Improving and developing maternity and newborn services in Bristol, North Somerset and South Gloucestershire

Consultation with members of the public
...a summary of responses

November 2008
This report

This is one of two reports which summarise the views people have expressed about the suggestions for changes to maternity and newborn services.

As well as this report summarising the views of members of the public, there is a separate report summarising the views of staff. This is available from the contact person below.

Acknowledgements

With thanks to all those people who took the time to comment on these proposals. Thanks also to all the groups, networks and organisations that were visited and to their members who contributed their views.

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Jargon buster
A 'jargon buster' on page 43 has explanations of terms and abbreviations used in this report.
Summary

Background
A review of maternity and newborn services is taking place across Bristol, North Somerset and South Gloucestershire. A consultation on proposals was held between June and October 2008 by Bristol Primary Care Trust (PCT), North Somerset PCT and South Gloucestershire PCT. This was for members of the public and for staff. This report summarises the responses from members of the public. The views of staff are summarised in a separate report.

People were asked for their views on eleven suggestions for change.

- More pre-pregnancy care will be provided.
- The midwife will be promoted as the first point of contact for all women as soon as they are pregnant.
- There will be a wider choice of antenatal classes.
- Home birth will be encouraged and we will work towards a target of 7-10% home births by March 2011.
- Cossham Birth Centre will be opened and more birth centres will be developed as demand grows, so that more women will give birth with a midwife they know, near to home.
- The midwife-led unit at Southmead will expand and develop and the midwife-led unit at St Michaels will become more home-like and will be staffed by midwives dedicated to the unit. We will work towards the target of 30% of women giving birth in a birth centre or midwife-led unit.
- More women will have one-to-one care from a midwife during labour.
- Women will be able to have their postnatal care with a midwife at home or at their local clinic or birth centre.
- There will be more support for families with very sick babies or babies who die.
- There will be improvements to services for women with mental health problems.
- We will target resources to those with greatest need by employing, for example, maternity support workers to work alongside midwives, drug liaison midwives, midwives who offer extra support to teenagers and better translation and interpreting services.

What happened?
In all, the views of at least 494 members of the public are represented in this report: 112 pieces of 'correspondence' were received, 11 people attended public meetings and at least 371 people's views were heard at 39 'special interest groups' that were visited. These were groups for parents of Disabled children, women from a number of Black and minority ethnic communities, refugees and asylum seekers, teenagers and young parents, women who have experienced domestic violence, women sex workers, women in prison, twins clubs, fathers groups, those who have experienced stillbirth or neonatal death, women with HIV, people with learning difficulties and women who use illegal drugs. They also included antenatal and postnatal groups in different geographical areas.
What did people say?

Most people who responded to this consultation supported the proposals, although there were some concerns about some of them. The most important to the majority of people was the provision of one-to-one care from a midwife - not only during labour (although this was the most important) - but from early pregnancy through to the postnatal period.

Also of great importance to most people was a safe and healthy delivery, choice of where and how to give birth and having a midwife as an early, first point of contact. Many people thought that to achieve these changes there would need to be increased staffing, particularly of midwives.

Pre-pregnancy care was not seen as an overall priority, although there was some support for it, particularly for people with specific needs.

The majority of people would like the midwife to be their first point of contact but there needs to be more information about how to contact a midwife and increased staffing so it is possible to get hold of one.

Most people would like a wider choice of antenatal classes, some outside of working hours, making partners welcome and catering for particular groups.

Some people were keen to have a home birth: others were not. Everyone felt it is important to have a choice. There was some discomfort about the idea of targets to increase home births as people felt this may put pressure on both pregnant mothers and midwives. Feelings were mixed about birth centres. There was some support for them, but also significant numbers of people who felt a midwife-led unit attached to a hospital was safer. People would like to see the midwife-led units develop and become more autonomous.

Most people simply wanted to have a choice about postnatal care and for it to be flexible. Certainly people felt that more support for families with very sick babies or babies who die is very important. Improvements to services for women with mental health problems were definitely thought to be needed.

There was support for resources to be targeted to those who need them most, but also a sense that this is a difficult time for everyone and everyone is in need of basic support. Better translation and interpreting services were seen as a need by most. Many ‘special interest groups’ identified particular needs and issues.

Other key issues were:

- the need for much better postnatal care and support in hospitals
- the current arrangement of services which leads to some North Somerset people deciding it is ‘safer’ to book in at a Bristol hospital rather than risk a transfer during labour
- the need for more breastfeeding support.

As well as commenting on the proposals, a large number of other comments and suggestions were made and these are also summarised.
Section 1: Introduction

This is one of two reports on a consultation held between June 30th and 17th October 2008 on improving and developing maternity and newborn services in Bristol, North Somerset and South Gloucestershire. The consultation was carried out by Bristol Primary Care Trust (PCT), North Somerset PCT and South Gloucestershire PCT.

This report summarises the responses to questions posed to members of the public about the proposed changes to services. A separate report summarises responses from members of staff.

Background

A review of maternity and newborn services has been taking place across Bristol, North Somerset and South Gloucestershire since 2006. Its aim is to ensure that every parent and baby has the best possible experience of birth and early days. The review is being carried out by Bristol PCT, North Somerset PCT and South Gloucestershire PCT.

There have been two stages of consultation and engagement.

The first stage included engagement with both the public and with staff and ran from December 2006 to March 2007. Two reports were written which summarised the findings from this stage.¹ This process identified people's priorities and what they wanted to see done differently. The key issues that emerged were:

- women want birth to be treated as a normal and natural event
- they want choice about where they give birth and how they give birth
- the need for continuity of care throughout pregnancy, childbirth and beyond
- there was a wide variety of positive and negative experiences of antenatal care, care during childbirth and postnatal care, and suggestions for improvement
- the need for more services in community settings including birth centres, antenatal and postnatal care and support for home births
- the need for more midwives and for their empowerment
- the need for more support for those women who want to breastfeed, and a request for less pressure to breastfeed from those who have chosen not to
- the need to make it easier for fathers to play an integral role
- a concern about the rising number of births by caesarean section and the possible reasons for this
- the need for more and better information
- women with particular support needs (eg young mothers, drug users and prisoners) generally felt well supported and cared for.

The PCTs then looked at different ways of making changes in line with what people said they wanted and in line with new national standards (see Appendix A) and made a number of suggestions.

From this process, the PCTs felt they should be:

- promoting normal childbirth
- providing choices for where and how mothers give birth
- providing safe and effective care to national standards
- reducing inequalities in the health of parents and babies
- making the best use of resources
- attracting and retaining staff by offering good experience and opportunities for development.

This stage resulted in eleven suggestions for change.

This second stage of consultation in 2008 asked for people’s views on these eleven suggestions.

<table>
<thead>
<tr>
<th>Suggestions for change to maternity and newborn services</th>
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<tr>
<td>1. More pre-pregnancy care will be provided</td>
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<td>2. The midwife will be promoted as the first point of contact for all women as soon as they are pregnant/Direct access to a midwife without having to see a GP first</td>
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How was this consultation carried out?

Views were sought on the eleven proposed changes. People were asked 'What is most important to you? What do you think of the changes we are suggesting?' And 'Do you have any other suggestions?' In some formats, people were also asked 'Do you think the plan will be equally beneficial to people of different ages, sex, race, religious belief, sexual orientation and to people with a disability?'

A booklet was produced and circulated widely with a freepost return slip. The booklet was offered in different formats. There was also a separate feedback form. People were asked for their views at public meetings, meetings with interested groups and meetings with a range of staff groups. A proforma was used to record views expressed. People were encouraged to write in, phone or email their comments. Information was on the PCT websites with the facility to send views and comments online. For copies of the form and the proforma see Appendix B.

What is in this report?

This is one of two reports which summarise the views people have expressed about the suggestions for changes to services. This report summarises the views of the public: a separate report summarises the views of staff.

There is not always a clear distinction between 'staff' and 'public'. In terms of these reports, staff includes anyone with a professional interest in maternity services who did not respond in terms of their own personal experience of using services. Councillors and voluntary sector organisations representing the public are included in this report, as their role is to represent those views. The views of some support workers who attended meetings with women with particular support needs are also included here, although if they were interviewed separately, they are included in the staff report.

This report aims to reflect areas of general agreement. As meetings were mostly informal discussions, numbers could not be accurately recorded. Individual views are confidential, but anonymous quotes are used throughout.

Author's role

The author of this report is an independent consultant, with a background in public health and health promotion. She has many years experience of working with communities on health issues, as well as five years experience of consultancy work. The interpretation and summary of responses to this consultation is hers.

What happens next?

The outcomes of this exercise will be reported back to the Bristol Health Scrutiny Commission, the North Somerset Health Overview and Scrutiny Panel and the South Gloucestershire Health Scrutiny Select Committee before the three primary care trusts make decisions on the way forward. Once the review is complete, a maternity and newborn service development group and a maternity service liaison committee will be set up to implement the recommendations of the review.
Section 2: What happened?

In all, the views of at least 494 members of the public are represented in this report. Appendix C gives a breakdown of all the responses. Appendix D gives details of meetings and numbers of people who attended. (In addition, 236 members of staff commented and their views are summarised in a separate report).

Profile of correspondence

Overall, 112 pieces of 'correspondence' were received from individual members of the public. More than half were from the leaflet tear off slips or the separate feedback forms and almost a fifth were website responses (see Appendix C).

Profile of meetings

Five public meetings were held in Bristol, Weston-super-Mare, Portishead and Winscombe in North Somerset and Bradley Stoke in South Gloucestershire. Eleven members of the public attended these (16 members of staff also attended).

Thirty-nine 'special interest groups' were visited (see Appendix D). These groups included groups for parents of Disabled children, women from a number of Black and minority ethnic communities, refugees and asylum seekers, teenagers and young parents, women who have experienced domestic violence, women sex workers, women in prison, twins clubs, fathers groups, those who have experienced stillbirth or neonatal death, women with HIV, people with learning difficulties and women who use illegal drugs. They also included antenatal and postnatal groups in different geographical areas. Responses also included (by letter) one from the Association for Improvements to Maternity Services which supports both parents and maternity staff. Comments have been included in the staff report.

Either presentations and informal group discussions were held, or individual interviews carried out. In all, the views of at least 391 people were heard at these meetings.

Profile of media coverage

Extensive and targeted media coverage included issuing nine press releases before and during the consultation, advertising - including in Primary Times which goes to all schools in our area - as well as six newspaper articles and items in NHS, community and local newsletters. There were also numerous radio interviews, including on Radio Bristol, Radio Ujima, GWR, Original Radio and Star Radio.

How well did the process go?

Engaging with the public

The process appears to have been successful in engaging with large numbers of members of the public. Considerable efforts were made to engage with the public through a range of avenues.
Some problems included:

- some meetings were cancelled and, at others, very few people attended.
- it was difficult to identify if responses were from members of the public or staff. All formats and meetings - apart from staff meetings - appeared to include both, but the forms, website responses etc did not ask people to identify themselves
- the notes of the public meetings seem to indicate that many of the views expressed were those of staff, although it was not clear.
- the separate feedback forms were circulated in two different versions, (although they were not radically different questions) and some people were not asked to identify why they were interested (which helped in separating staff from public)
- the list of eleven suggestions on the separate feedback form did not relate exactly to those in the booklet, although they were factually the same, overall. The forms gave more detailed information on the proposals so these have been used as the structure of this report.

In terms of these reports, responders were assumed to be members of the public, if there was nothing to indicate they were members of staff. At public and special interest groups, people were assumed to be members of the public if it wasn't clear. Of course some are both. At staff meetings, people were assumed to be members of staff.

The responses...

The focus of this consultation was on what people thought of the proposed changes. However, many people, not surprisingly, responded to the consultation with details of their own experiences of maternity services - both good and bad - and these are very important in terms of seeing services from a client's point of view. Care has been taken to try and identify within these stories the key issues for this report.

Other comments and suggestions indicate what else is important to people and how exactly people want to see services provided and these have been summarised in Section 5.

We need to bear in mind that:

- people with the strongest views (positive and negative) are those most likely to have responded
- this is a very emotionally charged area
- being pregnant or a new parent is not the easiest of times to be able to respond to consultations.
Section 3: What did people say?

This section summarises all the written responses, telephone calls and comments made at public meetings and events. These are the responses to: ‘What is most important to you’ 'What do you think of the changes we are suggesting? It summarises people's views about whether or not the plans would benefit all groups and it also summarises any issues which relate particularly to each of the three PCT areas.

3.1 'What is most important to you?'

Overall, the majority of people were very positive about the changes. Some people answered this question in relation to the eleven changes (see page 2): others did not. These are the issues identified as most important to most women.

**Choice of where and how to give birth:**

To have enough information to make choices and to have those choices respected by health professionals. For all women to have the choice of home births, birth centres, freestanding midwifery units, hospitals and access to birthing pools.

'...the birth experience affects the rest of mother and babies lives together...'

**A safe and healthy birth:**

As natural a birth as possible and access to medical expertise if necessary.

'..the best medical care for mother and baby in the most appropriate way for each individual...'

**One-to-one-care from a midwife from early pregnancy, at the birth and afterwards:**

At the birth is most important. More one-to-one care during pregnancy will help to give confidence to avoid intervention.

**More resources:**

All the changes are important and more midwives, increased staffing levels and more resources are needed to implement them.

**Midwife as first point of contact:**

To have early, regular, consistent and easy access to a midwife.

Other issues that were identified by many people as particularly important were:

- the quality of aftercare in hospital
- that all staff are trained well and are competent
- active support for normal childbirth
- the need for specialist midwives to support people with particular needs
- a choice of antenatal classes, including outside working hours
- stronger support for breastfeeding
- fathers being able to stay with mother and baby after the birth for longer.
3.2 Pre-pregnancy care

*More pre-pregnancy care will be provided*

Feelings about more pre-pregnancy care were fairly mixed. Mostly people felt it was probably a good idea for other people! There was some debate about who would provide it and people felt it may be provided by GPs, midwives, health visitors (for possible second-time mothers) or at specialist clinics such as diabetes clinics.

Some felt it was important for those with particular health problems or disabilities and for those trying to conceive to have local support and advice. A number thought that encouraging healthy lifestyles and having more advice on diet and exercise would be useful, particularly if it was in local community venues with plenty of publicity. They felt it was important that it linked in with work in schools and children's centres.

>'Very important women are aware of how to get their body in the best possible state before becoming pregnant.'

Other people felt this was a good idea but not a priority compared to other changes, especially as many pregnancies are not planned. People commented that there is a lot of information available already and that 'people may not want more.' There was a feeling from some that this 'will only reach the privileged' and that the money could be better spent on other services

>'..most people know they should lose weight and give up smoking...'

If more pre-pregnancy care is provided then people would like to see:

- it reflect working patterns to allow involvement of both parents
- it targeted towards those with greatest health needs and linking into the school curriculum
- care taken not to alienate women who have not planned their pregnancies
- local support and advice for those trying to conceive
- partnerships with local organisations eg leisure services

>'It would be nice to have midwives more visible in health centres or on the high street with clinics where we could get pre-conception advice and care early in pregnancy.'

3.3 The midwife as first point of contact

*The midwife will be promoted as the first point of contact for all women as soon as they are pregnant*

The majority of people felt that this was a really positive move, especially if they could contact the midwife earlier in their pregnancy. Some felt it was a waste of everyone's time to see their GP first and delayed access to the midwife.

>'Often the first visit to the doctor is a deflating experience at the moment.'

Some women live in areas where direct contact with the midwife already happens and felt it works very well. Many felt that midwives can address both emotional and physical needs and are more 'available' for advice (although time is an issue). People want access to information about changes to expect and any problems they
may have as soon as they are pregnant. Many commented on how much they value - or would value - being able to talk to a midwife.

'\.sometimes I feel uncertain about something and know that it is not an emergency. It would be good to speak to a professional rather than having to ask a friend who has had a baby.'

A few felt that they preferred to see their GP first and said:

- some mothers need to see their GPs because of other clinical issues
- in early pregnancy contacting a midwife from work can be a problem because of confidentiality
- it is sometimes easier to get hold of your GP (and sometimes the opposite)
- it is alright as long as the mother gets on with midwife.

'Not so important [to contact the midwife]. I trust my GP and need his advice during pregnancy as well as the midwife.'

A key issue for many (especially young people) was knowing how and where to contact their midwife and many used their GPs to find that out. They pointed out that GPs are sometimes easier to contact (although some people pointed out the opposite). They felt that more publicity and information about midwives could be provided in supermarkets, pregnancy testing kits and pharmacies. Written information and names of local midwives could be given to mothers from the start.

But many of those who knew how to contact their midwife, still found it difficult to actually get hold of them. Many people are aware that there is a shortage of midwives and that their local midwives are very overstretched. Some people felt 'palmed off' on the GP for antenatal visits because midwives did not have the time. Many who saw the midwife felt that the visits were very rushed and would like longer appointments. Many people said they would value easier access to their midwife.

'If I need to see a midwife I have to physically go in, because they cannot answer the phone.'

'They are always really busy. I have never seen the same midwife.'

One person felt that for people with particular health needs, such as diabetes, that her medical needs were met, but that the midwife had limited experience so there was 'a real gap' between services. She felt she had nowhere to ask 'non medical' questions.

Some concern was felt for women whose pregnancies ended with early miscarriage, as they:

'\.often have to contend with waiting rooms full of 'blooming' still-pregnant women and literature about perfect pregnancies.'

3.4 Antenatal classes

There will be a wider choice of antenatal classes

Overall, people were very much in favour of more high quality NHS classes, at different times and for different ages, first/second time mothers etc. It was generally not identified as one of the most important things, (compared to birth choices and access to midwives) but nevertheless, there are the following comments.
**When and where** - classes out of working hours would mean that fathers could be involved more and women who are working could attend. People also said:

- a set schedule means you can meet the same parents each week.
- would like more frequent antenatal care - shorter but more often, spread out more, funded well enough to have smaller groups ‘to encourage discussion and foster friendships’
- an early pregnancy class would be good
- a one day ‘refresher’ class at the weekend for those who are not first-time parents.

**Free classes** - not everyone can afford National Childbirth Trust (NCT) classes which can be very expensive if both parents attend. Others felt it was good to have the choice of NCT or NHS.

**Who for?** - important for first time parents and:

- for different ages including teenage parents
- classes for 2nd/3rd timers where toddlers can play nearby and with different subjects covered
- more support and information for single parents and dads to be.

‘It is unrealistic to expect mothers to remember everything when they are in the pain of labour and birth partners therefore need to be equally well informed.’

**What the classes should include** - need to be up to date with information and latest guidelines about birth and baby care and:

- want more information about coping after birth
- more parenting classes and ‘less about the benefits of washable nappies’
- practical sessions on breathing, labour etc
- breastfeeding information but also teach women how to bottle feed as well as how to breast feed

‘Out of eight women in my antenatal class only two were successful at breastfeeding and the other six had to bottle feed without knowing what to do.’

- more about natural birth ‘There is a lot of talk about epidurals…’
- overall messages should be positive rather than ‘it will be very painful; you will need drugs.
- should include information about induction and what happens and about Strep B
- include massage, exercise classes
- more opportunities to get to know the other women.

‘I think they could have run the classes in such a way to encourage us to talk to each other and make friends.’

A number of other comments were made.

- Better information about classes is needed, including information about classes and groups for those expecting twins and about non NHS classes.
- Drop in local antenatal care would be good and perhaps use children’s centres and community venues.
Some men felt that women only classes should not be offered if this was to the detriment of fathers.

Outsourcing to NCT would mean accepting NCT philosophy.

Access to a 24 hour antenatal (and postnatal) helpline would be helpful.

3.5 Home birth

*Home birth will be encouraged and we will work towards a target of 7-10% home births by March 2011*

Generally, people were in favour of having choice about where they have their babies. Feelings were mixed about whether home births are a good idea or not, but everyone was very clear that this should be a choice. There was some discomfort about the idea of targets. Many people felt this would result in pressure being put on mothers and midwives. There were people who felt the target was too high and others who felt it was not high enough.

Overall, people felt some concern that women will really have a choice and not feel pressured into having a home birth. They said choices should be presented equally, the pros and cons discussed and the woman's decision respected. Information should be available about why it is being encouraged and more support and advice should be available from both midwives and consultants.

>'There should be more encouragement towards home births but not a target. It will put pressure on mums to be and midwives.'

Some people expressed concerns about whether or not there were enough midwives, if they had the skills and if they offered home births. Good back up was seen as crucial. Some people felt frightened at the idea of a home birth and were clear that they would prefer a hospital setting in case of complications. A few felt it was better from an infection control point of view. One person said hospital gave women the chance to establish breastfeeding.

>'I personally would like the reassurance of being in a hospital.'

Some other concerns about encouraging home births were:

- not sure that women want it. Is it to save money?
- it is not always practical; what about the home - would it be assessed?

>'Women need to know they can do it and help will be there.'

>'People are put off home births because they can't guarantee that the midwife you know will be the one you will get and if there isn't one at all then you would have to go into hospital anyway.'

And one person was sceptical about the logic for promoting home births.

>'Although it is clear statistically that those having home births are less likely to have birth interventions I feel it is over-simplistic to aim for more normal births solely by offering more home births...factors leading to normal birth are multiple and the PCT should be more ambitious and seek to address more of these.'

One person felt this may be a step too far:

>'Let's get women feeling able to give birth in midwife-led units first...'
3.6 Birth centres

*Cossham Birth Centre will be opened and more birth centres will be developed as demand grows, so that more women will give birth with a midwife they know, near to home.*

There was strong support for this suggestion, both for the idea of having a midwife-led service and to having it in this particular area. People like the idea of birth centres being close to home and several people are keen that other centres are opened. Some women saw it as a 'halfway house' in terms of moving further towards home births. One woman suggested it is important that women are involved in the running of the birth centres.

'This will transform women's experience of childbirth...'

**There were some concerns...**

People are mostly in favour of local services 'because traffic is getting worse.' But there were also worries about possible transfers, should they be necessary. Some felt that for this reason, a midwife-led unit attached to a hospital is better.

'I prefer midwife-led centres on the same site as emergency care.'

Some were worried about technological advances being available.

'We don't want our babies or partners to be put at risk.' (a father to be)

People feel there must be midwives based there and the shortage of midwives is an issue. Again, many people identified choice as a key issue and did not want women to feel pressured into giving birth there.

There were some practical concerns - that it would not be used or that it would not be big enough with all the local housing development going on.

3.7 Midwife-led units

*The midwife-led unit at Southmead will expand and develop and the midwife-led unit at St Michaels will become more home-like and will be staffed by midwives dedicated to the unit. We will work towards the target of 30% of women giving birth in a birth centre or midwife-led unit*

This suggestion was supported by the majority of people. It was felt that a midwife-led unit is more personal. There was some anxiety that they may not get in and 'end up in hospital anyway'. Having the hospital services nearby seemed, to many, to be the best of both worlds.

'Great. Still in hospital if something goes wrong.'

There were many positive comments about the service at Southmead at the moment, and some recognition that the environment could be improved. People do not want Southmead to become too big or it may 'lose the culture'. It was felt by many that St Michaels needs radical change to become truly midwife-led.

'It is a shame the criteria for giving birth in the midwife-led unit is so strict, couldn't they make use of the fact they are on a hospital site to take more risks. Everything about the Southmead midwife-led unit is really good, we need to learn locally from this excellent model.'
There were also positive comments from people about St Michaels and some who 'wouldn't have had my babies anywhere else,' although it is not clear if this was about the midwife-led unit. There were some comments about the need for management change to enable this unit to work as a midwife-led unit.

A number of comments were about the staffing of the units, saying that they need more midwives so that they are not so rushed and stressful.

A number of people felt that improvements to the environments would be very welcome including cleanliness, decoration, more natural light, more birth pools more facilities so that fathers can stay - the more homelike the better. Some were not sure about why people would use the unit.

'..if people are low risk then why not go to a birth centre instead?'

Promoting the centres...One or two people liked the idea of the video that St Michaels uses to show people what it is like. But for many there was resentment that that they could not go and see for themselves.

'St Michaels are too busy to let me look around before D day itself.'

3.8 One-to-one care from a midwife during labour

More women will have one-to-one care from a midwife during labour

This was identified as one of the most important issues by a majority of people. It was identified by many as the ideal situation and one that would increase normal delivery rates. It was felt that staffing should be provided to enable this to happen. And some felt it may be unrealistic.

However, it is important to people that there is some continuity throughout their pregnancies and afterwards - not just for the birth. People would like the same midwife all through pregnancy, labour and afterwards, although some recognise that this may be something that could be aimed for rather than be guaranteed. Throughout labour is the most important to most people and they would like to know who it will be beforehand and meet her.

'Really, really important. Just as important is that women know the midwife...have had them throughout pregnancy.'

Other comments included:

- it's what midwives want as well as mothers
- you ought to be able to change your midwife if you don't feel comfortable with them
- women want to see the place of birth
- the midwife should be known to the father as well as the mother if possible.
- maybe 'buddying' a woman with say three midwives might help.

'A lovely idea but I wouldn't expect one midwife to stay on duty for 18/24/36 hours!'

Some people felt that one-to-one care would not solve everything. It was also said that one-to-one care from a midwife throughout labour, who does not know the
mother beforehand and/or disregards the mother’s birth plan will not improve things for many mothers.

One person said ‘It didn't make any difference to me that I didn't know my midwife - I just wanted them to be nice to me...’ Some were also aware that a balance needs to be achieved:

‘...between the midwives employment rights and the pregnant woman’s rights: at the moment there is not enough attention to the pregnant woman.’

It was suggested that there should be a target set for women to know their midwife at birth, otherwise it would not happen. One person was concerned that midwifery assistants would be doing the work of midwives, to allow the midwives to do more one-to-one care in labour.

3.9 Postnatal care

*Women will be able to have their postnatal care with a midwife at home or at their local clinic or birth centre*

Many people responded to this question with comments about their hospital care after giving birth. There appeared to be more concerns about this, than either postnatal care at home or antenatal care. Certainly many people said they would like:

‘better postnatal services and better support after baby is born.’

Most people thought that it was having the choice that was important, although reservations were expressed about some of the practicalities.

‘...midwife would just turn up at some point in the day. It is really frustrating because you can wait and waste a whole day waiting for them to arrive.’

Most people favoured a first visit at home. People particularly wanted to know what they could expect and how often it would be.

‘This needs to be really flexible and not determined in advance of the birth.’

There were some concerns, given how overstretched midwives are that they really would have a choice and that appointments would not be difficult to make.

‘More support is required not just being left to do it all on your own because health centre/midwives are short staffed.’

Other concerns included:

- choice is particularly important after a caesarean section
- breastfeeding help is very important
- home visits should remain available and are important to some people
- postnatal care is not well publicised.

‘Not every new mum has an army of friends and family to support them emotionally or physically. The midwife is important as human contact and also needs to understand the home environment.’
3.10 Support for families with sick babies or babies who die

There will be more support for families with very sick babies or babies who die

Not surprisingly, everyone who commented was in agreement with this. People felt it was very important and in particular that it is long term (see also section 4.9). A number of comments showed how difficult the simple practical issues are such as buying food, finding accommodation etc. There was a sense from many people of being left to fend for themselves.

‘My youngest was readmitted to the Children’s Hospital at 2 days old. I stayed with him but had to source my own food even as a breast-feeding mum of a neo-nate. I wept when a doctor suggested that my baby’s fits could be related to a lack of vitamins in my breast-milk - have you tried to get an affordable healthy meal near the Children’s Hospital on a Sunday!?’

People also identified the need for ‘a separate space and time to grieve or be with an ill baby.’ and the need for support for women who have miscarriages too. Some felt that there should be separate people looking after this area.

Many people also felt that staff need to tell parents what is on offer and that they 'shouldn’t have to push for it’ eg respite care for parents with sick babies. They felt support must include consideration of the family and it must acknowledge the importance of breastfeeding.

‘As it was an emergency admission, I did not have spare clothes, nappy changing kit etc. and it would have been very helpful to be able to borrow or purchase these without leaving the hospital.’

‘At the very least you need BLISS leaflets available in hospital and in the community.’

3.11 Support for women with mental health problems

There will be improvements to services for women with mental health problems

The majority of people felt that more support is desperately needed and that high quality, comprehensive services, should be available. A whole system of care is needed for those diagnosed with a mental health problem and for those developing postnatal depression.

‘This seems to be quite neglected at the moment. It is difficult to know who to turn to for help.’

A number of women felt that it was important to encourage open discussion about this and work to destigmatise postnatal issues, including not bonding and depression.

‘Too much postnatal depression is not picked up.’

Some felt that postnatal depression is still not dealt with very well. Prevention of postnatal anxiety and depression is just as important as providing ‘improvements to

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\(^2\) see www.bliss.org.uk
services’. They felt that more should be done to identify those with multiple risk factors prior to birth so that women can be followed up more carefully in the weeks immediately after birth.

One person described the difficulty of coping with mainstream mental health services that were unable to make provision for a breastfeeding mother.

‘There is a complete lack of understanding, provision and knowledge of how to care for a woman who had recently given birth.’

Other issues raised included:

- be aware that experience during pregnancy can affect mental health
- postnatal depression should be discussed at antenatal classes
- need better communication between services and should link to voluntary sector organisations providing support as well
- this requires a new role rather than expecting current staff to adopt the responsibility

‘I don't know if there is an equivalent in the Bristol area but the Stroud maternity night telephone line is a huge reassurance that I think stopped me developing depression - however bleak 3 am is, knowing there’s someone awake and concerned nearby and that you could even go there if desperate provides great emotional support.’

3.12 Targeting resources

We will target resources to those with greatest need by employing, for example, maternity support workers to work alongside midwives, drug liaison midwives, midwives who offer extra support to teenagers and better translation and interpreting services

Views on this were quite mixed. Although many people agreed with this suggestion in theory, there was also some concern that others were not left without support. There was a strong sense from many that this is a time when people are really in need and although it is important to target resources, some people felt that it should not distract from the priority for one-to-one midwifery care, or mean that others received a sub-standard service.

‘Good - but do not leave those with no special vulnerabilities to fend for themselves.’

Some likened this to how they see the health visitor service, in that it is ‘..really difficult to get help from them if you are deemed able to cope - no-one copes with no sleep and postnatal depression.’

There was also a concern that resources not be taken away from other services for this and that resourcing should be spread, not all funded by services in deprived areas.

‘More midwives in general would be better.’

But many people thought targeting was essential in order to improve services to the most vulnerable customers and that it would allow people to receive the extra
or specific support they need, rather than be ignored or pre-judged. Many appreciated the role of specialist midwives.

'Creative ways to help ease the load on midwives would be good, but this needs to be done without diluting the midwives role.'

Some other suggestions and comments included:

- translation is clearly a problem. More printed literature is needed and information in different formats. Maybe free language training for midwives who want it?
- there is a training need for midwives - around cultural awareness, sexual orientation etc
- link workers for particular community groups to promote midwifery services
- the booklet referred to 'second-time' mums. Those who have had more than two pregnancies are not always considered
- perhaps maternity support workers could show women around the hospitals.
- two-parent families should also be accepted as normal!

Suggestions as to where else these 'extra resources' could be used were:

- for Southmead particularly at night when there is not enough support eg one midwife and twenty babies.
- help us to support each other! Support more postnatal support groups - including repeat mums, dads' groups etc.

'Can't you target resources at the medical care to provide consultants on call for the birth centres?' (Mum in Weston)

3.13 Equally beneficial to all people?

_Do you think the plan will be equally beneficial to people of different ages, sex, race, religious belief, sexual orientation and to people with a disability?_

Many people did not comment on this question and it was not included on all the feedback forms. Most that commented felt that the plan would benefit all. Others suggested that there will always be people who are more aware of the choices they have and services available and it is difficult to change this. Most people felt that none of these groups should be disadvantaged by restricted choice or access.

‘..particularly people with disabilities, previous caesarean delivery and younger/older inexperienced women will find it harder to feel confident enough to plan a non-medicalised birth… they may actually end up feeling somehow cheated of making a choice even if it is in their best interests.’

Groups that people felt might not benefit equally were:

- lesbian couples may feel alienated by some services eg antenatal classes
- people who do not speak English will not have access to information.

‘How real are choices for people with a disability?’

One person suggested that an equalities impact assessment be undertaken in order to answer this question. A summary of responses relating to equalities is in Appendix E.
3.14  Any geographical issues?

Five public meetings were held in Bristol, South Gloucestershire and in North Somerset. Antenatal and postnatal groups were also visited. In the case of individual written responses, it was not possible to identify where they came from, unless specific points were made which related to the area. Overall support for the proposals was similar across the three PCT areas, and comments have been included in the previous section - apart from a few key points which are summarised here.

**North Somerset**

There were particular issues raised in North Somerset related to the distance from Bristol hospitals. Many people commented that people are opting for births in Bristol because they want to avoid the risk of being transferred in labour.

> 'Why can't we have epidural assisted delivery and caesarean options here to take the pressure off St Michaels? It seems ridiculous that 11 out of 12 mums at my antenatal class have opted for Bristol.'

Some commented that it had been easy to get appointments with their midwife and there were some obvious benefits to living in North Somerset.

> 'In Clevedon, there are three midwives and mums see the same midwife every time.'

Some people felt that there was an element of competition between Bristol and Weston hospitals that was not helpful.

People valued the help of the health visitor but were concerned that her visits to new mothers were being cut from six to two. They felt that the ‘drive’ was to get new mums to attend clinics. There is concern that there is no privacy if seen in a group setting in a clinic. Other comments included:

- there is a lot of pressure to breastfeed which is not helpful

> 'I felt discriminated against for not being able to breast feed. I was very pressured and made to feel a failure. There should be more sympathy and support…'

- partners are not encouraged to attend antenatal classes
- a 24 hour telephone advice line and drop-in support would help
- it is difficult to get to baby clinics with a tiny baby and other children.

**South Gloucestershire**

People were concerned in all areas about the shortage of midwives, but this was particularly apparent in South Gloucestershire and particularly for community midwives.
Section 4: Special interest groups

Visits were made to 39 groups, including antenatal and postnatal groups. Many of the issues raised were the same as from individual responses. This section summarises those issues that are particular to specific groups. In some cases these are views of small numbers of people and are useful for highlighting possible issues, but do not reflect the views of any whole population group.

4.1 Parents of Disabled children

Three groups were visited in Bristol and South Gloucestershire and some individual responses received. Many parents felt that the quality of care from specialist staff was generally good. Many talked of the great support that they received, particularly from individual midwives and health visitors. But many felt there was a need for improvements to some aspects of care. They identified the following as key issues:

How they were told about their child having a disability - some people were told in public places in an offhand manner. ‘There were lots of people around and I felt terrible.’ They were given no point of contact for any questions they had. One person had to wait 36 hours to see a doctor, even though they had said they thought something was wrong. When the doctor did turn up he would not wait to speak to her until her husband was able to be with her.

‘We were given very negative messages about all the things our child wouldn’t be able to do. It is a difficult balance of how much information to give and when...Contacts to local and national support networks are very important.’

Empathy - there is a need for midwives to show greater empathy to parents and to improve the quality of communication.

‘I could overhear midwives talking about women and their children and found their attitude very negative and patronising. My baby was referred to as ‘the Down’s Baby.’”

Sharing of information between health professionals - people described getting different advice from the Special Care Baby Unit (SCBU) and other units and problems with staff not sharing information.

Extra emotional support - people need more time and emotional support and some would like access to counselling. This is a particular issue where the disability was not anticipated before birth.

Particular expertise - people need staff who understand and can help with extra needs, such as specific breastfeeding problems. Staff need training in this.

‘I found out 14 weeks into the pregnancy and received excellent antenatal care but poor postnatal care. The impression was that staff thought I knew everything I needed to know and didn’t need support.’

Practical help - with completing Disability Living Allowance forms would be valued. One mother of a Disabled daughter described how hard it was for her to visit her
daughter in special care as she had had a caesarean section and a wheelchair was not available for her after the first day.

In relation to the proposals for change, people said that one-to-one care in labour was very important and more midwives are needed in order to provide this. They were pleased that choice will be increased in relation to home births and birth units, although several would not wish to have a home birth and their preference would always be to have ready access to a consultant-led unit. Other issues included:

- some women would like a scan at 12 weeks
- support after having a miscarriage - a system exists which means that the cause of miscarriages is not investigated until a mother has had three. One woman felt this should be less.
- the need to look at the most effective way of enabling access to support from community paediatrics and therapy services.
- part time community staff means that support is often not consistent with no opportunity to build relationships
- concern that midwives may be unwilling to give direct advice during the birth, maybe because of fear of litigation. The inexperience of community midwives was mentioned as a concern by some
- access to speech and language therapy was felt to be a gap
- a model was suggested (based on a service in London) of a clinic with access to specialist services which can be accessed for appointments but also has a more informal drop-in service - suggested possibly as an expansion of the Frenchay Special Needs Children’s Centre
- parents’ overnight accommodation at St Michaels is inadequate and access is ‘hit and miss’.

‘Every child with Down Syndrome is different. They and their parents need to be treated as individuals.’

4.2 People from Black and minority ethnic communities

In all, five groups were visited in Bristol and South Gloucestershire.

Chinese women

The Chinese women who spoke preferred hospital care, although most had also had bad experiences around birth. These experiences appeared to relate to poor communication, lack of understanding of cultural needs and lack of one-to-one continuity of care. They felt that continuity of care by a midwife was ideal, although the role of midwives was not understood well, or valued by all. There were concerns about the shortage of midwives.

Some women wanted to know about caesarian sections and the disadvantages and it was clear that these had never been explained to them.

‘It’s not the Chinese culture (caesarian section) but if the woman has a difficult labour and she wants one she should have it.’

Feelings around natural birth seemed mixed amongst Chinese women. Some said Chinese women prefer natural births. Others said they feel more comfortable in hospital with doctors.
'Even the next generation of young mothers are led by the in-laws...so it is a lot of effort to come round to home births.'

The support Chinese women get from their families was highlighted as important. Chinese women said there is a lot of isolation here around birth and postnatal depression.

Women's experiences indicated some hospital staff's lack cultural awareness. Interpreting and translation services are a key issue.

'It is most important to me that they provide interpreting services for antenatal and postnatal classes and give out written information in different languages.'

There was a lot of comment on poor feeding advice and the need for more help and a comment that there is less support now: 'postnatal services are not as good as they used to be.'

'The midwives are doing too much paper work and not enough hands on.'

**Asian women**

This meeting was for Bangladeshi, Indian and Pakistani women.

**Home births** - the women overall said they preferred a hospital type environment and are not interested in home births.

**Birth centres** - feelings about birth centres were mixed. Most felt that they are a good idea and would use one if it was nearby.

**One-to-one care** - the women feel it is particularly important for them to know their midwife, as:

'...our women don't know anyone in hospital - its tough for them - if they know the midwife it is more comfortable.'

**Postnatal care** - there was some feeling that postnatal care, in particular support for breastfeeding, was lacking, although care for depression was felt to be good. Women would like more support and for midwives to 'come to our homes.'

**Midwife-led units** - many women did not know about all the facilities available. No one knew about the midwife-led unit at St Michaels. All the women used St Michaels hospital, rather than Southmead.

'A small hospital in the community would be good so that family and children can visit.'

The midwife's role was not understood by some. In general it was suggested that Asian women prefer doctors here, although the younger women:

'...have less fear and want to be in control of their births. They want a normal birth.'

**Targeting resources** - interpreters are seen as central to the care received. People talked about feeling afraid in an alien environment with people they didn't
know and where there is always a shortage of staff. There was some feeling that people are sometimes pushed into have a caesarean section in hospital.

'First time mothers really need help and support....this would be better with midwives they know nearer home.'

**Somali women**

Somali women identified the need for better antenatal care and information - face to face, not on paper. Some would like classes with others - not just for Somali women. They also would like hospital staff to have 24 hour access to interpreting services - particularly at birth. They would like birth settings to be less alien. Maternity support workers were valued and they felt that for a woman to know her midwife at birth and have one-to-one care was important.

Most people had their babies at St Michaels. Some women said they had heard negative comments about it, but all the women said they personally had a good experience. There were some complaints - about running out of vegetarian food, staff slow to help and some staff attitudes.

People felt that hospital staff did not understand Somali culture and this could cause problems. But also that Somali women do not always know about the NHS so they do not know who to go to if there is a problem.

**Polish community**

Polish women said that they support normal birth although they point out that sometimes a caesarian section may be necessary.

**Antenatal care** - in Poland the approach is a very cautious one with a lot of scans and internal examinations. Here they feel there are not enough of these. One person felt there should be an earlier scan than twelve weeks.

'How do you know there are no risks without enough scans and internals?'

**Home births, birth centres and midwife-led units** - women do not want home births for themselves. Nor do they want birth centres (as opposed to midwife-led units alongside hospitals) They want hospital births but did not know about the midwife-led unit at Southmead. They would generally like to be looked after by a midwife in a midwife-led unit, next to a hospital. They are generally happy with midwives but always want access to a doctor, although they feel doctors do not have enough time to discuss things. There was some concern about leaving hospital too soon because of a risk of infection.

**One-to-one care** - they would like this but point out:

'one-to-one care sounds good but what if you don't like your midwife?'

**Postnatal care** - a choice of where postnatal care takes place is welcomed. They have found breastfeeding support good both at home and in hospital. Other issues raised were:

- they would like the 'level of understanding' by the interpreters to be better.
Not all women know there are interpreters and there should be leaflets telling people this
• putting Polish women in contact with other Polish women would be helpful, especially if they speak English
• some women had been given information that they had not understood
• the role of the midwife was not understood well and it was not valued compared to that of doctors. But also there was some interest in knowing more about less medicalised births.

Gypsies and Travellers
Gypsies and Travellers supported one-to-one care during labour, more support for women who have sick babies or babies that die and better services for women with mental health needs, especially if they do not have family and friends nearby.

Pre-pregnancy care - the women were generally positive about pre-pregnancy care, particularly if women have any health problems.

Midwife as the first point of contact for all women - most of the women had been to see the midwife first and they thought this was okay. But access to the doctor is important for any health problems.

A wider choice of antenatal classes - women would like to be told about classes (sometimes they are not) and some would be interested in going.

Home births and birth centres - the women said they would not want to have a home birth. They all wanted to be in a hospital close to the doctors and machines. One women said she could not give birth at home with the other children around. The women also preferred a hospital over a birth centre as they wanted doctors on hand. There were concerns about safety and about having to be transferred to a hospital anyway.

Women described hospital experiences that were mostly not good ones - mistakes that no-one apologised for; labours that lasted many days. One woman felt worried that she would not be allowed to have a caesarean section next time, even though she has very big babies. One woman said she had a trainee midwife with her at Southmead and she was very good.

Postnatal care - the group thought it was better for the midwife to come to them, as it was more relaxing. One woman said she would prefer to see the doctor as she has other health problems.

Targeting resources to those with the greatest need - they all thought it was good to help those people who need help the most. All the women interviewed thought there had been some discrimination against them from staff in the hospital because they are Travellers

‘...they were funny with the Travellers because they are not great scholars.’

In particular, one woman said that staff kept using long words that she didn't understand. Many women were unhappy about their husbands and their mothers
not being allowed to stay. One woman said she was not given any pain relief and that the staff were very busy and did not have enough time to help her.

Other suggestions included:

- staff should explain the rules at the hospital when you first go in, so you understand what you can and can not do
- one woman thought there should be more scans at the end of pregnancy as she felt this would have shown up a problem that she had
- people should be able to choose to have a caesarean section - family members in Ireland had this choice.
- one woman said she had wanted her mum with her but she was only allowed someone in when she was in the delivery suite. She felt very alone.

All the women were very positive about the service they had been given by the community midwives.

4.3 Refugees and asylum seekers

There was support from refugee and asylum seekers for many of these changes, in particular more pre-pregnancy care, the midwife as first point of contact, one-to-one care during labour, choice of antenatal classes and of postnatal care and more support for people whose babies are sick or die.

Home births and birth centres - home births were felt to be quite dangerous with time wasted getting to hospital. Certainly they felt people should have a choice about this. Birth centres were felt to be less risky than a home birth, at least. They queried who knows better about child birth - the midwives or the doctors?

’If more women are going to have their babies with a midwife there needs to be at least one doctor who is very experienced on call. The doctor should be close by so they can come and help if things go wrong.’

They also identified a lack of translation and interpreters for people who do not speak English, and a lack of support for people with mental health problems.

One person said that in the paperwork in the yellow book and the blue book, under occupation for her it said ’asylum seeker’ and she was very unhappy about this.

’Why do all the staff need to know that I was seeking asylum in this country. I was asked very personal questions about why I wanted to live here, and why I had left my husband back home. I don’t think other single mums would be asked such personal questions, it felt like discrimination. Quite a few mothers have also complained about this. I do not think this is right.’

4.4 Women who have experienced domestic violence

The views of these women were similar to others. They feel as others do that choice is really important in terms of where and how women give birth. Women should be able to choose what they need.

’Give people the options, explain them in detail so they understand them. Most women are intelligent enough to make their own choice.’
Support for pre-pregnancy and antenatal care was high, as was the midwife being the first point of contact. Home births were also supported if there were enough midwives.

**Birth centres and midwife-led units** - were supported although there was some worry about possibly needing to be transferred. Midwife-led units it was felt addressed this problem.

**One-to-one care from a midwife during labour** - some thought all women already had this and that it is important.

> 'I would have liked the midwife I’d had in the community in the hospital.'

**Postnatal care** - some felt it was important that the midwife go to the home and that people have the choice. It was important that women did not feel pushed into going to a group.

> 'When midwives go into the person’s home they can pick up if there is a problem such as domestic violence. I would be concerned about women going to a clinic, the midwife might miss the signs.'

Some felt concerned that women might have postnatal depression and 'slip though the net'.

> 'There needs to be follow up for those who have not turned up to a group...'

**Support for families with very sick babies or babies who die** - is seen as important.

> 'I lost a baby at 26 weeks and the midwives didn’t check up on me. I was left without any help...'

**Services for women with mental health problems** - these are very important and should include services for people with mental health problems related to drug use.

**Targeting resources** - this is important, although there needs to be a system for assessing need. Midwives trained in drug use are a good idea. More health visitors are needed and are key to picking up on domestic violence problems.

Some women suggested that health visitors need to be informed about what is happening locally, such as mum and toddler groups, play groups, coffee mornings etc, so they can help encourage mums to get out of the house and make friends.

### 4.5 Women who are in prison

Women in prison had similar views and concerns to others.

Most of the women were not interested in pre-pregnancy care as many had not planned to get pregnant. Some felt that improvements to pregnancy testing were needed as their pregnancies were not picked up when they arrived at the prison.

The midwife being the first point of contact and one-to-one care throughout labour were both felt to be a good idea. And more support for people with babies who are
very sick or die was seen as important. Support for people with mental health problems was also viewed as important.

Some of the key issues identified by women in prison were:

- **antenatal classes** - women do not get any antenatal education and all said they would like it. They would like to talk about how to prepare for the birth and what to expect.
- **home births** - home births are not suitable for this group of women, as there may be a security risk. But also many of the women use drugs so their babies need to be monitored after birth.
- **birth centres and midwife-led units** - there was interest in birth centres, although some women said they would be worried if anything went wrong. One woman queried whether social services would be involved if she gave birth in a birth centre. Midwife-led units were much more popular. Women liked the idea of giving birth in a more home-like environment while being close to doctors and equipment if anything went wrong. One woman asked if she could give birth in a birthing pool and whether she would be handcuffed during labour.
- **postnatal checks** - would be in the mother and baby unit which they were happy about. Others will have left prison by then and thought at least the first appointment should be at home.
- **targeting resources** - there was agreement with this. One woman suggested the NHS employs a maternity support worker to come into the prison. They found having a drug liaison midwife at Southmead was helpful. Women said they did not think they were discriminated against because they were in prison. A number were complimentary about the community midwives.

But there were some ways in which the women did feel discriminated against:

- not having any antenatal education
- not having a scan picture of the baby (this is being addressed).
- a need for more rehabilitation help for woman to come off drugs
- terminations - having someone to talk to about their options
- safety - fighting and being knocked over in the prison is an issue
- they would like a full time midwife at the prison
- for staff to listen more.

Health staff at the prison raised a few issues on behalf of the women, namely:

- the lack of antenatal education - perhaps the midwives could use some creative thinking to provide something
- it would be helpful if the midwives could prioritise arriving on time, although staff realise this is not always easy. The women are only allowed out of the cells at certain times and if the midwives are late this causes problems.
- many women at the prison do receive some pre-pregnancy care through a women’s health clinic.
- there is a problem about midwives picking up child protection issues as they only have a short time with women and this system needs to be looked at.
4.6 Young people

Three groups were visited - one antenatal clinic in Bristol and two groups of young parents in Bristol and in Weston. Young people shared many of the same concerns as other groups of women, including the wish for continuity of one-to-one care, and for their views to be listened to and their wishes respected.

‘...it is more about the midwife showing interest in how I feel, that is important.’

Support for families with very sick babies or babies who die and services for women with mental health problems were both felt to be very important especially if women did not have any family of friends around to help them.

Pre-pregnancy care - this was not of particular interest to young people. They said they could see it might be a good idea for those over a certain age.

Midwife as first point of contact - generally most people said they preferred to go to their GP first as they knew where they were and how to get hold of them, although those who had already given birth were more positive about midwives.

Antenatal classes - views were mixed about antenatal classes. There was very little experience of attending them. Some said they would like them with other young people so they felt comfortable; some would like them with other people as they felt they might learn from the other mothers. Some were not interested at all. As with other women, there was a need for classes in the evenings and at weekends so that partners could attend. The special teenage antenatal clinic at St. Michaels was viewed positively.

Home births - Most young people were not in favour of home births as they were worried about being transferred if 'anything went wrong.' One or two were interested and thought they were a good idea.

Birth centres and midwife-led units - the idea of a birth centre was popular with some (but not all) and in particular the fact that it would be ‘family-friendly.’ But there was concern about having to be transferred to a hospital if there was a problem. Generally young people were less keen on birth centres than older people. Midwife-led units were seen as a good idea and should be home like.

Postnatal care - most young women were particularly keen that the midwife came to their homes and were anxious about taking such a young baby to the clinic. For those who had already given birth some seemed to feel a lack of support and felt pushed into breastfeeding.

‘You should have a choice because from day one I said I wanted to ‘bottle’ but on my notes it said ‘unsure.’

Targeting resources and equal access - some young women found that the extra support they got meant that there was more continuity for them; they saw the same midwife, whereas at the general clinic they did not.

Some young women felt surprised and pleased that they were treated like everyone else and people were 'not funny with me because I am young.' But others
felt patronised by some staff and 'talked about.' Other issues that young people raised were:

- how important it is to them that midwives ask about how they were feeling as well as doing medical checks
- how transportation to the hospital can be difficult and how information would help
- there were lots of mixed comments about hospitals - Southmead was very much favoured
- there were comments about negative experiences - (e.g. being sent home from hospital told not in labour and giving birth two hours later) that young people put down the fact that they were young.

Overall, there seemed to be an assumption from young people that when something went wrong it was because people were not listening to them, or giving them an inferior service because they were young (which may be true). This is coupled with a sense that it is very difficult for young people to feel confident enough to ask for information when they do not know how systems work.

For example, one woman said 'they didn't tell me nothing.' Another woman described not being shown where the food was served in hospital so she didn’t eat anything for two days. She said she was not sure what to do with her baby when she wanted to go to the toilet, she wasn’t sure if she was supposed to take him with her, and she didn’t know where to put dirty nappies.

4.7 People who have twins and multiple births

Visits were made to three groups. A huge number of comments were made which are summarised briefly here. This seems to be an area where a number of practical changes could make a huge difference to people’s experiences and this summary cannot do justice to all these comments. Further consideration of the comments is recommended.

A key issue was the need for midwives to have a better understanding of the needs of parents with multiple births, and to be aware of sources of information and support in order to signpost parents. They felt there should be designated specialist multiple birth midwives, 'my midwife had no experience at all with multiple births'.

Midwife as the first point of contact - people felt this is important and should be earlier at six to eight weeks.

Antenatal support - women felt that there was sometimes poor liaison between the foetal medicine team and the midwifery team at St Michaels and a lack of clarity on who was responsible for what i.e. blood tests. Lack of early access to scans can be a problem.

Antenatal classes - people would like a 'multi-birth' class with specialist advice (more than one special session). Some antenatal classes do not broach twin breast feeding, the implications of having to hold two, etc
'It would have been nice to see the midwife with two dolls at antenatal class, and then you can see the practicalities of having more than one baby.'

Some mothers said they were unable to go to any antenatal classes because their babies were early. As multiple births are almost always early, classes need to be earlier.

'I didn’t see my midwife, I had to go to scans every two weeks, so they thought that I would get that support there, but I didn’t.'

**Home birth** - they felt that women should have a choice and that less interventions should be encouraged. Some were not interested in home births and there were some concerns about what happens if there are problems.

**Cossham Birth Centre** - there was support for this. People said it would take the pressure off hospital staff and provide an environment that could just focus on maternity. Concerns included timely access to specialist care.

**Midwife-led units at Southmead and St Michael’s** - again were supported as it as felt that they offered that bit more security of specialist help nearby.

**One-to-one care from a midwife during labour** - is seen as essential so that trust can be built with the midwife. Some women wondered if it is realistic.

**Postnatal care** - a choice is important. A local clinic provides opportunities to get out and meet other mothers but with twins it is good to have home support initially. Some women commented on their aftercare in hospital.

'I felt that there was constantly not enough staff to cope with all of the mothers, and you don't get enough chance to recover before you are dispatched home.'

**More support for families with very sick babies or babies who die** - people need one-to-one support and help, not ‘a stream of different workers’. Some women have found a lot of support has been available.

**Services for women with mental health problems** - problems should be identified early to help put support in place eg counselling.

**Targeting resources to those with the greatest need** - this is supported by most women, particularly support for young people and interpreting services.

**Equally beneficial to all?** - Comments were that it sounded good - apart from for people who have multiple births. Disability is also an area which needs more focus.

‘...when pregnant with twins I received a lot of care and support. After the birth I was just left to get on with things – with twins you could do with more help.’

Other suggestions and comments made included the need for:

- husbands/partners being able to stay and give support
- more aftercare and support
- equal access to services where surgery is provided eg St Michaels' babies have priority over Southmead babies.
• more facilities so can avoid being transferred to another hospital because of the availability of facilities
• improved communication, for example, explain systems and processes, housekeeping etc – maybe have a card listing some of the rules.

A particular issue for parents of twins (or for those who have multiple births) is being able to get their babies weighed because of the access issues at clinics of having a double buggy and staff being too busy to help with undressing etc.

There were a number of comments about being in hospital:
• It gets forgotten that you are there for far longer in hospital and have twice the amount of babies.

  'There are small things that could be improved that would make a huge difference, for example you can’t have a toaster in the hospital because it is a fire risk, so you can’t have toast. I know it sounds small, but I was there for eight weeks and it does matter because you want a homely environment.'

• The doctors come on ward rounds before visiting hours, before your husband comes in, and ask for decisions about the babies that I didn’t want to make on my own.
• My caesarean section kept being cancelled and then finally they gave me half an hour's notice to get my husband there.
• They should sell twenty four car park passes from midwifery reception or from a machine in maternity.
• You aren’t really treated any differently to mums who have had one baby, and you need this because you have two babies and are in for longer.
• I had my babies in two push-around incubator cots, and had to push them both around myself. Going to the toilet is awful - you take one in and leave one outside because there is no room.
• The support focuses so much on the actual pregnancy, and not on what you will be feeling, what to do if breastfeeding doesn’t work.
• Some breast feeding classes and things like that are during visiting times, when you are in hospital for a long time, you want to spend this time with your family and friends, so you miss out.
• All of my experiences with midwives were very good; they took the babies a lot so I could rest.
• The special care nursing was fantastic though overstretched.
• There is a lack of midwives on the night shift to provide post birth care.
• I wanted to breastfeed but found it very difficult. I felt there was too much pressure.
• More advice is needed - routine advice such as breast feeding, teeth brushing, winding. More on breastfeeding post caesarean section; more on mixed feeding, which can maintain at least partial breastfeeding for longer.

  'Need more midwife support in hospital. I was left alone for 24 hours after a caesarean. As a first time mum I wanted breastfeeding information but the midwife was very abrupt with me. The ward was very busy at the time and it was made clear that there were a lot more urgent cases than me.'
Comments about support at home included:

- The health visitor came to my house for a year to weigh my babies; otherwise I wouldn’t have been able to get them weighed.
- My midwife didn’t come to see me at all but perhaps I was just unlucky.
- There is no multiple births group at St Michaels but the one at Southmead is said to be good. It would be good if all mothers could access that group.
- Every time I needed advice I was referred to the consultant but as it was a different one every time I couldn’t build a relationship. I would have preferred advice from the midwife.
- Midwifery input was inconsistent; health visitor continuity has been good.
- Midwives weren’t geared up to give practical information or signpost to sources of support.
- I was routinely referred to a consultant but they weren’t very helpful – their routine response was ‘I don’t know why you are here?’ Consultants need training in how to talk to people.

4.8 Fathers groups

Fathers groups were visited in Bristol and Weston. Fathers supported improvements in maternity and newborn services. They particularly felt that one-to-one care from a midwife is important throughout pregnancy and labour. They are aware that there need to be more midwives to be able to do this.

**Antenatal classes** - fathers would like to be involved in these and are very much in favour of having them in community venues and for them to be more flexible, in the evenings and appropriate to the needs of dads, e.g. after work, have inputs from local dads with children, some separate sessions for dads etc

‘...make it less like a class and more like a social event.’

They would also like fathers to be made to feel more welcome e.g. when mothers book in for first appointment with the midwife, invite both mum and dad to antenatal class with a separate invite for dad.

‘There is a feeling that you are not really welcomed and wanted at the classes as a dad.’

**Birth centres** - there are particular issues in Weston. Some said that there is a lack of beds in Weston birth centre. Some Weston residents choose to give birth at St Michaels or Southmead as an ‘insurance policy’ to avoid last minute transfers. It was suggested that publicising the figures for non-planned transfer might reassure people and encourage more use of the birth centre.

**Hospital care** - some fathers said that they felt women were sent home too quickly from hospital. They feel they should have more time to get used to the new baby and have help. Some felt that professionals tended to ignore fathers.

‘...sometimes professionals ignore the father even when he is at an appointment with the mother, e.g. he asks a question and the midwife replies to the mother.’
4.9 Those who have experienced stillbirth or neonatal death

The Stillbirth and Neonatal Death Society (SANDS) has worked closely with the PCT on this issue. It is not possible to do all this work justice in a brief summary and this report will pick out key messages only.

The society supports the proposals - and has contributed to them - and in particular welcomes the commitment to reduce the number of still births and increase access to counselling and care in subsequent pregnancies.

More pre-pregnancy care

The society supports this and feels it should cover psychological as well as physical aspects of pre-conception. Women should be made aware that this is available. Mothers with other health risks should be a priority.

The midwife as the first point of contact

Publicity is needed so that people know how to access the midwife and training will be needed for reception staff.

Wider choice of antenatal classes.

There is support for this, particularly the idea of refresher courses. The social element of these classes is very important.

Home birth

Comments about home births included:

- need to make sure transport is in place to cope with problems during labour and after birth
- safety and choice are both important
- mothers need to understand the risks
- some midwives are not keen on home births. They need to feel comfortable about delivering a baby at home.

One particular comment from a woman whose baby died in hospital said:

‘as I was in hospital I had 29 hours with him, if I'd been at home it would have been much less.’

Cossham Birth Centre

The group were not keen on the idea of a birth centre. In particular there was concern:

- the obstetric unit may be full and you may have to transfer 20 miles away
- if they only take low risk mums the midwives will not be experienced to deal with problems
- things go wrong sometimes even if you are low risk.

‘What if a problem develops....when the baby needs to be delivered in 30 minutes?’

Midwife-led units at Southmead and St Michael’s

The SANDS group felt that this was the best option as transfer is easier in case of problems. Training is an issue. The group suggested more rotation of staff from
obstetric units, midwife-led units and neonatal intensive care unit (NICU) so they can share skills.

**One-to-one care from a midwife during labour**

This is felt to be really important although it is recognised that midwives can 'only do their shifts.' People queried why the model of midwives working in both community and hospital was not more widespread?

**Postnatal care**

The importance of this being a choice was highlighted.

**Support for families with very sick babies or babies who die.**

The group was strongly in favour of this. They suggested that women who use NICU on second pregnancy need more support from midwives and health visitors.

- A paediatric pathologist is needed that is able to be on call/ available and able to travel between hospitals.
- Why don't we have bereavement midwives?
- The importance of having a normal birth is so drummed into people that if things don't go well people feel as though they have failed.
- One suite is not enough. There are 40 neo-natal deaths per year at St Michael's. It could be a room with shared use as long as priority is given to people whose baby had died. In the booklet, page 21 – number 13 – Bristol hospitals have a bereavement lavender suite and maple suite. These are a great resource for people having a still birth. For those people who have a neo-natal death this is not a good resource. Need a similar resource linked to neo-natal units. If decide to withdraw care – you want to hold the baby and you may not have long. Also the two rooms there are always full.

‘My baby died in a store room, it was not good enough.’

**Services for women with mental health problems**

The group supported this and said that there is good support for very mentally ill women but not for women with low level mental health problems. They said:

- in Bristol there is no support for women suffering from antenatal depression. New Horizons offer one or two listening sessions. If you have lost a baby you may suffer antenatal depression. No provisions for child care if you have a toddler and depression
- PCT should take this on board and make a financial investment.
- no perinatal psychiatry consultant; needed as a lead
- there is no service other than New Horizons and it needs building up.
- lots of mums won't realise what the problem is and with less health visitors it may not be picked up
- support for postnatal depression should not rely on a charity providing this
- need to follow NICE guidelines
- the support group Mothers for Mothers provides support for people with low level mental health problems – they need funding from the PCT to provide a wider number of groups.
Targeting resources to those with the greatest need

Maternity support workers would be good for women who have had a still birth as long as they are well trained. The group agree with targeting and they think it should also include women who have lost babies before.

‘It feels hard when drug users have a support worker, there are midwives to help people stop smoking but if you have lost a baby you get no extra support.’

Equally benefit everyone?

The group felt that services should be the same for teenagers and older mums and that nobody should be made to feel different. Translation and interpretation services are a key need. Better support is needed for people who are not religious. Same sex couples should get equal support and should not have any discrimination. The new birth centre will need the same level of access for Disabled people as hospitals. Many Disabled women will need extra support in labour.

Other suggestions or comments

The group also listed a number of specific proposals made previously but not included in the eleven suggestions including SANDS Teardrop stickers to be used and understood by all staff. Other suggestions made were:

- Paediatric pathologist to be employed by one of the Bristol Trusts. (In hospitals where these are on call to speak to bereaved parents about post-mortem, uptake may increase)
- Choice to be able to take dead baby home if parents wish to do so.
- Support for people who lose a baby who then can’t have another child.
- Recurrent miscarriage investigations to be offered after three miscarriages to bring in line with other parts of the country.
- Parents to have access to a health visitor even if they have no other children.
- Greater staff understanding of the fact that giving birth to a subsequent child can resurrect the grief from the previous loss.
- Monitoring of fetal growth: Use of the Perinatal Institute’s customised growth charts to promote normal birth and help staff identify where growth problems may exist and further investigations are necessary.
- Biochemical testing of placenta function (Mother’s only encouraged to take this test as a marker for trisomies or spinabifida. Should be encouraged to take this test as a marker for placenta insufficiency)
- Monitoring of foetal movements (it is not enough to ask if ten foetal movements have been felt in the course of 24 hours, foetal movements should be monitored by the mother at the baby’s active time of day, what should be noted is if it is taking the baby longer than usual to have ten distinct movements. Waiting until no foetal movements are felt is often too late.)

With regard to the recommendation for universal adoption of Nice Guidelines SANDS suggests a caveat in respect of NICE 45 Antenatal and Post Natal Health 1.3.1.4 page 14 (Feb 2007) re: seeing and holding the baby, following further research and correspondence (this information is available in detail from SANDS). Many SANDS parents and many others support:
• having a choice and having the offer made to them since it would often not have occurred to them
• the value for very many of having seen, held and spent time with their baby.

SANDS recommends that the offer should be made, and the various options explained and parents helped to make their own choice.

SANDS also suggests additional standards should be adopted, namely:

1) We will make a commitment to reduce the number of stillbirths and neonatal death (NND) through improvements in antenatal care of the middle and later stages of pregnancy in order to diagnose more accurately where a problem may exist which could lead to the death of a baby.

2) We will provide more bereavement counsellors and bereavement midwives.

4.10 Women with HIV

Overall, women supported these proposals, in particular, pre-pregnancy care, midwife as first point of contact, more support for people whose babies are sick or die and more support for people with mental health problems. One-to-one care from a midwife was especially important. They also made the following points.

Antenatal classes - the women had both had experience of antenatal classes but their responses were opposite to each other - one useful; one boring.

Home birth - the women said they preferred to have their babies in hospital so they were closer to doctors and equipment if anything went wrong, although there was some concerns in hospital about confidentiality. One thought that home might be better as long as the midwife was trained and confident.

Birth centres and midwife-led units - they were positive about the idea of a birth centre with the proviso that the midwives were well trained and able to cope on their own. They favoured midwife-led units, as they provide a home-like environment but are close to doctors if anything goes wrong.

Postnatal care - the women said they would prefer to have their postnatal care at home.

Target resources to those with the greatest need - they were very supportive of the idea of targeting resources to people with the most need.

One key issue for these women is confidentiality. One woman had asked for her HIV status to be kept confidential. Her GP did not know. However, when she went to the GP after she had had her baby, she saw that they knew she was HIV positive as it was on their computer. She was very upset about this.

A second woman said her first midwife had completely changed towards her once she had been diagnosed as HIV positive.
'At her first appointment the midwife had been very nice, but after the results of the blood test came back and I found out I have HIV, she completely changed. She made me wait and when I did get into to see her, she rushed everything. She postponed lots of my antenatal care.'

'I found out about the HIV because of having a blood test linked to my pregnancy. Two people came from [...] to tell me and it was a very big shock. They took their time to tell me and they gave me plenty of time to ask any questions. It was very difficult but they handled it well.'

Another woman said that staff in hospital were very careful about the questions they asked and kept her HIV status completely confidential. The women thought staff should know about Terrance Higgins Trust, so they can tell people about it.

A support worker said that women generally have concerns about confidentiality, and staff should ask themselves who needs to know rather than telling everyone. They also need to explain to women if they need to break their confidentiality and why.

There should be extra training for midwives on HIV, as part of their initial training and after they have qualified. Lots of women are diagnosed during pregnancy and it needs to be handled very sensitively. Staff need to be aware of HIV services so they can refer women to the support that is available. Most of the time this does happen.

Staff need to be aware that it should make absolutely no difference; they should care for women and talk to them in exactly the same way as everyone else.

4.11 People with learning difficulties

People from one parenting group in Bristol were visited. Generally people were in favour of the proposals. They supported pre-pregnancy classes. They said that having a midwife as a first point of contact was a good idea.

Antenatal classes - generally people do not want a separate antenatal class for people with learning difficulties. They would rather have a 'mixed' group to meet a wide range of people. But people would like extra support so that they are able to understand what they are being told. They would like an advocate to be there too. Weekend/evening classes would be preferable.

Home births - one person thought these were best as there was less interference by nurses. And the birth centre they felt would appeal to women who do not like hospitals. The midwife-led units were seen as a good idea for those who do not want a home birth and want to have doctors close by. One-to-one care is important.

Targeting resources - was seen as a good idea and people felt that people with learning difficulties should have this too as they have extra needs. The idea of maternity support workers was well received. And a learning difficulties liaison
midwife who understood their needs and had more time to explain things would be very helpful. They also need:

- midwives who understand the needs of people with learning difficulties
- training for midwives
- people to understand that they may not be able to read papers that they are expected to sign
- for partners to be able to be at the birth of their children. One person said: the midwives had ignored him... 'they had no concern for his rights'.
- more support after going home, particularly from health visitors.

The group were angry that social workers and midwives talked about them behind their backs without explaining what was going on. Some parents described how their children were taken away from them without any explanation. One person felt she had been tricked into signing adoption papers. They described health and social care staff as not supportive. They felt strongly that staff should be open and honest about what was happening and for them to be included in all conversations. One felt it was important that people are told who is in charge of their case.

They would like everything explained in plain English and for staff to stop using complicated jargon. They said people should look at you when they speak as some people who have hearing problems are able to lip read. All information should be in plain English font size 20 and with pictures to help explain. Sessions on parenting skills could be held at Bristol People First meetings.

People want accessible information on a whole range of things including:

- how to care for your child in the home - about making homes safer
- keeping your child healthy ie first aid, childhood illnesses etc
- healthy eating - feeding, what babies, toddlers to older children should eat
- services so they can choose the support they want
- how to complain about bad service, or staff not doing their job properly
- an accessible support plan that says who is helping with what.
- going to court, including about having an advocate and accessible information from solicitors to explain what is happening.

They feel it is important that professionals get proper training on how to communicate with people who have hearing impairments as well as learning difficulties, for example. And they would also like:

- to see a change so that adult and children's teams work better together
- time to look at reports and understand what they say before meetings or court.
- people to really listen, to have compassion and treat them with respect.

4.12 Women who use illegal drugs

Women discussed this together with a drug liaison midwife. They welcomed the proposals overall and made the following comments.

Pre-pregnancy care - feelings were mixed about this as many women did not intend to get pregnant. They felt it would need to be very accessible and perhaps linked to the work of the drug workers.
Midwife as the first point of contact for all women - the women supported this idea. The drug liaison midwife thought it was important for women to get to know their midwife as early as possible so they can assess them in relation to any other medical or social problems.

Antenatal classes - this idea had limited support, although antenatal education is covered in the clinic. There is a plan to run parenting classes on a drop in basis.

Home birth - women were not keen on the idea of a home birth, preferring 'the security' of a hospital, and because of accommodation being too small.

Birth centres and midwife-led units - although there was some support for another birth centre, particularly close to home, there were concerns about having to be transferred whilst in labour. A birth centre is not suitable for these particular women as they need a special care baby unit (SCBU) and paediatricians nearby. Women liked the idea of the midwife-led unit on the same site as the SCBU and doctors.

The drug liaison midwife agreed with the changes put forward, and thought they should be more stand alone, so staff are not easily pulled into the obstetrician units. She thought there was more chance of one-to-one care in a midwife-led unit.

One-to-one care from a midwife during labour - this is important and there needs to be good staffing levels for this to happen.

Postnatal care - these women wanted postnatal care at home. Some women have transport and health problems which would make getting to a clinic difficult.

Support for families with very sick babies or babies who die - they all thought long term support was very important and that people need to know where they can get this support from.

Services for women with mental health problems - there was lots of support for this. It was said that this was getting better as there is now a designated mental health nurse who works specifically with pregnant women. There were some concerns about social services taking babies away from women with mental health problems.

Targeting resources to those with the greatest need - women found having a drug liaison midwife really helpful. The women said they had not experienced any discrimination from staff at the Boulevard or in the hospital, which they really appreciated.

4.13 Women sex workers

A family worker talked to women sex workers and obtained their feedback.

Women did not comment directly on the proposals but said that the following are issues for them.
There was a feeling from women that they do not always feel listened to, that things are done behind their backs and that midwives generally can be a bit insensitive and uncaring with them. One spoke of a urine sample being sent to toxicology without her knowledge when she felt the midwife should have been 'upfront and honest' with her. Both women felt that at the birth of their babies, procedures were carried out without warning and without regard to their wishes. For example, one woman said that a student midwife broke her waters although she wanted them to break naturally.

It was also said that sometimes there is a lack of sensitivity when women are examined vaginally and sometimes the examinations are not necessary. It can be particularly insensitive if women have a history of sex work and/or have been sexually abused in the past.

Specialist drug liaison midwives at St Michaels were said to be very supportive and the women appreciated this.
Section 5: Other suggestions

Many other comments were made in the course of this consultation and this section gives a summary of other key points made. It should be pointed out that many people are very satisfied with the care they have had or parts of the care they have had. Many people commented that they appreciated the opportunity to comment and one suggested just 'Keep asking parents!

About the plans overall

- Prioritise - these plans are over-ambitious for the resources available.
- Changes are pretty cosmetic. There needs to be a shift away from considering pregnancy and childbirth as medical conditions.
- Plans do not mention further training or strategies for promoting normal birth and reducing caesarian rates. How will you actually do this?
- Don't believe any improvements will be made as NHS cannot afford it.
- Booklet does not mention maternal deaths...‘think this should be talked about...affected families will need much support’.
- Booklet does not address the issue of recruiting more midwives - which will underpin success or failure.
- Disappointed there is not more discussion re postnatal care in hospital. Need more and better postnatal care.
- Seeking your views has omitted the importance for the system to deal well with mothers who are having to stay in hospital. This is very important and should be addressed in the review more than it appears to have been.
- I support all of the suggestions but think that more focus needs to be given on basics e.g cleanliness, communication, information, support especially for those who fall into the following categories:
  - multiple birth (antenatal class type information prior to birth)
  - fertility treatment (support in early stages)
  - parents with babies in NICU (practical support on maternity wards and appropriate discharge procedure for mothers- not a problem on NICU but is on the general maternity wards).

Other suggestions for antenatal care

- A leaflet explaining antenatal checks in your particular area would help. The NHS leaflet explains all sorts of tests but not all are available in every area.
- Services to support and advise fathers are needed
- Have a birth plan (concern that this is threatened by shortage of community midwives).
- More specialized classes such as prenatal teen PEEP(Peers early education partnership)
- Drop in sessions in early stages of pregnancy in some areas were found helpful
- Nuchal Translucency Scans as standard
- Videos of baby scans to be sold in aid of hospital
- It would be nice to have an optional scan at 30 weeks

About specific needs

- Ideally a specialist midwife team is needed for complicated pregnancies
- Up to date medical advice is needed on specific conditions (eg diabetes)
• For women who have had fertility treatment, they have often had a long process of medical appointments, drugs etc. Once they become pregnant they are signed off from the fertility clinic but it can be several weeks before they get an appointment with a midwife. This can be a very anxious time. Extra support should be given – not have to wait till 10-12 weeks pregnant.
• Midwives need training on supporting people with babies in special care. The staff on the NICU units are fantastic but the midwives on the general maternity ward need more training in this area.
• Midwives should be more aware of symptoms of dehydration in neonates in early days of breastfeeding; nearly lost my daughter despite begging for a formula top-up for two days, the breastfeeding lobby is so strong that no-one would provide formula.

Birth
• There is no support for going against the grain.’(Being pushed into a caesarian for a breech birth) Choices are not clear cut. One person had experienced this and remembered it as being very disempowering. Want better provision of independent advice and more open discussion.
• To promote normal birth, need to invest more in removing the fear surrounding childbirth and give women tools to cope with pain.
• Monitoring instead of hospital-driven schedule of e.g. inducing 12 hours after waters break etc.
• Introduce hypno-birthing as this will reduce time in labour
• Better care in early labour could avoid problems, and therefore interventions, in later labour and birth. Currently, the policy in this area is to very strongly encourage women to stay at home as long as possible, ostensibly as 'you'll be more comfortable there'. Birth choice must include hospital admission earlier than this if the mother requests it.

Hospital care
• Fathers to be more welcome on postnatal wards - feels barbaric for fathers to be shut out at night. Other hospitals have facility for partners (or other immediate family members) to stay over night. All that is required is a chair.
• Communication skills need to be improved. Some women feel patronised and told off like naughty school children, and first time mothers can feel particularly unsupported. Improved communication between medical staff, midwives, patients. Make sure all registrars/consultants introduce themselves to patients pre birth.
• A very basic thing but the wards were not adequately clean at St Michaels. Bathroom areas dirty, including bloody, at Southmead. Only one shower for whole ward at Southmead, no hooks for towels, no shelf for shampoo meant that women who had just given birth, or had caesareans, were bending down to get items off a dirty floor.
• Women should be entitled to pain relief without being told 'there are no anaesthetists available'
• More single rooms - will help people to sleep and help with including fathers.
• A few midwives are 'old school' and make new mothers very uncomfortable and unhappy. I think the hospital should send a memo out reminding everyone how scary it is being a new mum.
• More parking at St Michaels
• Essential to keep two consultant led units in Bristol

Other sources of support

• MAMA in Portishead is a peer support group. It is an independent group that has to fundraise to pay for somewhere to meet. The NHS need to develop ways to work with local women who help other women in their own time.
• It might be good to get experienced mother to help other local mums one-to-one.

Community midwives and health visitors

• The Granby House model of community midwifery was mentioned by many people as a good model that works well
• Need to introduce a way of manageable caseloading for community midwives so they can give continuity of care (but also need more midwives)
• Keep independent midwives and urge you to contract independent midwives into insurance scheme
• Promoting Kangaroo mother care / baby wearing, as a way of promoting breastfeeding. option of 'kangaroo mother care' in birth centres
• Postnatal (parentcraft) classes are helpful and shouldn't be lost in the new services
• We would like a milk bank locally
• Information for new mothers on tongue-tied babies
• Design of services should meet high standards for control of infection
• Part-time midwifery training and posts to enable mothers to become midwives (i.e. those keen to train / work as midwives after giving birth but hence also busy)
• The apparent disparity between the views of midwives and the medical profession generally is not the problem of pregnant women, but we often seem to be caught between the two
• Doulas should also be encouraged.
Section 6: Conclusions

Most people who responded to this consultation supported the proposals, although there were concerns about some of them. The most important to the majority of people was the provision of one-to-one care from a midwife - not only during labour (although this was most important) - but from early pregnancy through to the postnatal period.

Also of great importance to most people was a safe and healthy delivery, choice of where and how to give birth and having a midwife as an early, first point of contact. Many people thought that to achieve these changes there would need to be increased staffing, particularly of midwives.

Pre-pregnancy care was not seen as an overall priority, although there was some support for it, particularly for people with specific needs.

The majority of people would like the midwife to be their first point of contact but there needs to be more information about how to contact a midwife and increased staffing so it is possible to get hold of one.

Most people would like a wider choice of antenatal classes, some outside of working hours, making partners welcome and catering for particular groups.

Some people were keen to have a home birth: others were not. Everyone felt it is important to have a choice. There was some discomfort about the idea of targets to increase home births as people felt this may put pressure on both pregnant mothers and midwives. Feelings were mixed about birth centres. There was some support for them, but also significant numbers of people who felt a midwife-led unit attached to a hospital was safer. People would like to see the midwife-led units develop and become more autonomous.

Most people simply wanted to have a choice about postnatal care and for it to be flexible. Certainly people felt that more support for families with very sick babies or babies who die is very important. Improvements to services for women with mental health problems were definitely thought to be needed.

There was support for resources to be targeted to those who need them most, but also a sense that this is a difficult time for everyone and everyone is in need of basic support. Better translation and interpreting services were seen as a need by most. Many 'special interest groups' identified particular needs and issues.

Other key issues were:

- the need for much better postnatal care and support in hospitals
- the arrangement of services which leads to some North Somerset people deciding it is 'safer' to book in at a Bristol hospital rather than risk a transfer during labour
- the need for more breastfeeding support.

As well as commenting on the proposals, a large number of other comments and suggestions were made and these are also summarised.
### Jargon buster and abbreviations

<table>
<thead>
<tr>
<th>Acute trusts</th>
<th>These Trusts manage hospitals including hospital and community maternity services and ensure that hospitals provide high quality healthcare and that they spend their money efficiently. They also decide on a strategy for how the hospital will develop so services can improve. The acute trusts involved in this review are University Hospitals Bristol NHS Foundation Trust, formerly United Bristol Healthcare NHS Trust; North Bristol NHS Trust and Weston Area Healthcare NHS Trust.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antenatal care</td>
<td>Professional care provided to a woman and her partner to support them and their baby through the pathway of pregnancy and to help them achieve the best possible health, psychological and social outcomes for the mother baby and family.</td>
</tr>
<tr>
<td>ARM</td>
<td>Artificial rupture of membranes</td>
</tr>
<tr>
<td>AWP</td>
<td>Avon and Wiltshire Mental Health Partnership NHS Trust</td>
</tr>
<tr>
<td>BAPM</td>
<td>British Association of Perinatal Medicine</td>
</tr>
<tr>
<td>BHSP</td>
<td>Bristol Health Services Plan, the NHS plan for health services in Bristol, North Somerset and South Gloucestershire. It covers both acute and community hospital services.</td>
</tr>
<tr>
<td>Caesarean section</td>
<td>An operation where the baby is delivered through an incision through the abdominal and uterine walls</td>
</tr>
<tr>
<td>Consultant</td>
<td>A doctor who is fully trained in a particular specialty area and has the ultimate responsibility for the clinical care of patients</td>
</tr>
<tr>
<td>Home birth</td>
<td>This is usually a planned event where the women gives birth at home, with care provided by a midwife. Should complications arise, all NHS home birth services are provided within a functioning swiftly responsive and well understood local network of emergency services and transfer arrangements.</td>
</tr>
<tr>
<td>MCA</td>
<td>Maternity care assistant</td>
</tr>
<tr>
<td>Midwife</td>
<td>Provides advice care and support for women, their partners and families before pregnancy, during pregnancy and labour and after birth. Modern maternity practices provide a 'woman centred approach allowing choice and continuity of care. The work involves caring for newborns, providing health education and parenting support. Midwives are responsible for newborns for the first 28 days, after which care transfers to a health visitor.</td>
</tr>
<tr>
<td>NCT</td>
<td>National Childbirth Trust</td>
</tr>
<tr>
<td>NICU</td>
<td>Neonatal Intensive Care Unit</td>
</tr>
<tr>
<td>NHS</td>
<td>National Health Service</td>
</tr>
<tr>
<td>NND</td>
<td>Neonatal death</td>
</tr>
<tr>
<td>PALS</td>
<td>Patient Advice and Liaison Service</td>
</tr>
<tr>
<td>PCT</td>
<td>Primary Care Trust</td>
</tr>
<tr>
<td>PICU</td>
<td>Paediatric intensive care unit</td>
</tr>
<tr>
<td>SANDS</td>
<td>Stillbirth and Neonatal Death Society</td>
</tr>
<tr>
<td>SCBU</td>
<td>Special Care Baby Unit</td>
</tr>
<tr>
<td>UBHT</td>
<td>United Bristol Healthcare Trust</td>
</tr>
</tbody>
</table>
## Appendix A: Standards to be achieved

<table>
<thead>
<tr>
<th>The Standard to be achieved</th>
<th>Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Choice of antenatal care</strong></td>
<td></td>
</tr>
<tr>
<td>1. Women will know how to refer themselves to local midwifery services as soon as they discover that they are pregnant</td>
<td>100% of women by March 2009</td>
</tr>
<tr>
<td>2. All women will be able to access antenatal care in a way that that enables them to build a relationship with their midwives throughout their pregnancy.</td>
<td>Improved results from feedback year on year to March 2011</td>
</tr>
<tr>
<td>3. Women will be able to visit the place where they plan to give birth</td>
<td>100% of women offered a visit by March 2009</td>
</tr>
<tr>
<td>4. Women and their partners will be able to choose from a wider range of antenatal class types, including women only, young people only, mixed groups</td>
<td>100% of women offered choice by March 2009</td>
</tr>
<tr>
<td><strong>Choice of birth setting</strong></td>
<td></td>
</tr>
<tr>
<td>5. Women are to be able to choose whether they give birth at home, in a birth centre or in a hospital, or to understand and accept any clinical reasons they were advised differently on</td>
<td>100% of women assessed and given appropriate choices by Dec 2009</td>
</tr>
<tr>
<td>6. Increase the numbers of babies born at home from current 3%</td>
<td>To achieve 7% to 10% by March 2011</td>
</tr>
<tr>
<td>7. Increase the number of babies born in birth centres and midwife units</td>
<td>To achieve 30% by March 2011</td>
</tr>
<tr>
<td>8. Reduce the caesarean section rate to a nationally recognised evidence based safe level</td>
<td>Reduce by 1% per year, until the best understood optimum level is achieved</td>
</tr>
<tr>
<td>9. Maternity units will be staffed to locally agreed levels. This will include sufficient midwifery or midwifery assistant staff for one-to-one care in labour. Also at least 98 hours of consultant presence in the delivery unit per week</td>
<td>95% of each target staffing levels to be achieved by December 2009</td>
</tr>
<tr>
<td>10. Mothers or babies developing problems that need transport to another unit will be collected by ambulance as quickly as necessary</td>
<td>100% emergencies within 8 minutes by March 2009. 100% other transfers within 30 minutes, by</td>
</tr>
<tr>
<td>The Standard to be achieved</td>
<td>Measure</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>---------</td>
</tr>
<tr>
<td><strong>Postnatal care</strong></td>
<td></td>
</tr>
<tr>
<td>11 Women to be able to have their postnatal care at home or at a clinic</td>
<td>100% of women offered choice by March 2009</td>
</tr>
<tr>
<td>12 Intensive care units for very sick newborn babies to comply with the standards set out by the British Association of Perinatal medicine, by December 2009. This includes one-to-one nursing care and 24 hour resident medical cover for intensive care</td>
<td>95% of each target staffing levels to be achieved by December 2009</td>
</tr>
<tr>
<td>13 All parents experiencing the death of their baby will be offered a quiet and private place in hospital for as long as they need. They will also be offered longer term support</td>
<td>100% by December 2009</td>
</tr>
<tr>
<td>14 Ensure sufficient newborn intensive care cots to provide for all local babies as well as those brought in from a wider area for specialised care</td>
<td>No refusals by March 2011</td>
</tr>
<tr>
<td><strong>Making the system work for all</strong></td>
<td></td>
</tr>
<tr>
<td>15 Women to have started their antenatal care before 12 weeks</td>
<td>90% to 98% by December 2011</td>
</tr>
<tr>
<td>16 Prevent low birth weight</td>
<td>3 year rate of low birth weight to be better than rate for England</td>
</tr>
<tr>
<td>17 Reduce the high rates of low birth weight in babies born to the most disadvantaged mothers</td>
<td>Downward trend each year in the percentage of babies born at low birth weight to mothers living in the most disadvantaged fifth of households</td>
</tr>
<tr>
<td>18 Every woman requiring telephone interpreting services will have access to this 24 hours a day</td>
<td>95% by 2009</td>
</tr>
</tbody>
</table>
Appendix B: Feedback forms

Improving and developing maternity and newborn services
Seeking your views

Feedback form
If you need this feedback form in a different language, or in another format such as Braille, audiotape, large print, or on disk, please contact the Bristol Health Services Plan office on Freephone 0800 015 5127 or email: bhsp@bristolpct.nhs.uk.

Please use this form to give us feedback during the consultation period, which is from 30 June to 17 October 2008.

Please read the consultation booklet for background information.
Tell us what you think

What is most important to you?

What do you think of the changes that we are suggesting?
1. More pre-pregnancy care will be provided.

2. The midwife will be promoted as the first point of contact for all women as soon as they are pregnant.

3. There will be a wider choice of antenatal classes.
4. Home birth will be encouraged and we will work towards a target of 7 -10% home births by March 2011.

5. Cossham Birth Centre will be opened and more birth centres will be developed as demand grows, so that more women will give birth with a midwife they know, near to home.

6. The midwife-led unit at Southmead will expand and develop and the midwife-led unit at St Michael's will become more home like and will be staffed by midwives dedicated to the unit. We will work towards the target of 30% of women giving birth in a birth centre or midwife-led unit.

7. More women will have one-to-one care from a midwife during labour.

8. Women will be able to have their postnatal care with a midwife at home or at their local clinic or birth centre.

9. There will be more support for families with very sick babies or babies who die.

10. There will be improvements to services for women with mental health problems.

Maternity and newborn services review: members of the public
11. We will target resources to those with the greatest need by employing, for example, maternity support workers to work alongside midwives, drug liaison midwives, midwives who offer extra support to teenagers and better translation and interpretation services.

12. Do you think the plan will be equally beneficial to people of different ages, sex, race, religious belief, sexual orientation and to people with a disability? If not please explain your concerns.

13. Tell us why you are interested in maternity and newborn services.

14. Do you have any other suggestions?

If you want us to come and talk to your group or have queries that you would like a response to, please provide your name, title, email and telephone number.

Please return this form to:
The Maternity and Newborn Services Review,
The Bristol Health Services Plan, FREEPOST BS1078
King Square House, King Square
Bristol, BS2 8EE
Fax: 0117 976 6601.
Thank you.
## Feedback proforma for meetings

<table>
<thead>
<tr>
<th>Name of Meeting:</th>
<th>Was the power point presentation used?:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date:</td>
<td>Contact name for the meeting:</td>
</tr>
<tr>
<td>Start Time:</td>
<td>Contact tel:</td>
</tr>
<tr>
<td>End Time:</td>
<td>Notes written by:</td>
</tr>
<tr>
<td>Location:</td>
<td>Speaker(s):</td>
</tr>
<tr>
<td>Number of Attendees</td>
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</tbody>
</table>

What were the main issues raised?

Maternity and newborn services review: members of the public
Appendix C: All consultation responses

<table>
<thead>
<tr>
<th></th>
<th>Numbers of members of the public</th>
<th>Numbers of staff</th>
<th>Total respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emails</td>
<td>8</td>
<td>2</td>
<td>10</td>
</tr>
<tr>
<td>Letters</td>
<td>0</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Website responses</td>
<td>19</td>
<td>0</td>
<td>19</td>
</tr>
<tr>
<td>Telephone calls</td>
<td>4</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Feedback forms from the booklet</td>
<td>48</td>
<td>0</td>
<td>48</td>
</tr>
<tr>
<td>Separate feedback forms</td>
<td>25</td>
<td>8</td>
<td>33</td>
</tr>
<tr>
<td>Five public meetings attenders -</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Bristol</td>
<td>1</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>- Weston super Mare</td>
<td>0</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>- South Glos</td>
<td>1</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>- Portishead</td>
<td>6</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>- Winscombe</td>
<td>3</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td>Southmead Hospital comments book</td>
<td>8</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>St Michael's Hospital comments book</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Weston Birth Centre comments book</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Meetings with 39 special interest groups (see list) - numbers who attended</td>
<td>371</td>
<td>20</td>
<td>391</td>
</tr>
<tr>
<td>19 Staff meetings and numbers who attended</td>
<td></td>
<td>184</td>
<td>184</td>
</tr>
<tr>
<td><strong>Total:</strong></td>
<td><strong>494</strong></td>
<td><strong>236</strong></td>
<td><strong>730</strong></td>
</tr>
</tbody>
</table>
## Appendix D: Meetings with special interest groups

<table>
<thead>
<tr>
<th>Name of group or meeting</th>
<th>Date and time</th>
<th>Venue</th>
<th>Nos attended/interviewed</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Parents of Disabled children</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hop, skip and jump</td>
<td>4th July, 3.30pm</td>
<td>Seven Springs South West, Kingswood</td>
<td>3</td>
</tr>
<tr>
<td>Bristol area Down's syndrome support group</td>
<td>21st July 8pm</td>
<td>57 West Town Lane, Brislington</td>
<td>10</td>
</tr>
<tr>
<td>Woodside Family Centre, Achievers group</td>
<td>10th October 12pm</td>
<td>Woodside Family Centre, Kingswood,</td>
<td>5</td>
</tr>
<tr>
<td><strong>Antenatal groups</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N Somerset</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Locking Castle Medical Centre</td>
<td>23rd July, 3.50pm until 4pm</td>
<td>Locking Castle Medical Centre, Weston super Mare</td>
<td>11</td>
</tr>
<tr>
<td>Yatton</td>
<td>17th September, 2pm</td>
<td>Horse Castle Chapel, Yatton</td>
<td>9 plus 2 staff</td>
</tr>
<tr>
<td>S Glos</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bishopston</td>
<td>Friday 18th July, 3pm</td>
<td>Buddhist Centre Gloucester Rd</td>
<td>30</td>
</tr>
<tr>
<td>Chipping Sodbury</td>
<td>Wed 30th July, 8.30pm</td>
<td>Chipping Sodbury Clinic</td>
<td>27 plus 2 staff</td>
</tr>
<tr>
<td>Lawrence Hill</td>
<td>Thurs 24th July, 3.30pm</td>
<td>Lawrence Hill</td>
<td>5</td>
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<tr>
<td>Patchway</td>
<td>Wed 6th Aug 11am</td>
<td>Patchway Clinic</td>
<td>21</td>
</tr>
<tr>
<td>Bristol</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Antenatal group, with some postnatal mums</td>
<td>Thursday, 24th July 11.15am to 12.00pm</td>
<td>New Withywood Centre, Withywood</td>
<td>17</td>
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<tr>
<td>Antenatal group</td>
<td>1st July, 1pm to 2pm</td>
<td>Children’s Centre, Easton</td>
<td>6</td>
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<tr>
<td>Antenatal group</td>
<td>1st July, 11.30am</td>
<td>Brooklea Children’s Centre</td>
<td>12</td>
</tr>
<tr>
<td>Name of group or meeting</td>
<td>Date and time</td>
<td>Venue</td>
<td>Nos attended/ interviewed</td>
</tr>
<tr>
<td>--------------------------</td>
<td>---------------</td>
<td>-------</td>
<td>--------------------------</td>
</tr>
<tr>
<td><strong>Postnatal groups</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N Somerset</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Portishead postnatal</td>
<td>17th September, 11.30am to 12.30pm</td>
<td>Portishead Medical Centre,</td>
<td>16</td>
</tr>
<tr>
<td>group</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weston</td>
<td>Tuesday 29th July, 1.45-2.15pm</td>
<td>Oldmixon Family Centre, Weston-super Mare</td>
<td>9 plus 4 staff</td>
</tr>
<tr>
<td>(both antenatal and</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>postnatal mums)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>South Gloucestershire</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kingswood</td>
<td>30th July, 10.30am</td>
<td>Cossham Hospital</td>
<td>11</td>
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<tr>
<td>Bristol</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hartcliffe</td>
<td>23rd July, 9.30am to 11am</td>
<td>Hartcliffe Children's Centre</td>
<td>11</td>
</tr>
<tr>
<td><strong>Meetings with BME groups</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bristol</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>South Asian, Bengali and</td>
<td>Late August 12.30pm to 1.30pm</td>
<td>SPAN centre</td>
<td>10</td>
</tr>
<tr>
<td>Indian women</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Somali Women</td>
<td>26th June, 2pm</td>
<td>Wellspring Healthy Living Centre</td>
<td>13 plus 6 staff</td>
</tr>
<tr>
<td>Polish women</td>
<td>13th September</td>
<td>Polish Church</td>
<td>15</td>
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<tr>
<td>Chinese women</td>
<td>5th October, 13.0 to 15.00 or 14.00 to 16.00</td>
<td>Jubilee Centre, Bradley Stoke</td>
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<tr>
<td><strong>Meeting with refugees and asylum seekers</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bristol</td>
<td>16th July 11am</td>
<td>Congregational Hall, Easton, Bristol</td>
<td>4</td>
</tr>
<tr>
<td>Refugee Rights drop in</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>centre</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Meetings with young parents</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Teenage pregnancy</td>
<td>Wed 23rd July, 2.00pm - 6pm</td>
<td>Level E, St Michael's clinic</td>
<td>5</td>
</tr>
<tr>
<td>clinic</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Meriton Centre</td>
<td>17th September 2-3pm</td>
<td>Meriton Centre, Meriton Road, St Phillips</td>
<td>10</td>
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<tr>
<td>Young parents group</td>
<td>17th September, 1.30pm</td>
<td>Ashcombe Children’s Centre, Weston super Mare</td>
<td>4</td>
</tr>
</tbody>
</table>

Maternity and newborn services review: members of the public
<table>
<thead>
<tr>
<th>Name of group or meeting</th>
<th>Date and time</th>
<th>Venue</th>
<th>Nos attended/interviewed</th>
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<tbody>
<tr>
<td>Women who have experienced domestic violence</td>
<td>15th July 9.15am</td>
<td>Bristol</td>
<td>3</td>
</tr>
<tr>
<td>Women sex workers</td>
<td>10th July</td>
<td>One25</td>
<td>2 plus 1 staff</td>
</tr>
<tr>
<td>Travellers and gypsies</td>
<td>30 Sept in SG;15th Oct in NS</td>
<td>Gypsy and traveller sites in SG and NS</td>
<td>8</td>
</tr>
<tr>
<td>Women who use illegal drugs</td>
<td>1st October, 1.20pm</td>
<td>47 The Boulevard, Weston super Mare</td>
<td>2 plus 1 staff</td>
</tr>
<tr>
<td>Pregnant women and mothers who are prisoners</td>
<td>Eastwood Park Prison</td>
<td>8th October, pm HMP Eastwood Park Prison</td>
<td>12</td>
</tr>
<tr>
<td>Societies/forums</td>
<td>SANDS (Stillbirth and neonatal death society)</td>
<td>22nd July, pm 10, Melita Rd, Bishopston</td>
<td>3</td>
</tr>
<tr>
<td>Twins clubs</td>
<td>Bradley Stoke Twins Club</td>
<td>Friday 25 July 2008, 10:30am Bradley Stoke Evangelical Church</td>
<td>8</td>
</tr>
<tr>
<td>Thornbury Twins Plus Club</td>
<td>19 August, 14:00 – 16:00</td>
<td>Sure Start Children's Centre Thornbury.</td>
<td>Not stated</td>
</tr>
<tr>
<td>Bristol Twins and more</td>
<td>Friday 1 August 2008, 10:30am</td>
<td>St George Community Centre</td>
<td>15-20</td>
</tr>
<tr>
<td>Fathers groups</td>
<td>Bristol</td>
<td>Fri 12 Sept, 9:00am– 12:00 Hartcliffe Children’s Centre</td>
<td>6</td>
</tr>
<tr>
<td>North Somerset</td>
<td>10th September, 6.30pm</td>
<td>Oldmixon Family Centre, Weston super Mare</td>
<td>3 plus 2 staff</td>
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Maternity and newborn services review: members of the public
<table>
<thead>
<tr>
<th>Name of group or meeting</th>
<th>Date and time</th>
<th>Venue</th>
<th>Nos attended/interviewed</th>
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<tbody>
<tr>
<td>People with learning difficulties</td>
<td>People First’s parenting group</td>
<td>9th September, 10am to 12pm</td>
<td>Bristol People’s First Offices</td>
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<tr>
<td>Women with HIV</td>
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<td>14th August, Tel interviews</td>
<td>THT</td>
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<tr>
<td>Meetings requested</td>
<td>Cossham Stakeholder Reference Group</td>
<td>Wed 8th Oct 10am</td>
<td>Cossham Hospital</td>
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<tr>
<td>Public events</td>
<td>St Paul's Carnival</td>
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<td>St Pauls</td>
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<tr>
<td>Total: 39 meetings</td>
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A number of other workers working with particular population groups, organisations and forums were contacted and, although meetings were not held or attended, in many cases information was circulated to individuals and feedback sent in. It was not possible to quantify this feedback but people/forums contacted included:

- Older People's Forum
- Youth Forum
- Disability Forum
- Women's Forum
- Lesbian, Gay and bisexual forum
- Race Forum
- Female sex workers
- Health visitors in North Somerset
- Resource and communication centres in South Gloucestershire
Appendix E: Summary of comments for an equality impact assessment

This table summarises the responses to Question 12: Do you think the plan will be equally beneficial to people of different ages, sex, race, religious belief, sexual orientation and to people with a disability?' (see Appendix B). It also includes other comments from individual responses and from meetings that relate to issues of equality. This is only a summary - Section 4 has detailed responses from particular groups who may experience inequalities.

<table>
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<th>Comments made by</th>
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<tr>
<td>Open meetings and individual responses</td>
<td>Many people did not answer Question 12 or said that they did not know, or did not have enough information to say. Many people who responded thought that the plan would be equally beneficial to all groups. 'None of these groups would be disadvantaged by restricted choice or access.' 'I think certain women will always be more aware of their choices and services available. Changing this is very difficult.' 'Probably more beneficial to women than men in general, but otherwise yes.' Many said without more midwives and resources the proposals would not be implemented and would not benefit everyone. Many comments were about increases in choice being welcomed, but also concern that they will be real choices for everyone. '[It is important that] all rooms have the same facilities like birthing pools and stools...not &quot;if you are lucky&quot; approach.' Needs to accommodate ALL mothers, not 'we only have one room with a pool etc.' '...people with disabilities, previous caesarean delivery and younger/older inexperienced women will find it harder to feel confident enough to plan a non-medicalised birth... they may actually end up feeling somehow cheated of making a choice even if it is in their best interests.' 'How real are choices for people with a disability?' A number of people felt that those people who don't make choices that the NHS want them to make i.e. they want pain relief, medical interventions in a hospital, and to bottle feed, and those who do not want to have a caesarean for a breech birth etc; some feel that despite all this talk of choice, that they will not have their choices respected and will not be able to have what they choose. There is concern that targets eg for homebirths will have an impact on actual choice. Proposals for home birth and continuity of care should increase access for more people: 'I chose an independent midwife because home birth and continuity of care were not both available.' 'Home births are great - should be accessible to all who need/want them.' '...the choice of a home birth or birth centre birth being available to everyone.'</td>
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<td>Some felt that <strong>pre-pregnancy care</strong> would only be accessed by 'the worried well' and not by those disadvantaged groups who could benefit. <em>‘How can we best reach women who were not born in this country and who don’t understand how the system works here?’</em></td>
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<th>Many people commented on needing <strong>antenatal classes:</strong></th>
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<tr>
<td>• in the evenings and weekends so that everyone is able to attend, including those who work</td>
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<tr>
<td>• refresher ante-natal classes to improve access for 2nd/3rd time mums.</td>
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*‘Many people cannot afford NCT classes.’*...especially if both partners to attend. |
*‘Could we facilitate peer-based learning rather than curriculum based. We need to have more informal drop ins. For example a midwife going once every two weeks to a Somali lunch club to answer any questions. We need to go to where they are and build up relationships rather than expecting them to come to a formal class for 6 weeks. This is also true for the travelling communities.’* |
*‘We need more focused antenatal support for women having twins and multiple births’* |
*‘I’m guessing that gay couples who don’t neatly fit into the mum/dad gender roles might feel alienated by some maternity services eg antenatal classes/inpatient services.’* |

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<th>There was support for <strong>targeting resources</strong> and in particular many people mentioned interpreters and translation services being needed. Many felt that providing extra staff such as maternity support workers and specialist midwives, would help those people with the greatest needs to access support and services. <em>‘Good to see support offered to vulnerable women.’</em></th>
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<tr>
<td><em>‘Particularly feel that specialist midwives dealing with high need subgroups are really important for welfare of mother and baby.’</em></td>
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<td>But there was also concern that resources would be taken away for other services for this. Although it is important to target resources, some said it should not distract from the priority for one-to-one midwifery care, or mean that others received a sub-standard service. <em>‘...really difficult to get help from them if you are deemed able to cope - no-one copes with no sleep and postnatal depression.’</em></td>
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| There were many comments about how unfair it was that **fathers** were unable to stay with their partners in hospital especially as they could help. |

| **Postnatal care:** *‘More postnatal support groups would be good - they seem to be in some areas but not in others.’* |

<p>| Many comments from <strong>people in North Somerset</strong> who feel that |</p>
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| If full services such as epidural, assisted delivery and caesarean sections were available in Weston, this would be fairer and people wouldn't opt to come into Bristol because they are worried about transfer in labour. 'Why can't we have epidural assisted delivery and caesarean options here to take the pressure off St Michael's? It seems ridiculous that 11 out of 12 mums at my antenatal class have opted for Bristol.' For **those with children** already: 'I feel that those of us who do have more than 2 pregnancies are not always considered.' 'More ease of access for 2nd/3rd timers with young children - not everyone has childcare on tap.' 'More support is needed for women who have miscarriages.' '...what about people who don't speak English.' This was the group mentioned by most people as likely to miss out on information about services etc. 'I would imagine as with many healthcare issues it would depend on how proactive you are in working with those who are (for example) younger and perhaps less vocal or well-informed.' 'Focus needs to be on individuals as far as is possible.' Some felt that the needs of people who have struggled to have a baby, particularly local support, are ignored. 'I was told that the problem is outside what the maternity service usually covers...'
<p>| Parents of Disabled children | Were pleased that choice is being increased but feel resources will need to be too. Felt that they had a great deal of individual support but also a need for more emotional support and practical help, and greater empathy. How people were told about their child's disability was an issue. People also mentioned the need for access to speech and language therapy as being a gap and parents accommodation at St Michael's as being inadequate. 'I could overhear midwives talking about women and their children and found their attitude very negative and patronising. My baby was referred to as 'the Down's Baby.'” |
| Women who have experienced domestic violence | Women said that they thought midwives trained in drug use were a good idea. They felt more health visitors are needed and 'are key to picking up on domestic violence problems.' |
| Those with specific medical conditions | A number of people said that they wanted access to more information and support from people who knew about their condition eg diabetes and that specialist midwives were a good idea. 'Unclear how expect budget to cover all needs. Everyone |</p>
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<td><em>thinks their needs are most important.</em>'</td>
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| People from Black and minority ethnic communities | Would like to see more translation and interpreting services and more awareness of different cultures so that appropriate care is given. Many people had not been given adequate information about the different choices and services available. Sometimes Traveller and Gypsy women are not told about antenatal classes and they all said they had experienced discrimination in hospitals with people being 'funny with them' and not explaining things properly. The role of the midwife is not well understood and many spoke of an 'alien' environment. *Staff should explain the rules at the hospital when you first go in, so you understand what you can do and what you can't do.* |

| Refugees and asylum seekers | One person said that in the paperwork in the yellow book and the blue book, under occupation for her it said 'asylum seeker' and she was very unhappy about this. *Why do all the staff need to know that I was seeking asylum in this country. I was asked very personal questions about why I wanted to live here, and why I had left my husband back home. I don't think other single mums would be asked such personal questions, it felt like discrimination. Quite a few mothers have also complained about this. I do not think this is right.* |

| Women who are HIV positive | One key issue is confidentiality. One woman had asked for her HIV status to be kept confidential. Her GP did not know. However, when she went to the GP after she had had her baby, she saw that they knew she was HIV positive as it was on their computer. She was very upset about this. A second woman said her first midwife had completely changed towards her once she had been diagnosed as HIV positive. *At her first appointment the midwife had been very nice, but after the results of the blood test came back and I found out I have HIV, she completely changed. She made me wait and when I did get into to see her, she rushed everything. She postponed lots of my antenatal care.* |

<p>| Women sex workers | The women did not always feel listened to, that things were done behind their backs and that midwives generally could be a bit insensitive and uncaring with them. They spoke of things being done without their knowledge and that the midwife should have been <em>upfront and honest</em> with her. At the birth of their babies, procedures were carried out without warning and without regard to their wishes. Sometimes there was a lack of sensitivity when women were examined and sometimes the examinations were not necessary. <em>It can be particularly insensitive if women have a history of sex work and/or have been sexually abused in the past.</em> Specialist drug liaison midwives at St Michaels were said to be |</p>
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<tr>
<td>Young people</td>
<td>Overall young people appreciated the extra support they got as it meant they got some continuity of care and support. Some said they would like antenatal classes with other young people so they felt comfortable; some would like them with other people as they felt they might learn from the other mothers. As with other women, there was a need for classes in the evenings and at weekends so that partners could attend. The special teenage antenatal clinic at St. Michaels was viewed positively. In hospital some young women felt surprised and pleased that they were treated like everyone else and people were 'not funny with me because I am young.' But others felt patronised by some staff and 'talked about.' Young people seemed to think that when something went wrong it was because people were not listening to them, or giving them an inferior service because they were young (which may be true). And it is very difficult for young people to feel confident enough to ask for information when they do not know how systems work. For example, one woman said 'they didn't tell me nothing.' Another women described not being shown where the food was served in hospital so she didn't eat anything for two days.</td>
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<tr>
<td>Fathers groups and individual fathers</td>
<td>Some fathers feel that they are not encouraged to be involved and particularly feel excluded from hospital after the birth when they could be helping. Some felt that professionals tended to ignore fathers. ‘...sometimes professionals ignore the father even when he is at an appointment with the mother, e.g. he asks a question and the midwife replies to the mother.'</td>
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<td>Women who are in prison</td>
<td>Women said they did not think they were discriminated against because they were in prison. A number were complimentary about the community midwives. But they did feel they were missing out in not having any antenatal education. They also need more rehabilitation help for woman to come off drugs; someone to talk to about their options if they are thinking about a termination; greater safety - fighting and being knocked over in the prison is an issue. They would also like a full time midwife at the prison and for staff to listen to them more.</td>
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<tr>
<td>People who have twins and multiple births</td>
<td>Women felt there should be designated specialist multiple birth midwives, 'my midwife had no experience at all with multiple births'. Some said they were unable to go to antenatal classes because their babies were early. As multiple births are almost always early, classes need to be earlier. 'I didn't see my midwife, I had to go to scans every two weeks, so they thought that I would get that support there, but I didn't.' Comments about equality were that it sounded good - ‘apart...’</td>
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<td>from for people who have multiple births. Disability is also an area which needs more focus.'</td>
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<td>'...when pregnant with twins I received a lot of care and support. After the birth I was just left to get on with things – with twins you could do with more help.'</td>
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<td>A particular issue is being able to get their babies weighed because of the access issues at clinics of having a double buggy and staff being too busy to help with undressing etc.</td>
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<td>There were comments about being in hospital: 'It gets forgotten that you are there for far longer in hospital and have twice the amount of babies. You aren’t really treated any differently to mums who have had one baby, and you need this because you have two babies and are in for longer. More advice is needed - routine advice such as breast feeding, teeth brushing, winding. More on breastfeeding post caesarean section; more on mixed feeding, which can maintain at least partial breastfeeding...'</td>
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<tr>
<td>Stillbirth and Neonatal Death Society (SANDS)</td>
<td>The group agree with targeting and they think it should also include women who have lost babies before. 'It feels hard when drug users have a support worker, there are midwives to help people stop smoking but if you have lost a baby you get no extra support.'</td>
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<td>The group felt that services should be the same for teenagers and older mums and that nobody should be made to feel different. Translation and interpretation services are a key need. Better support is needed for people who are not religious. Same sex couples should get equal support and should not have any discrimination. The new birth centre will need the same level of access for Disabled people as hospitals. Many Disabled women will need extra support in labour.</td>
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<tr>
<td>People with learning difficulties</td>
<td>People felt that people with learning difficulties should have extra support as they have extra needs. A learning difficulties liaison midwife who understood their needs and had more time to explain things would be very helpful. They also need:</td>
</tr>
<tr>
<td></td>
<td>• midwives who understand the needs of people with learning difficulties</td>
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<td></td>
<td>• training for midwives</td>
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<td>• people to understand that they may not be able to read papers that they are expected to sign</td>
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<td></td>
<td>• for partners to be able to be at the birth of their children. One person said: the midwives had ignored him...‘they had no concern for my rights’.</td>
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<td>• more support after going home, particularly from health visitors.</td>
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<tr>
<td>The group was angry that social workers and midwives talked about them behind their backs without explaining what was going on. Some parents described how their children were taken away from them without any explanation. One person felt she had been tricked into signing adoption papers. They described health and social care staff as not supportive. They felt strongly that staff should be open and honest about what was happening and for them to be included in all conversations. One felt it was important that people are told who is in charge of their case. They would like everything explained in plain English and for staff to stop using complicated jargon. They said people should look at you when they speak as some people who have hearing problems are able to lip read. All information should be in plain English font size 20 and with pictures to help explain. Sessions on parenting skills could be held at Bristol People First meetings.</td>
<td></td>
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<tr>
<td>Women who use illegal drugs</td>
<td>Women found having a drug liaison midwife really helpful. The women said they had not experienced any discrimination from staff at the Boulevard or in the hospital, which they really appreciated.</td>
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