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Chapter 8: Maternity Care and Every Child Matters

Fiona Hutchinson

'Children and young people are important. They are the living message we send to a time we will not see; nothing matters more to families than the health, welfare and future success of their children. They deserve the best care because they are the life blood of the nation and are vital for our future economic survival and prosperity....' (Page 4)

Aynsley Green (2004)

The above quote succinctly summarises how important it is to invest time and effort in caring for our younger generation. Maternity services are delivered by a range of key professionals both in primary and secondary care. The principal care providers are midwives, neonatal nurses, health visitors, obstetric staff, general practitioners and the recently introduced maternity care workers. Other professionals who may be involved are dietitians, mental health specialists and health promotion experts (National Evaluation of Sure Start (NESS) 2005). This chapter will focus on care provided to the mother and baby before, during and immediately after birth. For this reason, the key roles discussed will be those of the midwife, neonatal nurse and maternity support worker. It is important to acknowledge however that the roles of the community midwife and health visitor are inextricably linked as the health visitor takes on the care of the family after the midwife has fulfilled her remit. Professionals involved in the immediate period before, during and after birth have an important role to play in ensuring that every child receives the best start in life and each play a part in ensuring that the phrase that 'every child matters' is the philosophy underpinning their practice.

The first part of the chapter will provide an introduction to maternity services in the UK and why it is the foundation of 'Every Child Matters'. It is the earliest healthcare intervention of all for the child and it is essential to get it right for babies and parents. The role of the key professionals involved with care provision will be explained as they may be unfamiliar to some readers. By using case studies as examples, the chapter will then explore how each of them contributes to addressing the key recommendations of Every Child Matters including the Common Assessment framework (CAF) and the strategic challenges of the Children's Workforce. The final part of the chapter will focus on discussing future trends in maternity care with relation to Every Child Matters.

Overview of Maternity services

In the early 1950s women had a 1 in 1,500 chance of dying during or after childbirth, today that figure has been reduced to 1 in 20,000 (Shribman 2007). During the 1960s 30 out of every 1,000 babies were either still born or died soon after delivery. Maternity care has greatly improved over the last 50 years due to better recognition of risk factors and advances in medical treatment. Childbirth today is a much safer event for the mother and baby. The disadvantage of this however is that there has been a dramatic increase in medical intervention in childbirth, thereby turning what is usually a normal process into a medical event. The Government Statistical Service stated that during 2003/2004 a total of 23% of deliveries were by caesarean section and approximately 12% were instrumental deliveries (Government Statistical Service 2005). In the 1950s 49% of women had their babies either at home or in a nursing home. By the 1970s 66% of women opted for a hospital delivery and the percentage of home births had fallen to about 12%. This was mainly due to the publication of the Peel Report which recommended that all births should take place in hospital (Hunt and Symonds 1995). Today only about 2-3 % of women opt for home births and about 4% in a midwife birthing centre (Shribman 2007). Whilst some would advocate that the hospital environment is lower risk, it does not meet all women's needs as the hospital environment loans itself to a more medical and interventionist approach to care. Over the last decade there has been a shift in policy towards a more 'woman centred' model of care based on research suggesting that the psychological and emotional needs of women impact on outcomes for both the baby and the mother (Kitzinger 1992). In light of this paradigm shift, recent government initiatives are geared towards providing women with a choice over where and how they want to have their baby with the emphasis on providing a safe service (Department of Health/Partnerships for Children, Families and Maternity 2007).

As discussed in previous chapters of this book, the fundamental aims of 'Every Child Matters' (HM Government 2004) are concerned with improving the health and well-being of all children. The health of the mother is of paramount importance in ensuring this as healthy mothers are more likely to have healthy babies (Department of Health/Partnerships for Children, Families and Maternity 2007). The weight of a baby at birth can be an indicator of long standing health problems in the mother and also a predictor of the baby's mortality and future health and well-being. To illustrate the significance of this the Office of National Statistics reported that 64% of infant deaths in England and Wales in 2003 were babies weighing less than 2,500 Grams which is the World Health Organisation definition of a low birthweight baby (LBW) (Collingwood Bakeo, Clarke 2006). A low birthweight baby is one who has either

been born prematurely (before 37 completed weeks gestation) or who has failed to reach the adequate weight for their gestational age. Babies may also be born with a combination of these two factors. Several follow up studies of babies have demonstrated that babies born with a low birthweight have a higher risk of developing chronic health conditions and also a reduced quality of life (Mayor 2005, Dineson and Grieson 2001, Dubois and Girard 2006). In addition to this, babies who are born prematurely are also more likely to have neurological and developmental disabilities thus reducing the quality of their life (Wood et al. 2000). These babies require specialised care at birth and immediately after to minimise the risk of any complications. Risk factors for babies being born with a low birthweight are summarised below:

- Maternal age (very young or older mother)
- Smoking
- Poor diet
- Substance misuse
- Socio-economic deprivation
- Lone mother
- Maternal illness
- Non-white ethnic group
- Domestic violence
- Mental Health problems

(Collingwood Bakeo and Clarke 2006)

The priority for today's maternity services is to provide a choice of safe, high quality care for all women and their partners taking cognisance of the above risk factors. Current challenges facing the Department of Health include improving neonatal outcomes for the more vulnerable and disadvantaged families (Department of Health/Partnerships for Children, Families and Maternity 2007). It is important to remember that maternity care is not just about delivering babies. It is also about striving to ensure that every baby has the opportunity to achieve their full growth and developmental potential. The role of the key professionals involved with maximising this potential will now be explored.

The midwife

For time immemorial women have helped each other in childbirth. The first formal arrangement for the control of midwives was made in 1512. All persons (male and female) seeking a licence to practice medicine were required to submit themselves for examination by the local Bishop (midwives were considered to be akin to surgeons at this time). In 1902 the Midwives Act

provided legal recognition and protection for midwives. State registration became compulsory by law. The training was three months long and the limits of their responsibility were set by doctors (Donnison 1977). Midwives could not practice unless they were certified on the midwives register. Up until 1948 (the implementation of the National Health Service (NHS)) women had to pay for the services for a midwife. Maternal and infant mortality rates were high, especially in the socially deprived population. Following the arrival of the NHS, GPs became the first point of contact for the pregnant woman and they were paid by the government for providing maternity care. The NHS Reorganisation Act (1973) allowed midwives to take on more responsibility for pregnant women, for example family planning, health education and neonatal care (care of the newborn baby). In today's NHS nursing and midwifery are regarded as two different occupations, this however has not always been the case. In 1861 Florence Nightingale, one of the pioneers of the nursing movement, funded her own school of nursing and midwifery at Kings College Hospital in London, but unfortunately the ward was forced to close because of repeated post natal infections (Donnison 1977).

The current regulatory body for Midwifery is the Nursing and Midwifery Council (NMC). There are two ways of becoming a midwife either through a three year degree programme, or if the applicant has a nursing qualification, they can undertake a shortened 18 month programme. In the UK midwifery education programmes can only be delivered at NMC approved educational institutions. Training takes place in a University and at least half of the programme is based in clinical practice. The statutory supervision of midwives is undertaken by Local Supervising Authorities (LSAs). In England the LSAs are the Strategic Health Authorities (SHAs), in Northern Ireland the Health and Social Services Boards and in Scotland the Regional Boards. The Health Inspectorate is the LSA for Wales (Nursing and Midwifery Council 2007). The role of a midwife may be summarised as someone who provides advice, care and support for women, their partners and families during the pre-conceptual, antenatal, intra-natal and post natal period. They are responsible for newborn babies until the 28th post natal day when care is transferred to the Health Visitor. Midwives are independent practitioners calling doctors only when there is a problem involving the mothers or the baby's safety. They can work either in a hospital or community setting and function as part of a multi-disciplinary team liaising with General Practitioners, Health Visitors and Social Workers (Nursing and Midwifery Council 2000). All midwives in the UK have to complete an 'Intention to Practice' form on an annual basis. This demonstrates that they have maintained their midwifery skills. Some midwives are also specialised in the management of the newborn baby, taking on skills that have previously been undertaken by medical practitioners. These skills include neonatal resuscitation,

stabilisation of the newborn at birth and the initial examination of the newborn (Redshaw and Harvey 2000).

The neonatal nurse

In the 1960s hospitals started to recognise the need for continuing education for nurses who had completed their initial registration with the General Nursing Council (GNC). During the 1970s and 1980s the specialty of neonatal intensive care developed significantly and nursing care of these babies became increasingly technical as more and more babies required respiratory ventilation as a result of being born prematurely. As a result of this, post registration specialty courses including ones for care of the vulnerable newborn baby were devised by English National Board during the 70s and 80s (Allan 2000). These educational programmes were considered to be the basic requirements for nurses wishing to develop clinical and theoretical expertise in neonatal care. Neonatal nurses work within specialist neonatal units or in the community. They care for babies who are vulnerable (either by being born with a low birthweight, prematurely or with a congenital birth defect). The neonatal nurse also has the role of supporting the families of these babies and encourages them to take an active role in the care of their baby. Registered adult and children's nurses as well as midwives can work in this specialism. Normally after a period of about six months nurses and midwives are encouraged to undertake continuing professional development (NHS Careers 2007). Their role has continued to expand and now several neonatal units employ neonatal nurse practitioners (NNPs). NNPs are neonatal nurses who have undergone additional education (usually at Masters Level) and are specialised in the provision of caring for newborn babies who require resuscitation at birth and management of a baby requiring ventilation. They also carry out the initial examination of the newborn (previously a task undertaken by medical staff) and undertake routine management of the newborn baby. Initial studies have demonstrated that their care is equivalent to that of a medical practitioner (Yoxall and Aubrey, 2001, Chan and Hey, 2006). An example of how the role of the midwife and neonatal nurse practitioner function collaboratively to provide high quality care for the mother and baby may be found in the North East of England (The Ashington Audit Group, 2004).

Maternity Support Workers (MSW)

The role of the Health Care Assistant has been around for quite some time and is one approach to managing diminished resources in health services. Thornley (2000) describes their development as 'a quiet revolution in recent years in the profile of the non-registered care-giving workforce in the NHS' (p451). Assistants are now increasingly being introduced into the maternity care

workforce and their role is considered by some to be somewhat controversial (Woodward, Clawson and Ineichen 2004). The main areas of controversy are that they are potentially an erosion of the midwives role and a means of reducing staffing costs. The Royal College of Midwives however state that if MSWs are appropriately trained and managed by midwives they can make a positive contribution to maternity services (RCM 2006). One of the problems of the role however is that there is currently a lack of standardisation in the training (Mckenna, Hasson and Smith 2003). Previous experience of working with parents and young babies is usually required and many hospital trusts also require evidence of some study at NVQ level 2 or 3 in health and social care. When starting employment MSWs undergo basic training on subject areas such as infection control, breast feeding support, risk management, child protection and health and safety (NHS Careers 2007). Some of the key roles that they currently undertake are to support women breastfeeding, assist with parent craft classes and visit women under the supervision of the midwife in the community setting. One London hospital employs two maternity support workers to help with its community midwifery service. Funded by Sure Start monies, the MSWs visit women at home and provide general support including teaching mothers how to massage their babies to calm them down in the home (NHS Employers 2006).

In 2004 the NHS Modernisation Agency produced a document which was a guide to role redesign in neonatal services (NHS Modernisation Agency 2004). This document was initiated by a report published by the Children Care Group Workforce Teams (CGWT) highlighting neonatal care as one of the major areas with recruitment problems. The CGWT stressed the urgent need for, amongst others, more neonatal nurse practitioners to invest in children's nursing. As a result of this the Skills for Health Council (SfH) devised a National Workforce Competence Framework for Maternity and the Newborn to provide a high quality service to newborn babies and their families (Skills for Health 2007). The SfH works in partnership with the Agenda for Change Key Skills Framework (Agenda for Change Project Team 2004) to ensure that the different frameworks support each other. This new framework has had a major influence on how maternity care is provided as it has resulted in changes in job descriptions for all grades of professionals. Examples of newly created posts may be seen in the NHS Modernisation Agency Publication 'Workforce Matters' (2004) and include Nursery Specialists (Play Therapy), Neonatal Nursery Assistants and Family Support Workers. Where roles have been redesigned, the DH emphasise the importance of ensuring that the individual is competent to undertake the sphere of practice and does not cross professional boundaries (NHS Modernisation Agency 2004). This becomes particularly relevant when

employing Maternity Support Workers as their role is not yet nationally regulated.

Every Child Matters and Maternity Services

As stated in the introductory chapter the starting point in improving services for children was to directly ask them what mattered most to them. The response was:

1. **Be healthy**
2. **Stay safe**
3. **Enjoy and achieve**
4. **Make a positive contribution**
5. **Achieve economic wellbeing**

(HM Government 2004)

This section of the chapter will explore how maternity services can play their part in assisting with the achievement of the above aims. Whilst all of the above aims are relevant to maternity services the ones which are directly influenced by the care received before, during and after birth are 'Be healthy' and 'Stay Safe'. The remaining three aims are dependent on the achievement of the first two. The role of the midwife has been specifically highlighted as one of importance in helping to achieve these aims. All maternity staff however contribute both directly and indirectly to the above aims.

1. Be healthy

A healthy mother is less likely to produce a baby who is born with a low birthweight. One of the recommendations of Every Child Matters was that the Chief Nursing Officer would conduct a review of the midwifery, nursing and health visiting contributions to the care of vulnerable children and young people. At about the same time as the publication of Every Child Matters the National Services framework for Children, Young People and Maternity Services (NSF) was published. This document provided clear standards for promoting the health and well being of children, young people and mothers. The 11th standard specifically addresses maternity services:-

'Women have easy access to supportive, high quality maternity services, designed around their individual needs and those of their babies'

(Department of Health 2004 p4)

The three main visions for the future are:

1. Flexible individualised services with the emphasis on the needs of vulnerable and disadvantaged women
2. Women being supported in having as normal a pregnancy and birth as possible, with medical interventions only if they are of benefit to the woman or her baby
3. All care to be based on providing good clinical and psychological outcomes for the woman and her baby, while putting equal emphasis on helping new parents prepare for parenthood.

(Department of Health 2004 p4).

A more recent report published in April 2007 (Department of Health/Partnerships for Children, Families and Maternity 2007) builds on the initial standard identified in the NSF. The report states that by the end of 2009 the Government plans to guarantee four choices for women:

1. A choice of how to access maternity care - Women and their partners will be able to go straight to a midwife if they wish, or to their General Practitioner. Self referral to a midwife will speed up access to maternity services and is likely to be attractive to women who would otherwise hesitate to visit their doctor.
2. A choice of the type of antenatal care - Women will be able to choose between midwifery care or combined midwife/obstetric care. For some women combined care will be the safest option
3. A choice of the place of birth (home, local facility under care of the midwife, or hospital) - In making this decision women will need to be aware that some forms of pain relief (eg. epidural anaesthesia) will only be available in hospitals providing a 24 hour anaesthetic service.
4. A choice of place for postnatal care - post natal care will be provided either at home or in a community centre such as a Sure start Children's Centre.

It is also anticipated that providing women with the choices listed above will also contribute to the achievement of the Department of Health's overall targets of reducing mortality rates and reducing health inequalities (as measured by infant mortality). Women who have control over their pregnancy and delivery are more likely to seek care. It is a sobering thought that current estimations suggest that 30% of domestic violence cases start or escalate during pregnancy and domestic violence is associated with increases in rates of miscarriage, low birthweight, premature birth, fetal injury and fetal death (Department of Health/Partnerships for Children, Families and Maternity 2007). Infant mortality is highest in manual socio-economic groups, black minority ethnic populations, teenage mothers and lone parent families. One of

the key contributors to bringing together services for vulnerable, disadvantaged women and their families has been the introduction of Sure Start Children's Centres.

Sure Start Children's Centres and Maternity Care

Sure Start programmes were launched in 1998 as part of the government drive to tackle childhood poverty and social exclusion by focusing on resources and support at the start of life. The programme is aimed at children aged 0-5 years of age, their families and the communities in which they live (Gustafsson and Driver 2006). The government funding behind the programmes was quite generous - £1.4 billion over five years nationally (Houston 2003). Programmes have been developed in different ways in Scotland, Wales and Northern Ireland (Roberts 2000). The fundamental aims of Sure Start are to work with parents and pre-school children to promote the physical, intellectual, social and emotional development of children - particularly those who are disadvantaged. In March 2006 Sure Start programmes were mainstreamed becoming 'Children's Centres'. These are places where families should be able to access seamless health and social care services. By 2010 it is anticipated that there will be 3,500 Children's Centres, one in every community in the country (Hassan, Spencer and Hogard 2006). Health services relating to pregnancy and childbirth provided in Children's Centres may include:

- ❖ Well baby clinics
- ❖ Parentcraft classes
- ❖ Healthy eating in pregnancy
- ❖ Smoking cessation for women who are pregnant
- ❖ Baby massage

These services will contribute towards helping the Primary Care Trusts to meet public health priorities such as reducing health inequalities, reducing adult smoking rates, halting the obesity rise in children and reducing the under 18 conception rate. An example of how this is working is provided in the box below:

Portsmouth's Maternity Outreach Programme

- ❖ All families with someone who is newly pregnant living in Sure Start areas are visited early in the pregnancy at home by the maternity outreach worker. They provide information on local services and offer support with parenting education, information about 'bumps and babies' groups, infant feeding and referrals to appropriate agencies such as the smoking cessation service and infant mental health team

- ❖ Vulnerable/socially women are offered individually tailored support as agreed with the community midwife and health visitor
- ❖ All teenage parents in Portsmouth are now allocated a maternity outreach worker wherever they live

(Armstrong 2007 Page 16)

The programme above is only one of many examples available. Southampton has reorganised services so that midwives can take care of disadvantaged women and their large refugee community. In conjunction with Sure Start Children's centres, interpreters, social services and GPs they have organised a social model of care to ensure continuity. Their evaluation demonstrated a reduction in the incidence of low birthweight babies (Department of Health/Partnerships for Children, Families and Maternity 2007 page 15). During the initial phase of developing Sure Start Centres, some tensions arose between Sure Start staff and mainstream staff. These mainly focused around the perceived under funding of statutory services compared with the large influx of money provided for the Sure Start Centres. Edgely (2007) suggests that this will be resolved once the services are placed under the umbrella of statutory provision. She hypothesises that once the Children's Centres are established, services will be drawn together in both a geographical and inter-professional working context.

The contribution of Maternity Care Workers in improving maternity care

Derby hospital NHS Foundation Trust has implemented a skill mix to increase the effectiveness of their maternity work force. Details are provided in the box below:

Derby hospitals have recruited maternity support workers to assist with breastfeeding support and advice, general health promotion, undertaking blood tests and appointment booking. This has enabled midwives to reduce their 'non-midwifery tasks' by 30% and there has been a reduction of 20% in waiting times in community antenatal clinics. 18% of the home visits are undertaken by Maternity Support Workers
(Department of Health/Partnerships for Children, Families and Maternity 2007 page 25)

The above example demonstrates how, by redesigning the skill mix there has been an improvement for both midwives and mothers. Women are more likely to attend antenatal clinics if the waiting time is short. St Georges NHS Trust employs MSWs to work with midwives with a multicultural population including refugee women. They assist the midwife with clinics such as smoking cessation, teenage pregnancy, breast feeding and drug abuse (NHS Employers 2006).

The contribution of neonatal nurses and neonatal nurse practitioners

The role of the neonatal nurse is multifactorial. Not only do they have to care for the sick baby, but also the family. By utilising a family centred care model, Henson (2000) demonstrates how families are supported whilst their baby is in the neonatal unit. This support may involve co-ordinating care with the midwife, health visitor and social worker as problems may only surface during the course of the stay in the neonatal unit. Part of the planning for discharge into the community involves physical, intellectual, emotional and social assessment (Henson 2000)

A baby born prematurely is dependent on expert care at birth and the immediate post natal period. Evaluative studies have demonstrated that skilled neonatal nurse practitioners can deliver good quality neonatal care without medical staff being resident on the neonatal unit (Ward Platt and Brown 2004). While et al (2006) in their article discussing cross-boundary working within child health services cite the example of the sick neonate being cared for in a neonatal unit as being a baby who is very dependent on good team working both in the high dependency setting and on discharge into the community. The neonatal nurse practitioners are ideally placed to liaise with other professionals to ensure that the care provided is seamless. These nurses have undertaken further academic study to build on their expertise of neonatal care. The Ashington Audit Group (2004) demonstrated in their evaluation of neonatal care that nurse practitioners built up a rapport with families who trusted them and found them easy to communicate with. Nicolson et al (2005) state that an effective neonatal care team should include a skill mix that is able to liaise with other health professionals such as midwives, health visitors, social workers and obstetricians.

- **Be safe**

<p>Michelle (17 years old) is the lone parent of baby Michael. Michael was born prematurely at 30 weeks gestation weighing 1200 Grams. Neonatal nurses have expressed concern that Michelle does not seem to appreciate</p>

Michael's needs and she often acts inappropriately eg. leaving him unwrapped thus allowing him to get cold. She is currently living in a flat with friends who regularly misuse substances. Michael is nearly ready for discharge into the community and the hospital team are anxious that safe provision is made for both mother and baby.

The important issue in this case study is to ensure that Michael is cared for in a safe environment. Whilst in the Neonatal Unit Michael would have been cared for in a comparatively safe environment, protected from hazards such as infection, cold and excessive environmental stimuli such as noise and light (Reid and Freer 2000). The main concerns following discharge into the community in this example are: lack of parenting skills, risk of exposure to substance misuse and inadequate housing. The neonatal team can ensure that both Michael and his mother are in optimum physical, mental and emotional health prior to discharge into the community. Expert antenatal, intranatal and postnatal care provided by the midwife, obstetrician, neonatologist, and neonatal nursing team would minimise the risk of immediate post natal health complications to both Michelle and Michael. It is essential to ensure that Michael's continuing care is appropriate to his needs. Michelle may need guidance in ensuring that Michael attends all his follow up appointments and attends the clinic for all his immunisations. This is especially important in view of his premature birth. Michelle would probably already be under the care of Social Services and would have had the opportunity to attend a Sure Start Children's Centre. The Sure Start Children's Centre can offer a continuing care package and provide an outreach programme if necessary. Activities available could include parenting skills, teenage parenting classes, paediatric first aid, early year's child development programme, baby massage, healthy eating, sexual health and training and learning opportunities for Michelle. Brett (2005) describes the development of a multi-agency team set up in London for teenage pregnancies providing examples of services available. Following the introduction of this service, some of the changes noted were: an increase in early access to maternity care, a fall in smoking rates among pregnant teenagers, and a reduction in the birth of low birthweight babies. As Michelle may need additional support to achieve the 'Every Child Matters' outcomes it is vital that all information regarding her circumstances is shared by health professionals. This may be achieved by the use of the Common Assessment Framework (Department of Health, Department for Education and Employment Home Office 2000). As stated in the introductory chapter, the main aim of the framework is to eliminate the need for families having to repeatedly 'retell their story'. It is a voluntary assessment and the midwife or neonatal nurse is

uniquely placed to identify risk factors to the mother and baby during pregnancy, birth and into childhood. An assessment may be undertaken at any time – on unborn babies, newly delivered babies or children or young people. Powell (2005) suggests that midwives are in a good position to identify vulnerability factors in relation to families. Nottingham's Children's Services have recently published a proposed integration plan for the CAF due to be implemented by March 2008. Amongst the professionals required to undertake the mandatory course in utilising the CAF and taking on the role of lead professional are midwives, neonatal nurses and health visitors (Partington 2006). The list below provides examples of how the three dimensions of the CAF can be applied to Michael's care.

- ❖ Developmental needs – Ensuring his immunisations are up to date, that he is receiving adequate nutrition and achieving his developmental milestones.
- ❖ Parents and carers – Ensuring that Michael is cared for in a safe, warm, environment. It is also important that he receives appropriate stimulation and physical contact.
- ❖ Family and environment – Ensuring that Michael is brought up in an environment which has basic amenities and that the wider family members do not have a negative influence on the baby. In this particular case study, one potential hazard is that Michael may be exposed to substance misuse at an early age.

The remaining three aims of Every Child Matters:

- **Enjoy and achieve**
- **Make a positive contribution**
- **Achieve economic wellbeing**

whilst being out of the remit of professionals working in maternity services, are strongly influenced by the care received during the antenatal, intranatal and post natal period.

Every Child Matters, Maternity Care and the future

The future of maternity services has been described in the recently published Department of Health Document 'Maternity Matters'. It demonstrates how commissioners, providers and maternity professionals can utilise the ongoing health reform agenda to shape future provision of maternity care (Department

of Health/Partnerships for Children, Families and Maternity 2007). Future services are being planned to address the current challenges which primarily are:

- ❖ Improving outcomes for disadvantaged and vulnerable families
- ❖ Redesigning the workforce to optimise skill mix
- ❖ Providing a choice of safe, flexible care for all women

The development of maternity services in Sure Start Children's Centres is one way of improving outcomes for disadvantaged families. Early evaluations of Sure Start initiatives however have suggested that these centres are not reaching the most vulnerable women (Ormerod 2005). Rutter (2006) argues that evaluations of the project have been undertaken too soon to realistically be able to assist their impact. Edgley (2007) in her study examining statutory service providers perceptions of Sure Start professionals found that part of the problem has been the way resources have been targeted to specific geographical areas and hypothesises that the reconfiguration of health services may address this by drawing services together geographically in Children's Centres. This would hopefully avoid situations as described by Elliman and Bedford (2006) whereby among disadvantaged families, greater benefits were achieved in the moderately disadvantaged families than those with severe disadvantage, thus increasing health inequalities. As part of the Social Exclusion Action Plan a model of intensive health-led home visiting is to be piloted in 2007/2008 across ten Primary Care Trusts in England. This is to be undertaken in conjunction with local authorities. These demonstration sites will evaluate the impact of a parenting programme provided for the most disadvantaged families. Ensuring that midwifery and health visiting services provide tailored support for teenage parents is a step forward in addressing problems such as poor levels of nutrition, late ante-natal booking, low rates of breast feeding and smoking during pregnancy. All of these factors contribute to poor health outcomes such as low birth weight and higher levels of mortality and morbidity in the baby (Department of Health/Partnerships for Children, Families and Maternity 2007). The organisations that regulate nurses, teachers and social workers (GTC, GSCC and NMC) have recently joined forces to help promote a shared approach to improving services for children and young people. The statement of inter-professional values recently published place much emphasis on working together more effectively in the interests of children (General Social Care Council 2007). This is an excellent opportunity to prevent the tragic incidents where vulnerable and 'at risk' babies and children slip through the net. It will also further enhance inter-professional communication and promote seamless care.

Amongst the national targets and local delivery plan measures described by the Department of Health (2006) is a requirement of local organisations to undertake a comprehensive review of their workforce capacity. With regards to the maternity workforce this also encompasses maintaining effective leadership skills to provide a supportive culture for change. This will hopefully provide the foundation for good maternity services that can fulfil the needs and expectations of women and their families. Geographical variations will also need to be taken into account as maternity services for an industrial town may not be appropriate for a rural area (Shribman 2007). Changing skill mix and redesigning the workforce has the potential to release the clinical time of midwives and doctors and improve outcomes for babies, but this must be undertaken with clear guidelines about the limits of responsibility (NHS Modernisation Agency 2004). Midwives have to be proactive in the development of Children's Centres and ensure that all good practices developed in the Sure Start initiatives are carried forward. Midwifery is a profession already embedded in the ethos of public health and roles building on this philosophy need to be a priority of the future (Edwards 2005). Ongoing staff development programmes are also essential to ensure that all staff caring for women during pregnancy and the post natal period have the appropriate clinical skills (Department of Health/Partnerships for Children, Families and Maternity 2007).

The government's philosophy on offering a choice for women during pregnancy and birth in the future is a challenging task for future organisers of maternity care. Maternal choice however has to be balanced with the priority of providing a choice of safe, high quality maternity care. Pregnancy and birth are usually normal life events supported by midwives, it must be remembered however that some disadvantaged women will need specialist care and when this is necessary it should be readily available and of the highest possible quality (Department of Health/Partnerships for Children, Families and Maternity 2007). Children's Centres offer a variety of help for women, but at the end of the day it is their individual choice as to whether they decide to make use of the services offered. A study undertaken by Avis, Bulman and Leighton (2007) provides illustrative examples of why some women choose not to participate in Sure Start programmes and their views should be respected by health professionals.

Conclusion

By exploring the differing roles of professionals involved in caring for women before during and after pregnancy this chapter has described the relevance and importance of maternity services to Every Child Matters. It may be worthwhile

at this point revisiting the 'wish list' of the children who were asked during the preparation of the 'Every Child Matters' document, what mattered most to them:

1. Be healthy
2. Stay safe
3. Enjoy and achieve
4. Make a positive contribution
5. Achieve economic wellbeing

(HM Government 2004)

Being healthy starts from pre-conception, as it is then that the foundation for a healthy life starts. All babies need to be kept safe from harm; again this is within the remit of the health professionals mentioned in this chapter as they may well be the baby's advocate. In order to achieve the last three 'wishes' any vulnerable baby must receive expert care at birth in order to maximise the potential to achieve optimum growth and development. It cannot be emphasised enough how important skilled antenatal, intranatal and post natal care is in preventing ill health in both the mother and the baby. Vulnerable groups such as pregnant teenage girls, women from ethnic minority groups and refugees may require differing maternity care. Initiatives such as the Sure Start/Children's Centres play a vital part in providing this care. Examples of maternity practices around the UK have provisionally demonstrated how a social model of care can provide a more holistic approach encompassing the wider determinants of health. It is too early to evaluate the overall effect of the Sure Start/Children's Centre initiatives on the population – only time will tell whether there has been a reduction in neonatal mortality and morbidity due to babies being born with a low birthweight or prematurely. A final quote from the current Minister for Care Services succinctly summarises the discussion in this chapter

The quality of the advice, support and care provided from the early stages of pregnancy to the initial period of a baby's life is important for all families but especially those parents most at risk. Antenatal and postnatal care are crucial in ensuring parents feel adequately supported and equipped with the skills and knowledge to give their child the best possible start in life'

(Department of Health/Partnerships for Children, Families and Maternity 2007
page 3).

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