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Author(s): Catherine Perry; Denise Alexander

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Centre for Public Health Research

**An evaluation of the Sure Start Widnes Trailblazer
Pampering Group**

**Catherine Perry
Denise Alexander**

September 2005

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Executive summary

Introduction

The Pampering Group is part of the Sure Start Widnes Trailblazer programme. It is held on a weekly basis and is organised by a multi-disciplinary team, providing health and beauty treatments such as massage, facials and hair care for parents-to-be and new parents, as well as an opportunity for informal advice and support from other parents and professionals about childbirth and parenting a young child. The aim is to provide a group approach to supporting parents during pregnancy and the baby's first year. This was a small scale exploratory study designed to explore the extent to which the Pampering Group had fulfilled its aim and objectives. The study explored the perspectives of both users and providers of the Group.

Study design and methodology

Attendance figures for the Pampering Group were obtained from Sure Start Widnes Trailblazer. Qualitative methods were used to describe the service and to record the perceptions of the service, its benefits and limitations according to users and providers. The study utilised three data collection methods: observation; semi-structured interviews; and a focus group. The data from observation sessions were used to provide a 'thick description' of the functioning of the Pampering Group on the occasions when the researcher was present. The interview and focus group data were combined and the transcripts subjected to thematic analysis. These findings were used to draw conclusions about the Pampering Group in relation to its aim and objectives and its function as part of the Sure Start programme.

Findings

The Pampering Group was valued highly by its users, and by the staff who ran the Group, particularly in relation to its perceived role in reducing social isolation, improving parental confidence and reducing anxiety and depression in parents. Thus the Group was able to meet the majority of its objectives. The support offered to parents was perceived to have a number of features.

- The opportunity to increase social networks, make friends and establish a sense of belonging in the community of parents in Widnes.
- A reduction in isolation for new parents, particularly mothers at risk of postnatal depression.
- An opportunity for parents to increase confidence and competence in parenting.

-
- An opportunity to access health promotion messages in a non-threatening and accessible way.
 - An opportunity for self care at a time when much attention is, necessarily, focused on the new baby.
 - The opportunity to interact with a range of professionals in the multi-disciplinary team. This benefit also extended to the professionals involved who were able to learn from each other.
 - Practical help to find other groups and services run by Sure Start.

Health professionals external to the Pampering Group perceived that the Group was valuable to some parents, although the view was expressed that a group approach to offering support would not be suitable for all women. It was also perceived that the Group failed to attract some of those most at need. Challenges for the development of the Pampering Group include:

- Attracting women antenatally, as although advertised as a group for pregnant women and those with babies of up to 9 months of age, very few pregnant women attended.
- Attracting hard-to-reach families and those most in need in the community, for example families struggling with financial, physical or emotional problems.
- Reviewing publicity about the Pampering Group, so that women hear about the Group earlier and in a more systematic way.
- Attracting fathers to the Group, although consideration may need to be given to how this may affect group dynamics.

Conclusion

The Pampering Group's activities are intended to give physical relaxation, emotional support, pragmatic advice and an opportunity for local parents to get to know and support each other. There is evidence in this study to suggest that the Group has achieved these objectives. As a result, the parents and babies are more likely to enjoy physical and mental good health. Any development of the Pampering Group should take into account the informal nature of the service, as this appears to be part of why women feel it is successful. In addition, the Pampering Group has not thus far been successful in engaging women antenatally, and there are also other hard-to-reach groups, for example teenage parents, who could conceivably benefit from the Pampering Group if they attended. It is impossible for the Pampering Group to change the external world that mothers-to-be and parents bring their children up in, but in

providing an opportunity to make contact with others, and gain practical help, the Pampering Group perhaps gives women the ability to better deal with their circumstances.

Chapter 1

Introduction

1.1 Background to the study

Sure Start is a government initiative introduced in April 1999 with the aim of meeting the needs of families with children aged 0-4 years who are living in areas of high socio-economic deprivation. All Sure Start services are expected to contribute to achieving Sure Start's objectives, which have recently been restated as:

- increasing the availability of childcare for all children;
 - improving the health and emotional development of young children;
 - supporting parents as parents and in their aspirations towards employment.
- (Sure Start, 2005).

These have been developed from Sure Start's original objectives, which were to improve health and the ability to learn, to improve social and emotional development and to strengthen families and communities. The original objectives were part of the ideology that informed the aims of the Pampering Group, and still remain core to its functioning.

It is a statutory requirement of the Sure Start Unit that monitoring and evaluation of Sure Start services is carried out. The Centre for Public Health Research was commissioned to carry out this study of the Pampering Group at the Sure Start Widnes Trailblazer programme.

1.2 The Pampering Group

The Pampering Group, which was initiated in October 2001, is part of the Sure Start Widnes Trailblazer programme. It is held on a weekly basis in the Ditton Early Years Centre, Widnes and is organised by a multi-disciplinary team including a family support worker, midwife, health visitor, massage and beauty therapist, community food co-ordinator and a maternity care assistant. The Pampering Group provides health and beauty treatments such as massage, facials and hair care for parents-to-be and new parents, as well as an opportunity for informal advice and support from other parents and professionals about childbirth and parenting a young child.

The aim of the Pampering Group is to provide a group approach to supporting parents during pregnancy and the baby's first year. It focuses on psychological and practical preparation for childbirth and parenting. The Group has a number of objectives. These are to:

- support parents to feel emotionally and practically prepared for childbirth;
- identify early those at risk of postnatal depression and provide treatment if necessary, and so reduce the incidence and/or the severity of depression during the baby's first year;
- foster self-care and infant care to maximize healthy infant development, including encouraging breastfeeding and smoking cessation;
- increase the number of confident and competent parents in the area by improving parents' knowledge and understanding of child development and their relationship with their child;
- give practical help so parents have the confidence and wherewithal to engage with the local community, and statutory and voluntary services, for example through adult education;
- encourage a sense of effectiveness, self-worth and self-care in all parents in the Sure Start area;
- ensure community involvement in the promotion of the programme;
- encourage fathers' participation in the programme;
- obtain and maintain good uptake of the Pampering Group by families;
- enhance multi-agency working.

1.3 Aim and objectives of the study

This study was qualitative and exploratory in nature and as such there was no specific hypothesis to be tested. It was designed to assess the extent to which the Pampering Group had achieved its aim and objectives.

The objectives of the study were to:

- describe the Pampering Group service;
- explore the perceptions of parents who had attended the Group, particularly in relation to how the Group had helped or supported them;
- give parents the opportunity to suggest improvements or changes they felt would be beneficial to the Pampering Group;
- explore the perceptions of the professionals who provided the Pampering Group, including suggestions for improvements or changes;

-
- obtain views from outside the Pampering Group from professionals who refer women to the Group, but who do not have a direct involvement with it.

1.4 Structure of the report

This report is organised into a number of chapters. Chapter 2 presents a review of the evidence base relating to the Pampering Group and its effect on social inclusion and health in deprived areas. Chapter 3 details the study design and methods used during the research. Chapter 4 presents the findings; and Chapter 5 discusses the findings in relation to the objectives of the Pampering Group and the literature reviewed.

Chapter 2

Background

2.1 Introduction

There is very little research related specifically to pampering groups, consequently the evidence described in this Chapter relates mainly to issues relevant to the aim and objectives of the Pampering Group. These issues are: providing emotional and social support for pregnant women and new parents, including identifying and reducing the incidence of postnatal depression; improving health-promoting behaviours such as increasing breastfeeding, reducing smoking and so on; and improving parents' confidence and the child's security and sense of well-being. The literature search strategy can be found in Appendix 1.

2.2 Support for parents and parents-to-be

The National Service Framework for Children, Young People and Maternity Services (NSFCYPMS) (Department of Health, 2004) acknowledges that some groups of parents may need more support than others in order to be prepared adequately for parenthood: this may take the form of needing advice on benefits, housing, education or relationship support as well as the more obvious health advice (Department of Health, 2004). In addition, the NSFCYPMS stresses that particular attention be focused on engaging parents who do not regularly use services. These families are often experiencing challenges, such as living in poverty or being homeless, which make parenting more difficult. Also, those who did not experience good parenting themselves can find parenting a challenging experience (Department of Health, 2004). D'Souza (2003) found that interventions designed to improve access to antenatal care, especially those that involve professionals and 'lay mothers', help to improve the health of teenage mothers and their children, another potentially vulnerable group.

2.2.1 Postnatal depression

It is estimated that between 10% and 15% of women who give birth in the United Kingdom each year will experience postnatal depression (Office for National Statistics, 2003). Postnatal depression is defined as any non-psychotic depressive illness of mild to moderate severity, which occurs anytime within the first postnatal year (Scottish Intercollegiate Guidelines Network, 2002); however, it is not uncommon for depression to occur in the antenatal period as well (Evans, Heron, Francomb, Oke & Golding, 2001). The suffering caused by depression is frequently underestimated (Scottish

Intercollegiate Guidelines Network, 2002), indeed, the World Health Organisation predicts that depression will be the second greatest cause of premature death and disability by 2020 (Murray & Lopez, 1996).

A woman who has postnatal depression experiences a range of symptoms: typically low mood and mood swings, disturbances in sleeping and eating patterns, poor concentration, and irritability. In addition to these, she may have to contend with guilt about her perceived inability to look after her new baby (Howard, 2004). Postnatal depression not only has immediate effects on the health of the mother and of the baby; increasingly it is becoming evident that, untreated, it has a long term negative effect on family cohesion and fosters poor health outcomes for the child (Allen, Seeley, Armour, & Britten, no date). It may even lead to a continuation of the cycle that means poverty, deprivation and a lack of life chances continues into the next generation. Postnatal depression is linked to a lack of secure bonding between mother and child, deficits in interactions between the infant and mother, and impaired cognitive and emotional development of the child, particularly boys, in areas of socio-economic deprivation (Howard, 2004).

Concerns have been raised about the efficacy of current screening for postnatal depression (Murray, Woolgar and Cooper, 2004; Heneghan et al, 2000, cited in Hendrick, 2003) and that medical professionals are 'missing' cases. This could also be compounded by the stigma associated with mental illness, and the reluctance of some women to be seen as not coping well with motherhood (Mantle, 2002). Early detection is important, because it seems to be a key factor in successfully treating postnatal depression (Howard, 2004). To this end, much research has been undertaken into the risk factors for postnatal depression. D'Souza and Garcia (2004) found that risk of depression is increased if the mother is isolated, without access to social support, if she has a past history of depression or other mental health problems, or lack of a supportive partner. Living in an area of high unemployment and high levels of deprivation increase a woman's chances of experiencing one or more of the risk factors for postnatal depression, which may begin a cycle of increasing hardship. In direct relationship to the risk factors, D'Souza and Garcia (2004) found that social and professional support were likely to help ameliorate postnatal depression, and specific advice, such as that included in parenting programmes, was likely to improve the psychological health of vulnerable mothers, such as teenagers.

Treating postnatal depression is done in a variety of ways. Morrell, Spiiby, Stewart, Walters, and Morgan (2000) found that it is important for women to receive an intervention as soon as postnatal depression is identified. Traditionally, psychological interventions such as cognitive behavioural therapy, and pharmacological interventions, such as anti-depressants, have been used (Appleby, Warner, Whitton and Faragher, 1997). Both of these interventions have been shown to be effective in decreasing symptoms and levels of anxiety (Highet and Drummond, 2004).

In addition to medical intervention, MacArthur et al. (2002) found that significant improvements in mothers' mental health were made when midwife-led care was increased from one month to three months after the birth. Cooper, Murray, Wilson and Romanuik (2003) and Murray et al. (2004) found that extra support for women through supplementary contact with a health visitor was perceived to be beneficial to those mothers who had mild to moderate postnatal depression. However, Morrell et al. (2000) found that well-being may not be affected by additional community postnatal support worker contact.

2.2.2 Social capital

A high level of 'social capital', in other words being able to draw upon friends, neighbours and family in the community can improve parenting and child behaviour (Grimshaw and McGuire, 1998). Providing opportunities for developing friendships, networks and possibilities for help with childcare is important in enabling parents to break out of the cycle of deprivation, and the poor health outcomes that are associated with it (D'Souza and Garcia, 2004; Vimpani, 2000). The NSFCYPMS obligates local Primary Care Trusts to help parents stay in education or find work as appropriate (Department of Health, 2004). One important factor in doing this is to increase the confidence of parents, particularly those living on low incomes or who are disadvantaged in some way, which makes parenting more of a challenge.

Research has shown that reducing isolation for parents is important in increasing self-worth and a sense of effectiveness. This in turn is important in allowing people to move from a cycle of hopelessness and poverty that is common in areas of deprivation. Davis and Spurr (1998) found that parent counselling, using parent advisers, increased mothers' self-esteem and decreased anxiety and depression in their parenting role. This was the case even though the external challenges the women faced, such as poor housing, crime, and violence, did not change. A more recent study into social support,

based on improving parents' problem solving skills, found no significant changes as a result of the intervention although the support was appreciated by the mothers (Brugh, 1999). An American study found that violent behaviour among young boys was less when their mothers received more social support (Roche, 1999). These findings and others have led the National Perinatal Epidemiology Unit to recommend that further research be undertaken to determine the effect of social support and parenting advice on postnatal depression, and other aspects of parent and child mental health. (Rowe, Jayaweera, Henderson, Garcia, & Macfarlane, 2003).

2.3 Health promoting behaviour

Health promoting behaviours, such as breastfeeding, or not smoking, are less prevalent in poorer areas than in more affluent areas, even though the health needs and the benefits to be gained for those living in poorer areas are greater (Rowe et al., 2003). Jarvis (2004) found that living in disadvantaged circumstances increased the likelihood of continuing to smoke. This is illustrated by the fact that among affluent populations, the proportion of smokers who have stopped smoking has increased from 25% thirty years ago to nearly 60% in 2004; among the poorest populations, the number has remained at around 10%. This may be because of a greater dependence on nicotine among poorer populations (Jarvis, 2004). In a study of disadvantaged pregnant women, Rowe et al. (2003) found that 35% of the mothers had smoked in the year before or during their pregnancy, and 20% continued to do so throughout their pregnancy. This is despite the fact that smoking cessation rates are slightly higher among pregnant women than other sectors of the population (Jarvis, 2004). The General Household Survey also shows a link between disadvantage and continuing to smoke. Whereas 63% of women classified as being in higher occupations gave up smoking while pregnant, only 38% of women in lower occupations and 29% of women who had never worked stopped smoking during pregnancy (Rowe et al., 2003).

Helping pregnant women to stop smoking has long been a focus of health professionals. However, interventions are not always successful. In the General Household Survey, 89% of pregnant women recalled being given advice to give up during pregnancy, but there is little evidence that this worked. (Rowe et al., 2003). Studies into routine interventions, such as written material and advice from a midwife, have shown little or no effect on smoking cessation rates (Tappin et al., 2000; Wisborg, Henriksen, & Secher, 1998; Severson, Andrews, Lichtenstein, Wall, & Akers, 1997). However, where interventions have continued with regular support throughout

pregnancy, they are more successful, although they do not seem to have an effect postpartum (McLeod et al, 2004).

The World Health Organisation recommends that babies be breastfed exclusively for six months before solid food be introduced (Kramer & Kakuma, 2002). When comparing occupational groups, mothers who were in the lower occupational groups or who had never worked had far lower rates of breastfeeding than their more affluent contemporaries. Just over half (52%) of mothers who had never worked breastfed their babies compared to 59% of those in lower occupations, 73% in intermediate occupations and 89% of higher occupations. The length of time a woman breastfeeds also correlates to occupational groups. Around 75% of mothers in higher occupational groups were still breastfeeding when their infants were six weeks old, compared to fewer than half of women in lower occupations (Rowe et al., 2003). Around a third of women from lower occupations or who had never worked had offered their babies solid food before they were three months old, compared to just 17% of women in higher occupations who had done the same (Rowe et al., 2003).

Helping women to continue breastfeeding for as long as possible, optimally for six months after birth, is more successful when women receive support from peers or professionals. A systematic review of the evidence surrounding breastfeeding indicated that peer support (such as via telephone), was effective in improving rates of breastfeeding for low income groups. Informal, small group education was also successful (Fairbank, O'Meara, Renfrew, Woolridge, Sowden, & Lister-Sharp, 2000; North, undated).

2.4 Confident parenting and emotional well-being

The NSFCYPMS states that it hopes to see all parents or carers having the confidence to bring up their children to be healthy – physically, emotionally and mentally (Department of Health, 2004). In order to develop this confidence, parents may need support. In turn, children whose parents are confident and supported are more likely to achieve a secure attachment to their family, and reap health benefits as a result (Department of Health, 2004).

Experiencing poverty or living in disadvantaged conditions can place a strain on parents' ability to form a strong relationship with their child. Providing social and practical support for such parents is likely to help ameliorate the challenges faced by

those living in poverty, and benefit the parents and improve outcomes for the children (Department of Health, 2004). A study that described the effects of increased social support in the form of health visitors providing monthly supportive listening sessions found that although some outcomes were not altered by this one intervention, such as maternal depression, maternal smoking and child injury, the mothers were more confident and less worried about their child's health or development. Thus, family well-being was increased (Wiggins et al., 2004). It is extremely important, however, that advice and support given is timely, otherwise parents' confidence can be eroded. One way of achieving consistent information is by agencies and professionals working together (Department of Health, 2004).

Babies that are securely attached to their parents are more likely to be healthy and develop strong emotional and social knowledge. A child without this attachment is more likely to experience behavioural problems at school, be aggressive or have mental health problems (Department of Health, 2004). Parents who themselves did not have secure attachments to their families are more likely to repeat the experience with their own children. Thus, stopping this cycle can only be advantageous.

2.5 The pampering approach

North (undated) argues that antenatal care that focuses only on medical aspects of pregnancy and birth does not meet the needs of parents, and non-traditional care that includes group discussion and plentiful involvement of midwives can reduce infant mortality and increase birth weight. Postnatal care that facilitates peer support can also help to promote healthy behaviours (North, undated). The Pampering Group which is the subject of this study can be viewed as a non-traditional support group aimed at both antenatal and postnatal women. The use of 'pampering' within the session gives a clear message that it is important to 'look after yourself' during and after pregnancy. So, for example, there is evidence to indicate that the use of massage and relaxation techniques can reduce stress (Field, 2000; Risberg, Kolstad, Bremnes, Holte, Wist, Mella, Klepp, Wilsgaard & Casileth, 2004), and providing such a treatment to pregnant women and the mothers of young babies is likely to be useful in terms of their health, self-esteem and well-being. A mini service evaluation of the Sure Start Pampering Group at Ellesmere Port concluded that the Pampering Group was an innovative approach to providing emotional and social support and health advice to antenatal and postnatal women (Rouse, Barrow, & Thurston, 2004). The importance of the Group in

introducing pregnant women to each other and to other Sure Start services was also highlighted (Rouse, Barrow, & Thurston, 2004).

2.6 Conclusion

Only one document (Rouse, Barrow, & Thurston, 2004) was found that specifically related to pampering groups in a parental support situation. However, several research studies were accessed that related to interventions to involve and engage parents and families in community activity. These had various outcomes such as improving the detection of and alleviating postnatal depression, help with smoking cessation, improving social capital and improving parenting skills.

It can be concluded that although not a great deal of research has been carried out exploring the idea of a 'pampering group', there is some evidence to suggest that the Group's activities may be successful in supporting parents. This is particularly important in an area of high economic and social deprivation, where evidence has shown that mental health in particular is more profoundly affected by circumstances.

Chapter 3

Study design and methodology

3.1 Introduction

This was a small scale exploratory study designed to explore the extent to which the Pampering Group had fulfilled its aim and objectives. The study explored the perspectives of both users and providers of the Group.

Qualitative methods were used to describe the service and to record the perceptions of the service, its benefits and limitations according to the users and providers. A grounded theory approach was used in the research, thus allowing data collection to be refined in the light of data gathered. The process was iterative, as the data were analysed in conjunction with further data collection, which in turn informed the future analysis. This method is summarised by Bryman (2001, p.390) when he described grounded theory as when “data collection and analysis proceed in tandem, repeatedly referring back to each other”. A thematic analysis of the data was undertaken, with data being coded in terms of concepts and categories.

3.2 Data collection

The study utilised three main data collection methods: observation; semi-structured interviews; and a focus group. In addition, attendance figures for the Pampering Group were obtained from Sure Start Widnes Trailblazer.

3.2.1 Observation

“Observation is a purposeful, systematic and selective way of watching and listening to an interaction or phenomenon as it takes place” (Kumar, 1999, p. 105). It is a particularly useful method of gaining data about a group, the behaviour of the group and the interactions that take place within the group. Observing the Pampering Group sessions gave an external view, one which did not rely on individuals’ memory and interpretation. It provided a background to the interviews and focus-group as well as the additional benefit of ‘fine-tuning’ the questions posed in the interviews and focus group, and introducing the researcher as a more familiar face to the parents, some of whom would then be interviewed.

Access to the Pampering Group for the observation was obtained via the Sure Start Core Team Manager and negotiation with the staff of the Pampering Group. No written

consent from the professionals present was sought before the observation, but verbal consent was obtained from all the staff present. It was not possible to obtain written consent from the users of the Group, because the 'drop-in' nature of the Group meant it was impossible to determine who would be present in advance. After obtaining consent from the professionals, the researcher explained her presence at the Group to the users, indicating that if anyone objected to the session being observed, she would leave. No objections were raised. The individual treatment sessions were not observed, due to the personal and intimate 'one-to-one' nature of the treatments.

The researcher observed the Pampering Group on two occasions, with the particular sessions chosen being based on researcher availability. The Group was observed on more than one occasion in order to reduce the likelihood of the researcher's presence causing a reactive effect (Bryman, 2001), which is when participants change their behaviour because there is a stranger in the room. Notes were taken during the observation session using an observation framework (see Appendix 2). There were three main focuses for the observation:

- setting – this focused on the environment where the Pampering Group was held, including the building and access to the building as well as the room where the Group was held;
- personnel and user interaction – this focused on the interaction between the users of the Group, their babies, and between the health professionals present and the users of the Group;
- time charting and shadowing – this part of the observation aimed to follow the progress of two sets of users throughout the life of each group, noting the interactions that took place with others and the activities that were carried out by those observed.

Notes were written up immediately after the observation sessions in order to reduce the likelihood of memory bias.

3.2.2 Semi-structured interviews

Semi-structured interviews were conducted with parents who attended the Pampering Group and with professionals who referred parents to the Group but did not have any further involvement with it. The interview topics were initially defined based on the stated objectives of the Pampering Group, but the semi-structured format enabled interviewees to express ideas that were important to them. This use of what Bryman

(2001, p.313) described as going off “on tangents” enabled valuable insights to be gained into what interviewees felt was significant, and issues could be probed in more detail than would be possible with a more rigid interview structure (Bowling, 2002). The interview schedules can be found in Appendix 3 (parents) and Appendix 4 (professionals).

Purposive sampling was used in order to select interviewees. This is a deliberately non-random method that seeks to select people who have knowledge of the subject valuable to the research (Bowling, 2002), thus the researcher judged who could provide the best information to fulfil the aims of the study. This type of sampling is very useful in constructing a historical reality, describing an event or expanding on something about which little is known (Kumar, 1999). In order to recruit parents to the study, the researcher attended one session of the Pampering Group to explain the study and gave every parent present a participant information sheet and a form to return with their name, address and telephone number if they were willing to be interviewed. The researcher returned the following week to collect returned forms. Potential interviewees were then contacted by telephone and a time for the interview was arranged at the interviewee’s convenience. Once an interview had been organised, a letter confirming the arrangement, a copy of the participant information sheet (Appendix 5) and a consent form (Appendix 6) were sent to the interviewee. It was made clear that if interviewees changed their mind, consent to participate could be withdrawn at any time. Written consent was obtained immediately prior to the interview.

Professionals who had referred parents to the Pampering Group were identified by Pampering Group staff. These individuals were telephoned by the researcher who explained the study and asked whether they would be willing to take part. If they were, a suitable date and time were arranged for an interview and a letter confirming the arrangement, a copy of the participant information sheet (Appendix 7) and a consent form (Appendix 6) were sent to the interviewee.

With each participant’s permission, the interviews were tape-recorded. The tapes were then transcribed verbatim.

3.2.3 Focus group

A focus group was carried out with the professionals involved in providing the Pampering Group. The focus group presented an opportunity to observe the group

dynamics of the professionals from different agencies and how they worked together, particularly in terms of power relationships. All of the professionals involved in the Group were invited to take part in the focus group by the researcher when she was in attendance at the Pampering Group session. Potential participants were given a participant information sheet (Appendix 7) and were informed that if they wished to attend, the focus group would take place the following week immediately after the Pampering Group session. It was anticipated that this arrangement would enable as many people as possible to contribute.

Immediately before the focus group took place, the participants were given another copy of the information sheet and written consent to participate was obtained. A focus group schedule had been developed (Appendix 8), which related to the aim and objectives of the Pampering Group. However, as with the interviews, the participants were free to explore issues that arose from the questions in more detail if they wished. This enabled staff to place importance on the most relevant topics for themselves. With the permission of the participants, the focus group session was tape recorded, and the recording transcribed verbatim.

One person could not attend the focus group, and so she was interviewed on a separate occasion, using the schedule of questions designed for the focus group.

3.3 Data analysis

The data from observation sessions were used to provide a 'thick description' of the functioning of the Pampering Group on the occasions when the researcher was present. This allowed the interview and focus group data to be interpreted in context, and also allows the transferability of the findings to other settings to be assessed.

The interview and focus group data were combined and the transcripts subjected to thematic analysis. These findings were used to draw conclusions about the Pampering Group in relation to its aim and objectives and its function as part of the Sure Start programme.

3.4 Ethics

The ethical issues inherent in this research were covered under an ethics application to Cheshire Local Research Ethics Committee (LREC). Ethical approval was gained in July 2004.

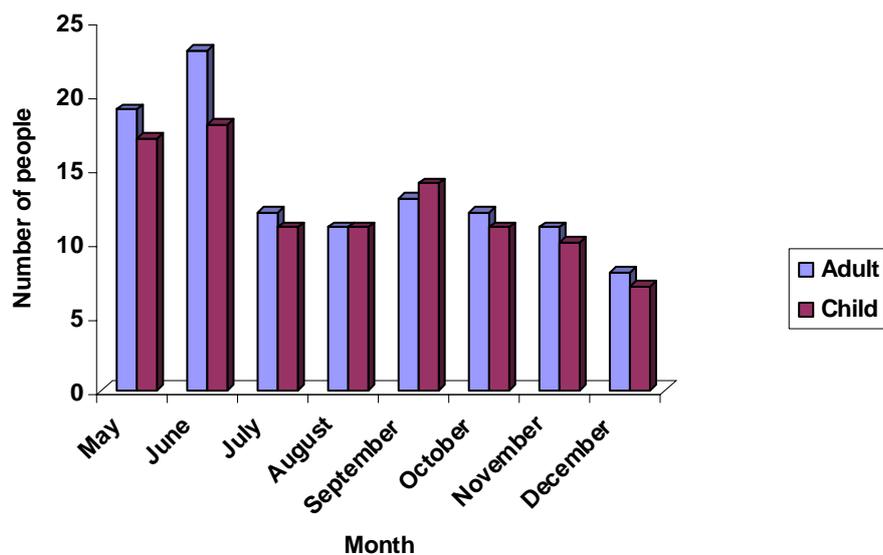
Chapter 4

Findings

4.1 Introduction

The findings of the study are presented in three sections: observation findings; findings from the interviews with parents; and findings from the interviews with health professionals who referred to the Pampering Group and from the focus group with professionals involved in the Pampering Group. Firstly however, the monthly attendance figures at the Pampering Group are displayed in the figures below. These show the number of individuals who accessed the Pampering Group.

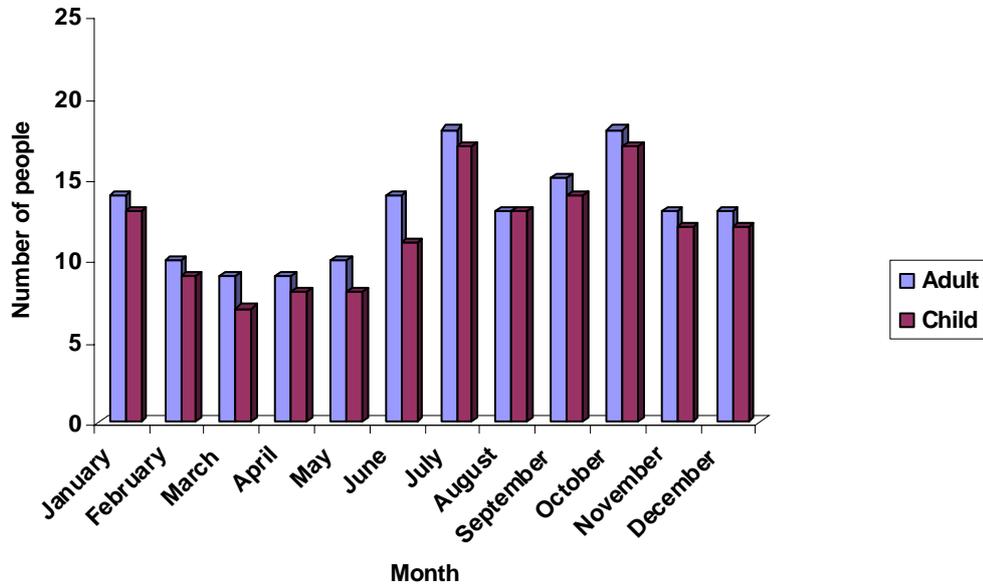
Figure 4.1.1 Attendance at the Pampering Group during 2003



Attendance figures were available for eight months of 2003, from May until December, and are displayed in Figure 4.1.1. The average number of individuals who attended the Pampering Group each month was 14 adults and 12 children.

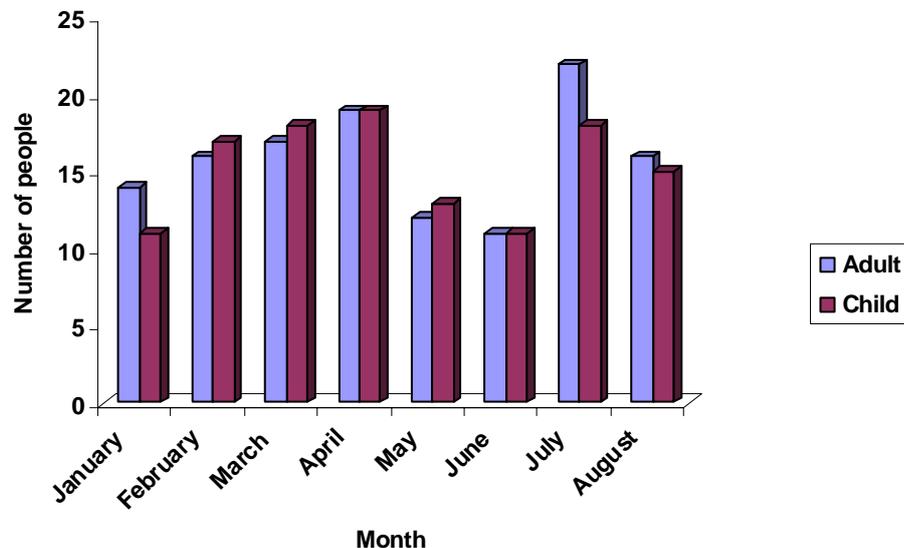
Figure 4.1.2 below shows the Pampering Group attendance figures for 2004. During this year, the average number of individuals who attended the Pampering Group each month was 13 adults and 12 children.

Figure 4.1.2 Attendance at the Pampering Group during 2004



Attendance figures for the first eight months of 2005 can be seen in Figure 4.1.3 below. The average number of individuals who attended the Pampering Group each month was 16 adults and 15 children.

Figure 4.1.3 Attendance at the Pampering Group during 2005



4.2 Observation findings

The observation of the Pampering Group took place on two occasions during March 2005. Findings related to the three focuses of the observation, setting, personnel and user interaction, and time charting/shadowing, are presented.

4.2.1 Setting

The Pampering Group was held in the newly built Ditton Early Years Centre in Widnes. The building was one storey and had a large car park outside. It was a new building, but had some graffiti on the exterior walls. Nearby were a playing field and a children's play area containing swings, a slide and a roundabout. Next door to the Ditton Early Years Centre was the Ditton Community Centre building, which housed the Sure Start offices and other Sure Start events, such as activity groups for older children.

To access the Ditton Early Years Centre building, the researcher had to ring an external doorbell and speak to a receptionist through an intercom system. The receptionist released a lock on a heavy glass door for the researcher to enter a porch area. Once inside, the researcher had to sign her name, where she was visiting and the time, before another electronic lock was released on a further heavy door to be allowed into the main building. This consisted of a large foyer area and to the right an area where prams were stored. The Pampering Group was held in a room next door to the foyer area, immediately adjacent to the pram store area. To exit the building, the researcher had to release the electronic lock on both doors and sign out of the building before leaving.

The researcher observed the main room where the Pampering Group was held rather than the consultation room (see Figure 4.2.1.1 overleaf). Essentially, this room was where parents waited for the pampering treatments. However, it was where the majority of the activities of the Group were carried out. The door to enter the room was a wide, heavy fire door. The room itself was a large, airy square room. The walls were painted a lilac colour and the carpet was a darker shade of purple. It looked recently decorated. The room was warm; there was a radiator by the door, covered with a radiator cover.

Figure 4.2.1.1 The Pampering Group setting



On two sides of the room there were large windows. On the other two walls were large pine coloured floor-to-ceiling cupboards, and on one wall a small kitchen area, containing a sink, worktop and wall units, was set up. On the kitchen counter there were jugs of hot water, milk, coffee and tea supplies, cups, baby wipes and pieces of paper used by the staff. A small bin was under the counter for rubbish. In the corner opposite the door a new chair, covered in bubble-wrap was placed, along with some large boxes and coats. Next to the kitchen area there was a notice-board which contained advertisements for relevant activities such as aquanatal classes, parenting classes, dads and kids swimming sessions, baby massage, sing-a-long sessions and so on. Next to the large cupboard on the other wall, a coffee table was set against the wall. On this table, the staff had set out a range of healthy food for the users of the Group. On one occasion, the food was quiche and salad, and on the other occasion a selection of cold meat, cheese, bread and salad was available.

In the middle of the room four large (three-seater) dark purple sofas were placed in a semi-circle. The sofas were leather and were in good condition. In the middle of the circle was a large, carpet rug in shades of burgundy and purple. On this baby gyms

and baby bouncers were placed. Behind the circle created by the sofas, in a corner opposite the door, two armchairs were set apart facing each other. Once all the sofas were filled, extra plastic chairs were provided by the staff. The plastic chairs were stored in one of the large storage cupboards in the room.

The consultation room was not accessed directly from this room, but was set up in an office across the corridor.

On both observation sessions the room was set up identically. On one occasion, the staff were still setting up the room when the researcher and two of the parents arrived. The Group was attended by fifteen mothers and babies in the first observation session, and sixteen, plus one pregnant woman, the next week.

4.2.2 Personnel and user interaction

There was a high level of interaction between the parents, between parents and staff, and between children and adults. The children (babies under one) were mostly passive in their interactions, and because of their age had limited interaction with each other. They appeared to be, on the whole, content, as evidenced by a general lack of outward evidence of distress, for example crying, and by their reactions to those around them, for example smiling. The atmosphere in the Pampering Group room was relaxed, friendly, and fairly noisy. During the middle of the Pampering Group sessions, when the room was full, the temperature as well as the noise level rose considerably. Most people were wearing light clothes even though the observation sessions took place in early March.

4.2.3 Parents interacting with parents

Examples of parents interacting together were numerous throughout the observation sessions. The sessions were characterised by a high level of chatting. Several of the parents arrived together in small groups, and all greeted other women and babies as they arrived. During both observation sessions, the only parents who came to the Group were women, except on one occasion when a father came to pick up the mother and baby towards the end of one of the observation sessions. Few of the conversations involved all of the women. Most were in small groups of two to three parents, holding separate conversations.

Conversations took place about aspects of parenting and many other subjects, such as dieting and going back to work. Parents discussed amongst themselves more specific 'medical' topics, such as the use of saline drops to treat a baby with a blocked nose – one woman had used them and was recommending which chemist they could be bought from, and a discussion about reflux and how to prevent it. Another conversation centred on whether boys or girls were more dextrous at an earlier age, and a further example was about speech and babbling noises the babies were making.

On one occasion, a baby had rolled over and become entangled in a baby gym, preventing him from rolling back. The baby made repeated attempts to roll back before crying because he was unable to move. This was unnoticed for several minutes because the parents were deep in conversation together nearby.

During the second observation session, a mother and baby visited the Group. The woman no longer came to the Pampering Group because her baby had grown too old, but she was greeted by several people as a friend, and asked how her child was developing and how she was enjoying working. On one occasion a mother swapped baby clothes and nappies with another woman whose child had grown out of them.

Two women attended the Group with twins. Both women were assisted in caring for the twins by others present, including feeding and undressing the babies for weighing.

During one observation session a pregnant woman attended the Group. This was an example of when the interaction did not appear to be so easy. The pregnant woman was observed alone at several points during the Pampering Group session, although she talked to the midwife, had a treatment and helped herself to food. The other women seemed to be using their experiences of caring for babies or the babies' behaviour to initiate conversations, which to some extent, excluded the woman who was pregnant. Conversely, the woman may not have wanted to interact with other women at that particular point in time.

4.2.4 Parents interacting with staff

There was a midwife, maternity assistant and two family support workers present in the Group on both observation sessions. On one occasion a health visitor was present. At the beginning of each session, the staff mostly interacted with each other, as they set up the room and prepared for the Group to start. Once the parents arrived however, the

focus of the staff was to talk to the parents. During the Group itself, they rarely interacted with each other except to ask questions or involve other parents in a conversation or discussion.

The main occasions of parent and staff interaction were at the beginning of the Group when a staff member made a hot drink for the parent and greeted her and the baby, when the babies were weighed by the maternity assistant and conversations were struck up between the maternity assistant and the parent, or with a midwife if there was anything notable as a result of the weighing. On one occasion, a parent discussed with the midwife her worries about the child refusing to drink her milk now that she was eating some solid food. The child's weight had dropped. The midwife was reassuring and made a note to weigh the baby the next week to check progress. One woman was extremely pleased her baby had put weight on because she had been very anxious as the baby had previously lost weight. At one point, the midwife explained to a number of women the meaning of the centile charts in the parent held record books. Other conversations between staff and parents were less 'medical'. There was a discussion about baby clothes, how much they cost and where to buy them, and where to buy the cheapest nappies.

The staff moved around the room joining in conversations and providing practical help with the babies. On one occasion, the midwife helped the mother of twins put one child in a car seat. Although it was not the responsibility of the staff to care for babies while mothers were out of the room, they were on hand to look after a baby while the mother went for a treatment. Care was shared between all present in the room. On one occasion, the family support worker gave a video to a couple of the mothers and gave advice on its contents.

The staff, particularly the midwife, were available to talk to new members of the Group. The midwife greeted one new person and introduced her to some other mothers in the Group. On more than one occasion, a staff member played with a baby, such as with a 'pop-up farm' toy.

The staff noted the order of arrival and order of treatment. They also let the parents know when it was their turn and facilitated negotiation between parents if treatment was not possible or if someone needed to leave early.

4.2.5 Parents interacting with their own babies

After arriving, most of the parents placed their babies (if awake) in the centre of the room, within the circle created by the sofas. Sometimes the mother played with the baby on her lap or the baby went to another woman or a staff member to be held and played with. On more than one occasion, a parent had brought along another family member (a mother or older child) to help with the baby. These people joined in the conversations easily and were included in the dynamics of the Group.

Many of the interactions between mothers and babies in the Group seemed to be focused around food. On one occasion, one of the twin girls became grizzly during the Group. The mother picked her up to give her a bottle, and the other twin was happily sitting in the bouncer watching other babies. Another mother spoon-fed her baby solid food from a plastic container while the baby sat in a baby bouncer. The mother used the hot water provided in the kitchen area to warm the food up. One baby girl was fed cheese, tomato and slices of chicken which had been taken from the coffee table where food was provided by the Pampering Group. The mother was very pleased that her baby was eating such a wide variety of food. On other occasions during the observation, babies were given a small amount of the mother's food to try, for example a piece of quiche or a ham slice. During both observation sessions, one or two mothers breastfed, or bottle-fed, their babies.

Weighing seemed to be another important focus for interaction between mother and baby. Several mothers undressed their babies in readiness for weighing. One baby was being given a treatment through a nebuliser in one corner of the room.

Play was another stimulus for interaction between mother and baby. One baby was held 'standing up' on his mother's lap. The baby laughed and looked around at the other children while this was happening. One baby was bounced up and down by her mother, and another was being 'walked' by his grandmother, who held his hands to support him as he walked along the edge of the room.

4.2.6 Parents and staff interacting with other babies

On many occasions, the babies were looked after and played with by women other than their mothers. At one point in the observation, it was difficult to ascertain which baby belonged to which parent. On more than one occasion during both observations, women talking all had a baby on their laps, but it was not always their own baby. There

was only one baby in the two observation sessions that would not go to anyone except her mother. The mother commented that she was a particularly 'clingy' child.

When a baby became grizzly or started crying, if the mother was not nearby, another woman or a staff member picked up the baby to comfort it. There was a great deal of help given to other mothers, particularly to those who had twins. For example, while one twin was breastfed, the other twin was comforted by another parent, who also undressed the baby for weighing and re-dressed it afterwards. The other woman fed the baby with a bottle of expressed breast milk afterwards. In another example, a baby played while its mother had a conversation on the other side of the room. The baby was undressed and weighed by a woman nearby and re-dressed afterwards. One baby was fed fruit puree by her mother as the baby sat on a friend's lap.

The babies that were left while the mother went out for a treatment, either remained on a baby gym mat or playing with a toy. On one occasion, a baby began to cry while her mother was having a treatment. The baby was calmed by the midwife who was nearby. When the mother of one of the sets of twins left for a treatment, the twins were looked after by one of the other parents and the family support worker.

4.2.7 Time charting and shadowing

At both observation sessions, one or two family groups were observed over a period of time in order to follow the story of a family group during the Pampering Group session. During the time charting, the activities of all those shadowed was similar. There was little movement around the room, and little activity other than leaving for a treatment. Most of the activity centred around conversation.

In one case, the mother arrived about ten minutes before the start of the Pampering Group. She placed her baby in the middle of the room in a baby seat, surrounded by the other babies who were present. The baby seemed content and looked around and smiled at the children near her. That mother sat nearby, but not next to the baby, on one of the sofas, and chatted to the other women in the Group. She was the first to receive a treatment in that session. While the mother was out of the room, the baby remained sitting where she was, and was not held or looked after by one particular person. At a later point in the Group, the baby was picked up by another woman, while the mother held a different child. The other woman prepared the baby for weighing and re-dressed the baby afterwards. Towards the end of the session, the baby became upset and tired. She was picked up and cuddled by her mother, who continued with a

conversation. The baby fell asleep and remained so for the rest of the session. When the Pampering Group ended, the mother dressed the baby in a coat, without waking her up.

A similar sequence of events was observed when a mother of three-month-old twins was shadowed through a Pampering Group session. She arrived at the beginning of the Pampering Group with the twins in a large pram. She left the pram outside the room and came in with one of the babies, which she placed on the floor, under a baby gym. She then left to collect the other twin who was in the pram. The mother sat on one of the sofas, holding one of the twins. She fed the baby with a bottle, and when she had finished, gave the baby to the maternity assistant to hold while she fed the other baby. The mother did not move around the room much, or help herself to the food on offer, but remained close to the twins. Throughout the Pampering Group, the mother talked to other women and staff members who were nearby. When she left the room to have a treatment, the twins were placed on the floor again to play with a baby gym; they were looked after by a friend and by one of the family support workers. When the Pampering Group ended, the mother left accompanied by two other mothers. They helped her to put the twins in the pram and manoeuvre the pram out of the building.

A mother of an older baby was also shadowed. She arrived about quarter of an hour after the Group had started and immediately began talking to the staff in the kitchen area, while holding her baby. She warmed a baby's bottle using the hot water provided. Although the family support worker appeared to be a familiar face to the family, the baby cried when the family support worker held her while the mother prepared the feed. The baby could not be comforted until she was reunited with her mother. The mother remained standing and talked to the family support worker and midwife. After a few minutes, she sat down on a nearby sofa to feed the baby. Once the baby had been fed (after refusing most of the bottle), the mother sat down on the floor and put her child on the floor to play. The mother struck up a conversation with another mother in the room, but remained sitting on the floor near to her child. The mother then played with the baby, throwing her up in the air and catching her, while the baby laughed loudly. About half an hour later, the baby vomited some milk. The midwife helped the mother find a cloth to clean up. The baby was weighed with her clothes still on to give the mother an idea of her weight. At three o'clock, before the official end of the Pampering Group, the mother left, without having had a treatment.

4.3 Users of the Pampering Group: interview findings

A total of six interviews were conducted with users of the Pampering Group. Participants were all women and had all attended the Group on more than one occasion. One of the women was a mother of twins. Several broad themes emerged from the interview data. These were:

- finding out about the Pampering Group and the activities within Sure Start;
- social benefits, including help with depression or grief;
- confidence in parenting, and improvement in self-confidence (including starting a follow-on group);
- the importance of the treatments;
- access to information;
- access to the Group and physical space within the Group;
- access to Sure Start services.

Quotations from the interviewees are used to illustrate themes that emerged from the interview material. In order to preserve anonymity, quotations are identified by a tape transcript number.

4.3.1 Finding out about the Pampering Group

All of the women interviewed had found out about the Pampering Group from their health visitor or from friends. No-one interviewed had heard about the Group from a midwife. Word of mouth was the most common means of discovering the Pampering Group. One woman commented:

'I think it was a friend [who told me about it] because she has got a baby the same age and she started going as well. That is how I started going.' (002).

Some women did not find out about the Pampering Group until their babies were a few months old. Regret was expressed by some of these women that they had therefore not been able to attend the Group earlier on in their babies lives. For example, one woman stated:

'I didn't actually find out (about the Pampering Group) until I think he was about four months old when I first started taking him. So he has basically hasn't done anything like the baby massage and everything, he was just too old to do it.' (002).

All of the women interviewed were using other Sure Start services, or intended to use other services for their children. Specific services that the women had accessed, such

as Musical Minis and the Early Learning Group, were mentioned. Women also spoke of groups that they planned to access in the future. For example, one woman stated:

'.....the other ones are all a bit more for older babies like swimming and things which I can't do yet because they haven't had the needles and things, which I will do when they are a bit older.' (003).

The women were also using Sure Start services designed for parents. These included classes for relaxation, such as hobbies, practical classes to improve life skills, or for further training. Some women were accessing a number of services. One woman explained:

'I was doing the healthy living on a Monday. I have just finished my cook and taste on a Friday and I know that there is some Spanish lessons that are starting up and some art and design so I will probably go to them but I have to fit it around work as well.' (004).

4.3.2 Social benefits

All of the women interviewed said that they had benefited socially from attending the Group. New friendships were made, a point raised by many interviewees, with one woman commenting that since she had her baby and joined the Pampering Group her social life had *'gone through the roof.'* (001).

The friendships made in the Pampering Group were, because of the nature of the Group, made when the babies were very young. The evidence from the interviews suggests that these friendships will continue to provide support after the parents and babies leave the Group and move on, thus reinforcing social networks and support as the children grow up. One woman commented:

'Well there are a lot of us staying in touch anyway. The likes of the girls on the road behind and we very often just nip round to each other's house now anyway.' (001).

The social nature of the Group seemed to be important in initially attracting the women, and in encouraging them to make more than one visit. Women commented that it was nice to get out of the house, meet other mothers with children of the same age, and have a chat. One woman talked about the courage that it took for her to come to the Group for the first time and why she decided to go back:

'I thought, I will just come. I was sat there quite shy and I just thought, I will go next week because I enjoyed just sitting there and listening because I prefer just to listen to other people's conversations as well. So I was just doing that and now I don't miss a week.' (004).

Some women thought that the social aspect of the Group was as important, if not more important, than the treatments. Thus, if a woman was unable to have a treatment, perhaps because there was not enough time, going to the Pampering Group was still perceived to be 'worth it', as this woman commented:

'No one is ever bothered if they don't get one [treatment] because you have still had a good laugh and a chat and a drink and watched your babies playing and stuff.' (001).

One parent had been referred to the Pampering Group because she was dealing with grief after a poor outcome from her pregnancy with twins. She felt that the Pampering Group had helped her to cope with parenthood and grief. Similarly, another woman had been very ill at the time of the birth of her child and for the first few weeks of parenthood. She felt that the Group had helped her overcome the stresses of this period and begin to enjoy her role as a mother. She commented:

'All that I had gone through with having a section and being poorly with a wound infection, I had persevered [with breastfeeding] through all of that ... but I was upset [after having to stop breastfeeding]. Then once I got out and I got to the Pampering Group and you see lots of other mums who are having a similar experience then that helped. But when I was isolated and not going anywhere and not doing anything, I thought it was only happening to me.' (006).

The Group was also perceived by the women to be helpful in combating depression. One woman described how difficult it was coping with maternity leave and parenthood after leaving a very busy and responsible job. She said:

'I felt like I had no structure any more ... there was no real structure to my day and I could see that it would be quite easy to get quite down and just get stuck into the everyday humdrum of having a new baby. Whereas when you have got somewhere to go like the Pampering Group, you have got a structure and it is good for them and it is good for you.' (006).

Some of the respondents had quite healthy social networks, others did not, but it was evident that social networks were expanded through exposure to the Pampering Group and other Sure Start activities. It was apparent that for this group of women, once they had engaged with one Sure Start service, they were encouraged by others to attend more. One woman commented:

'One of my friends was going as well and I did know a couple of people that were going to go because we got to know each other in Baby Massage, and like I say, one of my friends got me in on that so I know her anyway and she was going to go.' (001).

One woman felt very strongly that, for her, an important function of the Pampering Group was to get her babies weighed in a relaxed and friendly environment. She commented on the differences between the 'baby clinic' environment and the environment generated at the Pampering Group. In particular, that other mothers were at the Pampering Group was important, and her perception was also that it was easy to ask if she had any problems. She stated:

'[at the clinic] it was very, very clinical and as I said there was no other mums in there anyway so I didn't meet any other mums. Again, you wouldn't anyway because you were just undressing them, getting them weighed, getting them dressed and you were leaving ... At the pampering class you tend to find because you have got the two of them there is always somebody who will say, here you are I will undress one if you want. Whereas at the clinic I had to do everything myself so it took me twice as long but as I said, you literally got the babies weighed, got them dressed and I left. Whereas there [the Pampering Group], you can have a cup of tea and you have a chat ... the thing that is better than the clinics because again there is somebody on hand if you want to ask people and it is like a midwife or a health care worker that is actually weighing them so if there are any problems you can ask them.' (003).

Women also commented on the perceived 'social benefit' that their babies derived from the Pampering Group. Babies were often talked to and played with by adults other than their parent at the Group, and although too young to have much sustained interaction with other babies, it was still perceived that the babies benefited from each other's company. For example, one woman commented:

'(Name of baby) really enjoys it. She likes the interaction with the other babies.' (006).

4.3.3 Confidence

All of the women were asked whether attending the Pampering Group had any effect on their own self-confidence. Women who perceived themselves to be quite self-confident anyway indicated that they considered that the Pampering Group would boost the confidence of those less sure of themselves, and less confident women articulated that attending the Group had improved their self-confidence. For example, one woman stated:

'Yes [improved confidence] because I am very, very shy ... It took me loads of effort to come.' (004).

Several of the women articulated that the Pampering Group had increased their confidence in themselves specifically as a mother. Even women who were

professionally experienced with children expressed this sentiment. For example, one woman commented:

'But the psychological aspect of being a new mum, nothing prepares you for that. It doesn't matter how much experience you have got looking after other people's babies. It didn't prepare me for looking after my own and I think it has helped in that respect greatly.' (006).

It was clear that those women who perceived that the Pampering Group increased their confidence as a mother obtained this support from other, more experienced, mothers as well as the professionals who were present at the Group. However, others with slightly older babies did not feel that the Group was as useful in this respect. For example, one woman commented:

'I can't really answer that [has it helped your confidence as a mum] because I didn't go when he was a baby. I suppose if I had gone when he was a baby, there is a lot of mums there that have got newborns and I think it does help them to talk to others.' (002).

To some, the Group was particularly useful in helping with questions they felt were too trivial to make a specific telephone call or visit to a health visitor or other health professional. One woman stated:

'Sometimes you feel stupid getting on the phone to the health visitor ... [if you have] just changed the consistency of her food a little tiny bit and you feel stupid. But when you are just talking then, people say, oh yes. So then you got confidence in your own thoughts then.' (001).

One example of both confidence and the value that the women placed on the Pampering Group was that some of the parents had arranged a follow on group from the Pampering Group, to take place later in the week. This group was designed to cater for older babies, who were not allowed to come to the Pampering Group once they were mobile. There was a lot of support for this group from the women, many of whom expressed the sentiment that they would be attending. One woman explained:

'My friend is starting a Friday group, which is the same age as him [the baby]... so we won't be able to go to the Pampering ... There are babies that are his age now that can't go because they are crawling about and the newborns are on the floor on the mats and it is not very fair to keep these pinned down. So that is the idea of the Friday group now. My friend is setting that up.' (002).

4.3.4 The treatments

As indicated in the previous section, the treatments available at the Pampering Group were not perceived by most women to be the 'be-all and end-all' of the Group. The women all went for treatments occasionally, although no-one seemed to have a treatment every week. That this may have been because there was simply not enough time was commented upon, and that some people may have liked treatments but were not able to have them due to lack of time, but this did not cause undue concern amongst the interviewees. Many of the respondents said they felt the treatments were an added bonus to a Group that they would probably have attended and enjoyed anyway. For example, one woman commented:

'That is like a bonus really ... then it is nice, because to go and have a treatment now you are looking for a babysitter and going off. So it is nice then to just go off and have ten/fifteen minutes massage or something knowing that your baby is looked after by other mums and the staff and they are OK.' (001).

Despite this attitude, the women commented favourably on the treatments available and even if seen as a 'bonus', the treatments were perceived to be a very important bonus. This was explained by one woman in the following way:

'For me it is like an added bonus, it is nice. That is the only 'me' time I get. The time that I had my nails done was the first time they had been filed and painted since I had had (name of baby) and that was only a couple of weeks ago and she is six months old. It is things like, you do only spend five minutes in the shower on yourself if that and you have usually got a crying baby sitting outside the shower cubicle somewhere. So it is nice to get some 'me' time.' (006).

Although for most women the reason for attending the Pampering Group was predominantly social, there was one woman who commented that she would probably not have started going to the Group if the treatments had not been available. In addition, when talking about the possibility of setting up a similar group for women with older children, the interviewees expressed the view that similar treatments should be available at such a group as *'older Mums still need a bit of pampering.'* (003).

4.3.5 Access to information

Many of the women commented on the Pampering Group as a source of useful information. The two issues that were specifically mentioned in this respect were childcare and training for employment. A number of women had been provided with useful information about these areas through the Group, from other mothers as well as from the professionals present. For example, although the woman below had found a

nursery place for her daughter at her own place of work, she describes how if this had not been available she would have turned to the Pampering Group for advice:

'(Name of baby) will be going in the nursery where I work, which was like the only nursery that I looked at really because that is where I wanted her to go but had I not been able to get her a place there ... I would have needed advice and support and I would have used the Pampering Group for that because I wouldn't have known what to do then.' (006).

4.3.6 Access and physical space

Most of the women walked to the Pampering Group venue. The distance was seen as a problem in some cases, and some wished there were alternative venues for the Group that were more accessible to those who lived further away. For example, one woman commented:

'It is half an hour to walk from here. That is the other thing, is the trek down there. There is one up here as well at Upton but I don't know what is up there. ... if there was one there then I would go there because it is two minutes rather than me walking half an hour down the road.' (002).

The majority of the respondents were positive about the venue and thought that the facilities were suitable for the Pampering Group. However, two main concerns were expressed: about access with prams; and about the capacity of the main room. One woman made the following comment regarding prams:

'There is an issue with the prams ... the people that own half the building, they go mad about prams being outside or sometimes you have to be inside the room because of health and safety because the prams for the nursery are also in the same area. So then the prams are in the room and we can't get in at all because you have to take the prams in with you sometimes.' (002).

That the main Pampering Group room could become very crowded when the Group was well attended was a concern for some. One woman described an incident where her baby's hand was accidentally trodden on. She explained:

'The only thing I would say now is that they probably need a bit more space because one of the girls stood on (name of baby's) fingers. She sort of realised as she was putting her food down, luckily didn't stand fully, and (name of baby) is on the play gym, just had her arms out to the side. So her arms were still on the play gym. It wasn't like they were hanging off but it is just they are so close to the settees. That is the only thing I would think if it was just spaced out a little bit more and then it wouldn't happen. She is OK.' (001).

One woman also commented about the room in which the treatments took place. It was generally used for other purposes and although the professional providing the treatments did her best to make the room comfortable and welcoming the environment was distracting for this interviewee. She explained:

'There are all computers in there and tables and things and she just has all the stuff in bags all over the floor ... maybe (it needs) dim lights and other things. She just tends to turn the light off and she has a little light.' (003).

4.3.7 Access to Sure Start services

Several of the women made general comments about access to Sure Start services, voicing the opinion that the 'postcode lottery' was unfair, or did not make sense, and that Sure Start services should be available to all, as they were something that all young families could benefit from. Some women spoke of other mothers that they knew personally who would like to access services but were ineligible to do so, despite living very close by. The following quotation is typical of the comments made:

I know a girl who is pregnant now and she is not in the Sure Start area and she is shy so I know she won't go to another one and it is a shame really because her sister is in this one and it would have been nice if she could have come. She only lives over the road as well and she is not in the Sure Start area because of the postcode.' (004).

4.4 Professionals: interview and focus group findings

In total, six professionals participated in this study. Two interviews were carried out with health professionals, both midwives, who had referred parents to the Pampering Group but who had no other involvement with the Group. The focus of these interviews was on access to and knowledge about the Group. Three professionals (one midwife and two family support workers) who were involved in running the Pampering Group took part in a focus group and a one 'involved' professional (a midwife) was interviewed on her own as she was unable to attend at the time of the focus group. The findings from the interviews and the focus group are presented here together. Where it is necessary to differentiate, those professionals whose involvement with the Pampering Group was restricted to referring, are termed 'referring professionals'. Those who help to provide the service are termed 'involved professionals'.

The broad themes to emerge from the data were as follows:

- awareness of the Pampering Group amongst referring professionals;
- social benefits of the Group;

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- the treatments;
 - the hard-to-reach;
 - team working;
 - developing the Pampering Group.

Quotations from the participants are used to illustrate themes that emerged from the interview and focus group material. In order to preserve anonymity, quotations are identified by a tape transcript number.

4.4.1 Awareness of the Pampering Group

Whilst the referring professionals did have some knowledge of the Pampering Group, the aim and objectives of the Group and how it was operated, there was evidence that they were not entirely clear about these things. One interviewee commented that she had never seen any aims and objectives for the Group but assumed it was designed for women who could not access other services, to enable them to meet women in similar situations. Another expressed some lack of clarity about exactly how the Group was run. She commented:

'Well I don't really know [about the setup]. I've never been to see it. I assume it's not confrontational at all and the massages are done in another room. Not in front of people. I say to women "I'm sure it will be done like that."' (008).

Although these professionals referred women to the Pampering Group, it was apparent that they did not always perceive telling women about the Group to be a priority in their role and that consequently they did not always say anything about it. One expressed the view that when she saw women at booking, there was too much information that needed to be given and that women would not *'take in'* information about an activity such as the Pampering Group. She explained:

'The thing is, women have just got to take in so much information when they are booking in. I just mention the Pampering Group and move on. ... women are just getting used to the idea of being pregnant, let alone anything else. It is usually better later on in the pregnancy. They're more used to the idea.' (007).

In addition, the referring professionals commented that they did not get any feedback about whether women they told about the Pampering Group actually attended or how helpful they found it if they did. Although they seemed to want this feedback, they stated that they did not ask the women in their care about it after they had passed on

the information about the Pampering Group to them. They indicated, however, that if they did get good feedback about the Group from their clients this might make them more likely to refer.

4.4.2 Social benefits of the Pampering Group

All of the staff involved with running the Pampering Group service agreed that the social benefits were the most important outcome of the Group for its users. They spoke of mothers gaining in confidence, being able to develop friendships and social networks, and thus reducing their sense of isolation. It was perceived that friendships made within the Pampering Group were carried on outside, with lasting relationships being forged. One professional commented:

'They come and they talk and they eat, they socialise and they get to know other mums because a lot of the mums are very isolated and there is no set group of women that this affects.' (010).

In particular, professionals articulated the view that the Pampering Group could be very useful for women suffering from mild depression. A professional talked about a particular woman that she had been involved with at the Group:

'One lady who had a terrible pregnancy who came to Pampering Group after she had her baby and came ... for quite a long time, week in week out. Had a massage every single week and that kept her going ... she needed [it] because she had some very serious issues with depression. She had seen all the women coming and going, coming to Pampering Group and then having to leave Pampering Group as they were going back to work. And she actually got enough confidence together, along with other things that she was doing in Sure Start, she is actually working now.' (010).

The referring professionals also articulated that for isolated mothers and those at risk of depression, the Pampering Group could serve a very useful function in terms of enabling contact with other women in similar situations and in developing social networks. In addition, as reflected in the interviews with the users of the Pampering Group, it was stated that it should be available to all women, not just those in the Sure Start area, as it was perceived that there were no other groups where mothers could easily meet others in a similar situation.

4.4.3 The treatments

Reflecting the findings of the interviews with the users of the Pampering Group, all of the involved health professionals perceived that, fundamentally, the treatments were

not the most important aspect of the Group. They commented that some mothers did not seem to mind whether they had a treatment or not. For example, one individual stated:

'I don't think some people come for the treatment at all, in fact they say they don't even want it.' (009).

This was reflected in the views of the referring health professionals as to the function of the Group. One of these interviewees stated:

'It is just another mother and baby group. I never hear any feedback like 'that was a lovely facial' or a brilliant massage etc. People go for a brew and a natter.' (008).

However, the involved professionals perceived that the treatments served a useful purpose. The idea that having a treatment boosted self-esteem for some women was articulated, as well as the idea that it meant that many women were able to experience something that they perhaps would otherwise not be able to afford. In addition, it was thought by these professionals that the treatments were important in attracting women to the Group in the first place. One interviewee commented:

'But I think at first when we advertise the Group and we say, we have got this Pampering Group and you can have a treatment 'Oh yes that's interesting.... that sells it for us.' (012).

Conversely, one of the referring professionals articulated the view that the treatments might actually deter women from attending. She explained this in the following way:

'I think some people are embarrassed about the whole pampering thing. It is not normally something that they would take up. You know like a massage.' (007).

4.4.4 The hard-to-reach

There was recognition amongst all of the participating professionals that some groups of women were not accessing the Pampering Group, even though the Group might prove useful to them. Staff involved with the Pampering Group identified teenage mothers and those women who were registered with Sure Start but never attended any services as hard-to-reach groups. One suggestion put forward was that everyone who registered should receive a follow-up home visit from a Sure Start worker at which all of the Sure Start services could be introduced and explained. However, it was articulated by the referring professionals that even after giving information about services face-to-face it could be very difficult to motivate women to attend a group such as the Pampering Group. One interviewee pointed out that some women would find it very daunting, initially, to attend such a group on their own. She stated:

'If you can get them there in the first place it might possibly help. The problem is getting them to go in the first place.' (007).

Another concern that was expressed by the referring midwives was that the Pampering Group was not attracting the most vulnerable and hard-to-reach women, who potentially had the most to gain. Thus, one interviewee commented:

'Are we still getting the motivated women to go? I think we are. Those who are educated, from better areas. Those with four kids, who smoke, who have relationship problems and no car don't go. There is no transport for the Pampering Group either ... I don't know why ... It isn't targeting the hard-to-reach women effectively.' (008).

In addition, doubts were expressed about whether the Pampering Group format was the best way in which to offer support to very vulnerable women. One interviewee suggested that being in a group with other women who were successful at something that you were finding difficult, for example breast feeding, could be very de-motivating, and that some vulnerable women needed one-to-one care. It was also articulated that the Sure Start midwives time might be better spent going out and visiting vulnerable women individually in the community, as at the Pampering Group they had a limited amount to offer. This interviewee stated:

'Does the Sure Start midwife need to go to it? ... We had women asking us about weaning and stuff. It is outside of our remit. We don't know ... That three hours time could be utilised more effectively, visiting the vulnerable women, teenagers and so on, one or two we have need social care.' (008).

There was general agreement amongst those professionals involved in providing the Pampering Group service that an important group of women who were not attending were pregnant women, and that more could be done to attract them. One professional described a woman who went to the Pampering Group while pregnant and initially thought she had gone to the wrong group, because everyone there had a baby. Nevertheless, she continued to attend because of the treatments, which were perceived to help her through a difficult pregnancy. An interviewee commented:

'I think we still have got work to do in how we present the Pampering Group to pregnant mums. ... there is a huge group of women that are missing out because out of 220 deliveries in Widnes that were within the Trailblazer area last year, we have probably only had 40 maybe 50 of those women back through the Pampering Group.' (010).

4.4.5 Team working

The involved professionals felt that they had benefited from working together in the Pampering Group, rather than providing their services in isolation. It was articulated that working in the Group greatly aided communication, both about work issues and also in a social sense, as staff had got to know each other better. In addition, one interviewee commented that the team approach aided continuity of care, because she was able to see women who she had cared for during their pregnancy and follow up their care with the other health professionals involved. Although some staff agreed that, at times, the team approach meant that they were technically working outside their normal roles, as women would ask them about issues which strictly lay within the remit of another professional, they felt this benefited their work both within the Pampering Group and in their other roles and responsibilities. One interviewee commented:

'I am working outside my role quite a bit actually... I'm quite happy with that. It has made me think in a much broader way and not so focused on the nine months of pregnancy and the one month after. To me it is much more about developing relationships with women further down the line and supporting them beyond the midwife period as such.' (010).

4.4.6 Developing the Pampering Group

As the mothers who were interviewed identified, 'overcrowding' due to the increasing popularity of the Pampering Group was mentioned as a cause for concern by the involved professionals, and an issue that needed to be taken into account when considering the development of the Group. Whilst originally the Group had attracted five or six women each week, interviewees explained that more recently they had been getting 10-14 women attending. One solution offered was to have more than one Pampering Group session per week. However, the staff were aware of the practical difficulties of arranging this, including the cost implications of employing the therapist. The increasing number of attendees had also led to staff thinking that a more formal structure to the Group may need to be adopted. An interviewee stated:

'We are planning on making a little booklet ... just to lay a few ground rules down for some mums. The fact that they are in charge of their own babies and when they go off to have a treatment to actually ask somebody, 'would you mind?' instead of just maybe taking it for granted sometimes [that someone will look after their baby].' (009).

The other development that was mentioned by the involved professionals was an increase in the health promotion activity of the Group. The Pampering Group was

perceived as a useful forum for this type of work and it was perceived that the possibility was not being fully exploited. One interviewee commented:

'We need to do more with health promotion. Things like weaning advice which I am not an expert because I am not a health visitor. I am a midwife.' (010).

Finally, involved professionals articulated the idea that the integrated approach of the Pampering Group was successful and could be transferred to other groups within Sure Start. Examples were given of where that was happening, for example:

'They are running a breastfeeding group from in here with the same thing, midwives and family support workers. So that is the plan.' (011).

Chapter 5

Discussion

5.1 Introduction

In this study, a description of the working of the Pampering Group has been presented, and the views of users of the Group, health professionals who provide the Pampering Group service and professionals who refer clients to the Group have been accessed. Those involved in the Pampering Group were, on the whole, extremely enthusiastic about its function within the Sure Start programme, and keen to see it developed. However, in order to assess the effectiveness of the Pampering Group, the findings will be discussed here in relation to the literature reviewed in Chapter 2 and the aim and objectives of the Group. Although there is little empirical evidence in the research literature specifically about pampering groups, the Group's structure and format is evidence-based in that providing supportive groups and pragmatic help in order to reduce social isolation, particularly in areas of high socio-economic deprivation, helps young families to foster good mental and physical health (Grimshaw & McGuire, 1998; North, undated). By using the objectives as a framework for discussion, it becomes evident where the Pampering Group has been successful in meeting these objectives, and where it needs to refine its purpose or pay particular attention to any difficulties.

5.2 Preparation for childbirth

The Pampering Group aimed to support parents to feel emotionally and practically prepared for childbirth. Potentially, the diverse needs of pregnant women could be successfully met by the multi-faceted approach of the Pampering Group. For example, the Group could be particularly valuable in aspects of health promotion such as smoking cessation, or encouraging the practice of breastfeeding, as the decision to breastfeed is often made during pregnancy (Earle, 2002), and also in terms of social benefits and in promoting good mental health. Forming friendships that last beyond the antenatal period can lead to the development of social capital in the form of people in the community who can be drawn upon for support. Having the opportunity to ask questions about pregnancy and childbirth is likely to improve a woman's confidence and lessen anxiety in pregnancy. Finally, being physically looked after – such as a back or foot massage in late pregnancy, is likely to improve a woman's health, self-esteem and well-being.

This was one area where the staff at the Pampering Group, the users and those referring to the Pampering Group perceived that more could be done. Very few pregnant women had attended the Group, and those that had did not tend to stay. Reasons suggested for this included the possibility that the women felt 'left out' when they did not have a baby. There was a perception that, although all women were welcomed into the Group by the professionals and the other women, sometimes attention was focused on the mothers of young babies. The babies were often the catalyst for conversations. Although some women had attended the Group whilst pregnant and perceived it to be a beneficial experience, they were in the minority, and when an individual pregnant woman did attend the Group there were usually no other pregnant women to talk to. Indeed, in one of the observation sessions carried out for this study, a pregnant woman attended the Group and was observed to have little interaction with other mothers, although she did interact with the professionals.

In order to attract and retain pregnant women, the findings of this study suggest that there are certain issues which could be addressed. Firstly, that of informing women about the Pampering Group. At present, midwives are expected to tell women about the Sure Start groups when they book in for maternity care (at around 12 weeks of pregnancy). As evidenced in the interviews, this is a period when there is a lot of information given to the women, and some professionals perceived that information about activities such as the Pampering Group would not be taken on board by the women. Possibly therefore, information about the Pampering Group and other Sure Start groups would be better repeated at another antenatal session, in addition to prominent posters and information given at antenatal clinics and anywhere else generally likely to be accessed by pregnant women.

On the other hand, it can be argued that the midwives have a very important role in informing women about the services they could access and that they should promote these positively at every opportunity. There was evidence in the interviews of a lack of clarity about the Group, the objectives of the Group, and how it was run, among those potentially referring women in, indicating a need for these professionals to increase their knowledge base. None of the women interviewed recalled hearing about the Pampering Group from a midwife, which does suggest that some opportunities for publicising the Group are lost.

In terms of publicity, information about the Group may need to be presented in different and multi-faceted ways. The present publicity strategy is not effective in attracting women when they are pregnant. Most of the users of the Pampering Group did not recall hearing about it until after they had their babies. In addition to midwife or health visitor referral, or hearing about the Group through Sure Start family workers, more varied forms of advertising could be used, such as posters or information through the post, which emphasises that the Group is for antenatal as well as postnatal women.

Finally, it may be beneficial to target specific groups of pregnant women. Staff recognised that certain sections of the population, such as teenage mothers, did not come to the Group. These women in particular would benefit from peer support as well as the treatments and advice available from the Pampering Group, and do not tend to access traditional antenatal services (Health Development Agency, 2001). At present, if a pregnant teenager attended the Group, she may be the only pregnant woman there as well as being the youngest in the Group. As the research literature suggests (Health Development Agency, 2001), the accessible, non-threatening and informal atmosphere of the Group would be an opportunity to provide a 'way in' for teenage parents to access support and advice from health professionals.

5.3 Postnatal depression

It is questionable whether any group such as the Pampering Group could help severe postnatal depression, which needs specialist medical or psychological help (Appleby et al., 1997). However, one of the objectives of the Group was to identify those at risk of postnatal depression and provide treatment if necessary. It is likely that because of the way in which the Group was conducted, with much informal contact between women attending and staff, there were ample opportunities for the health professionals to 'pick up' any indications of postnatal depression. The literature indicates that supplementary contact with a health visitor postnatally can be effective in preventing depression (Cooper et al., 2003; Murray et al., 2004) and the users of the Pampering Group perceived that the contact they had with the professionals in this informal setting was helpful.

There was evidence in the findings of the work with both professionals and mothers that the Pampering Group was considered helpful in combating mild levels of depression. Professionals gave examples of women who they considered had been helped in this way, and women themselves spoke of their own experiences of

depression and how the Pampering Group had impacted upon them. Two women in particular who had been referred by health visitors because of worries about depression, one who was grieving the loss of a child and another who had had a difficult labour and first few weeks of motherhood, both credited the Pampering Group with helping them to enjoy parenting and overcome the challenges they faced. The mechanism by which this was achieved appeared to be twofold. Firstly, there was the social support that was generated by the Pampering Group. Women met others in similar situations and were able to help and encourage each other. The peer support offered was evidenced in the observation of the sessions. In addition, many of the women at the Group had formed friendships and met up outside the Group. Secondly, the treatments offered served an important function as they focused on the mother and gave her some individual attention, at a time when almost all attention would be focused on the newborn baby. Both of these aspects of the Group could help to reduce the isolation and loneliness that can foster depression. All of the women interviewed were in stable relationships, and most had family support nearby, both factors which would have helped combat postnatal depression. Nevertheless, it is probable that the Pampering Group would have a positive effect on women who did not have support networks, by providing opportunities to create them.

5.4 Fostering self-care and infant care

Health promoting behaviour has been shown by research to be inextricably linked to good self-esteem, feeling valued and feeling a part of a community (D'Souza & Garcia, 2004; Vimpani, 2000). The Pampering Group provided an opportunity for women to learn about self-care and infant care, while helping to foster the improvements in self-esteem and inclusion in the community that is a requirement for their successful application.

At the time of the study, most health education and promotion activity took place in an informal way between the women themselves and between the professionals present and the women, and this appeared to be a successful approach. For example, one mother talked about how her experience had helped another woman struggling with breastfeeding to breastfeed twins successfully. Another example of informal health promotion around self and infant care was the food available at the Pampering Group sessions. Each week a selection of healthy food was available for the women attending the Group and for their babies if appropriate. It was evident in the observation sessions that the food was a central feature of the Group. Both mothers and babies were

observed trying food that they had not eaten before. Many of the interactions and discussions between the parents centred on food and the feeding of children, perhaps because of the age of the babies, who needed frequent feeding and were at the point of being weaned onto solids. By having healthy food available, discussion about healthy eating for adults and children was encouraged. During the period of this study the community food worker did not attend the Group, but it was commented by staff that they had in the past had the support of this worker at the Group and that they would again in the future.

The staff perceived that more could be done in terms of formal health promotion in the Pampering Group, and plans for short talks about self and infant care becoming a feature of the Group were articulated. In developing more formal talks it may be important to ensure that this does not stifle more informal channels of information as, for example, peer support has proven very successful in helping women continue breastfeeding for the optimum time of six months (Fairbank et al., 2000).

The treatments were a very obvious way in which self-care was encouraged and enabled at the Pampering Group. It was clear from the findings however, that all of the participating professionals and the users of the Group perceived the treatments to be secondary to the social aspect of the Group. Nevertheless, treatments were regarded as important and comments were made about how helpful and enjoyable they could be. They give a clear message about the legitimacy of self-care and, as such, could prove especially valuable to women with young babies who are perhaps focused on caring for their baby, as well as giving individuals a short amount of 'time out'.

5.5 Increasing parents' confidence

The cohort of women who were interviewed for this study were relatively confident about their parenting ability. They were in general, from large, close families or were experienced parents already. However, most commented that they had seen the Group help other, younger or less experienced mothers, and they perceived that the Group was very beneficial in educating people about parenting and improving their confidence. The women all reported however, that the sharing of knowledge between parents and between parents and health professionals in the Group had the capacity to improve their confidence and competence. In particular, women articulated that sometimes, if they were worried about what they regarded as a trivial matter, they were able to bring it up during the Pampering Group but would probably not have made a

specific telephone call or visit to a health visitor to ask for advice. This is possibly an example of how hard-to-reach women, if they could become engaged with the Pampering Group, could be supported.

5.6 Increasing self-efficacy and social cohesion

The Pampering Group had objectives about increasing the self-efficacy of parents and enabling them to engage in the local community. Striking evidence of the success of the Pampering Group in increasing self-efficacy was the follow on group set up by parents who formerly attended the Pampering Group. This group was organised entirely by parents whose children had outgrown the Pampering Group, and was run by parent volunteers. During the interviews, a great deal of pride in this achievement was voiced, as well as enthusiasm for the new group. In addition to this, evidence of widening circles of friends, and peer support outside the Pampering Group, was contained in the interview data. Women reported visiting each other at home regularly, going for nights out and staying in touch as their children grew older. It is possible that, as the parents get to know each other, a 'snowball' effect of friendships will develop as each woman introduces another into a wider social network, thus contributing to the social coherence of the community of young families in Widnes and to community capacity building.

It was evident from the observations and the interview data that there was a high level of trust within the Group. This was possibly unexpected as many were new mothers, and many came from areas of deprivation and high crime where trust of outsiders is perhaps not a common feature. The parents and babies seemed to feel secure in the Group, and there was rarely an occasion when a baby was distressed by being left in the Group while the mother went for a treatment. Even when the parents were present, babies were passed around and played with by the other adults. In particular, on more than one occasion, babies were undressed and weighed by adults other than their parents. This is quite an intimate act that requires a great deal of trust. However, professionals were concerned that, on occasion, babies were left without a specific person asked or nominated as a carer and this, they felt, needed to be changed so that an individual was deemed responsible for the child while, for example, the parent had a treatment. This is another example of where it was thought by health professionals that the Group's organisation needed 'formalising', but where there might be a tension between organisation and the informality that has characterised and arguably contributed to the success of the Pampering Group.

5.7 Participation in the programme and the hard-to-reach

It was perceived by the professional interviewees that the number of users had increased significantly in the first months of 2005. Attendance figures indicate that average attendance has gradually risen since 2003. Staff attributed this partly to recent Sure Start events, such as Pampering Days, which promoted the Group. The number of women attending meant that on occasion the Group was crowded and it was not possible for everyone to have a treatment every week. Once families became engaged with the Group, they generally attended regularly until their children were too old, indicating that they felt they benefited from, and valued, the Group.

However, there was concern expressed by interviewees, both professionals and users, that there were many families who could benefit from the Group who did not attend. Professional interviewees commented that the Group only attracted a small proportion of families compared to the total births in the Sure Start area, and groups such as pregnant women (as discussed earlier), teenage mothers, and women who registered with Sure Start but who never accessed services, were identified as being among the 'hard-to-reach'. Specific strategies to engage these women may be necessary if their participation is to be increased, and those who potentially have much to gain are to become engaged with the Pampering Group. It was also articulated that for some women, a group approach to offering support may not be appropriate. For this group, contact with professionals needed to be on an individual basis, at least initially. It is important to note that Sure Start services are not designed to replace statutory services and so all women would continue to receive one-to-one support from their own midwife and health visitor. Possibly, some women could be encouraged to engage with the Pampering Group and other Sure Start initiatives through this one-to-one contact with, and support from, a health professional. There is also the possibility that Sure Start community parents could support women in attending. In addition, it is through individual midwives and health visitors that potentially hard-to-reach women may be targeted, underlining the importance of joint working between professionals.

A group notably absent from the Pampering Group was men. No fathers participated in the Group during the period of this study, although one father joined the Group towards the end of one of the observation sessions in order to take his family home. Neither the users or the professionals mentioned involvement from fathers during the interview process, although the objectives of the service refer to 'parents' not specifically 'mothers'. The title of 'Pampering Group', with its connotations of beauty treatments,

may be off-putting to fathers and the timing of the Group, during normal working hours, may mean that working fathers could not attend. In order to attract more men to the Group, the pampering element could be refocused more on massage and less on beauty treatments. However, it may be necessary to consider whether having men attending the Group may alter the dynamics and detract from the value of the Group for the women who attend.

In terms of participation in the Group, many of those interviewed made comments about the Sure Start boundaries. Almost all of the users of the Group had friends or neighbours who they felt would really benefit from attending the Pampering Group, but who were ineligible to attend because of their postcode address. This evidence suggests that there could be a wider demand for the Pampering Group in Widnes than that covered by the Sure Start Widnes Trailblazer area alone.

5.8 The future of the Pampering Group

The desire to attract more families to the Pampering Group needs to be balanced against the facilities available, as the environment of the Group is potentially important to its success, and health and safety issues. This includes the suitability of the building where the Group is held, access, and space for the necessary equipment a parent will bring (such as a pram, car seat, large bag and so on). The majority of the interviewees commented on what was perceived to be the pleasant environment of the room in which the Group took place. The issue of overcrowding was alluded to however. Issues of access and space for equipment such as prams and the possibility of overcrowding are ones that the Pampering Group staff are aware of and are currently trying to resolve.

One difficulty with the Group identified by the users was that it was inaccessible to women who already had older children. They could not bring the older child to the Pampering Group even if they had a younger one who was eligible to attend. The possibility of a crèche that could be used by older children while younger siblings and parents attended the Pampering Group may be worthy of exploration.

An issue which emerged from the observation of the Group was a tension between the need for security and the ability for a parent to access the building easily. The need to contact a receptionist and sign in and out of the building was understandable for reasons of security (the graffiti on the outside was perhaps a confirmation of the

requirement for stringent security procedures), and the heavy doors were an important measure to combat the risk of fire and of unauthorised entry. However, this could also be interpreted as obstructive to local parents of children, for whom the Early Years Centre has been created, as they have to negotiate entry along with a pram and perhaps a heavy bag to carry. On the other hand, none of those interviewed commented on this observation.

Potentially, having different health professionals working together with women at the Pampering Group is very effective in providing holistic 'joined-up' care. The value placed by the parents on weighing babies, for example, and the chance they have at the same visit to ask for advice or to clarify problems supports this type of working. At least one health professional articulated the perception that the multi-professional working that she had experienced at the Pampering Group had also benefited her professionally. This way of working reflects the ethos of the Government paper *Every Child Matters*, which advocates multi-disciplinary team working with the needs of the child and family at the centre of care (Department for Education and Skills, 2003). Although some interviewees perceived that multi-professional working had not always been successful, it was pointed out that it had been made more difficult during the last few months of 2004 and the beginning of 2005 due to the absence of a manager for the midwifery service and the absence of the Sure Start midwife at the same time.

5.9 Conclusion

The Pampering Group's activities are intended to give physical relaxation, emotional support, pragmatic advice and an opportunity for local parents to get to know and support each other. There is evidence in this study to suggest that the Group has achieved these objectives. As a result, the parents and babies are more likely to enjoy physical and mental good health. Any development of the Pampering Group should take into account the informal nature of the service, as this appears to be part of why women feel it is successful. In addition, the Pampering Group has not thus far been successful in engaging women antenatally, and there are also other hard-to-reach groups, for example teenage parents, who could conceivably benefit from the Pampering Group if they attended. It is impossible for the Pampering Group to change the external world that mothers-to-be and parents bring their children up in, but in providing an opportunity to make contact with others, and gain practical help, the Pampering Group perhaps gives women the ability to better deal with their circumstances.

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Appendix 1
Literature search strategy

Literature search strategy

A search of the evidence base surrounding the Pampering Group was carried out at University College Chester on 4th February 2005. The search strategy was as follows:

Database	Terms used	No of results
Web of Science	Pamper* AND group AND pregnant* OR parent*	0
ASSIA	Pamper* AND group AND pregnant* OR parent*	0
PsychInfo	Pamper* AND group AND pregnant* OR parent*	0
	Breastfeed* OR smoke* AND parent* OR pregnant* AND intervention AND group OR support	77 of which 20 were read
	Social capital AND parent* OR pregnant* AND group OR support	37 of which 12 were read

In addition, the recently published National Service Framework for Children, Young People and Maternity Services was interrogated; and the National Evaluation of Sure Start website, www.google.co.uk, the National Electronic Library for Health, Health Technology Assessment programme, Social Exclusion Unit and the Joseph Rowntree Foundation databases were searched for items on "Pampering Group".

Appendix 2
Observation schedule

Observation Schedule

Ditton Children's Centre as a suitable environment for the Pampering Group

- Who are the parents greeted by?
- Is there a set procedure for entering and leaving the room? (pram store)
- How many people are there?
- Do the parents come alone or bring a friend / relation to help with the baby (n.b. twins)
- What evidence is there of multi-disciplinary team working and how was this demonstrated?

Physical Setting

- How was the room set out – what was visible?
- Does the room represent a welcoming and pleasant environment?
- How does the layout of the room impact on the atmosphere of the Pampering Group?
- Are there any other factors that impact on the Group, for example, the noise from and movement of other children and parents?

Personnel and user interaction

- To what extent do the staff interact with the parents?
- Do the parents interact with each other? (Do they hold each other's babies, swap stories or experiences? etc)
- To what extent does the staff interact with each other? (Planning future activities, administration, making arrangements for the Pampering Group / other groups etc).
- To what extent do staff and parents negotiate who has a treatment?
- Who decides in what order the treatments should take place?
- How do they decide who goes first?
- What do the other parents do while treatment is going on?
- What happens to the baby when its parent is having a treatment?
- Does anybody go to the counselling room? How do they indicate they would like to?

Time Charting/Shadowing

Follow the actions of a few parents (2 or 3) from the time they enter the Group to when they leave – in order to see how individual families react to the environment, and identify those who don't follow emerging patterns.

Look at body language, facial expressions, noises/ slight speech (not in depth speech analysis, but may pick up on certain common expressions of pleasure?).

Look for certain events / occurrences of interest (e.g. parent worrying about child's weight, and asking for advice; display of emotion – crying?)

– adapted from “prompt sheet for classroom observation” www.soewrs.rdg.ac.uk/artdesignpgce/schoolclassroom-observation.htm (retrieved 24.03.03)

Appendix 3
Parent interview schedule

Parent interview schedule

General

Is this your first child? How old is she/he? How many children have you got?

How did you find out about the Pampering Group? How many times have you used the Pampering Group? Was it what you expected?

Did you come to the Pampering Group before your baby was born? (Did it help you feel more prepared for the birth and looking after a young baby? Did you have a different experience of antenatal care with this child because of the Pampering Group?)

Facilities

What types of treatment have you had at the Pampering Group?

What did you find most enjoyable? Are there any other treatments you would like to see provided? Which ones?

What do you think of the room where the Pampering Group is held? Is it private enough? Do you find it easy to get into the Pampering Group? (Getting into the building with a pram etc)

Mixing with others

Do you think the Pampering Group has any other benefits other than the treatments? (Like getting together with other parents? Making friends) Do you find it easy to talk to others at the Pampering Group sessions? (What about when you first came? if not, is there anything that can make that easier?)

What do you think is more important – getting together or having a treatment?

Do you think going to the Pampering Group has helped in things like improving your confidence? As a mother? Generally? Do you think it has made a difference to your relationship with your child?)

Has it helped you in any other ways? Have you learnt anything useful about how to look after yourself or your baby because of the Pampering Group? (health visitor or midwife advice? Breastfeeding or smoking cessation?)

One of the aims originally was to help people find out about childcare or employment; do you think it's helped you in this way? Are you going back to work or college? (Has any of the information in the Pampering Group helped you do this? Do you think there is anything the staff at the Pampering Group can do to help you find a job or get training?)

Do you find it easy to talk to the professionals there? (What about if you have worries or if you are feeling low? Have any of the staff there helped you get help from elsewhere – e.g. a doctor?)

Travel

How do you get to the Pampering Group?

Do you ever find it difficult to get to? (Do you think there should be another venue for the Group in another part of the area?)

Other Sure Start Services

Did you use any Sure Start services before coming to the Pampering Group?

What about now, are you going to any other Sure Start activities? (Did you find out about these because of the Pampering Group?)

Other

Do you think the Pampering Group is a good service? What do you like best? How might it be improved?

Will you be sad to leave the Pampering Group when your baby is too old? (Are there other services that are more appropriate once your child is older? Would you like a Pampering Group for mothers of older children?)

What might you say to someone who was unsure about coming to the pampering Group?

Is there anything else you'd like to say about the Pampering Group?

Thank you for your time

Appendix 4
Professional interview schedule

Professional interview schedule

How did you find out about the Pampering Group?

Can you say any more about your connection with or involvement with the Pampering Group?

Are you aware of the aims of the Pampering Group?

What do you think about the Pampering Group?

- (success / failure / waste of time or money?)
- Do you think it is a good service?
- Do you think it has any real (long lasting?) effects on the parents of young babies?
- Do you think it is just a social group?
- What about postnatal depression, increasing confidence, social networks, access to services etc?
- Can you give examples?

Please can you talk about the referral process for the Pampering Group – is this effective? How?

Do you know how many people go along after being referred?

How does this sort of approach compare with traditional methods of supporting pregnant women and new mothers, especially with reference to problems such as depression?

Can you comment on the future of the Pampering Group? How do you think it should/could be developed?

Any other comments regarding the Pampering Group?

Thank you for your time

Appendix 5
Parent participant information sheet

Parent participant information sheet

We would like to invite you to take part in a research study. This information sheet will help you understand why the research is being done, and what it will involve. Before you decide if you would like to take part, please read the following information carefully. If you have any questions, please ask.

Thank you for reading this.

Why study the Pampering Group?

It is important to find out if the Sure Start Pampering Group is successful in supporting local pregnant women and families with babies. Would you like to comment on the Pampering Group? Do you have any ideas to improve the Pampering Group, or how it could provide more support for local families?

Why have I been chosen?

We would like you to take part because you live in the local area and you have attended the Pampering Group in the past.

Do I have to take part?

It is up to you whether or not you take part. If you would like to take part, you will be given this information sheet and be asked to sign a consent form. You are still free to withdraw at any time without giving a reason.

If you decide not to take part it will not stop you being entitled to use Sure Start or other services, or from being involved in any part of Sure Start.

What will happen to me if I take part?

If you would like to take part, please keep this information sheet, tear off and fill in the last page and give it to a member of staff at the Pampering Group. The researcher will ring you to arrange an interview.

The researcher will ask you to sign a consent form and will interview you once. The interview lasts for about half an hour. With your permission, the interview will be audio-taped. Your name and everything you say will be kept completely confidential. The tapes will be destroyed once the research has finished.

What are the possible disadvantages and risks of taking part?

We don't think there are any disadvantages or risks of taking part.

What are the benefits to taking part?

You may enjoy talking about and sharing your experiences of the Pampering Group.

Will my taking part in this study be kept confidential?

No names or details that could identify you would ever be used in any verbal or written report of the study.

What will happen to the results of the research study?

Hopefully, the results will be used to improve and develop the Pampering Group. A written report will be produced, but as already stated nobody who takes part in the study will be identifiable.

Who is organising and funding the research?

The research is being funded by Widnes Sure Start. Researchers from the Centre for Public Health Research, University College Chester, are carrying out the study.

What do I do if I want further information?

Please contact Denise Alexander on 01244 375444 (extension 2059) if you would like any more information about the research.

or you can write to: Centre for Public Health Research,
University College Chester,
Parkgate Road,
Chester, CH1 4BJ.

Thank you. Without your help we would not know what the community thinks about the support available to local families.



Please tear off this page and hand it to a member of staff at the Pampering Group.

I agree to a researcher contacting me to arrange for me to take part in an interview.

Name: Address:

Telephone Number:

Is there a good time to ring you?

Signature: Date:

Appendix 6
Consent form

Consent form

Title of Research: Evaluation of Halton (Widnes) Sure Start Pampering Group

Name of Researcher: Denise Alexander

Please initial the boxes

I confirm that I have read and understood the research information sheet for the above study

I understand that my participation is voluntary and that I am free to withdraw at any time without my rights to services being affected

I understand that the interview will be taped and that the tapes will be securely kept for the duration of the study and then destroyed

I agree to take part in the above study

Name Date

Signature

Name of researcher Date

Signature

Appendix 7
Professional participant information sheet

Professional participant information sheet

The Sure Start Programme aims to provide support and meet the needs of young families in the area. The Sure Start Unit highlights an increase in partnership working as an essential component for the success of Sure Start. Parents who have attended the Pampering Group are being asked about their perceptions of services in the area.

Reasons for involving professionals in the research

Only a partial picture can be established from the views of the parents alone. In order to examine how effective the Pampering Group is in terms of its benefits, practicality and inter-agency working, the perceptions of professionals working for the Pampering Group or referring to the Pampering Group are essential.

Reasons you are being asked to take part

You are being asked to take part because you work in the local area and you take part in the Pampering Group or you refer people to the Pampering Group. As such, you can make a valuable contribution to the evaluation of the Widnes Sure Start programme.

Who is organising the study?

The study is being organised by the Centre for Public Health Research at Chester College. The research will start in February 2005 and be completed by May 2005.

What does it involve?

Taking part in the research involves participating in an interview or a focus group about your perceptions about the Pampering Group and the way in which the service provided is able to meet health and social needs. It will take about 30 minutes.

The interviews will all be anonymous and confidentiality will be maintained at all times. Interviews will take place either in your place of work, at one of the local community centres or a place of your choice. The interviews will be taped and stored securely. Following completion of the research, the tapes will be destroyed.

The focus group will also maintain confidentiality at all times. It will be taped and the tapes stored securely, following completion of the research, the tapes will be destroyed.

There will be no names or other identifiable information in the completed research.

Your rights

Participation in the research is voluntary, and you may withdraw from participating at any time.

This study has been approved by the South Cheshire Local Research Ethics Committee.

The results of the research will be available from the Sure Start Co-ordinator in June 2005.

Further information about the research can be obtained from:

**Denise Alexander at the Centre for Public Health Research on 01244 375444 ext.
2059**

Thank you for your interest and co-operation in this research

Appendix 8
Focus group schedule

Focus Group Schedule

Can you all begin by identifying your roles within the Pampering Group?

Can you talk about the ideas behind the Pampering Group and what you are aiming to achieve? - What are the advantages/disadvantages of doing this through the Pampering Group?

Please talk about the interaction of the staff within the Pampering Group and any benefits you can identify of this way of working? Do your roles complement each other, if so how / in what way? What is working less well? What about the venue?

How are the parents 'engaged' with the Pampering Group? Who is it targeted at? Has it been successful? What hasn't worked (do people come back more than once?) (Have many fathers/male partners come to the Group? If they have, what has been their response? Does the name Pampering Group put them off?)

How successful has the service been in engaging so-called 'hard-to-reach groups'? Which people you would regard as hard-to-reach, and how effective this service has been in engaging these people? How has this been possible? What specifically has enabled this to happen?

Do you think some of these methods could be transferred to other Sure Start groups/activities and/or mainstream services? How?

Can you identify any benefits of the Pampering Group to the users? What outcomes have you witnessed for families/individuals and how have these been achieved? (what have been the 'impacts' for families?)

How does the Pampering Group contribute to achieving the Sure Start objectives? - Improving social and emotional development; improving health; Improving children's ability to learn; Strengthening families and communities.

Do you think the Pampering Group has been successful in meeting its objectives? Has this been monitored? If so in what way? What about 'indicators of

success' for those using the Pampering Group, how do you think these could be measured?

Have any difficulties been encountered with the Pampering Group – if so what and how could they be overcome? How could the service be improved?

Do you think this service could be mainstreamed – if so how? What would be the implications of this for mainstream services?