Parents 1st Independent Evaluation

"Someone in my corner"

a volunteer peer support programme for parenthood, birth and beyond

Final Evaluation Report:
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Gillian Granville and Wendy Sugarman

gilliangranville associates

www.gilliangranville.com

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1. INTRODUCTION

Parents 1st is a Social Enterprise, a not-for-profit Community Interest Company, that was set up in October 2008. The company's profits and assets are used for the benefit of parents, particularly those who may be disadvantaged as a result of social, health or educational issues[1]. In 2009, Parents 1st was awarded a 3-year Department of Health Third Sector Investment Grant to disseminate the Community Parent concept across the UK. In 2010 it was also awarded a 2-year Social Enterprise Investment Fund grant to enable their products and services to grow and develop.

In 2010, Parents 1st was commissioned by South West Essex (now NHS South Essex) to deliver an early intervention programme to parents and families living in the south of the county, including Basildon and Thurrock. The programme, named by the first cohort of volunteers, 'Pregnancy Pals and Birth Buddies', consists of a volunteer peer support service offered to vulnerable parents in pregnancy and for the first three months after birth. Volunteer parents in Essex are recruited and trained to offer parents-to-be friendly support and encouragement to keep healthy, have a positive birth and give their babies the best possible start.

In 2009, Parents 1st commissioned Gillian Granville Associates to undertake a two and a half year independent evaluation to support the growth and development of the organisation and to measure the outcomes and impact of the local programme being delivered in South West Essex. An initial draft Theory of Change was developed in 2010 with the staff and Parents 1st Board. This was later developed through learning events and feedback. The evaluation was divided into three phases:

1. Scoping and orientation
2. Case study evaluation of the local programme in South West Essex
3. Capturing further developments and final report

About this report

This resource document is the final evaluation report bringing together all phases of the evaluation. It is intended to be a comprehensive account of the development of Parents 1st. It includes primary evidence on the effectiveness of the peer support service and identifies the key drivers for change.

The audience for the report is wide ranging and includes commissioners and policy makers interested in improving the chances of disadvantaged families and reducing inequalities in health. Local authorities, NHS practitioners and managers and Third Sector organisations will find it informative for understanding both how services to families can be better integrated and how

[1] http://www.parents1st.org.uk/who-we-are.html viewed September 2012

different organisations can work together better. The research and evaluation community will be interested in the contribution the evidence makes to understanding the peer volunteer, or lay, model of support to vulnerable families within the spectrum of family support.

Structure of the report

Following this introduction:

- **Chapter two** considers the development of Parents 1st from its origins as a Community Mothers scheme in Thurrock, Essex to becoming a national Social Enterprise. It looks at the national influence of the organisation, the collaborations and partnerships it has developed and measuring impact and social return.

- **Chapter three** reviews the UK literature on the volunteer peer support model.

- **Chapter four** gives an overview of the evaluation approach and methodology used in the evaluation. The rationale for using Theory of Change methodology to establish a baseline is explained and the processes for collecting data are presented.

- **Chapter five** forms the main body of the report and presents the primary evidence of effectiveness against the outcomes for the volunteer peer support programme in South West Essex. A final Theory of Change is presented (in appendix 1 on page 62) and there is a discussion on the key messages and learning that has emerged from the evidence.

- **Chapter six** explores the fast growing area of measuring social and economic impact. Examples of benefits-to-cost impacts are given against the evidence presented in this report.

- **Chapter seven** explores the future of Parents 1st and how it may sustain and increase its social impact through scaling up and out, becoming part of a continuum of support, more collaborations and partnerships and its role in building sustainable communities.

An Insights paper has been developed which outlines the key findings from this report with a specific focus on the programme in South West Essex and explaining in more detail the Theory of Change that underpins Parents 1st. This is available on the Parents 1st website.

2. THE DEVELOPMENT OF PARENTS 1ST

This section summarises the journey of Parents 1st from its roots as an NHS Community Mothers' project in Essex, to becoming a nationally recognised social enterprise.

It explores the advantages and disadvantages of the social enterprise model in establishing and delivering a community driven service and the importance of developing collaborations and partnerships to create impact. The challenge of measuring economic and social impact is presented in chapter 6.

2.1 Becoming a Social Enterprise

Social Enterprise has moved into the policy mainstream in recent years. Under the labour government social enterprises were regarded as a potential deliverer of public services and facilitators of civic action, community capacity and cohesion. The coalition government is continuing on this path with the 'Big Society' emerging as an important theme[2]. The Office for Civil Responsibility, which is part of the Cabinet Office[3], works across government to translate the Big Society concept into practical policies. The current public sector reforms are seen by government as enabling social enterprises, charities and private sector companies to provide alternative models to the public sector. The Big Society vision hinges on economic reform balanced with support for local and civic life, and which cannot continue to be addressed separately[4].

The Department of Health defines a social enterprise as:

> *"A social enterprise is a business whose objectives are primarily social, and whose profits are reinvested back into its services or the community. With no financial commitments to shareholders or owners, social enterprises are free to use their surplus income to invest in their operations to make them as efficient and effective as possible".*

Critiques of the model[5] have built on this definition and describe a social enterprise as:

> *"A business with primarily social objectives whose surpluses are principally re-invested for that purpose in the business or in the community, rather than being driven by the need to maximise profit for shareholders and owners".*

[2] Cox and Schmuecker (2010) *'Growing the Big Society: encouraging success in social and community enterprise in deprived communities'*: Institute for Public Policy Research
[3] www.cabinetoffice.gov.uk
[4] Social Enterprise Coalition (2011) *'Time for Social Enterprise: A Report From The Social Enterprise Coalition'*
[5] Simon Teasdale (2010) *'What's in a name? The construction of social enterprise',* Third Sector Research Centre, working paper 46

The Social Enterprise, Parents 1st, developed from a volunteer led Community Parents Project in Thurrock funded by South West Essex Primary Care Trust[6]. In 1991, the current Managing Director of Parents 1st, Celia Suppiah, designed, piloted and managed the South West Essex service. In 2008, following an evaluation of the South West Essex project and other projects around the country[7] and with a Department of Health Third Sector Investment grant, Celia set up the social enterprise to develop and disseminate the community parent model across the UK. In 2010, Parents 1st was commissioned by NHS South West Essex to develop and co-ordinate a package of support services which focused on antenatal mothers and their babies up to three months. The learning from this early intervention model would be used to evidence and expand the approach nationally.

The focus on social enterprise rather than delivery through statutory services presented the opportunity for a community driven, innovative approach to be developed outside of the public sector. The evaluation of the Social Enterprise Pathfinder[8] programme supported this approach, evidencing the key benefits of the social enterprise model as:

- The ethos and values are a catalyst for improving choice, equality and access to services and enable services to be delivered in an innovative and efficient manner
- Social enterprises are not seen as being commercially driven and are often seen as more acceptable to both service users and staff, especially those that are in the NHS
- Social enterprise is a model, which appears to be valued by Primary Care Trusts

Some of the key challenges identified by that research were:

- The benefits of the social enterprise model are not always clear, not only to potential commissioners, but also to staff and stakeholders
- New social enterprises may be at a competitive disadvantage in terms of not having the same legal and HR back up as commercial providers
- Although the social enterprise model appears to fit well with staff principles, the potential loss of NHS branding and the feeling of no longer being within the 'NHS family' is a concern
- Understanding the issues around pensions
- Timing – the timescale required to establish a social enterprise is often underestimated. A social enterprise can take between 3 and 5 years to establish and trade

[6] Thurrock Community Mothers Programme in Tilbury
[7] Suppiah, C (2008) *A Collective Evaluation of Community Parent Programmes,* Parents 1st
[8] Tribal Newchurch (2009) '*Social Enterprise Pathfinder Programme Evaluation'*

Evidence from the literature[9] suggests a number of key enablers of success for social enterprises. These are:

- A strong team, with the right skills or access to skills, extended not only to staff and volunteers, but to board members and mentors.
- A strong leader with a clear vision was essential
- Networks and profile – participating in mixed networks that offer opportunities to build profile and learn about business opportunities
- Service provision and identifying a niche, accessing markets and developing new ones. Good quality market research and professional marketing is required
- The value of organisational review, bringing greater clarity about their mission and how to achieve it. Often this involved stopping some activities and embracing a more enterprising mind set

It is also acknowledged that there is a need for support to allow organisations to reduce their reliance on grants and move to more enterprising activity.

The decision to deliver a community focused innovative approach to supporting parents through a social enterprise rather than through a statutory agency has enabled Parents 1st to be flexible and adaptable. It is responsive to changing policy drivers and commissioners' priorities and is developing a service that complements professional roles rather than conflicts with them.

The challenges for Parents 1st support those discussed above in the literature; there has often been a lack of understanding of what Parents 1st is trying to achieve, suspicion of the social enterprise model and in particular, inconsistent funding levels. If the political vision for the social enterprise sector is to flourish, consistent funding streams, rather than short-term grants and contracts that can easily be withdrawn in times of funding pressures, need to be fully addressed.

2.2 Collaborations and partnerships

Parents 1st have developed and grown over the last three years through creating and establishing a range of partnerships and collaborations. At a local level in the delivery of the South Essex Birth Buddy and Pregnancy Pal service, a number of collaborations have allowed a more joined up approach to delivery. These have included links with the National Childbirth Trust through their network of trainers and as a director on the Parents 1st Board; working closely with Children's Centres to deliver services into the community and belonging to a range of professional networks. For example, one of the antenatal teachers attends the Maternity Services Liaison Committee at Basildon hospital and this provides a good link to the Parents 1st programme and raising awareness and understanding of the service. Nationally, Parents 1st has been represented in a

[9] Cox and Schmuecker (2010) *'Growing the Big Society: encouraging success in social and community enterprise in deprived communities'*: Institute for Public Policy Research

number of ways. Membership of the Department of Health's Expert Reference Group for Preparing for Birth and Beyond explored the evidence base and the potential of creating the conditions for growth in empowerment and self-efficacy for individuals and communities.

At a national level, Parents 1st have been very active in partnering with other organisations. For example, Parents 1st became the first doula[10] replication site for the roll out of the Goodwin Development Trust's volunteer doula programme. Parents 1st collaborated with the Goodwin Development Trust by adopting the Open College Learning package for doula training into their already established City and Guilds parenting model. Learning was shared between the organisations in a number of ways including the antenatal teachers at Parents 1st visiting the Goodwin project in Hull, and Goodwin acting as assessors for the breastfeeding module.

Parents 1st and One plus One (Marriage and Partnership Research Charity) partnered and was one of six national pilots commissioned in the Transforming Early Years project funded by NESTA and the Innovation Unit. The Parents 1st and One plus One project explored the concept of Children's Centres becoming community owned hubs and focusing on families from conception to the early months of life rather than the two to five year olds. This early partnership work has fed into the development of future collaborations and wider partnerships.

As a result of the Department of Health's Expert Reference group and the relationships that have developed through partnership working, Parents 1st is collaborating with three other national organisations[11], combining their expertise to develop an early intervention model for vulnerable families that mobilises communities and connects semi-formal and formal services to support parents and babies in improving their health and wellbeing. This initiative has the potential to bring together the work of each organisation and systematically scale up and influence the way early intervention services are delivered for parents and babies across communities in the UK.

2.3 National network

In addition to the collaborations and partnerships discussed above, Parents 1st have provided national support roles to other Community Parent initiatives across England including Carlisle, Barrow in Furness, Isle of Dogs, Fulham, Lowestoft, Liverpool and Cheshire.

The local projects interviewed for this evaluation felt a strong need for a National Network particularly in addressing isolation, good practice, learning, support, re-energising and identifying strategies for challenging other services that may be negative about, or not understand, the model. The importance of

[10] A doula is a trained and experienced partner who accompanies a woman through pregnancy, childbirth and for the first few weeks of family life. *Goodwin Development Trust 2009*

[11] One plus One, The Goodwin Development Trust and Altogether Better

"ensuring everyone takes the same approach" was also raised by one of the co-ordinators interviewed.

One of the mechanisms Parents 1st have developed to support other Community Parent services and encourage new ones to grow, is to become an approved City & Guilds accreditation centre, which enables Community Parent volunteers across the country to gain national qualifications. The national dissemination strategy is spread through a network of UK Community Parent Programme coordinators, specialist external evaluators, and a team of affiliated experienced trainers, A1 assessors and internal verifiers.

In addition, there is a range of publications available for projects to purchase, including manuals, tools for working with parents and a recruitment guide. These are available on the Parents 1st website.

One of the national co-coordinators described their experience of being part of the Parents 1st network:

> *"There is a sense of being part of a bigger thing...because (Director Parents 1st) welcomes people's input and is so generous about inviting everybody to things that you do have that sense of belonging to something bigger"* (Community parent co-ordinator).

Another co-ordinator said that: *"Being part of a national network gives our work credibility locally and helps to profile it";* the examples she gave were national training and evaluation.

Parents 1st brings the national network together through conferences and specific initiatives such as developing training material and resources.

3. OVERVIEW OF THE LITERATURE ON VOLUNTEER PARENTING PROGRAMMES AND EARLY INTERVENTION

Summary of the literature

The UK evidence of what works in volunteer peer support programmes is beginning to show us a picture of what works, although the evidence of impact of peer support in pregnancy and early parenthood still needs further development. A summary of the evidence includes:

- Community volunteer roles increase confidence in the volunteers
- Peer volunteers can connect people in communities to networks and services
- The model is particularly effective in disadvantaged communities
- The model has the potential to be most effective if it is part of a continuum of support alongside professional and semi professional roles
- The professional and volunteer interface needs to be strengthened

The literature

This section gives an overview of the current evidence base in the peer volunteer, or 'lay' health worker, literature. In the past most of the evidence has come from North America, but more recently the UK is developing its own evidence base about what works in peer volunteering models to support parents and families. The evidence can appear inconsistent at times, which may be due to the wide ranging focus and methodologies used. But as the evidence base builds, a clearer picture is emerging of 'what works', for which groups of people and why and this will support the spread and replication of the model. Initially the research into peer volunteering has come from the US. However, the context in the UK is very different from the US in terms of our systems, politics, culture and approach to research and evaluation.

In the US, Professor David Olds, who has carried out random control trials over a period of 15 years on home visiting models, and in particular the Family Nurse Partnership (FNP), compares professional models of home visiting with paraprofessional models. He concludes that professional models are more effective than paraprofessional[12] ones in improving outcomes for parents and children against key indicators of disadvantage. The paraprofessionals mimic the professional role; the participating paraprofessionals had to be educated to degree level (although no professional nursing background) and were required to replicate an intervention primarily designed for professional nurses. The only occasion when paraprofessionals scored significantly was where mothers who had low psychological resources interacted more responsively than those in the

[12] Paraprofessionals is the term used in the US to define lay health workers. Old (2002) defines paraprofessional home visitors as *"those with no formal training in the helping professions".*

control group (neither professional or paraprofessional home visitor). Professor Olds suggests that when professionals are trained in a model programme of prenatal and infancy home visiting (FNP) they produce significant effects on a wide range of maternal and child outcomes which are not achieved by paraprofessionals[13]. However, this model differs significantly from volunteer peer models, which recruit volunteers from the community where parents live and are not required to have formal qualifications.

The UK peer volunteer models have their strength in empowering and reaching into communities, combining community development approaches with parent support programmes, and it is the impact of this combination that is beginning to emerge in the UK literature.

A UK national study carried out in 2008 into the effectiveness of community mothers support programmes[14] (the first of its kind to consider the impact for mothers and children) found that the parents who benefitted most from a structured home visiting programme were those facing higher levels of disadvantage. Statistically significant positive change was shown on a wide range of parenting including accessing emotional support, feeling confident about handling children's behaviour and having time in the day for meeting others. It also found that volunteers operated more effectively by, for example, optimising support to parents who are likely to benefit most and offering volunteer-to-employment pathways to build long-term programme sustainability. A number of issues arose around programme delivery including a poor understanding of community development processes among professionals.

An earlier study[15] was carried out in Dublin on a community mothers' initiative, which had developed from the Child Development Programme. The programme had run out of money and was testing a non-professional, volunteer model, through recruiting experienced mothers to implement the programme instead of health professionals. In Ireland, by 1988, there were 90 community mothers recruited working with 450 families. There was a lack of any research into this type of model (except for the Head Start programme in the US – see Home Start below) and a randomised control trial was carried out with 260 mother and infant pairs. The study concluded that non-professionals could deliver a health promotion programme on child development effectively, but whether they do it as effectively as professionals required further study.

[13] Olds, D, Robinson J, O'Brien et al (2002), Home visiting by Paraprofessionals and by Nurses: A Randomised Controlled Trial, *Pediatrics:* 486-496

[14] Suppiah, C (2008) *A Collective Evaluation of Community Parent Programmes,* http://www.parents1st.org.uk/resources/research-report.html

[15] Z. Johnson (1993) Community Mothers Programme: Randomised controlled trial of non-professional intervention in parenting, *British Medical Journal, 306, 1449-52.*

Another small qualitative study in Ireland using a randomised control trial[16] explored a peer-mentoring programme with first time mothers in an area of disadvantage. This found that difficulties in the peer mentor initiating contact, developing the peer-mentor relationship and time constraints all imposed challenges to delivering lay worker peer support in communities. It is suggested that professional support may help to resolve some of the issues and improve effectiveness. The MOMENTS Study[17] found particular women valued advice given in the context of personal experience of child rearing.

Evidence from a community based peer support programme in Glasgow[18] for breastfeeding found that initiating and maintaining peer breastfeeding support was possible and acceptable to mothers and health professionals, and in a review of the evidence on lay engagement in preparation for parenthood[19], receiving lay support was found to help prolong exclusive breastfeeding.

A rapid evidence review of the Health Champion[20] role in preparing for pregnancy[21] found a fairly strong evidence base on the effectiveness of lay health workers promoting access to and uptake of services, particularly in disadvantaged communities. There was an absence of information in the literature on whether peer-led interventions as part of antenatal education were effective in terms of outcomes for mothers and children; with the exception of breastfeeding there was little information on other models involving lay people in preparation for parenthood.

One research study in 2008[22] focused on how the presence of a volunteer doula influences the experiences of women during childbirth. The findings demonstrated that a supportive relationship and personal empowerment are fundamental needs of all women and that the volunteer doula service was perceived as beneficial to both childbearing women and doulas. The study reaffirmed that volunteer doulas have great potential to assist mainstream

[16] Murphy c et al (2008) Peer-mentoring for first-time mothers from areas of socio-economic disadvantage: a qualitative study within a randomised control trial*, BMC Health Services Research: 8, 46*

[17] Cupples, M et al (2011) A RCT of peer-mentoring for first-time mothers in socially disadvan taged areas: *Arch Dis Child: 96, 252-258*

[18] McInnes, R and Stone D (2001) The process of implementing a community-based peer breast-feeding support programme: the Glasgow experience, *Midwifery: 17, 65-73*

[19] South J, Gluntoli G and Kinsella K (2011) *Altogether Better Preparation for Pregnancy Project- findings from Rapid Evidence Review*, Centre for Health Promotional Research, Leeds Metropolitan University

[20] Community Health Champions are individuals who are engaged, trained and supported to inspire and help their friends, families and work colleagues lead more healthy lives, see www.altogetherbetter.org.uk (August 2012)

[21] South J, Gluntoli G and Kinsella K (2011) *Altogether Better Preparation for Pregnancy Project-findings from Rapid Evidence Review*, Centre for Health Promotional Research, Leeds Metropolitan University

[22] Green, J (2008) *Volunteer Doulas for women in a sure start area: What does the service mean to them?* University of Hull

maternity services. Currently a multi-site evaluation of the volunteer doula service is being carried out by the University of York and the University of Nottingham, funded by the National Institute of Health Research, Service Delivery and Organisation programme. The final report is due in March 2013 and will provide further valuable insights into the impacts and experiences for the women, the doulas and the NHS.

The largest body of UK evidence on volunteer family support programmes is currently the work of Jacqueline Barnes and Kirsten McPherson[23] who evaluated Home Start, a national home visiting programme with trained volunteers supporting families with children less than 5 years. There is an increasing emphasis in the programme on early intervention designed to enhance infant development and family wellbeing, especially to disadvantaged families. The research found that the parents it was most important to reach are less likely to take up the offer of informal support from a trained Home Start volunteer. There were many reasons including some parents feeling that forming a relationship with a volunteer would be challenging and others feeling they wanted to cope without additional input. Support by a volunteer was not always welcome and parents felt unease about having a stranger in the house; this linked to input from friends who felt the volunteers must simply be 'nosy parkers'. The conclusions were that families with multiple difficulties may require a different approach, one focusing on professional intervention.

An earlier study into Home Start[24] found that, whilst users valued the service, there was limited evidence for its effectiveness as measured by child and maternal outcomes. Appreciation does not necessarily lead to a measurable impact and there remained doubts about cost-effectiveness of the intervention.

A more recent study on Home Start into support for mothers with new babies[25] found that being supported by a local community member should be helpful. Access to the neighbourhood was important for extending the range of support available, but the concept of the volunteer being matched to the family and in consequence likely to become a friend was a problem. The conclusions were that volunteers and professionals provide different kinds of support and there may be a role in supplementing more professional forms of assistance.

A study by the Centre for Excellence and Outcomes in Children and Young Person's Services[26] suggests that a spectrum of support for early intervention

[23] Barnes J, MacPherson K and Senior R (2006) Factors influencing the acceptance of volunteer home-visiting support offered to families with new babies, Child and Family Social Work: 11, 107-117

[24] Frost et al: (1996) *Negotiated Friendship: Home-Start and the Delivery of Family Support,* Home Start, UK, Leicester

[25] MacPherson et al (2009) Volunteer Support for mothers of new Babies: perception of need and support received, *Children and Society: 24 (2010) 175-187*

[26] C4EO (2010) *Getting Better? Improving outcomes for children and young people*, London: C4EO

is required; more needs to be done to promote the use of peer support volunteers from the community (including local parents) who are trained to work alongside professionals, but whose similar life experiences bridge 'the approachability gap'. They are able to convey positive influences from their own experiences and encourage local families full use of advice and practical help from local services and agencies. The research refers to a continuum of services required to identify the most appropriate intervention for children and families in order to match specific needs at a particular point. It reinforces the importance of engaging parents in a collaborative approach, building on their strengths and taking account of their views and experiences.

An alignment of parenting programmes and providing programmes as part of a comprehensive framework of family support could address both poor attendance following initial referral and the perceptual barriers limiting engagement. These were the conclusions from a review of factors associated with poor engagement with parenting programmes[27]. The referral source may be an important contributor to the likelihood of parents participating in support programmes. The review found that the most successful parenting programmes support an expansion of parent's social networks. Parenting programmes are not divorced from the wider community and might benefit from links with both formal and informal support services.

A study of people in public health[28] including the lay role (peer education, peer support) found that a broader approach to commissioning, target setting and evaluation is required that values the role of active citizens in bridging the gap between communities and services. It found that involving members of the public in delivering health programmes offers a way to utilise the knowledge, skills and resources in communities, and that valuing what people offer should remain at the heart of strategic planning and development.

This links to the evaluation of the Altogether Better Community Health Champions model carried out in 2010[29]. It found that greater recognition needed to be given to the range of outcomes that can result from engaging champions. Physical and mental health outcomes were linked because of the capability of champions to both connect people to groups and services as well as support their engagement with these over time. Community health champions as they grow in confidence can organise new activities and build social networks, eventually helping to build healthy and cohesive communities.

[27] Whittacker K and Cowley S (2010) *An effective programme is not enough: a review of factors associated with poor attendance and engagement with parenting support pro grammes,* Children & Society, National Children's Bureau and Blackwell Publishing Ltd.

[28] South J et al (2010) *People in Public Health: a study of approaches to develop and support people in public health roles:* Report for the National Institute for Health Service Delivery and Organisation Programme

[29] South J, White J and Woodall J (2010) *Altogether Better Community Health Champions and Empowerment: Thematic Evaluation Summary,* Leeds Centre for Health Promotion Research, Leeds Metropolitan University

Sections 4 and 5 form the main body of this report and present the primary evidence from the Parents 1st volunteer peer support programme for parenthood, birth and beyond in South West Essex.

4. EVALUATION APPROACH AND METHODOLOGY

Theory of Change is the approach used for this evaluation, which explores what works, for which groups of people, in which particular circumstance or context and most importantly, why. It is the methodology of choice in complex social change programmes where there are multiple outcomes and longer-term impacts expected in a range of different contexts, and the attribution and contribution of the project can present a challenge. By developing a draft Theory of Change and then testing and refining it, a final model of change emerges which demonstrates what has driven the changes and tests these against the original assumptions (hypothesis or small 't' theories) of the programme and the intended outcomes and impacts. The final Theory of Change Model for the South West Essex Pregnancy Pals and Birth Buddies Programme was developed through workshops and learning events with volunteers, staff and trustees, it is shown in appendix 1 on page 62.

The evaluation is focused on measuring outcomes - in other words it measures what changes as a result of the intervention. The outcomes tested in this evaluation were:

1. Families working with the Parents 1st model are confidently prepared for birth and parenthood
2. Parents with young children have built confidence and parenting skills
3. Parent volunteers: Accredited training leads to employment pathways and community involvement
4. Parents, volunteers and children have improved health and wellbeing

Indicators were developed for each outcome and appropriate methods to measure change were put in place. A number of evaluation questions were also put in place (appendix 2) to guide the development of the measurement tools.

Evaluation activities

The focus of the fieldwork was to understand *in more depth* the relationship between the parent and the volunteer peer supporter, and how that relationship brought about change. 11 in depth interviews were carried out with 5 volunteer and parent pairs, and one with a volunteer when it was not appropriate to interview the parent[30]. The volunteers and parents were interviewed separately although the volunteer took the evaluator to meet and introduce them to the parent, allowing an opportunity for observation of the relationship. An example of the interview schedules for parents and volunteers is included (appendix 3). In selecting the volunteers and parents to interview a sampling matrix was developed (appendix 4) to cover the range of parents using the service and ensure effective representation of the sample group.

[30] The family was part of the social care system and the baby went to foster parents shortly after the birth.

Parents 1st has developed evidence based[31] data collection tools which it continues to improve and refine in line with commissioner and policy priorities. These tools are used throughout the organisation and the data was collated for the evaluation to give breadth to the findings.

Two volunteer focus groups were carried out with cohort 1 and cohort 2 volunteers. Four observation visits were conducted: one at a volunteer training session, one at the exercise class and two at outreach sessions. These allowed an opportunity to observe the interaction between volunteers, professionals and parents and to engage in conversations with these groups.

Interviews were carried out with nine professionals in the locality who had direct experience of using the service or were aware of it through promotional activities or other colleagues. They included six midwives, two social workers and one counsellor. Where possible, interviews were carried out with professionals who had been involved with the parent interviewees, therefore allowing triangulation of the data and ensuring robust findings.

In addition, fifteen stakeholder interviews were carried out with a range of local and national stakeholders, academics, commissioners and partners, to provide important context to the evaluation. Interviews were conducted with seven Parents 1st staff and Trustees to gain greater understanding of the organisation and its values and beliefs. A mapping exercise of local services was also undertaken.

The data was analysed against the four outcomes above, using a thematic approach to draw out the indicators of change. From this analysis, a Theory of Change was developed.

Use of language in the report

Throughout the report, the direct quotes from evaluation participants are in *italics* and quotation marks. Each quote is labeled with one of 5 categories:

- 'Parent' refers to the parents receiving the service from Parents 1st
- 'Volunteers' refers to the Parents 1st peer supporters, who in the text are also called Pregnancy Pals, Birth Buddies or parent volunteers.
- 'Parents 1st' includes Parents 1st staff and trustees
- 'Professional' includes midwives, counsellors and social workers
- 'External stakeholders' refers to partners, commissioners and national organisations

The next section presents the findings from the local programme.

[31] Suppiah, C (2008) *A Collective Evaluation of Community Parent Programmes,* http://www.parents1st.org.uk/resources/research-report.html

5. EVIDENCE FROM THE LOCAL PREGNANCY PAL AND BIRTH BUDDY PEER SUPPORT PROGRAMME IN SOUTH WEST ESSEX

In this chapter we present the evidence of impact from the local Pregnancy Pal and Birth Buddy peer support service operating in South West Essex. It begins with an explanation of the local programme (5.1) and who has been involved over a 12-month period (April 2011- March 2012). We then detail the changes that have occurred for parents, families and volunteers as a result of receiving the service (5.2), as well as the experiences of the local professionals (5.3). Section 5.4 explores what has driven the changes and the chapter concludes with the learning that has emerged in the programme's development.

The diagram in appendix 1 summarises the model or theory of change that has taken place:

5.1 THE LOCAL PROGRAMME

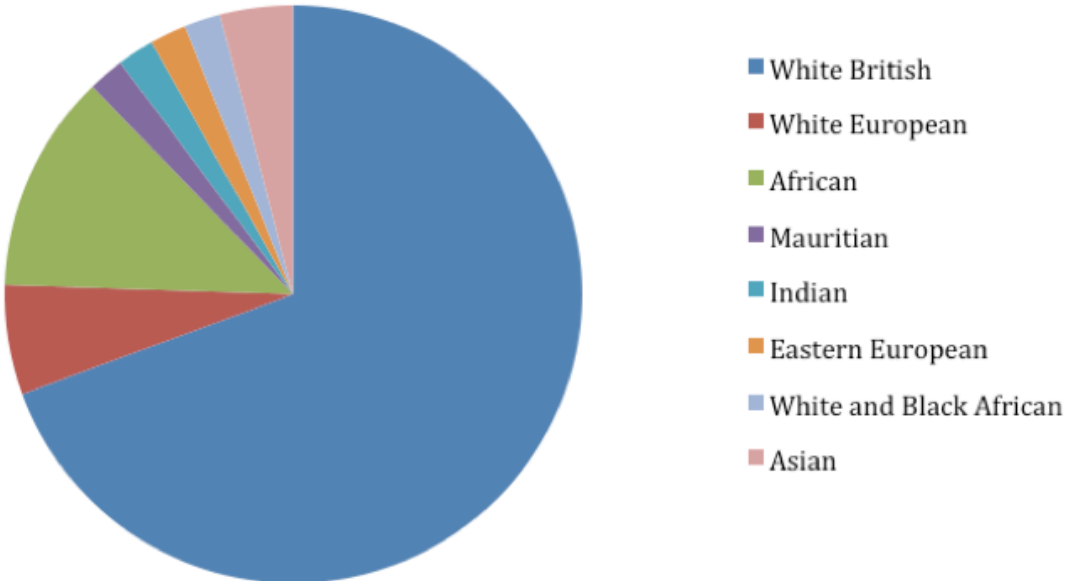
The local programme consists of four inter-related partnerships and approaches. These include:

- One to one peer support from pregnancy to three months after birth, primarily at the parents home
- Antenatal sessions facilitated by National Childbirth Trust (NCT) tutors
- Exercise sessions in the community with an independent fitness instructor
- A programme of outreach sessions in community and service venues

One to one peer support

Volunteers are recruited, trained, supported and supervised by Parents 1st staff. In the period April 2011 to March 2012, 50 parents were supported on a one to one basis by either a Pregnancy Pal or Birth Buddy. For twenty two of the parents supported this was a first pregnancy, with twenty eight having had a previous pregnancy. Nine of those supported were single parents, ten were in a relationship with the father but not living together, thirty were in a relationship and for one the data on this was not clear. Further information about the 50 women supported is broken down in the tables below.

Ethnicity of parents supported April 2011 to March 2012



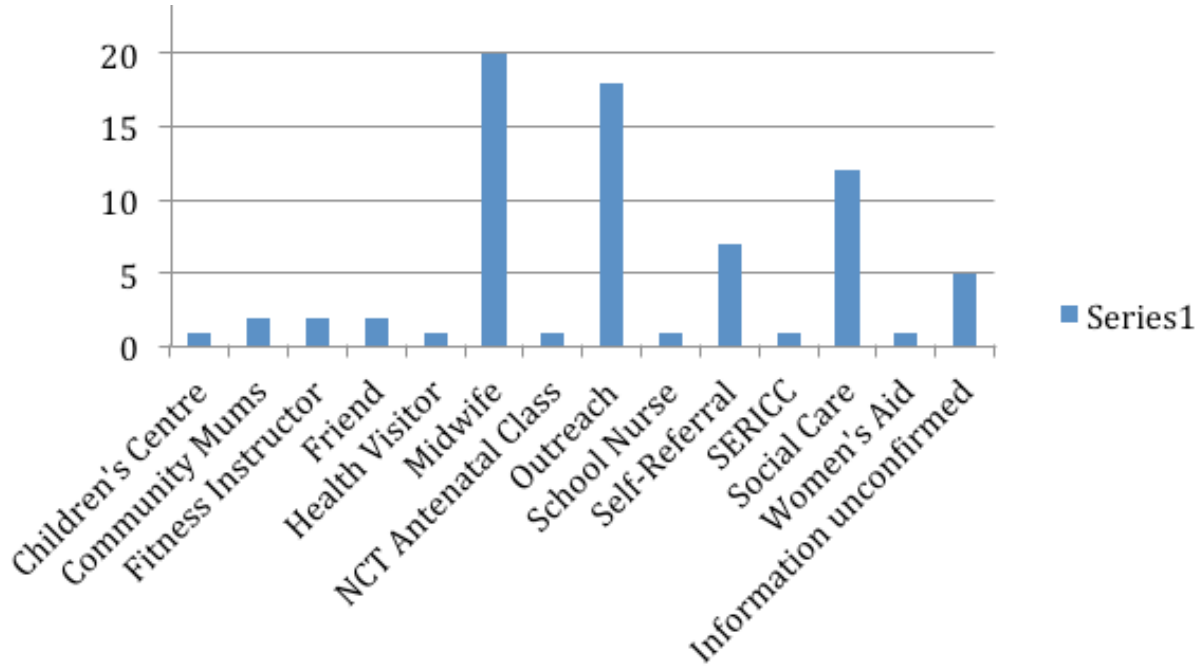
Age of Parents Supported

19 and under	**11**
20-25	**12**
26-30	**4**
31-35	**14**
36-40	**6**
40 +	**1**
Not stated	**2**

A further 24 parents applied for support and were not supported for a variety of reasons as broken down in the table below:

Reason	Number of parents
Adequate support already in place	3
Decided service not for her	4
Out of area	4
Parent misinterpreted service	2
Parent unsuitable for service	2
Unable to contact	8
Volunteer capacity fully stretched	1

For the 74 parents who have been through the application process this year the main sources of referral were as follows:



One of the midwives who had referred is a specialist in mental health and counselling. The majority of the outreach referrals in this period had come from one Tilbury Children's Centre in Tilbury.

Antenatal sessions

Parents 1st has established a collaborative partnership with two NCT trained experienced antenatal teachers. They are subcontracted directly by Parents 1st to provide free group support sessions to expectant parents.

In the period April 2011 to March 2012, 78 parents accessed and completed the courses in Thurrock and Basildon. This included 48 mothers and 30 fathers. None of the mothers was aged under 20 years, 16 were from Black or Ethnic Minority groups. The sessions are often held at weekends and the teachers thought there is the potential to increase the numbers attending the sessions and reach more vulnerable women through the development of the outreach service. The teachers were very aware of the parents who may benefit from the one to one support and on three occasions, peer support volunteers have come along with a parent.

Below is a summary of the self-completion questionnaires issued at the end of the sessions:

- Friendly, supportive group learning experience / felt able to ask questions/concerns were listened to - (n=19)

- Lovely venue (clean, comfortable, safe, easy to access) - (n=17)
- Felt better prepared for how to cope with labour (breathing, massage, relaxation techniques, birth positions, pain relief) - (n=17)
- Quality of course content (evidence based, easy to understand, use of visual aids, well organised, options and choices) - (n=16)
- Knew better what to expect after the birth (including bathing and nappy changing skills) - (n=12)

The partnership with the experienced NCT antenatal teachers is highly valued by the Parents 1st team. They contribute to the peer support training in active birth and are City and Guilds assessors. Through these roles they build up relationships with the peer supporters and are available to offer extra support and guidance, although they are aware of not creating a dependency for information from the volunteer. One teacher told us:

> *"I don't mind the volunteers contacting me and being used in that way (for particular information). It is often quite specific things they want to discuss" (Parents 1st).*

The teachers clearly feel part of the Parents 1st team:

> *"Definitely one of the team, there are so many things going on that we may not be (directly) involved but we are always kept up to speed through team meeting and emails" (Parents 1st).*

They also appreciated the opportunities for their own professional development offered by Parents 1st and being able to attend learning events. One example was the antenatal teachers observing and meeting people running a Doula programme in the North East.

'Fit 4 Mums to be' – exercise sessions

In collaboration with Parents 1st, a fully qualified fitness practitioner with 12 years experience of working with pregnant and early post natal women provides a weekly exercise programme and group peer support at 3 venues across South West Essex. Each session lasts 2 hours including an exercise class, group discussion and refreshments. Between April 2011 and March 2012, **112 sessions** have been run at 3 centres across South West Essex, and there were 59 new referrals.

The instructor carries out a thorough medical history and postural analysis prior to accepting each participant on the programme. Participants also confirm medical clearance to participate by the midwife or GP.

The sessions can be a source of referral to the peer support service as the fitness instructor finds that many women are unaware of the support that is available to them. Peer supporters also volunteer at the sessions and take

part in the informal discussions so they can introduce themselves and the Pregnancy Pal / Birth Buddy services on offer.

A sample of women interviewed for this evaluation had found out about the service at different points in their pregnancy and half of those wished they had known about the classes earlier. The biggest issue was getting the information and being referred by the statutory agencies.

There is more discussion on this element of the programme in section 5.2.4.

Outreach sessions

The outreach sessions have been put in place to complement and promote the peer support programme in the community, and they provide an opportunity to promote the free antenatal classes and exercise sessions. Three parents who were experienced peer support volunteers with Parents 1st are now employed part time (3x15 hour posts) to carry out this programme of outreach activities. Between April 2011 and March 2012, 104 two-hour sessions have been held with 468 face to face contacts, of which 71 per cent were first time contacts[32].

The purpose of the outreach sessions is:

- Information stands and informal introductions to expectant parents
- Sharing useful information including specific information aimed at fathers
- Signposting to a range of services
- Building relationships with midwives

A wide range of issues is reportedly discussed at these sessions. They range from breastfeeding (most common), planning for the birth and general health and wellbeing issues to benefits and housing enquiries, worries about previous birth experience and support following bad news after a scan.

The sessions have taken place in one Childrens' Centre, two Health Centres, Basildon ultrasound scan department and antenatal clinics in five medical centres. This element of the programme is still developing in order to find the best approach and location to reach women who would benefit most from the Parents 1st service. As it becomes more established, it has the potential to reach further into communities. It also offers opportunities to reach fathers who may be accompanying their partner to scans or antenatal appointments.

The outreach service has opened up opportunities to build rapport and relationships with midwives and raise awareness of the service. In some venues there is more contact with midwives than in others where this still can be challenging. In one case the midwife meets the Parents 1st outreach worker after each session and discusses potential referrals.

[32] Parents 1st monitoring data

5.2 THE IMPACT OF THE PROGRAMME ON PARENTS, FAMILIES AND VOLUNTEERS

In this section we describe what has changed for parents, families and volunteers as a result of the Parents 1st Pregnancy Pals and Birth Buddies service in South West Essex. These changes were measured against the following four outcomes as previously described in the Theory of Change:

1. Families working with the Parents 1st model are confidently prepared for birth and parenthood
2. Parents with young children have built confidence and parenting skills
3. Parent volunteers: Accredited training leads to employment pathways and community involvement
4. Parents, volunteers and their children have improved health and wellbeing

5.2.1 Families working with the Parents 1st model are confidently prepared for birth and parenthood

There is good evidence from the evaluation that parents working with Parents 1st peer supporters are more confidently prepared for birth and parenthood and their birth experience is improved. Confidence increased because the parents built a trusting relationship with the volunteer, they felt better informed and they were more in control of their pregnancy and birth.

Building trust

The women described feeling confident because they built up trust with the supporter and this led to them feeling better able to prepare for the birth. They felt they had someone to rely on, who had time to give them the extra support they felt they needed. One woman met her peer supporter when she was four months pregnant with her second child:

> *"The first pregnancy made me (feel) very upset and hopeless. This one I had confidence. The first three months (of the pregnancy), I thought 'How am I going to do it? How am I going to bear the pain?' You take confidence; take strength to face everything, so you can do it" (parent).*

One peer supporter described how she started to build the trusting relationship with the woman through a careful pattern of visiting. The mother had recently moved into the area and was extremely shy of meeting new people:

> *"I interacted with the baby to almost show her that I do have an interest in babies. I used to go for 20 minutes to half an hour so she knew I was there and then once I'd built up my trust with her, I'd be there an hour to an hour and a half because she'd open up to me a bit more and tell me what her concerns were. She had questions over the birth but she actually listened to what you were saying to her, which was proof in the pudding*

when the baby came along because she'd actually listened to everything you'd said" (volunteer).

One woman who had a Birth Buddy described how the peer supporter helped her when she went into labour at home through reminding her of what she had learnt in the antenatal period about breathing. The woman was alone as her husband was at work and she explained:

"She (peer supporter) filled a gap. I thought there was nobody, so she filled it mentally and physically. She massaged me and she just said 'breathe in, breathe out', all the exercises, and she calculated how much the pain is starting and ending. If she had not been there that day, I don't know, I can't think" (parent).

A woman expecting her third baby was referred to Parents 1st late in her pregnancy and had already chosen to have an elected Caesarean Section. She felt that if she had been able to have the support of the peer supporter earlier, she would have attempted a normal delivery. This was because of the support she now received and the trusted bond that had developed between them. She added:

"(Volunteer) was there for me, where I have never felt a lot of people could give me support. She was really there, giving that sort of friendly support that I was lacking and I'd not been able to find from my friends or family" (parent).

Trust and confidence were built because the mother felt the peer supporter was there for her, that her wishes were being listened to and that she was not going to be told *"you need this", "you need that"*.

The evidence suggests that in some cases trust was built between peer supporters and parents who were from different backgrounds. This includes different cultures. One parent said:

"As an Asian woman when you are seeing a white woman you are thinking she's not going to understand me, she won't know my feelings and that is something that vanished" (parent).

A number of the parents interviewed were isolated and did not have immediate family around them for a number of reasons. The isolation was something that the peer supporters really helped address and in turn this enabled the parents to feel more confident and build up trust. Having someone that believed in them and their right to make choices and be empowered really helped. One parent explained how the peer supporter enabled her to address the isolation:

"Every woman is expecting the mother in her pregnancy time so at that time I felt I had nobody which is a hardship for me, and I couldn't bear

that feeling. So that time (peer supporter) came, it filled my mother's gap...she gives the confidence and steadiness" (parent).

Trust was also built with vulnerable parents by never making false promises even if that was what the parent wanted to hear, and may be heard from people around them. For example, one volunteer showed how her training had helped her maintain her boundaries and consequently led to her retaining and further building the trust of the mother:

"What was on my mind was that I never made any false promises to her; this all comes under the training on boundaries – what the boundaries were, and what we can and can't promise" (volunteer).

Better informed

An important factor in building confidence in parents came from the fact that the parents felt well informed about what would happen during their pregnancy and the birth, and this made them less fearful. The supporters would find out information on behalf of parents and sign post them to, for example, relevant website addresses. Two parents gave these accounts:

"She put me onto a couple of websites where I could read about birth and about fear and how I could empower myself" (parent).

"(I) knew more with this one than I did with other two (children), so (I was) more relaxed for birth. Compared to previous pregnancies, I have so much more knowledge" (parent).

One parent said that her peer supporter was a *"missing link",* because if there was anything bothering her, the volunteer would find the information for her and keep her well informed. Another woman explained how her supporter helped her prepare for the birth by answering her numerous questions on what to do. This was particularly useful to her, as she had initially felt unable to ask questions of the midwife because she did not feel she had a relationship with her. She also felt unsure of the role of the midwife in answering her queries. For one mother, whose pregnancy was unplanned and concealed from friends and family, talking about the pregnancy to her peer supporter helped her accept the reality of the situation and begin to prepare for the changes:

"It was nice to be able talk about my pregnancy so I got a bit more excited about it and it took a lot of my worries away" (parent).

One volunteer gave an example of a father who went through all the information she gave to the family on postnatal depression, and this led him to understand how he could help his partner.

Taking control

The availability of information that was relevant to the parent and specific to their concerns and worries, was a significant factor in enabling parents to feel they had more control over the birth and labour. The role of the peer supporter was to focus on the issues that the parent wished to focus on, even when it may appear to the volunteer that there are other factors to consider. Women spoke of the reassurance they felt when the volunteer was able to give them information on issues that were bothering them, and how this helped them approach the birth in a more positive way.

The result of building confidence led to the women feeling able to make their own decisions and for some, developing birth plans was a practical means to do this. The volunteers supported parents in an informal way to plan for the birth in areas such as packing a bag for hospital, discussing positions for giving birth and whether they wanted 'skin to skin' when the baby was born. One peer supporter explained:

> *"We went through quite a lot in the birth plan but I wouldn't say it is properly structured: 'Right I have got a list of what to do?' No, I think it's important not to do that, almost because I think they may start looking at you as a professional" (volunteer).*

One parent explained that she did not realise in her previous pregnancies how much control she could have:

> *"She (peer supporter) kind of helped to empower me. I didn't realise before with my other pregnancies, how much control I could have, how much I could be involved in my own pregnancy, in my own birth" (parent).*

An example was a woman who had been abused as a child and was very frightened of having internal examinations. As the relationship between the peer supporter and the mother developed, the woman explained how she felt and this led to an addition to her birth plan, asking that staff offer her a choice if any examinations were required.

Another woman who was in the social care system and at risk of having her baby taken into care, developed a relationship with her peer supporter, which allowed the mother to take control of the birth by deciding to have skin to skin after birth and to initiate breastfeeding.

5.2.2 Parents with young children have built confidence and parenting skills

There is good evidence that parents who received the Parents 1st service in the antenatal period and the first three months after birth feel more confident in their parenting skills in the period following the birth.

The indicators for this are increased confidence built during the pregnancy and an improved birth experience (as evidenced in section 3.2), reducing social isolation and expanding social networks. The peer supporters connected parents to community services, encouraged the development of friendships with other parents in the local community and supported them to confidently access other child support services.

Parents developed their confidence in parenting through the relationship that had developed in pregnancy with the volunteer. The role of the volunteer is to help the parent identify their goals and to affirm the parent's actions. One parent expressed this:

> *"I feel more secure about what I am doing for the baby – even if I knew something, maybe I wasn't 100% sure that I was doing it right when the baby was here, and from her experience as a mum especially, she was always encouraging me – 'yes, you are doing it right' - and that helped me a lot" (parent).*

Accessing health and other child support services

A key role of the volunteers has been supporting parents to use health services and child support services appropriately and more confidently. Parents said that if they were anxious going to antenatal appointments, scans, hospital check ups and so on, the support of the volunteers gave them more confidence to attend. One woman who had a history of postnatal depression described her experience:

> *"I didn't have anyone to go with for an antenatal appointment and I was dreading going on my own. (Volunteer) came with me, it was nice to have her there to give me support and I didn't feel as bad when I went for the appointment" (parent).*

The approach of Parents 1st volunteers empowers parents to express their needs and views and therefore to question appropriately when contacting professional services. This has the potential to lessen dependency on professionals and on the use of over stretched services.

A significant finding in the evaluation was the role of the volunteers in signposting and supporting parents to use other services when Parents 1st role ended. In the Birth Buddy and Pregnancy Pal programme the volunteers end their involvement at 3 months after the birth. The aim of the programme is to empower parents to move forward on their own and become confident parents, rather than building a dependency relationship. One of the ways this was achieved was to sign post and support parents to access services that already existed in the community and which could offer other support if required.

Volunteers could provide parents with a plan of all the local groups so that parents knew when and where activities were held. In two of the observations

of parents and volunteers together information about local services was given to the parents to consider which services they may want to access. In one case the volunteer also supplied a map to support the parent to attend, as the parent was new to the area.

One parent we interviewed was referred by the Parents 1st volunteer to the local Community Parents service who could offer support until her child was 2 years. Another volunteer worked with the parent to develop a rapport with a Children's Centre outreach worker, so she would continue to support the mother. One volunteer supporting a mother with a moderate learning difficulty was able to refer the mother onto a specialist service that could offer particular expertise in working with people with low educational attainment.

Reducing isolation

Volunteers helped to reduce parents' isolation by introducing them to different group activities during pregnancy, encouraging them to try different opportunities and to make friends with other parents. The peer supporters often accompanied the parent initially to a new event. One mother who had two previous children explained that in the past, if she went out she had always stayed on her own and not joined in activities with other parents:

> *"Since I have been going with (peer supporter), it's like I'm encouraged to talk to them and make conversation with them (other mothers). She always says if the person's face looks ok make a conversation, you might strike a friendship, you never know" (parent).*

This has resulted in an increase in confidence for that parent. She was speaking about how she would feel when the volunteer completed her support:

> *"After I stop seeing her, I know personally, I have improved in socialising with people and in having confidence – oh if they talk, I can actually talk back" (parent).*

One volunteer explained how she helped reduce a parent's isolation through giving her information on local services:

> *"She is quite young but she hasn't got anyone. She's a bit isolated so I help her, just telling her places she can go to get out" (volunteer).*

One parent who had been in Britain for 3 years and spoke English as a second language, was isolated from her own family. She explained how she felt before she had her peer supporter; she missed her mother, was very low in spirits and felt that there was no-one who focused on her:

> *"I didn't know anyone so I have no friends, no relations, no one is for me" (parent).*

The volunteer explained the change she saw in the mother at the end of her involvement from when she first began visiting her around the 5th month of pregnancy:

> *"She's blossomed from when I first went there. It was very dark, the curtains were always closed, the TV wouldn't be on, it was just very dark to now; there are no curtains, the curtains are gone, the TV will be on and it'll be playing music" (volunteer)*

Expanding social networks

Peer supporters are people recruited from the local community and in most instances they work with parents who live in the same locality. They have developed a sound knowledge of local services and have an understanding of *'what it is like to live around here'*. One parent put it this way:

> *"(Volunteer) is a local woman, she is a mum, she understands, she's got the local connection, even the community midwives don't have that local connection that the volunteers do" (parent).*

This local knowledge enables Parents 1st peer supporters to connect parents with local parent groups where they can develop new friendships and increase their confidence in parenting skills through the exchange of knowledge and information.

5.2.3 Parent volunteers: Accredited training leads to employment pathways and community involvement

There is clear evidence that supports the developmental aspects of the volunteers and how their experience has given them new opportunities, helped them develop confidence and led to potential training or employment pathways.

Motivation

Community involvement was a key driver. Volunteers spoke about how their own experiences could help them in the role and their genuine motivations for wanting to support and help others. They reflected on their own, sometimes difficult, experiences - whether that was a bad birth experience, trouble breastfeeding, feeling alone, a breakdown or recovering from an addiction. One volunteer explained her reasons for applying to become a volunteer and how her own experience could help others:

> *"I was a young mum at 16 and you do get a bit of grief from other people being judgemental and that. So I wanted to help someone through that situation and show them that not everyone is judgemental to you" (volunteer).*

Social capital addresses the connections within and between social networks. Indicators of social capital can include sociability, social networks, trust, reciprocity, and community and civic engagement[33]. The volunteers demonstrated a lot of social capital and care for the parents; they wanted to support them, to address the issues they presented and ensure they were cared for within a trusting environment and encouraged to develop social networks and engage with local services. One volunteer said:

> *"I have always had that in me to make sure someone has the best support, that is me inside, I want to help people. My birth experiences weren't great, my breastfeeding experiences were there but again not good, it hurt and now I know it's not meant to hurt. So that pushed me as well to become part of Parents 1st" (volunteer).*

There are two types of social capital: 'bonding' and 'bridging'. Bonding capital refers to building social capital within specific community groups and bridging capital builds social capital across community groups. The volunteer / parent relationship showed evidence of both with more emphasis on bonding capital. Demonstrating that feeling of bonding with other parents, one volunteer put very simply her motivation:

> *"Helping other mums to be honest, getting them on the right stepping stones to having a good relationship and becoming good parents" (volunteer).*

In terms of the impact on the parents, one volunteer spoke about the satisfaction she got from being a volunteer:

> *"It's been a pleasure for me to go into these people's lives, and even though I am not a health professional, to make a difference and to make a change" (volunteer).*

A sense of purpose

Another driver for volunteers was around a sense of purpose. In some cases this was linked with wanting a change of direction or to explore different options for future employment pathways. One volunteer explained:

> *"I've got a bit of a purpose now apart from being a mummy, which is a great purpose, but something else for me. I guess I have found my niche a bit.... I can see which direction I might try and go in when I go back to work" (volunteer).*

[33] Morgan & Swann 2004, *Social capital for health: issue of definition, measurement and links to health,* Health Development Agency

This was often linked to developing confidence and many volunteers reported increased levels of confidence. One volunteer said:

> *"I have been a stay at home mum for a long time and didn't have too much adult company and it just feels more like I can stand up and talk to people, whereas before I would have been shy so it has given me a lot of confidence as well" (volunteer).*

Another spoke about what she had achieved both in terms of confidence and experience:

> *"I've done conferences since and spoken at NESTA conference which if you'd told me two years ago that's what I'd be doing I'd be going no way! And I think I am also a lot more confident in what I do now" (volunteer).*

A staff member at parents 1st had observed an increase of confidence and assertiveness in the volunteers after training:

> *"I have noticed some of the women I have worked with have gone from being passive to being members of a group who are willing to share their feelings" (Parents 1st).*

Gaining qualifications

The course work through the Parents 1st training, including the City and Guilds accreditation and the Open College Network Breastfeeding Peer Support Programme, is something that many volunteers cited as their biggest achievement to date. Whether it was doing the course work or gaining the qualification it was clearly something that volunteers were quite rightly very proud of. The table below shows achievement to date of the City and Guilds accreditation:

Volunteer Cohort	Number gained	Number in process
One	8	3
Two	0	18
Three	0	13

One volunteer said:

> *"(The training was) refreshing my brain through the assignments and stuff as right now I'm not doing anything" (volunteer).*

Another volunteer described the accreditation as a benefit that was timely for her:

> *"The benefit that I would get an accreditation and I was thinking that by*

the time my little boy goes back to school, and I don't work, and you know it gives you that something else to strive for in between" (volunteer).

The level and quality of the training was acknowledged by volunteers in the way they felt ready to undertake the peer support role. There was also a strong feeling of being supported and volunteers reported a good supervision structure enabling them to process their roles, reflect on difficult situations and discuss in detail their interventions with parents:

"I think given all the training as well it helps you to recognise your limits. The support and supervision I personally have already experienced and it has been profound" (volunteer).

Whilst acknowledging the high level of training received, one volunteer recommended that there was more training for volunteers on Social Care as an area of further training development. She felt that additional training would be beneficial to give an insight into:

"What social care is about, what avenues they can go down, when they take children away, why they watch families" (volunteer)

Pathways to employment

Some volunteers were very clear about wanting a future career linked to their role as Pregnancy Pals or Birth Buddies – through discussion, some roles that were discussed by volunteers included training as a midwife, a family support role and an interest in social care. When outlining their hopes for the future at the volunteer focus groups it was clear that around half of the participants were looking longer term at a new employment and a career pathway. One volunteer explained:

"I will hopefully pursue some career in health care, health visiting, midwife. I don't know what yet.... this volunteering is exposing me to lots of new areas" (volunteer).

The range of experience volunteers have through Parents 1st can really offer them a wide-ranging and diverse experience in which to make future career or further education choices. Volunteers spoke about feeling they had a 'grounded' experience which included feeling they were trained for the role. The issues being presented to them by the parents were wide ranging and offered potentially different and new challenges.

One volunteer explained more around how her experience with a parent opened up future choices:

"With the cases that I've been dealing with like social care and post

natal depression, it's opened different avenues for me that I'm really interested in" (volunteer).

It is clear that the high level of training, and the strong support and supervision received by volunteers, enable volunteers to work with parents presenting a wide range of issues. This in turn equips volunteers to offer support to vulnerable parents and keep the overall quality of the Parents 1st intervention high.

Another successful factor for some volunteers has been gaining the opportunity to work for Parents 1st as an employee. This is an area that was not envisaged by volunteers when taking on the role but something that had come along as an opportunity and supported them to get back into work. This may be an area Parents 1st can look to build on in the future. In addition to the actual opportunity volunteers commented on how the ethos of the organisation supported them to both be a parent and be in the workforce with flexible work hours around their childcare commitments. One volunteer talked about working for Parents 1st:

"I didn't take on the volunteering role with the aim of getting a job.... It was nice to start a job and to have familiar surroundings and to have familiar people and it made the transition back into work a lot easier" (volunteer).

5.2.4 Parents, volunteers and their children have improved health and wellbeing

There is emerging evidence that the parents, volunteers and their children have improved health and wellbeing through receiving the services of Parents 1st. This is evidenced through parents' and volunteers' increase in self-esteem and confidence and in their use of services (evidenced above); an increase in breastfeeding, benefitting mothers and their children, improved physical activity in pregnancy and improved mental health and wellbeing.

Increase in breastfeeding

Breastfeeding is an indicator of improved health and wellbeing for both baby and mother[34]. The initiation and continuation of breastfeeding in lower income and more vulnerable families has been a cause for concern and nationally there have been a number of initiatives to improve the rate. In **South West Essex, 69.8 per cent of women initiated breastfeeding,** which was below the national average of 74 per cent; similarly, **37.6 per cent were wholly or partially breastfeeding at 6-8 weeks**, which was significantly lower than 49 per cent nationally (all figures for 2011-2012).

[34] http://www.breastfeeding.see.nhs.uk/title/Breastfeeding-the-facts-28

Breastfeeding rates for mothers receiving **Parents 1st** one to one peer support show a marked improvement on the national statistics and a substantial improvement on the South West Essex figures: **nearly 80 per cent initiated** breastfeeding and **nearly 60 per cent were still breastfeeding**, either wholly or partially, at 6-8 weeks (see table below).

Figures April 2011- March 2012[35]

	Parents 1st	South West Essex	England
Initiated breastfeeding	**79.8%**	69.8%	74.0%
Wholly or partially breastfed at 6-8 weeks*	**59.0%**	37.6%	49.0%

* Prevalence as a percentage of those infants with a known 6-8 week breastfeeding status

Although the numbers are quite small (n23/29 initiated and 13/22 wholly or partially breastfed), the trend is very encouraging, particularly when working with vulnerable families. It can also be difficult to attribute this higher percentage to the intervention of Parents 1st, but evidence from this evaluation demonstrates the significant contribution Patents 1st peer supporters are making to increase breastfeeding rates in Essex. It also supports evidence from the Doula peer support programme in Hull where 77 per cent of women breastfed and 51 per cent were still wholly or partially feeding at 6-8 weeks. This was a significant rise on the local figures from Hull Primary Care Trust of 59 per cent and 33 per cent respectively (2011-2012 figures).

Parents 1st provides all volunteers with an Open College Network (ONC) Breastfeeding Peer Support skills training course. This is provided in house by their skilled and experienced breastfeeding counsellor (who is also a Director of Parents 1st). The course meets the UNICEF Community Baby Friendly Standards and all peer supporters complete the training before they start supporting parents.

Peer supporters demonstrated how they supported mothers to breastfeed by discussing it in pregnancy, in the planning of the birth, by encouraging skin-to-skin and initiation of breastfeeding when supporting the mother at the birth, and signposting them to other support that was available in the community. One parent, who had her fifth child, had never had skin contact after birth or breastfed. She had support from the volunteer, which led to her changing her mind and for the first time had skin contact and breastfed her baby successfully. The supporter explained how building up the woman's self

[35] Department of Health Integrated Performance Measure return 2012

confidence and helping her set her own goals meant that breastfeeding was sustained: she visited the mother at home after the birth and found the mother was worried that the baby would not latch on; she wanted to give the baby a bottle. Peer supporters are trained to be non-judgemental and give confidence in parenting skills and the volunteer's approach was:

> *"You've given him his first feeds which is absolutely fantastic, what do you want to do now? The mum said ' May I give him a bottle?' and I said 'If that's what you want to do, that's fine'. While I went to get the bottle, I came back and she had latched him on, so she'd achieved her goal, without me being there and felt confident to do so" (volunteer).*

One woman having her first baby thought she would like some help from her peer supporter with breastfeeding. She had set two goals in pregnancy and one of those was to breastfeed. She explained how the peer supporter had helped her achieve her goal through preparing in pregnancy for breastfeeding and then supporting her during the first three months:

> *"(Peer supporter) gave me lots of support to breastfeed when I came back" (parent).*

Another mother wanted support with breastfeeding but found the hospital staff too busy to help her:

> *"When I was in hospital I needed support with breastfeeding then and I really wanted (volunteer) to come onto the ward because I felt comfortable with her" (parent).*

One mother spoke of the support she had from the volunteer after the baby's birth, because although she had initiated breastfeeding successfully, she found that without the encouragement of the peer support she would not have continued because *"breastfeeding used to get me down" (parent).*

One peer supporter commented on how the mum she was working with had grown in confidence around breastfeeding:

> *"She picked her up and instantly got her cushion and fed her whereas before she was trying to lay down and had all these cushions but this was instant and she was comfortable. She seems more confident with her feeding" (volunteer).*

The one to one peer support programme also promotes breastfeeding by introducing mothers to a range of other breastfeeding services in the community, such as self-help groups. They are able to sign-post parents to services as well as make direct referrals to relevant agencies.

Motivation to improve physical activity in pregnancy

As discussed, the Pregnancy Pals and Birth Buddies Programme delivered by Parents 1st includes exercise sessions for expectant mothers (Fit-4 Mums-to-Be) run by a trained fitness instructor. Between April 2011 and March 2012, **112 sessions** have been run at 3 centres across South West Essex, and there were 59 new referrals.

The motivation for the majority of women attending was to improve their physical fitness in preparation for labour. The second most common issue was lower back pain followed by keeping weight under control and anxiety and depression. There were also a variety of medical conditions that led to referrals from midwives, including diabetes, high blood pressure and symphysis pubis dysfunction.

As stated, a key reason for attending was those women who wanted to keep their weight under control or were already overweight, and a number wanted to keep healthy and active. A discussion carried out for this evaluation showed how the classes helped and supported women to exercise in pregnancy:

> *"Excellent support system – it helps when you are at home and end up unconsciously doing exercises" (parent).*
>
> *"The advantage is exercising with other people in the same circumstances and (it is) accessible and all free" (parent).*
>
> *"The stability ball was really good for labour – I had no idea before. Now the baby's here, all the other kids and my partner use it for exercises" (parent).*

It was also a valuable mechanism to meet and get to know other expectant mothers in the local community, as this comment confirmed:

> *"Exercise, keep fit and relax, share experiences, talk to other people and go out – not sitting at home on your own" (parent).*

We heard how some of the mothers meet up again after their babies are born and this has the potential to increase social networks and provide informal support to parents. We were also told about women visiting after the baby is born and being really supportive to the pregnant women in the class who can ask questions about the birth and meet the babies.

The exercise groups provide a direct referral route to the one to one peer support service and there is capacity for this to increase further as the service becomes more well-known. Peer supporters often volunteer at the classes so they can meet up with local mothers and talk about the service on offer.

The evidence presented shows that some pregnant women in South West

Essex were motivated to increase their physical activity in pregnancy and it would be reasonable to conclude that this had the potential to lead to a healthier pregnancy. It also led to less social isolation for some mothers. What is less clear is whether these parents changed their behaviour after the birth and continued to pursue a more active and physically fit lifestyle, therefore improving their general health and wellbeing.

Improved mental health

Sections 5.2.1 and 5.2.2 demonstrate the value of the Pregnancy Pals and Birth Buddies service in reducing social isolation and developing social networks. It was one of the reasons that professionals referred to the service. At the initial needs assessment carried out by Parents 1st, 33 per cent of expectant mothers either knew no-one or only one person who was close by and with whom they could talk to about any worries or problems.

The women involved in the evaluation had a variety of reasons why they were isolated. This included moving into the area, having a different cultural background, no family involvement, concealing a pregnancy or giving up work and knowing no-one in the local community. This in turn led to low mood, feelings of depression and fear of developing postnatal depression.

The peer supporters encouraged women who were isolated to go to groups and meet other local parents. Parents found that having a focus in their week gave them a purpose to go out, rather than remain on their own. One isolated young woman expecting her first baby found this extremely useful:

> *"At the exercise class, I met the girl who I still hang around with now, which is lovely. At the time, it was just some reason to get up and get out of the house and I enjoyed it, I really enjoyed it. It was nice because new mums are invited back. So I met a couple of new mums with babies and you were able to ask questions there" (parent).*

One parent, referred to Parents 1st, had had postnatal depression with her first child and was concerned that she would have it again in the current pregnancy. She asked her counsellor if there was anyone who could give her more support because:

> *"I don't have a lot of family support, I said I wish that someone could be there for me, someone like a parent because I don't have a mum or dad that live close by" (parent).*

Following the birth of her baby, the parent did not experience postnatal depression, and she felt this was because the peer supporter helped her to be positive and gave her extra support on top of the professional services:

> *"It was that positivity that kept me going, and it was just someone to really listen to me and really understand what I was going through. She's*

been there for me to talk to, when other services aren't always available" (parent).

In particular, she appreciated the time given by the peer supporter saying:

"She was able to give me the time that I needed" (parent).

5.3 PROFFESIONALS' EXPERIENCE OF WORKING WITH PARENTS 1ST AND PEER SUPPORTERS

A range of professionals were interviewed, including midwives, counsellors and social workers. The majority of the professionals, who used the service or had heard about it from colleagues, were positive about peer supporters. They were pleased to have the option of offering extra support to their clients, especially if they worked in areas with high social need. They outlined a number of reasons why they thought the service was beneficial and added value.

A different type of support

Parents 1st peer supporters were perceived as being there to support the parent in a way that was different to the professionals' role. They were seen as part of the local community, as an informed friend and there to offer practical and emotional help. Some professionals felt it was an advantage for parents to have support of someone younger, who was outside the family and completely neutral from the statutory authorities. The role of peer supporter was described as someone who the parent can communicate with on the level of a friend, offering friendship to parents who may be socially isolated or lacking in confidence.

One professional recognised the non-judgemental approach of the peer supporters whilst acknowledging that colleagues could at times make judgements of clients based on their background knowledge. One mother had told the professional that she never felt judged by the peer supporter and that she had *"just felt safe".*

A peer supporter was seen as someone who could guide a parent through the unknown and help to build independence. The role had the potential to improve the birth experience and was described by one midwife, who attended a woman who had a Birth Buddy, as really reassuring to an anxious first time mother. She continued:

"(The mother) became much more confident going into labour, being a parent and a first time mum, and knowing she had friends out there" (professional).

Another midwife spoke of the value to the parent of having someone who had time to be with the parent and how this could improve the individual's

confidence and self-esteem. She recalled one parent who had a Pregnancy Pal:

> *"(Parent) who had peer support seemed to get more confident and a little bit more self esteem because someone was prepared to spend time with her. I think it gives a little boost of confidence – just having someone to spend time with you. A lot of people have a family around but they are all too busy doing their own thing" (professional).*

Bridging the gap between professionals and parents

Some professionals expressed the view that because parents perceived Parents 1st peer supporters as not being part of the formal, statutory services, they were less intimidating or threatening to vulnerable parents and more able to reassure and develop a parent's confidence. One professional explained the relationship between a peer supporter and a parent like this:

> *"I think (the volunteers) treat the parent with respect, (parents) don't find them intimidating or threatening because they are not from a statutory service. They give the parent so much reassurance and because they are meeting up with the parent regularly and they are there on the telephone, taking them out into the wider community and being part of the wider community with them…not being a professional that is walking into the home" (professional).*

One midwife described how a peer supporter acting as a Birth Buddy helped her in carrying out her professional role more effectively:

> *"It was a refreshing change to work with someone who complements your role" (professional).*

The peer supporter was described as very professional in her outlook and kept her boundaries well, whilst acting as a bridge between the professionals and the mother. She did this by looking after the mother's pastoral care.

Another midwife described her experience of working with a peer supporter when the parent had safeguarding issues. Parents 1st was part of a package of services, offering extra visits and support to the family. She described the impact on the family:

> *"It was really beneficial to the client as she was able to have someone who was less official, as it were, but who still fell into the agreement of supervision" (professional).*

Another professional felt the service filled a gap that, because of high caseloads, they were not always able to offer the level of support that vulnerable families need. One volunteer explained the bridge she built between parents and professionals:

> *"I feel really lucky to do this role because I don't have to make the (hard) decisions. I go in to support this mum with a completely non-judgemental view. I am there for her unconditionally to just listen and support her in what she needs at the time" (volunteer)*

Enabling access to other services

The valuable role of peer supporters in enabling parents to use other services, such as GP appointments and ante natal clinics was recognised by professionals. Professionals explained how their large caseloads, clinical responsibilities and limited time often prevented them from supporting mothers to attend sessions in the way they would wish. Peer supporters were able to introduce women to, for example, antenatal and exercise classes, breastfeeding support groups, and accompany them if required by the parent. One midwife explained:

> *"A couple of times she (parent) went to activities like yoga and shopping and stuff. Just having someone there with her was good – as much as midwives would like to do these things, it's near impossible" (professional).*

Other professionals acknowledged that taking clients to services was outside the limits of their role but through working in partnership with Parents 1st, that valuable service could be offered to clients:

> *"It is just not my role to go to baby massage, exercise classes or community groups with a woman. It really helps as you can see women are getting the extra bit of support that we are just not able to offer, well we are not experienced enough to offer that, so it is working in partnership with other organisations" (professional).*

Peer supporters who were volunteering with families with safeguarding issues, were able to attend the meetings and case reviews alongside Parents 1st staff. Their role was to support the parent to consider what is taking place and helping them manage their response to stressful situations. In one situation, this included supporting the parent to take time out to think when she needed to as opposed to reacting immediately and in anger.

Maintaining roles and boundaries

Parents 1st Birth Buddies and Pregnancy Pals service is a relatively new service and not very well known to local professionals working in the area. Whilst some professionals understood the volunteer role, there were inevitably misunderstandings and misconceptions of the role of the peer supporters, which had the potential to create tensions with professional staff. Some midwives were concerned that volunteers would act inappropriately because they were not clinically trained.

It was reported that some midwives had been concerned at peer supporters looking with parents at the patient held records and helping explain some of the terminology. They thought it was inappropriate for volunteers who were not clinically trained to explain medical terms and also that it could cause confusion for the parent. There was a strong feeling that it undermined the midwife's role. On another occasion a midwife thought the presence of the volunteer, who had accompanied a parent to a consultant's appointment at the hospital, was unhelpful when she appeared to contradict the doctor by suggesting to the parent that there may be other alternatives to consider. These examples demonstrate the need for further work in clearly understanding the role of the peer supporter and how that role is carried out in, for example, empowering women to speak out and make informed choices.

Similarly there had been reported occasions when the peer supporters felt ignored by the midwives. They were not acknowledged by the staff or recognised for the role they were playing. In another incident, a peer supporter had been refused access to visit a parent who had asked her for support with breastfeeding, because the ward had restricted visiting for non-family members.

Lack of clarity and knowledge of Parents 1st service

In part, the misunderstanding between the professional and volunteer roles and boundaries was due to a lack of clarity by professionals about the peer support service. The majority of the professionals involved in this evaluation did not know the content, breadth and range of the training undertaken by the volunteers. They also were mainly unaware of the extent of the professional support and supervision the peer supporters had from their organisation. One professional said:

> *"I didn't really know what was on offer and how it could help or what they were doing as opposed to what the midwives were doing" (professional).*

Some professionals were uncertain how to refer to the service although those who had worked with a Pregnancy Pal or Birth Buddy said they would not hesitate to recommend them to colleagues and *"spread the word".*

A few professionals, who identified parents they thought may benefit from extra support, found that the parents did not always want to accept the service. They thought this was because it was not always easy to explain what the service offered beyond having a friend to communicate with in pregnancy. One midwife explained that she found it difficult to put the service across to her clients even when she could see the advantage to them:

> *"I see ladies who would really benefit from having someone to talk to, give them a reason to go out, meet a buddy for a walk or go for a coffee*

– those bordering on depression or isolation and lack of self esteem. They can't visualise it or it's not the cultural norm, so you have to sell the idea" (professional).

This lack of clarity persists in spite of considerable effort by Parents 1st to explain the service to professionals. Presentations have been made to midwifery team meetings and dissemination of information through the midwifery managers and social care staff. One professional commented that there was a need to constantly remind midwives that the service exists. As the outreach service develops and volunteers are present in clinics alongside professionals, a clearer understanding of their role may emerge. Similarly, one professional suggested that more community development activities, reaching into communities and explaining the role directly to women, would be useful rather than an over reliance on professionals spreading the word.

Fragmented community services

Professionals expressed concern over what they perceived as the number of projects in the community designed to help vulnerable families. The professionals found it difficult to keep up to date with all the services, and to distinguish the differences between what was being offered by which organisation and by whom. There was a feeling of overlapping, duplicate services, which made it difficult to refer clients to the service that was right for them, although there was an acknowledgement that there was a need for extra support to some families. Some professionals also felt that when they did build up a relationship with a staff member or volunteer, that service may lose its funding or because of revised funding, begin offering a revised service. One midwife explained:

"We are bombarded all the time with new services to support vulnerable families, sometimes it's too much, there is overkill" (professional).

This issue is developed further in section 5.5 on key messages and learning.

5.4. WHAT IS DRIVING THE CHANGES FOR PARENTS, VOLUNTEERS AND PROFESSIONALS?

Sections 5.2 and 5.3 above present the impact of the Parents 1st Birth Buddy and Pregnancy Pal service on parents, volunteers and professionals involved in the programme. Section 5.4 looks at what is driving those changes and in what context, and sheds light on the different elements that are required to make up a successful peer support model of delivery. This is represented in appendix 1 in the model or theory of change diagram.

5.4.1 The peer supporter

One to one relationship

The one to one relationship between the parent and the volunteer is significant because parents felt that, often for the first time, there was someone whose primary interest was the parent. This for many was a new experience and they valued the fact that there was 'someone in their corner'.

> *"She has been there for me when I have felt no-one has been there for me apart from my husband" (parent).*

It gave them the opportunity to express their particular concerns and have those concerns taken seriously. This helped to give the parents confidence that what they said was important and this led to trust being built. A volunteer explained it this way:

> *"I go in to support the mum…I am there for her unconditionally to just listen and support her in what she needs at that time" (volunteer)*

Whilst it was recognised by the parent that the peer supporter was there for them and this was usually the mother, it also led to support for the whole family. Parents spoke of how the peer supporter through helping them also helped the family. One parent told us:

> *"She's not just been there for me, she's been there for the whole family and it's kind of kept us together a bit and kept us talking" (parent).*

There were examples of how the peer volunteers also supported fathers' individual needs. A volunteer was supporting a safe guarding case when the baby was taken into foster care shortly after the birth. When the mother wanted the father there when the baby was removed, the father felt he couldn't cope. The volunteer explained:

> *"I knew the mum really wanted him (father) there and it would benefit her and I knew that, but I'd got to respect him, he's got feelings around this. So I said to him: 'If you don't want to be here I completely understand, I am not here to put any pressure on you, this is your choice'." (volunteer)*

The volunteers tread a careful path between taking on the role of a friend who develops trust and support with another person whilst maintaining clear boundaries on what they can and cannot do. Also, the relationship is time limited because the peer supporter ends their involvement at three months after the baby is born. The volunteers were aware of the boundaries between being a friend and raising expectations and they looked for ways to enable isolated parents to find their own friends in the community.

The Parents 1st service also creates opportunities for parents to come together through the fitness classes and antenatal sessions so that parents can meet and get to know each other. Parents are encouraged to share experiences with each other and develop friendships with other local parents. Thirty fathers also attended the antenatal classes giving them an opportunity to meet other men about to become fathers.

The approach

The volunteers are trained to empower parents, rather than create a dependency culture. They do this by engaging and actively listening to what the parents want and being clear that nothing they say is irrelevant or unimportant. They show respect for each parent's particular needs and wishes, and make it clear they were not there to judge the parents, or to be concerned with issues in the past. One volunteer working with a parent who was in the social care system, explained it this way to the parent:

> *"I don't care about your past, I'm here for you in the 'right here' 'right now', in how I can help you now. My role was different from others because I didn't have an agenda and when she realised I was there just for her, that made it a very different relationship for her, and one she could talk in and confide in" (volunteer).*

Empowerment is achieved by working with parents to set their own goals that are realistic and achievable, however small those steps may appear to others. The volunteers affirm the parents' choices by helping them in their choice of goals. At each meeting between parent and peer supporter, progress towards the goals are assessed and reaffirmed, and if appropriate, new ones are set. An example of how setting goals is carried out was given by this volunteer:

> *"The whole idea is what we're meant to do is, with the mums, set goals. So if for example, they're not getting out, we say to them, even if you just put the baby in the pushchair and walk up the road for 10 minutes and then come back, you've got out for 10 minutes" (volunteer).*

Part of the local community structure

Peer supporters first and foremost are part of the local community and parents recognise that local connection. The volunteers are respected for their local knowledge, and are seen as reliable, credible sources because they understand 'how things happen around here'. The fact that peer supporters are also mothers was important and parents had confidence that they know what is available for parents in the area.

Similarities in age between volunteer and parent appeared less important, as did differences in race and ethnicity, although this would benefit from further investigation. The age of the volunteers' children also did not appear significant. One volunteer spoke of how she tried to 'mould' or adapt the way

she presented herself so that parents felt comfortable and able to accept her. Examples of how she would do this included what knowledge and experience she shared with parents and in the way she dressed.

Parents 1st is committed to a volunteer model of delivery, recruiting people from the local community. Being a peer supporter increased opportunities for volunteers in the community to develop their own confidence and self worth, and the opening up of opportunities to do further training or gain employment.

Bridging the gap between professionals and families

A key driver for change leading to the improved outcomes for parents and families was the role of the peer supporters in bridging the gap between local professionals and the families.

In some cases relationships with professionals may be difficult and parents found it hard to discuss their concerns and worries with them. There were several reasons for this including a misunderstanding of the professional's role or lack of time to build up a relationship:

> *"Being my first baby, I didn't know what a midwife is supposed to do. (Volunteer) helped me there because I would ask her questions I should have asked the midwife, but I didn't have a relationship with her" (parent).*

In some cases there was a history of poor engagement with professionals and in some cases professionals have to make judgements, for example in safeguarding issues, which go against the parent's wishes. The peer supporters have clear ground rules, through their training in safeguarding, but the evidence shows that they can help the parent to express their concerns or, because of the trust built up in the relationship, can support the parent in starting to accept difficult decisions. The role of the peer supporter is different from professionals because as one volunteer described it *"I did not have an agenda"*. A professional involved with a mother who had social care issues explained:

> *"The Parents 1st service offers a good source of support; the volunteers build up a rapport, bridges that gap between the professional role and the mum. We are seen as the enemy!" (Professional)*

5.4.2 The Organisation: Parents 1st

Values and beliefs

The role and organisation of Parents 1st is a key driver in enabling significant impact for parents and families. The organisation is underpinned by a clear set of beliefs and values, which recognises that parenting is the most important job there is and that every child in society matters. It believes in social justice

for all and is committed to convincing others of the value of the peer approach. These values and beliefs filter through the whole organisation, offering a nurturing environment to the staff team and volunteers. In turn this empowers the volunteers to carry out their role confidently with parents. One stakeholder summed up the view of others:

> *"When you actually look at the characteristics of empowerment which are about sharing knowledge, growing together, working collaboratively, respecting each other and assertiveness. All these characteristics that make up an empowered community they (Parents 1st) actually model them. They model speaking to people appropriately and valuing them as equals and they model respect and diversity and they model consultation. THEY DO IT, that is what they do and that is what they are good at!"* (External stakeholder)

For example, when selecting parents into the service, Parents 1st do a home visit to potential parents for one to one support, looking for vulnerability which includes social isolation, homelessness, drug or alcohol issues, those experiencing domestic abuse or had a previous birth that was quite difficult. Having said that they also try to balance the specific issues against self-assessment and if the parent feels they really need the support:

> *"If the parents assess themselves as needing extra support we need to look at doing that and balance it against the people funding the programme who want this intensive support to be accessed by those who really need it" (Parents 1st).*

Recruitment and training

A robust recruitment strategy is in place for selecting volunteers who are suitable to become peer supporters. Parents 1st have built on their experience of recruiting volunteers to ensure they have people with the right personal qualities and commitment. They do this by constantly reviewing their information and carefully filtering the applications received against specific criteria. Taster courses are set up which are a two way process between the organisation and the volunteer to see if they are the right fit for each other, and help to ensure resources are not wasted; following the taster session interested applicants are interviewed, ensuring that all the processes for recruiting volunteers are in place such as Criminal Records Bureau (CRB) checks and references followed up.

Once selected, volunteers undertake a unique training specifically designed by Parents 1st. The City and Guilds 3559 Award in Work with Parents is integral to the package and leads to a level 3 qualification, as well as the Open College Network Breastfeeding Peer Support skills qualification.

There is a programme of on-going training which builds on and refreshes areas covered in the introductory training programme, for example preparation

for birth, breastfeeding, peer support, boundaries and ground rules, communication and listening, home births and vaginal births after caesarean sections.

Volunteers can request topics where they feel they would benefit from further training and recent topics identified include grief counselling, postnatal depression and insights into Social Care.

There are also opportunities for volunteers to access external training and development opportunities and they are encouraged to take these up, often with financial support from Parents 1st. Examples of external training include local authority safeguarding and child protection training, local community based training programmes, as well as conferences and events.

Parents 1st have demonstrated their commitment to volunteering by being awarded the Investing in Volunteers Kite Mark awarded by Volunteering England. This involved an in-depth assessment of how the organisation recruits, trains, manages and supports its volunteers (9 quality standards).

Supervision and support

There is a structured programme of supervision in place for all the volunteers; this includes monthly group supervision and for those volunteers carrying out individual support there is also one to one supervision.

There are a number of levels of support for the volunteers, which enables them to carry out their role sensitively and with confidence. All Birth Buddies have a 'back-up' volunteer in case the first volunteer, for whatever reason, is unable to be present at the birth. The volunteers also support each other and create opportunities to get together and share experiences.

> *"Also the other volunteers, we chat to each other a lot – maybe if you just want someone's advice or their thoughts on something so you really, really are well supported. I would definitely say that there should be no volunteer who should ever feel that they don't know what to think or don't know what to do because there is always someone at the end of the phone" (volunteer).*

The staff team at Parents 1st make the original introductions to the parents and accompany the volunteer on the first visit. Volunteers are carefully matched with families through the assessment visit, and a through risk assessment carried out with the volunteer. One to one support and supervision is put in place and at the end of the volunteers' support to the family, an evaluation is completed with the parent and volunteer.

The staff team have two experienced health visitors who support the volunteers with child protection and safeguarding issues, offering guidance to the volunteer, reaffirming their role and attending case reviews with them. The

volunteers feel confident carrying out their work with more vulnerable families because of the level of support that is provided by the organisation.

Building an organisational learning culture

Parents 1st are committed to measuring the impact of their work and have developed a number of evaluation tools across all areas of their service, including the training (example in appendix 5), volunteer diaries and feedback from families. The volunteers' feedback can be quite extensive including long records of the birth experience from Birth Buddies. All of the existing data can be used for organisational learning and development.

They have put in place systems to capture relevant numerical data. The development of tools that are simple to use and easy to extract data from is a current priority and work in progress for Parents 1st who continue to develop and refine this process through a self-assessment tool and database currently nearing completion. They are also investing in data monitoring and analysis to support this work and ensure that current information on parents worked with to date is being fully analysed.

Their commitment to an external evaluation is another example of how they strive as an organisation to learn from and improve what they do. This has included four learning events with the staff, board, volunteers and external partners to comment and refine the emerging findings and explore ways to take the learning forward in the organisation.

5.5 SUMMARY OF KEY MESSAGES AND LEARNING FROM THE PREGNANCY PAL AND BIRTH BUDDY SERVICE

Evidence in the report shows that the service is effective in preparing families confidently for birth and parenthood in the first 3 months of life. Parents involved in the programme had better birth experience, felt more in control and were better informed. Parents built up their parenting skills and there were indications of improvement in the health and wellbeing of parents and their children. In particular there was an increase in mothers initiating breastfeeding and continuing to breastfeed at 6 to 8 weeks. The reduction in social isolation and opportunities to network locally with other parents was a key factor.

The programme is inline with the drive to promote prevention and early intervention initiatives, particularly in the areas of mental wellbeing and the initiation of breastfeeding.

The volunteer peer supporters developed their self-esteem and self worth, and their experiences opened up opportunities for more community involvement, training and employment.

As with all complex social change programmes, some useful learning has emerged that could be considered in future expansion and development of the

programme. We suggest 4 key areas for future exploration.

5.5.1 Getting the message 'out there'

Parents 1st is a new Social Enterprise that is building on previous work carried out by the Director with the NHS locally[36]. Parents 1st has developed at a fast pace over the last two years and has focused on getting its internal systems and processes in order, as well as developing the business case for embedding in local structures.

The evidence offered in this report gives an ideal opportunity now to move forward and market the peer support approach confidently and more intensively. Many of the professionals we spoke to for this evaluation did not know the extent of the recruitment, training and supervision of the volunteers, and were uncertain of how Parents 1st differed from other family support services.

Referrals from professionals are one of the routes to engaging parents and a clear simple message that professionals can pass on to the parents would be beneficial and ensure that within restricted appointment timeslots professionals were equipped to make the Parents 1st offer and represent the service in a concise and clear way.

Information can be channelled through professionals who had positive experiences of working with Parents 1st and would be able to give first hand knowledge to their colleagues. Developing dialogue with professionals who have had a Parents 1st experience and encouraging them to feedback to their colleagues or sending them a regular newsletter will support building professional networks and spreading success stories and encourage more recommendations by word of mouth between professionals.

Ways of increasing self-referrals is considered in the next key message on community engagement.

5.5.2 Adopting a community development approach to outreach

One of the challenges for the programme is how to reach and engage parents, particularly pregnant women, who would benefit most from the extra support of a peer volunteer. A structured programme of outreach services is now in place with three previous volunteers employed for 45 hours a week. The focus of the outreach service has been to take information and engage with parents in areas where professionals are working, such as antenatal clinics at GP surgeries, midwives clinics in hospital and more recently at the hospital ultrasound scan department. This has helped to make the service more visible to professionals and offered opportunities to promote the fitness classes, antenatal sessions and one to one peer support.

[36] Thurrock Community Mothers Programme in Tilbury

Evidence from the evaluation shows that peer volunteers are valued by parents because they are parents themselves from the local community and this is one of their distinctions from professionals. It is possible that by outreach solely having a presence in professional arenas such as doctors surgeries and hospitals confuses the Parents 1st message that their service is different to the one offered by professionals. We would suggest that a natural next step for the Parents 1st outreach work would be to build on volunteers' community connections through an approach that is based on community development.

The outreach workers could get to know in detail what is happening in a particular neighbourhood, for example, which groups exist, who runs them, who goes, local schools contacts, local churches and mosques. Specialist community groups such as young parents (one is to begin shortly run by Basildon and Thurrock University Hospital NHS Foundation Trust in Grays and Basildon), children with disabilities and ESOL classes would be other sources of local contacts and reaching expectant parents. This would also enable the outreach workers to link in with particular initiatives and area based programmes such as Pitsea Broomfields, one of the new Big Local programmes[37]. Each Big Local area aims to build communities and have a Local Partnership and this kind of programme could be an ideal vehicle to support Parents 1st in reaching communities.

This approach would enable Parents 1st to move forward from being a service that can respond to referrals or be contained within health settings or Children's Centre to one that is embedded within the community. It may also be something that could be developed in terms of a Reaching Communities bid to the Big Lottery as a way of expanding and sustaining the current outreach team.

5.5.3 Working in co-production with professionals

The two sections above have suggested ways for making the Parents 1st message clearer and reaching groups of parents who would benefit most from the service. Referrals from professionals both in the NHS, social care and other Third Sector organisations is however an important mechanism for parents to engage with Parents 1st.

Considerable efforts have been made by Parents 1st to engage with professionals and spread the message of what they offer, but as section 5.3 above illustrates this has been a difficult task. The number of referrals from midwives is beginning to increase but closer working together has the potential to develop that further as professionals and Parents 1st staff and volunteers gain a greater understanding of each other's roles, strengths and opportunities.

[37] http://www.localtrust.org.uk/?project=pitsea-broomfields

Co-production[38] can be carried out in a number ways but is based on an equal relationship and equal power. For example, opportunities to co-train on volunteer and midwives training courses would be beneficial; shadowing each other for a day and joint working groups exploring ways to support parents in the community are other examples of co-production in practice.

5.5.4 Working with commissioners

One of the issues raised in this report is the number of services available in the community to support families and children. However, there is an apparent lack of clarity, particularly among professionals, as to how these services operate and work together. It would be an advantage for commissioners to work more closely with local providers, that is statutory, voluntary and social enterprise organisations, and look across the whole spectrum of support that is required. Services could then be commissioned that provide support on a number of different levels with clear pathways and referral routes in place.

The implementation of the Health Visitor's Plan and the introduction of the MECSH (Maternal Early Childhood Sustained Home-visiting) programme (discussed in section 6 below) are examples of how a continuum of support can be developed in local areas.

A wider policy issue is that with the level of austerity cuts, services may close longer term and more sustainable funding streams are required if a continuum of support to vulnerable families is to be maintained. The recent report[39] on the civic unrest in Britain in August 2011 recommends that for public services, early intervention is key. The report makes 63 recommendations, including building positive relationships between adults and children. It suggests that:

> *"Local public services look at ways, such as the Community Mothers Programme, to ensure the community can become engaged in supporting children in their neighbourhoods" (Recommendation 6; After the Riots)*

[38] NESTA: "Co-production is a new vision for public services which offers a better way to respond to the challenges we face - based on recognising the resources that citizens already have, and delivering services *with* rather than *for* service users, their families and their neighbours. Early evidence suggests that this is an effective way to deliver better outcomes, often for less money". Viewed May 16th 2012: http://www.nesta.org.uk/areas_of_work/public_services_lab/coproduction

[39] *After the Riots: Final report by the Independent Riots Communities and Victims Panel,* http://riotspanel.independent.gov.uk/ March 2012

6. MEASURING ECONOMIC AND SOCIAL IMPACT[40]

The need to measure the impact of interventions and show value for money has never been so important as in the current environment of reduced funding. The Allen report[41] on early intervention was clear that early intervention investment has the potential to make massive savings in public expenditure, reduce the costs of educational underachievement, drink and drug abuse, teenage pregnancy, vandalism and criminality, court and police costs, academic underachievement, lack of aspiration to work and the bills from lifetimes wasted while claiming benefits. Just a small part of these savings will be required to pay back public and private investors for the outcomes they will achieve. The report concludes that:

> *"Early Intervention investment will not only repay all of its investors, public and private, but make enduring reductions in public expenditure".*

This evidence makes a powerful case for scaling up the early intervention, volunteering model developed by Parents 1st.

A number of measures are emerging for measuring the social impact of third sector organisations. However, research shows that despite considerable interest from funders and public policy towards social impact measurement, there is still considerable diversity within the third sector with regard to its take up and approaches. This, researchers argue, is due to the different motivations of organisations but also competition between different approaches to assessing impact, such as social accounting, social return on investment[42], cost benefit analysis and a wide range of other labels[43].

Parents 1st have started using these approaches to measure social impact. As part of the NESTA Innovation project, Parents 1st carried out a case study[44] to assess the costs of a model based on the early intervention model to show whether early intervention is more cost effective than crisis intervention. The calculations, using a social return on investment (SROI) methodology, showed that for every £1 organisations spent on supporting volunteers, they received an average return worth between £3 and £8 dependant on the number of parents volunteers support. The return on investment using the SROI methodology for Parents 1st was approximately £7 per volunteer. The total cost of recruiting, training and supporting a volunteer to become a Pregnancy Pal and Birth Buddy is £1243. Some of the financial proxies used within the model were reduction of ante-natal appointments not attended because of

[40] Figures for Parents 1st supplied by Parents 1st
[41] Allen, G (July 2011) *Early Intervention: Smart Investment, Massive Savings The Second Independent Report to Her Majesty's Government*, HM Government
[42] New Philanthropy Capital 2010, *Social Return On Investment Position Paper*,
[43] Lyon, F and Arvidson, M (2011), *Social impact measurement as an entrepreneurial process,* Briefing paper 66 Third Sector Research Centre
[44] Carried out by Margaret Hornsby, Policy Consultant, 2011

the volunteer support (calculated on £200 per appointment missed) and increase in breastfeeding reducing costs to the NHS by approximately £100 per week per baby for every week additional breastfeeding achieved through the volunteer support.

In the Allen review, the investment benefit-to-cost ratio for Early Intervention data in the US suggests that £40 million invested in positive parenting interventions could save £400 million over a 15-year period. An independent review has placed the average economic benefits of early education programmes for low-income 3 and 4-year-olds close to two and a half times the initial investment: these benefits take the form of improved educational attainment, reduced crime and fewer instances of child abuse and neglect.

Parents 1st has a particularly important role to play in building social capital by nurturing social networks within disadvantaged communities and empowering volunteers living within those communities. The economic cost of widening health inequality is drawn out in the Marmot Review Report[45] including three papers on the economic costs of health inequalities[46]. The report reminds us that:

> *"Health inequalities are largely preventable. Not only is there a strong social justice case for addressing health inequalities, there is also a pressing economic case. It is estimated that the annual cost of health inequalities is between £36 billion to £40 billion through lost taxes, welfare payments and costs to the NHS".*

Parents 1st is continuing to develop methods of measuring their social and economic impact using evidence of their impact in early intervention activities. It will also be an important dimension in the establishment of collaborations with other organisations. Recent feedback was encouraging from the Social Innovation Pioneers[47] initiative which was impressed with how Parents 1st specified the impact they have had through their activities; the next step was to develop more data around social impact. The current potential of Social Impact Bonds offers a promising way forward for future sustainability[48].

[45] Marmot, M (2010) Fair Society, Healthy Lives: The Marmot review, UCL Institute of Health Equity

[46] http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review (viewed October 15th 2012)

[47] http://www.deloitte.com/view/en_GB/uk/about/community-investment/social-innovation/index.htm (August 23rd 2012)

[48] Margaret Hornsby, Policy consultant 2012

6.1 Examples of a benefit-to-cost ratio

Parents 1st provide in depth rigourous, quality assured volunteer training. The total cost of recruiting, training and supporting a single cohort of 12 new Pregnancy Pal/Birth Buddy volunteers is £14,920 (i.e. recruitment, taster course, mentoring, foundation training, assessments, observations and internal verifying to gain their City & Guilds Level 3 Award in Work with Parents and OCN Breastfeeding Peer Support qualifications).

The cost of training a single volunteer is therefore £1243. The volunteer retention rate at the end of a year is high at 70%. Each volunteer provides intensive one to one support through pregnancy, birth and post-birth to an average of 3 vulnerable families per year.

The following table gives an example of the return on the £1243 investment in terms of the number of years a volunteer stays and the number of vulnerable families supported. The cost per family in terms of training a volunteer reduces the longer the volunteer stays with Parents 1st.

Number of years volunteer stays	Number of families supported per year	Total families supported	Cost per family supported in terms of the cost to train a volunteer
1	3	3	£414
2	3	6	£207
3	3	9	£138

A detailed case study carried out by Parents 1st of one of the families supported by a volunteer identified that 78 hours of volunteer support had been provided to the family (the mother had suffered abuse as a child, postnatal depression and a traumatic birth with her previous baby).

The wider gains for each volunteer also need to be considered e.g. gaining 2 national qualifications, new life skills and self-confidence, and improved access to employment.

Parents 1st can begin to demonstrate other cost savings to statutory provision, private investors and the public purse through comparing their unit cost against a number of indicators linked to the social impact of their work. These compare the potential costs that are incurred through **not** investing in prevention and early intervention in the early years. For example:

Breastfeeding

Section 5.2.4 identifies a marked improvement in breastfeeding rates for mothers receiving Parents 1st one to one peer support. A cost effective

modeling exercise by NICE[49] found that peer support which achieves a relatively high increase in breastfeeding rates saves the NHS money, because levels of hospitalisation of babies drop, breastfed babies grow up into healthier children and adults, fewer women develop breast cancer, and less has to be spent on infant formula. This is achieved at an estimated 20 percentage point increase in breastfeeding initiation. Where only 20% of mothers currently initiate breastfeeding, an increase to 40% or more would be cost saving. So too would be the increase from 60% to 80% or more.

Looked after children

The total cost of looking after a child without any additional support needs, who remained in the same authority foster placement for 20 months was £35,106. The total cost for a child with emotional and behavioural difficulties was more than six times higher, £215,756[50].

Welfare benefits[51]

The average cost of an individual spending a lifetime on benefits is £430,000, not including the tax revenue. It cost £1243 to train a volunteer, and evidence in this report shows that becoming a peer volunteer was a pathway to employment opportunities. Outcomes for the families supported by the volunteers in terms of increasing value in the way benefits are spent also warrants further investigation e.g. spending more wisely, debt reduction, reduced smoking, healthier eating, increased potential to enter employment etc.

Youth unemployment

The cost of each additional young person not engaged in education, employment or training (NEET) is approximately £45,000[52]. The productivity loss to the state as a result of youth unemployment is estimated at £10 million every day[53].

Parents 1st volunteer training has included teenage volunteers. Section 7.2 identifies the potential for growth for Parents 1st in this area to benefit vulnerable teenage parents graduating from the Family Nurse Partnership programme.

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[49] Jacklin P (2007) *Modeling the cost effectiveness of interventions to promote breastfeeding,* NICE Maternal and Child Nutrition Programme

[50] NICE public Health Programme Guidance 28 (October 2010): *Promoting the quality of life of looked after children and young people, costing report,* National Institute for Health and Clinical Excellence

[51] Allen, G (July 2011) *Early Intervention: Smart Investment, Massive Savings The Second Independent Report to Her Majesty's Government*, HM Government

[52] Allen, G (July 2011) *Early Intervention: Smart Investment, Massive Savings The Second Independent Report to Her Majesty's Government*, HM Government

[53] Allen, G (July 2011) *Early Intervention: Smart Investment, Massive Savings The Second Independent Report to Her Majesty's Government*, HM Government

Criminal Justice System

The evidence of potential cost savings to the public purse if secure infant attachments are developed between parents and babies from birth and during early infancy is overwhelming[54]. The one to one support provided by Parents 1st volunteers during this critical time when vulnerable parents are developing relationships with their babies is another key area for demonstrating cost benefit. A young person who starts showing behavioural problems at age five, and is dealt with through the criminal justice system will cost the taxpayer around £207,000 by the age of 16. Over £113 million a year would be saved if just one in ten young offenders were diverted towards effective support[55].

Mental health[56]

Thirty-three percent of referrals to Parents 1st peer supporters were socially isolated. Those involved in the evaluation identified low mood, feelings of depression and fear of postnatal depression. The support provided had reduced social isolation, built up new friendship groups and had provided networks for social support. The costs associated with mental health problems in the UK are estimated at £105.2 billion. This represents an increase of 36 per cent since 2002–03 and an increase in the health and social care share of these costs of over 70 per cent.

The final chapter explores how Parents 1st may move forward to increase its social impact.

[54] Allen, G (January 2011) *Early Intervention, The Next Steps,* An independent report to Her Majesty's Government

[55] Community Links (November 2011): The Triple Dividend: Thriving lives. Costing less. Con tributing more. The first report of the Early Action Taskforce, http://www.community-links.org/earlyaction/the-triple-dividend/ (Viewed October 15th 2012)

[56] Allen, G (July 2011) *Early Intervention: Smart Investment, Massive Savings The Second Independent Report to Her Majesty's Government*, HM Government

7. GOING FORWARD: INCREASING THE SOCIAL IMPACT

7.1 SCALING UP

Parents 1st has ambition to scale up beyond delivering small scale, local services and to increase its social impact at a national level. This is not an uncommon goal in the social enterprise sector and is seen as taking a programme that has helped to resolve a problem in a limited way and then scaling it up so that the programme's impact on society becomes wider (i.e. helps more people in more places) and deeper (i.e. reduces the negative effects dramatically)[57].

The impact of Parents 1st peer volunteer programme in the early years is increasing through new internal activities and more sites, such as working with more NHS organisations and local authorities in Essex. It can also be as a result of growth beyond the organisation, such as the Parents 1st City and Guilds Accreditation Centre and supporting a national network whilst influencing the spread and quality of the approach. In spite of tough political and operating conditions in an austerity climate, Parents 1st are developing internally and its external influence is increasing in the UK. This development is due, in most part, to a strong, visionary leader and a dedicated team of directors, staff and volunteers who are driven by a clear set of values and beliefs.

The organisation strives to understand and measure its impact through a commitment to evaluation, continuing to refine and improve its data collection and through creating a learning environment, both internally and with local and national stakeholders. Demonstrating measurable outcomes is essential if the ambition to scale up is to be achieved.

7.2 A CONTINUUM OF SUPPORT TO VULNERABLE FAMILIES AND COMMUNITIES

Growth of Parents 1st will depend on clarifying the role of peer support volunteers and their unique contribution to supporting vulnerable families and communities in the early years of pregnancy and parenthood. A number of structured services models are developing to support families and communities in the early years, and here we look at four of those and how Parents 1st complements and supports these initiatives: the Healthy Child Programme and the Health Visitor Implementation plan, the roll out of the Family Nurse Partnership (FNP) Programme and the Essex pilot of the Maternal Early Childhood Sustained Home-visiting (MECSH) programme.

[57] Lyon F and Fernandez H (2012) *Scaling up social enterprise: strategies taken from early years providers Working Paper 79,* Third Sector Research Centre

The Healthy Child Programme for pregnancy and the first five years of life[58] in 2009 focuses on a universal preventative service, designed to offer a core, evidence based programme of support starting in pregnancy and the early weeks of life and throughout childhood. It provides families with a programme of screening, immunisation, health and development reviews, supplemented by advice around health, wellbeing and parenting. It is led and delivered by health visitors who are responsible for its quality and outcomes. There is an emphasis in the programme on integration and alignment of early years services.

In order to develop the capacity of health visitors to deliver the Healthy Child Programme, the Health Visitor Implementation plan[59] set out a call to action to expand and strengthen health visitor services. In 2010 the Coalition government gave a commitment to increase the numbers of health visitors by 4,200 (over 50 per cent) by 2015. The latest progress report[60] shows that progress to deliver these numbers is in line with the government's expectations.

Essex[61] has become a year two Early Implementation Site, giving Parents 1st an ideal opportunity to work locally with the Strategic Health Authority and demonstrate how volunteer supporters are an important part of the delivery of the new health visiting service. In particular it can demonstrate how it contributes to a package of services supporting families with complex needs (Universal Partnership Plus) and how it can enable communities to provide support for themselves (Your Community). The Implementation Plan also has a Health Visitor Communities of Practice - local networks of health visitors and other interested professionals who support the delivery of services to children, families and their communities. These networks will be used to support the delivery of the service commitment and would be a useful opportunity for Parents 1st to promote and expand their service.

The Family Nurse Partnership is a voluntary, preventive programme for vulnerable young first time mothers. It offers intensive and structured home visiting, delivered by specially trained nurses, from early pregnancy until age two[62]. It is a licensed programme based on evidence from the United States and the license sets out core model elements covering clinical delivery, staff competencies and organisational standards to ensure it is delivered well. The evidence is being strengthened in the UK through a formative evaluation of

[58] Department of Health (2009) *Healthy Child Programme: pregnancy and the first five years of life,* Department of Health

[59] Department of Health (2011) *Health Visitor Implementation Plan 2011-15*, Department of Health

[60] Department of Health (2012) *Health Visitor Implementation Plan: Quarterly Progress Report – April-June 2012*, Department of Health

[61] Essex North and South Cluster comprises: South East & West Essex; Anglia Community Enterprise and Community Interest Company, Central Essex Community Services and North East London Mental Health Foundation Trust.

[62] Department of Health (July 2012) *The Family Nurse Partnership Programme: Information Leaflet,* Department of Health

the first 10 sites in this country[63] and a large scale randomised control trial[64], involving 18 of the sites, is underway. The Government made a commitment in October 2010 to double the number of places on FNP to 13,000 by 2015. There are now around 9,000 places in 74 teams in 80 local areas.

FNP complements and supports the Healthy Child Programme and as the programme rolls out throughout the UK, it will be necessary for Parents 1st to clarify with commissioners as well as communities how the peer volunteer model can work with FNP in delivering the Healthy Child Programme. One suggestion is that the 'graduates' of the programme can become peer supporters in their communities, supporting other vulnerable parents.

Fourthly there is the MECSH Programme[65], which is a structured home visiting programme for families at risk of poorer maternal and child outcomes. Child family health nurses who are embedded within universal child services deliver the service. It forms part of a comprehensive integrated approach to services for young children and their families. East of England is the first UK Health Authority to pilot the model and it is being rolled out through the whole of Essex. All health visitors in Essex are to receive 5 days training and it forms part of the Universal Partnership Plus level for families with complex and challenging needs. This provides Parents 1st with another opportunity to work closely with the development of MECSH and collaborate with commissioners to integrate the peer volunteering model into the training modules.

7.3 COLLABORATIONS AND PARTNERSHIPS

Parents 1st will continue to develop its partnerships and collaborations in order to maximise its impact. Collaborations such as the one described in section 2.2 are excellent examples of this in practice. Partnerships with other third sector organisations working in the pregnancy and early years arena are essential and Parents 1st is well placed to facilitate and grow those partnerships.

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63 Barnes, J et al (2008) Nurse-Family Partnership Programme: First Year Pilot Sites Implementation in England, London DCSF. www.education.gov.uk/research/data/uploadfiles/DCSF-RW051%20v2.pdf
Barnes, J et al (2009) Nurse-Family Partnership Programme: Implementation in England – Second Year in 10 Pilot Sites: the infancy period. London DCSF. www.education.gov.uk/research/data/uploadfiles/DCSF-RR166.pdf
Barnes J (2011) The Family-Nurse Partnership Programme in England: Wave 1 Implementation in toddlerhood and a comparison between Waves 1 and 2a implementation in pregnancy and infancy. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance /DH_123238

64 The independent randomised control trial is being led by the South East Wales Trials Unit at Cardiff University in collaboration with Universities of York, Bristol and Glamorgan.
The study, known as 'Building Blocks', will assess whether FNP benefits women, children and families over and above usual services as well as its cost effectiveness in the UK and is due to report initial findings when the children are aged 2 in early 2014. http://medicine.cf.ac.uk/primary-care-public-health/research/early-years/current- projects/building-blocks/

65 *Maternal Early Childhood Sustained Home-visiting: MECSH at a glance:* University of New South Wales, Undated

7.4 BUILDING SUSTAINABLE COMMUNITIES

Parents 1st have demonstrated the importance of engaging local parents in communities to support each other and how this can increase parents' confidence and their ability to access local services. This is supported by other research[66] that shows many professionals lack confidence in working with parents, and that volunteers from the local community with similar life experiences who work alongside professionals can bridge the approachability gap.

The Coalition government has shown a commitment to building the capacity of communities to support themselves through policy drives such as the Big Society and the Localism agenda. There is also a growing recognition of the need for early intervention and preparing for pregnancy if the cycle of deprivation is to change and health inequalities be addressed. The recent report of the Independent Review on Poverty and Life Chances[67] states that:

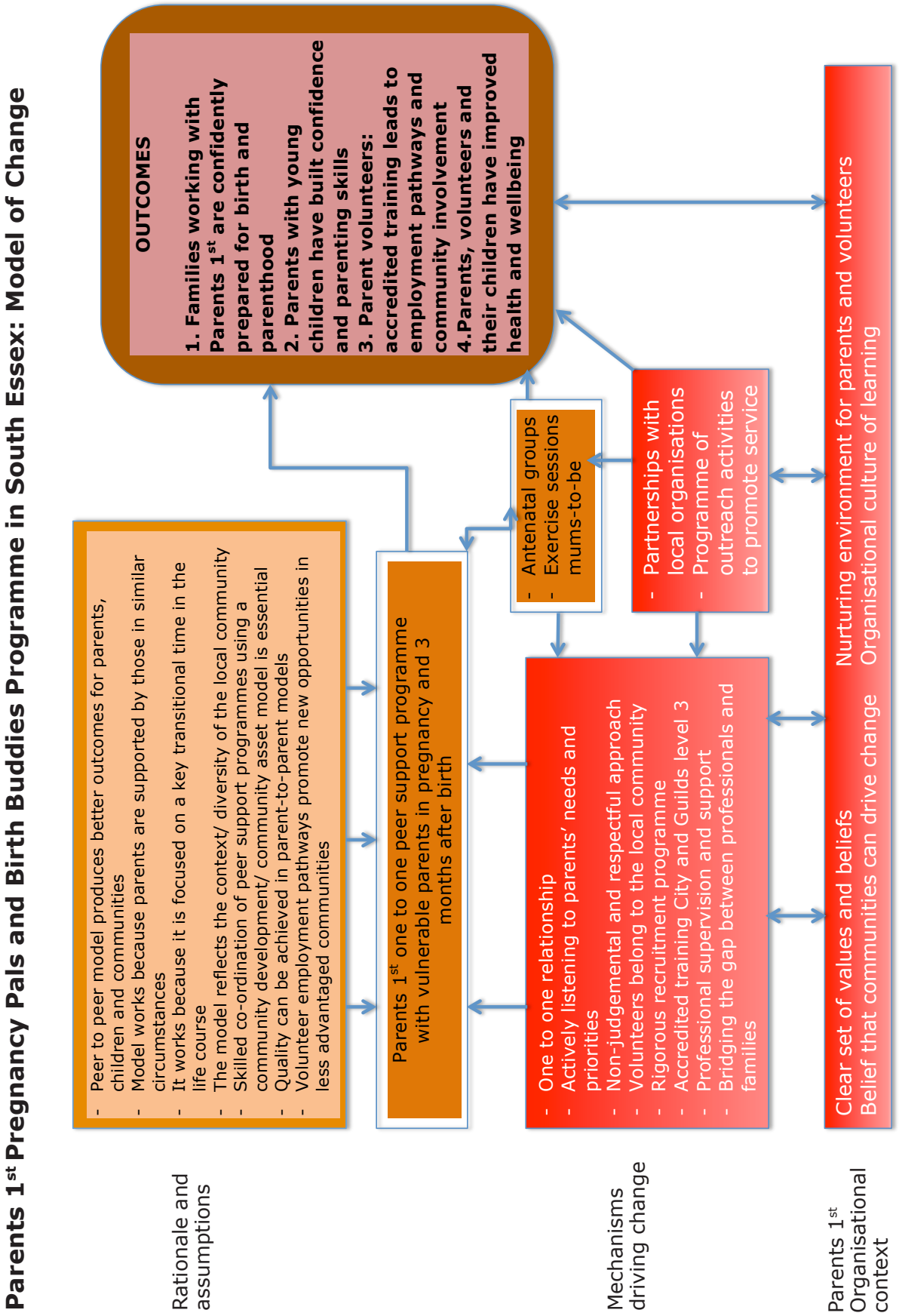
> *"Later interventions to help poorly performing children can be effective but in general, the most effective and cost-effective way to help and support young families is in the earliest years of a child's life".*

Organisations working with communities, such as Parents 1st, are well placed to take this forward. As the health inequalities gap widens in the UK[68], there is a greater need to develop mechanisms for sustaining communities through building social networks, encouraging people to join voluntary and community groups, nurturing inclusivity and enabling everyone to make a contribution[69].

> *"Family, neighbourhood, community are the Core Economy. The Core Economy produces love and caring, coming to each other's rescue, democracy and social justice. It is time now to invest in rebuilding the Core Economy" (Edgar S Kahn, Civil Rights lawyer, social innovator and founder of Timebanking).*

[66] C4EO (2010) *Grasping the nettle: early intervention for children, families and communities,* C4EO.
[67] Frank Field (2010) *The Foundation Years: preventing poor children becoming poor adults,* Independent Review on Poverty and Life Chances
[68] Buck D and Frosini, F (2012) *Clusters of unhealthy behaviours over time: implications for policy and practice*, The Kings Fund
[69] Wilton C (2012) *Volunteering: unlocking the wealth of people and communities,* Think Local Act Personal, In Control, CSV, ADASS and SCIE

Appendix 1: Theory of Change diagram



Appendix 2: Evaluation Questions

As a result of the early intervention focusing on Pregnancy, Birth and the 3 month post birth period:

1. What changes (outcomes) have occurred for parents and their newborn babies? Did they have a positive birth experience? Is there a strong bond developing between parents and babies? Have parents been engaged at an earlier stage in pregnancy?

2. Is breastfeeding established among the client group? Are the babies totally or partially breastfed at 6 weeks? What has been put in place to encourage breastfeeding? What impact has the programme had on breastfeeding initiation and continuation rates in the areas it is operating in?

3. Who has the programme reached and engaged with? Would those reached have otherwise accessed support services? What happens after the 6 weeks intervention? What are the referral mechanisms?

4. Are the parents well prepared for parenthood? How has being part of the programme contributed to this? What did not work and why?

5. How has being a volunteer on the programme influenced the parenting of the volunteer? What has been the impact on their children and families? Is there evidence of changes in nutrition, smoking and physical activity among the volunteers and their families?

6. What is the quality of the training and supervision provided to the volunteers? How does this impact on the quality of support provided to expectant parents?

7. What has worked well with the antenatal model? What has worked less well? How does it fit with other early intervention programmes? What is unique about what is being offered?

8. How has the programme complemented the work of professionals such as health visitors and midwives? Are there any overlaps or gaps?

9. How is the programme supporting the work of GPs? Is there evidence of appropriate use of GP services in the antenatal and post natal periods? Are parents more confident in when to seek medical advice and when not to?

10. Are there clear referral pathways and feedback mechanisms into and out of the project? How effective have these been?

11. How does the programme work with other organisations offering parent support? Is there evidence of collaboration and partnership to avoid duplication?

12. What has worked well for volunteers? Who has gained the national qualification? What changes have occurred for them? What changes have occurred in their community?

13. How are partnerships developed? And with whom? What are the links with commissioning? How is Parents 1st influencing commissioning of children's services locally?

14. How is parents 1st recording its achievements and feeding them into the development of the social enterprise model? What has been achieved as a result of the intervention in terms of influencing local policy?

Appendix 3: Interview schedule for parent and volunteer

Parents and volunteers semi-structured interviews Topic Guide (2)

Narrative style interviews with prompts plus observation guide

Parent

1. Can you tell us a little about yourself?

- Lived in Basildon/Thurrock?
- How many children?
- Working life? Volunteering?
- Extended family?

2. Can you tell us how you met your supporter?

- How long ago?
- Where?
- Why did you feel you needed a supporter?
- What brought you together?
- How long is/was the relationship?

3. What happens when you meet? Talk us through a meeting

- Setting goals
- Birth story
- Going along to a service
- Looking at cartoons

4. What has changed as a result of you having a supporter? (Include q5 if also had a Birth Buddy)

For Pregnancy Pal and Birth Buddy

- Confidence
- Information
- Social interaction/new friends
- Use of services
- Relationship with health professionals- attending appointments
- Breast feeding
- General health and wellbeing
- Health behaviours – smoking, alcohol, exercise, diet
- Mental health – depression
- Relationship with partner

5. In addition, Birth Buddy:

- Birth outcomes
- Breast feeding
- Attachment

6. What has been the best thing about having a supporter?

7. Can you explain any difficulties or challenges in having a supporter? How have these been overcome?

8. How do you see the future?

Thank you

Volunteer

1. Can you tell us a little about yourself?

- Lived in Basildon/Thurrock?
- How many children?
- Working life? Volunteering?

2. Why did you became a volunteer with Parents 1st?

- Are you a BB or PP or both?

3. Can you tell us how you met the family?

- How long ago?
- Where?
- Do you live in the same community?

4. What happens when you meet? Talk us through a meeting

- The interaction – setting goals
- The birth story
- Going along to a service
- Looking at cartoons

5. What has changed as a result of being a parent supporter/ volunteer?

- For you and your family
- For the parents/family you support
- For the community

6. Can you explain any difficulties or challenges in being a supporter? How have these been overcome?

- Supervision
- Parents 1st contacts
- Peer support

7. What has been the best thing about being a parent supporter/ volunteer?

8. How do you see the future?

Thank you.

Observation of relationship when parent and peer supporter are together

1. How are they communicating?

- Verbal
- Body language
- Listening
- Empathy

2. What is taking place?

- Information giving
- Showing cartoons
- Reinforcing goals

3. Why are they behaving as they do? Are there any potential barriers?

4. Is there anything unexpected happening?

GG/WS January 19th 2012

Appendix 4: Parents Sampling matrix

Characteristics	Essential	Desirable
First cohort volunteer support- Thurrock	E	
Second cohort volunteer support- Basildon	E	
Beginning/ middle of support	E	
No longer supported	E	
Social services/ child protection issues		D
Socially isolated	E	
Other family support		D
Breastfeeding	E	
Parents from minority ethnic communities	E	
Father		D
First baby	E	
Other children		D
Pregnancy Pal Support	E	
Birth Buddy Support	E	
English as a second language		D

E – essential
D - desirable

Appendix 5: Example of a Parents 1st evaluation tool for Introductory Training Programme

Introductory Training Programme (Option 1)
Week one - 22.03.11

How did you feel when you walked through the door?	What went well or not so well during the session?	How do you feel now the session has ended?	How do you feel about next week?
Scared. I didn't want to come.	Everything went well.	Relieved. Worried about assignments.	Looking forward to it, glad there were some of my old group.
Excited but guilty (Son's 13th Birthday).	Everything went well, but one topic (safeguarding) made me feel sad and angry.	Nervous about the paperwork still and so I have made arrangements to work with another group member.	I'm looking forward to it.
Happy and excited about the course and seeing everybody.	The course went well. I feel I'm going to settle more in the coming weeks.	Still happy. Tired as it's 9.30pm. Can't wait for next week.	Ready for more exciting information.
Very excited about starting course.	I was reassured about the work (as I was nervous about it).	Excited about carrying on the course. Over loaded with info.	Still nervous but looking forward to it.
Happy.	Everyone got on well.	Good.	Excited.
Excited but unsure what to expect.	It all seemed to go well. Tutors and other girls seem nice.	Looking forward to next session.	Unsure how I will get on with homework. But looking forward to next week.
Embarassed as I was late and my hair was a mess!!	I stayed awake throughout even though I was very tired!!	Glad I made it. Lots of info given which was good.	Gonna be more prepared!