



## NHS QUALITY IMPROVEMENT SCOTLAND

### Parent Education Core Syllabus for Scotland Consultation Feedback Form

The consultation period for the Parent Education Core Syllabus for Scotland takes place between Tuesday 6<sup>th</sup> July – Monday 16<sup>th</sup> August 2010. Please send us your comments using this feedback form to Dawn Robb ([Dawn.Robb@nhs.net](mailto:Dawn.Robb@nhs.net)) no later than **Monday 16<sup>th</sup> August 2010**.

We would be grateful if you could take the time to complete this form as fully as possible, all comments will be considered and will help to shape the final syllabus and identify what support for implementation might be helpful.

#### About you:

<b>Job Title – must be completed</b>	Policy Development Manager
<b>NHS Board / Local Authority / Organisation - must be completed</b>	Children in Scotland

#### Overall comments

I have completed the form according to the headings. However there are some overview points that it is easier to make outwith the structure of the form. There is much that is positive in this report, and indeed the effort to improve the quality of care for women and their partners is welcomed. However, this report is also a huge opportunity to embrace the challenge set out in the Early Years Framework and more recently in the pledge by education and health ministers at the child health summit. They said that if we are really to transform children's lives, then transformational change is required. We need to change the "business as usual" approach and "think radically". This report is currently better "business as usual" and does not rise to the challenge of rethinking what we do in order to transform the lives of children.

There is a lot of variety in the quality and content of "parent education" classes across Scotland, as there is in the experience and outcomes of birth and early parenting. While it is important this document is based on the latest research and evidence to enable all health professionals to have the best information for parents-to-be, there is no

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information or evidence (at least none cited here) as to the *impact* of the quality of existing parent education programmes, nor on joining the dots between better, universal, parenting education and better well-being and life chances for young children. Instead, this document is offering a standard content heavily geared towards traditional parenting classes, based on either existing or aspirational practice.

The tone of the document is mechanistic and so emphasises a delivery/input approach. Although there is mention of partnership, active learning and building on parents' knowledge, the tone and structure suggests that the purpose of parent education is for professionals to deliver information to passive parents. This is linked to the assumption that the best way to 'deliver' such information is in formal classes by trained individuals. The document lacks a human element and the understanding that much good "parenting education" can be 'delivered' in informal chats with GPs, between parents to be and existing parents in waiting rooms and elsewhere, and at every encounter with health and other professionals (eg social workers).

There are plenty of very positive statements of what should be happening in "parenting education", but not much guidance as to how or why. What might be more (or at least equally) helpful to practitioners is a 'how to' guide, with case studies, and examples of how to reach the so-called hard to reach, or how to encourage and influence behaviour in the case of alcohol, smoking, nutrition, birth choices, etc. The Scottish Government and the NHS have an obligation to actually influence parents in a positive direction, not simply to deliver information with little regard for how it is heard, understood and acted upon by parents.

It is, without doubt, vital to have clear and standardised research-based information to hand, but without inspiring, practical guidance in how to communicate and then to measure the impact of such communication, there is a great danger that this information will be of little help to changing behaviour and improving outcomes.

In drafting and distributing this document there needs to be clear sense of *how* it will change the practice of midwives, GPs and consultants – all those health professionals tasked with the care of parents to be – and *what impact* this is intended to (and actually does) have on babies, mothers and fathers/partners.

This document focuses on the "teaching" and "knowing" of information, and gives little consideration to the "learning" or "doing" of that information. There might be excellent teaching and some parents-to-be might know a lot. However,

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unless a soon-to-be mother or father/partner really learns something in a way that is meaningful to them, they are unlikely to change their behaviour, or 'do' anything differently. Given that what counts, in terms of changing children's lives, is that parents-to-be learn and do, ie. they change their behaviour, that is where resources should be put, in efforts to motivate, encourage, persuade and influence rather than simply inform.

### **Establishing the purpose of “parent education”**

The document does not set out clearly and emphatically the purpose of communicating certain information to pregnant women, women trying to conceive, and their partners. Without this being clearly articulated it is very difficult for any health board to properly plan or evaluate its work. We would assume the purpose of “parent education” is to include the following aims:

- increase the number of “normal” births, ie reduce interventions, reduce c-sections, decrease infant mortality, and so improve the health and wellbeing of babies and new mothers.
- Increase the number of women breastfeeding, and so improve the health and wellbeing of babies and new mothers
- Improve the health (eg alcohol, smoking, nutrition) of pregnant women and their babies resulting in, for example, fewer pre-term babies, still births, healthier weight babies, an overall healthier babies (eg higher apgar scores)
- Improve women and father/partner's resilience, so, whatever the birth outcome – or challenges facing the newborn – they are better able to recover emotionally and physically
- With improved resilience, to therefore reduce the rate of postnatal depression (including men's), and associative problems such as poor attachment or relationship breakdown
- Improve health professionals' understanding of local families to enable further support to be offered in the early days, months, years of a child's life – i.e. linked to Hall 4.

While universal “parenting education” is not a magic bullet and can only achieve such outcomes in conjunction with other aspects health and maternity services, it is essential that efforts to improve care are focused on establishing, measuring and charting the progress of the difference that such services are in fact making. Evidence is what allows and informs progress.

### **The methods**

Parenting education is not just about classes. It is important that any document focusing on how parents learn about the process of becoming parents should not move straight to the concept and content of classes.

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The main aim of working with parents to build on their knowledge and understanding of the process of becoming parents is to improve the health and wellbeing of babies, mothers, and fathers/partners.

The process of building knowledge and confidence about birth and parenting, and expectations and relationships with health services takes place from before a woman becomes pregnant. Therefore, in considering how health and maternity services can best provide information and support, it is important to consider the whole service and involve *all* related professionals.

While the main professionals tasked with building strong and influential relationships, with prospective mothers and fathers are midwives, any material such as this document should be equally aimed at GPs, consultants, and health visitors. Given the often perceived higher “status” of GPs and consultants, a view sometimes held by women from different cultures, these professionals can have a strong impact, and so need to share the same approach to building relationships, birth planning and information sharing as midwives. Other key individuals such as sonographers, waiting room staff, maternity care assistants/all hospital staff should all be aware of the important influence/impact they can have (often unwittingly) on women and their partners. Social workers are for some families an important professional in their lives who must understand and be on board with the same messages as health professionals.

The problem with an emphasis on classes is that it can devalue and ‘let off the hook’ all other staff and their meetings with women and men. Midwives at ‘booking’ or ‘dating’ clinics may feel they need not discuss such issues because they will be covered in parenting classes. Instead, each contact between health professionals and women in particular, should be considered an opportunity to build confidence, resilience and understanding, and to inspire and motivate changes in behaviour. The better the relationship and level of trust between a woman and her midwife, the better able the midwife is in building a woman’s confidence in her ability to give birth and to cope with whatever experience she has.

Therefore, effective “parent education” requires consistency of care, that is one or two midwives sharing the care of a woman and her family throughout pregnancy.

Other ‘methods’ of “parent education” outwith standard classes include:

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First-rate, easily understandable, persuasive, pre-conception health information routinely available in settings where women, (particularly younger women) are likely to attend, e.g. GPs, sexual health clinics, school/college, young people's drop-in centres etc;  
Information displays and leaflets and browsing material such as Ready Steady Baby, in GP waiting rooms, appointment rooms and clinics. These should match those on display in hospitals, concerning birth, breastfeeding and early parenting;  
Welcoming areas for young children in waiting rooms;  
Extended one-to-one sessions (including home visits) with prospective mother and fathers when requested or when the need seems clear to the health professional.  
Informal drop-in sessions; and  
Hospital or birth centre visits or tours.

As with all attempts to market any kind of message – there are different methods for different audiences. While the document does acknowledge this point, the inclusion of examples of different ways of communicating and persuading needs much greater emphasis.

There is a lot of information outlined here, but more thought needs to be given to the core/priority information or health promotion messages. For women who make contact with health professionals late in pregnancy, or who attend only a few appointments, health professionals need to have a sense of what information is most important to share/obtain.

## **Evaluation**

There are specific outcomes in terms of babies, women and men's health that need to be measured as outlined above. Although it is difficult to determine everything that contributes to positive birth outcomes, much already is known and should be communicated effectively. It is important to build a picture of current outcomes – e.g. types of birth, birthweights, rate of postnatal depression, etc – so that in changing and improving any part of maternity care, it might be possible to measure whether this is contributing to the hoped-for improvements.

A simple start, in addition to collecting data about the health of babies and methods of birth, would be to ask a range of women and men frequently and regularly about the impact of care on their experience of ant-natal care, birth and the postnatal period and what they found to be of most benefit. Services could and should use this feedback to further

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develop what they offer and how they deliver it. It is important to understand the “why” behind the judgements of both ‘success’ and ‘failure’ as both have valuable lessons for policy maker and practitioners.

Question	Response
<p>1. What are the gaps in the syllabus?</p>	<p>Measuring outcomes/evaluation is weak.  As above – not enough about wider concept/method of ‘parent education’.  ‘Human’ touch – “finding out about feelings” eg p5. Relationships  Role of fathers and issue of postnatal depression affecting fathers.  Use of word fathers as opposed to just partners. Important to stress particular role/presence of men, while being sensitive to other birth/relationship partners  Should be something about shared responsibility of all health professionals, not just about ‘education’ and classes</p>
<p>2. What changes would you suggested to the <b>order</b> of the syllabus to make it easier to read and understand?</p>	
<p>3. What changes would you suggested to the <b>layout</b> of the syllabus to make it easier to read and understand?</p>	<p>Many NHS documents are written in landscape format, which is difficult to read.  Should be portrait format or use columns for narrow text sections.</p>

**Please provide your comments on the sections of the syllabus**

<b>Section</b>	<b>Your comments</b>
<b>Introduction</b>	See above comments
<b>Background</b>	p/8 - none of these objectives include finding out the impact of “parent education”
<b>The syllabus</b>	The first aim should be improved health and wellbeing of babies, mothers, fathers/partners.
<b>Section 1: Inequalities</b>	<p>P11. The use of alcohol and the prevention of foetal alcohol harm, needs greater emphasis throughout the document and should be listed in par 2 and in the bullet points.</p> <p>P12 preconception health should also be listed in bullet points.</p> <p>P13 “often little is known about the experience and abilities of expectant parents” - often other professionals know a lot – importance of linking with GPs, social workers, carers</p> <p>Add “obesity” to list of risks and consumption of alcohol specifically in addition to substance misuse.</p> <p>Also add: neighbourhood, own experience of being parented (particularly in respect of attachment/bonding), and level/quality of family/friends support available</p> <p>Use the word fathers, their presence in documents such as this, named, as opposed to more general parents, improves professionals’ awareness of their role and importance to the wellbeing of babies and children.</p>
<b>Section2: Adult Learning, Needs and Approaches</b>	See above main points.
Purpose and overall aim or statement	
Key elements and considerations	<p>“more than just knowledge acquisition” is a key point – confidence, trust, relationships – this should be overarching point.</p> <p>“women who spend more hours at classes were less likely etc”; this quotation is</p>

Section	Your comments
	not helpful – women who spend more hours etc are probably middle class, may well attend other classes (eg NCT) and be better educated and more able to get information for themselves. The research might recognise this, but this quotation does not.
A universal approach	
Signposts to local and national services and groups	
Quality / standard	
Health promotion messages	
Learning climate	
Flexibility in teaching approaches	
Range of mode of delivery	
Holistic approach is adopted	
Learning incorporates emotional dimensions and reflection.	
Respected	
Promoting positive parent child attachment	<p>“Assistance should be given to parents to help them understand and appreciate the capacities of their babies as they grow and change.” – (e.g. such films as The Social Baby)</p> <p><i>See recommendations of Infant Mental Health: A guide for practitioners, report of the expert working group on infant mental health, 2007</i>  <i>Helping parents to appreciate the capacities of their babies</i>  Assistance should be given to parents to help them understand and appreciate the capacities of their babies as they grow and change. Doing so has been shown to improve interaction and cognitive outcomes.  Two methods are recommended for use at different times in infancy:  The <i>Brazelton Neonatal Behavioural Assessment (7)</i> should be demonstrated</p>

Section	Your comments
	<p>to all parents before discharge or at home after early discharge to alert parents to the capacities of newborns.</p> <p>The <i>Maternal Assessment of the Behaviour of her Infant</i> (MABI) (8) should be completed after birth and every week until four weeks to raise parent's awareness. Health visitors/public health nurses could use this as part of a structured evaluation of the family's need for additional support in the first few weeks, in keeping with <i>Hall 4</i> (5) recommendations.</p>
Promoting value of attending parent education	
Appropriately educated, supported and resourced staff	Knowledge exchange – not one way, staff should be learning about those they are caring for and then sharing this knowledge with e.g. health visitors (among others).
Evaluation	This needs more detail – how should work be evaluated? Need to measure outcomes, not just process.
Resources	
<b>Section 3: Labour and Birth</b>	
Purpose and overall aim or statement	
Key considerations	
Content	
A universal approach	Different approaches etc – this is where much help/ideas/case studies would be welcome –
Signposts to local and national services and groups	
Recommendations to ensure quality	<p>“reality” of labour ward – this is the issue of managing expectations. This needs much more clarity. Would hospital visits help in managing expectations and understanding the reality of care? Would more birth stories – a whole range – help understand? This is vital part of role of health professionals –</p>

Section	Your comments
Health promotion messages	communicating what to expect from them.
Onset of labour	
Labour	
Coping strategies for labour	While it is vital that a normal birth is emphasised, it is also important that it be emphasised that these coping strategies are not just useful for labour, but are useful for any other experience throughout birth and early days/weeks, i.e. visualisation, relaxation, etc – useful for c-section, stitching, early breastfeeding. Given that there is a high rate of non ‘normal’ births and many women experience discomfort and difficulties in early feeding –coping strategies for labour are useful beyond just labour, helping women learn these methods is useful way of building resilience (and also to avoid creating a feeling of failure when births are not ‘normal’) to stress women’s abilities to create a level of control and calm over other physically demanding/potentially stressful/frightening experiences.
Birth	
Other options	Balance of information etc – see above. Easy to say, but need examples of how to do this.
Resources	
<b>Section 4: Infant and Maternal Nutrition</b>	<p>A health visitor should be involved in sharing this information, both so that they fully understand the issues themselves and to establish a relationship with parents, so that there is continuity of care around the existing 10 day hand over period, when even though breastfeeding might be begun, it will likely require continuing support.</p> <p>This section emphasises the facts, which many people know, but still fail to act</p>

Section	Your comments
	upon. There needs to be greater emphasis in this section about how to encourage and motivate and build relationships – how to bring about change in behaviour not simply to share the facts.
Purpose and overall aim or statement	
Key elements and considerations	
Content	
A universal approach	
Signposts to local and national services and groups	
Recommendations to ensure quality	
Health promotion messages	P34 – stop alcohol intake – important to raise awareness of foetal alcohol harm.
Maternal diet	
Making informed infant feeding choices	
Skin to skin	
Recognising that a baby is hungry	
How to feed a baby	
How to know that a baby is getting enough milk	
Support for feeding	
Bottle feeding	
Healthy start	
Alcohol	
Smoking	
Exercise	
Resources	
<b>Section 5: Early Days and Parenting</b>	
Purpose and overall aim or statement	

Section	Your comments
Content	
Key considerations	
A universal approach	
Signposts to local and national services and groups	
Recommendations to ensure quality	
Health promotion messages	Hygiene, cleanliness, washing your baby, changing nappies frequently and hand washing need to be included.
Baby communication and attachment	<p><i>See recommendations of Infant Mental Health: A guide for practitioners, report of the expert working group on infant mental health, 2007</i>  <i>Helping parents to appreciate the capacities of their babies</i></p> <p>Assistance should be given to parents to help them understand and appreciate the capacities of their babies as they grow and change. Doing so has been shown to improve interaction and cognitive outcomes.</p> <p>Two methods are recommended for use at different times in infancy:  The <i>Brazelton Neonatal Behavioural Assessment (7)</i> should be demonstrated to all parents before discharge or at home after early discharge to alert parents to the capacities of newborns.</p> <p>The <i>Maternal Assessment of the Behaviour of her Infant (MABI) (8)</i> should be completed after birth and every week until four weeks to raise parent's awareness. Health visitors/public health nurses could use this as part of a structured evaluation of the family's need for additional support in the first few weeks, in keeping with <i>Hall 4 (5)</i> recommendations.</p>
Baby skills	
Physical recovery	

<b>Section</b>	<b>Your comments</b>
Emotions and relationships	
Support for parents	
Resources	
<b>Appendix 1: Draft Framework for developing parent education theme</b>	
<b>Appendix 2: Universal Parent Education Programme Assessment Tool</b>	
<b>Implementation Support</b>	
We appreciate that there are many challenges in implementing the syllabus and would be grateful if you could identify any tools that you think would help you to implement this syllabus?	<p>Not clear what is being implemented – use of information, more classes? How would you measure the implementation of this document?</p> <p>Need much more information and guidance, training and inspiration on <i>how</i> to achieve this exchange of information. Case studies, training, suggested data indicators, suggested questionnaires for parents/evaluating impact. Need a coalition of different health professionals including consultants to champion the importance of the developing parents confidence, knowledge and skills.</p>
<b>Other</b>	
We are interested in receiving any other comments that you have to help shape the final syllabus and would ask if you could add them here.	<p>One of the major opportunities here is to properly help parents when birth outcomes are not 'normal' and differ from what the parents had anticipated. This can range from correctable conditions (e.g. cleft lip/palate to life-threatening conditions or chronic special needs/disabilities). This opportunity is not really embraced and acted upon in ways and to the extent needed.</p>
We are interested in receiving any photos which relate to sections of the syllabus. These may be used in the	

Section	Your comments
<p>final publication, therefore please ensure that the correct permissions have been sought.</p> <p>Please note that by sending us this information you are agreeing to it being shared more widely and possibly in the core syllabus.</p>	