A Community Health Needs Consultation: Partington & Carrington Children’s Centre

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FINAL REPORT

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Executive Summary

The Community Health Needs Consultation for Partington and Carrington Children’s Centre focused on 3 key areas: the formulation of a picture of health and social trends for Partington and Carrington, identification of the perceived health needs of the local community and partner agencies in Partington and Carrington, and provision of data to inform the future development and improvement of services provided at the Partington and Carrington Children’s Centre.

The report utilised existing (national and local) health and community data that related specifically to children and families to inform the review of health trends. Qualitative data collected during March and April of 2007 informed the other findings of this report.

Key Findings

Health Trends

- Children in Partington and Carrington live in a community characterised by:
  - Geographical isolation with inadequate transport links and limited sources of good value local food supplies
  - Well established (often extended) family networks
  - Families operating a division of labour where mothers are the primary carers
  - A mainly white working class community with a well established gypsy/traveller camp on the outskirts of the locality
  - Major issues of territorility: the Oak Road end v the more affluent “top end”.

- The hard to reach groups in this community tended to come under the “service resistant” and “slipping through the net” categories rather than “minorities” due to the nature of the population. The previous history attached to the Children’s Centre – that of a social services facility – intensified this.

Perceived Health Needs

- While government policy and health agendas focus on five key areas of the National Service Framework for Children, Young People and Maternity Services, these were not meaningful concepts to most parents in terms of connecting to their children’s health.

- Many participants who were residents expressed denial that the needs of the population in Partington were any different to the rest of the population.

- Health and social care professionals, and some workers at the Centre, held this to be a matter of ignorance of need rather than absence of need. Deprivation, unemployment, and poor parenting practices were thought to be serious problems.

- Barriers to providing a healthy diet for children were reported by residents to centre on the lack of available fresh food at a reasonable price. This was intimately linked to the perception of an inadequate transport infrastructure and the lack of choice of shops locally.

- Activities for children were thought to be seriously limited. Some parks and playgrounds were acceptable (safe, clean, and in a state of good repair), but others were considered to be unsafe.

- A significant proportion of participants recognised lack of motivation as a major contributing factor in failure to access available help and facilities.

- Issues of safety tended to revolve around hazards in playgrounds (broken glass, animal faeces), and, to a lesser extent, fear of local youths. However, workers and professionals also recognised a problem with drug misuse and poor safety in the home.
The role of the nurseries, the crèche, and local primary schools in promoting child development was recognised as an important factor in ensuring that young children enjoyed life and achieved what was expected. However, both residents and professionals recognised low levels of parental expectations for their children.

What the Centre does well, and why people use it

- Both residents and service providers considered that the Children’s Centre made a positive contribution to the health and well being of the population of Partington and Carrington.
- The Children’s Centre particularly was seen as providing a good service in terms of variety, resources, and professional help, and this compared favourably with other providers of services. Most facilities, courses, and campaigns were positively regarded by those who accessed them.
- Most of the registered Children’s Centre users expressed satisfaction with the communications they received from the Centre,
- Access to specialist health professionals was a positive aspect of the service.
- In addition to the variety of activities that took place, facilities used at alternative centres (church nurseries, for example) all offered something different to the Children’s Centre in terms of location, staff, and the parents that attended. The Centre’s services were viewed as part of a raft of provision for under-5s.
- The Oak Road Family Centre was seen as a valuable resource by many, particularly the activities that took place during school holidays and after school. The location was seen as more convenient for some residents. There was a general feeling amongst some local people that the success of the Central Road site came at the expense of the Oak Road provision.

Barriers to Centre use and suggested changes

- There was some reluctance to initiate a visit to the Children’s Centre due to the perception of parent group cliques (linked to the strong pre-existing family ties in the area).
- The “first come first served” approach to allocation of some places was widely viewed as being problematic. It was seen to favour those with personal transport, and was cited as a reason why some parents do not use the Centre.
- The timing and flexibility of the available services were also found to be barriers to use of services at the Children’s Centre.
- Many struggled to juggle the needs of more than one child if there was an age gap, since they could not attend two facilities aimed at two different age groups at the same time.
- There was a perception that the activities provided at the Children’s Centre were overly orientated towards babies, rather than the broader range of children under five.
- There was also a perceived unwillingness to focus on the needs of adults, even in their role as the parent of the child. There was particular concern that there were not enough activities to involve fathers, who were unwilling to access services that were used primarily by mothers.
- Both staff and users also recognised that the cost of using the Centre could be prohibitive, particularly for those with low incomes, those with several children, or child minders.
The bus service was generally viewed as being expensive, infrequent, and difficult to access.

There was some recognition amongst the staff that reluctance to access services often applied to the most vulnerable families.

**Accessing the local population**

- Recognising the existence of distinct areas of Partington and Carrington was essential to understanding responses and to formulating effective strategies for establishing communication.

- Word-of-mouth was a vital feature of communication throughout Partington, but especially in the Oak Road area.

- Parents of disabled children felt particularly isolated and neglected.

- The traveller community felt similarly isolated, though in a more active sense, perceiving outward hostility from residents and some workers.

- Advertising of services to non-registered parents was not effective.

- Leafleting to all addresses in Partington and Carrington proved to be an effective form of communication. Similar efforts through the use of local newspapers was found to be less effective, though often recommended.

- Posters and leaflets in local shops held potential as a means to inform the population, and there was some initial support for this from shopkeepers.

- More use could be made of communication through primary schools. The schools were prepared to assist in this way.

- Recourse to other sources of contact, particularly childminders, was recommended by participants.

- Some professionals and workers were found to have key roles in reaching all parts of the population, particularly midwives, health visitors and specialist workers such as those in the community drug teams. However, the professionals were experiencing difficulty in finding time to undertake this role to the extent that it might be possible.

**Key Messages**

To reflect the consultative nature of the project, the report outlines key messages rather than the traditional “recommendations”.

**Health Needs in Partington and Carrington**

A major effort was needed to persuade the residents of Partington of the severity of health problems affecting young children. These problems were well-recognised by health and social care professionals and included childhood obesity, teenage pregnancy, and poor parenting practices against a background of unemployment, deprivation, and widespread substance misuse. For many residents the isolated nature of life in Partington militated against acceptance of advice and understanding of the need for changes to lifestyles.

Some groups, notably gypsy-travellers and parents of disabled children, felt dissociated from mainstream health services and required focussed endeavours to engage them and to meet the needs of their young children.

The lack of availability of reasonably priced fresh food was a serious deterrent to the provision by parents of a healthy diet for young children. This combined with perceived lack of opportunity for young children to engage in safe play and exercise to cause concern in many parents for the
healthy development of the under-fives. Help with resolving issues of poor transport and better upkeep of play spaces would be valued by the community.

**The Contribution of the Children's Centre**

What the Centre did, it did well, and its services were valued by those who used them. These services included the physical facilities, activities, courses and staff. It was important that these successful services were not compromised in any amendments to strategy as a result of this consultation.

However, many parents in Partington did not know what the Centre did or what it was intended to achieve. More effective advertising was required including alternative means to reach those who did not access services. This could be improved by occasional leaflet drops, leaflets in local shops, via the primary schools, and with childminders.

The Centre needed to address perceptions as well as facts. Much of the resistance to accessing services at the Centre related to misguided and misinformed views of its nature, purpose and mode of operation. Much work was needed to reverse perceptions of social services surveillance in the Centre, imposition of advice and interventions, and the cost of activities. Nursery and crèche staff held great potential to achieve this, as did community workers who were trusted, such as health visitors and midwives. This human resource needed to be exploited more effectively.

Some barriers to accessing services – both perceived and actual – could be addressed by the Centre:

- Within the context of avoiding a pricing policy which would damage other local provision, costs of some activities needed to be reviewed.
- Access to some services at the weekend and spreading these more evenly across the day would encourage use by working parents.
- Integrating the Centre’s provision such that parents with children of different ages could access facilities for both age groups simultaneously would facilitate their use of the Centre.
- The gap in provision between baby massage and toddler activities needed to be reviewed.
- Previous attempts to provide alternative transport to the Centre needed to be revived.

The Centre’s provision of leadership and support for the local community to address some issues (such as improved transport, safer access to the leisure centre, better upkeep of playgrounds) would promote engagement with parents and improve the image of the Centre among some service-resistant groups.
Section 1  Context of the Project

Children’s Centres

Sure Start children’s centres are one of the key delivery mechanisms for achievement of the objectives set out in *Every Child Matters* (Department for Education and Skills (DfES) 2004) where the aim is to improve health and social outcomes for all young children and to close the health, social and economic gap between the most disadvantaged groups and others. This is based on the premise that outcomes and options for children, families and their communities are enhanced by the availability of high quality and integrated childcare, early learning, and health and family support services at *neighbourhood* level.

Children’s centres were developed to support those in most need, and to tailor provision to the needs of individuals, families and diverse communities. Provision typically includes information and advice about health services, parental outreach, and preventative health in accordance with relevant government initiatives (DfES 2004, Department of Health (DH) 2004a).

Children’s centres are also the cornerstone for delivery of early years learning by local authorities, and as such are crucial in the delivery of government initiatives such as *Choices for Parents, the Best Start for Children* (HM Treasury 2004) and *Every Child Matters* outcomes such as being safe, healthy, enjoying and achieving, economic well being, and making a contribution. Children's centres are also significant resources for the support parents in terms of their aspirations towards employment as well as support for parenting.

Partington and Carrington Children’s Centre

The Central Road Children’s Centre was launched in January 2005 – evolving from the Sure Start Partington and Carrington Local Programme. It aimed to create a one-stop-shop for children and families in an area described on the Sure Start website as “relatively isolated, surrounded by farmland, with limited transport to access services out of area”.

After a period of consolidation, the children’s centre was looking to develop and improve the service and to build the client base further. This included increasing the numbers of registered users and converting registered non-users to registered users of the service.

This project was therefore an exercise involving members of the local community and partner agencies that aimed to explore their perception of local health needs. A combination of qualitative and quantitative data was collected from service users, staff, and the local community, including where possible those from “hard to reach” groups. This data related to local health and social trends, and to the use and perceptions of children’s services in Partington and Carrington. The data was analysed and the findings discussed in the context of current health policy with the ultimate aim of addressing identified needs and informing the future development of public health services at the children’s centre.
Section 2   Method

PROJECT OBJECTIVES

To formulate a picture of health and social trends for Partington and Carrington using existing health and community data that relates specifically to children and families.

To identify the perceived health needs of the local community and partner agencies in Partington and Carrington.

To provide data that will effectively inform the future development and improvement of services provided at the Partington and Carrington Children’s Centre, more specifically
  ▪ To identify aspects of the services that are viewed positively, and that are thought to be effective
  ▪ To identify barriers to access and use of the children’s centre by registered non users.
  ▪ To identify barriers to access, registration and use of the children’s centre for hard to reach groups within “pram-pushing” distance of the centre.

Research Questions

These objectives were operationalised into the following research questions.

  o What are the health and social trends for Partington and Carrington relating to children and families?
  o What are the perceived health needs of the local community?
  o How can this data be used to inform the development of services at the Children’s Centre?
  o What are the factors that contribute to successful access to/use of the Children’s Centre?
  o What are the factors that hinder access to/use of the Children’s Centre?
THE PROJECT TEAM

The project was undertaken by a team with wide expertise and experience of both practice and research in health and social care with children, young people and families. It included 5 academics from 3 research centres in the University of Salford Institute for Health and Social Care Research. All members of the research team had current CRB clearance.

Debbie Fallon (Project Manager) has a clinical background in children’s nursing, working particularly children with disabilities resulting from neurological or metabolic disorders and their families. She has an academic interest in issues on the boundary of health and social care for children and families. In addition to other projects that involved the evaluation of services for children and families, her work in the field of teenage pregnancy and adolescent risk behaviour has led to international conference presentations and publications.

Patric Devitt is Senior Lecturer in Child Health with a clinical background in children’s nursing, particularly with children with cancer and their families. He is a member of the steering group of the Royal College of Nursing’s Research in Child Health Group and was part of a research team which undertook the Evaluation of Bury and Rochdale Health Action Zones. He also serves the community through engaging with young people in sport.

Lindsey Dugdill is a Reader in Exercise and Health with experience in applied community health projects in the North West. For the last five years her work has focused particularly on local physical activity initiatives including evaluations of two adult exercise referral schemes and the development and evaluation of children’s physical activity programmes. Recent projects also include the Regional Health and Physical Activity Coordinator (RHPAC) Evaluation and the North West Physical Activity Audit.

Tony Long is Professor of Child and Family Health and leads on research with children and families in the research institute. His personal research programmes are in evaluation of health and social care services for children and families, safeguarding children, and excessive infant crying. Together with other members of the research team he is currently engaged in evaluating a project to improve health and social care services for chaotic and “difficult” families with a view to reducing persistent re-referral.

Michael Murphy is Senior Lecturer in Social Work. A qualified social worker and counsellor, he has wide experience in dealing with substance misuse, looked after children, chaotic families, and safeguarding children, and has published widely in these areas. He acts as a training consultant to several training organisations (DATA, NWIAT, Right from the Start, Bolton HSCB). He is the chair of Bolton Substance Misuse Research Group and was an executive member of PIAT (the promotion of interagency training in childcare).

Eileen Oak is Lecturer in Social Work who has worked almost exclusively in the field of child care in the specialist areas of child protection, family and child guidance, child care intake teams, youth justice and a looked after children’s team. She is currently involved in the North West Gypsies and Travellers Project.
**PROJECT DESIGN**

While discrete phases for the project were identified in the brief, the short timescale (9 weeks) necessitated that some of the work would be undertaken simultaneously. Opportunities to collect data for different parts of the project were therefore seized as the opportunities arose.

**Health Trends**

Clearly, the collection of a set of statistics or other data that might lead to a comprehensive health needs analysis was beyond the remit of this project. However, a range of data relating to the health and social trends for Partington and Carrington was readily available which included Trafford NHS Trust statistics for deprivation and childhood obesity for reception age and year six, the 2006 DH health profiles for Trafford, the IMD (ODPM 2004), “Bright Futures” The Trafford Children and Young People's Plan 2006-2011, the 2005 OFSTED reports for schools in the locality, and the accelerated Teenage Pregnancy Strategy (DfES 2006)

Data from these documents was reviewed and a meta-analysis of various data sets that inform service provision local to Partington and Carrington produced. This was then analysed with the purpose of highlighting strengths, weaknesses and potential application to service provision for this area.

**Perceptions of health needs, use and barriers to use of the Children’s Centre**

The proposal identified “partnership” to be a significant aspect of service provision in Trafford. Indeed partnerships with children, young people and families, the voluntary and independent sector, local communities and staff was highlighted as essential in establishing “a culture of participation” which is thought to facilitate the service aim of becoming “a child and young person focused organisation” (“Bright Futures” p21).

In order to facilitate the participation of the local community, the research team developed an interview tool that was sensitive to the needs of a socially excluded population. They also collaborated with key staff from the Children’s Centre in order to identify a sample including individuals or organisations that would avoid exclusion of those who are more difficult to engage with and which also advanced the needs of the consultation. The sample is outlined in detail in the data collection section.

Visits to individual dwellings were avoided in order to maintain safety for both the researchers and the participants. With the welcome assistance of the service providers, engagement with small groups, individuals, and families took place in safe locations both within and outside the Centre. Telephone interviews were often the preferred form of contact for the participants and were used effectively.

Interview data was recorded in the form of a combination of verbatim transcription of tape recorded interviews, notable messages and illustrative quotations. Findings were compared by 3 of the research team members.

The resulting data was stored on a secure Blackboard (Virtual Learning Environment) site to enable secure access and manipulation of the data by the research team. The analysis was guided by the research questions and the overall purpose of the consultation. Outcomes focused on the research questions and the requirements of the brief, and the results collated into major findings, illuminated by selected data extracts.
Recruiting Participants

In accordance with the project brief, participation was restricted to residents of Partington and Carrington with children under 5 years of age, together with workers and professionals from the Centre and elsewhere who managed or provided services for the population.

Representation from the whole of Partington and Carrington

As is the case with Trafford as a whole, Partington is recognised to include areas both of relative affluence and of relative deprivation. Indicators such as housing stock, together with results from previous reports, indicate that the population generally perceives there to be a loose boundary (formed partly by the A6144 – Manchester Road-Warburton Lane) between at least two elements of Partington. These are commonly referred to as the “top and bottom ends”, the bottom end centred on the Oak Road estate, with the top end lying to the north and east of the centre and centred partly on Lock Lane. Carrington and the outlying areas to the north east are sometimes considered to be a third element, while the travellers site is commonly held to be a fourth. The project team made particular efforts to capture the views of residents across the whole area of Partington and Carrington.

Participant location by Partington Census Output Areas

(6 postcodes not known)

Postcode Checks

All residents who participated were asked to provide their postcode. Mapping of these against Census Output Areas for Partington showed a widespread picture of participation, including both the “top” and “bottom” ends of town, as well as representation from the catchment areas of the four local primary schools. There was little representation of Carrington, however.
Of the 112 postcode areas relating to registered users of the Centre, 32 were included in the project. A further 27 postcode areas were reported by participants who were not registered with the Centre. These do not represent counts of individuals, since many of the postcode areas related to several registered users or participants, but they indicate a fairly even geographical spread of both registered users and non-registered residents within the sample.

**Leafleting**
A leafleting company was employed to post project promotion fliers to every address in Partington and Carrington. Of the 99 individuals interviewed, only 7 reported that they had not received the leaflet in this manner. Given that a proportion of respondents might be expected to dispose of the leaflet with other "junk mail" without recognising its content, it seems likely that coverage was almost total.

**Primary school contact**
One school – Our Lady of Lourdes Catholic Primary School – agreed to attach the leaflet to the school newsletter being taken home by every child, and this was reported by some respondents as the stimulus for them to contact the project team. This means was not available or appropriate at the remaining schools due to difficult circumstances (with imminent closure of one school, and major structural damage from a recent storm at another). However, Partington Primary School agreed to provide access to nursery class parents and facilitated this for 2 group interviews.

**Canvassing in the centre of Partington**
The project team spent time canvassing around the market, shops, the leisure centre, and Children’s Centre in Partington on two occasions. This proved only moderately effective, with notably few residents to be seen in town on a Saturday morning and afternoon.

**Notices**
Notices were also displayed in the Children’s Centre and in the Children’s Society Centre on Oak Road, and shop windows in Partington centre.

**Additional Contacts**
Since participation by groups which are often less likely to participate or which are considered “hard-to-reach” was specifically sought by the Children’s Centre, the project team, in consultation with the Centre’s Public Health Manager, made contact with residents and workers in specific fields. These included the travelling community, a young mothers support and action group, fathers (through a five-a-side football league), workers supporting substance-abusing parents, and parents known to primary school teachers, some of whom were identified as experiencing particular difficulties or requiring support. Particular efforts were made to contact parents of disabled children.

This was augmented by informal discussions with other residents and individuals working in Partington while clarifying issues arising from the data. Primary school teachers, for example, were helpful not only in arranging group interviews with parents, but also in explaining attitudes, circumstances, and behaviours of some parents in relation to recognising and reacting to health needs. Local shopkeepers, receptionists, and leisure facility workers clarified comments made by participants. Discussion with workers at the Oak Road Children’s Society children’s centre also proved to be insightful. Specific issues were pursued with other agencies. For example, comments by participants about local bus services were discussed with a representative of Greater Manchester Passenger Transport Executive.

**Contacting the Project Team**

**Information in the recruitment leaflets**
The information provided both orally and in writing explained the purpose of the project and the request for residents to participate, indicated the nature of participation, and stated the means by which the project team could be contacted. (See Appendix A)
Means of contacting the project team
Details of preference for means of responding, together with personal contact details were taken in person from those individuals who stopped to speak to the research team during the canvassing in the town centre. For others, the leaflets offered a choice of five means by which those interested in participating might contact the project team.
- Speak to a research team member on a dedicated mobile phone number
- Leave a voice message on a dedicated mobile phone number
- Send a SMS text message to the same mobile phone number
- Email one of the researchers
- Return a reply slip in a pre-paid envelope available from the Children’s Centre or Oak Road Children’s Society Centre.

Each of these means was used by respondents, but only one response was received by the prepaid envelope route.

In each case, the respondent was asked to indicate whether they would prefer to be interviewed by telephone at a time of their convenience or to take part in a group interview. They were also asked to state their preferred means of being contacted.

Most of the nursery workers were interviewed as a group, but other professionals and workers were interviewed individually in person or by telephone.

Engaging with Hard to Reach Groups
The proposal gave an indication that the terms hard to reach had to be defined by the service providers themselves in order to be a useful construct. Previous research (Doherty et al 2004) suggested that the following broad terms might be useful:

- Minorities – Traditionally under represented, marginalised, disadvantaged and socially excluded
- Service Resistant – The overlooked, the invisible, and those unable to articulate their needs
- Slipping through the Net – The over targeted and disaffected, “known” families, and those who are wary, suspicious or distrustful

The context of the consultation was also an important consideration. Specifically, the term “consultation” itself perhaps implied a wider and more intense dialogue with the local community than was proposed in the planned time-span. That said the initial recruitment activity involved a leaflet drop to every household in the area, i.e. 3,726 delivery points over 255 postcodes between 5th and 9th March 2007. Recruitment also took place via word of mouth and face to face contact in the local area, via service providers and follow up from a contact list provided by the Centre manager.

The research team provided a third party in terms of this consultation. Participants were all informed that the information was being collected at the request of the Children’s Centre management, but that this was a project that offered them an opportunity to put their views forward to an independent group of researchers. This served to reduce the power dynamic between consulter and consulted that McLaughlin et al. (2004) suggest is an essential consideration in such activity.

The residents of Partington and Carrington were not treated as a homogenous group. It was acknowledged that the structural constraints of poverty, unemployment, deprivation lack of educational opportunity – all impact on people’s capacity to engage. More importantly, in discussion with the participants the researchers made efforts to convey that this project did not represent an end point, but an initiating event.
DATA COLLECTION

Data was collected from a number of sources using four main methods.

- Health statistics were examined as background and to provide context for the interpretation of other data.
- Structured interviews were conducted in the streets of Partington using the questionnaire in Appendix B.
- Telephone interviews were conducted with residents of Partington or Carrington, and with key workers in a variety of agencies associated with the project focus. The interview script is included in Appendix C.
- Focus group interviews were held with residents and with workers.
- Individual (face-to-face) interviews were conducted with professionals associated with services for the population of Partington and Carrington.

Profile of Participants

A total of 99 residents took part formally, together with 18 workers and professionals.

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<tr>
<th></th>
<th>Telephone interview</th>
<th>Group interview</th>
<th>Street interview</th>
<th>Individual interview</th>
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</thead>
<tbody>
<tr>
<td>Residents</td>
<td>32</td>
<td>54</td>
<td>11</td>
<td>2</td>
</tr>
<tr>
<td>Workers / professionals</td>
<td>1</td>
<td>6</td>
<td>0</td>
<td>11</td>
</tr>
<tr>
<td>Sub-total</td>
<td>33</td>
<td>60</td>
<td>11</td>
<td>13</td>
</tr>
<tr>
<td>Total</td>
<td></td>
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The professionals and workers included nursery staff (n=6), health visitors (n=3), drug team (n=2), speech therapist (n=1), speech therapy support (n=1), dietician (n=1), and community midwife (n=1), neighbourhood community development officer (n=1), social worker (n=1) traveller education service (n=1).

Group interviews were conducted with crèche parents (n=15), primary school nursery parents (n=33), and members of a young mothers support and action group (n=6).

Limitations

The timeframe of the project – over 2 months – prevented detailed surveying, though wide coverage was achieved nevertheless. Despite efforts to ensure their participation, only 5 men were included in the survey of residents. Two of these took part in group interviews, two opted for telephone interviews, and the fifth responded to the structured interview in the street in Partington town centre. The research team attempted to make contact at local 5-aside football matches and at the leisure centre, but the targeted team failed to show for the arranged matches, and the event reported to be being held at the leisure centre did not occur. Several of the female participants were asked if their male partners would consider taking part, but this was always met with a negative response. A further limitation was that most statistical information relates to Trafford as a whole or to the ward, with little relating specifically to Partington.

However, these issues were countered to a large degree by access to staff networks facilitated by the Assistant Manager of the Centre, by co-operation with IT staff at the Trafford PCT, by the willing participation of workers and professionals, and by the provision of funds to recompense participants retrospectively for their time and inconvenience. The inclusion of young mothers, travellers, parents with disabled children, and residents of all parts of Partington helped to ensure that the consultation was not skewed towards those who are more easily recruited.
DATA ANALYSIS

The analysis was conducted using a variation of the Framework Analysis process (Ritchie and Spencer 1994). This is particularly useful when answers to specific questions are sought (rather than an exploratory study to identify which questions need to be answered) and when the data collection has been structured intentionally around the specific research questions. It is often used in health-related research to provide specific information, usually within a short time scale. The use of a pre-planned sample and the identification before commencement of issues which must be addressed further reinforce the selection of framework analysis. The primary concern in this project was to describe and interpret aspects of a specific problem within a specific setting.

The usual stages of framework analysis are:

- Familiarisation (Gaining an initial notion of key ideas and recurrent themes)
- Identifying a thematic framework (Identifying key issues more confidently, and using these to form a framework or index)
- Indexing (Application of the index/framework to the data to label the data items)
- Charting (Data items arranged according to the new scheme and laid out in chart form to allow for comparison across themes or cases)
- Mapping and interpretation (The process of interpreting the arranged data to provide answers to the research questions.).

It is common for an a priori element of the second stage to be included. That is, the thematic framework will often be partly structured from the research questions or key issues to be explored rather than solely from the data collected during the project.

The project research questions formed the first part of the framework:

<table>
<thead>
<tr>
<th>1 Health trends</th>
<th>2 Perceived health needs</th>
<th>3 Positive factors</th>
<th>4 Negative factors</th>
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<tbody>
<tr>
<td>(What are the health and social trends for Partington and Carrington relating to children and families?)</td>
<td>(What are the perceived health needs of the local community?)</td>
<td>(What are the factors that contribute to successful access to/use of the Children’s Centre?)</td>
<td>(What are the factors that hinder access to/use of the Children’s Centre?)</td>
</tr>
</tbody>
</table>

Perceived health needs

<table>
<thead>
<tr>
<th>2.1 Is Partington different?</th>
<th>2.2 Staying safe</th>
<th>2.3 Enjoying and achieving</th>
<th>2.4 Making a positive contribution</th>
<th>2.5 Achieving economic well-being</th>
</tr>
</thead>
</table>

Positive Factors

<table>
<thead>
<tr>
<th>3.1 A positive contribution to health</th>
<th>3.2 Varied facilities</th>
<th>3.3 Staff as a resource</th>
<th>3.4 Courses and events</th>
<th>3.5 Campaigns</th>
</tr>
</thead>
</table>

Negative Factors

<table>
<thead>
<tr>
<th>4.1 Not for me: Perceptions of not belonging</th>
<th>4.2 Availability: opening times, allocation of places</th>
<th>4.3 Cliques</th>
<th>4.4 Association with Social services</th>
<th>4.5 Transport and accessibility</th>
<th>4.6 Cost</th>
</tr>
</thead>
</table>

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As part of the project the team evaluated its efforts to reach the population and to inform (hard-to-reach groups) of the consultation. In interviews by telephone, in groups, on the streets and in person, as well as in informal discussions with locals, the question was asked: “If we or others like us wanted to consult with people like you again, how should we go about it?” This added a fifth structure to the framework: Accessing the population.

<table>
<thead>
<tr>
<th>5 Accessing the population</th>
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<tbody>
<tr>
<td>5.1 Elements of the population</td>
</tr>
</tbody>
</table>

**ETHICAL CONSIDERATIONS**

Part of the consultation involved assessing awareness in the population of the services on offer at the centre, and advertisement of the consultation was part of this effort. Varied means were used to provide information to ensure informed choices about participation, as detailed above. The project team was prepared to make information available in languages other than English if this need had been identified.

Written consent from some populations and for some research topics is notoriously difficult, since this is associated with regulatory authorities and elements of the welfare system. True signatures are rarely offered if at all. For this reason, and due to the informal nature of the consultation, verbal consent (rather than written consent) was sought from participants. However, the researchers ensured that individuals who wished to disengage from a discussion were enabled to do so without embarrassment or fear of untoward consequences.

Access to summarised or pooled data about the local population held by the children’s centre was sought for the purposes of the project, most of which was anonymised before being provided or already lay within the public domain. The research team undertook to respect local regulations and processes. The usual ethical standards relating to research with vulnerable populations and the use of potentially sensitive data were pursued by the project team. In particular, data was stored securely, with access restricted to members of the project team. Such personal information as was essential to the project relating to respondents (whether service users or service providers) remained confidential and was moved to secure storage in the university where required, destroyed by the project team, or retained by the Children’s Centre on completion of the project. The project team abided by the research ethics guidance offered by the British Sociological Association 2002 and the Royal College of Nursing 2007.

The researchers’ safety was considered, and visits to areas of concern were made only when accompanied by a worker from the centre or partner agency or another member of the research team, and then pursuing the lone researcher policy in operation within the research centre.

The project team did not seek to identify individuals as NHS patients (past or present), but rather as members of a community served by a local resource, and the project did not fall within the realm of COREC approval (now National Research Ethics Service). Formal approval was secured from the University of Salford Research Governance and Ethics Committee.
Section 3 Health and Social Trends in Partington and Carrington

Partington and Carrington were, up until 2004, part of the Bucklow ward in Trafford which has a population of 7,723. Within Trafford, Partington and Carrington has the highest number of residents in the following age ranges 10–14 years (9% of the population), 20-24 (6% of the population) 30-44 (23% of the population) with the lowest rate for people aged 75+ (less than 3%) of the population.

**Ethnicity**

Based upon the Census 2001 figures the ethnic composition of Partington and Carrington is as follows:

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Partington &amp; Carrington</th>
<th>Rest of Trafford</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>96.89%</td>
<td>91.64%</td>
</tr>
<tr>
<td>Mixed</td>
<td>1.18%</td>
<td>1.52%</td>
</tr>
<tr>
<td>Asian or Asian British</td>
<td>0.95%</td>
<td>4.05%</td>
</tr>
<tr>
<td>Black or Black British</td>
<td>0.61%</td>
<td>0.95%</td>
</tr>
<tr>
<td>Chinese</td>
<td>0.26%</td>
<td>0.54%</td>
</tr>
<tr>
<td>Other</td>
<td>0.12%</td>
<td>0.30%</td>
</tr>
</tbody>
</table>

The categories of the Census 2001 have been criticised by researchers (Parekh 2002: Modood et al 1997) on the following grounds:

- They conflate ‘race’ with ‘ethnicity’ (eg Black, a skin colour, and nationality, such as Bangladeshi).
- The category ‘other’ is too vague and does not encapsulate the diversity of ethnicities and cultures amongst the white populations of the UK (particularly with the recent diaspora from eastern Europe).
- They do not include a category for people of Irish nationality.

In addition, despite it being a statutory requirement of both the 1976 Race Relations Act and the 2000 Race Relations (Amendment) Act to include ‘Gypsy’ as an ethnic category there are no details of Gypsies. The number of Gypsy-Travellers (which is considered an ethnic classification distinct from New Age Travellers) in the UK is estimated widely between 100,000 – 350,000 (Bhopal 2006). Figures collected from recent DfES data collection Exercise (DfES Minority Cohesion Team 2003) show that there are 42,879 Gypsy Traveller in England. Within Partington there are 94 Gypsy-Traveller adults and children. Fifteen of the children are under five and a further twelve are between 10 and 15. This accounts for 1.22% of the local population.

Both the difficulties with the Census 2001 data and the lack of detailed information on Gypsy-Travellers has implications for providing ethnically and culturally sensitive health and social care services where English is not the first language.

**Age of local population**

<table>
<thead>
<tr>
<th>Age Range</th>
<th>Partington &amp; Carrington</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - 4</td>
<td>480</td>
</tr>
<tr>
<td>5 - 7</td>
<td>308</td>
</tr>
<tr>
<td>8 - 9</td>
<td>243</td>
</tr>
<tr>
<td>10 - 14</td>
<td>621</td>
</tr>
<tr>
<td>15</td>
<td>125</td>
</tr>
<tr>
<td>16 - 17</td>
<td>235</td>
</tr>
<tr>
<td>18 - 19</td>
<td>222</td>
</tr>
<tr>
<td>20 - 24</td>
<td>497</td>
</tr>
<tr>
<td>25 - 29</td>
<td>489</td>
</tr>
<tr>
<td>30 - 34</td>
<td>1804</td>
</tr>
<tr>
<td>45 - 59</td>
<td>1293</td>
</tr>
<tr>
<td>60 - 64</td>
<td>352</td>
</tr>
<tr>
<td>75 - 84</td>
<td>332</td>
</tr>
<tr>
<td>80 - 89</td>
<td>51</td>
</tr>
<tr>
<td>90+</td>
<td>20</td>
</tr>
</tbody>
</table>

(Source DH: ‘Health Profile for Trafford’ 2006)
Social Exclusion, Poverty and Deprivation in the area

For Trafford as a whole, the Index of Multiple Deprivation 2004 (ODPM 2004) suggests that life expectancy is 77.3 for men and 80.8 years for women. Air quality is defined as ‘poor’ and 57.9% of council properties do not achieve the ‘decent homes standard’ - which is worse than the national average. Conversely violent crime is lower than the national average, as are road injuries and deaths. In terms of educational attainment (measures as 5 GCSE passes, grades A-C) Trafford is above the national average. Statistics also suggest that 22.3% of adults ‘binge drink’ in Trafford.

In terms of Partington and Carrington, indicators such as air quality may differ due to the geographical location and amount of open space in the area. However, life expectancy in the poorest quartile of wards such as areas’ like Partington, Clifford and Urmston indicate that the average male life expectancy is under the Trafford average being 75.9 years. With regard to standardised mortality rates Partington is in the highest group in England with 132 – 212 per 100,000 of deaths under 75+. Statistics for violent crime, road deaths and binge drinking are difficult to generalise. Residents of Partington and Carrington are less satisfied with their local area as a place to live than residents of any other area of Trafford (Trafford MBC 2007).

Statistics from the local high school "Broad Oak" provide a much more accurate account of the educational attainment figures for the area, stating that pupils enter the school with attainment that is well below national averages. In the time they spend at school all groups of pupils make satisfactory progress but attainment by the end of year 9 remains below national levels and by the end of key stage 4 attainment is also significantly below the national average. Importantly, though, the report indicates that significant progress is being made at the school, and that in 2005 the proportion of pupils who achieved 5 or more A* to C grades at GCSE improved markedly from 22% to 34%.

The IMD 2004 puts Partington and Old Trafford as the areas with the highest levels of deprivation in Trafford. In addition Bucklow (which includes Partington and Carrington), Clifford and Talbot are in the top 25% of the worst deprived areas in England, while Urmston, Stretford, St Martins, Park and Sale Moor in the second worst 25% of the most deprived areas in England. Partington measures a 60+ score in terms of multiple deprivation putting it in the top quartile of the multiple deprivation areas in the country whereas Carrington scored a 30 -39 IMP score putting it the majority 80% of areas with an national average of multiple deprivation.

However in terms of the IMD report (ODPM 2004) it is important to be aware of the limitations of its measures of poverty, deprivation and the criteria to establish social exclusion. The index of multiple deprivation developed by Oxford University Department of Social Policy and Social Research is based upon seven dimensions of deprivation which can be measured separately then aggregated to give an overall deprivation figure. These include: income deprivation and disability, education, skills, training a, barriers to housing services, environment deprivation, employment, deprivation and crime. These dimensions are an extension of the formulations of the Department of Works and Pensions (DWP) formulated in 2002 in conjunction with the Social Exclusion Unit. These have been criticised for various reasons.

Income deprivation is calculated using the “Below Household Average Income” figures which the government has used since 1997 to calculate Job Seekers allowance and Working Tax Credits.
Using these figures, benefit is calculated at 60% of the median before housing costs. The Child Poverty Action Group (CPAG) argues that there are considerable problems with measuring income deprivation using a before housing cost calculations because there are big regional differences in housing costs e.g. on domestic fuel, travel costs, rentable properties, and the number of families on low incomes. In terms of the benefit rates Howard et al’s (2001) research identified that an average couple in receipt of benefit with two dependent children is still £11 per week short of the government’s own official poverty line. Child Poverty Action Group argues that, in using the before housing cost figures, the government in 2002 estimated that there were 9.3 million families in poverty, whereas alternative sources estimate a figure of up to 12.9 million. In addition, CPAG points out that within the poorest 10% of the population there has been a 39% increase of the proportion of lone parents (particularly lone mothers with children under 5). Additionally, income deprivation figures make no allowance for factors such as the correlation between income deprivation and disability (39% of those with a physical disability live in poverty, and the increased financial burden of travel or housing adaptations or supported living costs faced by people with disabilities. Moreover, given the correlation between poverty, disability and increased likelihood of neglect or physical abuse (Petrie 2002, Corby 2001) it is necessary, in order to make a full assessment of deprivation factors affecting service user participation rates in services, to ascertain the number of children with disabilities registered with Trafford Council. However, this data is compiled only from a voluntary register informed by parental reports. At the time of this report, there were 440 children in Trafford registered as disabled, with a further 30 notifications being processed. Not all of these children should be considered to have need for health and social services support.

In terms of assessing deprivation related to living environment, the figures used in the IMD 2004 for Trafford do not include the number of people who live in temporary accommodation, hostels, bed and breakfast accommodation or who are homeless, or the mobile populations such as Gypsy-Travellers.

As well as the lack of consideration of the impact of disability and poverty, gender and social exclusion, the IMD has been criticised for its limited dimensions of social exclusion. Byrne (2002) argues that government sponsored research and SEU (2003) definitions fail to consider the special dimensions of social exclusion in terms of the urban regeneration projects in UK cities like Glasgow, Sunderland, Manchester and London and the way many members of local communities often on the peripheries of these cities are socially excluded from the decision-making process which is often left in the hands of private building companies and local authority planning.

Byrne (2002) identifies the weaknesses of the White Paper Bringing Britain Together: A National Strategy for Neighbourhood Renewal (CM4045) which claims to be the ‘template’ for partnership between local communities and regeneration projects. Byrne (2002) argues that such a template is ineffective given the relative powerlessness that residents in these areas experience due to fragmentation of the communities caused by income differentials, age, and ethnicity with those in the poorest and run down areas thought to be in a particularly weak position. The application of Byrne’s (2002) critique to the demographics of Partington would indicate that (for example) the plans to regenerate the local shopping area would benefit from consultation with the local residents which would then inform the take up rate for local services.

Social exclusion is a dynamic entity particularly for those aged 20–35 years where the extent of the problem is contingent on their mobility back and forth from unemployment to insecure low paid employment (Byrne 2002). However, social exclusion remains fairly static for older people, particularly the 70-85 age range and for lone female parents aged 25-35 years.

However, a greater awareness of the multidimensional nature of social exclusion, particularly for vulnerable service user groups such as lone parents and older people is also required (Burkardt et al 2002). This may relate particularly to exclusion from material resources, from social relations such family and community networks, from civic activities such as voting and from basic or neighbourhood services such as health facilitates, Sure Start, schools and social services. Such
exclusion may also be illustrated by housing estates with high proportion of empty houses, with no banks, shops, or health and social services offices in the immediate area.

Health

In line with current health policy, several issues emerged as being of particular interest to the management at the children’s centre. These issues included for example childhood obesity, and teenage pregnancy. The available statistics indicate that for Partington, 21% of reception age children were recorded as overweight and 6% recorded as obese. In the Partington Primary Schools out of 87 pupils 15% were recorded as overweight and 23% obese. This compared to Trafford overall in Year Six where 14% were recorded as overweight and 15% as obese.

The Trafford Health Survey (DH 2006a) reveals other causes for concern. A recent health summary examined issues such as drug abuse, binge drinking, quality of housing, teenage pregnancy, violent crime life expectancy infant mortality, ‘poor’ health’ diabetes and tooth decay. The survey identified a red dot (significantly worse than England average) and orange dot (significantly better than England average but ‘may still indicate a significant health burden’). The authority scored red dots for issues such as poor quality housing, binge drinking, drug misuse, diabetes and orange for violent crime, quality of older people’s supported accommodation, teenage pregnancy, smoking, male life expectancy, infant mortality, road injuries/deaths, ‘poor health’ alcohol related hospital stays (DH ‘Health Profile for Trafford’ 2006). More specifically the DfES (2006) under 18 conception rate statistics indicate that in 1998 the number of under age conceptions within Trafford MBC was 53.6 females per 1000 aged 15 to 17 years and in 2004 the rate was 53.9 per 1000. The percentage change of +0.6 within this time span resulted in Trafford MCD being located in the red “traffic light” area for under 18 conceptions. Again all these factors may contribute to a sense of social isolation and impact on capacity to engage with services.

Summary

The data collected from service providers and available demographic documentation therefore indicated that the children in Partington and Carrington live in a community characterised by:

a) Geographical isolation with inadequate transport links and limited local retail outlets;
b) Well established (often extended) family networks;
c) Families operating a division of labour where mothers are the primary carers;
d) A mainly white working class community with a well established gypsy/traveller camp on the outskirts of the locality, and major issues of territoriality: the Oak Road end v “the top end”.
e) Deprivation and high unemployment in distinct parts of Partington;
f) Notable health problems for children, particularly in relation to dental health, obesity, and teenage pregnancy.

The hard to reach groups in this community tended to come under the “service resistant” and “slipping through the net” categories rather than “minorities” due to the nature of the population. The previous history attached to the Children's Centre – that of a social services – facility intensifies this.
Section 4 Perceived Health Needs

What do people in Partington and Carrington perceive to be their health needs with regard to children under 5?

The National Service Framework for Children, Young People and Maternity Services (DH 2004 p10) indicates 5 key areas in which services should seek to support children and young people:

- Being healthy
- Staying safe
- Enjoying and achieving
- Making a positive contribution
- Achieving economic well-being.

Is Partington different or not?

Perhaps the most graphic description of the needs of children under five in Partington was provided by a community midwife, who provided a complex picture:

“For care in the antenatal stage the needs in this area are great and complex. There are issues about pregnant women taking drugs, smoking, drinking or depressed. There are a lot of children with special needs. I think drinking is an insidious problem - maybe the biggest problem. Deprivation is a problem, but it’s not the worst place in Trafford. Its complex, the reality is that we have 3 or 4 generations of people who have never worked, and that causes problems. There’s lots of people who have fathers or brothers or sons in prison. There is a lack of parenting skills, it’s an education thing. They don’t view safety in the same way, parents take a lot of chances, letting the kids play on the road etc. There is a lack of facilities; they need more safe areas to play.”

The identification of health needs using the five key areas as prompts initially presented a challenge for most of the service providers or residents who participated. An effective approach to this difficulty involved a researcher prompt relating to the services they felt the area required, which then opened up opportunities to discuss the needs such services would meet. The residents, perhaps unsurprisingly had a more limited insight than the service providers in these matters since they did not have the benefit of an overall view of the area in terms of service use. In addition, the childcare staff at the centre had noticeably different perceptions to the healthcare staff relating to the health needs of the children of Partington and in a similar vein to the residents, several commented that Partington had no additional or more severe health problems when compared to the rest of Trafford. The health care staff were more able to provide data that related to their area of expertise, for example:

“Obviously I see speech and language as a priority – the numbers of parents who continue bottle feeding, late cup use affecting a child’s speech, not communicating verbally with the child, bottles with Weetabix in …”
(Speech and Language Therapist)

It was notable, however, that many of the respondents were keen to avoid pinpointing Partington as being “different” to any other area in terms of its health problems and needs, indicating unambiguously that perceived labelling of Partington as a problem area (even if expressed as an area of particular need) was sometimes a possible cause of annoyance and resentment.

“There are no problems that are particular to Partington.”
(Primary school nursery parent)
“Health needs are the same as everywhere else.”
(Crèche parent)
“I don’t feel that Partington is any different to anywhere else in terms of health needs, although there is a high level of unemployment.”
“Partington is no different for this (safety issues). There are no special problems.”
(Primary school nursery parent)
“How the usual general health needs.”
(Community drug team)
“General health needs of all children, really.”
(Social worker)

These responses may be interpreted as a reaction to perceived criticism of residents themselves (rather than the social, economic or environmental circumstances), or (as one local worker suggested) a representation of frustration with repeated identification of problems to which no solution is available. It might even be an indicator of community cohesion or, in relation to some issues, a simple statement of fact.

That said, Partington did have some individual features to consider. In agreement with the community midwife above, many of the staff interviewed commented on Partington’s “close knit” community which emerged as a key feature of the demography throughout the qualitative data. It was sometimes described as a positive feature in terms of support, but with some recognition (by residents as well as service providers) that this may also be a negative feature of the community:

“Extended families are there – but sometimes their influence is not totally positive”
(Health professional)

“The families are very close. They don’t move out of the area. The families I have most problems with are those with a big family or social network, all being given poor advice from their own parents and siblings. The filtering through (of health advice) is very slow”.
(Health professional)

In contrast though, adverse family experiences were sometimes perceived as the motivation for change, as one health professional commented:

“In Partington there are people who are eager to be good parents, and some of them have had poor role models in their own parents and don’t want to be like them. They access everything, they want to do it right. … but they reinforce poor skills with each other sometimes. They are in a pre awareness stage, they might not pick up on a developmental delay until the child gets to school because they don’t have anyone to compare with and then they start asking well why isn’t my child doing that? You know there are sometimes small windows when they should be making changes like weaning, and it’s difficult to get that back if they haven’t attempted it at the right time. You know, they think well once he gets to school he’ll be alright”

These references to close family ties highlight how the health experiences of the children in this locality can be deeply embedded in the experiences and knowledge of their extended families. Health professionals are sensitive to this, recognising that whilst family support is important, it can sometimes create a dilemma for them in terms of effectively promoting the health of the child. The difference that nurses, midwives and health visitors can make in improving children’s health is clear. While et al (2005) note that “the involvement of these professionals resulted in less maternal child abuse, uptake of immunisations, positive parenting skills, infant nutrition, better health for mothers and accident prevention” (p41). However, those professionals, together with their colleagues in health and social care, may face considerable difficulties in achieving this in Partington.
Being healthy

It was evident that there were contrasting perceptions between residents and service providers in terms of health needs in the locality. Often these were areas of national concern, where service providers were clearly influenced by national initiatives, targets and guidelines relating to (for example) childhood obesity, teenage pregnancy and smoking. However, in Partington, several of the residents interviewed did not share these concerns. For example, the subject of young mothers and teenage pregnancy was sometimes met with shrugs, and at times provoked a heated response.

“There are probably a lot of young mothers, but no more than anywhere else. The ones that you see seem to be coping, and the children seem well looked after.”

“You shouldn’t pick on young mothers anyway, until you’ve seen how they are managing. My daughter does really well, and her kids are fine.”

Only two respondents mentioned smoking as a health issue, one (a childminder) asserting that “we need more no smoking areas”, and a parent wishing that “they would deal with the problem of passive smoking”.

For some families, and particularly those who had children with disabilities, access to dental services was a major problem.

“Access to a dentist is the worst thing around here.”

“Dentists, we need more dentists. There needs to be a dentist at the Children’s Centre.”

“The dental services are very good but don’t offer care specifically for children with complex needs.”

Healthy eating

These contrasts were particularly evident in terms of healthy eating. A typical comment from health professionals suggested:

“We need to educate children at school about healthy eating … you can’t expect mothers who don’t eat well to suddenly start feeding their children well. Obesity is a problem; the cheap food from the shops is all high in fat and sugar.”

On the contrary, residents’ comments included:

“Childhood obesity - no, that’s not really a concern.”

“I don’t think that obesity is a particular problem in Partington.”
(School nursery parents)

Although the issue of obesity did not appear to be a cause for concern, there was a strong recognition of the need for a healthy diet:

“I don’t know how bad obesity might be as a problem for Partington, but there’s lots of evidence of poor diet.”

There appeared to be three main concerns for both residents and service providers, which included healthy eating, exercise, and attitudes towards these factors, as a crèche workers stated:
“A lot of it is basic parenting skills, nutrition. We have some parents who know nothing but who don’t want help. Some of the parents in the nursery bring their kids to the crèche but others won’t because they have to stay. A divided area really. Some of it is how they’ve been brought up themselves. We have others who know exactly what to do. It’s the same with the Play Boat.”

There was some awareness that diet and exercise form the two key components of a healthy lifestyle, even if they were not always implemented. For example, parents said:

“I think it’s that they need to eat well and develop well. They need to get exercise.”

“Healthy eating and exercise, that’s it, really.”

However, as both residents and workers acknowledged, there were deficiencies in knowledge or a negative attitude towards these factors. Responses from parents included:

“Some people don’t know how to be healthy.”

“Lots of people probably don’t think to give children less common fruits like Kiwi fruit etc, and these are more expensive anyway.”

“Everyone is on about healthy food all the time. Kids eat what they will eat. Here in the nursery they eat fruit and milk puddings. You’ve got to keep it in proportion. They have to eat some junk food and some sweets. You just stay sensible about it.”

One worker, recognising the efforts that were made to provide the information and to encourage parents to follow guidance on healthy eating, perceived a problem both with knowledge and motivation in some parents:

“They need to know what is healthy, though, and they have to decide to do it. I think that there is probably a problem with both of these in some parts of Partington.”

This was backed up by parents who independently acknowledged that there was a plethora of information and guidance about healthy eating, suggesting that the population are now “bombarded” with information via the media, but that this was pointless in the face of lack of incentive to act upon the advice, suggesting for example:

“I think that people are just too lazy. I don’t do it myself.”
(Parent)

“I mean they learn things from the TV Gillian McKeith and Supernanny – they listen to them when they won’t listen to us.”
(Health Professional)

The availability of healthy food was a major concern for both residents and professionals, and emerged as a very strong theme in the data.

One parent dismissed what she saw as inadequate excuses for not buying healthy food.

“You hear such a lot about healthy diet for children. I work at Tesco so it’s OK for me, but you couldn’t rely on the shops in Partington to get a healthy diet. But, you know, the bus goes directly to Tesco, so it shouldn’t be a problem for anyone to get decent food.”
The main barrier to adopting a healthy diet for children was the absence of availability of suitable food, caused mostly by the lack of choice in shops.

“Getting decent food is a big problem for eating better. It all tends to be frozen food. There just aren’t any food shops with fresh food.”
(Childminder)

“There is fresh fruit, for example, but it’s poor quality, and the Co-Op is expensive. The kids here in the crèche are all on fresh fruit for a snack, but where would you get that if you had to buy it here?”
(Crèche worker)

“It’s already an easy option to go for high calorie junk food, and this is what is mostly available in the Co-Op. That’s the only place to shop locally - public transport is pretty poor. These poor quality foods are also cheaper, so there’s nothing to encourage people to give kids a healthier diet.”

“We need to have a choice of healthy, fresh food and baby products. You can’t get these in Partington, and not everyone can get to the big supermarkets.”

“The shops are useless, and the staff are very unfriendly. I work in Irlam so I go to Tesco. I realise that not everyone can do this. There’s a desperate need for more shops in Partington. It’s been talked about for years but no action has happened. Food, other supplies for babies and toddlers are all hard to get. That makes it more likely to buy junk food and to just let the children watch TV instead of playing out in a healthy manner.”

“We need more shops and more choice. I am able to shop out of town, but I hate to think how I would manage otherwise. It’s not just food (which is awful in Partington) – it’s things like clothes and toys for the baby.”

“The Co-Op is expensive. We need an Iceland so I can do all my shopping in one place. Lots of us live away from our families: the transport to see them and to go shopping is so bad.”

“Healthy eating is a joke for many people. I’m OK because my partner drives and I can shop out of town at Tesco. Otherwise, you are stuck using the Co-Op which is really expensive, and the shelves are usually half-empty. What they have is poor quality anyway. We really need a Tesco or something. They are supposed to be knocking down the old shopping centre and rebuilding it, but they are always promising these things but it’s never done.”

The recent “Healthy Start” initiative (DH 2006b) emphasises the long-term benefits to mothers and their children of more nutritious and better balanced diet during pregnancy and for both mother and child after birth. The provision of vouchers for some disadvantaged families is designed to encourage the incorporation of fresh fruit and fresh vegetables into the diet. Without access to appropriate outlets in which these items can be found, this part of the initiative may be of strictly limited use to many potential recipients.
Exercise

In terms of exercise, as might be expected, there was an understanding that children’s leisure activities change with the times, with many suggestions that children of all ages and all circumstances now undertake more sedentary activities such as watching TV or playing computer games.

“There are beautiful fields and play parks around here but they aren’t used as well as they could be. They all sit in front of the Playstation or whatever. And the TV. There is a lot of over stimulation. Also very few of the houses around here have dining tables. They eat whilst they watch the TV. In fact some of the parents I speak to just let them eat their tea in their bedroom. Food is not seen as a social activity, or an opportunity for a chat. When you go for a home visit they don’t turn the TV off. The houses are always very busy, there are lots of adults in and out during the day and often during a visit you are competing with the TV and this sort of activity, friends, friends children it’s really difficult. There is hardly ever a quiet time for them”.

(Health professional)

However, when asked about exercise, most residents related this to the safety, availability and maintenance of local playground facilities and parks. These were considered by both residents and staff to be available but not well used because they were not well maintained. With the exception of “one good playground on Derris Road” all other open spaces were considered unsuitable. Some parks for example have open space, but there’s nothing to play on although the skate park is used by older children. The Housing Association playground was described as “looking good, but always locked” with no notice informing local people about opening times.

“There’s a distinct lack of play areas. The Housing Association one is good, but it’s never open.”

“There’s almost nowhere for children to play. Some parks have open space, but there’s nothing to play on. The skate park is used by older children. The Housing Association playground looks good, but it’s always locked, and there’s no notice to tell the opening times.”

“We could really use some more sports facilities, and better playgrounds for kids to play on.”

“Kids do all sorts of stuff in the nursery and then at school. They are active all the time. It’s not a problem. Playgrounds are not so good, and there aren’t enough places for kids to kick a ball about where you can watch them from the house.”

“They need space so they can be active that will allow them develop normally. They need safe places to play.”

“There’s no facilities for exercise – particularly for those with little money.”

It was not only playgrounds that concerned parents. Other opportunities for exercise were noted, but so, too, were the problems associated with utilising some of these. The confusion and
misinformation that is so likely to occur in a community which is reliant on information by word of mouth was clear in an exchange during one group interview with parents.

“Take the swimming: they have a mother and baby session but only on the first Monday of the month. That’s no use. It needs to be every Monday so that you get into a routine and don’t go on the wrong day anyway.”

(Another participant clarified) “It is on every Monday, but on the first Monday there is extra staffing available.”

“Well, it’s still a problem if you’re taking more than 1 child. You’re only allowed to supervise one child under 8. It’s one adult per child.”

One mother remarked that she had not been able to find information about swimming activities for mothers and babies, despite searching the local paper and asking around. Another noted that there was no “baby pool” at the leisure centre – just the main pool. One professional added later that the leisure centre under discussion was located at the end of a lane where she would not choose to walk alone.

**Staying Safe**

Many parents linked opportunities for young children to exercise with being safe and enjoying life.

“It’s harder for kids to be active and outside than it used to be. It’s not safe very often for various reasons: other people’s behaviour, or hazards in the environment like broken glass. Facilities are poor. My daughter has a bike, but there’s nowhere to ride it safely or in a pleasant environment.”

“Playgrounds? I don’t go to them. Everything is broken. Broken glass, cigarette butts everywhere, and “worse things”.”

“The playgrounds are sometimes locked, but others are OK. I wouldn’t take mine to the one near the youth centre. It’s not maintained and there’s glass everywhere.”

“Opportunities for activities are really lacking. There is only one playground that’s suitable for small children – the Housing Association one on Derris Road. The others are for older kids and you wouldn’t want to take a little one there. It’s too dirty and there’s nothing for them to do there.”

“They need to be able to exercise safely. The parks need repairs, fencing off, cleaning up, particularly in relation to “dog poo”. I’m also frightened of the hooligans who frequent the open spaces.”

(Childminder)

Some parents were measured in their responses, recognising that all was not bad, and that improvements were to be found.

“The area used to be deprived. Regeneration has changed things in the last 5 or 6 years. There’s a lot going on, but there’s still the need for somewhere to play. There isn’t any where safe. The open areas are not safe, they are vandalised, and there are always burnt-out cars, and horse and dog poo.”

“There is a need for play facilities – for different age groups. There’s nothing much for babies. One good playground is on Davies Road. The Housing Association playground is always locked and I wouldn’t use the others. They’re not clean, and they’re not safe. Facilities for older children are really poor –
playgrounds always broken (no seats on the swings), and there is a lot of anti-social behaviour. I wouldn’t let him go there. But then the open ground on the parks are used a lot.”

“In terms of safety I feel OK. It’s a quiet area with a noticeable police presence. In terms of accessing services I feel OK to do that.”

For some it was again a matter of Partington not being a special case, and perhaps a message of resistance to unnecessary intervention.

“Partington is no different for this. There are no special problems. Playing out can be a worry, but there’s no real problem with traffic – it’s usually backed up and going slowly anyway.”

“Most people can look after their children OK without interference. You just want facilities. It’s up to parents to keep their own children safe, and later on the children learn it in schools.”

Some health professional, however, perceived greater risks to safety, with domestic violence, child protection issues, general deprivation and substance misuse as particular hazards. Additionally:

“We are targeting Partington – there are lots of drug problems with some sudden deaths.”

“The community is very cut off- buses don’t run after 7pm etc.”

“Safety is a key issue. Keeping the house safe for children – there are lots of accidents with under-5s and most are at home.”

Several residents responded that such issues were “dealt with really well through courses at the Centre”.

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Enjoying and achieving

This was an issue that puzzled many parents, but those who responded tended to equate this with the promotion of child development, particularly in the domain of social skills acquisition (and the parents’ needs in the same area.

“Occasionally a parent will use the nursery to help a child socially and that parent might take up other events going on at the centre.”
(Nursery worker)

“Sometimes the groups have a mix of toddlers and babies, that can be difficult. You want him to play with others of his age group and learn how to interact with them.”

“Development – children need to be able to mix with other children to develop social skills and relationships.”

“Parents have needs, too, to able to act as good parents. They need to meet other parents and have adult conversations (rather than spending all the time with the baby/toddler). So you need to cater for that – mother and baby activities. And fathers, sometimes.”

Professionals, too, recognised the essential role of the crèche and nursery in providing much-needed stimulus and opportunity for young children to develop social skills. Primary school nursery parents were sometimes dismissive of this as an issue, preferring more emphasis on “enjoyment” and less on “achieving”.

“The children are happy in the nursery, and at the school afterwards. There is a bit a concern about closing one school, but that will clear up eventually. At least there is a school for everyone, and they are all good schools.”

“It’s stuff that they do at school. There’s already too much testing and stuff: SATS etc. You should be teaching them to play together and not to compete all the time, anyway.”

This perspective was borne out by a midwife who noted that:

“Peoples expectations are very low for their child. They think ‘why do you need to stimulate your child?’”

When asked what people might be doing instead of accessing services at the Children’s Centre, one young mother remarked:

Nothing. Watching Tricia or Jeremy Kyle. Making a cup of tea while their kids are learning nothing, or they’re stuck in another room watching CBeebies.

Making a positive contribution

One group of primary school nursery parents was dismissive of this as an issue, associating it with political rhetoric: “That sounds like that Tony Blair stuff! Kids when they are under 5 aren’t concerned with that.” However, there were examples of parents in the community actively seeking to address the infrastructure which was seen as essential for children to grow to be able to make a positive contribution. One community group for single mothers (the Power group) is campaigning for better buses, improving the park, and provision of more crèche places. The members seemed confident when talking about their needs, although perhaps less sure about how to action the issues that they identified. In general, however, parents were simply not connected to these ideas.
in terms of their children’s health, viewing them as rhetoric rather than something tangible for them to act upon.

**Achieving economic well-being**

For parents this was sometimes seen as a problem without a solution, and responses that commonly indicated a sense of acceptance, apathy and hopelessness.

“This is out of the hands of the parents, never mind the Centre. Unemployment is a problem, but that’s nothing new. What can be done about it anyway? More people than you think have cars, the buses are usually OK, and a lot of people go out of town to work.”

“You would always want your children to be better-off, but it’s not a worry. Fat chance in Partington! If you sort out unemployment first, maybe the kids will be better off, but no-one is interested in Partington. It’s a forgotten place. I’m on the dole. What’s the point of doing anything else?”

**Summary**

Many parents held strong views on specific health issues, notable healthy eating and exercise, but they denied the existence of childhood obesity as a particular problem in Partington. There was often especially strong feeling that the needs of the population in Partington were no different to the rest of the population. While the need to support young mothers was identified, the importance of avoiding unhelpful labelling was also emphasised. Deprivation, unemployment, and poor parenting practices were thought by workers at the Centre to be serious problems which were difficult to address in the light of negative attitudes within the population.

Barriers to providing a healthy diet for children were reported by residents to centre on the lack of available fresh food at a reasonable price. This was intimately linked to the perception of an inadequate transport infrastructure and the lack of choice of shops locally. Linked to this, opportunities for young children to engage in vigorous exercise safely were thought to be seriously limited. Misinformation about some services, together with fears about lack of safe access further restricted opportunities. A significant portion of participants recognised lack of motivation as a major contributing factor in failure to access available help and facilities.

Concerns about safety tended to revolve around hazards in playgrounds, and, to a lesser extent, fear of local youths. However, workers also recognised a problem with drug misuse and poor safety in the home. The role of the nurseries, the crèche, and local primary schools in promoting child development was recognised as an important factor in ensuring that young children enjoyed life and achieved what was expected.
Section 5  Children’s services in Partington and Carrington: the benefits and the barriers to access

A Positive Contribution

It was clear from the responses of both the residents and the service providers that the Central Road Children’s Centre is considered to make a positive contribution to the health and well being of the population of Partington and Carrington. However, there were also areas that both residents and service providers recognised as requiring reappraisal and further development. This section discusses this aspect of the data, highlighting aspects that the population found to be of benefit, and exploring those that were described as potential barriers to access.

“The centre is great … we are lucky.”

All of the residents interviewed expressed some level of satisfaction with the services provided both by the children’s centre and surrounding facilities. The children’s centre particularly was seen as providing a good service in terms of variety, resources, and professional help, for example:

“I think we’re quite lucky to have SureStart because that’s not something everyone in Trafford has got access to and it does offer some fantastic services. A massive nursery, soft play, crèche and the sensory room. We only used to have a tiny family centre before … the difference is massive”.
(Resident)

“The change in my child since attending the Children’s Centre is unbelievable. They just come on so much better … the people at Sure Start, they’re just there for the children … they encourage you … everyone does this.”
(Resident)

Some of the residents were able to compare this provision favourably with that of other areas they knew of, as these interview extracts illustrate:

“I know someone with a child the same age as my youngest, they live in (suburb of North Manchester) where they haven’t really got a Sure Start. My child was walking and talking and didn’t have a dummy and was drinking out of a cup, but her child wasn’t doing any of that, and she kept asking me “why?” … and I used to say “well I’m being told that I should be doing this or that … I’m getting help from Sure Start” The one we’ve got here when compared to the one they’ve got is totally different. They don’t have a nice building, it’s like a hut, there are no lovely toys, just a few things scattered in one room with parents just sat around on chairs in a circle”
(Resident)

“I think children’s needs are well catered for in Partington. I used to live in (Salford suburb) and the facilities there were much more expensive”.
(Resident)

Facilities

The list of facilities used and described positively was lengthy. It included the soft play, sensory room, crèche, Play Boat, safety gate provision, nursery, drop-In, baby massage, Energise, evening training classes, mother and baby groups, 5 a-side football for dads and their sons, and various training courses. The registered users particularly were also aware of the varied campaigns that took place at the centre including safety in the home, the “bottle to cup” campaign and the availability of breast feeding advice.
“The crèche, soft play, sensory room, and training courses for parents all help to make the day more interesting, and for meeting other mothers ... it's something to do”.
(Resident)

*Drop-in*

The soft play provision seemed to be the easiest service to access, and many suggested that this was their first contact with the children's centre. Most of the participants asked had either used or heard about the soft play provision. Facilities such as the "play boat" and the drop-in were valued as a less formalised social activity, where for example one parent suggested that it was good for her child (being an only child) since it enabled her to play with other children. Some parents commented that if the "play boat" is full, the soft play area is a good fall back resource however, many others described the difficulty with the “first come first served”. This was viewed by many as favouring those with personal transport, in that it is easier for those with cars to ensure they are there at the appropriate time. It was also given as a reason why some parents do not use the centre.

“If you have school children to drop off first you wont get to the centre on time and it takes a while if you have to walk from Oak Road ... you get up early, get the children ready, and then they may be disappointed because they don't get in .....the children go “ape” ... and then you just have to take them home again”
(Resident)

“The first come first served is a disaster. If you get there and it's already full they turn you away. That screws up the child’s routine. They get unhappy then because they've looked forward to going. I think many parents lose their nerve about trying again”
(Resident)

“For the drop – in ....if you're too late and there's no places left you are turned away ... then you are left with screaming kids who feel let down ... you just don't want to risk it again”
(Resident)

The comments clearly illustrate that this is a difficulty for some parents but perhaps more importantly it impacts on their motivation to access the facility again.

Both staff and users also recognised that the cost of using the centre could be prohibitive, particularly for those with low incomes, those with several children or those who are child minders. Examples of this were that payment had to be made per session rather than per hour, which meant that attending only part of the session proved to be expensive, and for some the start time of 7.30am was unrealistic. As one respondent commented:

“If you work or have tax credits it works for you, but if not it doesn't because it's inflexible ... you have to pay for a whole session ... it would be better for me if I could pay by the hour ... a whole session is too long for (child) anyway.”

*Crèche*

The crèche was also a valued service. The parents who had used it appreciated the respite places and soft play sessions which took place whilst they were on courses which were also described as “very important”. A minority of parents expressed concern that the turnover of staff at the crèche was high, evoking comments about commitment or competence. In contrast, others commented that “parents have got everything they need at the crèche”. It was also viewed as an appropriate opportunity to promote healthy lifestyle messages, where for example the provision of the fresh
fruit snack was welcomed by several of the parents. Some respondents were also able to compare the different facilities within the centre, so for example one parent commented that she appreciated that her child was given fruit at break times at the drop-in which reinforced her diet at home but that other play groups like the Play Boat had biscuits and cheese which she felt was not so good.

Nursery

The nursery workers talked about “our” parents – i.e. those that access the nursery. This included parents who work full time, parents who take up places funded by social services, parents who use the nursery to help a child socially, or parent who are attending other events going on at the centre. One nursery worker commented that “we get good feedback from the parents … they recommend to other parents”. In a similar way to the crèche, the nursery at the children’s centre is viewed as a core focal point not only in terms of child care provision but in terms of opportunities to promote the health of the local children:

“The meals provided in the nursery are freshly prepared, we don’t have any jars and we help parents with recipes if they ask. The dietician has provided recipes for the parents at the nursery. Then they can provide the same type of food that we provide. The children are happy at the nursery, and the parents have confidence in the staff. We provide places for working parents. Sometimes a neighbour with concerns might mention it to someone at the centre”.

(Nursery Worker)

“We also have an outreach team to help parents with fire alarms and stair gates – we call it the extended team and they work at the main office. We can recommend parents to them, for things like poor sleeping we can pass them over. They do drop-ins, and we put notices on the door – that’s the main thing, or word
of mouth. Courses like cooking and health and safety are put on the door ... like networking”
(Nursery Worker)

Courses and Events

Specific courses mentioned as valued and effective included the Hannon programme, the “Wallflower to Wonder Woman” programme and the Webster Stratton programme. Healthy eating sessions, cookery courses and access to children’s food cook books and recipes were all mentioned in a positive light. Safety in the home sessions were also viewed positively, illustrated by comments such as “I think safety is dealt with really well through courses at the centre” and those who completed the courses were feature in a celebratory manner in the centre newsletter.

There were clear gains in terms of knowledge provided by the courses. In addition though they appear to be the main opportunity for the local population to engage with the children’s centre on in a less formal basis and were occasionally the initiating event for further contact or support. The “Wallflower to Wonder Woman” course for example had the basic premise of building confidence and raising self esteem in those parents who participated with a view to facilitating the skills required to enter or re-enter the job market. An unexpected spin-off from this course was the formation of a local pressure group whose members now felt that they had the skills and confidence to attempt to address local issues such as public transport.

Several respondents also mentioned ad hoc events such as the funded “shopping run” to specific supermarkets out of the locality, and the annual “fun-day”. In terms of social events though, some commented that “They always seem to be in the summer, not a lot else goes on through out the rest of year”. The residents had some awareness of the various constraints faced by the centre staff including the financial aspect of running various programmes, and vandalism. For example

“I went to baby massage previously and that was good ... I also went to the “Energise” event. It was advertised as being free, but not enough interest shown so they made a small charge. That stopped everyone else going and it folded.”
(Previously registered user)

“They wanted to keep the outside play area open but they always get vandalised”.
(Registered user)

Barriers

Despite the positive feedback relating to the childcare facilities, courses and events, there were views expressed by residents which indicated a perception that the activities provided at the children’s centre were overly orientated towards babies, rather than the broader range of children under five. Staff also suggested that the services in the locality for the over 5s and teenagers were considerably weaker – a factor mentioned in Trafford Council’s own resident survey (Trafford MBC 2007). The perceived lack of activities for older children restricted some parents from accessing the services at all. One mother for example suggested that unless services were provided for school age children during the holiday times, that many would find it difficult to continue to access the services. There was also a perceived unwillingness to focus on the needs of adults, even in their role as the parent of the child with particularly concern that there are not enough activities to involve fathers who were unwilling to access services that were primarily used by mothers.

“They [fathers] aren’t going to go into a room full of mums and tots, and if they do they won’t stay.”

The timing and flexibility of the available services was also a strong theme to emerge in the interviews where some respondents commented that the centre was inflexible in the way it ran, which made it difficult to fit in with young children’s routine. Concerns were expressed that too
many of the sessions took place in the morning and not enough in the afternoon. One mother suggested that it would be more use to her if her child were in the centre for the whole of two days rather than 5 half days as this would allow her to complete her domestic tasks more easily. It was also suggested that the start times of the sessions could be made closer to those of the local schools to allow parents to use both. The timetable of activities available from the centre clearly indicates that there are sessions that take place in the afternoon, indicating that for some residents the perception of inflexibility is incorrect. However, the sessions are not available on an hourly basis, and the services provided currently all take place on weekdays during traditional working hours, and are not available during school holidays if the child is over eight years old. This clearly has an impact on uptake of the services by parents (and fathers were often particularly mentioned here) who work full time and who do not use the child care facilities such as the nursery or crèche. Several of these parents suggested that the availability of the centre during the weekend would increase their opportunities to use it.

Many also struggled to juggle the needs of more than one child if there was an age gap, since they could not attend two facilities aimed at two different age groups at the same time. There appeared to be a noticeable gap in provision between the under-1s baby massage sessions and the toddler group, with nothing in between. Others suggested, however, that that when the age groups were mixed then the younger children were often in danger of being knocked over.

**Access to Professionals**

The service provision at the Central Road Children’s Centre was described by staff as valuable and valued where the environment was welcoming and “bright and breezy”. A similar list of services to that given by the residents were identified, particularly those that related to the under 5s, and it was seen as a positive factor that they were all under one roof. Additional services mentioned related to family support services, support groups, access to professions allied to medicine and plans to launch an out-posted drugs service from the centre.

When individual centre staff members were mentioned by the respondents it was always in a positive manner. Of the staff in the reception area for example it was suggested “at the centre, they are helpful – they let you take the buggy down to the room instead of having to try to carry … all the gear from the foyer.” Specific comments about health and social care professionals have been omitted from the report since they may identify the respondent either by the nature of the child’s particular need or family circumstances. However, those mentioned included the speech therapy service, the dietician, the dental hygienist, the nursery staff, the crèche staff and the midwives and health visitors. Interestingly, the midwives and the nursery staff members were often described as a potential but underused contact with other facilities, service users and professionals within the children’s centre. Some respondents also discussed the role of the nursery in teaching dental health and their role in health promotion such as the organised visit from a guest dental hygienist.

Opportunities for inter-professional communication were clearly viewed as a strength of the centre.

“There are good relationships between drugs services and the child care system – we always get invited to child care meetings”

Access to specialist health professionals at the centre was also described as a very positive aspect of the service, where professionals commented that clients felt some “ownership” of services that emerged from the primary care setting.

“The specialist services such as speech therapy and dietician are used well and accepted. Unfortunately the O.T service hasn’t been replaced but they were invaluable – especially in terms of developmental checks which are now completed by letter (as recommended in Hall). The people felt more ownership of these services and less like they are being watched. They see results, and don’t
have to go to a hospital – perhaps they have been “spoilt” in this regard but the services are being pushed to the limit again now.”

(Health Visitor)

“There are lots of services based here at the centre and elsewhere. There are lots of one to one sessions in people’s homes. There’s is speech and language to help with speech and also a dietician to help with fussy eaters. All the services come through the centre here, it’s like a hub we link in closely with the schools, we went to the nativity and they came here when their roof blew off.”

(Nursery Worker)

Colleagues within the centre also recognised the role that the nursery staff played in terms of building a rapport with the parents. It was suggested that this might lead to identification of a need for other support that they could then pass on to the outreach workers. It was also suggested by both staff and parents that there was some potential for the nursery staff to expand their base, for example working in the crèche occasionally to facilitate communication and connections between the two facilities and other parents which might then lead to a boost in the parent’s confidence. This may also address the comment that nursery parents often do not get to meet each other.

Similar comments about facilitating parental access and connections to the centre were made of the midwifery service.

“At the doctors, when you get the pregnancy confirmed, when you get the first pack and when you meet the midwife, you could meet someone from Sure Start at the same time. It would be good if you were introduced to others in the same boat, you might form a friendship and go together.

(Resident)

Several health professionals made similar comments:

“The midwives have been quite good … they have accessed hard to reach families because they are more welcomed in the home than anybody else because they’re there for an obvious reason. We had a lot of requests for places on workshops that came via the midwives, those that came enjoyed it and we hoped they’d pass it on but that hasn’t really happened”

(Health professional)

The importance of the midwife as a connection to the children’s centre is clear, particularly when parents lack the confidence to access the services. This is further emphasised in the following extract from the same parent, who compares her current experiences of the service with her previous experiences, suggesting that the facilitation of contact with health professionals is currently not as robust as her previous experience with an older child, she stated

“I have seen a real difference between what was available ten years ago and what is available now, it’s much worse now. You seemed to have a HV there all the time before, and a midwife. Even throughout the pregnancy you seemed to need to go to the doctors much more before. It’s changed a lot.”

(Resident)

Not all of the positive feedback about the professionals focused on the centre, the services that took place in the home were also viewed positively for example the HV from the traveller site was described as “brilliant” and “very helpful” in her commitment to going to the site weekly.
Other local children's services

The facilities provided at the health centre were also recognised as an effective service by many respondents, stating for example:

“The health centre is good ... they will get you whatever you need, a social worker or someone to help with post-natal depression”.
(Resident)

Other local children's services accessed that were not connected to the children's centre included the Buttons club at library, Chapel Lane playgroup, creative corner, the toy library, the toddler gym at Forrest Gate, ball pool, swimming, the Children's Society “Play and Stay”, and the St Mary's Church playgroup. In addition to the variety of activities that took place, these facilities all offered something different to the children's centre in terms of location, staff, and the parents that attended. One participant who found the mobile library particularly good and asked why it was no longer provided.

The school nurseries were also valued for their convenience, specifically because if other children in the family went to school it could all be “done in one run”. The parents felt that the children enjoyed their time there as they were “active all the time”. The school nursery staff members were described as “trustworthy” with a “good” attitude. Parents also felt this was good preparation for school transition.

The café at the healthy living centre and the centre itself were viewed as a relatively under-used facility. Many commented that it looked good but that they did not know what went on there or that those who lived nearby wouldn’t need to go to the café.

The Children's Centre staff held similar views about the surrounding services. It was recognised that the school nurseries are used a lot, along with church nurseries and play groups, for example, St Mary’s play group. The young mothers club at the youth club on Moss Lane was seen as a good resource for classes and trips, where the variety was valued. As one commented: “you can even get decorating done.” One nursery worker suggested:

“There are quite a few primary schools in the area that have a nursery attached. Sometimes they might choose to put their children in the nursery attached to the school their other children go to. There are a couple of different playgroups. A lot of people who attend sessions here will pick up other services as well, like the playgroup at the library.”

The Oak Road Family centre raised a number of interesting issues. It was seen as a valuable resource by many, particularly the activities that took place during school holidays and after school. Several commented that the staff at Oak Road had a wider view of parents needs, for example providing the driving test theory sessions. The staff members were described as “welcoming” and “trustworthy” with a “good attitude”. The location was also seen as more convenient for some residents. However, there were many comments made that indicated a general feeling amongst some local people that the success of the Central Road site came at the expense of the Oak Road provision, which was now a “poor relation” with no outside play area, since “money was taken from there to build the Central Road site”. The subsequent difficulties that Oak Road faces were considered by many residents to be a direct result of an unfair relocation of finances.

Engagement with local population

The project team experienced no difficulty in terms of accessing information about courses and events taking place at the children’s centre, since the timetables, leaflets and posters were all readily available at the centre itself. However, it was recognised by several of the centre staff that many parents may not have the confidence to take the initial step of actually coming through the
doors. Additionally, those residents that were interviewed who were not registered at the centre, (including child minders and the participants from the travelling community) explained that they did not know what took place at the centre because they did not receive any kind of information. Others indicated that they struggled with the complexity of the timing, commenting for example “It’s difficult to remember when you are looking after the kids. Saying the third Monday of the month is ok, but which Monday is that?” Two parents also commented that they used to receive regular information but no longer did. However, most of the registered children’s centre users expressed satisfaction with the communications they received from the children’s centre, for example:

“They send a sheet out every week to say what they are doing.”

“They send a leaflet every month telling you what is on.”

A number of health professionals discussed the paradoxical issue of the local free newspaper for Partington (The Transmitter) which differed from the rest of Trafford. The Trafford free paper was sold in Partington but was not free or delivered. Whilst The Transmitter had been used to good effect in the past, one commented that Partington parents missed out on events and information that the rest of Trafford had access to.

The variety of responses indicate that it is difficult to determine the usefulness of the current contact processes, but that information about forthcoming events may be biased in the favour of those that already attend the centre. Parents may benefit from a different form of reminder or advertising of all the services, and in particular when new activities were available. This might also help break down the cliques referred to by many of the respondents.

There was general agreement amongst both staff and clients that those who did access the services found them useful:

“People are impressed with the services once they get to use them. Particularly baby massage and soft play and the drop in”.

However, there was also some acceptance by staff that some clients would not consider using the centre despite encouragement and a surprising number of residents indicated that they felt the local population simply couldn’t be bothered to access the facility, suggesting that:

“I’m just lazy and can’t be bothered”

“I think that some people are just too lazy”

“I think there are a lot of feeble excuses”

“Some people are just too lazy – bone idle”

“Some people just aren’t interested in their children”

Many of the health and social care professionals expressed concern about the lack of uptake of some important services. One health visitor gave an example of a recent consultant paediatrician surgery where three families had failed to attend.

“Some children’s health needs are not being addressed. They are not being immunized because they miss health appointments and (less often) they won’t seek medical help for emergencies.”

(Social worker)
Others commented:

“My client was offered the services at the Children’s centre, but she would miss appointments and DNA (Did Not Attend) … all the professionals tried really hard to engage with her.”

(Health worker)

“We did offer a family gym pass, but she didn’t take it up.”

(Health worker)

There was some recognition amongst the staff that reluctance to access services often applied to the most vulnerable families, or those that Doherty et al (2004) would define as “service resistant”. Some service providers (particularly those who work with drug users) were able to give examples where their clients had regretted involvement with Sure Start because it resulted in unwelcome intrusion into their family lives, or because they feared that their drug use or other details would become common knowledge amongst other centre users. The service providers explained the difficulties some of their clients had in prioritising their children’s needs above their own highlighting the difficulties their circumstances created, leading to client’s comments (for example) about keeping professionals “sweet”. This clearly presented several health workers with a dilemma, as the following extract highlights

“The most vulnerable families … the ones we want to use the centre … don’t … unless they are under instruction or supervision”

(Health worker)

The residents themselves were also very aware of the difficulty associated with motivating some parents to access the services, one commented of her friend:

“I don’t think she uses it because she feels like a bit of a loner … she has … like … depression … and she doesn’t mix very well with people. We’re forever trying to get her to join our group … and she says she’ll do it but then she backs down.”

(Registered user)

During the course of the interviews with the staff who support drug using parents it became clear that they felt the poorest, the most socially excluded, the least well supported parents often did not use the family centre at all. It was commented that the parents who saw themselves, or were seen to be part of a minority community (of any kind) seemed unlikely to see the centre as being ‘for them’ and were unlikely to access the centre. The reasons for this were multiple, and in agreement with some other professionals they explained that their clients saw the centre as ‘set apart’ or ‘out of bounds’ from the poorer parts of Partington (i.e. Oak Road).

This leads to one of the most significant reasons for the reluctance of some locals to access the services at the centre - its historical connection to a social service facility. This seemed to have particular resonance with the nursery staff who recognised that misconceptions persisted within the community that it was a facility for children “at risk”, or that parents were concerned that there own children would be affected by the presence of children who were able to take up social services funded places. One nursery worker commented:
“It’s a shame. It is something that puts parents off that their children are with the children at risk … but all of the children are the same: they are all treated the same. We reassure parents about that.”

There was some agreement that this perception was diminishing, but that the process was slow. However, the stigma attached to Central Road (as opposed to the Oak Road family centre which was seen as far more neutral) was exaggerated by the fact that monitoring of vulnerable children still took place, as one professional commented “First you get monitored then you get CAFd”. The residents expressed similar concerns. Typical comments included:

“People think it’s the social place, where people who can’t look after their children go … people are worried what other people think.”
(Resident)

These perceptions, however misguided, had tangible impact on the service users.

“I feel like I become a different person at the children’s centre I feel like I have to watch my own actions. I love my children to bits, I don’t mistreat them or anything but you feel like you have to watch your actions, how you speak, how you put yourself across. And it’s not as though they’re terrible, they’re so nice, I know them all, some of them have known me since my child was really small. They’re all really nice people.”
(Resident)

Furthermore, some respondents identified a very “top-down” approach resulting in them feeling as though they were constantly being told (for example) how to feed their children. In contrast though, the recent changes to the child surveillance system had not gone unnoticed, as one resident explained:

“I was expecting a three year check but I just got a letter with questions on asking me how I thought he was doing, you know problems with hearing or speech and that was it, that was the three year check. With my oldest, when he had a three year check they came to the house. It’s so impersonal now… they used to have them doing things you know, jumping and all that. I filled mine in and I didn’t even know what I was talking about. I just thought well everything’s fine.”

Another participant commented of this:

“Some people will just say everything’s fine even if it’s not, or if they don’t know any better. I mean sometimes if your child has a problem you don’t want to admit it to people. And they get passed over, they’re overlooked which is crazy because half of the kids round here can’t speak or walk proper…”

The paradoxical nature of primary health care services as perceived by local populations creates something of a dilemma for service providers. Clearly, what is welcomed by some as a helpful intervention is soundly rejected by others as monitoring and surveillance. In this project, many of the staff recognised that it is the same people or groups who tended to access, and whilst these groups were welcome there was some understanding of the need to widen the group of registered users. Most of the staff expressed uncertainty about how to break that trend.

“The centre is really good but many of the people who it is for don’t use it. What happens here is right but we need more of it. The people who come do it because they know what their children need but some others don’t know what their children need. There is every thing people need here but they don’t use it.”

The use of the centre by the same groups of people is perhaps unsurprising since many of the services and facilities are initially advertised on the doors and in prominent leaflet holders at the
children’s centre or at the reception which means that current centre users are therefore in a better position to see what is available. However, this perception seems to have resulted in some reluctance to initiate a visit by those who do not currently use the centre since they view it as “cliquey” and again with many references to the very strong pre-existing family ties in the area. One mother describes it as being like “the new girl at school trying to fit in” whilst many others suggested that a certain level of self confidence is required in order to join a pre-existing group, commenting for example that “It's hard going into a room full of people you don't know”.

The staff had clear perceptions of a strong group culture at the centre and an awareness of the difficulties this presented for example to younger mothers, the gypsy-traveller group, and those who had recently moved into the area. There was also some acknowledgement that some parents had greater social resources to draw on in order to access the service than others:

“The facilities are so good that sometimes out of area more middle class mums get in before local mums.”

These perceptions reinforce the importance of the comments made earlier about staff in the locality that might develop their roles in terms of connecting the parents to the services – midwives and nursery staff. Many primary care trusts are currently implementing a “community health trainers” programme in order to meet this need, but assessment of this as a possibility was beyond the scope of this consultation.

**Transport / Accessibility**

The inadequacies in the public transport system emerged as a strong theme in the data analysis which mirrors Trafford Council’s own findings that transport is an issue of greater importance in Partington than elsewhere in the borough (Trafford MBC 2007). The bus service was generally viewed as expensive and infrequent and difficult to access with buggies because so few “low rider” buses are available (which are also difficult to negotiate with a double buggy). Some parents reported being refused entry to buses as there were already too many buggies on board.

Whilst it was not by any means a universal view, many respondents said that the centre was too far away for them to access it, and that services should be provided on a more local and easily accessible level.

One participant explained why they didn’t take up an appointment as a direct result of the transport issue. She explained:

“It’s a pain even though it’s only a bus ride away, sometimes I don’t have bus fare, once I’ve paid the bills I don’t really have money to get anywhere. You’re stuck, you’re isolated in Partington.”

( Resident)

Consultation with GMPTE unravelled some of the confusion about the bus services. The 247 service has no low floor. This service is provided by Arriva. The 255 service, provided by Stagecoach, has a low floor and specific space for pushchairs or prams. Only early morning and evening (rush hour) services are subsidised by GMPTE, and only subsidised services can be required to have low floors by GMPTE. However, both bus companies can be contacted directly to
request such a service. Alternatively, GMPTE can make the request to them. Additional investigation of the most important times for the revised service would be required. Provision for double-buggies or prams (arranged side-by-side) is unlikely to change.

Summary

To conclude this section, it seems clear that in terms of the question “What does the Centre do well, and why do people use it”, those working at the Centre can be assured that their contribution is a positive one. The range of facilities, including childcare and courses, has been described as a positive addition to the locality. However, it is clear that some members of the community are better served than others. In terms of Partington and Carrington, then, those best served are the working parents who use the nursery, and mothers (or childminders) with one child (or other children who are in the full time education system) who have the time to access the variety of services on offer during the day, between traditional working hours on Monday to Friday.

Those who struggle to access the services, or choose not to do so, are mothers (or childminders) with a number of children under five who are not in full time education, parents (both mothers and fathers) who work full time but who do not use the nursery, those living on the gypsy / travellers site, and unaccompanied fathers.

A further key aspect of the community is the perception that the Children’s Centre remains an essentially social service orientated facility where (covert) surveillance of the children and families may take place. This has an impact on the “service-resistant” and on families or parents who are currently being monitored by social services or who may have been monitored the past.

In terms of engagement with the local population, it is registered users who receive the newsletter and who therefore who have the advantage in terms of information. Others parents in the locality do not receive any information. Initiation of the first visit, and joining established groups was described as difficult, especially for some parents with less developed social skills.

The flexibility of the facilities in terms of opening hours, the “first come first served” system, and the lack of hourly sessions also presented a problem. Despite evidence to the contrary in the form of the centre weekly “timetable”, there is a strong local perception that very little happens at the centre in the afternoon. The lack of school holiday provision for over eights and the closure of the centre during the weekend (and particularly the locking of the playground) also had an impact on local access. The provision of facilities particularly for families with children of varying ages (or childminders) was problematic in terms of expense and the inability to access more than one age appropriate session at a time. There were also thought to be gaps in provision, for example nothing available between the ages of 9 months (cut off age for baby massage) and the toddler groups.

Opinion varies about transport. Local buses are fairly new, and there are several routes servicing Partington in the direction of Manchester centre and also surrounding towns with major supermarkets. However, few of these are designated for easy access, so causing difficulty for parents with prams or pushchairs. The various routes are clearly detailed on timetables available in Partington centre, including a large overall map of the area, though few copies are ever collected by residents. However, everywhere is within walking distance of the centre.
Section 6   Accessing the Local Population

As part of the project the team evaluated its efforts to reach the population and to inform all elements, including those often excluded or considered hard to reach, of the consultation. In interviews by telephone, in groups, on the streets and in person, as well as in informal discussions with locals, the question was asked: “If we or others like us wanted to consult with people like you again, how should we go about it?” A number of lessons were learned from the study about consulting people in Partington and Carrington which could be adopted by the Centre.

The nature of the communities

Both residents and those who provide services for them recognised the existence of more or less distinct groups in the population of Partington and Carrington. The matriarchal nature of life in the Oak Road part of town was explained by several respondents (residents and professionals) in both individual and group interviews. While this may present particular difficulties at times in promoting change in health behaviours, it cannot be ignored as an influence in the community.

Many residents from the Oak Road estate insisted that word-of-mouth was the most effective means of conveying information. However, there was also agreement that disputes between and within families often resulted in blocked channels of communication. Furthermore, the potential for this mode of information exchange to multiply misunderstanding is huge, so printed information must be an essential part of the strategy. Discussion with workers at the Oak Road Children’s Society centre emphasised the need for simplicity in printed information, including much more use of pictures and signs rather than text, if even the simplest messages are to be understood by a significant proportion of the community.

Parents of disabled children expressed the need for different information and messages, focusing particularly on assurance that the staff are safe, experienced, qualified, and professionally competent. The general feeling among this group of parents was that disabled children are dissociated from the mainstream population, and that their families were (passively) excluded from much relevant information. They indicated the need for particular efforts to target such families with specific information about services of relevance to their disabled children.

The traveller community felt similarly isolated, though in a more active sense, reporting outward hostility from other residents and lack of understanding from some workers and professionals.

Advertising – especially to non-registered families

It became clear very quickly that advertising from the Centre is directed at registered users, though not all of these receive updates and expected marketing materials. Non-users often expressed complete lack of awareness of the purpose and facilities of the Centre. It was common for respondents to suggest that better advertising might result in greater uptake (or at least interest in) services at the Centre. An exchange with the Power group was indicative of this:

“It’s word of mouth isn’t it? I mean I’m forever saying to my friends oh you should come with us its really good, but if you are registered with SureStart you get the newsletter, the monthly one.”

“I’m registered, but I don’t get it.”

“If you’re not registered, or unless you are there every week you don’t find out what’s going on.”

“I’ve not had my newsletter for a while.”

“But they only send the newsletter out to people who have registered.”
One of the most successful means used by the research team was to employ a leafleting company to provide every household in Partington and Carrington with a printed leaflet advising of the consultation and inviting volunteers to contact the team. While many of the leaflets would be delivered to households without young children, grandparents, friends and neighbours are clearly an important part of the family network, and discussions in the centre of Partington revealed that leaflets had been passed on to others. Checking with respondents at interview revealed that almost all had received this leaflet. Of the few who denied receiving it, it might be presumed that some had treated it as junk mail and disposed of it without reading.

“I got the leaflet through the door. So that worked for me.”

“The leaflet through door was good idea.”

“My Mum got a leaflet through the door but I didn’t (Wood Lane), but I think that that would work.”

“Do the leaflets again, but make it clear that it’s not junk mail.”

“The leaflet through the door was great. I thought that someone had taken the trouble to ask me.”

As a means to alert parents to events, services or other sources of information leafleting could be a valuable instrument for the Centre. Other suggestions, while enterprising and reasonable, would prove to offer less value for money.

“Everyone watches TV – advertise there.”

“Families learn things from watching television - Gillian McKeith and Supernanny. They listen to them when they won’t listen to us.”

However, one means that has been used by the Centre was recommended. Well-advertised events at the Centre, such as a fun day with activities and resources freely available, were sought. With expressed perceptions that there was little else to attend which could be fun for children and useful for parents (and without any requirement to “sign up” or be committed to anything in order to attend), such events would be attractive to many, and more frequent timing might be effective. In the words of one participant:

“They should get out there, dress up stupid, get balloons and give out leaflets.”

**Local resources**

There was much agreement from residents that advertising in the local press would reach many families. In particular, The Transmitter was recommended, though it was noted that this was not delivered everywhere, and “some don’t have time or inclination to read it”. Another alternative – the Partington Messenger – was suggested, especially since this is delivered by volunteers, but it was recognised that distribution could be patchy. There is a further problem, noted by the Speech Therapist:

“The big problem here is that the local newspaper (The Messenger) is not the same as for the rest of Trafford. It’s something to do with funding – which goes to the Transmitter. They get it free everywhere else, but they have to pay 10p for it here. There is a picture of one of my families in the paper, but they won’t see it unless they decide to buy it. If they could sort it out so that it came free in Partington, then they’d know what goes on in Altrincham and Sale as well. They miss out (on information) because they don’t get the paper.”
Respondents reported use of the library to be important to them, and they thought that more information could be advertised there. It is interesting that the library should be suggested as a location for information about the Centre (since the buildings could hardly be in any closer proximity to each other), but the misconceptions about the Centre’s purpose and access reported earlier, together with reluctance to enter the building to find out more perhaps indicate that this could be a useful location for Centre marketing materials.

More use of local shops to display information and to hold leaflets was proposed. One mother explained:

“I was given the leaflet about the study at the Chinese takeaway.”

Another advised that:

“Lots of people go in Bargain Booze and those shops. They could put stuff about SureStart in there.”

Informal enquiry in a selection of local shops indicated that there was willingness to help in this manner, although display space was sometimes limited. Respondents in one group discussion called for more information to be made available “at the other end of Partington: down the Wood Lane end”.

**Primary schools**

Almost all children of 5 years go to school, the vast majority locally. Moreover, parents with children in primary school are also more likely to be the ones with other children under 5 years of age and to have a network of contacts with other parents of similarly aged children. For these reasons, the research team sought to work with local primary schools to engage parents in the study. One school, despite coping with major disruption during emergency structural repairs following storm damage, arranged for two large groups of nursery parents to attend group interviews. Another school agreed to attach project leaflets to newsletters sent home with pupils. Two other schools were engaged in the imminent closure of one school and transfer of pupils to the other, so while staff were agreeable to help, the team avoided adding to the existing difficulties.

Parents in interviews also suggested primary schools as a means of contact with parents of young children.

“You should go through the nurseries and schools. Everyone has kids there.”

“I didn’t get the leaflet through the door that others got (Hampshire Rd), but I got the leaflet from Our Lady’s school.”

“Schools could do more to help with advertising. They are always sending stuff home from school – but not about the Centre.”

One of the schools already has a close relationship to the Centre, but perhaps more use could be made of contact with other schools. For some issues, contact with pupils and parents from secondary school might also be appropriate, though the research team found this to be outside its remit for this project.

**Co-operation with other providers of support for parents**

Despite potential difficulties with perceptions of competing businesses, it is possible that alternative sources of support and service for young children could be accessed to contact additional members of the local population. There were specific suggestions about school nurseries and church groups services:
“There is a toddler gym SureStart session at Forest Gate 10-11 on Wednesdays. You could take leaflets there.”

The possibility of contacting parents through childminders was also mooted. Indeed, there was strong feeling about the potential for collaboration with childminders, but this was mixed with resentment about the Centre’s perceived attitude towards them. One childminder explained that the decision to charge childminders for the use of services which would be free to the parents of the same children was seen as being unsupportive and provocative. Whatever the facts of this, there is clearly an issue to be resolved if this source of contact with parents is to be exploited.

**Local health facilities**

Opinion varied as to the accessibility of medical and dental services, but many respondents thought that it would be appropriate and helpful to leave information about the Centre and its facilities at doctors’ and dentists’ surgeries.

“Leave stuff in the doctors’ and dentists’ surgeries. We all go there.”

“You want to have posters and leaflets at the doctors.”

“Leaflets in the doctors and dentist surgeries would be good, and in the Healthy Living Centre, too.”

The possibility and usefulness of including the Healthy Living Centre was not universally supported. There was fairly widespread scepticism about its utility and its appeal to a large part of the population – a view that was expressed particularly well by one group interview participant:

“You could try the Healthy Living Centre, but not many of us would go in there. It’s a £4,000,000 café.”

This view was explored with other respondents, most of whom agreed either with the sentiment or that this was a common view, and informally with workers and visitors to the Healthy Living Centre. Many local residents shun the Healthy Living Centre other than to keep appointments at the health centre. Similar perceptions appear to predominate about the Healthy Living Centre as have been expressed about the Children’s Centre. Few of the leaflets on display were taken, and there were very few visitors to the building other than to use the café or to attend the surgeries.

**Workers and professionals**

Health and social care professionals were clear that they played a role in linking the Centre to families and in providing information for parents. A common message from them was that those who had direct contact with families, and particularly those who visit families in their homes, had enormous potential not only to provide accurate information and correct misunderstanding, but also to influence choices being made by parents. A drug team worker noted:

“I could be the ‘link’ to my families, and I could also encourage them to use the services.”

The importance of midwives, particularly, making the first contact with families was highlighted by a speech therapist.

“Some come to us from GP referrals or from the health visitor with a particular problem. The midwives have been quite good (at directing families to other services). They have accessed hard to reach families because they are more welcomed in the home than anybody else because they are there for an obvious reason. We had a lot of requests for places on workshops that came via the midwives.”
Parents, too, held this to be true. Seizing early opportunities to engage families in supportive services and to feel welcome at the Centre was recognised as a vital role for community workers and professionals.

“The health visitor and the midwife both told me about the Centre when the baby was born – maybe they could distribute more information.”

“I think it would be better if someone kind of registered you or put you forward when you arrive in Partington or when you have your baby. You know, working with those people who do get in contact with families with kids under 5.”

“Well, they wouldn’t have found me unless they asked the midwife.”

Sadly, and as ever, the professionals found themselves to be under pressure of work, and they believed that more could be done with more human resources. A recent report from the Family and Parenting Institute (2007) details the relative proportions of WTE health visitors to children under 5 in most Primary Care Trusts in England, and shows Trafford PCT to be ranked 83rd out of 140 for the ratio of health visitors to children under five. The report highlights the importance of a preventative health visitor service; one which “is the key to unlocking other early years services” in a time when “most vulnerable families are missing out on children’s centres and other health interventions” (Family and Parenting Institute 2007, p1). This is reinforced in the “Reaching Out” report (Cabinet Office 2007 p49) which identifies health visitors as “essential for early identification of risk factors, engagement with parents and delivery of support”. The same report also notes that “health visitors and midwives can play a pivotal role, as they provide a universally available service at a time when parents are typically highly receptive to external advice and support” (Cabinet Office 2007 p52).

This message is not restricted to the case of health professionals, however. Similar sentiments were expressed by workers in substance misuse, neighbourhood community development, social work, and traveller education. Since these individuals work with some of the more isolated or excluded groups and with those who may be most resistant to service uptake, it is vital that their role in providing contact with families is exploited.

Summary

Recognising the existence of distinct areas of Partington and Carrington was essential to effective communication. Word-of-mouth is a vital feature of communication throughout Partington, but especially in the Oak Road area. Parents of disabled children, as well as the gypsy-traveller community, felt particularly isolated, and special effort was needed to ensure their inclusion.

Advertising of services was not always effective, and more information about services and facilities would probably lead to greater uptake of services by some parents. Leafleting to all addresses in Partington and Carrington proved to be most effective. Posters and leaflets in local shops has considerable potential as a means to inform the population. More use could be made of communication through primary schools and childminders.

Some workers have key roles in reaching all parts of the population, particularly midwives, health visitors. However, the professionals were experiencing difficulty in finding time to undertake this role to the extent that it might be possible.
Section 7   Key Findings

Health Trends

• Children in Partington and Carrington live in a community characterised by:
  o Geographical isolation with inadequate transport links and limited sources of good
    value local food supplies
  o Well established (often extended) family networks
  o Families operating a division of labour where mothers are the primary carers
  o A mainly white working class community with a well established gypsy/traveller
    camp on the outskirts of the locality
  o Major issues of territoriality: the Oak Road end v “the top end”.

• The hard to reach groups in this community tended to come under the “service resistant” and
  “slipping through the net” categories rather than “minorities” due to the nature of the population.
  The previous history attached to the Children’s Centre – that of a social services – facility
  intensifies this.

Perceived Health Needs

• While government policy and health agendas focus on five key areas of the National Service
  Framework for Children, Young People and Maternity Services (DH 2004), these are not
  meaningful concepts to most parents in terms of connecting to their children’s health.

• Many participants who were residents did not believe that the needs of the population in
  Partington were any different to the rest of the population. Childhood obesity was viewed as not
  being a real problem, while young mothers were thought to be victimised by the attentions of
  health and social services rather than to be in need of support.

• Health and social care professionals, and some workers at the Centre, held this to be a matter of
  ignorance of need rather than absence of need. Deprivation, unemployment, and poor parenting
  practices were thought to be serious problems which were difficult to address in the light of
  negative attitudes within the population.

• Barriers to providing a healthy diet for children were reported by residents to centre on the lack
  of available fresh food at a reasonable price. This was intimately linked to the perception of an
  inadequate transport infrastructure and the lack of choice of shops locally.

• Activities for children were thought to be seriously limited. Some parks and playgrounds were
  acceptable (safe, clean, and in a state of good repair), but others were considered to be unsafe.
  The Centre playground is envied, but not accessible. Other opportunities to engage young
  children actively (such as swimming) were not taken up due to misinformation or lack of safe
  access.

• A significant portion of participants recognised lack of motivation as a major contributing factor in
  failure to access available help and facilities.

• Issues of safety tended to revolve around hazards in playgrounds (broken glass, animal faeces),
  and, to a lesser extent, fear of local youths. However, workers and professionals recognised a
  problem with drug misuse and poor safety in the home.

• The role of the nurseries, the crèche, and local primary schools in promoting child development
  was recognised as an important factor in ensuring that young children enjoyed life and achieved
  what was expected. However, both residents and professionals recognised low levels of parental
  expectations for their children.
What the Centre does well, and why people use it

- Both residents and service providers considered that the Children’s Centre makes a positive contribution to the health and well being of the population of Partington and Carrington.

- The children’s centre particularly was seen as providing a good service in terms of variety, resources, and professional help, and this compared favourably with other providers of services. Most facilities, courses, and campaigns were positively regarded by those who accessed them.

- Most of the registered children’s centre users expressed satisfaction with the communications they received from the children’s centre.

- The soft play provision was the easiest service to access, and was often the first contact with the children’s centre. The “Play boat” and the drop-in were valued as less formalised social activity.

- The crèche was also a valued service. Parents appreciated the respite places and soft play sessions whilst they were on courses. A minority of parents expressed concern that the turnover of staff at the crèche was high, evoking comments about commitment or competence.

- The nursery at the children’s centre is viewed as a core focal point not only in terms of child care provision but in terms of opportunities to promote the health of the local children.

- Ad hoc events such as the funded “shopping run” to specific supermarkets and the annual “fun-day” were welcomed, though limited to the summer months.

- Access to specialist health professionals was a positive aspect of the service.

- In addition to the variety of activities that took place, facilities used at alternative centres (church nurseries, for example, all offered something different to the children’s centre in terms of location, staff, and the parents that attended.

- The Oak Road Family centre was seen as a valuable resource by many, particularly the activities that took place during school holidays and after school. The location was seen as more convenient for some residents. There was a general feeling amongst some local people that the success of the Central Road site came at the expense of the Oak Road provision.

What prevents people using the Centre and what they want to have changed

- There is some reluctance to initiate a visit to the children’s centre due to the perception of parent group cliques (linked to the strong pre-existing family ties in the area).

- The “first come first served” approach to allocation of some places was widely viewed as being problematic. It was seen to favour those with personal transport, and was cited as a reason why some parents do not use the centre.

- The timing and flexibility of the available services were also found to be barriers to use of services at the children’s centre. Concerns were expressed that too many of the sessions took place in the morning and not enough in the afternoon. Several parents suggested that the availability of the centre during the weekend would increase their opportunities to use it.

- Many also struggled to juggle the needs of more than one child if there was an age gap, since they could not attend two facilities aimed at two different age groups at the same time. There appeared to be a noticeable gap in provision between the under-1s baby massage sessions and
the toddler group. This was linked to perceptions that the activities provided at the children's centre were overly orientated towards babies, rather than the broader range of children under five.

- There was also a perceived unwillingness to focus on the needs of adults, even in their role as the parent of the child, with particularly concern that there are not enough activities to involve fathers who were unwilling to access services that were primarily used by mothers.

- The perceived lack of activities for older children restricted some parents from accessing the services at all. Unless services are provided for school age children during the holiday times, many will find it difficult to continue to access the services.

- Both staff and users also recognised that the cost of using the centre could be prohibitive, particularly for those with low incomes, those with several children, or those who are child minders.

- The bus service was generally viewed as expensive, infrequent, and difficult to access with buggies because so few “low rider” buses are available (which are also difficult to negotiate with a double buggy). Some parents reported being refused entry to buses as there were already too many buggies on board.

- There was some recognition amongst the staff that reluctance to access services often applied to the most vulnerable families. Some service providers (particularly those who work with drug users) were able to give examples where their clients had regretted involvement with SureStart because it resulted in unwelcome intrusion into their family lives, or because they feared that their drug use or other details would become common knowledge amongst other centre users.

- During the course of the interviews with the staff who support drug using parents it became clear that they felt the poorest, the most socially excluded, the least well supported parents often did not use the family centre at all. It was commented that the parents who saw themselves, or were seen to be part of a minority community (of any kind) seemed unlikely to see the centre as being ‘for them’ and were unlikely to access the centre.

- There was also some acceptance by staff that some clients would not consider using the centre despite encouragement and a surprising number of residents indicated that they felt that the local population simply couldn’t be bothered to access the facility.

**Accessing the local population**

- Recognising the existence of distinct areas of Partington and Carrington was essential to understanding responses and to formulating effective strategies for establishing communication.

- Word-of-mouth is a vital feature of communication throughout Partington, but especially in the Oak Road area. This can be positive in that messages can be disseminated, but also negative in that information becomes distorted, and issues may be exaggerated.

- Parents of disabled children felt particularly isolated and neglected, feeling that they required special efforts to ensure that their family needs are recognised. The traveller community felt similarly isolated, though in a more active sense, perceiving outward hostility from residents and some workers.

- Advertising of services to non-registered parents is not effective. There was some indication that more information about services and facilities would lead to greater uptake for some parents.
• Leafleting to all addresses in Partington and Carrington proved to be most effective in getting messages to the population. Similar efforts through the use of local newspapers was found to be less effective, though often recommended.

• Posters and leaflets in local shops was thought to have considerable potential as a means to inform the population, and there was some initial support for this from shopkeepers.

• More use could be made of communication through primary schools. The schools are prepared to assist in this way.

• Other sources of contact such as childminders were also recommended by participants.

• Some professionals and workers were found to have key roles in reaching all parts of the population, particularly midwives, health visitors and specialist workers such as those in the community drug teams. However, the professionals were experiencing difficulty in finding time to undertake this role to the extent that it might be possible.
Section 8   Messages From The Project

Health Needs in Partington and Carrington

A major effort is needed to persuade the residents of Partington of the severity of health problems affecting young children. These problems are well-recognised by health and social care professionals and include childhood obesity, teenage pregnancy, and poor parenting practices against a background of unemployment, deprivation, and widespread substance misuse. For many residents the isolated nature of life in Partington militates against acceptance of advice and understanding of the need for changes to lifestyles.

Some groups, notably gypsy-travellers and parents of disabled children, feel dissociated from mainstream health services and require focussed endeavours to engage them and to meet the needs of their young children.

The lack of availability of reasonably priced fresh food is a serious deterrent to the provision by parents of a healthy diet for young children. This combines with perceived lack of opportunity for young children to engage in safe play and exercise to cause concern in many parents for the healthy development of the under-fives. Help with resolving issues of poor transport and better upkeep of play spaces would be valued by the community.

The Contribution of the Children's Centre

What the Centre does, it does well, and its services are valued by those who use them. These services include the physical facilities, activities, courses and staff. It is important that these successful services are not compromised in any amendments to strategy as a result of this consultation.

Many parents in Partington do not know what the Centre does or what is it for. The Centre needs to advertise itself better and to adopt alternative means to reach those who currently do not access services which could be of great benefit to them and their children. This could be improved by occasional leaflet drops; by leaving leaflets in local shops (post offices, Bargain Booze, Spar, Chinese takeaway, etc); through the primary schools; and with childminders.

The Centre needs to address perceptions as well as facts. Much of the resistance to accessing services at the Centre relates to misguided and misinformed views of its nature, purpose and mode of operation. Much work is needed to reverse perceptions of social services surveillance in the Centre, imposition of advice and interventions, and the cost of activities. Nursery and crèche staff have great potential to achieve this, as have community workers who are trusted, such as health visitors and midwives. This human resource should be exploited more effectively.

Some barriers to accessing services – both perceived and actual – could be addressed by the Centre.

- Within the context of avoiding a pricing policy which would damage other local provision, costs of some activities need to be reviewed.
- Access to some services at the weekend and spreading these more evenly across the day would encourage use by working parents.
- Integrating the Centre’s provision such that parents with children of different ages could access facilities for both age groups simultaneously would facilitate their use of the Centre.
- The gap in provision between baby massage and toddler activities should be reviewed.
- Previous attempts to provide alternative transport to the Centre should be revived.

The Centre’s provision of leadership and support for the local community to address some issues (such as improved transport, safer access to the leisure centre, better upkeep of playgrounds) would promote engagement with parents and improve the image of the Centre among some service-resistant groups.
References


Department of Health (2006a) *Health Profile for Trafford 2006*. http://www.communityhealthprofiles.info/profiles/00BU-HP.pdf (accessed 05.03.07)


The “Tell Us” Project
Partington and Carrington

Q. Are you a parent (or main carer) for a child or children under five years of age?

Q. Do you live in the Partington or Carrington area?

A team from the University of Salford is looking at how local children’s services are being used by local people - it’s called the “Tell Us” project.

Can you spare 20 minutes to talk to us, either

- One - to - One?
- In a small group?
- Or over the telephone? (we call you)

We’d simply like to know how you use the services, or why you can’t use them, or why you prefer not to use them.

We don’t need to know your name or your address but you must live in Partington or Carrington. Anyone who takes part will receive a £10 gift voucher for a place of their choice on completion of the interview.

Everyone who has a child under 5 is invited to take part.
If you can take part please contact us:

- By text on **07948 276854**
- Via e mail at **d.fallon@salford.ac.uk**
- By telephone on **0161 295 2768** to leave a message
- By post - simply pick up a *pre-paid* envelope at the reception of the Children’s Centre (Central Rd) or the Children’s Society (Oak Rd Estate)

We will be talking to people all through March 2007.

If you’d like your voice to be heard, get in touch!

Let us know if there are several people you know who would like to be interviewed together.

If you know somebody else who would like to take part - please pass this leaflet on to them.

Thanks for reading this. Sorry to inconvenience you if it is of no relevance to you or if you are not interested.

**Your child’s details have not been passed to us by the school.**
APPENDIX B: The street interview schedule

1) Do you live in Partington or Carrington? (If “No” don’t continue)
2) How many children do you have under 5? 1 2 3 4 5
3) Are you registered at the Children’s Centre? Yes (Go to 4) No (Go to 7)
4) Do you use the Centre? Yes (Go to 5) No (Go to 7)
5) What services do you use at the centre?
6) Which service(s) do you value the most at the Centre?
7) Why don’t you use the Centre?
8) What do you think would encourage people to use the Centre?
9) (Thinking about children under 5 years of age) What would you say were the health needs of people in Partington and Carrington?
10) What services would you like to see provided for children under 5?
11) Should these services be provided at the Centre or somewhere else?
   Centre Somewhere else (Where?) _________________
12) So that we have an idea of whether or not we are talking to people from all over Partington and Carrington, could I ask the last 3 digits of your postcode?

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APPENDIX C: The telephone interview script

Telephone Interview Schedule
Local residents

The Brief
The purpose of the interview is to listen to your views on the best way to provide local services for parents with children under five years old in Partington and Carrington.

The centre provides a wide range of services, and many parents find these helpful. However, there are many more who could use the services but don't. We would like you to help us to understand why this might be, and what could be done to make the services accessible and appealing to them.

We want to know what makes the children’s centre services attractive to some.
We want to know what prevents others from using the services.
We want to know what would be better for some parents.

We want to emphasise that this need not restrict the discussion to what can be provided in the centre. We want you to tell us what is important, and what you and people like you need. Then maybe we can understand better how to provide local services that are what people want and need.

Key Questions
Remembering that this is about children up to 5 years old, what would you say are the health needs of people in Partington and Carrington?
(If stuck – prompt with 5 key areas. Move on to these anyway if own ideas exhausted.)

What sort of services would help to meet those needs?
(Probe – where should they be provided.? What would make them attractive?)

What services at the centre are good, and what makes them attractive?
(Probe – Is there anything about the centre itself that makes it appealing or not?)

What might put people off using the centre?
(Prompt – anything about the centre itself? The location? The staff? Need to register?)
(Probe – Is it that some people can’t use the centre? Is it that some won’t use it?)
(Probe – Are there any particular groups that might feel particularly unwilling or unable to attend?)

What other sources of support are there? Why are these used instead?
(Same prompts as for the centre)

What would make it easier for people to access services that they need?
(Prompts – consider problems identified above and seek solutions)

If we or others like us wanted to consult with people like you again, how should we go about it?
Contact the Salford Centre for Nursing, Midwifery and Collaborative Research:

Wendy Moran (Research Administrator)
Tel: +44 (0) 161 295 2768
E-mail: w.e.moran@salford.ac.uk

http://www.ihscr.salford.ac.uk/SCNMCR/childfamilyhealth.php

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