



Right From the Start

A scoping study of the implementation of the GIRFEC practice model within Maternity Care in three contrasting sites across Scotland

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2. EXECUTIVE SUMMARY

Getting it Right For Every Child (GIRFEC) is an important component of Scottish Government's goal to achieve more timeous, proportionate and appropriate services that achieve better outcomes. Its specific remit is to ensure that universal services are based in a commonly understood, well rounded concept of wellbeing and that all relevant agencies work together to deliver effective support and early intervention where necessary in order to improve outcomes for all Scotland's children. The pre-birth period is critical in the development of these outcomes. For this reason GIRFEC has become an integral part of the Refreshed Framework for Maternity Services (The Maternity Services Action Group, 2011). This report draws on experiences from GIRFEC implementation in maternity care in three contrasting sites in order to learn lessons that will contribute to the wider implementation work on-going across Scotland.

2.1 Summary of Findings

Midwives voiced an appreciation for the benefits of the GIRFEC approach and conveyed the sense that it was enabling better joined up working, greater mutual understanding and appreciation of roles across agency boundaries. This in turn is enabling deeper and fuller conversations with women that increase problem solving resources for practitioners and families alike. In this context the study identified important considerations that are useful to draw upon as policy continues to be implemented across Scotland:

- The benefits midwives identified as flowing from the use of the GIRFEC approach are that it
 has resulted in them asking deeper questions and getting a fuller picture of women's
 situations that does help them problem solve better with women across the full range of
 levels of need and variety of concerns.
- GIRFEC's implementation as a universal approach plays an important role in paving the way for more intensive work should that be needed and prevents a sense of stigma from being attached to engagement with services.
- Earlier joint working during pregnancy with social work when there are child protection concerns is perceived to be an important improvement.
- Increased working with social work has enabled Early Years Workers to provide crucial support in pregnancy which is perceived to be very beneficial.
- There is increased communication between midwives and public health nurses with important information flowing both ways enabling better work with families.
- Although initiating an ante-natal assessment of concern can meet with resistance by families, the care environment and skills of midwives offer a unique opportunity to work through concerns and dispel misconceptions. This has worked to develop a more beneficial footing for working with the family after the child is born.
- Different localities have different relations with GP's, Inter-agency Support Officers and social work departments with tensions remaining around sharing information and forums for decision making in some areas.
- GIRFEC does increase midwives workload. Solutions for minimising administrative tasks whilst retaining the important documentation function they serve is a concern for midwives in all health boards consulted.
- Mothers consulted expressed a high degree of trust of midwives and felt they had helped them problem solve and access services. Where there are child protection concerns mothers emphasised it is important to talk through concerns with parents and where possible take a gradual approach to intervention.

2.2 Key Recommendations

Flowing from these findings are the following recommendations:

• Further training resources and opportunities for midwives are needed as well as mechanisms to cascade learning as highlighted in Table 1.

Table 1: KEY TRAINING NEEDS

KEY ASPECTS OF IMPLEMENTATION THAT REQUIRE FURTHER TRAINING				
	Translating GIRFEC language and approach into accessible form for families to engage with.			
	Dealing with conflict that may arise within multi agency working.			
	Exploring sensitive topics with women and gaining consent to share information.			
	Managing meetings, particularly solution focussed meetings, and coordinating inter-agency working.			

- Developing agreed administrative infrastructure support that maximises resources and
 effectively ensures skilled practitioners can focus on delivery of care would be useful.
 Sharing models of best practice of administrative coordination across agencies would be of
 great benefit as implementation continues to be rolled out across Scotland.
- Further development of evaluation mechanisms that allow midwives to gauge the effectiveness of their work in implementing GIRFEC, should be considered. This should include reflective practice and be a key part of supervision.

As well as ensuring effective implementation of GIRFEC these recommendations also address the priorities laid out in *Reducing Antenatal Health Inequalities Outcome Focused Evidence into Action Guidance* (Scottish Government 2011).

3. INTRODUCTION

The Early Years Framework (Scottish Government 2010c) and Equally Well (Scottish Government 2010) both highlight the critical importance of maternity care in giving all children the best start in life through improving infant and maternal outcomes and reducing inequalities in those outcomes.

CEL 29: 'Implementation of the Early Years Framework through Getting It Right For Every Child (Scottish Government, 2010d)' outlined the need for the health sector to support the development of early years services across the NHS. The Refreshed Framework for Maternity Care (The Maternity Services Action Group 2011) has GIRFEC as an integral approach to improving maternal and infant health. However, the application of GIRFEC within a clinical service model such as maternity care has a number of distinct challenges that require to be addressed if implementation is to be both meaningful and successful. This requires a focus on addressing core behaviours, core governance and professionalism within maternity services.

3.1 Aim of Study

The aim of this study has been to examine the way in which GIRFEC has been implemented in specific areas of NHS Scotland, to identify barriers and facilitators to integration of the GIRFEC model and to develop possible strategies for improved integration of the GIRFEC model across NHS

Scotland. This has been done by conducting realist evaluation (Pawson and Tilley 1997) within three health boards at differing points of uptake of GIRFEC that also serve a representative range of demographic areas.

3.2 Methodology

Evaluation interviews were conducted with those with key management responsibility for implementing GIRFEC, practitioners and women with current experience of maternity care. From this methodology an understanding of the workings and impact of the complex intervention and change processes was derived. This will be important to inform interpretation of any process and outcome measures analysed quantitatively on a more national scale.

Sampling

Three case study sites were purposively sampled from health boards where progress in integrating GIRFEC is well advanced and where there are indications that progress is less well advanced. Advice was sought from management within midwifery services in each locality to ensure those key to the implementation of GIRFEC where included in the research. Within NHS Lanarkshire and NHS Highland midwives were consulted across the full range of localities served. A more centralised approach was adopted in NHS Greater Glasgow and Clyde. To ensure confidentiality, throughout the report findings are identified by reference to the health board in which research was carried out. For ease of reading, abbreviated reference has been adopted throughout the report: Highland for NHS Highland, Lanarkshire for NHS Lanarkshire and Glasgow for NHS Greater Glasgow and Clyde. Comparing data across these three NHS boards has enabled an examination of the spectrum of perspectives in relation to the opportunities and challenges GIRFEC implementation entails. Within each site individual or group interviews were conducted with key informants who have been involved in implementing GIRFEC. The scope of data collection was constrained by the time available for completion of this study, however, the views of the following key informants were collected:

- 3 midwives with senior management responsibility for GIRFEC policy within maternity services
- 2 NHS Child Protection Advisors
- 3 midwives responsible for GIRFEC implementation training within their health board areas
- 5 specialist midwives with responsibility for mothers with alcohol and substance misuse issues
- 22 frontline midwives implementing GIRFEC across standard maternity provision
- 1 Public Health Nurse
- 2 Maternity Care Assistants
- 1 Obstetrician
- 15 women currently accessing maternity services, 13 identified as having some risk of poorer pregnancy outcomes (see appendices 1 for demographic information)

Staff groups

Once staff and service user interviews were completed findings were fed back into staff focus groups where possible. This enabled findings to be validated and further explored and for discussion about possible solutions and strategies to overcome challenges to be developed amongst practitioners attending.

Analysis

All interviews were digitally recorded and transcribed. Data analysis utilising the Realist Framework (Pawson and Tilley 1997) approach was carried out by the research fellow with rigour achieved via secondary coding and respondent validation.

Analytic Framework

The intention is that Getting It Right For Every Child builds on existing good practice and the trust and good relationships that have been built over time within and between agencies. Implementation is designed to create a single system of service planning and delivery across children's services that:

- improves outcomes for children through doing things differently so as to make better use of existing resources
- involves children and families in decision making and respects their rights
- consistently identifies at an early stage children who need help
- increases the capacity of health and education to meet children's needs
- reduces paperwork and duplication of system time and resources and develops consistently high standards of practice
- draws help towards the child rather than passing the child from one service to another
- frees up staff time to take action that will improve the life chances of children and families.

(Scottish Government 2010b: 8)

However to assess to what degree and how these changes will produce the intended outcomes a more detailed look at the operational mechanisms of the policy needs to be taken. Evaluation work has identified a number of key steps for successful implementation (Stradling et al 2009, Kosonen 2010, Scottish Government 2010b) as indicated in table 2.

Table 2: Key Innovation Steps and Intended Impact

KEY INNOVATION	IMPACT	
1. Commitment to Inter-agency working at Senior Management Level	Provides clear direction about how policy is to be interpreted and implemented. This instils confidence that changes will be adequately resourced, which, in turn, supports practitioners to proactively adopt policy rather than adopting a conservative approach which leads to watered down or bolted on implementation.	
Inter-agency working group to pathfind localised policy implementation Business process mapping to identify gaps and duplication in assessment and service delivery	Brings practitioners together to see their respective	
Integration of practitioner decision making tool (SHANARRI) into working practices and documentation and adoption of named person and lead professional model across services	Reduces duplicate assessment and confusion over terminology. Where localities adopt forms to be used across services such as Child Concern Form and Request for Assistance Form this improves quality of information practitioners can exchange and build upon, which also works to build families' confidence in cohesive joined up services.	
3. Interactive Staged Training	Promotes team problem solving skills and allows pratitioners time to embed learning before moving on to more in depth engagement.	
4. On-going evaluation and quality improvement	Provides motivation, gives important feedback about how each practitioner's contribution feeds into a common assessment and developmental record for the child and provides evidence of better outcomes.	

Interviews were conducted to gain information about how each of these key implementation steps are being taken within maternity services and the impact they are having, both in terms of positive outcomes and unintended consequences that threw up barriers or diversions and impede progress towards reaching stated outcomes.

4. FINDINGS

4.1 Context

To provide a context for the evidence presented below, it is important to first provide contextual information gleaned from documentation developed in each area as well as through the data collection process itself. For ease of comparison this is provided in Table 3 below:

Table 2: Context of Implementation in Three Contrasting Sites Across Scotland

	NHS <u>Highland</u>	NHS Lanarkshire	NHS Greater Glasgow &
			Clyde
Practice context	A mixed urban, rural and remote service area. Ten maternity locations, with some areas of high socioeconomic deprivation	A mixed urban/ rural area. One large maternity unit. Areas of high socio- economic deprivation	A large mainly urban area with six maternity locations and areas of high socio-economic deprivation
Development	2004-2006 Conceptual work done across children's services to develop the SHANARRI practice tool. 2007-2009 Pathfinder area within Inverness and surrounding area developed processes and forms and trialled these. Sept. 2008. Consultant Midwife seconded to lead implementation within maternity services 2012: Focus of development work on condensing health board areas and moving towards single authority across health and social services for children.	2010-2011 Pathfinder area used case study approach to develop processes and tools for adopting practice model. Midwives identified to develop training for all community midwives across Lanarkshire. Business Process Mapping done with operational managers across services (Getting It Right for Every Child Learning Partnership 2012). Pre-birth multiagency meetings strengthened through the GIRFEC process so that they are more effective and targeted to well defined needs. 2012 Prototype of Request for Assistance form being trialled in some areas as a precursor to roll out across all agencies and localities. IT system to coordinate and disseminate information appropriately in such a way as to minimise administrative cost and time under	Task Force currently considering range of policies to address needs of vulnerable families. Special Needs in Pregnancy (SNIP) Team continues to deliver a multi agency service for women who have been identified by social work as at high risk.
Training	2009 Training programme leading to full implementation across Highland. Three phase approach taken consisting of:	development. 2012 Training delivered in a phased approach. Midwives involved in development cascaded training to community midwives, including joint	2012: SNIP midwives continue to draw on training on sensitive topics such as blood borne viruses, domestic abuse, and conflict to
	1.) Awareness raising	problem solving activities,	underpin practice

Implementation	for a broad base of statutory and volunteer sector practitioners. 2.) Basic training for practitioners working within named person roles. 3.) Developed training for practitioners working with vulnerable families and likely to take lead professional role. Where possible training integrated GIRFEC with other progamme implementation such as KCND. 2012 Refresher training is planned. 2010-2012 Roll out across all Highland areas with support of practice champions.	examples and case studies, and prompts for specific implementation tasks such as introducing Getting It Right to families and ensuring questions cover all SHANARRI outcomes. Awareness raising training now on-going within acute services across maternity services as a whole. 2012 Trained midwives currently trialling use of practice model with straight forward admissions, beginning with one family a week and implementing more fully as confidence grows. Some midwives introducing process at 34-36 week and post-natally	sensitive to the specific circumstances and needs of women in their care. 2012 Special Needs in Pregnancy Midwives and other specialist teams across provision for vulnerable families, such as the health visitor team for homeless families have familiarised themselves with the SHANARRI language and use it
Evaluation	2009: Survey of 106	in order to give PHN's cases with which to work. 2012 Joint evaluation in	when communicating with each other. 2012 Current
	mothers in pathfinder area indicated an increased sense of "being part of the team". Wider document analysis and interview evidence indicates fewer families slipping off the radar. 2012: Ante-natal plan monitored for quality within case audits.	locality teams across Lanarkshire under development. Continued monitoring of documentation by Women's Services Coordinator.	assessment of need feeding into policy decision making about vulnerable families pathway.

4.2 Evidence of Management Support for Inter-agency Working

Taking the components of the innovation in turn we looked first at the evidence for senior management support for inter-agency working. Management support in the areas most engaged with GIRFEC is at a point of transition, further integration of services in Highland has shifted the focus of integration work. In both Highland and Lanarkshire short life funding for seconded staff to do developmental work has expired. The change that the work of the previous years has produced is evident in tools developed and the strategy in place. The degree to which strategy and implementation of tools has worked it's way down to front line practice is evident from interviews with frontline practitioners and mothers.

4.2.1 Timeous, Appropriate Interagency Working

It is useful to begin a review of GIRFEC's impact on inter agency working by considering the views of midwives where GIRFEC has yet to be rolled out in a systematic way. In Glasgow, where this was the case, specialist needs midwives raised particular concerns about a lack of effective inter-agency

working. Midwives voiced concern that inter-agency work with high need families should begin in pregnancy to prevent crisis situations that parents can find quite daunting. There is a concern that better parenting work pre-birth would improve the situation for families, reduce crisis in which intervention was required and provide a better foundation of relations for continued work with families. In their view too many families on the cusp of high intervention do not have accessible services such as parenting classes, support sessions which take into account their particular circumstances and concerns or access to Early Years' Workers one to one support that could also address these issues. The provision of these proportionate services would be very welcome.

The strongest message emerging from areas where GIRFEC is implemented address the concerns voiced above. GIRFEC is enabling important work to be done with families pre-birth and this has meant the post birth period in hospital is less of a

Women saw clear benefits to the GIRFEC wellbeing assessment, in some cases spurring them to think about factors impacting upon their pregnancy that they had not previously considered.

crisis period. This way of working has been supported by standardisation of child protection procedures across Scotland, which can now be initiated between 28 and 32 weeks of pregnancy (Scottish Government 2010e). Highland midwives stressed the importance of this:

So you can have that all set up before the birth whereas in the past it used to be a right clamber right at the end. You had the Sheriff coming in and putting that order in place, in the maternity unit when the baby was just born. So hopefully that won't happen as much.

Midwives illustrated this prevented unfortunate scenarios from occurring that in the past led to a lack of trust just at the point it is vital that practitioners build trusting working relationships with parents:

In the past, sometimes, social work hadn't been speaking with us. And (when child protection came in after the birth) you lost that relationship you had. This girl had been engaging with you, she felt you'd been supporting her and then thought: "that midwife, she

never told me this was going to happen". And that's because I didn't know it was going to happen. So that has improved. There are still differences but that's to be expected.

Midwives report that families and practitioners are better prepared for decisions and actions when the baby arrives with this new way of working. In some areas of Highland midwives also report a marked increase in trust particularly between themselves and social work colleagues and attribute this to a shared language to communicate concern.

The use of ante-natal plans to pick up on low level concerns also lays important groundwork, in the words of one midwife "like good foundations for a house". A Highland example was cited where using the process to note a low grade concern was immensely helpful when circumstances suddenly changed and much more robust support was needed. It meant much was in place that otherwise practitioners would have been scrambling to initiate had this not been the case.

The views of expectant mothers who are at increased risk of poor health outcomes who contributed to the study also emphasised that if child protection is being considered this should as much as possible be a gradual rather than an abrupt process and should begin by informing and consulting with parents about concerns.

Mothers from the more general population also consulted expressed the view that attention should be given to more families than those identified as at greatest risk:

They need to spread it (attention) around, they should give their focus to every family rather than just focus on one and not another. And if there are concerns they should take their time rather than just jump in before they know the full story.

All mothers consulted felt that their current care by midwives was very helpful. Where there were concerns or problems that mothers were dealing with, they felt midwives had helped them problem solve, gave them appropriate information and helped them access other services.

Highland and Lanarkshire both report an increase in two way communication between PHN and midwives that creates a picture of the family as a whole. NHS Child Protection Advisors consulted for the study concur and see this as an important improvement. Midwives report increased joint visiting and joint working with PHN's and report that requests for support that previously would have been made verbally over the phone, are now documented. Whilst time consuming, this feeds into a process of developing a chronology of significant events for the family and an evidence base for practice. The input midwives are making to children's plans is having benefits for families as a whole. In one case a midwife related this fuller picture of family circumstances substantially changed how teachers were able to address concerns they had for older children in the family.

Inter-agency working has paved the way for increased involvement of early years workers (EYW) pre-birth. Highland midwives report increased working with them to develop targeted parenting education and support that has achieved beneficial results for families. However the availability of EYW's varies depending on relations with social work in each locality, as they are allocated through social work.

Highland midwives also report that increasing use is being made of Maternity Care Assistants who provide a supportive role, particularly post birth. Maternity Care Assistants consulted for the study related that they think their support is valuable and that they provide useful information that contributes to a holistic picture of family circumstances, strengths and weaknesses.

There is also particular appreciation for improved communication with police. Again the benefits are seen to flow both ways, with better information relating to midwives' safety being communicated at the commencement of work, and reliable follow up by police of any concerns which midwives communicate to them.

Midwives involved in delivering training in Lanarkshire are also acting on the impetus of GIRFEC to encourage midwives to increase their knowledge of volunteer sector resources:

Midwife: I don't think we would necessarily have to say, "Right, now, we're looking for respected." No, I would just say "Have you got all your baby's equipment? Have you got the cot?" So that's respecting the baby as an individual that needs his own place to sleep. We wouldn't say, "are you responsible?" but we would know in our head that it is responsible.

If the girl has nothing, then you could say, "Now look I'm going try to get you some help". And some midwives may say, "but we're not social workers". "We're not asking you to be social workers but we do want you to know where to signpost these girls without a doubt what's available in your area".

Researcher: Do you think that midwives are gaining knowledge of what is available or is that part of the task of embedding GIRFEC?

Midwife: I think they are accepting of it, and the longer it's going they will become accustomed to it

However the picture of inter-agency working arrangements is a mixed one. In some areas this is still dependent on the forging of good relationships with GP's and social workers on an individual basis rather than enjoying stronger systematic support. Midwives would welcome a standard of quality of engagement at both transition points for women entering and leaving their care such as relevant case record information from GP's as women are referred from GP's at the point of booking, and consistent engagement from social work in the event of pre-birth planning and meetings.

The degree to which a "single assessment process" in which services follow the family and not the family the services is developing is not yet clear. Request for Assistance Forms and processes are taking time to roll out as they require inter agency negotiation. Within Lanarkshire there is reference to part one and part two assessments which feed into inter-agency work, however, there is still reference to other assessment pathways. As one midwife explained:

Each service still has their own assessment process; we use the same language to communicate with each other about that.

4.2.2 Administrative Support for Information Sharing

Whereas the long term goal is for GIRFEC to reduce practitioner time and resource spent on paperwork, the view of all midwives was that in the first phase of implementation this was increased. Midwives are recording the same information in different records and systems. In Lanarkshire there is a strategy for developing an integrated IT system which will be designed to reduce time spent filling in information by hand multiple times. Within Highland this remains a long term goal, but at present midwives are finding solutions as and when they can, drawing on skill sets gained outwith their remit as midwives. Where Integrated Services Officers (ISO's) are providing administrative support this frees up midwives time to concentrate on building relationships and

identifying appropriate support. However, Highland midwives report widespread differences in the appointment, availability and approach of ISO's in each locality.

Midwives in all areas could see that some of the time they spent gathering information could reduce the time HV or PHNs had to devote to this task and would give them a more robust starting point with mums as a child's profile or plan was transferred to them. The form that handover to PHN and HV's takes does vary.

There is also the perception that communication with social work has been streamlined with clear benefits as one midwife reports:

It used to be that forms were coming here there and everywhere. With so many forms we were using child protection forms when we wanted more information and we were doing the wrong thing. Whereas now when we say child protection we mean it.

4.3 Evidence of Training and Implementation Support

In examining training and implementation support, it is important to note strong similarities of approach in the two health boards where work is moving forward. Training within Lanarkshire and Highland has taken a phased approach and sought to balance an explanation of the background of the policy and its importance with coverage of what the changes are and how to implement them. Training included case studies and interactive problem solving using the tools developed for the policy. The approach to training seems to incorporate the strength based message, in that trainers communicated an appreciation of what practitioners were already doing and already skilled at and offered the tools and approaches as effective ways to communicate that skilled assessment to other practitioners. Within that framework training had to address a number of challenges:

- Impart an understanding of the practitioner tools and strategies for using them when working with expectant mothers and their partners
- Explain how to use tools with counterpart practitioners in other agencies to communicate in contexts with many complexities
- Develop a strength based approach with families that incorporates the use of the tools alongside SWHMR.

4.3.1 Practice Model: Decision and Communication Tool

As this training has just been delivered within Lanarkshire, practitioners there felt that they had limited scope to evaluate it; however, the tools disseminated with the training are proving useful. Midwives in Lanarkshire report that they find the GIRFEC-based nidation calendar tool is very useful as a prop that helps start the conversation about wellbeing:

I like using the wheel with women. You're clearer with woman what the assessment is and it helps explain the baby's development. It's a visual aid to allow them to understand. . . It's about involving women more in their wellbeing.

Awareness raising about the resilience framework component is part of training within Lanarkshire. The resilience approach is embedded within maternity services, and is drawn upon more explicitly in tools to work with families as the child matures. How the three components of the practice model (The SHANARRI (Safe, Healthy, Achieving, Nurtured, Active, Respected, Responsible, Included) Wellbeing Indicators, The My World Triangle, and the Resilience Matrix) work together is something that should be monitored as there is scope for differences to develop within different services, which could decrease the degree to which services are using the same language to refer to the same

KEY FINDING:

Adopting a Paced Approach

Midwife: "It's delving that wee bit further. And if they answer a question, it might give you an inroad to another question. . . Don't ask too much at the first visit. We will have about seven or eight visits over the time this girl is coming to see us. So we aim to ask something each time."

concerns and processes to address them. Developing a common language is something midwives are aware needs to be worked at as one midwife reports:

It's getting used to the language we're having to use now from what we've used in the past. We've always done an initial assessment of vulnerability, but we're now having to use different terms to describe it, like the wellbeing indicators.

A goal of GIRFEC is to increase the quality of analysis contained within reports so that vital information is not difficult to pin point within records. When asked specifically about the degree to which SHANARRI enables better assessment midwives communicated that they felt they already did a holistic and accurate assessment of need for pregnant mothers, but what SHANARRI did enable them to do is share this assessment in terms that other practitioners could more easily pick up and continue to work with once the child is born.

The practice model's most important use may be as a framework for consistent communication of decisions made to other practitioners who work with the same

child or family. There are concerns in areas that have not engaged in pathfinder and learning partnership work about how to engage with the practice model as a visual piece of information. It is not a flow chart or map of a process, rather, it is a set of concepts to bear in mind throughout assessment. Further consideration to how both frontline practitioners and families can interact with the visual model would be useful.

Women interviewed for the study had useful insights into what GIRFEC tools communicate. As one woman commented in assessing the usefulness of the nidation wheel, which is used in Lanarkshire NHS to introduce GIRFEC:

The book (Ready Steady Baby) is there to give you information. This is more to do with psychology, the instinctiveness to do better for your baby. This isn't just about when the baby is inside, this is your baby while you're pregnant and after. I think there are people who should know there are support services there. That they've put their phone number on it is ideal

There is a danger that GIRFEC in constrained circumstances comes to be applied primarily to women identified as having higher risk of poor outcomes in pregnancy. The practice model's inclusion in the SWHMR provides a useful prompt to introduce the well rounded concept of wellbeing at the heart of GIRFEC to all women, where other introductory tools have yet to be developed. In this way the objective set out in the Refreshed Framework for Maternity Services that: "Every antenatal contact is seen as an opportunity for health assets/strengths based health promotion" (Maternity Services Action Group 2011:35) can be supported.

4.3.2 Role of Named Person and Lead Professional

The role of named person and lead professional are important for a consistent, accessible model of service delivery across Scotland, and, as such, are an important feature of GIRFEC policy. Midwives report that initially there was confusion about the difference between Lead Professional and Named Person but this has become clearer as they have had practice adopting these roles. Whilst anxieties about Named Person status have been raised by midwives yet to have much practice experience of this, Highland midwives report this aspect of the policy has not been problematic. Differing localities within Highland have taken a selective approach to the extent of paperwork attached to this role. However, having named person status does require more paper work. To address these concerns Lanarkshire has focussed training on efficient ways to fold the paperwork into current working practices as one midwife explains:

What we're doing is finding a working solution for it. So it's done timeously so you're not having a backlog of part one assessment or part two assessment. We're looking at redistributing the workload. Because it is additional, it's not that we've stopped doing something we've done previously. So it's looking at wider picture and seeing how things can be worked out.

The benefits midwives identified as flowing from the use of tools are that they are asking deeper questions and getting a fuller picture of women's situations that does help them problem solve with the mother better. This is evident in the views Lanarkshire midwives gave:

What it has done for midwives, is we now ask deeper questions, more extended questions. For example if they've got a toddler at nursery age we're asking "do they go to nursery?" If they're working "what's their childcare arrangements?" So we are now going a wee bit deeper than what we did previously.

Because I think in the past a lot of the time you thought, If I don't ask, I'll not know about that problem, then we won't have to deal with it, or passing the buck to social work. Hopefully that'll stop.

As another midwife involved within training in Lanarkshire also pointed out, key to asking questions sensitively and effectively is pacing them across care delivery as a whole:

It's delving that wee bit further. And if they answer a question, it might give you an inroad to another question. Now what you need to watch is that you don't ask too much at the first visit. We will have about seven or eight visits over the time this girl is coming to see us.

So we aim to ask something each time -- because, let's face it, if-- for instance you ask if they are employed. If you asked at the booking all about employment and they said yes they are employed (and you don't ask again) in six months time they might be unemployed, and yes, they might have a lovely home with four bedrooms, but ask more and it might be a private rent and they have no security.

Women interviewed in Lanarkshire (5) report that they were surprised at the thoroughness of the questions midwives asked. Those with previous experience of maternity services marked this as a change from previous practice. Women were quick to clarify that they did not find this intrusive and thought that inquiries were conducted in a sensitive and supportive manner. They saw clear benefits to this approach in some cases spurring them to think about factors impacting upon their pregnancy that they had not previously considered.

Whilst asking more probing questions and using the SHANARRI framework to assess responses may seem daunting at first, Lanarkshire midwives draw parallels to experiential learning on the job that they are often called to do. That same approach is useful in implementing this innovation:

I think it's confidence. The more midwives get used to using this, getting problems thrown up. Once you've dealt with a problem you'll know how to deal with it: "listen I did that with that family, I'll go back and see if that will work". So I think it will grow in confidence and eventually midwives will be able to see the benefits of it.

These methods of practitioner reflection need to be supported with a mechanism to maintain a proactive solution focus to discussion of problems that taps into examples of good practice that midwives can share.

4.3.3 Enabling Better Partnership Working with Families

In turning to examine this dimension of policy implementation it is useful to consider the views of women accessing maternity services with risks of poorer outcomes. Young women, aged 16-18, reported very positive experience of working with their midwife and appreciated the consistency of being able to see the same midwife throughout their pregnancy. They found that the midwife related to them in a way different to other professionals with whom they had had contact in the past and characterised them as being caring and easy to talk to. One participant who had previous experience of social work involvement in her childhood felt her midwife was more like social workers who had run a girls group she had attended, which she had had a good relationship with, and less like the social worker who had responsibility for managing her case whom she felt was too distant. She reflected further that what made the difference was a sense of humour, an ability to use humour to defuse awkward or difficult issues when they arose and a more general sense of not being easily offended.

KEY FINDING:

Building Confidence through Reflective Practice

Midwife: "I think it's confidence. The more midwives get used to using this, getting problems thrown up. Once you've dealt with a problem you'll know how to deal with it: "listen I did that with that family, I'll go back and see if that will work".

These younger women reported that it would be helpful to have more information early on about the process as a whole and indicated it is helpful to have support to ask questions as they may be afraid that their questions are silly or out of place. As one young woman remarked, who had a concern that she was afraid to bring up, "I wouldn't want to tell them their job".

Younger women appreciated learning about pregnancy and parenting by speaking to other young women in similar circumstances, however they did not want to attend classes where participants were called on to demonstrate particular skills in front of the whole group or other teacher-centred approaches. The common characteristic of this approach was that it was "a bit boring". They would find it most helpful if they were allowed to bring a friend they already knew to such a group or had an informal opportunity to meet other participants beforehand. It mattered much more knowing who else was attending the group than meeting the group facilitator beforehand.

They also reported that a person talking through information was more helpful than leaflets or books. One participant said that she had found watching *One Born Every Minute* the most helpful source of information, as it had shown her how different pain relief methods could affect someone. This had greatly influenced her decisions on her own choice of pain relief. This suggests that there would be many benefits to developing co-produced digital resources with younger mums that took an experiential approach. This could usefully build on forum theatre work recently piloted by NHS Education for Scotland.

The four young women who participated in the study in Glasgow reported a number of different stressors that potentially could affect their pregnancy, from housing and benefits to family relations. However they felt that there was limited help midwives could give and were not aware of other sources of help in their community. They conveyed a sense that social work "were the ones that made the decisions" and that getting a hold of social work was very difficult.

All six younger women were very clear that if there were concerns that meant social worker involvement might be sought, they would want to know about this earlier rather than later. As one young woman commented, "I would be really upset if I was sent to the social work. I'd want someone to explain to me."

As all respondents indicated, the importance of listening is paramount. This raises the issue of communication within GIRFEC implementation and the role of dialogue within it. For both parents to reach the GIRFEC outcome of increased and empowered participation in service planning the language that practitioners are using to do that planning is something families also need to become familiar with. However introducing the SHANARRI assessment framework and the integrated approach of GIRFEC can be a daunting prospect. It falls to midwives to negotiate this, and it can be a very delicate task. In speaking with midwives about how they introduce GIRFEC terminology Lanarkshire midwives speak of the need to adopt a gradual approach tailored to the needs of each mum:

We had to find a way to put it in mum's language so that she understood what these wellbeing indicators and assessments mean for her and her baby. I don't use the word assessment because that can put a barrier up right away. Once you've done that initial consultation, depending on their understanding of it, you break it down. There isn't one sentence that fits all for them; you need to be able to adapt to your individual mums.

Basically what I say to mums is during their pregnancy jointly we'll look at what they're doing with their lifestyle to ensure they're as well as they can be during the pregnancy and also to make sure that during the pregnancy their baby is healthy and that afterward that they have the capability to be able to provide the best for their baby. It's finding a balance so mums actually understand what you'll be doing with them during their pregnancy.

Interviews with women highlighted that there are some issues around terminology. The policy title, Getting It Right For Every Child and its acronym (GIRFEC) were unfamiliar to all women, apart from those who are themselves working in health or social services. Nor is the term "named midwife" easily recalled. Women more readily report that their midwife let them know they were their "key contact", even when they had the nidation wheel in front of them with a space for name midwife filled in. As maternity services are first to introduce this terminology, it may take awhile for parents to become familiar with it. Further guidance may be needed to identify which terminology it is

important to consistently use, and which can be translated into terms women are more comfortable with.

Midwives in some localities raised concerns that families resist any assessment process. Some midwives felt that the introduction of the ante-natal plan in Highland, which is the particular tool used to introduce a process of developing inter agency support for a family, are increasing tensions with families. Concerns raised by midwives in Glasgow anticipate this problem. They have

reservations about being seen as an extension of social work assessment of parenting. For this reason they negotiate language and questions they ask the women they work with carefully. They see a need to keep roles distinct, and that, as they are a service to the mother primarily, part of that role is as an advocate for them throughout any protection assessment or intervention. This is also reflected in Guidance for implementing GIRFEC in NHS Highland (2010) that emphasises the importance of respectful support for women regardless of pregnancy outcomes.

Aware of the potential anxieties that may be attached to the assessment of wellbeing, midwives in Lanarkshire have developed guides for introducing the SHANARRI language to parents that help focus the introductory conversation on the goal of ensuring care and providing support rather than judging parenting (NHS Lanarkshire 2011). While some

Approaches Young Women Value:

- A sense of humour
- An ability to use humour to defuse awkward or difficult issues when they arose
- A general sense of not being easily offended.

families may be more cautious about what they disclose once they are made aware that needs and risks are being assessed, midwives feel that trust can be built that includes rather than skirts around difficult topics. Highland midwives describe the longer term benefit that results from this:

Once it is out in the open they can relax a little. Once they know support is there to help the child stay, they trust us a little bit more. We were worried there would be a backlash from parents, but most have been very good. It means we are more realistic with parents and in the end it's easier for parents because they aren't hit with a sudden crisis once the baby is born.

In the more remote Highland areas where individual families can feel more conspicuous, midwives spoke about the importance of GIRFEC being a universal initiative which applies to everyone. The inclusion of the practice model in the SWHMR eases the introduction of questions that explore needs and paves the way for the conversation to focus upon support without mothers being anxious they are being singled out. Mothers consulted In Lanarkshire confirmed this view. However one mother pointed out women may feel some unease in carrying around their SWHMR once confidential information about their history or social circumstances has been recorded in it.

Being open and honest about degrees of support and intervention is an important part of establishing good working relations with families that subsequent named professionals for the child can build upon. An important aspect of this work is ensuring parents are aware of the information sharing policy and give their consent to it, particularly as information will migrate across agency boundaries as named person responsibility is transferred. As a midwife in Glasgow remarked, "partnership working means partnership working right from the start", an important component of

that is being honest about information sharing. Guidelines in Highland and Lanarkshire emphasise midwives should let parents see wellbeing assessments and plans and contribute their views to them before signing off on them. To varying degrees midwives are following these guidelines. Midwives in Lanarkshire talk about writing alongside the parent creating a sense of developing it together. Some Highland midwives spoke of extra work to make sure the wording of assessments is done in an accessible way that parents can accept prior to showing it to them. One Highland midwife shared an example of an ante-natal plan in which the mother had taken the opportunity of reviewing the plan to add her own comments. This proved to be a vehicle to express her concerns as part of an ongoing working relationship with those providing support. This is yet another feature of the process that can work to change prevalent perceptions of what inter agency working can mean and allay perhaps outdated views of child protection as overly interventionist.

The adoption of strength based approaches has the potential to transform a threatening experience into an empowering one. At a strategic level, managers indicated that midwives should be familiar

KEY FINDING:

The importance of training in developing person centred skills:

Midwife: "I haven't had training to deal with some of these sensitive situations. I'm drawing on my experience as a mother, as a grandmother, as a human being."

with strength or asset based approaches through motivational interviewing (MI) techniques they will have been trained to adopt around smoking cessation and drug and alcohol reduction. When midwives were asked if they were familiar with strength based approaches from training in Alcohol Brief Intervention (NHS Health Scotland 2010) midwives in all areas did not associate this training with supportive or strength based approaches but recounted that this training focussed on accurately assessing units of intake based on women's anecdotal recall of drinking activity and that it is about technical assessment rather than communication skills. Many midwives seemed unfamiliar with the term strength based approach When a description of the approach was described some midwives reported that they had had some training over ten years ago in approaches like this in relation to blood borne viruses. Training for routine inquiry into domestic violence was also seen

as relevant. Several midwives felt more training and information about these crucial aspects of how to implement GIRFEC should be available. As one Highland midwife reflected on her practice:

I haven't had training to deal with some of these sensitive situations. I'm drawing on my experience as a mother, as a grandmother, as a human being. But we can be singing from a slightly different hymn sheet depending on life experience. We could do with more training in this area.

In highlighting these training concerns, the degree to which midwives are drawing on experience both personal and professional should not be discounted, rather, these valuable resources should be drawn upon and acknowledged as important resources within training. As the Healthcare Quality Strategy (Scottish Government 2010a) indicates, person centred, strength based approaches to care are core skills and are important to integrate into training, reflective practice and supervision.

Clearly there is some very good strength based work going on as is indicated in a Highland midwife's description of working through a plan with a mother:

The reason behind the plan is support; it's the carrot and not the stick. It's done sitting down and working through it with the woman. A mother can get so caught up in whatever is going on that doing the plan actually gives them the opportunity to sit down. And it does give them a chance to gain some insight. The penny drops or something and they can see this is not the best way to behave or whatever it is that is the problem. It helps them look at what support they can call on, whatever the issue, and it's not just pressures it's helping them look at strengths. It's taking a balanced look. When you look at the pressures and strengths you realise the family is functioning. Sometimes there can be terrible situations and the family is functioning, there's a grandparent or other support and the family is functioning. Every family is unique and you are trying to find out about that particular family, that particular woman.

One midwife, who has helped deliver the training for midwives in Lanarkshire, identified the importance of the philosophy that underpins strength based approach of GIRFEC when working through the SHANARRI assessment:

What we want people to remember, if you have a lot of negatives find a positive. Help them feel, "All right, I've done this." Set them a goal they can work at.

4.4 Evidence of Evaluation and Sustainability Strategy

In considering evaluation mechanisms and sustainability strategies, it is important to bear in mind that areas began implementation within different policy contexts nationally. As Highland began pathfindng GIRFEC, Sure Start Funding was available nationally for midwifery posts and this was utilised to develop the capacity to work with families with complex and intensive need. This resulted in a concentration of work for specific midwives, rather than an even distribution of cases across community midwives teams in the early stages of implementation. A more distributed approach has now been in place for over a year.

The reflections of midwives who worked more intensively provide comparative insight into these contrasting models of implementation that are useful. Midwives commented that working within a specialist role had advantages such as increased specialist training for drug and alcohol misuse, domestic abuse, and child protection, dedicated work space and closer more consistent working relations with colleagues in other services. However, they also noted drawbacks such as isolation from the rest of the community midwives' team which led to changes in how they assessed thresholds of need as they were no longer doing this across a full spectrum of family profiles. Midwives reported that they found the intensive work rewarding with a clear sense they made important differences to the start in life children were receiving. Nevertheless, they cautioned that such a role is difficult to sustain with changes to perceptions of thresholds a particular concern.

Growing out of this experience was also the reflection that working with particularly complex or intense cases could do with dedicated supervision arrangements. Whilst Child Protection Advisors can offer some support, as can peers within the community team, this may not be an adequate forum to process particular concerns or their impact on a midwife's practice. In Lanarkshire planning with the midwives who have delivered the training is underway to spend time in the community areas offering support and time for reflection on cases they have been involved in. Team Leaders are

also prepped to include GIRFEC implementation in supervising staff and are now incorporating it into the KSF (Knowledge &Skills Framework) annual review.

Midwives, in assessing the difference they hoped the policy would make, were focussed on less families slipping through the net or off the radar. They indicated that this outcome would justify the extra time and administrative work. Key to sustaining motivation will be effective evaluation of this. As a midwife in Lanarkshire said:

We need to know it's not just going to be filed in the back of a record but is going to be progressed.

As a Highland midwife commented, across the NHS there is more a culture of feeding back information when things have gone wrong, and this is quite right, however, feeding back when things have gone well is not as common as would be helpful.

5. DISUSSION OF FINDINGS

Midwives voiced an appreciation for the benefits of the approach and conveyed the sense that it was enabling better joined up working, greater mutual understanding and appreciation of roles across agency boundaries and deeper and fuller conversations with women which in turn increased problem solving resources for practitioners and family alike. In this context midwives identified important considerations that are useful to draw upon as policy continues to be implemented across Scotland. We consider the views collected in light of other evaluation projects and the wider literature on decision making (Paley et al 2007) and work flow management (Hay and Finch 2009).

5.1 Managing Expectations

In discussing the findings of the study the Scottish Midwifery Research Collaborative, drawing on awareness from a number of other studies and consultation exercises, note that outwith areas that

Integrating a Strength Based Approach Throughout Care:

Midwife: "What we want people to remember, if you have a lot of negatives find a positive. Help them feel, 'All right, I've done this.' Set them a goal they can work at."

have done concerted work on implementation, such as Highland and Lanarkshire, there is confusion about the implementation and impact of GIRFEC. This may be due to the long roll out that policy implementation can entail. More awareness raising about the implementation model itself, that is, trial by a small area with opportunity for robust practitioner and service user engagement, followed by training and phased implementation, would reduce concerns, anxiety or misleading assumptions around expectations.

5.2 Getting Inter-Agency Working Right

Midwives in both areas currently implementing the practice model indicate there are concerns about the practicalities of taking the role of lead professional within inter-agency work. The role requires midwives to chair meetings, take and circulate minutes, and monitor and evaluate how colleagues follow through on plans made within meetings. This requires skills for which midwives have little formal training, particularly where conflict management may be needed. However, the role also requires meeting space, meeting expenses, administrative time and resources to circulate minutes. This is where inter-agency cooperation at a local level is most important. As Weatherly et al. (2010) report, the strongest evidence for benefits of integrated working are when cooperation is strongest at this level, regardless of integration at higher levels. Concerns are raised by Highland midwives that the larger and more costly integration work being done at higher levels of management is not always translating into localised cooperation particularly between social work and maternity services. Guidance in this area needs to be considered.

It also should be noted that where services are co-located such as where midwives and PHN's are co-located, or where addiction services and social work maintain a presence at special needs clinics fewer problems with working together are reported.

5.3 Use of Practice Model to "Think Ecologically"

A fundamental premise of GIRFEC, founded in robust research (Aldgate 2006) is that ecological or holistic approaches lead to better outcomes. However there may be differences in understanding of what this means and what changes in underlying philosophy and conceptual thinking it may require Previous evaluation (Stradling et al 2009) noted that use of ecological thinking was leading to practitioners referring more consistently in meetings and records to the person as a whole rather than as a case, client or patient to be treated. It is this emphasis on the person with a range of dimensions, encapsulated in the SHANARRI headings, which GIRFEC seeks to integrate. Whilst a move towards this basis for analysis is being encouraged across policy initiatives (The Maternity Services Action Group 2011, Scottish Government 2010c, 2011) evaluation of the Highland Pathfinder Project revealed further work is needed for the approach to be fully adopted and the benefits of this to be fully realised.

Evaluation of the Highland Pathfinder Project categorised three levels of engagement with ecological model of needs assessment:

- 1. At the first level practitioners rely on previous modes of assessment and translate these into practice model categories.
- 2. At the second level practitioners with increasing confidence support concerns across a wider spectrum of indicators and draw on specific evidence for each outcome area.
- 3. At a third level practitioners become confident enough to also alert other professionals to more impressionistic information which could help a practitioner in another service to contextualise the concerns. It is this third stage which the report refers to as 'thinking' in an ecological way about the child's wellbeing. (Stradling et al. 2009: 48)

The present study found that work is underway to embed SHANARRI terms within the thinking and assessing midwives do on a daily basis. There are examples from interviews of the kind of behaviours and conditions midwives are looking to support and record for each SHANARRI heading within wellbeing assessments. The Lanarkshire wellbeing assessment has embedded within it guidance for how to explore each SHANARRI indicator with families and is supported by further training materials.

Midwives in the initial stages of applying the model within their practice with families are reporting that they find using the practice tool "repetitive", and that whilst they appreciate the reinforcing influence this has, they do find it time consuming. This may indicate that across several of the SHANARRI categories they are noting the same concern. If the tool can be used to increase reflection on HOW the factor impacts each wellbeing section differently and the interactions between them this would increase the tool's usefulness as both a needs assessment and problem solving tool. This may also entail looking for different evidence for each outcome. Progress towards a more in depth understanding of ecological thinking and its creative application could usefully be supported through dissemination of examples, resources, training and on-

Using the Wellbeing Assessment as a problem solving tool means thinking through HOW a factor makes an impact across all aspects of wellbeing.

going forums for practitioners to compare and reflect on their practice. Examples of more in depth use of the tool leading to creative low cost solutions are particularly helpful. A project to collect and effectively share such examples should be considered.

5.4 Involving Families in Decision Making and Planning:Turning Threats into Opportunities

A core component of the GIRFEC model is the involvement of children and families in decision making and respect for their rights (Scottish Government 2010b) and is a core component of strength based approaches to health as highlighted in *The Healthcare Quality Strategy for NHS Scotland* (Scottish Government 2010a) and *Reducing Antenatal Health Inequalities Outcome Focused Evidence into Action Guidance*, (Scottish Government 2011). However there is a lack of clarity about what increased involvement means or how practitioners facilitate this. Within social services there are a number of models for integrating service users' involvement in setting, working towards and assessing outcomes (IRISS 2011) that are premised upon strength based approaches. Lessons from innovations in self directed care may be relevant here (Miller and Cook 2011). There are a growing number of examples of service user involvement tools leading to creative solutions that service users own and utilise well.

However, a lack of clarity about terminology and the degree to which training and support for these approaches has been available are concerning, a concern reflected in the recent Learning Needs Analysis for the Refreshed Framework for Maternity Services Final Report (ESKOGEN 2012). The confusion and lack of ready identification of strength based tools is of particular concern if one considers the literature on motivational interviewing which cautions that training in motivational interviewing (MI) to be clinically effective requires a sustained training and development approach. Early studies comparing different training models for MI found that one-off training workshops:

... convinced clinicians that they had acquired MI skilfulness, but their actual practice did not change enough to make any difference to their clients (Miller & Mount, 2000). This indicated that trainees need more than a one-time workshop to improve skilfulness in this complex method. Two common learning aids seemed good candidates for improving training: progressive individual feedback on performance, and personal follow-up coaching. . . . A practical challenge in training clinicians in MI, then, is to help them persist in behaviour change past an initial workshop exposure that may erroneously convince them that they have already learned the method, a motivational challenge not unlike that of helping clients change lifestyle behaviours. (Miller and Rose 2009)

Crucially, part of Motivational Interviewing is allowing the patient to develop motivation to change before moving on to the strategizing phase of the interview. This requires particular skill to assess. Where this transition is rushed Motivational Interviewing does not deliver significantly higher returns on investment. The one key factor in both the training and implementation of MI and, arguably, any strength based approach is time. Guidance to be flexible about working through the SWHMR questions is important to highlight, if midwives are to be able to adapt the process to each women's capacity to engage. The recent study on women's uptake of opportunity to write in hand held health records (Entwhistle et al. 2011) observed that although women viewed this invitation positively, there were was limited uptake of this offer within the SWHMR. However, the report also noted other forms of collaboration or co-production could be facilitated through the discussions the SWHMR enabled and recommended further research on context-sensitive evaluations of different approaches to supporting women's use of the SWHMR.

Within interviews midwives were drawing upon common sense or strategies developed over a period of time through conferring with colleagues that enabled them to address sensitive issues with women and gain their cooperation. These embedded practices of learning would work well with the training methods recommended above. Just as SHANARRI helps clarify communication about quality of life outcomes. So too could practitioner tools about strength based approaches clarify change or process outcomes (Miller and Cook 2011).

5.5 Creating a Learning Network of Services

Getting it Right for Every Child has cultural change as a key objective (Scottish Government 2010b). An important dimension of cultural change is creating a learning organisation, that is, one in which learning and evaluation is integral to how staff go about their work. The importance of evaluation within the innovation process was highlighted in Changing Professional Practice and Culture to Get It Right for Every Child:

Opportunities for staff to meet periodically to reflect on the practice change process and explore ways of building this into the continuing professional development of those who work in children's services enhance the processes and help embed them.

Ultimately the primary aim of the training, CPD, mentoring and quality assurance is not just to get staff to use the new tools and follow the intended pathways, it is to get them to apply these tools and process in an analytical way in order to critically assess the impact which the concerns are having on the child's growth, development and well-being. (Stradling et al 2009: ix-x)

Re-orientating practitioners towards evaluation requires time and attention to adapting existing evaluation mechanisms. Increasingly care requires midwives to assimilate multiple cues in time pressured situation. Good decision making in such context requires strong diagnostic support both in terms of tools that help midwives quickly coordinate information and training to use them effectively. Further attention to this phase of implementation would be useful both in terms of system evaluation and feedback mechanisms and within supervision arrangements for individual

midwives and will help to support uptake of *Reducing Antenatal Health Inequalities Outcome Focused Evidence into Action Guidance* (Scottish Government 2011). The importance of feeding back quality information about outcomes for families to practitioners putting in extra time and effort to implement GIRFEC should be considered. It is also important to recognise the role clinical judgement plays in making decisions within complex and dynamic situations (Paley et al. 2007) Support to develop these skills requires a continual learning spiral. It may be useful to consult work commissioned by the Scottish Government on the role evaluation and analysis should play within reflective practice to implement GIRFEC, such as Helm (2010).

5.6 Implementation of GIRFEC within Wider Integration Strategy

Within interviews senior and front line midwives voiced concern about maternity's dual role as an adult service and also a duty of care for the wellbeing of the unborn child. How maternity services sit within reorganised and integrated services is a concern. Drawing on an adults' parental role can be a powerfully motivating factor to make changes to protect their own and their child's wellbeing. However, this does need to be balanced with consideration of their needs and rights as an individual in their own right including the need for a professional to be a supportive presence for them in meetings and proceedings (Kosonen 2011).

5.7 Consideration of Context Dependent Factors

Realist Evaluation examines how contextual factors impact upon policy effectiveness. Its usefulness is in its capacity to identify where some contexts can produce factors that mean policy steps produce unintended effects. Within GIRFEC we note that where resources are constrained and concentration of need high, inter agency working is strained. In these contexts increased time on paperwork can come at the expense of face to face time necessary for quality communication either with families or with other practitioners they need to be working with. The expanded number of questions within the most recent edition of SWHMR can compound this effect. Continued careful attention needs to be given to how records can support clinical care so that it does not come to overshadow the innovations in person centred, strength based engagement with families. The Refreshed Framework for Maternity Services (The Maternity Services Action Group 2011) and SWHMR Guidance advise that questions can be spaced out across appointments. For all midwives to feel able to exercise clinical judgement in this respect, this message may need to be re-emphasised. The Wellbeing Assessment developed by NHS Lanarkshire provides a framework for adopting a strength based approach for broaching many of the contextual questions recently added to the SWHMR. How these two tools could be brought together to aid work flow management (Hay and Fitch 2009) would be useful to explore.

Use of visual tools can streamline time spent recording information and planning and are possible to integrate into digital management of records. A sample of such a tool that IRISS (2011) recommends for outcomes assessment with parents with drug and alcohol issues was positively reviewed by midwives in the focus group stage of this study and is included in appendices 1.

6. CONCLUSION AND SUMMARY OF RECOMMENDATIONS

The picture that emerges from this study is primarily a positive one. This is underscored by the positive views expressed by mothers currently receiving care. However challenges do require attention, particularly within constrained budgets.

6.1 Recommendations

Flowing from the findings are the following recommendations:

• Further training resources and opportunities for midwives are needed as well as mechanisms to cascade learning as highlighted in Table 4.

Table 4: KEY TRAINING NEEDS

KEY ASPECTS OF IMPLEMENTATION THAT REQUIRE FURTHER TRAINING				
	Translating GIRFEC language and approach into accessible form for families to engage with.			
	Dealing with conflict that may arise within multi agency working.			
	Exploring sensitive topics with women and gaining consent to share information.			
	 Managing meetings, particularly solution focussed meetings, and coordinating inter-agency working. 			

- Developing agreed administrative infrastructure support that maximises resources and
 effectively ensures skilled practitioners can focus on delivery of care would be useful.
 Sharing models of best practice of administrative coordination across agencies would be of
 great benefit as implementation continues to be rolled out across Scotland.
- Further development of evaluation mechanisms that allow midwives to gauge the effectiveness of their work in implementing GIRFEC, should be considered. This should include reflective practice and be a key part of supervision.

6.2 Further Research

The following topics have been identified as being of particular usefulness to pursue:

- Research that follows families across inter-agency support to gain a better understanding of transitions and the longer term impact of initial work by midwives.
- The place of GIRFEC implementation within structured supervision and its impact on practice
- Barriers and enablers to interdisciplinary working across public health nursing and midwifery
- The role of midwives in promoting secure infant and maternal attachment during the antenatal period and postnatal period- barriers and enablers.
- Further exploration of Ecological Thinking within Clinical Judgement and how record keeping impedes or supports this

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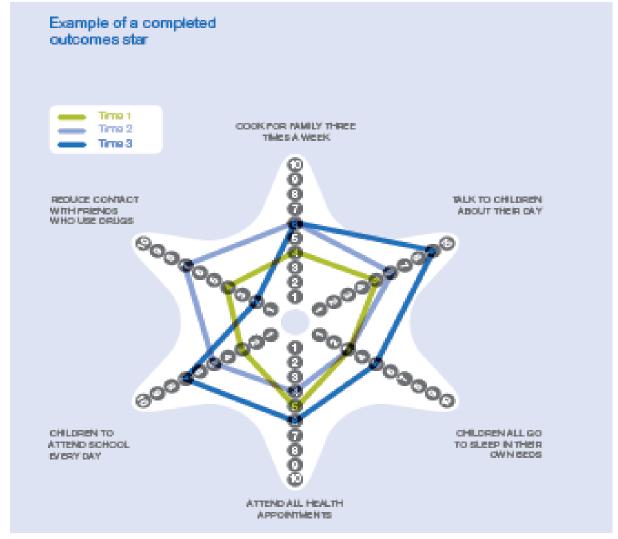
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8. APPENDICE ONE: PARTICIPANT DEMOGRAPHIC INFORMATION

Receiving Maternity Care in:	NHS <u>Highland</u>	NHS <u>Lanarkshire</u>	NHS Greater <u>Glasgow</u> and Clyde	Total
Women Participating	6	5	4	15
Parity Primiparous (first child) Multiparous (at least one previous child)	2 4	1	3	6 9
Age <20 20-35 >35	1 2 3	1 2 2	4	6 4 5
Risk Factors* Medical/Obstetric Risk Mental Health Concerns Previous social work Involvement Unspecified No Risks Identified	4 2 1 1	1 3 1	3	5 5 4 1 2

^{*}Multiple Risks Identified in Some Cases

9. APPENDICE TWO: OUTCOME TOOL FOR POSSIBLE ADAPTATION



From Leading for Outcomes Parental Substance Misuse: A Guide, Glasgow: IRISS.

There are two applications of this quick visual way of summarising information. A similar wheel with eight spokes for the SHANARRI outcomes could help midwife and parents set and measure progress or improvement in circumstances between visits thus increasing a sense of partnership working towards wellbeing.

It also may have a use for keeping track of what areas of wellbeing have been discussed if these questions are asked over a number of visits. Guidance suggests that not all SWHMR questions should be attempted in one booking visit and this tool could help track what questions have been asked should care need to be shared amongst a midwifery team.

These tools would need to be supplemented by narrative but may provide some time savings both in recording and reviewing them. There is also the advantage that they would translate easily into an IT application.