure Start targets

The tables below are drawn substantially from annual monitoring data and show the data for the targets for 2001-02 to 2004-05.

Contribution to midwifery service targets

Target: *Low birthweight babies (weighing less than 2500g) as a percentage of total live births*

Table 3: Percentage of low birthweight babies

Year	Number of low birthweight babies	Total live births	Percentage with low birthweight	95 % Confidence Intervals
2001-02	20	215	9.30	6.12-13.94
2002-03	25	212	11.79	7.45-16.13
2003-04	51	267	19.10	14.39-23.82
2004-05	29	247	11.74	8.31-16.36

Chi-square test for trend $\chi^2 = 2.040$ 2df $p = 0.153$
Source SS C&S Annual Monitoring Data

It is not possible to detect any trend in the incidence of low birthweight within the areas covered by Sure Start Stepney and Collingwood's Midwifery Programme. The numbers are comparatively small so the proportion of low birthweight babies in any one year is subject to wide variation. This is shown by the confidence intervals around the percentage of low birthweight babies in each of the four years. These confidence intervals overlap so it is not possible to say whether the proportion increased, decreased or remained static and no difference was detected by the chi-square test for trend. The percentage of low birthweights in the Sure Start Stepney and Collingwood was high compared to 8.3% in London and 7.9% in England as a whole in 2001.

Meeting National targets

Target: *Antenatal advice and support available to all pregnant women and their families living in the Sure Start local programme.*

Table 4: Women contacted for antenatal support

Year	Number of pregnant women contacted during pregnancy	Number of women who had live births	Percentage contacted	
			%	95 % CI
2001-02				
2002-03	0	212	0.00	
2003-04	62	267	23.22	18.16-28.29
2004-05	79	226	34.96	29.03-41.39

Chi-square test for trend $\chi^2 = 7.88$ 1df $p = 0.005$

Source SS C&S Annual Monitoring Data

The midwifery project has been successful in increasing the proportion of mothers who were contacted for antenatal support and advice during pregnancy. The proportion rose from 23% in 2003-04 to 35% in 2004-05, representing a significant increase over these two years.

Target: *Information and guidance on breastfeeding, nutrition, hygiene and safety available to all families with young children in Sure Start local programmes*

Table 5: Level of breastfeeding

	Number of mothers breastfeeding at birth	Number of mothers with newborns where feeding status is known	Breastfeeding at birth % 95% Confidence interval	Number of mothers breastfeeding at 6 weeks	Number of mothers with 6 week olds where feeding status is known	Breastfeeding at 6 weeks % 95% Confidence interval
2001-02			36.00			27.00
2002-03	189	232	81.47 76.47-86.47	401	793	50.57 47.09-54.05
2003-04	149	164	90.85 86.44-95.27	124	164	75.61 69.04-82.18
2004-05	118	130	90.77 84.55-94.61	97	130	74.61 66.48-81.31

Chi-square for trend:

Breastfeeding at birth $\chi^2 = 7.68$ 1df $p = 0.006$

Breastfeeding at six weeks $\chi^2 = 44.718$ 1df $p = 0.000$

Source SS C&S Annual Monitoring Data

The numbers of mothers breastfeeding at birth rose significantly and remained at 91% for the last two years of the project. The numbers breast feeding at six weeks also increased and remained steady at around 75%. Again this trend is statistically significant. Whilst the Midwifery programme may have had some impact on this the separate breastfeeding initiative is likely to have had more influence.

Target: All families with new born babies to be visited within the first 2 months of their baby's life and given information about the support services available to them.

Table 6: Visits to families

	Number of families visited within first two months of life	Total number of families with new babies reaching two months of age	Percentage visited	
			%	95 % CI
2001-02				
2002-03	0	212	0.00	
2003-04	160	267	59.93	54.05-65.80
2004-05	161	226	71.24	65.01-76.74

Chi-square for trend $\chi^2 = 6.98$ 1df $p = 0.009$

Source SS C&S Annual Monitoring Data

The midwifery programme appears to have had a substantial impact upon the number of families visited within the first two months of the baby's life. The percentage visited increased from 60% of families in 2003-04 to just over 71% of families in 2004-05.

Target: To achieve by 2005-06 a 6% reduction in the proportion of mothers who continue to smoke during pregnancy.

The data available were inadequate for assessing progress towards this target, but Bangladeshi women have a low prevalence of smoking in any case. Side stream smoke from male members of the family may be a more important issue, but again, no data were available.

Target: A 10% reduction in children in the Sure Start area aged 0-3 admitted to hospital for gastro-enteritis, a lower-respiratory tract infection or a severe injury by 2004-05

Table 7: Emergency admissions age 0-3 for Gastroenteritis

	SSC&S		Other LBTH Sure Start local providers		Total
	n	% of admissions form Sure Start programmes within LBTH	n	% of admissions form Sure Start programmes within LBTH	
2001-02	6	13	41	87	47
2002-03	7	15	40	85	47
2003-04	11	28	29	72	40
2004-05					

Source SS C&S Annual Monitoring Data

The most recent data relevant to this target were not yet available at the time of writing. The numbers of admissions were small and the proportion the Stepney & Collingwood account for of all the emergency admissions for gastroenteritis are not very stable over the three years. So it is not possible to comment in terms of any trend, this is especially so as infections and thus admissions for gastro-enteritis show seasonal trends and trends over a number of years, which makes the interpretation of these data particularly difficult given the small numbers.

Table 8: Emergency admissions age 0-3 for lower respiratory tract infection

	SSC&S		Other LBTH Sure Start local providers		Total
	n	% of admissions form Sure Start programmes within LBTH	n	% of admissions form Sure Start programmes within LBTH	
2001-02	16	16	83	84	99
2002-03	9	12	66	88	75
2003-04	22	22	80	78	102
2004-05					

Source SS C&S Annual Monitoring Data

The numbers are small and as with admissions for gastro-enteritis above the proportions are not very stable. Again interpretation is

difficult as infections and thus admissions for lower-respiratory tract infections show seasonal trends and trends over a number of years, which makes the interpretation particularly difficult.

Table 9: Emergency admissions age 0-3 for severe injury

	SSC&S		Other LBTH Sure Start local providers		Total
	n	% of admissions form Sure Start programmes within LBTH	n	% of admissions form Sure Start programmes within LBTH	
2001-02	10	13	98	87	108
2002-03	8	10	73	90	81
2003-04	9	11	74	89	83
2004-05					

Source SS C&S Annual Monitoring Data

The most recent data for this target were not available at the time of writing. Again interpretation is made difficult by the small numbers.

Table 10: All Emergency admissions age 0-3

	SSC&S		Other LBTH Sure Start local providers		Total
	n	% of admissions form Sure Start programmes within LBTH	n	% of admissions form Sure Start programmes within LBTH	
2001-02	32	13	222	87	254
2002-03	24	12	179	88	203
2003-04	42	19	183	81	225
2004-05					

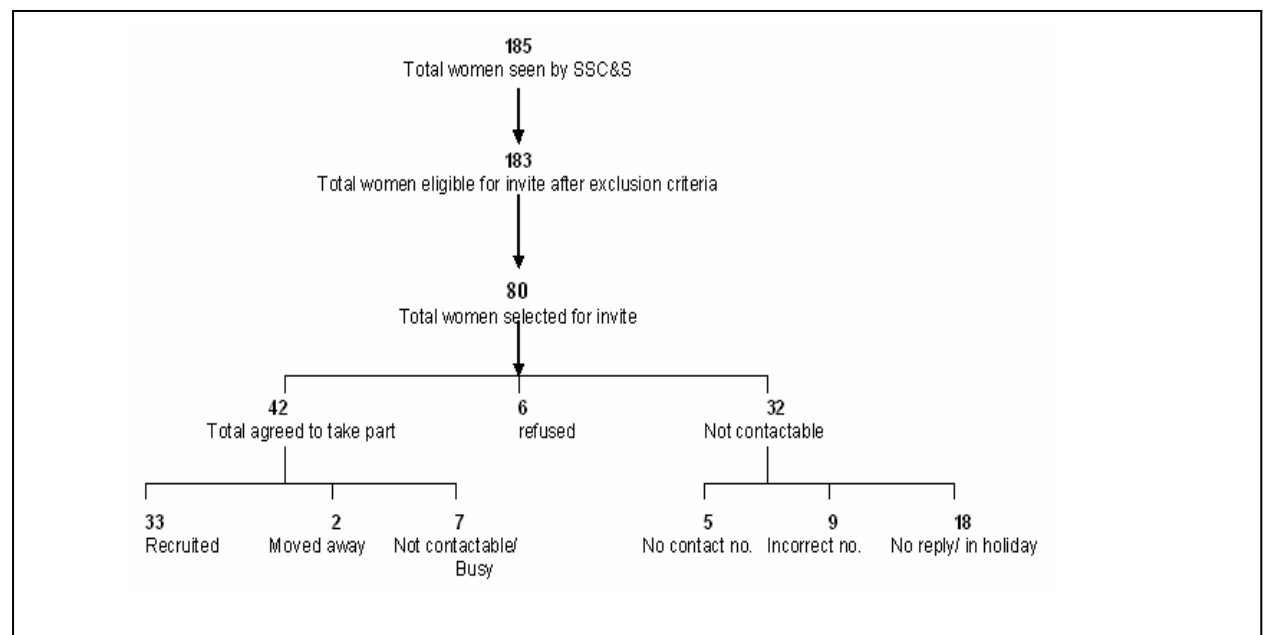
Source SS C&S Annual Monitoring Data

Even overall the numbers of emergency admissions for children aged 0-3 are too small to be able to say anything in terms of trends. Ideally data from a much larger area should be aggregated to look at this or several years worth of local data, but as the project has only been running for a couple of years and is about to be incorporated in the new children's centres this is not be possible.

Interviews with service users

Initially 185 women who had used the project were identified 183 of whom were eligible for the study. A sample of 80 were selected or entry into the study as described in the methods above. Sure Start Collingwood and Stepney attempted to contact these 80 women selected for the study. Forty two (52.5%) agreed to take part, six (7.5%) refused and 32 (40%) were un-contactable as Figure 1 shows. After obtaining verbal consent from these 42 women their contact details were forwarded to the study team for interview. Of the 42 who had agreed to take part 33 (78.6%) completed the interview. Two 2 (4.7%) had moved away and seven (16.3%) were either un-contactable or too busy to complete the interview. Figure 1, sets out the selection and recruitment of the study participants.

Figure 1: Population of women seen by Sure Start Collingwood and Stepney and sample population of the evaluation.



Characteristics of the study participants

Table 11 and Table 12 below summarise the socio-demographic and socio-economic characteristics of the women taking part in the survey.

Table 11: Socio-demographic and socio-economic characteristics of study participants Part 1

	Number	Percentage
Age		
20-29	18	55
30-39	14	42
40 or over	1	3
Ethnicity		
White Irish	1	3
White British	6	18
Caribbean	1	3
Pakistani	2	6
Bangladeshi	19	58
Other	4	12
Place of birth		
UK	13	39
Bangladesh	16	49
Other	4	12
Main language spoken at home		
English	10	30
Sylheti	14	42
Both	2	6
Other	7	21
Fluency in English		
Yes	22	67
A little	7	21
No	4	12

Over half the women were of the aged 20-29 and just under half were of 30-39 years of age. There were no women in the study younger than 20 and only one woman in the 40 or over group.

Fifty-eight percent of the study population were Bangladeshi. The second largest ethnic group in our study was White British (18%) followed by Pakistani (6%) and one of each of White Irish and Black/Caribbean. Twelve per cent of women classified their ethnicity as 'other'. They included Somali, Somali British, Moroccan, half Moroccan and half Italian women.

Nearly half (49%) of the women were born in Bangladesh and this reflects the ethnicity of the sample. Thirteen (39%) women were born in the UK and only four (12%) were born elsewhere, including: Pakistan, Somalia, Ireland and United Arab Emirates.

A significant percentage of the sample did not speak English at home, 42% speaking Sylheti at home compared to 30% speaking

English. The other languages women in the study spoke at home included Arabic, Bengali, Italian, Spanish, Somali and Urdu. Women were also asked whether they considered themselves able to understand and communicate in English. Two thirds said yes, but just under a quarter (21%) said they had little fluency in English. Four (12%) said they were unable to understand or speak in English.

Table 12: Socio-demographic and socio-economic characteristics of study participants Part 2

	Number	Percentage
Marital status		
Married	25	76
Cohabiting	3	9
Single	5	15
Education		
Postgraduate qualifications	2	6
Undergraduate qualifications	6	18
A-level/equivalent	7	21
GCSE/equivalent	13	39
Other qualification	5	15
Home		
Own home	5	15
Rent from the Council	23	70
Rent from Housing Association	4	12
Rent Privately	1	3
Employment status		
Full-time mother/carer	24	73
Employed part-time	5	15
Employed full-time	3	9
Student part-time	1	3
Partner's employment		
Full-time carer	4	12
Employed part-time	5	15
Employed full-time	17	52
Unemployed	3	9
No partner	1	9
Student part-time	1	3
Total	33	100

Three quarters of the women were married, three (9%) were cohabiting and five (15%) were single parents. Most of women (39%) were educated to GCSE standards and under a half of the women were educated to A-level or above. Fifteen per cent of the

women had all their education in countries outside of the UK, including Bangladesh, Pakistan and Somalia.

Twenty three (70%) of the women were living in council accommodation, five (15%) owned their own homes, four (12%) were living in homes rented from housing associations and only one (3%) was renting privately. The majority of the women (73%) were full-time mothers. Very few were employed full-time (3%) and five (15%) were employed on a part-time basis.

Only one woman had no partner. Just over half (52%) of the women's partners were in full-time employment. A number of partners were full-time carers (12%) and three (9%) were unemployed.

Previous pregnancies and family circumstances

Twelve (36%) women were primiparous and 21 (64%) were multiparous. None of the women recruited had any stillbirths but nine (27%) had had previous miscarriages. Two of these women were primiparous and seven were multiparous. No association was detected between parity and ethnicity (Fisher's Exact Test, $\chi^2 = 5.8$ 6df $p=0.466$) even when ethnicity was merged into four categories of White, Black, Asian and 'any other' (Fisher's Exact Test, $\chi^2 = 2.468$ 3df $p=0.491$). There was also no association detected between parity and age (Fisher's Exact Test, $\chi^2 = 3.215$ 2df $p=0.190$) in this sample. Small numbers may mean that these analyses will have missed a true association because they are underpowered.

We asked women how many children they had under their care at home. The majority of the women (36%) had one child under their care, 15 (45%) had two or three children, five (15%) had four children. One woman had six children under her care living at home.

We also asked women the number of children under four years old they had at home. Two thirds of the women had just one child, 10 (30%) had two children and only one (3%) had three children under the age of four.

No statistical association was detected between the number of children at home and ethnicity.

Health and health related behaviours

The women were asked whether they had a longstanding illness or disability, and if so, whether it limited their activities in any way. Eight women (24%) reported that they had longstanding illness or disability and seven (21%) of these said this limited their activities. Half of those reporting longstanding illness were of Bangladeshi origin, and their ages ranged from 28 to 32 years. Three were White and one was in the 'other' ethnic category.

Many more women reported their general health as being "good" (78%) than "fairly good" (18%) or "not good" (6%). No statistical differences were detected between general health and age ($\chi^2 = 3.297$ 4df $p = 0.509$) or ethnicity ($\chi^2 = 3.169$ 6df $p = 0.787$).

Table 13: General health status

	Number	Percentage
Long-standing illness		
Yes	8	24
No	25	76
Limiting activities		
Yes	7	21
No	1	3
General health		
Good	25	78
Fairly Good	6	18
Not good	2	6

Women in the sample were asked whether they ever smoked cigarettes or chewed paan with tobacco.

Table 14: Tobacco Use

	Number	Percentage
Smoke cigarettes		
Yes	6	18
No	27	82
Chew paan with tobacco		
Yes	5	15
No	28	85
Smoked during pregnancy	1	3
Chewed paan during pregnancy	3	9

Only six women reported smoking and five chewed paan with tobacco including one who both smoked and chewed tobacco with paan. Of those that smoked only one smoked during pregnancy. Three had given up before they knew they were pregnant. Those who smoked were predominantly White except one Bangladeshi woman.

All the women that were chewing paan with tobacco were Bangladeshi. Of the five women chewing tobacco, three continued to chew tobacco during pregnancy. The two who had stopped chewing tobacco did so for other reasons other than being pregnant.

Those who had given up smoking did so as a result of social and peer support. Few women gave up due to being pregnant and for the health of their child.

Women were asked if they had received any advice or information about smoking or chewing paan with tobacco from the Midwifery Project. Most women 19 (58%) received either verbal or written information about smoking. Eleven women reported that they had not received any information, however. Two said they were unable to remember whether they received any information or not and one woman did not answer the question. The information received did not contain anything on chewing paan with tobacco.

We also asked women whether they thought the information supplied would help someone wanting to give up smoking. Seventeen women answered this question in total. Of these 11 (65%) said “yes” and six (35%) said they were “not sure/don’t know”.

Table 15: Reasons for emergency admission to hospital

Reason	Number of visits
Diarrhoea	3
Muscle Tumour	2
Diary product allergy	2
Blood Infection	2
Arm injury (inflated)	1
Knocked his head	1
Chickenpox	1
Jaundice	1
Ear infection	1
Flu and high temperature	1
Circumcision - heavy bleeding	1
Total	16

All women were asked if in the last 12 months their child had had an emergency admission to hospital. Twenty three (70%) responded that their child had not had an emergency admission to hospital and 10 (30%) said they had. A total of 16 emergency admissions to hospital were made by the children of the 10 women. Four made two visits, one made three visits and five made one visit each.

Maternity care

We asked women a series of questions to establish their experience of their maternity care including antenatal care, care during labour and delivery and postnatal care and support with breastfeeding. We also asked who had provided this care, the mainstream services or the Sure Start Team.

Routine antenatal care

All women in our sample had routine antenatal care. The majority of women had this care either at their local health centre (42%) or at a combination of their local health centre and hospital (39%). Fewer (18%) had all their antenatal care at their local hospital.

Over 50 per cent of women's antenatal care was provided by a midwife alone while 24% had a combination of care from a GP and midwives. Consultant only care and GP only care was received by the same proportion of women (9%). One women reported receiving antenatal care from a midwife and a consultant and one women reported receiving care from a combination of a statutory midwife and the Sure Start midwifery team.

Table 16: Awareness of and attendance at antenatal education

	Number	Percentage
Aware of antenatal education		
Yes	23	70
No	10	30
Attended antenatal education		
Yes	10	30
No	23	70
Total	33	100

Table 16 demonstrates how many of the women in the sample were aware of the availability of antenatal education and of these how

many attended classes. Seventy per cent of the women were aware of antenatal education classes but only 30% attended them. Of these 10 women four were Bangladeshi, four were White and one was Moroccan and one Pakistani. Of the ten who attended antenatal education eight were primiparous women and only two were multiparous women. Of the 10 women who were not aware of antenatal education classes, six were Bangladeshi and there was one woman from each of the White, Caribbean, Somali and Pakistani groups.

We asked women the reason why they did not attend antenatal education. A total of 20 women responded to that question and Table 17 outlines their responses.

Table 17: Reasons why women did not attend antenatal education classes

Reason	Number	Percentage
Busy	9	45
Did not know about it	5	25
Unable to take time off work	1	5
Not well at the time	1	5
Was informed of it late at 6 months	1	5
Just didn't want to attend	1	5
Knew already what to expect	1	5
Waste of time	1	5
Total	20	100

Many women were too busy to attend either because they cared for other children or had other responsibilities that made it difficult for them to attend. Five women were not aware of the education classes and one woman was told about it when she was six months pregnant, by which time she felt it was too late to attend any of the classes. Antenatal education was mainly provided by midwives at community health centres and hospitals.

Breastfeeding

Table 18 shows that 82% of the women had breastfed their babies and only 18% did not breastfeed. The duration of breastfeeding among women in the study was consistent for the first six months and showed some reduction thereafter. Bangladeshi women breastfed for longer than those from other ethnic groups and multiparous women breastfed for longer than primiparous women.

Table 18: Breastfeeding

	Number	Percentage
Duration of breastfeeding		
No breastfeeding	6	18
Less than 1 month	8	24
1 - 3 months	7	21
4 - 6 months	8	24
7 - 9 months	4	12
10 - 12 months	6	18
Received support to breastfeed		
Yes	29	88
No	4	12
Total	33	100

Table 19 shows the sources of breastfeeding support that the women received. It appears that Sure Start midwifery project provided the majority of breastfeeding support to the women in the sample. The Sure Start bilingual co-worker provided slightly more breastfeeding support alone than the rest of the team itself. The other sources include support provided by GPs, a bilingual worker from the hospital, hospital doctors and a hospital nurses.

Table 19: Source of breastfeeding support

Support received from	Number	Percentage
Sure Start bilingual co-worker	11	30
Sure Start midwifery team	10	27
Other midwife	10	27
Health visitor	2	5
Other	4	11

The Sure Start bilingual co-worker provided the most breastfeeding support to the Bangladeshi women, but she also supported a number of women from other ethnic groups. All the women except one found the support satisfying. Overall, 49% were very satisfied and 33% were satisfied with the support she gave.

Contact with the Sure Start Stepney and Collingwood Local midwifery team

We asked women how much contact they had had with the Sure Start midwifery team and what form the contact had taken and whether the women had initiated contact with the midwifery team.

Antenatal contacts were made with women for a number of reasons. These included giving advice about particular activities run by the Sure Start Midwifery Project, giving information in response to a request and follow-up calls to see how women were getting along in general. This question was adapted after the three pilot interviews with women and hence the sample size for these two questions was 30 instead of 33. Nine of the 30 women had received some antenatal contact from the midwifery team. Seven of these women had between one and three antenatal contacts with the midwifery team while two women had between seven and eight contacts with the team. No association was detected between the number of contacts with the midwifery team and women's ethnicity ($\chi^2 = 12.783$ 15df $p = 0.619$), parity ($\chi^2 = 7.033$ 5df $p = 0.218$) or age ($\chi^2 = 100.833$ 85 df $p = 0.116$).

Figure 2: Numbers of antenatal contacts with women by mode

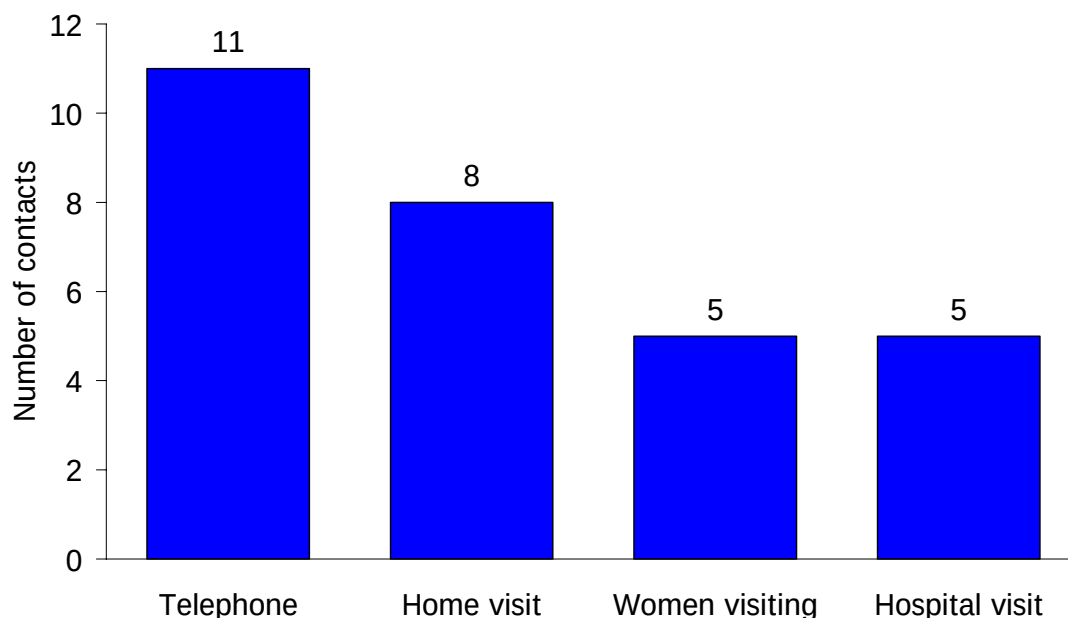


Figure 2 shows the antenatal contacts by the midwifery team with the women interviewed. Antenatal contacts by telephone were more common than other forms of contact. Home visits were the second

most frequent form of contact. A number of contacts, five in total, were made as a result of women contacting the team and an equal number of contacts were also made at the hospital. It is clear from the graph that the midwifery team had a number of different channels to contact women antenatally and for women to contact them.

All women were asked whether they received a visit from the Sure Start midwifery team within the first two months of their most recent baby's birth. One women was unable to recall receiving a visit. Only four (12%) said they had not received a visit from the midwifery team and the overwhelming majority 28 (85%) had received a visit from the team.

Women were also asked whether they had any postnatal contact with the midwifery team and how this contact was made. As with antenatal contacts, the sample size was 30 women as the questions were amended after the pilot. Two of these women (7%) had no postnatal contact with the midwifery team. The reason for this is known for one woman who said she was in Bangladesh for a while but not for the other woman. She also did not receive any antenatal contacts from the team but mentioned receiving support from the team for her older child. All the other women 28 (93%) had some postnatal contacts with the midwifery team.

Figure 3: Frequency of postnatal contact with women by mode

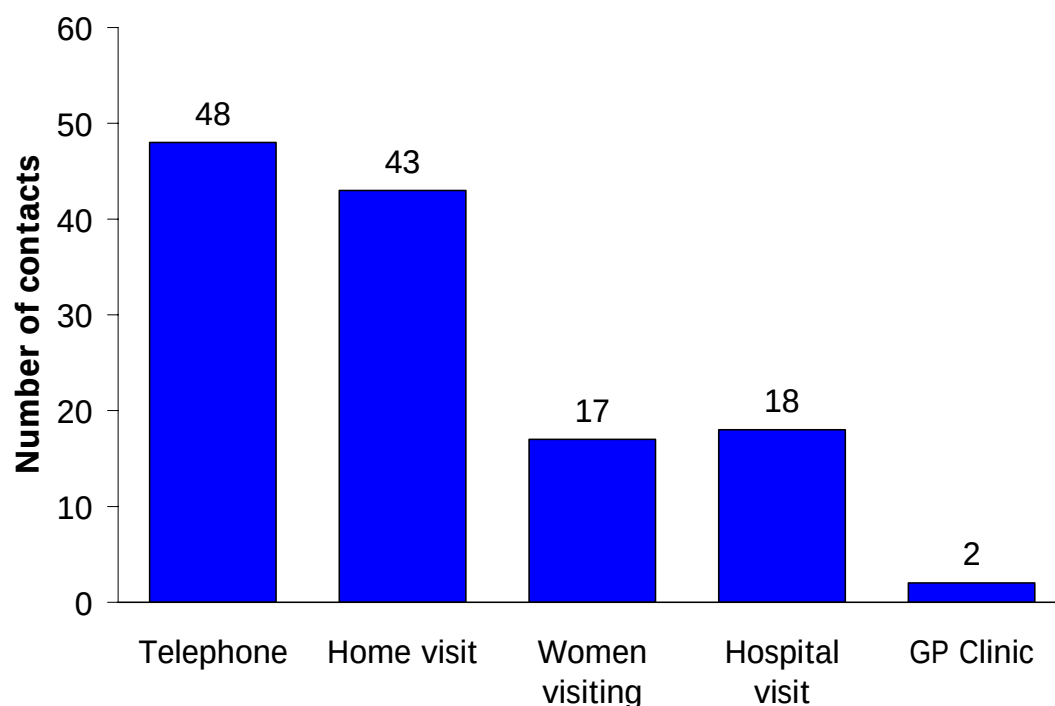


Figure 3 shows the numbers of postnatal contacts that were made with women. Most (48%) of the contacts were by telephone closely followed by home visits (43%). A number of contacts with women were also made at hospital (18) and these were mainly after birth. Only one woman was seen twice at a local GP Clinic. A number of contacts between women and the midwifery team were initiated by women themselves, mainly to find out about attending classes/activities set up by the midwifery team.

Eighty five per cent of the women interviewed were seen postnatally Sure Start midwifery team compare with only 30% who were seen antenatally.

Midwifery team referrals to other services

All women were asked whether the Sure Start midwifery project informed them about services other than health care services available locally and what these were. Table 20 shows these. The numbers do not add up to 33 as there was some women gave more than one response.

Mother and baby groups which included fun days out, discovery groups and soft play were reported most commonly by women. Seven women appear not have been provided with any information or were unable to remember if they were provided with information about any of these services locally.

Table 20: Information about other services available locally

Type of service	Number
Baby toddler group, mother and baby group	14
Fun days, discovery groups, soft play, list of play groups	8
None	5
Not sure, can't remember	2
Toy library	2
A pack of information in a binding folder, didn't read no time.	1
Activities about children, can't remember	1
Information about different classes	1
Something about social security can't remember	1
Information regarding child difficulties with speech	1
Support group - talking to midwife about problems with baby	1

Women were also asked whether the midwifery team was able to help them with any other needs they or their family may have had. Only two women reported being helped with other needs. In the quotations which follow, women's ethnicities are reported as White, Black, Asian or Any other to ensure confidentiality of the women's identities. One woman reported being provided with a safety pack for use around the house:

"(They) Give you a pack and observe your house. Pack tells you what you need around the house, safety pack for video, socket, door, cupboard so that children don't hurt themselves." ID 21, White.

The other women reported that one of the members from the Sure Start team wrote a letter for her to support with moving house:

"(name of Sure Start team) from Sure Start wrote letter to housing to help me to move house." ID 25, White.

It can therefore be seen that the Sure Start midwifery team referred women to relevant services and helped to ensure that other needs of women and their families were met

The role of the bilingual support worker

It is very evident that the bilingual support worker played a key role within the Sure Start midwifery project. All women were asked questions specifically about the bilingual support worker. The aim was to see whether they had received support from her and how useful they thought she was in terms of providing care and information to them and their child. An overwhelming majority 31 out of 33 (94%) found the bilingual support worker useful in her role. Only one woman mentioned not receiving any support from the bilingual support worker but this woman had been in Bangladesh for a while particularly at times when she would have received support from the midwifery team. Only one woman reported not finding the bilingual support worker useful but this did not reflect on the service the bilingual worker provided as the woman explains:

"Did not need her (the bilingual support worker)... telephone conversation useful, but moved away so had no contact would have liked advice from Sure Start of links or contacts to follow-up in area I moved to." Id 18, Black.

All women who reported finding the bilingual support worker useful were also asked how useful they found her and why. This was an open-ended question which had been thematically analysed and the results are reported in Table 21, using frequency counts to represent the commonality of reasons for finding the bilingual support worker useful.

The reasons described are in the women's exact words. The numbers of responses do not add up to 33 because each woman reported more than one reason why she found the bilingual support worker to be useful. Most women reported that she helped them with advice and support with general feeding and breastfeeding. The next most commonly mentioned reasons described the personal characteristics displayed by the bilingual support worker when working with the women. As can be seen, she was described as informative, experienced, knowledgeable and yet professional. The bilingual support worker provided support to most of the women in this study and not a single woman reported finding her support as unhelpful.

Table 21: Why the bilingual support worker was useful?

Reason	Number of women
1. Provided support with breastfeeding and general feeding	13
2. Gave most information, good advice, nice and friendly to talk to	7
3. Helpful, Informative, experienced, knowledgeable, professional	7
4. Informed where to go for help	6
5. Provided health and safety information	4
6. Followed up to see if everything was alright/needed anything	3
7. How to handle/manage baby, changing and washing baby	3
8. Left numbers of people to contact should I need help	3
9. Explained everything clearly	3
10. Advised to call her any time	2
11. Information about groups like toddler groups	2
12. Provided information about smoking	1
13. Support with non-health activities	1
14. Good point of contact if I needed anything	1
15. Showed exercise to do	1
16. Helped antenatally	1

The following direct quotes help to further describe the reasons why women found the bilingual support worker to be useful:

“Good advice, she gives information so nicely that it feels like it’s her baby, as though she is caring for her own baby. Very nice and helpful.” ID 23, Asian.

“Informative, gave me details of dietician, health visitor. Surprised she wasn’t a midwife, was very experienced.” ID 30, Any Other Black.

“She always informs me where and how to get information.” ID 7, Asian.

“She is very helpful; always calls me to tell me if class/group is cancelled and what else is happening in the area for baby and mother.” ID 21, White.

Women’s overall views about the Sure Start midwifery project

As part of our evaluation exercise we asked women a series of open questions placed throughout our questionnaire. We sought women’s views on their satisfaction or otherwise with the service they had received and what was good or bad about the service. Out of these free text answers, came suggestion and recommendations from the women themselves. We have summarised their responses below.

In general the majority of the women sampled in this evaluation gave very positive feedback about the work of the Sure Start midwifery team. This was true across the whole range of age, parity and ethnic groups in the study. In the women’s responses they usually describe the midwifery project or team as Sure Start.

The responses have been categorised into three groups, positive feedback, negative feedback and recommendations. These three groups were then thematically sorted and sub-categorised to draw out the key issues raised from the survey. The results are presented below using direct quotations from the women themselves.

Positive feedback

- **Approachable, warm and friendly**

The majority of the women in the sample found the midwifery project services to be a useful service in the area for them and their families.

“Best Sure Start programmes. Approachable” ID 10, White.

“Warm and friendly” ID 25, White.

“It’s good, everything is good about them” ID 1, Asian.

- **Concerned about people and make follow-up contacts**

A number of women reported that the midwifery team was great because it appeared to be concerned about people in general and this was shown in the follow-up calls made to women to see how they were getting along. Women also reported being able to contact the midwifery team when they needed something. It is clear from the two quotations from women below that the midwifery team had created a two way system for contacting women to see if everything is all right, allowing women to contact them when required and then following up women to see if all was well with them.

“Good with keeping track of people. They follow up to see how things are going. They are concerned about people and follow up to see if problem solved.” ID 25, White.

“They are very good, because I can call them when I want.” ID 14, Asian.

- **Point of contact for information**

The midwifery project was evidently providing women with information that helped other members of their family and direct links to other services outside of Sure Start working boundary. Women were seeing the Sure Start midwifery project as a point of contact for gaining information about other services, as demonstrated by what the following women have said:

“Helped to find out about speech difficulties for (her) son.”
ID 17, Any Other Black.

“Helped with seeing a dietician for my child” ID 28, Asian.

“Sure Start gave tel. no. of PALS (Patient Advice and Liaison Service) for me to get support on how to complain about the way I have been treated at the hospital.” ID 19, White.

- **Cannot imagine life without Sure Start**

The team had clearly impacted on local women's lives and they felt passionate about the service they had received and felt that the local area actually benefited from this kind of service. Women do want this type of service to exist in the area in the long term as two women described below.

“Without Sure Start I wouldn't have been able to cope. They are like your family, supporting all the way through. I hope they carry on existing in this area. If it wasn't for them, I don't know how I would have managed postnatally.” ID 21, White.

“Can't imagine life without Sure Start. People are wonderful, area benefits from it...” ID 10, White.

- **If hospital would match Sure Start services**

As many as 15 of the 33 women reported that the worst care they had received was at hospital, either before or after birth. None of the women reported Sure Start midwifery project services as the source of their worst care. One woman had made an explicit comparison between hospital and the Sure Start midwifery project and rated Sure Start services over hospital services. Four women reported midwifery project services as the best care they had had through out their maternity care. The following views emerged during the telephone interviews with women:

“If hospital would match Sure Start service that would be good.” ID 12, Asian.

“(describing best care she had) After care with (two names of the Midwifery team). Good with breastfeeding and other things with regard to other Sure Start activities like potty training.” ID 10, White.

"Sure Start antenatally and postnatally, personable, approachable, give time to ask questions. Use time to find out information for me like breastfeeding material." ID 19, White.

"Sure Start people, helpful, don't feel stupid asking questions to them, make me feel at ease. (names two bilingual workers from Midwifery team)." ID 21, White.

Negative feedback

- **Don't make much contact with women**

A few women reported that the midwifery team did not make much follow-up contact with women to explore how they or their baby was doing. There appeared to be variations within the midwifery team with regard to knowledge and providing additional information to women when requested as demonstrated by the woman with ID 28.

"...them to be more friendly. Should have phoned up for follow-up calls to see if I and baby is all right." ID 27, White.

"Helped with seeing a dietician for my child, but as I had to miss one appointment. I rang SS (Sure Start) to give me tel (telephone) of dietician they say there is no dietician in SS and don't give a no. for me to follow-up.... they don't make much contact" ID 28, Asian.

- **Don't go fishing for people's needs**

Some women thought that the midwifery team should make more effort to probe women for problems and get them to talk. These same women reported that the team was willing to help if women identified the problems they were facing.

"Sure Start should have pushed me more to talk Willing to help if you can identify it for them. They don't go fishing for people's needs. Had to pay postage for information wasn't nice, they said normally I wouldn't but because the pack of information I required were heavy I needed to pay. I haven't had chance to speak to them about it and ended up paying anyway." ID 27, White.

- **Not representing the community: feel isolated and excluded**

Some women felt very strongly about the midwifery project not representing the whole of the community and felt that the services being provided were predominantly for the local minority ethnic communities that were large in numbers.

“SS (Sure Start) not representing community, they don't cater for minority Arab ethnicity. Workers to be Arab or Black background. It would be easier to communicate with SS.” ID 29, Any Other Black.

“Some classes are dominated by certain ethnic groups/languages. No interaction. Wasting time going to these, feel isolated cause they talk in languages other than English, and would like to take someone with me so that I can talk and join in with someone at least.” ID 3, White.

“During hospital stay felt excluded because the Sure Start girls only spoke to Bangladeshi women and not me. They were bilingual so don't see why I wasn't given breastfeeding advice. I felt excluded.” ID 16, White.

Recommendations from women

- **Make follow-up contacts**

Although large number of women liked the midwifery project services due to the follow-up contacts they made with women there were a few women that did not receive the same kind of services, in particular those women who moved away from the Sure Start catchment area. Women also wanted the midwifery team to contact them about their views on the classes recommended by the team. This is a significant comment to make, particularly as one woman had negative views about one of the classes run by the Midwifery Project.

“... Would have liked advice from Sure Start of links or contacts to follow-up in area I moved to.” ID 18, Black.

“SS (Sure Start) should follow people up i.e. ring them to see how we are doing, how we found groups/classes they recommended...” ID 28, Asian.

“Liked statutory antenatal classes, more engaged, more and more no. of women attending. SS (Sure Start) dragging on more, concentrating more on how she was performing than teaching. Very few women attended.” ID 29, Any Other Black.

- **Information should be centrally monitored and distributed**

Some women wanted the midwifery team to inform them about activities going on more widely and that this type of information should be centrally monitored and distributed.

“On the whole +ve experiences with SS. SS didn't know how to go about things like information i.e. more flyers needed, days out, centrally monitored and distributed information...” ID 27, White.

“To inform more widely when activities are happening and where.” ID 7, Asian.

- **Information should be culturally and religiously sensitive**

None of the women reported that the midwifery project was in any way insensitive culturally or religiously. Given the diverse nature of the population within the Sure Start Collingwood and Stepney catchment area, however, a few women recommended that the team consider delivering information that could be tailored to include some cultural and religious issues, to meet the needs of the local women and families.

“Should have handouts on ...cultural issues around what to eat.” ID 33, Asian.

“Very good service. Consult with local women more about what they would like, ask them about what their needs are. Islamic thoughts around practices of maternity issues.” ID 30, Any Other Black.

- **More antenatal support and involve fathers more**

Other suggestions made by women are described below. One of these included involving fathers more, in particular in discussions around smoking.

"SS should provide support antenatally." ID 33, Asian.

"For Sure Start to get fathers involved, particularly with smoking." ID 7, Asian.

"Most information in English, would have liked them in Bengali. Also to talk about what to expect as a first time mother." ID 24, Asian.

Stakeholder Interviews

The synthesis and analysis of the 7 completed stakeholder interviews, the schedule for which can be found in Appendix 2, is presented below. It is broadly structured around the emerging themes but also specifically addresses the contribution of the project to meeting targets and the role of the bilingual support worker. Recommendations for how the project might be carried forward and lessons be learned are shown separately in a final section.

Benefits of the Sure Start midwifery programme.

This section explores the stakeholders' views on the general benefits arising from the midwifery programme. This is followed by separate sections describing its impact on breastfeeding rates, smoking rates and emergency admissions to hospital for children aged four and under and the role of the bilingual support worker.

Interviews were positive about the impact of the midwifery programme:

[Do you feel it is a valuable service]" Definitely, definitely, because a lot of the people would never have dreamed of accessing any sort of services." 5

"I would say that it was a valuable service." 1

An important feature of the project, highlighted by several interviewees, was the beneficial impact the midwifery project had had on identifying vulnerable clients.

"And one of the other things that I think I've really noticed as well has been in identifying more, perhaps more vulnerable families." 1

"I think because they're able to pick up and provide more intensive support to some more vulnerable women." 2

"I think there would certainly be pockets, or some clients, that we wouldn't have been able to maintain the contact if we hadn't had the project." 2

"it's a universal service to all the mothers in the Sure Start area, and instead of waiting for referrals or waiting for them to come to you, you can actually approach them and offer your service. So ... and that I think inevitably reaches the more disadvantaged people who normally wouldn't approach for help." 3

"it was targeting the most vulnerable they're the women who are going to end up having your highest, and the perinatal mortality rate is very high in the East End of London compared to the national average." 7

The ability of the project to give that little bit extra for mothers, and to establish a rapport with them, was a valued feature. This was both in terms of being able to spend more time with mothers and also being able to offer the women extra services not normally available from mainstream midwifery. Interviewees also highlighted the role of the midwife.

"Its ... the same sort of job as any other midwife, but with more time to put all the things that midwives should do into practice." 3

"So we actually have the time to sit down and talk about feeding, see how long they're taking to feed baby, any other issues say with the children, how's she getting on with her family, letting her know about services we offer with Sure Start." 4

"I think it's being able to offer extra services and making it really more accessible, and having more time to spend with families to get points across. and you've had extra resources that you haven't got on the statutory service, so that if you do see a mother that's depressed or you feel needs extra help, then you've got, you're paid to actually go and provide that extra help, so that's been a real good bit of the job." 6

"I think one of it is that it has got the time to chase up. For example I was saying about people ... they go round and they might not be there for an appointment that they should be there. It's having the time to sort of I suppose be a bit more persevering with that family. and if you have socially isolated women, who's going to listen to them about sort of just general fears and anxieties that

are perceived and may not be real, but they're struggling with, and the impact that has. So this team's been able to spend time doing that." 1

"I think the fact that we have the time, we have more time to go and see people, we can bring up a lot more things than just purely childbirth issues. We can talk a lot more about the benefits of breastfeeding. We can pick up on postnatal depression, pick up on if a mum feels that she's coping, we give her lots of support that she's doing fine, she's being a good mum. We can invite her to sessions that will help her develop as a mum and meet other mums as well." 2

"for the mothers to have someone outside their own family to talk to, so many people who are trying to help you, and it's for them to have someone with a health background or with some sort of knowledge on health and so on, they find it more reassuring listening to advice than say what the mother-in-law has said, or what their next-door neighbour has said or the auntie said, I think that was a really useful thing for them." 5

"We're talking about public agenda to get families more involved with services, and you get more involved if you develop trust, public profile, and accessibility locally really." 6

"some mums have really been inspired to go on and do courses and gone on to breastfeeding health courses." 4

This approach was seen to have had a positive effect on women using the service:

"I just think it's helped, you know, there are women who don't have obvious, really terrible social problems but are needy in one way or another, and it just sort of, I think, helps those women to know that there's somebody that can perhaps support them and has time." 3

"I think it has made people more aware of their health, of themselves, of their children as well." 5

Several interviewees made reference to the role the midwifery project had in linking in with other healthcare and social services

and the role it played in facilitating mothers' and families' contacts with these services.

"they're very closely linked to the health service, to the health visitors, the GPs." 7

"I think that's very good actually in terms of the midwifery project, and ...attend the Albion Baby Clinic on a weekly basis so there's a direct link there to the health visiting, ... but also there's a presence there that GPs I guess can be aware as well." 1

"We are a good liaison with our main health centre, which is the Albion Health Centre. The vast majority of our women come from there, so I get phone calls from GPs and the nursery nurse and the health visitors and if there's any issues concerning me I can get back to them quite easily. I talk to other mainstream health visitors if I've got a concern about a family." 4

"So I think we had a huge impact in that way, that people are more aware of all the services that are at Tower Hamlets, for themselves and their children." 5

"I think having a midwife visiting mothers who are having babies or just had their babies is a very helpful role in terms of engaging families at an early stage with add-on services." 6

Links were also forged with other, non-health related, services:

"So a lot of the time they would just pick up something about a housing problem or 'I'm having problems with my husband' or a woman would tell them and we could refer them on confidentially to another service within our own team, or the mainstream health services. And I think because of the relation we had with the mainstream health service as well, that made it easy for them to refer to us and us to refer to them as well." 5

"there's been quite detailed and quite intensive work with social services, so it's been good." 2

"So the midwife and the co-worker have made quite a lot of referrals to FWA, Family Welfare Association, to provide more in depth support to families." 1

Respondents were clear about the importance of the interaction between the Sure Start midwifery project and mainstream midwifery services. Integration was key to them, not only in terms of avoiding duplication of effort but in terms of fostering positive working relationships.

“When the project was first being discussed what we made sure is the two team leaders at that point were very much involved in shaping the project and what they felt the need was from the midwifery perspective and how that could be fed into a project proposal. and it’s also helped to foster quite good working relationships, so referrals are fairly smooth and communication’s quite smooth between the project and the existing team, which is crucial, otherwise you do get the mainstream team sitting back and thinking ‘right, I don’t need to worry about that. That’s all sorted,’ whereas that’s not happened I think.” 1

“So basically there’s just a lot of cooperation and working together and not ...trying very hard not to duplicate services.” 3

The close working had an impact on mainstream midwifery services too:

“I know that the midwives have been working really well in terms of the UNICEF Baby Friendly Initiative ... they’ve been working really closely with the mainstream services on that initiative. So that’s I suppose ... a really positive thing, and they are making an impact there and there have been proposals submitted that have had to be signed up to by Barts and the London primary care trusts, about going forward for Baby Friendly status.” 1

“they’ve been good in looking at and really challenging how mainstream services provides care, so it’s been quite positive.” 2

Several features of the project were identified as being key to its success. Not least of these were the staff employed by the project:

“I think as well it’s down to the dynamics within the project team. They were very confident workers so they were able ...not waiting, but they were able to take steps and make sure that they were speaking to the right people.” 1

"Well crucially I think what makes it work well is having the right people in post. With having the kind of ...midwives that enjoy working in a very flexible, a kind of less restricted way, and it doesn't suit all at all." 2

The project was seen as being complementary to the mainstream midwifery provision, able to add a bit extra to the care women received.

"We don't try to repeat any of the stuff that the midwife does at the clinic or anything. What we would do is we would try to compliment what they are doing." 5

"Well I think it's hard to quantify, it's hard to describe really, because it's just that added extra to normal midwifery care really." 3

"it's been great to have an opportunity to work in a different way, and I think we'd all say that, where we can be more creative if you like, in our response to situations, and be well supported in terms of office space and colleagues, and appreciated I suppose." 6

"So the midwifery team have very much welcomed the additional support." 1

"So I think they did communicate very well, and it's that extra support for the team." 7

The specific role of the Sure Start midwife was identified as being different from that of a mainstream midwife:

"it's very different from being a mainstream midwife and probably not everybody would want to do it, because it's not clinical midwifery and it's midwifery in quite a loose sense, but it's a really good opportunity for those midwives who want to develop their careers." 4

"I think it's the kind of public health aspect of midwifery care, which sadly seems to get eroded away at the expense of riskier aspects that midwives need to deal with or targets that midwives need to ensure that we meet, and those kind of public health issues and just general parenting, and just general listening and supporting,

which all new parents need, and those are the kind of things that have got chipped away.” 2

Problems and issues arising from the Sure Start midwifery programme.

While the impression was overwhelmingly positive, the project and the way it operated was not without criticism.

There were problems with the interaction with mainstream midwifery services. These were driven by a number of factors, including services being overstretched, poor communication and the isolation of the Sure Start midwifery project from mainstream midwifery services.

“I think initially there was some, the Sure Start midwives and the people really pushing for that work and coming up with some quite strong ...well not resistance, but ...well, probably some resistance.” 1

“There were anxieties that they were based away from mainstream services for too long and you wouldn’t get those interactions.” 2

“I don’t think there’s really an understanding on how chronically under funded mainstream services are.” 2

“the mainstream services are very pushed and they don’t ...first of all they’re not able to have the time to spend with the mothers.” 4

“the maternity services here ...have got thirty less midwives in the whole-time equivalent establishment than what they should have. and when they did the community estimate of staffing levels, they were 50% under. and only about 15% of our women get parent-craft classes, and then selective postnatal visiting, and I don’t think they get as much support during the postnatal period as they should.” 7

The tensions within the service derived by funding and other factors created the possibility for antagonism to develop between the project and mainstream midwifery.

"I mean it can create antagonism if people feel that somebody's got an easier job, as it were, whilst they're working really hard picking up on stuff, when somebody's just taking on little bits." and

"can make it, work not so well is this kind of them and us aspect." and

" I know within the unit there is a perception that the Sure Start midwives have a bit of an easy ride of things; it's a bit like a holiday camp almost." 2

"I think it has had some conflict between the in-house midwives and ...like ZXXX, because they haven't had an understanding of what the Sure Start services are and the midwives in the statutory service are working in a very pressured way." 6

Dissatisfaction was expressed with the communication with other agencies and within midwifery, within Sure Start across the borough and with mainstream services.

"I talk to my Sure Start colleagues probably more because I see them more. And so ...I have got opportunities to referrals and also for feedback from the staff. [IA] If I need to contact my mainstream colleagues I can do, but I don't ... I don't see them on a daily basis because I'm not in the same area." 4

"We interact as far as I try to go up there at least once a week just to say hello to the other midwives. I mainly work with two teams, the Globe team and the Stepney team, and don't have a great deal to do with them, to tell you the truth, just because it's not practical that I do really. I need to be getting on with my work." 4

"they need to get the health visitors on board to do that with us, and in principle they are on board, but there's a difference between how it actually works in reality and actually getting the job done." 1

"So flow of information I think probably could have been better". 6

"But perhaps communication between maybe the midwives on the ...you know like I was saying about

identifying when there is a need ...I don't know. Maybe it seems like we're doing it all from scratch if you like, whereas maybe there's a bit more information that could be shared." 1

A powerful theme that developed was one of not knowing what was going on in the wider context for the Sure Start team in the project context for mainstream services.

"I think if it was right from the beginning I think we would have tried to go for a borough-wide approach, which other maternity units at the time did with some success. So that we would ...and it's something that we're doing with the children's centres now, but also going for a borough wide approach with a team of midwives that can impact across the sector of midwifery care and target a particular group of women, whatever that may be. I think the difficulty is for Tower Hamlets, I mean with seven programmes it kind of states how deprived and difficult a borough it is, so the kind of ...your goal posts get ever so wide on what makes somebody vulnerable or what ...I don't know ...shocks you. So it would have been difficult, but I think we might have been able to demonstrate a greater impact with a kind of ...rather than little pockets of midwifery activity going on, to have something across the borough, and perhaps more cohesive rather than three days a week here, four days a week there, five days a week somewhere else. But things came on board, so there was waves of the Sure Start, so things were coming on board at different times." 2

"even though they were under the management of the maternity services I don't ever ...I don't feel I had a real handle on what they were doing." 7

"I think it was the way it was set up. I could be very wrong, but I think it was the way it was set up in this particular ...but I'm talking about the whole Sure Start in Tower Hamlets." 7

"I don't know if anyone had a real handle on what ... the programme was doing in general, and so you had individuals like my girls doing their caseload, doing whatever, but I don't think there was any robust management of it throughout the project. And I could be very wrong, but it was just ... my impression. So that when the children's centres came on board I went and said, 'look, you know, I'm not prepared to go down that

route again. I would be happy to consider another route but I would want to do a, b, c, d.' Which is what they've agreed to." 7

"I think what I would have done, which has happened in a lot of other areas, rather than the Sure Start being isolated that actually what the Sure Start board should have probably done was come together and said 'right, what is it we need to provide across the whole of Tower Hamlets?'" 7

"Ideally it would have been better if they were all ring-fenced into one team, which has happened in other areas, providing antenatal and postnatal care to these women, it was their caseload and they were actually able to do parenthood education, so they're actually looking at their defined caseload or with a defined number." 7

There were also problems in contacting women antenatally, partly due to poor communication with mainstream midwifery.

"But perhaps communication between maybe the midwives on the ...you know like I was saying about identifying when there is a need ...I don't know. Maybe it seems like we're doing it all from scratch if you like, whereas maybe there's a bit more information that could be shared." 1

"I know we're still finding it difficult antenatally in terms of contacting people antenatally, which ...again people who are accessing mainstream antenatal support, so maybe there's something about information sharing there, especially picking up on those families at that point, because there would be knowledge about whether there's specific needs." 1

"And I don't think we've as easily been able to access data around antenatal." 1

Meeting Targets.

Because of the importance of meeting government specified midwifery and Sure Start targets we asked the respondents about how they thought the project helped to meet government targets,

as well as reviewing the monitoring data discussed at the start of this report. We were primarily interested in the project's perceived impact on breastfeeding rates, smoking and emergency admissions to hospital for children.

It was clear that respondents felt the project had had a beneficial impact on breast feeding rates.

"I think one of the big impacts is obviously on the breastfeeding rates, which the project does link with the breastfeeding support project, but in the early stages of the project our actual breastfeeding support workers and so on were on maternity leave, so the midwifery co-worker did a lot of the support work around breastfeeding information and the rates are actually quite high for exclusive breast ...you know, they have gone up, and there is actually some statistics to back that up as well, although I don't have it to hand." 1

"Breastfeeding's probably the biggest strength." 2

"Yes. I think it does help, and it certainly helps ...it helps those mums who are already breastfeeding to stay breastfeeding for longer, and supports them and hopefully reduces mix-feeding somewhat." 4

"I think it's been a tremendous success to be honest, and a lot of people have said they did not know the benefits of breastfeeding before Sure Start and a lot of people have said they would not have exclusively breastfed the baby if it wasn't for Sure Start." 5

"I know that breastfeeding uptake has improved and I think they've done very well actually, I think they've done extremely well." 7

Views about smoking reduction targets were more complex, because the service saw very few mothers who smoked:

"Smoking is a bit more difficult I think to gauge really, because in terms of the baseline data that we've got for smoking it shows that it's actually very few women smoking during pregnancy." 1

"The smoking isn't very much of an issue with the mums I see. I've never come across a mum that ...well I've come

across one mum that smokes. It tends to be the husband, and I have made quite a few referrals to the smoking cessation, but I don't know what their follow-up has been, but it's certainly a thing that I always mention." 4

"We don't actually, because we deal mostly with mothers and female clients, I mean we do see the families and we do sometimes see the fathers, but most of the time I think, 90% of the time we were only seeing female clients not the families, all out working or something. And I think last year the Bengali mums that we saw did not smoke. OK? There was very few, some, very few I think, one or two that I remember, did smoke." 5

One respondent did raise the issue of tobacco chewing

"There's not that many women that smoke in our area, they're mostly Bangladeshi, but we have picked up on tobacco chewing." 6

Smoking was still an big issue, however, not among mothers but among family members, especially fathers:

"It tends to be the husband, and I have made quite a few referrals to the smoking cessation, but I don't know what their follow-up has been, but it's certainly a thing that I always mention." 4

There was a strong sense that intervention should be with the whole family and the father was needed:

"It tends to be the husband, and I have made quite a few referrals to the smoking cessation, but I don't know what their follow-up has been, but it's certainly a thing that I always mention." 4

"The partners that smoke. And again we would say to them, talk to the partners if necessary, and if they wanted to give up smoking they took our numbers, we got a few calls but not many." 5

[And are the husbands amenable to anti-smoking intervention? Interviewer]

"Yeah, sometimes, yeah. I mean especially with first time parents, you can have a way in really because you're talking about looking at their lives and having a child and

smoking around a child, and people are quite motivated, I think, when they're expecting their first baby." 6

"perhaps more there's a case for us really about promoting it within the family ...well not promoting smoking! <Laughs> Preventing smoking within the family more generally." 1

There was also the issue of how the benefit of the Sure Start midwifery project should be measured.

"I think it was quite difficult too <interruption>...because it's quality it's quite hard to measure, whereas with midwifery mainstream services they're able to say 'well actually we did so many antenatal appointments, we did so many bookings, so many visits,' and that's harder to measure, and because they were all kind of working slightly isolated, even though as a team they got on very well actually, for the midwives on each of the different projects." 7

Emergency admissions to hospital for children under four years old were not felt to be a big issue.

"I'm not aware of any that are children ...we've been to see some children ...some babies that have already had emergency admissions. Erm ...but they tended to be for something that couldn't be prevented like jaundice." 4

"Emergency admissions, we haven't really." 1

There were questions about the poor quality of data on emergency admissions:

"I guess then that goes on to emergency admissions for gastroenteritis and my understanding is that by promoting exclusive breastfeeding we reduce the likelihood of that, but we don't have that much accurate data on emergency admissions, so I don't fully know the actual data for that."
1

The lack of a joined up service with health visitors and the possible impact of this on emergency admissions was mentioned:

“they need to get the health visitors on board to do that with us, and in principle they are on board, but there’s a difference between how it actually works in reality and actually getting the job done.”¹

The bilingual support worker.

The importance of the role of the bilingual support worker was recognised by all the respondents. Indeed it was often regarded as essential not just as an interpreter but also as someone who was culturally attuned to many of the mothers.

“Well things that I think make it work well is having the bilingual support, because that is certainly an advantage...well, needed really, I won’t say it’s an advantage, I think it is essential in this area.” ¹

“Well I think the support worker’s vital.” ³

“OK. I mean yeah, they’re invaluable. We can’t do our job without them.” ⁶

“I think it’s invaluable to the project, especially as the majority of our mums either don’t speak English or don’t have very good English, certainly not the level of English that you could have a good conversation with them about the targets that you’re trying to reach. So she’s invaluable as far as that’s concerned.” ⁴

“I think working in Tower Hamlets and Stepney and Collingwood especially, I think someone has to be a bilingual worker; we know that definite aspect of it. Otherwise people don’t feel they can talk, and because even though they might have questions and stuff they might not be able to communicate it and I think there’s a lot of tradition and cultural stuff.” ⁵

“it does mean that you haven’t got to rely on family members to translate, which is full of pitfalls, so if you have a skilled midwifery support worker that’s a very valuable asset.” ³

The role of the bilingual support worker was also seen in a broader context beyond being a translator and being culturally aware. The role was perceived as a co-worker in the midwifery team, someone who was able to work on their own with mothers too.

"I think what I liked about this one was that they had a midwife and the advocate, the support worker, together, and ... I think you got the best out of the midwife but actually you got a lot out of the support worker that a midwife would have been traditionally doing elsewhere, which actually the support worker was doing, and financially I think that would have been cheaper and I think it's ...you know the support worker is a Bengali support worker, so she was part of the local community, so ... she would have an in depth, more understanding of the issues and she probably was able to communicate more effectively with the women and get the message across." 7

"And also it's bilingual support, they're very much part of the team, so it's not somebody coming in to do a bit of interpretation. It's somebody that is actually getting trained." 4

"That worker's actually been a full time role and so been able to develop the role themselves and get their own skills and, for example like the baby massage training." 1

"They could offer different things as well as providing the often much needed language support, they could offer actually a wider role than bilingual support." 1

"it doesn't always have to be a midwife. That did reinforce that home, well to me particularly, and there was some learning from that. Because I think when you're stretched and pushed, only a midwife can do these things, you become very protective and you can't really think outside the box about how you provide the different care." 2

"I'm doing a lot more visits and stuff without the midwife. You know, I'm doing , I'm doing a lot more. And a lot of the cases I felt like I was doing the midwife's role."
[anonymised]

The role of the bilingual support worker was not without its problems. There were issues of confidentiality within a relatively circumscribed community.

“There’s always an issue in the Bangladeshi community of people knowing each other, which sometimes makes some mothers reticent about talking with the bilingual support worker. So as a midwife I’ve had mothers say ‘I just want to talk to you directly’ but of course if they don’t speak the language they’re not able to do that. So I mean that’s the caveat really.” 3

There were also issues around the appropriateness of the role, what should a midwife be doing and what should the support worker be doing.

“In order for it (bilingual support worker) to be fair on the mothers as well, they needed to see a midwife (as well as a support worker).” [anonymised]

“And a lot of the cases (the support worker) seemed like (the support worker) was doing the midwife’s role.” [anonymised]

“the midwife should have a little more involvement in the project.” [anonymised]

It was accepted that the person required to do the job of bilingual support worker could be just anybody.

“Well I think it has to be the right person. I’m someone who works with support workers all the time and ... some are excellent and some not quite so excellent.” 3

“You need to ensure that the support workers are someone who respects confidentiality and appears trustworthy to the mothers, because there is this big issue of everybody knows everybody and there’s all inter-relations. It is an issue.” 3

The future.

Respondents were generally unsure about the future that the introduction of children’s centres would hold. In particular, there was an anxiety that the essence of the Sure Start midwifery programme would be lost in the process. It was felt that this would impact negatively on the care that women would be able to receive, especially the time to identify needs which may not be immediately apparent.

"I think that's the beauty of Sure Start that will unfortunately probably be a bit lost when we move in to children's centres, that you can actually, you know, it's a universal service to all the mothers in the Sure Start area, and instead of waiting for referrals or waiting for them to come to you, you can actually approach them and offer your service." 3

"the whole ethos in terms of midwifery in postnatal case is very much like numbers. It's not actually about what we're offering." 6

There were particular anxieties about the role of the midwife in the new set up.

"it's quite hard work, working with vulnerable people all the time, so for a midwife it's quite nice to have a bit of a mixed caseload, where you have some people who are a bit more straightforward. I think the midwives are worried that they'll need support as well if they're just concentrating on the very needy families, without having a bit of a balance." 1

"I'm a bit concerned that the local links will be weakened and I'll be chasing my tail all over the borough." 6

There were also concerns that the new service run from children's centres might be doing work that should be the role of mainstream midwifery.

"the children's centre targets are being used to provide a service that perhaps should be provided by mainstream services." 4

So having a team that targets vulnerable groups is very much, in your view, a mainstream midwifery function?
[Interviewer]

"Yes. I think it's valuable one, it should be there, but I don't think it's a children's centre thing." 4

The lack of provision for support workers in children's centres was an issue

"it didn't include any support worker provision, the

proposal, so that's the other thing that's been highlighted." 3

Respondents were more positive about the ability to learn the lessons from the Sure Start midwifery programme and incorporate these into the models of midwifery provision for the new children's centres, particularly where such innovations would be resource neutral. Some felt it was a rushed process, though.

"we are meeting to see how we can keep going with the transition into different projects and keep the good points going in how we mainstream it." 2

"What can we continue in terms of working practices which may not need additional staff, because we don't have the money for them." 2

"We want to see what's already working quite well in some of the localities, and whether we can pick that up and continue. As ever it's a bit lastminute.com isn't it really, trying to get it finished in March, but we're trying to identify, but I don't know yet, fully." 2

Being able to link and network with local services was seen as a particularly valuable feature of the Sure Start midwifery programme. Respondents felt that this was something that could be positively taken forward in children's centres.

"One of the things that the Sure Start midwives have said all the time is that the most valuable thing is the kind of links that they've been able to develop with the localities, other local services, ones that many healthcare staff don't traditionally think of. If there's an issue, people immediately ...say if there's a family issue people immediately think social services and that's the only option, whereas they built up a lot of local intelligence about other things families can be directed to or told about, that can have really good benefits. And I think those are some of the good things that they'll bring into this new programme." 2

"I would like to see in my role that our fruitful links with the psychologists for example, locally, develop, so it's not just me having easy access to them, but it's my team colleagues, and I can see that sort of seeding out across Tower Hamlets so that they have an opportunity

to have supervision as it's called, support for troubleshooting on difficult situations and families, because it's quite hard work." 6

Despite the anxieties about the future of "Sure Start" midwifery in the children's centres there was a realisation by all respondents that there was a need to be realistic about resources. In particular, it was appreciated that the same level of service could not be provided on the same budget for the whole borough.

"Well it's resource led isn't it? I mean we've covered a small area, so we've got to cover a bigger area." 6

"it is difficult to see how a similar service is going to be carried forward, unless more money is forthcoming to employ more midwives." 3

"the funding that the children's centres offered us ...was exactly the same amount of funding that we receive from Sure Start at the moment with four ...four or five, gosh, four projects. And there's absolutely no way with the best will in the world that you could multiply those programmes to provide a borough wide approach. It's just impossible." 4

"I think obviously looking ahead to children's centres we're going to be servicing every family throughout Tower Hamlets, so we have to be realistic about what resources are going to be available and we have had, we have been in the fortunate position where we have been able to say OK, well our midwife will aim to visit every family in our area. I don't think we're going to be able to do that and we do need to perhaps be targeting more families." 1

"If we're looking at reaching it's something like 19,000 children under five or something in the area. So it's not just health, it's all our services that are affected by this, and I suppose in a way, in some ways I think well, you know, it is making people think about how they're going to mainstream services quicker than they would have done." 1

"The reality that we have in community services is that we've got 24 whole-time equivalent midwives working in the community, we undertook a birth-rate plus audit,

which is a midwifery workforce planning tool, and we're just under 24 whole-time equivalents short. So we have only funding for half the midwives that we physically need, so the reality is not a lot is going to be able to be picked up." 2

"we have secured funding for a midwifery team, only four whole-time equivalents across the borough, to provide midwifery care to vulnerable women, with particularly mental health needs and domestic violence and so on." 2

The response to the lack of resources was an acceptance of the need to focus on vulnerable families, although this approach is not without its dangers.

"I think in terms of moving to children's centres, we're having to think about how our, for example, family support work, how do we target that and how do you ...because it's all very well saying you need a targeted approach, but it's how we know who to target." 1

"four out of the seven Sure Start's have a midwifery project, so for example some of the target is the midwife will see all the women in the catchment at some stage, I mean you couldn't do that across the borough with four staff. You're looking at 5,000 bookings. It'd just be crazy, and it wouldn't even be worth attempting just to tick the box. It's not worth midwifery time trying to achieve something that ...so we had to look at something else in targets." 2

"people are worried about who do you target, how do you get referrals, the caseload might become overwhelming." 3

“The majority of women that I’ve picked up with issues such as postnatal depression and domestic violence,the vast majority of those women have been non-targeted Women.” 4

“Because most of them have come from quite ... you know, comfortable ...they certainly don’t meet the criteria that the vulnerable thing would ...” 4

“I just think we probably need to be a bit more structured in a sense of finding women I think, in order to provide an effective service.” 5

“we’re having the discussions at the moment about how we’re going to get those vulnerable families, and I think in the Sure Start areas we’re getting them anyway, and if I look at in my area I’ve got a self-selecting group of women I’m seeing. They’ll fill all the criteria in terms of homelessness, prison, domestic violence, asylum seekers, teenage pregnancy. We’ve covered everybody really. Mental health problems.” 6

Discussion and conclusions

The midwifery project had seen 183 women at the time of the study. Due to the small numbers, it was difficult to detect clear trends in the various maternity and perinatal indicators laid down for Sure Start projects. Despite this, some findings have emerged from the routine data.

Meeting Sure Start targets

The population of Sure Start Collingwood and Stepney has a high level of low birthweight babies, 11.7% in 2004-05 which is higher than Tower Hamlets and much higher than the figure of 7.9% for England as a whole in 2001. While there did not appear to be any increasing or decreasing trend in low birthweight, the overall level of 13% for the four year period of 13% is very high, compared to England as a whole and to the rest of Tower Hamlets. In general, low birthweight is associated with poorer development and poorer health in later life although the overall lower birthweight in South Asian populations may have to be taken into account.⁽⁵⁾ It would not be expected that the midwifery project, which had been running for only 15 months, would have had a measurable impact on local birthweight distributions.

Quite clearly, antenatal and postnatal support increased during the life of the project, with the level of antenatal visits increasing as well as postnatal family visits which increased dramatically from 60% to 71% of families. The level of breast feeding also increased and remained steady at a high level. Of the women interviewed 91% commenced breast feeding and 75% were breastfeeding at 6 weeks. It is impossible to comment on the rate of emergency admission to hospital for children aged 0-3 years as the data are inadequate.

The survey of service users

A quota sample of 80 mothers was chosen for the survey, to reflect the age range and ethnic diversity of mothers in the area. Thirty three mothers agreed to take part, the majority of whom (58%) were Bangladeshi. The sample also included White British, Pakistani, White Irish and Black/Caribbean mothers and 12% from other ethnic backgrounds. Forty nine per cent of women were born in Bangladesh and only 39% were born in the UK.

Only 30% of the mothers spoke English at home, but 67% felt they were able to communicate effectively in English. Thirty-three per

cent had little fluency in English or spoke none at all. Sixty-four percent of mothers were multiparous but there was no association between ethnicity and parity. Most women (78%) reported that their health was good but 24% also reported that they had a longstanding illness that limited their activities.

Only 18% of the mothers smoked and only one did so during pregnancy. Fifteen per cent chewed Paan, a tobacco containing product. Most women had received information from the Sure Start Collingwood and Stepney midwifery project on smoking cessation and found it useful. Thirty per cent of the mothers in the study reported that their child had had an emergency admission to hospital in the last 12 months.

Women were also asked about their experiences of the Sure Start Collingwood and Stepney midwifery programme. All women had routine antenatal care and 50% received all their antenatal care from a midwife. Although 70% of women were aware of antenatal classes, only 30% attended them. The main reasons for this were reported as being unaware of the classes or being too busy.

Eighty two per cent of women breast-fed their babies and the Bangladeshi mothers breast fed for the longest time. Overall 24% of mothers were still breastfeeding at six months. In 57% of cases women received their breastfeeding advice from Sure Start Collingwood and Stepney.

Overall, 30% of women had some antenatal contact with the Sure Start project, mostly by telephone but many more, 93% of women, had contact with the project postnatally. Nearly half, 48%, of contacts were by telephone and 43% were home visits. The remainder of contacts with women were in other setting, including hospital and women visiting the Sure Start Collingwood and Stepney office. The project was also an important source of referral to other voluntary and statutory services locally.

An overwhelming majority of women, 94%, found the bilingual support worker useful. Women found the support worker particularly helpful for general feeding and breast feeding advice. The support worker was also highly valued for her own personal attributes. She was described as informative, experienced, knowledgeable and professional.

Mothers were also asked to share their overall views on the Sure Start Collingwood and Stepney Midwifery Project. On the positive side, mothers found the service to be very approachable, to be warm and friendly and a useful point of contact for information and

advice. Women experienced the service as being concerned about them. This was evidenced by the follow-up contacts the service made with women to see how they were getting along. Mothers felt quite passionate about the service to the point where some women said they did not know what they would do without it and said they wished hospital services were as good.

On a less positive note some women felt that the service could have made more contact with them and that they sometimes got different messages from different individuals within Sure Start Collingwood and Stepney. Several women also felt that the project could have made more effort to probe for problems women were experiencing although they did feel once the problem had been identified they were well supported. There was also a feeling, particularly from women from minority ethnic communities other than Bangladeshi, that the service did not cater for them very well and was “too” focused on the Bangladeshi community.

In terms of what women would like to see, the need for more follow up contacts was high on the list of priorities. Another priority was a desire to have more information about what was available and what was going on. Some women also wanted the information to be more culturally specific in an Asian and an Islamic context. Women also felt that there could be more involvement of fathers especially in discussion about smoking.

Stakeholders' views

Analysis of the seven stakeholder interviews indicates that the project was valued. In particular, the role of the bilingual support worker and the ability of the project to take that extra step that mainstream services are unable to, due to time and resource constraints. This applied especially to the ability to identify vulnerable clients. It was felt that the project had had a positive effect on mainstream midwifery services and was a valuable link to other services both in health care and social care.

Respondents felt that the project had had a significant impact on breastfeeding rates but were unsure whether it had had an impact on smoking and emergency admissions. Among the principal features identified as sources of the project's success were the personal qualities of the staff involved, particularly the midwife and the bilingual support worker.

The biggest fear of respondents was that the move to children's centres would disadvantage the client group as universal coverage would no longer be provided. Universal coverage was felt to be key

to delivering services to the most disadvantaged families as these people are not always on the "radar" of mainstream services. The midwifery project had the time and resources to uncover hidden problems that mothers, children and families were experiencing.

In terms of taking the project forward, time and policy have intervened and children's centres have already been established. There are still valuable lessons that can be learned and incorporated into children's centres to a greater or lesser extent. They are probably equally applicable to other potential future configurations of non-mainstream midwifery provision.

Observations and recommendations

A number of observations and recommendations have arisen from our work. They are loosely grouped around three themes, the personal qualities and role of the Sure Start midwife and the bilingual support worker, the organisation of a local midwifery service to complement mainstream midwifery services and the women's experiences of the service.

The personal qualities of the Sure Start workers

The personal qualities of both the midwife and the bilingual support worker were identified by both the mothers and the stakeholders as key to the success of the project. In particular, they had good interpersonal skills and a broad professional knowledge, together with an ability to work proactively and on their own initiative. Personal qualities are very difficult to embed in a system, especially a system in change but thought should be given to identifying individuals with these skills for future roles. It should also be borne in mind that the success or otherwise of future projects could be quite person specific.

The bilingual support worker played a particularly crucial role in the project and evidently provided support to the vast majority of the women in this sample. Not a single woman reported finding her support as not useful, this view was shared by women from all ethnic groups and ages. Women also received the majority of their breastfeeding support and information from the midwifery project itself and, in particular, from the bilingual co-worker. This should be taken into consideration when planning future services in the children's centres. Careful monitoring of the bilingual co-workers work activities and style of work should be used when planning similar services in the future.

The relationship between children's centres and mainstream services

Now that children's centres have been established, it is important to continue as many as possible of the valuable elements of Sure Start, including the public health role of the midwife. Inability to provide a bilingual support worker may create real problems. The role was not just a patient advocacy and translation. It was almost that of a fellow professional complementing and enabling the work done by the midwife. The ability to identify vulnerable clients, a feature of the project highlighted by women's desire that the midwife ask more probing questions to identify needs, may be impeded by the targeted approach taken rather than the universal coverage provided in Sure Start areas. Furthermore if the children's centres take a very focused approach to vulnerable mothers then the workload may become too onerous. The planning and staffing of the midwifery component of children's centres should take this into account.

The organisational elements refer mainly to recommendations and observations that focus on communication, both with external organisations and within midwifery services. It will be important to retain the links that each of the midwifery projects has established with local healthcare and non-healthcare providers. This is based on developing local knowledge so that referral is an active process and not a passive one. For instance rather than a blanket referral to say a local social services department, there are possibilities for referrals to a particular project or voluntary organisation which might be the most suitable source of advice and help. The midwifery project has been able to help a number of clients with these kinds of referrals. Children's centres may well prove be a good place to capitalise on all the individuals' experience and local knowledge so that these referral links can be shared across these board.

Parallel to these rich local contacts there have also been communication problems in the past, particularly with other agencies. This may be because of the difficulties experienced by small projects in making themselves seen and heard. Bringing agencies together in children's centres may well help with this as midwives can share contacts and there is one easily recognised point of contact for outside agencies and individuals.

There have also been some communication problems with mainstream midwifery services, partly due to the perceived "ease" of being a Sure Start midwife. These may have arisen from an incomplete understanding of the project and have also been related to resource and time pressures within mainstream services. It is

important that the children's centres continue to complement mainstream midwifery and do not duplicate or replace services.

In terms of evaluating the new provision in children centres, a clear lesson learnt from evaluation of local Sure Start projects is that borough wide targets are more appropriate than targets for small areas. In small areas, numbers are too small to detect whether changes have occurred over time in response to interventions or provision of additional resources.

Recommendations based on women's views of the project

Lastly but no less importantly are a number of specific recommendations for the services that are delivered from the women who took part in the evaluation.

Many women did not attend antenatal classes either because they were too busy or because they did not know about them. This is reflected in the timing of contact with mothers. Many more women were contacted postnatally than antenatally by the Sure Start midwifery project. The women interviewed wanted to be contacted antenatally. This is an important window for intervention as contact in this period is likely to have an influence on women's knowledge and awareness of issues related to health behaviour in pregnancy. One area that may help to increase antenatal contact is to review the approach to the timing and publicising of antenatal classes.

Another issue that was raised by women was smoking cessation. This was not a big issue among the mothers who accessed the service as smoking rates were low. The biggest need was for smoking cessation in the home, principally amongst fathers. Both women and stakeholders identified this as a priority. It may also be possible to combine this with involving fathers to a greater extent in the antenatal period.

We also suggest that the impact of chewing Paan with tobacco during pregnancy should be explored further and included in all health promotion and prevention activities, as data from this evaluation suggest that some Bangladeshi women continued to chew Paan with tobacco during pregnancy.

Bangladeshi women clearly needed the services provided by midwifery project and were the largest ethnic group in the catchment area but women from other minority ethnic groups in the same area and felt that their needs were ignored. They expressed the view that there was too much emphasis on Bangladeshi mothers and Sylheti speakers. It is therefore important to undertake a needs

assessment of the needs of smaller ethnic minority groups in areas where one group predominates.

Some mothers also felt that more culturally specific information was needed, in an Asian and an Islamic context, particularly relating to feeding issues.

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Appendix 1 Service Users Interview Schedule

Telephone Interview Schedule: Service Users

Study ID:

Date:

Sure Start Stepney and Collingwood Local Programme Midwifery
Project Evaluation

1. Demographic Details

1.1 Your age group:

- ☐₁ 18 – 19
☐₂ 20 – 29
☐₃ 30 – 39
☐₄ 40 or over

1.2 Place of birth:

- ☐₁ UK
☐₂ Ireland
☐₃ Bangladesh
☐₄ Other (Please describe)

1.3 Ethnicity:

White

- ☐₁ Irish
☐₂ British
☐₃ Other White

Asian or Asian British

- ☐₇ Indian
☐₈ Pakistani
☐₉ Bangladeshi
☐₁₀ other Asian

.....

Black or Black British

- ☐₄ Caribbean
☐₅ African
☐₆ other Black

Any other (Please describe)

- ☐₁₁.....

1.4 What is the main language you speak at home?

- ☐₁ English
☐₂ Sylheti
☐₃ Both
☐₄ Other (Please describe)

1.5 Fluency in English language:

1.5a Do you find English easy to understand?

- ☐₁ Yes
☐₂ A little
☐₃ No

1.5b Do you find English easy to communicate in?

- ☐₁ Yes
☐₂ A little
☐₃ No

1.6 Marital status:

- | | |
|--|---|
| ☐ ₁ Married | ☐ ₄ Separated |
| ☐ ₂ Cohabiting | ☐ ₅ Divorced |
| ☐ ₃ Single | ☐ ₆ Widowed |

1.7 What is your highest level of education?

- ☐₁ Above degree/equivalent
- ☐₂ Degree/equivalent
- ☐₃ A-level/equivalent
- ☐₄ GCSE/equivalent
- ☐₅ Other qualifications (Please describe)

1.8 Your home, do you:

- ☐₁ Own your home
- ☐₂ Rent from the council
- ☐₃ Rent from the housing association
- ☐₄ Rent privately

1.9a Employment, are you:

- ☐₁ A full-time mother/carer
- ☐₂ Employed part-time
- ☐₃ Employed full-time

1.9b Is your partner / husband:

- ☐₁ A full-time carer
- ☐₂ Employed part-time
- ☐₃ Employed full-time
- ☐₄ Unemployed

2. Family history/parity

2.1a How many previous pregnancies have you had?

.....

2.1b What was the outcome? (i.e live births, stillbirth, miscarriage etc)

.....

2.1c here were the babies born? (home or hospital birth, country of birth)

.....

2.1d How did you feed your previous children?

	Breast	Bottle	Mixed
1	☐ ₁	☐ ₂	☐ ₃
2	☐ ₁	☐ ₂	☐ ₃
3	☐ ₁	☐ ₂	☐ ₃
4	☐ ₁	☐ ₂	☐ ₃

2.2a How many children do you have at home under your care?

.....

2.2b How many children under 4 years old do you have at home under your care?

.....

3. Most recent pregnancy

Antenatal care

3.1a Have you had any antenatal check-ups?

☐₁ Yesgo to 2.1b

☐₂ NoIf No, why not?go to 2.4

3.1b How many and where?

.....

3.1c By whom? – (Sure Start midwife, Community midwife, Support worker)

.....

3.1d What information were you provided with?

(Prompt if necessary: Breastfeeding, nutrition, hygiene and safety, smoking)

.....

...

.....

...

.....

...

3.2a How satisfied were you with

	Very satisfied	Satisfied	Not satisfied	Not at all satisfied
The standard of care you received				
The amount of information you were given				

The support you had with decision making				
<i>The availability of choice in terms of the type and location of birth</i>				

3.2b Which was the best source of this care? Sure start or community services?

.....

3.2c How many contacts antenatally did you have with the Sure Start Midwifery team?

.....

3.2d Of these how many are:

- ☐1 Via Telephone
- ☐2 Home Visits
- ☐3 You visiting them
- ☐4 Hospital Visits

3.3a Did you know about antenatal education /classes?

☐1 Yes

☐2 No

3.3b Did you attend?

☐1 Yes

☐2 No.....if no, why?

.....

3.3c What was your antenatal education about?

.....

...

3.3d Who delivered the education?

.....

...

3.3e Did it help prepare you for childbirth and looking after the baby, in what way?

.....

...

Labour and Delivery

3.4 Where did the birth take place?

.....

3.5 Was this where you planned the birth to take place?

- ☐₁ Yes
- ☐₂ No.....if no, why?
- ☐₃ I thought this was the only place I can give birth

3.6 Who cared for you most during the birth of your child?

.....

3.7 Did you receive a clear explanation of what was happening during birth / delivery?

.....

.....

Postnatal care

3.8a Did you receive a visit from the SS S&C Midwifery project within the 1st 2nd months of your most recent baby's birth?

- ☐₁ Yes
- ☐₂ No

3.8b How many contacts postnatally did you have with the Sure Start Midwifery team?

.....

3.8c Of these how many are:

- ☐₁ Via Telephone
- ☐₂ Home Visits
- ☐₃ You visiting them
- ☐₄ Hospital Visits

Breastfeeding

3.9 Did you intend to breastfeed?

- ☐₁ Yes
- ☐₂ No

3.10 Did you breastfeed?

- ☐₁ Yes
- ☐₂ No

3.11 How long did you exclusively breastfeed?

.....

3.12 Did you receive any support to breastfeed?

- ☐₁ Yes

☐2 No.....If No, would you have liked some support?

3.13 What kind of support did you receive?

.....
.....

3.14 By who?

.....

3.15 How satisfied were you with the support?

☐1 Very satisfied

☐2 Satisfied

☐3 Not satisfied

☐4 Not at all satisfied

Information and advice

3.16 Was the Sure Start midwifery project able to inform you about other non-health services available locally, what were these?

.....
.....
.....

Satisfaction with care

For antenatal, labour and delivery, post natal care

3.17 What was the best care you had why was it and who gave it?

.....
...

.....
.....

3.18 What was the worst care you had why was it and who gave it?

.....
.....

.....

4. Bilingual support worker

4.1 Did you find the bilingual support worker (Aysha Begum) useful?

☐₁ Yes

☐₂ No

4.2 How or why?

.....

...

.....

.....

4.3 Are there any comments you would like to make about this service?

.....

...

.....

.....

5. Your health

5.1a Do you have any longstanding illness or disability? (Anything that has troubled you over a period of time)

☐₁ Yes

☐₂ No

5.1b Does it limit your activities?

☐₁ Yes

☐₂ No

5.2 How would you describe your general health?

☐₁ Good

☐₂ Fairly good

☐₃ Not good

5.3 In the last 12 months how would you describe your general health?

☐₁ Good

☐₂ Fairly good

☐₃ Not good

5.4 Have you ever smoked cigarettes or chewed paan with Tobacco?

Cigarettes

☐₁ Yes

☐₂ Nogo to 4.9

paan

☐₁ Yes

☐₂ Nogo to 4.9

5.5a When did you smoke or chew paan with Tobacco? *(tick as many that apply)*

☐₁ Before pregnancy

☐₂ During pregnancy

☐₃ After pregnancy

5.5b How many did you smoke a week?

5.5c How often did you chew paan a week?

5.6 Are you still smoking or chewing paan?

☐₁ Yesgo to 4.9

☐₂ Nogo to 4.7

5.7 When did you give up?

☐₁ Before you knew you were pregnant

☐₂ As soon as you found out you were pregnant

☐₃ Later on during your pregnancy

☐₄ After the Birth

5.8 What helped you to give up smoking or chewing paan?

.....

5.9 When pregnant did you receive any advice or information about smoking (or chewing paan) from the midwifery project?

☐₁ Yes.....go to 4.10a

☐₂ Nogo to 4.11

5.10a Do you remember what they were? (list name).....

5.10b Do you think they would help someone wanting to give up smoking/chewing paan?

☐₁ Yes

☐₂ No

5.11 Over the last 12 months has your child (specify) had an emergency admission to hospital? (for: Gastro-enteritis, Respiratory infection, Severe Injury or Other – please describe)
.....
...
.....
.....

6. Referrals

6.1 Has the Sure Start midwife or bilingual support worker been able to help you with any other needs you or your family may have had?
If so what were they able to do for you?
Did you find this useful?
.....
...
.....
.....

7. Any other Comments

.....
...
.....
.....

Thank you.

Appendix 2: Stakeholder Telephone Interview Schedule

Interview Schedule: Stakeholder

Study ID:

Job title:

Years in post:

Date:

Are you aware of Collingwood and Stepney Local Sure Start Midwifery Project?

If no Prompt by midwife/bilingual support worker name
(if no recognition – end off interview)

If yes Can you describe the service that they provide?

What are effects or impact that the SSS&C LP Midwifery Project has had?

How do you think it interacts with existing midwifery services?

How do you think it interacts with other existing health services?

How do you think it interacts with other existing social services?

Do you think that it helps in the drive to meet government targets for:

breastfeeding

Smoking

emergency admissions to hospital for children <4 yo

Do you think the project is reaching the most disadvantaged members of the community?

Do you feel it is a valuable service?

What in particular is most valuable?

Is there a particular feature that makes this project work well or badly?

Are there any gaps in the provision of the midwifery project?

If there was anything you could change about it what would that be?

Do you have any comments to make about the role of the bilingual support worker?

How do you think the project could develop and be taken forward?

How do you envisage the midwifery project working with the introduction of children's centres?

Are there any other comments or observations that you would like to make?