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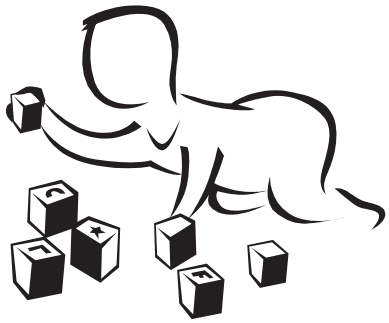

Interim Report 5

Local Evaluation, Sure Start Newcastle East

Service Delivery in Breastfeeding, Smoking Cessation and Speech and Language Development

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1. Executive Summary

1.1 Background

- This is the first interim report from the second phase of Sure Start Newcastle East's local evaluation; carried out by researchers at Sustainable Cities Research Institute at Northumbria University. It began in April 2003 and will be completed in April 2004.
- It is exploring three health-related target areas - breastfeeding, smoking cessation in pregnancy, and speech and language development.
- The first stage, the findings of which are presented in this report, focused on service delivery with regard to the three target areas; the second stage considers 'hard to reach' groups in relation to the three targets; and the third stage focuses on cost effectiveness.
- The intended aims of this stage of the evaluation were:
  - To examine the process of developing individual services in relation to need, outputs and expected outcomes relating to the three target areas;
  - To assist the Partnership in identifying key principles in relation to the delivery of services designed to facilitate the programme's progress towards the three target areas;
  - To evaluate the development of services relating to the three identified aspects of health improvement, in order to assist the Partnership in improving support for these issues;
  - To feed back the findings through this Interim Report.

1.2 Methodology

Introduction

- The PSA targets to be considered in the first two stages of the second stage of evaluation were:
  - Information and guidance on breastfeeding, nutrition, hygiene and safety available to all families with young children in Sure Start local programme and Children's Centre areas; antenatal advice and support available to all pregnant women and their families living in Sure Start local programme and Children's Centre areas (Objective 2: Improving Health);
  - In fully operational programmes, achieve by 2005-06 a 6 percentage point reduction in the proportion of mothers who continue to smoke during pregnancy (Objective 2: Improving Health);
  - In fully operational programmes, achieve by 2005-06 a [R2] [x] per cent increase in the proportion of children having normal levels of communication, language and literacy at the end of the Foundation Stage and an increase in the

proportion of young children with satisfactory speech and language development at age 2 years (Objective 3: Improving Learning).

- Stages 1 and 2 of this evaluation were combined for data collection purposes. A multi-method approach was taken; research methods included:
  - Internet searches
  - Document analysis
  - Semi-structured interviews with Sure Start staff, mainstream staff and service users
  - Participatory Appraisal with parents and local people
  - A questionnaire on breastfeeding conducted among local people.

Internet and Library Searches

- This involved searching the Internet and library catalogues to locate various research findings, government papers, statistics and details of service provision elsewhere in relation to the three target areas.

Document Analysis

- Documents acquired from programme staff included:
  - details of service provision
  - strategies
  - academic papers.
- These documents, alongside previous research and methodologies found on the Internet and National Evaluation of Sure Start (NESS) website, provided background information on service provision and current activities nationwide. They helped shape interview schedules, questionnaire format and PA questions.

Interviews

- Semi-structured interviews were conducted with programme staff, mainstream staff working in the programme area, and parents.
- Interview schedules followed a general structure covering joint working, the three specified target areas (environmental influences and barriers), 'hard to reach' groups, capacity building and training. The interview content depended upon the role of the respondent (see Appendix 1 for schedules).
- Ten individual interviews and one small group interview were completed with Sure Start staff. A combination of individual and group interviews were completed with twenty-one mainstream staff (health visitors, community nursery nurses, midwives, and nursery staff). Five individual interviews were undertaken with parents accessing services within the programme. Two managers of other Sure Start programmes in the region were also interviewed in person, and two speech and language therapists from other Sure Start programmes by telephone.
- Interviews lasted between 20 and 90 minutes. They were conducted in the respondent's work or home environment and the majority were audio taped for transcription purposes. Each respondent was assured anonymity with regards to the information given.

Participatory Appraisal (PA)

- PA, designed to seek the views of local people in a visually stimulating and non-threatening way, uses visual aids such as simple maps, charts and diagrams.

- PA was carried out at a number of Sure Start and associated events as well as at two public venues in the area. These are listed below with approximate numbers of respondents at each venue given in brackets:
  - Young mums' group (5)
  - Thomas Gaughan family centre fun day (7)
  - St. Anthony's Children's House family snack (2)
  - Wharrier Street playgroup (7)
  - West Walker family fun day (6)
  - Byker Sands family centre (15)
  - Church Walk shops (25)
  - Byker Primary School (7)
- The evaluators were trained in a range of PA tools and used a combination of two or three tools to elicit comments on each service from service users. The tools used included:
  - Graffiti Wall
  - Bean Voter
  - Impact Ranking
  - Spider Chart
  - H-form

Questionnaire on Breastfeeding

- The programme management requested that a questionnaire be carried out among local people in the programme area to explore attitudes to and influences on breastfeeding practice. Topics included exploring why breastfeeding had a low uptake in the programme area, environmental influences upon infant feeding practices, sources and extent of antenatal contact, familial influences upon the mother's decision regarding feeding, respondents' awareness and knowledge of the benefits of breastfeeding, and the impact of social/cultural responses to breastfeeding. The questionnaire was designed for all local people, that is male and female of all ages from 16 up and with or without children.
- After piloting the questionnaire, evaluators made some alterations to the format, resulting in the final questionnaire (Appendix 2), comprising of four sections. Section one was for all respondents, section two for parents only, section three for mothers who had breastfed and section four for people expecting their first baby.
- Questionnaires were delivered by two evaluators in a number of venues, including Sure Start activities and family centres, and 'on the street' with non-service users.
- The evaluators posed the questions and recorded the responses in writing. The questionnaire took between 1 and 4 minutes to complete.
- The questionnaire was completed with 335 respondents (274 female and 61 male) at twenty-one different locations across the programme area.
- Questionnaire responses were analysed using Microsoft Access. Data was entered into two separate databases, one for female respondents and one for male respondents. A list of questions was drawn up based on the information considered most important, and queries were run accordingly.

1.3 Summary of Findings 1: Breastfeeding

Progress towards breastfeeding target

- Environmental influences on breastfeeding/ bottle-feeding practice in the area were identified by staff and parents as follows:
  - Family: matriarchal society; bottle-feeding chosen so that other family members can help feed the baby;
  - Bottle-feeding as the cultural norm;
  - Absence of support network for breastfeeding which leads some who try it to give up;
  - Lack of self-confidence;
  - Partners' attitudes;
  - The role of the media in promoting bottle-feeding;
  - Lack of public places to breastfeed;
  - Public reactions to breastfeeding/ breasts seen as sexual objects;
  - The availability of formula milk in hospitals after birth;
  - Religion;
  - Effects of breastfeeding on the body;
  - Birth-related issues;
  - Peer pressure.
- The conditions necessary to enable mums to breastfeed were identified as follows:
  - A raised profile of breastfeeding, only achievable by exposing people to it more often;
  - Developing effective support networks, especially through the midwife;
  - Consistency of information on breastfeeding given by midwives: this was seen as improving;
  - Information on breastfeeding being given at the right time.
- Opinions regarding the actual impact of Sure Start upon breastfeeding rates in the programme area varied. Comments ranged from Sure Start having no impact, to the programme opening up women's minds to the idea of breastfeeding, to the benefits of mainstream midwives being able to link in with the Sure Start midwife, especially in terms of borrowing resources.

The breastfeeding questionnaire results - quantitative

- <u>Among the female respondents with no children (28 in total):</u>
  - 28.5% had been breastfed as babies.
  - 47% of those who were bottle-fed as babies were able to name any/some benefits of breastfeeding compared with 80% of those who were breastfed.
- <u>Among the female respondents with children (243 in total):</u>
  - 29.5% had been breastfed as babies.
  - Equal proportions (47%) of those who were bottle-fed and those who were breastfed as babies were able to name some/any benefits of breastfeeding.
  - Of those aged under 20, 27% had breastfed at least one of their own children. Of those aged 20-34, 38.5% had breastfed. Of those aged 35-49, 45% had breastfed. Of those aged 50-64, 41% had breastfed. And of those aged 65+, 76.5% had breastfed.
  - Of the white mums, 52% had solely bottle-fed their babies, compared to only 12.5% of the minority ethnic mums.

- 65% of the mums who were bottle-fed as babies never attempted breastfeeding their own children, compared to only 31% of those who were breastfed as babies.
- Of the mums who solely bottle-fed their babies, 30% decided this before they even became pregnant, compared with 47% of those who breastfed.
- Of those mums who solely bottle-fed, 6% got help from a partner with this decision, 3% from family/friends, 23% from professionals, and 68% made the decision by themselves. For breastfeeding mums the respective figures were 8%, 19%, 25% and 48%.
- Of those mums who only bottle-fed, only 38% said they knew someone who had breastfed, compared to 69% of those who had breastfed.
- Of the mums who breastfed (105 in total):
  - 40% received support from professionals while breastfeeding, 5% from family/friends, 10.5% from professionals and family/ friends, 4% only from their partner, 3% from partner and professionals, and 2% from Sure Start specifically. The remaining 35.5% received no support at all while they breastfed.
  - 67% felt they breastfed for as long as they wanted to, 14% felt they breastfed for too short a time, and 8% felt they had breastfed for too long a time.
  - Of those who had not received any support, 33% did not say how long they had breastfed for, while the remainder (77%) had all breastfed for at least four months. Of those who had got support only from professionals or only from family/friends, all had breastfed for at least two months. Of those who had received support from professionals and family/friends, all had breastfed for at least six months.

- Among male respondents without children (11 in total):
  - 18% had been bottle-fed as babies, 36.5% had been breastfed, and the remainder (45.5%) did not know.
  - None could name any benefits of breastfeeding.
  - None were comfortable with women breastfeeding in public.
- Among male respondents with children (50 in total):
  - 64% said they had been breastfed as babies.
  - Of the dads who were bottle-fed as babies, 78% were able to name some/any benefits of breastfeeding, compared to 83% of those who were breastfed.
  - The 1 aged under 20 had a breastfed child. Of those aged 20-34, 22% had breastfed children. Of those aged 35-49, 39% had breastfed children. Of those aged 50-64, 66.5% had breastfed children, and of those aged 65+, 43% had breastfed children.
  - Of the dads who were bottle-fed as babies, only 4% of their partners breastfed their children. Of the dads who were breastfed as babies, 39% of their partners breastfed their children.
  - Of the dads whose partners bottle-fed their children, 31% said they decided to do so before they were pregnant, 35% during their pregnancy, and 21% once the baby was born. 14% did not know when their partner decided to bottle-feed. Of the dads whose partners breastfed their children, 22% said they decided to do so before they were pregnant, 44% during pregnancy, and 11%

once they had the baby. 22% did not know when their partner decided to breastfeed.[1]

- 28% of the dads whose partners solely bottle-fed said they helped to make the decision. None said their partners received help from family/friends when deciding to bottle-feed, and 21% said their partners received help from professionals with their decision. Only 11% of the dads whose partners breastfed said they helped to make the decision, while 11% said their partners received help from family/friends, and 33% from professionals.
- 54% of dads whose children were bottle-fed thought it was okay to breastfeed in public, whilst 89% of all dads whose children were breastfed thought it was okay to breastfeed in public.
- Of the white dads who responded, 64% of their partners solely bottle-fed their children and 14% solely breastfed. Of the 8 minority ethnic respondents, only 38% had children who were not breastfed at all.

The breastfeeding questionnaire results - qualitative

- Respondents were asked to name any benefits they knew of breastfeeding. Of the 274 female respondents, 200 were able to name benefits, while of the 61 male respondents, 40 were able to name benefits. The benefits mentioned most often are listed below, with the numbers of respondents who named each benefit in brackets:[2]
  - Better/ healthier for baby/ children (110)
  - Immunisation for baby (33)
  - More nutrients/vitamins/ protein for baby (31)
  - Convenient/ easier than bottle-feeding (28)
  - Bonding and love/closeness (23)
  - Helps mum get figure back/ loose weight (21)
  - Cost - cheap/free (17)
  - Antibodies/ protection from illness/ infection (15)
  - More natural than formula milk (14)
  - Instant (9)
  - Mum feels healthier generally (6)
  - Best start to give baby (6)
  - Reduces allergies in baby (5)
- Respondents were also asked if they thought there were any drawbacks to breastfeeding. Of the 274 female respondents, 145 and of the 61 male respondents, 14 named the following drawbacks:
  - Inconvenient to feed in public/ difficult to find place to feed (33)
  - Painful breasts/ nipples (31)
  - Only the mum can feed/ partners cannot feed (16)
  - Mum is tied to baby (15)
  - Other people's reactions (10)
  - Embarrassment for mum (7)
  - Can't go out/ no social life (7)
  - Time consuming/ mum constantly feeding (5)
  - Breasts leak (4)

[1] It must be recognised that these two sets of statistics may not be accurate: they reflect dads' *perceptions* of when their partners had made their decision about how to feed their baby.

[2] These are listed in full in Section 4, where those mentioned by female and male respondents are listed separately - here they are listed together.

1.4 Summary of Findings 2: Smoking Cessation

Progress towards smoking cessation target

- Environmental factors which contribute both to the uptake of smoking and the low rate of smoking cessation in the area were identified by staff and parents as follows:
  - General life stresses
  - Peer pressure
  - Social events
  - Alcohol intake
  - The side effects of stopping smoking, especially weight gain
  - Smoking being culturally acceptable in the area
  - Socio-economic status
  - The availability of cigarettes on the black market at very cheap rates
  - Lack of accessible information
  - Lack of support from family, especially in the case of young mums living with their parents who smoke
  - The habit – 'once they stop smoking, what do they do with their hands?'
- Sure Start and mainstream staff take the following approaches to the promotion of smoking cessation:
  - Using coasters (for drinks) to promote the benefits of smoking cessation - subliminal messages.
  - Encouraging services to link together and promote all smoking cessation activities widely.
  - Making information regarding smoking cessation available in different formats and throughout Sure Start centres.
  - Recognising the importance of the individual's choice - A parent commented: 'Every time people say to me “are you going to stop?”, I don’t want to because I feel as though I’m doing it for them and not for me'.
  - Creating a non-judgemental and non-threatening environment for those accessing smoking cessation support groups.
  - Offering the information at the right time; however, some mainstream staff suggested that Sure Start could not fully embrace this idea due to the restrictive nature of their targets and thus their service delivery.
  - Building up a relationship with clients first.
  - Recognising the value of any attempt to stop smoking, successful or not, as those who had stopped smoking but then relapsed would be more likely to be successful at stopping at a later date.
  - Engaging a number of people in a group: One Sure Start worker felt that the group situation - having each other for support and empathy - was partly responsible for successful quit attempts.
  - Educating children about the risks of smoking.
  - Understanding other issues affecting a quit attempt.
  - Avoiding formal approaches to education, especially with teenagers.
  - A parent commented that Sure Start’s smoking cessation provision was successful due to its format and the worker running the group.
- Mainstream and Sure Start staff identified the following barriers to smoking cessation:
  - The procedures necessary to access medication to support smoking cessation.
  - Lack of preparation for smoking cessation.

1.5 Summary of Findings 3: Speech and Language Development

Progress towards Speech and Language Development

- Sure Start and mainstream staff made the following points about the role of the family in children's speech and language development:
  - Early communication is an essential part of children's speech and language development, and many felt this was often lacking among families in the area. Parents 'may have no understanding of their role' in the speech and language development of their child. One Sure Start worker felt that early communication may not 'come naturally' to young mums in particular.
  - The type of language used by some parents to their children is not conducive to good speech and language development - too much disciplinary language and too little imaginative language.
  - Television is a major barrier to stimulating and imaginative language being used between parent and child.
  - Parents may not have the literacy skills or the motivation to promote reading with their child.
  - Where children have a lot of contact with members of their extended family, this is often good for their speech and language development.
- Staff emphasised the following aspects of support for children with speech and language problems:
  - The importance of early intervention: One interviewee felt that when parents ask health professionals for support, they were 'told not to worry'. This led to parents feeling isolated feeling and like 'it's taken out of your control.'
  - Ensuring that referrals to Speech and Language therapists are not made too soon, especially as clients can often regard any external service with suspicion. Therefore playgroups and nurseries play an important role in building up relationships with parents and children before referrals are made.
  - Providing support in a nursery environment overcomes the fear of stigmatisation to a certain degree.

Impact of Sure Start upon Speech and Language Targets

- A local playgroup worker commented that having the Sure Start speech and language team known in the playgroup enables the parents to ask questions and to get knowledge and advice.
- Mainstream staff described how they refer children to mainstream speech and language therapy and then refer to a Sure Start speech and language therapist for intervention while the child is on the six-month waiting list.
- Sure Start playgroup staff described how they felt that they contributed to the reduction of inappropriate referrals to mainstream speech and language, as parents often consult them to ask their opinion on advice they may have been given by the health visitor for example.
- Some local nursery staff felt they were able to provide direct support for speech and language development without Sure Start input.
- The training provided by Sure Start speech and language staff for mainstream professionals working in the programme area aims to provide a cost effective way of disseminating speech and language skills. By equipping staff not directly working in speech and language with knowledge and skills to pass on to families to help their children's speech and language development themselves, the number of referrals to mainstream speech and language therapy may be reduced.

Mainstream staff who had completed the training made the following points about it:

- Useful update for us but it hasn't changed our practice.
- Did make a difference to the way I work with the children.
- Now more confident in assessing clients' speech
- Now give exercises for parents to do with the child while they are waiting for the referral
- Better understanding of the development of speech and language therefore you can explain it better to parents
- More aware of what is immature speech and what is a speech problem

- The West Walker speech and language group was felt to have had the following impact on children's speech and language development:
  - Children are more socially aware, with better speech and language development as well as improved social skills and confidence.
  - Some families referred to it still do not turn up
  - One parent cited the following outcomes of her attendance with her son at the group:
    - Being more patient with her child now
    - Passing information from the group onto other parents
    - Support and guidance.
- The Children Talking Display at local nurseries and playgroups was felt to have had the following impact:
  - Parents and children can look at the pictures to see the routine of the playgroup day.
  - Improved educational function of nursery staff.
  - Parents take the ideas home.
  - Generates discussion between parents and children.
- Parents whose children had received one to one input from Sure Start speech and language staff described the following impacts:
  - Improved child's communication.
  - Helped parent 'to put things in the right order' for child to process them.
  - Enabled mum and child to 'have a conversation'.

1.6 Summary of Findings 4: All Three Targets

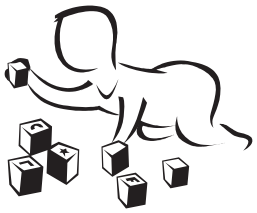
Ranking the three targets

- Sure Start and mainstream staff were asked to rank the three target areas in order of which they felt was the easiest to achieve, and which the most difficult. All respondents felt that speech and language was the easiest, because:
  - It's for the children rather than for the parents personally.
  - It's something that comes up all the time, but that parents can just do quickly, when they remember.
  - It's not about changing life choices.
  - People see the benefits much more readily.
- Outreach staff said they saw speech and language more often on referral forms than the other two targets. This reflects the view of most staff that speech and language was the easiest to achieve of the three target areas.

Joint working

- Some mainstream professionals felt that Sure Start targets may be inappropriate when they conflict with an individual's personal targets or with the most pressing issues in a community:
- Others highlighted the dangers of associating specific targets with particular groups, whereby a group may be considered to have failed to meet certain targets when in fact its participants may be gaining holistically from attending the group
- All interviewees emphasised the need to have 'collective aims and objectives' during joint working and, although this can be difficult when 'people have their own agendas', one interviewee identified compromise as the key to successful relationships and outcomes.
- Mainstream and Sure Start midwives are aware that they need to improve their links with one another, although joint working does occur successfully.
- Mainstream midwives appreciate the opportunity to share their workload with the Sure Start midwife as breastfeeding support involves an intensive period of assistance.
- Nurseries and playgroups were seen as ideal places to target parents about these issues.

2. Background



2.1 Research Context

This interim report is the first from the second phase of local evaluation of Sure Start Newcastle East being carried out by researchers (local evaluators) from the Sustainable Cities Research Institute at Northumbria University. This began in April 2003 and will continue until April 2004. It follows on from the initial phase of evaluation of the programme undertaken between July 2001 and April 2003 which culminated in four interim reports and a final report.

The second phase of evaluation is considering Sure Start Newcastle East's progress towards three identified national target areas as well as a cost effectiveness exercise of specific aspects of service delivery, as required by the Sure Start Unit. The three target areas to be explored are:

- Breastfeeding
- Smoking cessation in pregnancy
- Speech and language development.

This is being done in three stages, the first focussing on service delivery relating to the three target areas, the second on engaging 'hard to reach' groups in relation to the three target areas, and the third on cost effectiveness. This Interim Report presents the findings from the first stage, that is how the programme is progressing towards these three target areas in relation to the delivery of relevant services.

2.2. Research Aims

The aims of this stage of the evaluation were:

- To examine the process of developing individual services in relation to need, outputs and expected outcomes relating to the three target areas;
- To assist the Partnership in identifying key principles in relation to the delivery of services designed to facilitate the programme's progress towards the three target areas;
- To evaluate the development of services relating to the three identified aspects of health improvement, in order to assist the Partnership in improving support for these issues;
- To feed back the findings through this Interim Report.

The intended outcomes were:

- Interviews with programme and mainstream staff to explore the relationship between the aims of health improvement, take-up of services and intended outcomes;
- Interviews and Participatory Appraisal with local parents to explore perceptions of the programme's impact in these three areas;

- Interim Report 5.

2.3 Research Process

Local evaluators held a meeting with Sure Start Newcastle East Programme Management in May 2003 to discuss the extended phase of the local evaluation. The Programme Management clarified the areas worthy of further study as three health-related target areas:

- breastfeeding
- smoking cessation in pregnancy
- speech and language development.

The first stage of evaluation, it was decided, would focus on the delivery of Sure Start services relating to these three target areas.

When the themes were finalised, the evaluators devised a leaflet to be distributed to staff and parents alike, in order to inform people of the evaluation process, and how their participation might be required.

3. Methodology

3.1 Introduction

In discussion with Sure Start Newcastle East management (May 2003), the decision was made to focus on three specific national target areas aimed at improving health. The PSA targets to be considered were:

- Information and guidance on breastfeeding, nutrition, hygiene and safety available to all families with young children in Sure Start local programme and Children's Centre areas; antenatal advice and support available to all pregnant women and their families living in Sure Start local programme and Children's Centre areas (Objective 2: Improving Health);
- In fully operational programmes, achieve by 2005-06 a 6 percentage point reduction in the proportion of mothers who continue to smoke during pregnancy (Objective 2: Improving Health);
- In fully operational programmes, achieve by 2005-06 a [R2] [x] per cent increase in the proportion of children having normal levels of communication, language and literacy at the end of the Foundation Stage and an increase in the proportion of young children with satisfactory speech and language development at age 2 years (Objective 3: Improving Learning).

These three overarching targets would run throughout the course of the whole evaluation.

In the context of Sure Start's aims and objectives, the issues of improving health and engaging 'hard to reach' groups are interlinked and, as such, stages 1 and 2 of this evaluation have been combined with regards to data collection. A multi-method approach was taken to ensure that appropriate, comprehensive qualitative and quantitative data was collated. Research methods included:

- Internet searches
- document analysis
- semi-structured interviews with programme staff, mainstream staff, and local parents
- Participatory Appraisal with local people
- a questionnaire on breastfeeding conducted among local people.

This section describes only those aspects of each method relating to stage 1 (those relating to stage 2 are detailed in Interim Report 6, forthcoming).

3.2 Internet and Library Searches

The first stage involved searching the Internet and library catalogues to locate various research findings, government papers, statistics and details of service provision elsewhere in relation to the three target areas.

3.3 Document Analysis

Documents acquired from programme staff included:

- job descriptions
- details of service provision
- strategies
- academic papers.

These, along with previous research looking at the three themes, found on the Internet and National Evaluation of Sure Start (NESS) website, provided background information on service provision and current activities nationwide and helped shape interview schedules, questionnaire format and PA questions.

3.4 Interviews

Semi-structured interviews were conducted with staff from the programme, mainstream staff working in the programme area, and parents. Discussion resulting from a semi-structured interview schedule appears informal and conversational, but is also carefully controlled and structured. Probing is an important aspect of the semi-structured interview, allowing the interviewer to get to the core of the issue.

Interview schedules for staff and parents followed a general structure covering joint working, the three specified target areas (environmental influences and barriers), 'hard to reach groups', capacity building and training. The interview content depended upon the role of the respondent - e.g. Sure Start staff, mainstream health worker, parent (see Appendix 1 for schedules).

Ten individual interviews were completed with Sure Start staff, ranging from outreach workers to ante/postnatal support to speech and language staff, and well as one small group interview with three playgroup staff. A combination of individual and small group interviews were carried out with twenty-one mainstream staff - community nursery nurses, health visitors, midwives and nursery/ playgroup staff. Five interviews were undertaken with parents accessing Sure Start Newcastle East services, three of which focused mainly on speech and language intervention. Two managers of other Sure Start programmes were also interviewed in person, as well as telephone interviews with speech and language therapists from two other Sure Start programmes.

The length of interviews varied between 20 and 90 minutes; the average was 30-40 minutes. Interviews were conducted in the respondents' work or home environments and the majority were audio taped for transcription purposes. Each respondent was assured anonymity with regards to the information given.

3.5 Participatory Appraisal

PA is a relatively new research method designed to seek the views of local people in a way that is visually stimulating and non-threatening. It uses visual aids such as simple maps, charts and diagrams to help local people to give their views on what kind of services they would like to see developed in their community, or on existing services.

PA was carried out at a number of Sure Start and associated events as well as at two public venues in the area. These are listed below with approximate numbers of respondents at each venue given in brackets.

Sure Start/ associated events:

- Young mums' group (5)
- Thomas Gaughan family centre fun day (7)
- St. Anthony's Children's House family snack (2)
- Wharrier Street playgroup (7)
- West Walker family fun day (6)
- Byker Sands family centre (15)

Public venues:

- Church Walk shops (25)
- Byker Primary School (7)

The evaluators were trained in a range of PA tools and used a combination of two or three tools to elicit comments on each service from service users. Comments were written onto flip chart sheets, following the format of the chosen PA tools. The tools used included:

Graffiti Wall/ Spider chart: These tools were used to stimulate responses from participants regarding sources of support/advice on their children's speech, stopping smoking, and breastfeeding.

H-form: This was used to reflect on the Children's Talking display. It comprises of positive and negative responses about the display, ranking the display from 0 – 10 and suggesting any areas for improvement.

3.6 Questionnaire

Sure Start Newcastle East management requested that a questionnaire be carried out in the programme area to explore attitudes to and influences on breastfeeding practice in the programme area. They expressed a desire to pursue further activities to increase the number of women who breastfed in the area and were keen to use the results of the questionnaire to develop this area of work. Topics of particular interest included:

- why breastfeeding had a low uptake in the East locality, including history
- environmental influences upon infant feeding practices
- sources and extent of antenatal contact
- family influences upon the mother's decision regarding feeding
- respondents' awareness and knowledge of the benefits of breastfeeding.

The questionnaire began as a comprehensive document, with six sections appropriate to respondents without children, parents who bottle-fed, mothers who breastfed, fathers whose partners breastfed, expectant mothers and fathers, and grandparents. It also included a comprehensive section for those with children, requiring responses concerning how their child was fed (e.g. if bottle-fed, was the formula milk free and if breastfed, how long for). After piloting the questionnaire, it was decided that the format was too complicated to complete swiftly (local evaluators completed the questionnaire in person with each respondent). As such, the format was revised and an updated version was piloted; this required a further few minor moderations and resulted in the final questionnaire, comprising of four sections (Appendix 3). The first section was for all respondents to complete, the second for parents only to complete,

the third section to be completed by mothers who had breastfed, and the final section for parents expecting their first child.

Questionnaires were delivered by two evaluators in a number of different venues throughout the programme area, to include both people using Sure Start services and accessing families centres, and those not. It was designed to target males and females alike, of all ages from 16 upwards. The following venues were targeted:

- Byker Sands family centre
- Thomas Gaughan community centre
- West Walker family centre
- Monkchester family centre
- Church Walk health centre
- Church Walk shops
- Falcon House health centre
- Byker Metro
- Raby Cross
- Welbeck Road Post Office
- St. Anthony's Post Office/ bus stop
- East End Library
- St. Anthony's Children's House
- St. Anthony's health centre.

Most locations were visited on more than one occasion, varying the day or time of day, in order to ensure a diverse range of respondents.

A standard note of introduction was made to each respondent approached, explaining who the evaluators were and the purpose of the questionnaire. The evaluator posed the questions and recorded the answers in writing. The questionnaire generally took between 1 and 4 minutes to complete, depending upon respondents' circumstances: for those with no children, it could be completed in 1 minute, while for mothers who breastfed or men with partners who breastfed it took about 4 minutes at most.

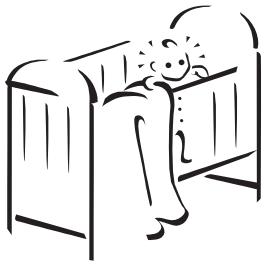
A total of 335 respondents completed the questionnaire, of whom 274 were female and 61 male.

Of the 274 female respondents, eight were from ethnic minority groups. Twenty-three were under the age of 20, 126 were aged 20-34, seventy-five were aged 35-49, thirty were aged 50-64, and twenty were over the age of 65.

Of the 61 male respondents, eight were from ethnic minority groups. Five were under the age of 20, nineteen were aged 20-34, twenty were aged 35-49, eight were aged 50-64, and nine were over the age of 65.

Questionnaire responses were analysed using Microsoft Access. Data was entered into two separate databases, one for female respondents and one for male respondents. A list of questions was drawn up based on the information considered most important, and queries were run accordingly.

4. The Findings 1: Service Delivery - Breastfeeding



The following views on bottle-feeding/ breastfeeding practice in the programme area were gained from individual interviews conducted with members of the programme team, as well as a large number of interviews conducted individually and in small groups with mainstream professionals working in the area.

4.1 Environmental Influences

Family

Generally, both Sure Start and mainstream staff were unsure of the reasons for such a low rate of breastfeeding in the East of Newcastle, particularly when and why the shift from breastfeeding to bottle-feeding had occurred. One Sure Start worker commented:

> Around here, it's a very matriarchal society and I think it's funny that [breastfeeding] hasn't been passed on because of the way that the culture is - it's quite strange. I don't know where the shift from breastfeeding to bottle-feeding came from here really. The support networks (for breastfeeding) are still here.

This worker suggested that 'some sort of cultural shift' may be responsible for the change in infant feeding practice, but did not know why this shift may have occurred. Whatever the reason, the general opinion is that today bottle-feeding is viewed as the norm in the East locality. It is seen to be encouraged as a better option than breastfeeding, 'because of free [formula] milk, because of society, families being brought up – everybody seems to be bottle-fed …'

The choice to bottle-feed is reinforced by family and friends, often based upon their own personal experiences of feeding infants, particularly if they have had a bad experience of breastfeeding: 'The influence of what your mother has done or your sister has done can be absolutely massive'. Mainstream midwives described the 'pressure' put upon young mothers from older family members:

> Breastfeeding rates are quite low because of family pressure from the women in the area. A lot of younger mums very much take what their parents and grandparents say on board, and they were probably from a culture where they didn't breastfeed so the daughters will not breastfeed.

Staff also described a perception among parents that 'I turned out alright so it must be okay to bottle-feed'.

The same is true regarding decisions to breastfeed rather than bottle-feed. One mainstream worker explained that of her clients who were considering breastfeeding, all had been breastfed themselves. Professionals interviewed also discussed a perception among clients that bottle-feeding was easier and more convenient than

breastfeeding in the sense that other people can bottle-feed your baby, while if you breastfeed you have sole responsibility. The family can also reinforce this idea of shared responsibility for feeding, thus encouraging bottle-feeding to enable this to happen. One Sure Start worker supported the notion of bottle-feeding to reduce the sense of sole responsibility for the baby by sharing feeding with others:

> Women are under so much pressure as it is to have the baby, keep a size 8 figure, get back to work, breastfeed, see to the house, everything at the same time. You get really, really tired and you need a break. You could share that responsibility if you bottle-fed.

A mainstream worker agreed:

> Sometimes it [breastfeeding] just doesn't fit into your routine. If you're a single mother with a biggish family, and you know your mother will be looking after the baby some of the time, sometimes it's just not practical to breastfeed.

Furthermore, if a woman makes the decision to breastfeed, she must have a support network in place to ensure she is able to continue to do so at home. As one mainstream health visitor explained:

> You will get some women and young girls who will try it, and then when they come home, because the cultural support isn't there, they'll give up. Families will say, 'that bairn's starving, it needs a bottle'.

Cultural norms and societal pressures

Another factor influencing decisions to bottle-feed mentioned by staff was self-confidence, which was seen as a pre-requisite for breastfeeding. This was seen as particularly important with younger mums, who may have strong concerns about body image. A Sure Start worker commented:

> I think a lot of it comes down to personal choice but also confidence. At 17 years old, would you like to have to get your boobs out? I don't think a lot of people would … There are enough barriers to teenagers breastfeeding just because they're teenagers and they're really self-conscious.

Commitment to continue breastfeeding when the situation can become difficult was also seen as important, as were partners' attitudes.

Sure Start and mainstream staff alike pointed to the role of the media in promoting bottle-feeding. A Sure Start worker commented that 'You don't often see people sitting with their breasts out on 'Eastenders'', while a mainstream worker added: 'Perhaps, without sounding derogatory, those are the sorts of programmes that maybe a lot of people in these areas would watch'. Indeed, results from PA carried out with local people for the evaluation revealed the importance of television, especially as a source of information on health-related issues (this part of the research will be reported in Interim Report 6, forthcoming). Television was felt to have a particularly important role in the promotion of formula milk.

Another commonly cited motive for not breastfeeding are the constraints it is said to place on mothers' ability to access public places. Professionals had received reports from breastfeeding mums of breastfeeding being looked upon as unacceptable in public areas, giving examples of mothers being told not to breastfeed in cafes, to breastfeed in the female toilets, being stared at by men, and a general atmosphere of disapproval. Mainstream workers described a lack of provision for breastfeeding mothers in the local area specifically: '[Even in GP surgeries] there's nowhere for the

mums to sit and feed their baby so what chance have they got [on Shields Road]?' One interviewee described a situation in a local family centre where public breastfeeding is an issue:

> People breastfeed at [the family centre] and it's still frowned upon. I've heard women complain about other women breastfeeding in the family centre.

Some interviewees attributed people's attitudes to public breastfeeding to the view of breasts as sexual objects. Comments included:

> They're looked at as sex objects rather than what nature intended them to be.
>
> You're talking about areas [of Newcastle] where your boobs aren't for the baby - they're for the men.
>
> There's nothing worse than when a woman comes into a centre to feed a baby and while she's feeding you've got young lads ogling her.

Some workers felt they reinforced the idea of breastfeeding being a private matter by encouraging women to feed in a private room. Although this was usually in response to seeing a mother feeling uncomfortable breastfeeding in public, workers felt this 'made matters worse' with regards to making it socially acceptable to feed in public.

Overall, there was a general consensus among staff that breastfeeding will not become the cultural norm in the East of Newcastle:

> I don't think it will happen. Culturally, generally, people stare at women who breastfeed.
>
> The bottom line is it's what they know.
>
> They've never seen anybody breastfeed so it's not a norm for them.

Breastfeeding is described as unfashionable, with people becoming 'visibly uncomfortable' when faced with it, and little provision in place for women who do want to breastfeed. One interviewee felt that no matter how much breastfeeding and its benefits are promoted, there will still be women who choose not to do it.

In contrast, mainstream workers discussed the infant feeding practices of asylum seekers living in the area, the majority of whom breastfeed. Their decision to breastfeed was attributed to their culture: 'That's the norm for those groups'. However, workers also felt that asylum seekers preferred to breastfeed in private and, as such, are not visible role models to other women in the area. So, 'figures will be up because of asylum seekers breastfeeding' in the area but not as a result of mainstream or Sure Start input. However, it seems that British culture is having an impact upon the infant feeding practices of asylum seekers. A mainstream midwife commented:

> It speaks volumes when you have … a woman who has breastfed four children, then comes to this country and ends up bottle-feeding - a totally alien concept in her own country.

She and her colleagues attributed this to the easy availability of formula milk in hospitals after birth:

> There's free milk in the hospital, ready made with sterilised lids to go on them and a milk token to bring home with you.
>
> They get their milk tokens so they can either spend it on milk for their family or baby milk. If they didn't have the milk token, I think a lot more of them would breastfeed; if £6.95 had to come out of their weekly shop budget, I'm blinking sure they'd breastfeed. Personally, I think they get it too easy - maybe there should be extras for breastfeeding mothers.

One interviewee suggested raising the status of breastfeeding by exposing people to it more often; mothers who choose to breastfeed should act as role models in those areas where breastfeeding rates are low. Moreover, although designated rooms for breastfeeding mothers are encouraged generally, this interviewee felt that the idea encouraged people to view breastfeeding as something to be hidden away:

> All these places in town, they've got these rooms where you've got to go away to breastfeed – but why, you know? Can you not just have a nice comfortable area where mams can chat and have chairs - somewhere they can feed?

Support

If a mum decides to breastfeed, then developing effective support networks is seen as vital to encouraging its continuation once the mum and baby return home from hospital. The role of the midwife is important in establishing this sense of support, particularly in the case of teenage parents. One mainstream worker believed the connotations linked to being a teenage parent affected some midwives' responses to teenage patients:

> Sometimes, from a midwife's point of view, people assume [teenagers] are not going to breastfeed so they're not going to give them the information, or they kind of gloss over it … I think there's so much to do with how midwives are with young women around every issue, not just breastfeeding.

Another midwife commented:

> If you look at areas in the country where there's higher incidences of teenagers who breastfeed, the biggest thing is intensive support and information. There've been midwives who work specifically with that age group, they've seen them consistently all the way through and have provided ongoing support and information, been there potentially at delivery, post delivery, provided that intensive support – because they need even more support than other mums do for lots of reasons, particularly around breastfeeding.

Another mainstream worker felt that whether or not a mum breastfeeds is down to 'the support network'. Another midwife pointed to the inconsistency of information delivery amongst midwives, believing that some midwives 'do a very effective job at doing the "drip" work…but I am sure, I know there are other midwives who don't do that'. This was particularly important when working with teenage mums:

> I still find it's quite a new concept to many [teenage mums] that there are actually health benefits - they've said no one's really talked to [them] about it.

Mainstream midwives reported a change in information delivery with regards to breastfeeding. Midwives no longer ask pregnant women whether they intend to breastfeed or not. Instead of 'ticking a box' at the booking visit to indicate whether they are going to breast or bottle-feed, they now give information bit by bit over the course of the pregnancy, thus 'sowing the seed'. This approach aims to reduce the risk of women feeling 'pushed into' breastfeeding by their midwife. Two mainstream midwives explained the limitations of the previous approach:

> If you say do you want to breastfeed and they say no, it's then very difficult to launch into a health promotion spiel on the positive benefits of breastfeeding.
>
> If we put you in a box to start with then that person feels they're in that box and can't move out of it.

The midwife also plays a supportive role during labour and birth, and the experience of this can effect a mother's decision to breastfeed or not. A number of women

consulted via the questionnaire cited a bad experience of labour /birth as a reason for not breastfeeding. Some mainstream midwives identify the attending midwife as being responsible: 'I personally think that's down to the labour ward midwife that they can't do it – they should have had someone with them after delivery to help them'. However, the same midwives felt that perhaps some women used labour and birth as '…an excuse to say why I didn't breastfeed'.

Sure Start and mainstream staff alike pointed to certain key times to promote breastfeeding. One advocated targeting secondary schools. Another commented:

> All the research is about people deciding how to feed their baby before they even become pregnant, so you've got to get the education in early which obviously means at schools and finding out what the norms are there, how people feel about it.

Another time considered opportune for promoting breastfeeding was during antenatal contact with expectant mums. A Sure Start worker commented: 'I think if we'd had a couple more midwives on the team for breastfeeding … A lot of people have asked for more antenatal care'.

4.2 Impact on Sure Start's Breastfeeding Target

Opinions regarding the actual impact of Sure Start upon breastfeeding rates in the programme area varied. Comments ranged from Sure Start having no impact, to the programme opening up women's minds to the idea of breastfeeding, to the possibility of Sure Start having more of an impact by setting up specific target groups. Generally, however, interviewees found it difficult to comment on whether Sure Start had had an impact of breastfeeding rates, as other factors often come into the equation. A mainstream Nursery Nurse commented:

> We have had one or two that you would have expected not to that have but again, I couldn't say it's to do with Sure Start. It might have been preference or peer pressure, I couldn't say.

A group of mainstream midwives discussed the increasing number of breastfeeding women in the area, estimating a 15 per cent increase of women initiating breastfeeding compared with ten years ago. However, they felt:

> A lot of it's to do with what we do and what, not necessarily Sure Start, other groups are doing.

One interviewee felt that, overall, 'the mums that you expect to breastfeed have', so little has changed in that sense. However, a mainstream worker believed that although women may not opt to breastfeed once they have chosen to bottle-feed, they may be more likely to think about it as a result of the new approach to discussing breastfeeding. Perhaps the midwife is 'sowing the seed' for any future pregnancies: if the mother has been exposed to information and guidance regarding breastfeeding, she may choose to try it second time around.

Regardless of any direct impact on breastfeeding rates, one mainstream worker described the overall input from Sure Start Newcastle East via the programme's midwife as positive:

> Certainly it's changed because people can link in with the Sure Start midwife. There's a lot more support for women out there now and that is making a

> difference; there's a lot more available now to the women than there was before.

Mainstream midwives also show appreciation to Sure Start for their contribution to resources in mainstream midwifery; one midwife discussed the issue of funding:

> We have such a problem getting up to date videos; financially, the Trust cannot provide it for everywhere and we're having to beg and borrow from the breastfeeding workshops, but [the Sure Start midwife] had the money to purchase them for her groups so she's actually letting us use them.

Resources borrowed from Sure Start by mainstream midwives included dolls to demonstrate breastfeeding, leaflets, flipcharts and a television for use during Parent Craft sessions.

> …if she's got them and she's not using them then we're more than welcome to use them which has been great for us. These are things that we've been asking for from the hospital for years.

Without Sure Start resources, this mainstream midwife and others in her practice would struggle to provide the same resources through NHS/mainstream funding, thus Sure Start is having an impact upon midwifery service delivery for breastfeeding in the area.

A nursery worker believed that it would be possible to increase breastfeeding rates in the area if there were a specific group set up focusing on breastfeeding: 'If there was a group we could access on breastfeeding, this is a good starting place - we would get a response'. Another mainstream worker also welcomed the notion of a group specific to breastfeeding, particularly for pregnant teenagers/teenage mothers who can find traditional Parent Craft classes inaccessible:

> We're trying to get around this Parent Craft issue because most of them don't come to Parent Craft but most of them want to go for a tour around the hospital.

As a result, she is trying to organise specific sessions for young people around breastfeeding, and a few of her clients have expressed an interest in attending these sessions. Although she is not expecting great numbers to attend, this interviewee felt that her experience with young women and the responses to the idea of a specific group were encouraging and the group would have a positive impact upon infant feeding methods.

Parent Craft, while believed to be inappropriate for younger women, was described in a positive light by other interviewees, particularly when compared with previous styles of antenatal education:

> Parent craft is done in a totally different way now, it's much more interactive, not somebody standing at the front telling them what to do. Therefore, you'll get questions and the whole group will hear the answers … it's much more open discussion.

Training relevant to breastfeeding

Of the mainstream and Sure Start staff interviewed, the majority had not received training specific to breastfeeding, and those who had had mixed feelings regarding its value:

> I don't personally feel it's helped in the delivery of it. I think that comes more from personal experience and knowledge rather than from what the course offered.

One mainstream worker felt that attending a Bloomsbury workshop had supported her work when she worked in an area with a higher breastfeeding rate: '…it helped me at that practice, with breastfeeding knowledge and skills'.

Mainstream midwives appreciated the change in service delivery over the years which was a result of further research into antenatal education, particularly '…breastfeeding teaching techniques.' Other factors contributing to this positive change included the role of facilitators at breastfeeding workshops and a more proactive approach to breastfeeding generally:

> Years ago, we didn't get the training. It's only been the last 8-10 years that they've trained the professionals on how to give information and support. Having people who are interested in it giving the information, as opposed to people who are not necessarily disinterested in it, but haven't had a lot of training themselves.

These midwives described training in a very positive light, encouraging a change in the whole approach to breastfeeding and methods of teaching to expectant parents. Before training in this area commenced, most midwives relied on personal experience of breastfeeding or practice followed by the hospital they work in, which often led to subjective or inconsistent advice being given:

> The idea is that the women are not going to get conflicting advice. We all have very much the same philosophy on breastfeeding here.

The Sure Start midwife had organised and delivered a short course for Sure Start workers and Community Nursery Nurses, entitled 'Breastfeeding: what's it got to do with me?'. The course encouraged all staff to acknowledge and appreciate the relevance of breastfeeding in their line of work and its impact upon the health of the child, including the role they could play in promoting it.

4.3 Parent's Views on Breastfeeding Service Provision

Several parents were interviewed about all three target areas. Discussion on breastfeeding focused on their own experience of feeding their babies, what might influence a woman's decision to breastfeed, and breastfeeding advice and support. Often women report feeling uncomfortable breastfeeding in public; however one parent explained that this was never an issue for her as she expressed her breast milk so that her partner could feed them from a bottle, and this could also be done when in public. Another issue often mentioned as an explanation for bottle-feeding is the involvement of the paternal figure in caring for the baby. If the mum breastfeeds, the father can feel excluded: 'With their dad, he did feel left out because he couldn't feed them … He wanted to give the baby the bottle and he couldn't'.

The same respondent explained the basic benefits of breastfeeding over bottle-feeding; she had 'never really heard anything bad about it':

> It gives the baby a good start in life; something to do with your milk and it's supposed to make them more brainier or something.

This interviewee did not attend any antenatal classes during her pregnancy and gained this information and more about breastfeeding from family, close friends and health visitors: 'I got [advice] off everybody!' She also believed that if a mother had breastfed her children, then it would be more likely that her children would choose to do the same with their children, particularly 'if you're on your own'.

Parents cited the following reasons why women might choose to bottle-feed as opposed to breastfeed:

- religion
- self-confidence
- feeling self-conscious
- effects of breastfeeding on the body
- birth-related issues.

One parent believed that those people who felt self-conscious about breastfeeding may do so because of cultural and historical associations regarding women's breasts – '…the fact that breasts are seen sexually.'

Peer pressure was also considered as having an impact upon infant feeding methods:

> If anyone does anything differently they become isolated… In this area it is not unusual for three people in one street to be due babies at the same time. If two bottle-feed and one decides to breastfeed, the latter immediately loses affinity. So it is just easier to bottle-feed so you stay in the loop.

One parent involved in offering breastfeeding support felt that the bottle-feeding culture needed to be tackled antenatally via outreach work. She suggested visiting youth clubs to speak with younger people, but not schools as pupils may see it as irrelevant. Some efforts have been made to improve breastfeeding rates:

> It is very competitive in relation to baby milk [but] baby milk reps are now banned from the RVI.

Another suggested encouraging those women who do breastfeed to do so in public places in order to make it more acceptable.

4.4 The Questionnaire Results - Quantitative

The following analysis considers female and male respondents separately, further dividing these sections into non-parents and parents. The actual numbers are given with the total in brackets.

Female Respondents

There were 274 female respondents. Of these, 8 were from ethnic minority groups. 23 were under the age of 20, 126 were aged 20-34, 75 were aged 35-49, thirty were aged 50-64, and 20 were over the age of 65. 28 respondents (10%) had no children, while the remainder - 246 (90%) - had children, either still young or grown up.

Female non-parents

Among this group, the following numbers in each age category were bottle-fed and breastfed (the total number for each category is in brackets):

	under 20	20-34	35-49	50-64	65+
Bottle-fed	9	4	3	1	2
breastfed	2	1	2	0	0
both	0	1	1	0	1
don't know	0	0	1	0	0
total	**11**	**6**	**7**	**1**	**3**

47% (9) of non-parents who were bottle-fed (19) as babies were able to name any/some benefits of breastfeeding compared with 80% (4) of non-parents who were breastfed (5) as babies.

37% (7) of bottle-fed non-parents were comfortable with others breastfeeding in public, while 60% (3) of breastfed non-parents were comfortable with public breastfeeding.

First-time expectant mums
Only two female respondents undertaking the questionnaire were expecting their first child, and these results are presented in total numbers.

One of these was bottle-fed as a baby (20-34 age category) and the other was breastfed as a baby (under 20 age category). Both were able to name some/any benefits of breastfeeding. The former respondent was intending to bottle-feed her baby, and the latter to breastfeed. Both respondents had made their decisions before they became pregnant, and by themselves, without help from partners, family/friends, or professionals. Both thought it was 'okay' to breastfeed in public.

Mums
Among this group, the following numbers in each age category were bottle-fed and breastfed (the total number for each category is in brackets):

	under 20	**20-34**	**35-49**	**50-64**	**65+**
bottle-fed	6	89	46	17	4
breastfed	0	14	15	12	10
both	2	11	4	4	0
don't know	0	4	4	1	3
total	**8**	**118**	**69**	**34**	**17**

47% (77) of those mums who were bottle-fed as babies (163 total) were able to name some/any benefits of breastfeeding. 47% (24) of mums who were breastfed as babies (51 total) were able to name some/any benefits of breastfeeding.

Of the mums who were bottle-fed as babies, 56% (91) were comfortable with others breastfeeding in public; of those who were breastfed, 45% (23) were comfortable with others breastfeeding in public.

The following numbers in each age category bottle-fed and breastfed their own children:

	under 20	**20-34**	**35-49**	**50-64**	**65+**
bottle-fed	8	73	37	17	4
breastfed	0	16	10	2	7
both	3	30	20	10	6
total	**11**	**119**	**67**	**29**	**17**

Of the 266 white mums, 52% (138) solely bottle-fed their babies and 12% (32) solely breastfed their babies. Of the 8 non-white parents, only one respondent solely bottle-fed their baby and four respondents solely breastfed.

65% (106) of mums who were bottle-fed as babies (163 total) solely bottle-fed their children (never attempted breastfeeding). 35% (57) of those who were bottle-fed as babies breastfed their children.

31% (16) of mums who were breastfed as babies (51 total) solely bottle-fed their children (never attempted breastfeeding). 67% (35) of mums who were breastfed as babies breastfed their own children.

Of the 139 mums who chose to solely bottle-feed their babies, 30% (41) decided this before they became pregnant; 50% (69) made the decision to bottle-feed during their pregnancy; 20% (29) decided to bottle-feed their baby once they had given birth.

Of the 36 mums who chose to solely breastfeed their babies, 47% (17) decided this before they became pregnant, 39% (14) made the decision during pregnancy, and 17% (6) decided at birth.

Of those mums who only bottle-fed, only 38% said they knew someone who had breastfed, compared to 69% of those who had breastfed.

Of those mums who made the decision to solely bottle-feed their baby (139), 6% (8) got help from a partner with this decision, 3% (4) got help from family/friends with their decision, and 23% (32) got help from professionals.

Of the mums who decided to solely breastfeed their baby (36), 8% (3) got help from a partner when making the decision, 19% (7) were helped by family/friends when making their decision, and 25% (9) got help from professionals when deciding to breastfeed.

When considering breastfeeding in public, 73% (102) of mums who had only bottle-fed felt comfortable seeing other women breastfeeding in public, whilst 72% (26) of breastfeeding respondents felt comfortable seeing other women breastfeeding in public.

On discussing support while breastfeeding, of those who had breastfed (105), 40% received support from professionals while breastfeeding, 5% from family/friends, 10.5% from professionals and family/ friends, 4% only from their partner, 3% from partner and professionals, and 2% from Sure Start specifically. The remaining 35.5% received no support at all while they breastfed.

67% felt they breastfed for as long as they wanted to, 14% felt they breastfed for too short a time, and 8% felt they had breastfed for too long a time.

Of those mums who breastfed, 39% (14) said they were happy to breastfeed in public whilst 36% (13) were not happy to breastfeed in public. Those who were not happy to breastfeed in public were mainly in the older age categories. Of the 39% (14) of breastfeeders who were happy to breastfeed in public, 86% (12) received general support whilst breastfeeding. Of the 36% (13) of breastfeeders who were not happy to breastfeed in public, 62% (8) had received general support whist breastfeeding.

Of those breastfeeders who had not received any support (9), 33% could not say how long they had breastfed for, while the others had all breastfed for at least four months (22% for 4-5 months, 22% for 6-9 months and 22% for more than nine months). Of those who had got support only from professionals (16), all had breastfed for at least two months (31% for 4-5 months, 31% for 6-9 months and 31% for more than nine months). Of those who had received support only from family/friends (7), all had breastfed for at least two months (14% for 2-3 months, 29% for 6-9 months and 57% for more than nine months). Of those who had received support from professionals and family/friends (3), all had breastfed for at least six months.

Male Respondents

There were 61 male respondents. Of these, 8 were from ethnic minority groups. 5 were under the age of 20, 19 were aged 20-34, 20 were aged 35-49, 8 were aged 50-64, and 9 were over the age of 65. 11 (18%) had no children, while the remainder - 50 (82%) - had children, whether they were still young or grown up.

Non-parents

Among this group, the following numbers in each age category were bottle-fed and breastfed:

	under 20	20-34	35-49	50-64	65+
bottle-fed	2	0	0	0	0
breastfed	0	0	0	1	1
both	0	1	1	0	0
don't know	2	2	0	0	1
total	**4**	**3**	**1**	**1**	**2**

The majority of male non-parents did not know how they had been fed as babies. None could name any benefits of breastfeeding, and none were comfortable with women breastfeeding in public.

Dads

Among this group, the following numbers in each age category were bottle-fed and breastfed:

	under 20	20-34	35-49	50-64	65+
bottle-fed	1	13	6	2	1
breastfed	0	5	7	2	4
both	0	0	2	2	1
don't know	0	0	2	0	2
total	**1**	**18**	**17**	**6**	**8**

The majority of male respondents with children did know how they had been fed as babies. Of the 23 dads who were bottle-fed as babies, 78% (18) were able to name some/any benefits of breastfeeding. Of the 18 dads who were breastfed as babies, 83% (15) were able to name some/any benefits of breastfeeding.

57% (13) of the dads who were bottle-fed felt comfortable with women breastfeeding in public, while 67% (12) of the dads who were breastfed felt comfortable with women breastfeeding in public.

The following numbers in each age category said their own children were bottle-fed or breastfed:

	under 20	20-34	35-49	50-64	65+
bottle-fed	0	14	11	2	4
breastfed	0	2	5	2	0
both	1	2	2	2	3
total	**1**	**18**	**18**	**6**	**7**

Of the 23 dads who were bottle-fed as babies, only 4% (1) of their partners breastfed their children. Of the 18 fathers who were breastfed as babies, 39% (7) of their partners breastfed their children.

Of the partners who bottle-fed their children (29), 31% (9) decided to do so before they were pregnant, 35% (10) during their pregnancy, and 21% (6) once the baby was born. 14% (4) of the male respondents did not know when their partner decided to bottle-feed.

Of the partners who breastfed their children (9), 22% (2) decided to do so before they were pregnant, 44% (4) during pregnancy, and 11% (1) once they had the baby. 22% (2) of the male respondents did not know when their partner decided to breastfeed.[3]

28% (8) of the dads whose partners solely bottle-fed (29) said they helped to make the decision. None said their partners received help from family/friends when deciding to bottle-feed and 21% (6) said their partners received help from professionals with their decision.

Only 11% (1) of the dads whose partners breastfed (9) said they helped to make the decision to breastfeed. 11% (1) said their partners received help from family/friends when deciding to breastfeed, and 33% (3) from professionals.

54% (15) of all dads (28) whose children were bottle-fed thought it was okay to breastfeed in public, whilst 89% (9) of all dads (10) whose children were breastfed thought it was okay to breastfeed in public. Six dads elaborated on this question and commented on whether or not they would mind their own partner breastfeeding in public. Five said they would not mind at all, while the sixth said he would not want his partner to breastfeed in public 'because of perverts'.

Of the 44 white dads who responded, 64% (28) of their partners solely bottle-fed their children and 14% (6) solely breastfed. Of the 8 non-white respondents, 38% (3) solely bottle-fed and 38% (3) solely breastfed.

4.5 The Questionnaire Results - Qualitative

In the questionnaire on breastfeeding carried out among parents and non-parents in the area, respondents were asked to name any benefits they knew of breastfeeding. The following benefits were named by female respondents. Of the 274 female

[3] It must be recognised that these two sets of statistics may not be accurate: they reflect dads' *perceptions* of when their partners had made their decision about how to feed their baby.

respondents, 200 were able to name benefits, 50 said they could not think of any benefits, and 24 said they did not know or did not comment. The benefits are categorised and the numbers of respondents who named each benefit is in brackets:

Benefits for baby

- Better for baby (60)
- Immunisation (27)
- Bonding and love/closeness (23)
- Healthier for baby (19)
- More nutrients/vitamins/ protein (16)
- Better than bottle (10)
- Healthier baby/children (8)
- More natural (7)
- Reduces allergies (5)
- Best start to give baby (4)
- Antibodies for baby (4)
- Protection from asthma/eczema (4)
- Baby/children more intelligent (3)
- Breast milk is the right temperature (3)
- Goodness in breast milk (3)
- Great for mother and baby (2)
- Protection from ear infection (2)
- Protection from infections (2)
- No chemicals in breast milk (2)
- Breast milk got everything in it (2)
- Helps baby thrive (2)
- Children end up big, strong and healthy (1)
- Protection from chicken pox (1)
- Prevents sickness, diarrhoea and wind (1)
- Bottle makes baby sick (1)
- Good for physical and mental growth (2)
- Better development (1)
- Stabilises baby's weight (1)
- More energetic (1)
- Comfort (1)

Benefits for mum

- Get figure back / loose weight (20)
- Cost - cheap/free (15)
- Convenient (14)
- Instant (6)
- Easier than bottle-feeding (6)
- Feel healthier generally (6)
- No need to make up bottles (3)
- Hygienic (3)
- Reduces risk of cancer (breast/ ovarian)
- Calming (2)
- No sterilisation of bottles (2)
- Don't have to make bottle in night (2)
- Fantastic (2)
- Relaxing (1)
- Womb contracts (1)

- Contraceptive (1)
- Can combine breast and bottle (1)

General benefits

- Loads of benefits (4)
- Everything (2)
- Breast is best (1)
- Best thing if you can do it (1)
- Loved it - recommend it (1)
- Wish I had breastfed (1)
- If you can do it, you should (1)

The following benefits were named by male respondents. Of the 61 male respondents, 40 were able to name benefits, 16 said they could not think of any benefits, and 5 said they did not know or did not comment. The benefits are categorised and the numbers of respondents who named each benefit is in brackets:

Benefits for baby

- More natural (7)
- Immunisation (6)
- Healthier baby/children (6)
- Better for baby (6)
- Nutritious for baby (5)
- Good start for baby (2)
- Protein for baby (2)
- More vitamins (2)
- Goodness from mother (2)
- Antibodies (1)
- Chemicals in bottle milk (1)
- Better than bottle (1)
- Calcium for baby (1)

Benefits for mum/ dad

- Cheap (2)
- Good feeling for mother (1)
- Automatic response from mother (1)
- Convenient (1)
- Men don't have to get up in night to feed baby (1)

General

- Most women breastfeed in my home country (2)
- Best thing to do
- Many benefits (1)

Respondents were also asked if they thought there were any drawbacks to breastfeeding. Of the female respondents, 108 could name no drawbacks, 21 said they did not know or did not answer. The remaining 145 female respondents named the following drawbacks:

- Inconvenient to feed in public/ difficult to find place to feed (29)
- Sore breasts (23)
- Only the mum can feed/ partners cannot feed (15)
- Tied to baby unless can express milk (13)
- People don't like you doing it/ public opinion/ other people's reactions (10)
- Embarrassment for mum (7)

- Can't go out/ no social life (7)
- Sore/ cracked nipples (5)
- Time consuming/ mum constantly feeding (5)
- Breasts leak (4)
- Mum can pass on bad things too, especially if on drugs (3)
- Some people can't manage it (2)
- Mastitis (2)
- Don't know how much milk baby is getting (2)
- Not being able to stop/ wean baby off (2)
- It is difficult to do (2)
- Baby can be sick after feeding (1)
- Expressing milk may not work (1)
- Baby can bite when teething (1)
- Difficult when returning to work (1)
- Permanently tied to child (1)
- Lumps on breasts (1)
- Depression - horrible (1)
- Everything (1)
- Breasts not filled with milk for first few days (1)
- Confidence of mum - baby might not take to it immediately (1)
- Effort (1)
- Hurts back (1)
- Wrecks mum's body (1)
- Dad is not as involved (1)
- I don't like it - it's disgusting (1)
- Constant demand for milk (1)
- Not nice in public (1)
- Baby never sleeps (1)
- Baby always wants to be fed (1)
- Milk spots (1)
- Demanding (1)
- Can't do what you want (1)
- Cancer (1)
- Need to build confidence up (1)
- Black nipples (1)
- Bad experiences put you off (1)
- You didn't show yourself in my day! (1)
- It depends on what mum feels like after birth (1)
- Baby clings to mum (1)
- Abscesses on breasts (1)
- Makes baby fatter as an adult (1)
- Some feeding rooms are not nice (1)
- Uncomfortable (1)
- Bottle is better (1)
- Tiring (1)
- Milk dries up (1)
- Can't do it with twins (1)
- It is supposed to protect baby from infection, but didn't in my experience (1)

Of the male respondents, 39 felt there were no drawbacks to breastfeeding, and 8 said they did not know or did not comment. Of the 39 who felt there were no drawbacks, many were very positive about it, making such comments as 'I'm all for it'. The remaining 14 made the following comments about the drawbacks:

- Inconvenient in public (3)
- Awkward (2)
- Pain (2)
- Mum is tied to the baby (1)
- Milk may not come through (1)
- Baby clings to mum (1)
- Difficult to change to bottle (1)
- Mum always has to feed (1)
- Embarrassment (1)
- Uncomfortable for mum (1)
- Cracked nipples (1)
- Lack of facilities (1)
- No privacy (1)
- Doesn't involve partner (1)
- Difficult to do (1)
- Hepatitis B is transferred through breast milk (1)
- 'Perverts' when women are breastfeeding in public (1)

The questionnaire also asked respondents to identify whether they or their partner had tried to breastfeed a child and then stopped, and if so why. The following reasons were given:

- Pain (13)
- Not enough milk (7)
- Hungry baby (5)
- Easier to bottle-feed (3)
- Baby did not latch on properly (2)
- Leaking (2)
- Needed to monitor amount (1)
- Couldn't get it right (1)
- Mum became ill (1)
- Baby lost too much weight (1)
- Made the mistake of expressing milk and baby got used to bottle (1)
- Difficult labour (1)
- Baby sleeping too much (1)
- Others were embarrassed and so I felt awkward (1)
- Didn't like it (1)
- Men's reactions - felt uncomfortable (1)
- Cracked nipples (1)
- Nowhere to feed in comfort (1)
- Embarrassing (1)
- Only tried breastfeeding because everyone said I should (1)
- Got pregnant again soon after (1)
- Mum had operation - too stressful (1)
- Took too long (1)
- Difficult (1)

Likewise, if they had more than one child and had breastfed the first and bottle-fed others, they were asked to explain why:

- Second child was premature (2)
- First child was still young, so I did not have enough time to breastfeed the second (1)
- Second and third children were twins and I was told not to breastfeed (1)
- Had first and second child very close together; if the second child saw me breastfeeding the baby, he would have wanted breastfed too (1)
- Breastfed four girls, then had a boy and bottle-fed him so that his sisters could help feed him (1)
- Breastfed first child (boy), then had a girl and bottle-fed her because I didn't want a girl at the time (1)
- Second child had kidney problems (1)

5. The Findings 2: Service Delivery - Smoking Cessation

5.1 Environmental Influences

Stress

Sure Start and mainstream staff alike mentioned general life stresses as an explanation for the high rate of smoking in the East End. The following is typical of opinion among mainstream and Sure Start staff working in the area:

> People here are under a lot of stress and pressure and they use smoking as an escape. If you take that away, they've lost enough to start with, taking that away from them - it's quite difficult…
>
> If smoking is their only vice it's not so bad

The pressures and stresses which may contribute to the uptake of smoking can also be responsible for an ex-smoker starting up again; examples given included peer pressure, social events, alcohol intake and the side effects of stopping smoking. One major concern for many people wanting to stop smoking is the weight-gain side effect.

A support group set up by Sure Start Newcastle East for those stopping smoking covers the issues which may cause people to start up again. The facilitator explained:

> We work around alcohol and the effects of your diet, how putting weight on is a problem when you pack in smoking as that itself can make you start smoking again. Weight gain, social life, peer pressure and general life stresses tend to get people starting up again.

Cultural norm

Staff felt that in the programme area, smoking is culturally acceptable. Comments made included:

> Part of it's cultural, the history of the area.
>
> Smoking is still embedded in that culture really.
>
> It's just a way of life for a lot of people.
>
> It's the norm to do it.
>
> It is a culture thing.

One mainstream worker attributed high rates of smoking to socio-economic status. Alongside the acceptability of smoking in this area, another issue is the availability of cigarettes on the black market at very cheap rates. This situation encourages the continuation of smoking by making cigarettes more easily available. Another explanation offered for low rates of smoking cessation was that 'information isn't getting out there in a way that's accessible to people to understand'.

Support from family/friends

Other than stress and the side effects of smoking cessation, and the acceptable nature of smoking in the programme area, support is vital if a person is to successfully quit

smoking. One suggestion made attributed difficulty stopping smoking to a lack of support from family, encouraged by the apparent normality of this habit in the area:

> I don't think people get a lot of support from their families, it's just a tradition that people here smoke and continue to smoke. So people don't get the support from their families and the encouragement they need.

One mainstream worker provided an example to support the above opinion; one of her clients, a pregnant teenager, wanted to stop smoking but had tried previously and was unsuccessful. The interviewee felt that this unsuccessful attempt was as a result of the home environment in which her client lived:

> It's incredibly difficult because, for most of them, they're living with their parents who are chain smoking, even then if they stop smoking, they're passive smoking aren't they? It's not like they're living independently with a partner when they can both say that they'll stop smoking together.

Basically, this worker felt that although the smoker may want to quit, family life and support (or lack thereof) are vitally important if the smoker is to succeed.

5.2 Impact on Sure Start Targets

Promotion

A major method of promotion of Sure Start services is leaflets. For smoking cessation, the Sure Start health worker has utilised coasters (for drinks) to promote the benefits of smoking cessation and believes that this is a more successful method of sharing information about smoking cessation with Sure Start service users:

> We put them in all the centres so they should be on tables if people are having coffees – that's more subliminal stuff, if people are sitting around having a coffee, they're more likely to read a coaster than a leaflet.

Smoking cessation and its support groups are also advertised in other family centres, Sure Start services and libraries, encouraging services to link together and promote all activities widely. Overall, information regarding smoking cessation is made available in different formats and throughout Sure Start centres; it is the decision of the individual to stop smoking and access a support group should they need it.

The issue of choice is important to those workers involved with Sure Start smoking cessation support groups; they recognise that their influence is limited as, ultimately, 'all I can do is say this is the information, it's your choice'. To encourage clients to stop smoking, Sure Start workers try to create a non-judgemental and non-threatening environment for those accessing smoking cessation support groups: 'you're not there to force anyone to change their habits.' A mainstream worker supported the notion of choice, believing that a change in behaviour can only take place when the person is ready to make that change. A cultural shift away from smoking will not 'happen in 1-2 years, you're talking about 10-20 years to change these behavioural patterns'.

Educating people regarding the ill effects of smoking cigarettes was considered to be the long-term solution to reducing smoking rates:

> Educating them about health and things like that is the way to start; it'll take a long, long time but all you can do is educate people.

However, the limitations of this approach were recognised: ultimately, the individual must choose to give up and want to go ahead with it: 'They'll still make their own

minds up on what they want to do'. Sure Start support workers emphasised the importance of the timing of advice on smoking cessation:

> If somebody comes into a group session in a total state, having had a terrible night with their [child] – what's the first thing they're going to want? A cigarette and a cup of coffee! You don't turn around and say you shouldn't smoke at this point; you try and get them through that bit and then work on the rest later.

She continued:

> Usually, if you're getting to that point with somebody where they're opening up to you anyway, you can usually get to the next part, gradually, educating them – you've got to gain their trust first.

Some mainstream staff suggested that Sure Start did not have the capacity to ensure that the timing of their advice on smoking cessation was right for the individual concerned because of the restrictive nature of their targets:

> I know from experience with the group, if you say 'shall we do a session on smoking cessation?', they're just like 'no'. It's how you package it, so if you get somebody down to the group who's doing smoking cessation, that's just going down like a lead balloon. They've got such set targets … In my mind [smoking cessation issues] are ongoing agenda items each week that you'd encourage to come up in discussion as much as possible, but pushing it, with young people in particular, is just pushing them in the wrong direction.

This interviewee felt that having set groups and sessions for specific issues (like smoking cessation) was not useful as this type of issue should be tackled continuously, and in response to client demand.

Medical input

Comments relating to the issue of accessibility concerned medication to support patients when trying to stop smoking. It was felt that the procedures necessary to access such medication acted as a barrier to stopping smoking:

> …the barrier for a lot of people is having to go to the doctors, getting a prescription, having to go through all that, then having a check up.

This interviewee suggested making medication available over the counter.

A Sure Start worker discussed the role of medication and the procedures they go through when stopping smoking via the Sure Start smoking cessation group:

> Each person gets an individual assessment and I'll assess which medication is best for them. We do the patches, you can have the high dose patches for 4 weeks, then we can reduce them slowly, and the lozenges or chewing gum. We measure with the carbon monoxide monitor, their AGPs.

Although it is recognised that medication has an important role to play, this worker was also concerned with the lifestyles of those individuals trying to quit and encouraging them to prepare for smoking cessation.

Dropout

Two interviewees commented on dropout rates from both mainstream and Sure Start smoking cessation support groups. One mainstream worker described the time commitment required by individuals wishing to stop smoking with the assistance of their GP surgery:

> It's a one-to-one basis. We do an initial assessment and then we do it over 12 weeks and they come back every two weeks.

This interviewee estimated that a third of those accessing the support 'actually stay the course, possibly less than that'.

Sure Start workers recognised the value of any attempt to stop smoking, successful or otherwise; one interviewee felt that those who had stopped smoking but then relapsed would be more likely to be successful at stopping at a later date:

> They might have relapsed at some point but they might make a better attempt and sustain it the second time around.

Smoking cessation was also discussed in relation to pregnancy; the same interviewee comments:

> What we've got to remember is that very few people manage to quit on their first attempt. We're not saying the pregnancy in isolation, that quit attempt might be so important for her when she tries next time because it might be the next time she does succeed having learned from the failed quit attempt.

Success of Services

Sure Start staff felt that the main concern parents had about stopping smoking was putting on weight, replacing the smoking habit with eating. This was a particular concern for female clients.

Interviewees suggested a number of aspects responsible for a successful smoking cessation service:

- engaging a number of people in a group
- timing of advice
- educating children about the risks of smoking, thus decreasing the likelihood of taking up smoking in the first place: 'Children are actually very aware, they get a lot of help at school, schools are quite good on health issues ... I think it's making a difference, I really do … You've got people that they respect saying 'don't do it', which probably means more than if you've just got me who's never smoked before saying don't do it.
- workers' understanding of other issues affecting a quit attempt.

An interviewee discussed the success of a Sure Start smoking cessation group where 5 of the 7 group members quit successfully. This worker felt that the group situation - having each other for support and empathy - was partly responsible. Another interviewee attributed successful smoking cessation to the timing of intervention only - 'whether they are ready' to stop.

Most interviewees felt that the most unsuccessful approach to educating people about smoking is in a formal manner, particularly in relation to teenagers:

> We have had people in to talk in a much more formal way … one girl stopped for a couple of days but that was it.

This interviewee felt that the members of this group were not ready to stop smoking 'because of circumstances at this point in time, there aren't any of them who are in a position where they would like to stop.' She prefers to discuss the issue of smoking at their weekly sessions, 'sowing the seed' as it were and making her clients aware that she is there for advice and support if they require it.

Training

Some interview respondents had completed smoking cessation training or had attended awareness days. Some interviewees felt that there were a number of sources of advice available to those who wanted to stop, including clinics run by pharmacists at GP surgeries, and, as such, did not feel the need for in-depth training or wish to set up a group. Some mainstream workers feel their role is to do 'more of the listening' and send them to the appropriate source of advice/support, so full training would not be useful to some staff. However, some Health Visitors do provide one-to-one support in the home around smoking cessation and so are trained in this. One mainstream worker completed training in order to set up a smoking cessation clinic at her surgery. Another interviewee, having 'done some bits on smoking cessation', draws on advice from her colleagues:

> I link in with [*name*] who is the smoking cessation midwife. I can always ask her if there's anything I'm unsure of.

Aside from this advice, this interviewee also completed smoking cessation training in relation to young people which has been extremely useful in relation to her work with clients. Another mainstream worker also undertook training specific to her role as a midwife:

> It definitely helped when I was working in the community, looking at and discussing smoking cessation with the women and partners.

The general feeling therefore was that training in smoking cessation which is specific to a job role is more useful than general training for non-related staff members.

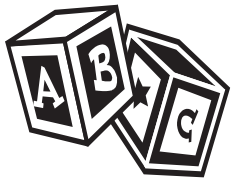
5.3 Parents' Views

Parents generally discussed the issues which prevented people from stopping smoking or made the quit attempt more difficult. Comments included:

> I'd say the habit – once they stop smoking, what do they do with their hands?
>
> With me, it's in case I put extra weight on, that's what scares me.
>
> Every time people say to me 'are you going to stop?', I don't want to because I feel as though I'm doing it for them and not for me.

Parent interviewees felt that Sure Start's smoking cessation provision was successful due to its format and the worker running the group. The smoking cessation worker has 'got the time to go away and find out' should the service user ask a question or ask for advice, while the GP does not have the time or opportunity to provide this intensive support. Furthermore, the format of the smoking cessation group is said to be a success because 'being together, it helps you more'. Two parents felt that the group situation was ideal when trying to stop smoking as 'you're always getting support and encouraging each other, being there for each other'.

6. The Findings 3: Service Delivery - Speech and Language



6.1 Background

The speech and language team at Sure Start Newcastle East consists of a speech and language co-ordinator, a speech and language therapist and a speech and language assistant. They work towards two national targets:

- An increase in the proportion of children having normal levels of communication, language and literacy at the end of the Foundation Stage
- An increase in the proportion of young children with satisfactory speech and language development at age 2 years (Objective 3: Improving Learning).

For the second, 'data will be collected from each Sure Start local programme by the application of a specially devised measure of speech and language development at age 2. The measure is a parent report administered by Sure Start workers in each local programme who return data to the Sure Start Unit (or their representatives) annually'.

It is an enabling service, with the emphasis on training and disseminating skills to:

- Other Sure Start staff
- Community nursery nurses
- Health visitors
- Mid-wives
- Playgroup and nursery staff

The speech and language team have delivered training to staff within the programme as well as to mainstream staff. As a follow-up to the training, they have a helpline one afternoon every month, where Sure Start speech and language staff are available for mainstream staff to phone up with any queries they may have. They also visit local nurseries and playgroups to provide more direct assessments and input for any children the staff may have concerns about in relation to speech and language development:

> It's a lot about disseminating our skills, and really getting across messages about language - strategies for language development. So we've done a big focus on training. But also part of our work is we have some consultation sessions in nurseries where the nurseries would talk about children that they're concerned about and individual consultation about those children. And we can always refer those children onto mainstream. We've always got to remember that children can access both services. We're not replacing a mainstream service, we're trying to add value and look at a different way of working.

In line with this approach, the team has developed 'Children Talking' displays at local nurseries and playgroups in the area. They take photographs of staff interacting with children, and children interacting with each other, in ways which stimulate speech and language development. These are then displayed, along with captions, in the foyer of the nursery/ playgroup for parents and children to see. The aim is to educate parents about what they can do to help their child's speech and language development, and to

emphasise the role of parents/ families in this aspect of their child's development. On a similar vein, the team has recently organised a 'Baby Talk' display at the East End Library, with photographs of mums and babies interacting.

The team runs a group for children with speech and language problems or delays and their parents, concentrating on speech and language through play. This was held at West Walker family centre, but has recently been moved to Thomas Gaughan community centre. It is delivered in conjunction with a mainstream health visitor and a mainstream nursery nurse. The health visitor concerned explained:

> We had the initial idea after doing a two year check, wanting to refer the child but the waiting list was really long. The child's problem may not have been a speech disorder, rather lack of stimulation or quality input – so, perhaps they didn't need to be put onto the speech and language therapy waiting list.

The group gives parents ideas on how to play with their child depending upon their developmental stage: 'It is about how we can leave things in place'. The waiting list for the group is approximately six weeks, compared to about six months for statutory speech and language therapy.

Mainstream staff involved in delivering the group explained that families will still need speech and language input once the group is over, and most will go from the group to mainstream speech and language therapy. However, the group should better prepare parents and children for formal speech and language therapy, enabling them to get more from the experience. Mainstream staff involved said they would like to make telephone contact or even home visits with the parents leaving the group, although this would be difficult with other caseload commitments. However, parents always have the option of phoning them or their own health visitor for extra support.

There are also plans for a PEEP (Peer Early Education Partnership) group on speech and language from birth upwards, which would incorporate social, emotional and child development as well as family support. This is about to be piloted (January 2004).

6.2 Environmental Influences on Speech and Language

A member of the Sure Start Newcastle East Speech and Language team pointed out that while environmental issues may have an impact on a child's speech and language development, they do not cause speech and language problems. Therefore Sure Start and mainstream staff were asked about environmental influences on speech and language *delay* in children.

Early communication was seen by mainstream and programme staff alike as an essential part of children's speech and language development, and many felt that this was often lacking among families in the area. It was felt that many parents 'may have no understanding of their role' in the speech and language development of their child. A member of staff at a local playgroup described how the Sure Start speech and language team had tried to arrange a coffee morning for parents at the playgroup, to discuss issues around speech and language development:

> The response was not very good. That wasn't because we hadn't advertised it, it was because a lot of parents see playgroup and child development as something that will just happen, rather than you have to work on it.

One member of the Sure Start team felt that early communication may not 'come naturally' to young mums in particular.

Some staff felt that the type of language used by some parents in the area to their children was not conducive to good speech and language development. A member of the programme's speech and language team pointed to 'a whole area there of the way people discipline their children and what percentage of their time is spent with that kind of language'. Some mainstream staff also pointed to a lack of imaginative language:

> Some parents don't partake in make-believe with their children, they think they sound stupid/feel stupid doing it but it's a very important part of developing speech and language.

A major barrier to stimulating and imaginative language being used between parent and child was television: 'One of the things we're dealing with is at a cultural level - houses where the telly is on all the time'. A parent interviewed perceived speech and language problems to be either hereditary, or 'if they were a big family, the older ones would speak for the little ones so they don't get a chance to do the talking'.

Staff also discussed the role of reading in a child's speech and language development: 'You can tell these children whose parents read with them'. A mainstream health visitor felt that parental support was crucial in this:

> It's the real domino effect. We can go out and give away as many free books as we want to, and you can give them a tonne of free books but if the parents' literacy skills are poor then the kids haven't got any chance because they're not going to open the books for the children. It's what you see your parents do isn't it? If they don't read, and they don't have books, then why should the kids bother?

However, a member of the Sure Start speech and language team pointed out that while there were many children in the area with delayed speech and language development for any of the above reasons, there was also 'an extremely high percentage of two year olds whose speech and language is great who we expected to find something worse'. She suggested that there 'may be something about an assumption about deprivation levels … an assumption that's almost within the Sure Start ethos - deprivation looks like this - levels of unemployment. She felt that often, advanced speech and language development in local children came down to the amount of contact they had with members of their extended family:

> I've met one or two young parents who are very much in their extended families - that happens a lot in the east of the city … where people are coming in and out all day - cousins, uncles … I think they benefit enormously from that. I've done one or two visits where I've seen everyone sharing the parenting, and it does seem to work very well, and the child gets a lot of stimulation …

6.3 Support

Interviewees emphasised the importance of early intervention with regards to speech and language support. However, one interviewee felt that when parents ask health professionals for support, they were ‘told not to worry’. This led to parents feeling isolated and feeling like ‘it's taken out of your control.’ Another interviewee expressed concern that referrals to Speech and Language therapists were made too soon, and they should be a ‘last resort’, especially as clients can often regard any external service with suspicion. Therefore playgroups and nurseries play an important role in so building up relationships with parents and children before referrals are made:

> The last thing you want to do is say 'I think we need to call in such and such' because it is viewed with suspicion. When we get new children in September, the first thing on your mind isn’t 'Let's get him seen by someone', it's 'let's give it up to Christmas and see how he goes'.

Another interviewee commented that the word ‘therapy/therapist’ deterred or threatened some parents and could be seen as stigmatising. Providing support in a nursery environment, on the other hand, overcomes the fear of stigmatisation to a certain degree. A mainstream nursery nurse felt that more support should be given in this type of environment. She described a situation where a parent of a child with speech and language difficulties continued to miss appointments at a mainstream speech and language support group:

> She said she couldn’t go because she couldn’t afford it. That child spends four or five days a week in a nursery – why couldn’t something have been done there? It doesn’t have to be with the parent… Language is learned, it doesn’t matter if it’s you, the mother, the teacher – the mum doesn’t necessarily have to do it, it's whoever is seeing that child on a regular basis.

This interviewee saw a role for nursery staff within support for children with speech and language problems and feels their skills should be drawn on before any other intervention is sought. Another local mum had been referred with her son to the same group, but had pulled out. She was then offered support for her son by the Sure Start speech and language therapist at the child's nursery, with a successful outcome. The Sure Start therapist made the following comment, based on what the mum had told her, on why the mainstream support had not worked for this family: 'I think it would be difficult for [the mum] to take learning from that situation and then do it. For the group to work for her I think she would then have needed some individual support to put that into place'.

The Sure Start speech and language therapist described support for families through nurseries and playgroups as follows: 'A lot of it is about information - informing parents, reassuring parents, really just giving messages about what they can be doing'. For parents of children at nurseries or playgroups who do not need specific speech and language intervention, information on speech and language development is there for the parents to read. A local playgroup worker commented:

> We’ve found what’s worked really well is having [the Sure Start speech and language team] just popping in every now and then, so [the parents/ children] know who they are. But they have used it, they’ve asked questions about speech and language, so the parents are getting knowledge and advice. I’d say

> that service is used more… they'd approach that service because it directly benefits their own children.

6.4 Impact of Sure Start upon Speech and Language Targets

Mainstream staff working in the programme area were asked whether they felt that the existence of Sure Start speech and language support meant that they were referring families less often to mainstream speech and language therapy. A mainstream nursery nurse explained:

> I always refer to PCT speech and language therapy, and then refer to [a Sure Start speech and language therapist] for intervention while the child is on the six month waiting list. The Sure Start speech and language team would then decide whether home visits or group work was appropriate … It is an extra string to our bow.

Sure Start playgroup staff described how they consult the inclusion worker from the playgroup network who gives advice on special needs, or ask educational psychology if concerned. They would also speak to parents and ask them if they could consult their health visitor. In addition, speech and language staff from the programme had shown them some basic Macaton: 'We get help when we need it'. They felt that they contributed to the reduction of inappropriate referrals to mainstream speech and language, as parents often consult them to ask their opinion on advice they may have been given about their child's speech and language development by the health visitor for example.

Some local nursery staff felt that they were able to provide direct support for speech and language development without Sure Start input:

> To a degree we are preventing referrals. Children spend three years with us. With the children who get in early enough, yes we are preventing referrals. The nursery is more concentrated than the home environment … There are no specifics on how we are going to work on speech and language - it's all things we're doing anyway. It's the way we're trained to work with our NNEB training - common sense indicators. We are told we're doing the right things for this age group.

Another felt that 'I don't think we're preventing referrals. I think a lot of parents are very wary about calling in anyone; if there was going to be a referral it would probably be done through the health visitor'.

The training provided by Sure Start speech and language staff for mainstream professionals working in the programme area aims to provide a cost effective way of disseminating speech and language skills. By equipping staff not directly working in speech and language with knowledge and skills to pass on to families to help their children's speech and language development themselves, the number of referrals to mainstream speech and language therapy may be reduced. The benefits in relation to nurseries and playgroups, according to a Sure Start speech and language therapist, are:

- raised staff confidence in what they already knew
- initial screening: 'They are going through that process so that they can present me with a prioritised list. Most times they are right'.

- nursery/ playgroup staff can have an ambassador role for speech and language development, 'because they're now very open to speech and language and they're very keen to help us pilot things'.

Mainstream staff who had undertaken the Sure Start speech and language training were asked whether they saw this as good value for money,[4] and specifically whether they have been able to provide help for a child they would have previously referred. Comments included:

> It was a useful update for us but it hasn't changed our practice because that's how we practised before.
>
> Yes, I think it did make a difference to the way I work with the children. From what I remember a lot of things came up that we just hadn't thought of. You were thinking that the children understood everything you were saying … [The trainers] explained that they weren't - it was the gestures they understood. They were just copying what the other children were doing.
>
> I am now more confident in assessing clients' speech. I give exercises for parents to do with the child while they are waiting for the referral. It gives us something extra to give to the parents.
>
> I have always been confident about assessing children's speech and language, but I am now more familiar with what the normal range is.
>
> I am now more aware … of what to look out for when reviewing speech.
>
> I suppose if I detect that they're not meeting the milestones that they should for speech and language, I would still be referring the way I've always done but I suppose I can give them some advice in the interim.
>
> I think [it] just gives you a better understanding of the development of speech and language and therefore you can explain it better to parents. At the end of the day, we're not specialists in speech and language therapy, and you would always want to refer on.
>
> I think it's made me more aware of what is immature speech and what is a speech problem that will need outside input.
>
> As far as parental expectations are concerned, that's been really useful for us and sometimes just to reassure and support parents, give them ideas on how to develop their child's speech … If the parent has got a definite concern about [something] they perceive as a problem, I would always refer anyway because, again, they see a speech and language therapist as a specialist in that role.
>
> It's just made you feel happier about leaving it a bit longer and knowing that things are going to develop anyway.
>
> We can go on courses for mornings or afternoons, but it's not the same as an expert like [the Sure Start speech and language therapist] coming in…

Aspects of the training identified as being particularly useful were:

- Books to photocopy for families, and literature to go with it.
- The Hanen care programme
- Active listening skills
- A tick list for words a child can say at the two year check: 'The parents were honest then whereas if you just ask them do they say this, they say "oh yes,

[4] At the time of the interviews being conducted, not all staff at the nurseries in the programme area had completed the Sure Start speech and language training, and so not all their views could be expressed here.

wonderful, perfect" when you know for a fact the kid has got dummy in its mouth and doesn't say that much'.

- Simple tips to give to parents like talking to your child when making sure there's no noise in the background.

Telephone helpline

Most mainstream staff who had completed the training had not actually used the helpline set up by the Sure Start speech and language team, where they are available to give advice one afternoon a month. At nurseries and playgroups visited by the Sure Start speech and language therapist, staff usually just ask her when they see her. Other staff described how they would just phone her when they needed the advice, rather than wait for the set helpline time. A health visitor gave an example where she rang the Sure Start speech and language therapist just to clarify that the advice she had given to a family was the correct advice:

> It was an unusual thing where four different languages were being spoken in the house – I just felt the kid was overwhelmed so I said just concentrate on speaking one language and don't have everyone speaking different languages. I just wanted to run that by [her] to see if that was the advice I should have given, and it was. So she was a sounding board for that

Another health visitor described how she tended to phone the mainstream speech and language department rather than Sure Start for advice.

In relation to value for money of Sure Start's speech and language provision, a focus group with two mainstream health visitors and two community nursery nurses led to discussion of an early intervention for language birthday party event which had been organised by the Sure Start speech and language team. They felt that this had not been cost effective, and could have been approached differently. While only one person attended out of the forty who had been invited, they felt that:

> If we had put it on, we'd have had 15-20 parents at least. Plus, who decided to have a birthday party to do with language at 1 year? Which parent wants or needs help with the child's language at one year old? They had two speech therapists, 1 health visitor, and 1 Health Development Worker – very expensive for one parent and one child.
>
> They're thinking about meeting targets, but not meeting the needs of the people.
>
> If you haven't done community work then you might not know how to get the community in. Why didn't Sure Start talk to the health visitors about the idea of the birthday party / language intervention? They would then have known what they should have been offering.

Some mainstream staff still felt they did not know enough about what Sure Start could offer: 'It would be very nice if someone could just come and say "hey, did you know Sure Start can do this for you, this is what we can offer"'. Although most mainstream staff were positive about the resources they had access to for speech and language matters as a result of Sure Start, one still felt there was scope for 'more access to library books to take out to people'.

West Walker (now Thomas Gaughan) speech and language group

Feedback from this group has been positive, with parents commenting that their children are more socially aware, with better speech and language development as well as improved social skills and confidence.

The mainstream health visitor involved in delivering the group gave an example where she suggested activities to the mother to do at home with her son instead of referring him to mainstream speech therapy, and this has helped his speech. She explained that she keeps other mainstream health visitors informed about the group, and keeps them up to date about children they have referred to the group.

However, comments from other mainstream health visitors and community nursery nurses about the group were mixed:

> The West Walker speech and language group sounds quite good in theory – but I don't know how well attended it is. I know that one of my colleagues has referred. Obviously, they've got a structured programme, things to do …but then the family that she had referred hadn't turned up to it. I don't know why as yet.
>
> We've had mams that have been referred who've been once and not gone back.[5]

An interview was conducted with a mum who took her 18 month old son to the group. Other family members had commented that he was not speaking, so the mum contacted her health visitor, who referred them to the speech and language group. Aspects of the group which the mum identified as being of particular benefit to her son were:

- group work and being with other children: Outside of the group, other children are speaking fantastically – being in the group means he has contact with children the same as him.
- spending time alone with his mother - one-to-one attention away from distractions of brothers and sisters: 'I have learned to make time for him'.

She felt that there was no stigma attached to attending group: 'everyone knows I come here'. She cited the outcomes of their attendance at the group as:

- She is more patient with her son now - listens to him when he talks, lets him take her by the hand and show her what he's trying to communicate.
- She has learned not to rush and give her son time to communicate.
- She passes information from the group onto her older daughter who has a baby.
- Her son would not have been referred to a mainstream speech and language therapist until he was at least two years old, so the group is very important, giving her the support and guidance she needed
- 'It has helped a lot. I feel really capable now'.

Children Talking Display

Sure Start speech and language staff cited the following benefits of the Children Talking displays:

- The parents and children can look at the pictures to see the routine of the playgroup day.
- Improved educational function of nursery staff.

[5] See IR6 - forthcoming - for further views on this.

- 'It generates a lot of language - a real interest actually'.

Comments about the Children Talking displays from staff at local playgroups and nurseries included:

> The reactions were 'it's nice to see what the children do', not specifically because of the language. I think parents found it interesting and I think they take those pictures home in their heads and think 'perhaps I could try that', playing in the sand and water. Sometimes when children come here the parents see it as a bit of relief for them, not education and things … I'm sure many of our parents, after seeing it, went home and have done things that they've seen. They don't really come into the play room so until really recently they haven't actually seen what we've got inside here, I'm sure they just think the children just go in and play - it's free choice and we just stand around supervising, making sure they don't hurt themselves. It was such a nice display, it said children need time to play on their own, to talk to each other, and I'm sure it did make a good impact … It generated discussion between parents and children. The children were looking for themselves, there's me, and there's such and such. So yes it does, anything with photos up, they loved them and talked about them, which is stimulating their language.
>
> It helped the way it was displayed, it was a lovely display. It probably had more of an impact with the photographs and everything than if you just give them a leaflet out.

A PA exercise was conducted at Wharrier Street playgroup to seek parents' opinions on the Children Talking display there. The following positive comments were made:

- it's easy to spot
- it brightens the place up
- it helped us learn other children's names
- it is an excellent idea
- it helped us to know what they do in playgroup
- it has had a positive impact on activities I do with my child
- it is good seeing the children playing and doing things
- the comments/ captions are good
- it is attractive
- it shows new mothers what playgroup is about
- it's good that my child is on it
- it is all perfect
- it has given the staff inspiration for the other children as well, helping them think more about all children, 'as it is all about including all children regardless of colour, creed or special needs'.

Negative comments were:

- I have learned nothing new from it as I have an older child
- I haven't noticed it (am new here and don't come often)
- it has not really had any impact - I do all that anyway
- it is too much to look at
- it is hard to see it - people are shields
- I haven't done anything differently because of it

Suggestions for improvement were:

- it is all perfect
- it could be simpler: 2 or 3 examples instead of 10

- I would have liked to have had input if had time.

One to one input

A mum whose daughter had received one to one intervention from a Sure Start speech and language therapist in the home described the very positive impact this had had on her daughter's communication. She felt that outside of Sure Start support, the support they would have had would have been 'sketchy and abysmal'. She described the Sure Start support as 'like map finder', and felt that it was very important to get the intervention as early as they did, as older children often start to give up. Although she herself as the mum had 'done most of the hard work', the Sure Start support helped her 'to put things in the right order for her daughter to process them'. It has also helped her with keeping communication simple, with symbols, and Macaton. She feels happy to phone the Sure Start speech and language therapist about any concerns she has. She felt that without Sure Start support, she could have been doing lots but not going in the right direction. Above all, she felt that since her referral to Sure Start, nothing she had said to anyone had been misinterpreted.

This mum was satisfied with the Sure Start speech and language support on its own, and did not view it as a stop-gap while being on the waiting list for mainstream support. She described how, after a few months of support from Sure Start, she and her daughter attended three group speech and language sessions at Newcastle University:

> In terms of the information I had already been given, we had a three month advantage on the other parents, so I felt we were taking the place of someone who would have benefited more, i.e. someone who had not yet had any intervention … Therefore I felt a bit patronised, and felt it was inappropriate for me to be getting support from those parents.

A mum whose son had received Sure Start speech and language support at his nursery and at home described her experience of a similar group at the RVI to which they had attended before receiving Sure Start support:

> I found I could do at home what they were doing. They just provided tea and biscuits, and had [my son] drawing pictures in another room. I took him a few times but then didn't go back.

This she compared negatively with the support they had had from Sure Start:

> [The Sure Start speech and language therapist] gave me advice on how to communicate with [my son], for example to talk slower (I was talking fast to him), to point at things etc. At the RVI they were watching him like teachers - I didn't like it. Since [Sure Start's] intervention [his] speech has come on leaps and bounds. [It] has made a difference to everything about [my son's] communication. I can now have a conversation with him.

7. The Findings 4: All Three Targets

7.1 Ranking

Sure Start and mainstream staff were asked to rank the three target areas in order of which they felt was the easiest to achieve, and which the most difficult. All respondents felt that speech and language was the easiest. The following reasons were given:

- 'Everyone wants their child to do well'.
- 'It's not for the parents personally, it's for their children'.
- 'Between the ages of 0-2, it's something you do during toddler sessions, group sessions and in the home (not everybody does it in the home mind)'.
- 'Parents would definitely approach speech and language services more often'.
- 'It's all the time, constant'.
- 'It's not a life choice that you're trying to change'.
- 'With speech, you can say "when you take him to the park, talk to him and point out things, just say the word and get him to repeat it back, say good boy if he's done it." That's a 5-second thing that you can do now and again'.
- 'With the language, you don't have to do it all the time, just when you remember'.
- 'Even with speech and language there isn't immediate benefits from receiving therapy but people see the benefits much more readily'.
- 'I think they see it because they're doing something to help their child … When they've got the child and need to communicate with the child, they're much more willing to look at avenues to explore that and techniques to use, follow suggestions offered'.
- 'There's more resources available now'.

Most staff found it difficult to distinguish between smoking and breastfeeding with regard to which was the most difficult target area to achieve. Among those who thought that smoking cessation was the hardest, reasons given were:

- 'It's a change in lifestyle: if they're only in their 20's but they've been smoking since they were nine, that's a decade of a way of life that you've got to change'.
- 'They all attend the groups ok but then when it comes to the last group where they have to stop, they don't turn up to that group! So they've had all the stuff for free and done all that bit but when it actually comes down to it… I think it's easier to persuade someone to try breastfeeding than it is to persuade them to stop smoking'.
- 'Smoking is an addiction'.

Among those who thought that breastfeeding was the hardest, reasons given were:

- 'You can retry to stop smoking, but once you've given up breastfeeding, you're not likely to go back to it'.
- 'It's a choice that's somebody's already probably made beforehand'.
- 'Breastfeeding is very personal'.

- 'There's certainly more people coming to the smoking cessation clinic than there are people in comparison that actually breastfeed'.
- 'It is about changing people - they already know the benefits'.
- 'In a way, with smoking and breastfeeding, you're intruding into lifestyles almost, particularly with breastfeeding, how you should bring your child up'.

It is worth mentioning that of the three target areas, speech and language was the one which outreach and family support staff at Sure Start found themselves working on most often. Outreach staff said they saw speech and language more often on referral forms than the other two targets. This reflects the view of most staff that speech and language was the easiest to achieve of the three target areas. However, it also suggests that it is the one which staff find it easiest to offer parents support about, for all the reasons given above.

7.2 Influence on Targets

A Sure Start worker emphasised the importance of promoting all three target areas in a holistic way rather than separately:

> You feed this information in to these groups rather than it be stand-alone. You might have this group that you come to from twenty weeks into your pregnancy and onwards and all these sort of things [all three target] are fed into that group. Primarily, it would be a social group which is more attractive than saying do you want to come to a smoking cessation group. Then hopefully, it would be health by stealth.

Joint Working

Many mainstream professionals commented on their experiences of joint working with Sure Start, often specifically on their views of Sure Start targets. Some felt that Sure Start targets may be inappropriate when they conflict with an individual's personal targets or with the most pressing issues in a community:

> You're never going to get your targets if you keep being so target driven because as far as young people are concerned, it might not be their target – it might be something else.
>
> That might not be what that specific community needs. Of course overall you want to increase breastfeeding rates but we can't focus on that when this community might be really struggling with the fact that they've got a major drug problem or whatever … If we had much broader targets around developing community services then that would give a lot more scope….

Others pointed to the dangers of associating specific targets with particular groups, whereby a group may be considered to have failed to meet certain targets when in fact its participants may be gaining a lot holistically from attending the group:

> Somebody might turn around and say "you haven't covered contraception and she's pregnant again" – you can say "but she's still with us, she's still coming to the group" so she obviously feels there's something beneficial from coming to the group … It might be the one thing that's stable. None of us know the impact; in a sense, you have to trust the people who vote with their feet, if they still keep coming then they obviously value what's in there'.

Another issue to arise related to the need to have 'collective aims and objectives' during joint working. Although this can be difficult when 'sometimes people have their own agendas', one interviewee recognised that compromise is the key to successful relationships and outcomes. Mainstream and Sure Start midwives alike are aware that they need to improve their links with one another, although joint working does occur successfully. Mainstream midwives appreciate the opportunity to share their workload with the Sure Start midwife as breastfeeding support involves an intensive period of assistance:

> We break our backs to spend more time with the girls that are breastfeeding but sometimes it's impossible to spend that amount of time that you need. If [the Sure Start midwife] knows the women and they're in her area, if you ring her up she'll say, "Yes, I'll go and see her, I'll go tomorrow".

This is beneficial for both themselves and the Sure Start midwife. The latter gains access to potential Sure Start service users, encouraging them to access other services she runs within Sure Start, whilst mainstream midwives benefit from a decreased workload and continued breastfeeding support for their clients. The Sure Start midwife relies upon mainstream midwives in a similar manner:

> …at the moment, there is a problem with me accessing data around who's pregnant and who might want to come to breastfeeding workshops so I do rely on the local midwives to invite women.

The overall feeling regarding joint working is that it can be successful but it needs to happen more often to improve parental antenatal attendance and breastfeeding success. All respondents recognised its benefits: 'You don't want it to be us and them, it's all about collaboration after all.' Other staff not directly involved with breastfeeding felt confident they would refer anyone who enquired about it to a Sure Start staff member they knew and trusted. A Sure Start worker made the following comment on joint working generally:

> There's a lot of benefits from it, you can benefit from each other's skills. Also, if one's on holiday, you've got cover as well, so a group doesn't lose out. If you both have different skills, you can bring different things to the group and sessions, so if I can't answer a question, the health visitor might be able to. Then you can give that person what they need, the right support.

Mainstream influence on targets

Mainstream staff were asked about their capacity to influence Sure Start targets. Nursery and playgroup staff felt that this was limited:

> The leaflets we put out about Sure Start etc. don't tend to disappear. Parents don't bother. Advertising Sure Start doesn't really work here.

However, it was also felt that nurseries and playgroups were an ideal place to target parents about these issues:

> We could have an impact on Sure Start's breastfeeding and smoking cessation targets. We are aiming at working with groups of parents, and are looking at working with parents on language and literacy. If there was a group we could access on breastfeeding and smoking cessation, this is a good starting place - we would get a response.

A mainstream worker criticised Sure Start for 'this mad idea that they can go in and set up a group, then eight weeks later they can leave the group running on its own. Well, you might be able to do that with a mother and toddlers group but you'll never

do that with 16 year olds – it's just madness! … We're a year on! They're nowhere near self-running - it would be chaos!'

8. Appendix 1: Sample Interview Schedules

Sample Interview Schedule for Sure Start Staff Members

Can you comment on what you think are the environmental influences on:

- breastfeeding?
- smoking?
- speech and language development?

What are the barriers to achieving these targets?

Do you have any training in relation to any of those three targets?

- What impact do you think that has had on your work?

What has been the impact of the speech and language training (provided by Sure Start) on your work?

- Are you more confident now as a result of the training to be able to tell whether a child's speech is delayed or whether there is a problem?

Which of the three targets do you work on most often in your work? Which least?

In relation to the three targets, what joint working do you do with any mainstream staff?

What do you think makes a service easy to reach?

Which of the three targets would you say was the easiest for Sure Start to achieve and which is the most difficult?

What do you think makes the difference between giving people the information and actually making a difference?

Sample Interview Schedule for Mainstream Health Visitors/ Nursery Nurses

Did you have any other speech and language training before you undertook the Sure Start speech and language training?

What difference has the training made to the way you work (especially 2 year assessments)?

- Since you've done the training, have you ever been able to provide help for a child you might have previously referred to mainstream speech and language therapy? Do you feel that training health visitors/ community nursery nurses provides good/ potential value for money in this way?

Have you ever used the telephone helpline (Sure Start speech and language)?

Have you ever referred to the West Walker speech and language group? What is your impression of it?

Have you done any joint working with Sure Start? Describe.

Have you had any training on smoking cessation or breastfeeding? What impact has this had on your work?

Did you participate in the team building event for health visitors/ community nursery nurses? Did this have an impact on your work?

Can you comment on the impact of Sure Start on these three issues in the area?

Which of these three targets is easiest to achieve/ most difficult to achieve? Why?

Definition of hard to reach? Which services are easiest to reach? Why?

How can Sure Start have an impact on these three areas?

- How can it make a difference to those who use the services?
- How can it have an influence on these issues among non service users within the Sure Start area, e.g. through statutory visits/ anything else?

Sample Interview Schedule for Parent of Child Receiving Speech and Language Input from Sure Start

How was your child referred to Sure Start's speech and language service? When?

Describe the speech and language input your child gets.

Impact:
- child's speech and language: examples of child using speech/ communicating?
- parent-child communication: does parent communicate with child differently? Put into practice methods/advice from SaLT sessions?
- child's confidence?

Do you feel stigmatised at all by using this service? Why?

Anything missing from sessions/ support generally?

Do you feel you/ your child get speech and language help from any other sources? Do you use any other Sure Start services?

Do you pass on what you learn at the home visits to other people coming into contact with your child/ other people with children?

Are you happy with options for future support for your child?

9. Appendix 2: Breastfeeding Questionnaire

Section 1 - ALL

Postcode _____

Gender: M F **Ethnicity:** White Other _____

Age group: Under 20 20-34 35-49 50-64 65+

1) As a baby, do you know if you were

bottle-fed? ☐ _____

breastfed? ☐ _____

both? ☐ _____

don't know ☐ _____

2) Do you know anyone who has breastfed their baby/ babies?

3) Can you think of any benefits of breastfeeding?

_____

4) Do you think there are any drawbacks to breastfeeding?

_____

5) Do you have any children?

Yes ☐ *Go to* **Section 2 (page 2)**

No ☐ *Go to* **Q9 (page 2)**

Expecting 1st ☐ *Go to* **Section 4 (page 4)**

Section 2 - ALL PARENTS

6) How many children do you have? ☐ Expecting another ☐

Were they: bottle-fed? _____

breastfed? _____

for how long? _____

both? _____

don't know _____

If changed: Why did you change the method of feeding? _____

7) When did you/ *your partner* decide which method of feeding to use?

before pregnancy _____

during pregnancy _____

at birth _____

don't know _____

8) Did anyone help you/ *your partner* decide?

the mother ☐ _____

the father ☐ _____

other family members ☐ Who? _____

health professionals ☐ Who? _____

other ☐ _____

9) How do you feel about other women breastfeeding in public?

comfortable ☐ unsure ☐

uncomfortable ☐ depends how public ☐

If applicable: Would you yourself breastfeed in public?

***End** for all except mums who breastfed/ are breastfeeding and expectant parents*

Section 3 – MUMS WHO BREASTFED/ ARE BREASTFEEDING

10) Did you get support with breastfeeding your baby?

Yes ☐ from professionals? Who? _____

from family? Who? _____

from others? Who? _____

No ☐

11) *If finished breastfeeding:* Did you breastfed for as long as you wanted?

About right ☐ Why? _____

Too short ☐ Why? _____

Too long ☐ Why? _____

If still breastfeeding: How long do you intend to breastfeed for? _____

12) Were/ are you happy to breastfeed in front of other people?

Yes ☐ _____

No ☐ _____

***End** except for those expecting another baby - Go to Section 4.*

Section 4 – EXPECTANT PARENTS

13) How do you intend to feed your baby?

bottle-feed	☐	Why? _____
breastfeed	☐	Why? _____
both	☐	Why? _____
undecided	☐	Why? _____ *Go to* **Q 16**

14) When did you/ *your partner* decide? _____

15) Who/ what influenced this decision?

expectant mum	☐	_____
expectant dad	☐	_____
other family members	☐	Who? _____
health professionals	☐	Who? _____
other	☐	_____

16) *If have other children, will have answered before:* How do you feel about women breastfeeding in public?

comfortable	☐	unsure	☐
uncomfortable	☐	depends how public	☐

End