Equalities In Health

NHS Greater Glasgow and Clyde

Inequalities Sensitive Practice Initiative

Analysis of the Maternity Services User Engagement Survey

Final Report

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National Context

The Multiple and Complex Needs Initiative (MCNI) was launched by the Scottish Executive (now the Scottish Government) in 2006. The purpose of this initiative is to improve public services for those with multiple and complex needs in recognition of the fact that such individuals may experience difficulties in accessing and/or capitalising on recent improvements in service delivery. Furthermore, it is recognised that not only can such individuals be amongst the hardest to reach; public service providers can find it difficult to deal with clients who have multiple, or a complex combination of, problems (Rosengard, 2007).

Who has Multiple and Complex Needs?

A very wide range of people have been identified as having multiple and complex needs (Rosengard, 2007). These include:

- People with mental health problems
- Young and older people
- Those fleeing abuse and violence - mainly women and refugees
- Those culturally and circumstantially disadvantaged or excluded - minority ethnic groups; travelling people
- People with a disability
- People who present challenging behaviours to services
- People who are multiply disadvantaged by poverty, poor housing, poor environments or rural locations which mean they are distant from services
- People who are 'marginal, high risk and hard to reach', who may be involved in substance misuse, offending and at risk of exclusion
- People who have a 'dual diagnosis' of mental ill health and substance misuse, or of other combinations of medically defined conditions.

Government Funding Of Pilot Projects

Through its Closing the Opportunity Gap Fund, the Scottish Government has devolved £4 million over the period April 2006 – March 2008 to projects that aim to explore how different services can better support individuals and families with multiple and complex needs. As a result, fourteen pilot/demonstration projects were established to:

- improve the way in which they engage with service users and attract them to use their services;
- improve how they assess and deal with their particular set of service needs/problems; and, hence,
- improve service outcomes. (Scottish Executive, September 2006)

These projects are required to explore how they can better meet the needs of those with multiple and complex needs.

Greater Glasgow and Clyde Health Board (NHS GG&C) is one of these pilots, and has received £740,000 to develop inequalities sensitive practices.

The Inequalities Sensitive Practice Initiative

NHS GG&C is committed to mainstreaming equitable practice. As part of its wider activity, it has established its Inequalities Sensitive Practice Initiative (ISPI). At a strategic level this initiative aims to embed inequalities sensitive practice in and across the diverse health and social care settings of addictions, children's services, maternity and primary care mental health. This involves helping NHS GG&C and its partners in the delivery of integrated services, to find out what will improve the effectiveness and efficiency of frontline practice, and to determine what type of planning and policy arrangements are required to facilitate and sustain those practice changes.

For the four types of settings identified, ISPI is underpinned by a model of health and social care that recognises:

- the need to extend beyond traditional, medicalised responses to the health consequences of inequality;
- the relationship between, and impact of, poverty and gender;
- the need for consistency in services' responses.

Maternity Services

With a long term vision to embed inequalities sensitive practice in and across settings in NHS GG&C, ISPI has identified a number of shorter term (2 year) outcomes for its maternity services. These include:

- increased detection of poverty related issues
- increased access to support for income maximisation
- increased detection of gender based violence; increased access to support for survivors of gender based violence
- increased detection of risk factors for maternal deaths; increased detection and reduction of risk factors for infants requiring implementation of child protection procedures
- earlier detection throughout the maternity episode of risk factors for perinatal mental health problems.

To meet its long - and short-term aims for maternity services, ISPI has engaged in a number of activities. These include:

- a mapping exercise to document the content of specialist and mainstream service provision and identify strengths, weaknesses and gaps
- a staff engagement exercise to ascertain current knowledge and practice, and identify factors that support and inhibit good practice
- user engagement interviews to gauge service user satisfaction with maternity care, document examples of what was regarded as good and what was regarded as unsatisfactory practice and to identify potential areas for improvement.

The remainder of this paper focuses on the user engagement interviews.

The Maternity Services User Engagement Survey

Discrimination as a result of inequality or prejudice in relation to social class, gender, ethnicity, disability, age and sexual orientation can affect anyone in Scotland who is made to feel inferior through assumptions of others that they are inferior. These assumptions lead to a power imbalance which has social, physical and material effects on people's lives (Planning and Priority Guidance 2008). Service users within the NHS may experience an inferior standard of care and treatment through overt or unwitting prejudice or discrimination. Such discrimination can be individually or structurally mediated but the impact on the service user is the same. Service users may experience poorer care, be given less options, feel less involved or in control and/or feel disrespected and devalued.

The ISPI Maternity Project Lead conducted a user engagement survey with women who were dealing with a range of factors in their lives that had the potential to create multiple and complex needs, in order to assess levels and sources of satisfaction (and dissatisfaction) with the care received from maternity services and partner agencies while pregnant, during childbirth and in the postnatal period.

More specifically, the objectives of this survey were (in summary):

- to capture service user accounts of their experiences
- to identify areas/sources of satisfaction and dissatisfaction, and factors associated with these feelings and experiences
- to highlight the implications that these have for strengthening inequalities sensitive practice in maternity services

The survey was designed and approached within the context of examining the service from the service user's perspective and making recommendations for service development. This context had implications for the approach taken by the interviewer, particularly around the active enquiry around life circumstances or additional need. The recording of pertinent social and cultural factors or additional needs was made on the basis of information provided by the woman and was not probed by the interviewer.

Recruitment of Participants

The survey aimed to recruit women who had a wide range of care needs stemming from circumstances related to health behaviours, lifestyle or social or cultural status. A range of statutory and voluntary organisations across Greater Glasgow and Clyde were invited to participate. The services comprised addictions services, social care agencies, an asylum seeker and refugee project, a Muslim Women's project, a mental health voluntary organisation, Women's Aid and community projects. Initial contact was made with a wide spread of projects across Greater Glasgow and Clyde; for example, all Women's Aid projects across the board area were invited to participate. The final participating projects are those who accepted the invitation and agreed to take part.

These services were invited to support the project by informing women using their service who had used the maternity services in the previous 3 years about the survey, and thereafter arranging times and venues for interviews.

It was hoped to gather data from respondents resident in different geographical areas and who experienced a range of inequalities and disadvantage. Due to the limited time available for fieldwork all respondents that agreed to participate were interviewed.

All participants read and signed a consent form agreeing to participate in the survey. Almost all interviews were conducted in the recruiting service's premises. Participants were given a £15 gift voucher as a thank you for their time.

Data Collection

An interviewer (the ISPI Project Lead for maternity services) guided participants through a questionnaire* (attached) developed to capture women's satisfaction ratings and personal (qualitative) accounts of the different stages of the care pathway. The interviewer prompting for more detail as required, noted responses, and typed these up on the same day.

Following data collection, NHS GG&C commissioned researchers to analyse and report on the data. The remainder of this report describes this process and findings.

Methods

The questionnaire used in the review captures both quantitative and qualitative responses. Data analysis took several complementary approaches to ensure the capture and consideration of all data and that meaningful analysis was made. Potential relationships within the data were identified and explored e.g. relationships between variables.

Phase One: Familiarisation with the Data

Both researchers began by reading through all the questionnaires available for analysis. This was an important early phase in the process which allowed them to become familiar with the data. This stage began the process of generating questions and curiosity about relationships between variables within the data. In thoroughly reading through all the qualitative responses, early themes began to emerge which the researchers went on to explore in more depth.

questionnaire* page 35

Phase Two: Taking a Systematic Approach to Data Management

The researchers developed a robust coding system to ensure the capture and retrieval of all data. A unique identifier code was developed and applied to each completed questionnaire. This comprised coding for relevant categories of data identified with the commissioner as follows:

- Respondent number
- Categories of Pertinent Social Factors Recorded
- Hospital Unit
- Service Providing Care
- Stage of Booking
- Ethnicity
- Disability

This system of coding allowed the original data to be revisited many times during the analyses and fresh relationships explored.

Phase Three: Analysis of Quantitative and Qualitative Data

Descriptive statistics (frequency and percentages) were extracted for all quantitative data, including relationships between categories as agreed with the commissioner. Due to the small number of questionnaires, no statistical analyses were conducted.

All qualitative data were extracted from the questionnaire, coded and analysed using thematic analysis according to key concepts and themes emerging from the data. This approach allowed the women's experiences to drive the analysis rather than the researchers having a priori notions or expectations of what was important. It also provides a description of areas of commonality, areas of difference and identification of unusual cases or experiences.

The researchers then contextualised the quantitative data by examining the relationships between quantitative and qualitative responses. This included looking at the category of satisfaction/dissatisfaction at various stages of the care pathway, and then considering further meaning of this through thematic analysis of qualitative responses. Due to the emerging complexity of the relationship between satisfaction scorings and qualitative responses, all qualitative data were extracted and analysed independently of the numerical scoring given.

Results: Quantitative Data

This section presents results of the data analysis under the following sections:

A. Characteristics of the whole sample

B. Satisfaction Rates across maternity services

C. Inequalities Sensitive Practice Enquiry

D. Qualitative Data Analysis

A. Characteristics of the whole sample

60 Interviews were conducted. Five of these were conducted with women who were currently pregnant at the time of interview and therefore no data were available for their delivery and postnatal period.

Women were recruited for interview through a range of community based projects in Greater Glasgow and Clyde as shown in Table 1. The largest number of women in the sample was recruited through the Community Addictions Teams and other addiction projects.

Table 1: Recruitment of Sample

Recruitment Project	Recruitment Project
Family Matters	5
South-East CAT	4
East CAT	4
West CAT	6
South West CAT	7
North CAT	2
Inverclyde Community Drugs Team	3
Lomond Drugs Service	1
Red Road Women's Centre	8
Hemat Gryffe Women's Aid*	6
Castlemilk Women's Aid	2
Inverclyde Women's Aid	1
AMINA (Muslim Women's Resource Centre)	6
ACUMEN Paisley	1
Renfrewshire Community Health Initiative	1
Homeless Team	1
Greater Easterhouse Alcohol Awareness Project	2
Total	**60**

* Hemat Gryffe Women's Aid specifically serves women from BME communities

Women in the sample received their hospital based maternity care via one of five main maternity services within the Greater Glasgow and Clyde area as illustrated in Table 2. For the remainder of the report each of these services is referred to using the following abbreviations:

PRM Mainstream
Care provided through the mainstream maternity service at Princess Royal Maternity, Glasgow.

PRM WRHS
Care provided through the specialist service Women's Reproductive Health Service (WRHS) based within the Princess Royal Maternity, Glasgow.

QMH
Care provided via Queen Mother Hospital, Glasgow.

SGH
Care provided via Southern General Hospital Maternity Unit, Glasgow.

Clyde: RAH
Care provided by Maternity Services within the Royal Alexandria Hospital in Paisley.

Clyde SNIPS
Care provided within the Clyde area by the specialist service, Special Needs in Pregnancy Service (SNIPS). These women then delivered their babies within the Royal Alexandria Hospital Maternity Unit, Paisley.

Table 2 shows the proportion of the sample receiving their care from each of the six main services.

Table 2: Sample by Maternity Unit

Maternity Service	No. Participants	% of Sample
PRM Mainstream	16	27
PRM WRHS	19	32
QMH	9	15
SGH	4	7
Clyde: RAH	4	7
Clyde SNIPS	8	13
Total	**60**	**101***

* Total Percentage > 100 due to rounding of percentages

Table 3 describes the sample by category of pertinent social factors. Data included within this category were captured by the interviewer at the time of interview in two ways: by the nature of the recruitment project through which the respondent had been accessed, and the way the woman defined her own needs during interview. The interviewer did not actively ask about the individual nature of participants' vulnerability or particular need. Many respondents have a recording of more than one category reflecting the multiple and complex needs of women in the sample.

Table 3: Sample By Pertinent Social Factors

Social Factors	No. Participants*	% of Sample
Drugs /Alcohol	30	50
Mental Health	7	12
BME	13	22
Domestic Abuse	12	20
Asylum Seeker	6	10
Other	10	17

*Participants may have more than one factor recorded

Within the 'Other' category the following factors were recorded:

• Child Protection • Disadvantaged Community • Vulnerable Young Person • Homelessness

Drugs and/or Alcohol use was recorded as a pertinent social factor for half of the whole sample. The next most frequently identified social factors were Black and Minority Ethnic (BME) and Domestic Abuse (22% and 20% respectively). These latter two factors frequently co-existed within this sample. This co-existence is however, explained by sampling, with six of the women within the sample coming from Hemat Gryffe Women's Aid which serves women from the BME community. It is therefore not regarded as being representative of the existence of domestic abuse within the wider BME population.

Seven (58%) of the women within the category BME were recorded as having experienced domestic abuse.

Table 4 shows the sample by deprivation indicator. The index used for this is the Scottish Index of Multiple Deprivation (2006) where category 1 is the most deprived through to category 5 which is the least deprived area.

Table 4: Sample by Deprivation Category (SIMD)

SIMD Quintiles (2006)	No. Participants	% of Total
1	29	67.4
2	3	7
3	6	14.0
4	4	9.3
5	1	2.3
	43	100

*Incomplete or Invalid Postcodes n=17

The majority of the sample **(74%)** comes from the most deprived categories 1 and 2. Some other participants who fall into more affluent areas include those who are living in temporary or refuge accommodation which are located within these areas.

Ethnicity of the sample was broken down as follows:

Table 5: Sample by Self Reported Ethnicity

Ethnicity	No.	(%)
White	40	67
Mixed	1	2
Asian	13	22
Black	5	8
Other	1	2

The majority of the sample was White. *n.b.* There are only 13 women included in the BME category of pertinent social factors, but 20 BME recorded in ethnicity – some of these are recorded as asylum seekers, but were not also recorded as BME. This distinction relates only to the boundaries of the sampling within this survey, where women were recruited via projects relating to their potential social vulnerability. It again highlights the complexity of need faced by most of the women included in this sample.

Table 6 describes what period of gestation women in the sample were when they booked for maternity care. Whilst the large majority of the sample had booked for care by 16 weeks gestation, it is worth noting 15% of the sample was late bookers for their care.

Table 6: Sample by Stage of Booking for Maternity Care

Weeks Pregnant when first booked for maternity care	No.	(%)
Up to 15 weeks	51	85
16-20 weeks	3	5
21-25 weeks	3	5
More than 25 weeks	3	5
Total	60	100

Disability

Seven respondents (12% of the sample) reported having a disability. Conditions given within this category were:

• Deafness in one ear • Arthritis • Dyslexia • Back Injury • Depression • Anorexia

B. Satisfaction Ratings

Respondents were asked to assign a numerical rating of their satisfaction across a range of different areas of their care. These included satisfaction with:

• Antenatal Care • Care during Delivery • Postnatal Care
• Care on Discharge • Involvement of their Partner • Inter-agency Working

They were asked to assign a satisfaction score between 1 and 5 where one is least satisfied through 5 most satisfied. For the purpose of this analysis, numerical scores 4 and 5 have been combined to give a *rating* of 'Satisfied'. A scoring of 1 or 2 is classified as 'Dissatisfied'. A score of 3 was analysed as a separate category and is described and reported later.

Satisfaction Rates are described below in relation to Maternity Unit and Social Factors Category. The 'satisfaction rates' described in each category below relates to the combined number of women giving a 'Satisfied' score of either 4 or 5.

It is important to bear in mind that the numbers involved in each category are **very small**, particularly in Tables 9-13. Therefore care must be taken in how these figures are interpreted and any significance inferred, particularly in making comparisons across categories. In light of the small numbers involved, it is more appropriate to consider where consistencies lie rather than inferring significant differences.

Satisfaction Rates by Stage of Care Pathway

The first four tables illustrate satisfaction rates within various stages of the care pathway for each of the six maternity service providers.

Table 7: Satisfaction Rates: PRM Mainstream (16)

Stage of Care Pathway	(No. of Women)	(%)
Antenatal Care	12	75
Delivery	11	69
Postnatal Care	9	56
Care on Discharge	14	87

The highest rate of satisfaction (87%) occurs with Care on Discharge. The lowest rate of satisfaction (56%) occurs within the hospital based post natal period.

Table 8: Satisfaction Rates: PRM WRHS (19)

Stage of Care Pathway	(No. of Women)	(%)
Antenatal Care	15	79
Delivery	8* (out of 17)	47
Postnatal Care	10* (out of 17)	59
Care on Discharge	13* (out of 17)	76

* missing data n=2 (interviewees currently pregnant at time of interview)

The highest rates of satisfaction (79%) within this service occur within the Antenatal period and with Care on Discharge (76%). The lowest rate of satisfaction (47%) occurs with Delivery. This is the one stage in the care pathway where women are not cared for by WRHS staff.

Table 9: Satisfaction Rates: QMH (Total QMH n = 9)

Stage of Care Pathway	(No. of Women)	(%)
Antenatal Care	7	78
Delivery	6* (out of 8)	75
Postnatal Care	3* (out of 8)	37
Care on Discharge	8* (out of 8)	100

* missing data n=1 (interviewee currently pregnant at time of interview)

The highest rate of satisfaction (100%) within this service occurs with Care on Discharge. The lowest satisfaction (37%) is with the hospital post natal care.

Table 10: Satisfaction Rates: SGH (Total SGH n=4)

Stage of Care Pathway	(No. of Women)	(%)
Antenatal Care	3	75
Delivery	2* (out of 3)	67
Postnatal Care	1* (out of 3)	33
Care on Discharge	3* (out of 3)	100

* Missing data n=1 (interviewee pregnant at time of interview)

The highest rate of satisfaction with SGH is with Antenatal care (75%) and Care on Discharge (100%). The lowest satisfaction (33%) occurs with hospital post natal care.

Table 11: Satisfaction Rates: Clyde RAH (Total Clyde RAH n=4)

Stage of Care Pathway	(No. of Women)	(%)
Antenatal Care	2	50
Delivery	2	50
Postnatal Care	0	0
Care on Discharge	4	100

None of the respondents in this maternity unit were satisfied with the hospital post natal care, whilst all were satisfied with care on discharge.

Table 12: Satisfaction Rates: Clyde SNIPS Service (Total SNIPS n=8)

Stage of Care Pathway	(No. of Women)	(%)
Antenatal Care	8	100
Delivery	4*	57*
Postnatal Care	4*	57*
Care on Discharge	7*	100*

* Missing data n=1 (interviewee pregnant at time of interview)

With SNIPS all women interviewed were satisfied with both their antenatal care and care on discharge, with just over half satisfied with delivery and postnatal care. It should be noted that 1) other community midwives within Clyde are also often involved in providing a key role in the care of these women and 2) as SNIPS is a community based service intrapartum and postnatal inpatient care is provided through the RAH consultant led unit.

Looking across the six maternity services, it is clear there is:

- A consistently high rate of satisfaction with community care on discharge across all units and services
- Consistently lower satisfaction rates with hospital post natal care across all units
- The one service with a higher satisfaction rate for the hospital post natal period is the WRHS. Women within this service often receive post natal care within a specific WRHS post natal ward staffed by midwives from the service. Respondents who received care in this ward described a range of experience. These are fully described within the section on Qualitative Analysis.

Satisfaction Rates by Social Factor Category

Women's satisfaction scores were analysed in relation to the category of pertinent social factors captured on their questionnaire. **Table 13** shows satisfaction rates for each of these categories. Where women were recorded as having more than one pertinent social factor, their satisfaction score is recorded for each category.

Table 13: Satisfaction Rate via Care Pathway by Social Factors

Social Factors Category/Stage of Care Pathway	Drugs/ Alcohol* (n=30)	Mental Health (n=7)	BME* (n=13)	Domestic Abuse* (n=12)	Asylum Seeker (n=6)	Other* (n=10)
Antenatal	26 (87%)	5 (71%)	8 (61%)	8 (67%)	5 (83%)	8 (80%)
Delivery	17 (61%)	3 (43%)	8 (73%)	6 (60%)	4 (67%)	5 (55%)
Postnatal	18 (64%)	5 (71%)	5 (45%)	6 (60%)	4 (67%)	6 (67%)
Care on Discharge	26 (93%)	7(100%)	9 (82%)	10 (100%)	6(100%)	9(100%)

* Percentages within these categories have been adjusted for Delivery, Postnatal and Care on Discharge stages to account for the women in the sample pregnant at time of interview.

Again, this shows a consistently high rate of satisfaction with care on discharge across all categories of vulnerability. The areas of lower satisfaction occur at the delivery stage for those within the 'Mental Health' category and in the hospital post natal period for those within 'BME' category, although again it should be noted the numbers are very small within most categories within Table 13.

Satisfaction with Partner Involvement

Participants were asked to rate their satisfaction with the opportunities to involve their partner or family member throughout their care. Table 14 describes these rates for each of the maternity services.

Table 14: Satisfaction with Opportunity for Partner Involvement by Maternity Unit

Maternity Service	No.	(%)*
PRMH Mainstream	10	71
PRMH WRHS	12	75
SGH	2	57
QMH	4	50
Clyde RAH	1	50
Clyde SNIPS	7	100

* Adjusted for missing and N/A data where women did not have a current partner

The highest rates of satisfaction for Partner Involvement were within the two specialist services, WRHS (75%) and SNIPS (100%).

Table 15: Satisfaction with Opportunity for Partner Involvement by Social Factors Category

Maternity Service	No.	(%)*
Drugs /Alcohol	22	81
Mental Health	4	67
BME	5	62
Domestic Abuse	2	40
Asylum Seeker	3	75
Other	5	62

* Adjusted for missing and N/A data where women did not have a current partner

The highest satisfaction rate (81%) for partner involvement across the Social Factors category was amongst drug/ alcohol users. The lowest rate (40%) appears in the domestic abuse category but particular care must be taken in interpreting this: only five women, out of the 12 women who reported domestic abuse responded to this question, and in many cases involvement of their partner would not be desirable or appropriate.

Satisfaction with Inter-Agency Working

Satisfaction rate with interagency working was high across all maternity units and across all Social Factors categories. A total of **36** respondents from a possible **42** rated inter-agency working as satisfactory (score of 4 or 5). This accounts for **86%** of the relevant sample total. Factors associated with satisfaction and dissatisfaction with inter-agency working are described within the section on qualitative data.

Table 16: Satisfaction with Inter-Agency Working across Maternity Services

Maternity Service	No.	(%)*
PRMH Mainstream	6 (out of 6)	100
PRMH WRHS	15 (out of 18)	83
SGH	2 (out of 3)	67
QMH	4 (out of 5)	80
Clyde Mainstream	2 (out of 2)	100
Clyde SNIPS	7 (out of 8)	87

Handling of '3' Scoring Category

All questionnaires with a scoring of 3 in any of the above areas of enquiry were placed in a unique category and the accompanying qualitative data examined. The qualitative responses accompanying this score largely revealed a mixed experience for women that included elements of both satisfaction and dissatisfaction. In the majority of '3' categories the balance of qualitative comment was around dissatisfaction. This is consistent with the qualitative data overall, which contains more detail on areas of dissatisfaction than satisfaction. The factors associated with satisfaction and dissatisfaction are described more fully under the section on qualitative analysis.

Relationship between Numerical Satisfaction Scores and Qualitative Data

Within the whole sample, there are several indicators which highlight the difficulty for women in assigning a single numerical score for a category which encompasses a variety of separate experiences and encounters. Often the numerical score did not wholly reflect the experience described within the qualitative responses. The most common occurrence of this was within a 'satisfied' score where the qualitative response would go on to describe some areas of dissatisfaction. Also, within a number of questionnaires women have found difficulty in assigning a single score and given a 'split' score for particular incidents or member of staff, for example a score of '1' for induction but '4' for midwife attending in labour. [1]

C. Inequalities Sensitive Enquiry

Women were asked whether they felt that midwifery staff took an interest in their wider life, and whether needs arising from this were discussed and met. **Forty five** women (75%) felt that staff had taken an interest in their wider life, and **37** (62%) felt that wider needs had been discussed and met.

[1] In analysis, these cases were discounted from 'satisfaction' categories 1 and 2, as on examination they revealed a very mixed experience of care.

Women interviewed were asked whether staff had enquired specifically about issues of:

• Alcohol Use • Drug Use • Money and Housing Matters • Domestic Violence • Female Genital Mutilation (FGM)

Within this report we refer to these questions as 'inequalities sensitive enquiry'.
Regardless of whether they had actually been asked about the above issues, the interviewer enquired about the acceptability of such enquiry. Almost the entire sample of women n=59 (98%) perceived being asked such questions about their wider lives as acceptable practice. Only one respondent, who was a drug user, thought this was not acceptable on the basis that it was not the role of the midwives to make such enquiry and a personal perception of being "pushed" into accepting help when she did not feel ready. All the other women who felt it was acceptable supported this view with responses describing a perception that the practice was done from the perspective of trying to help and support the woman and/or her baby.

Table 17 shows in more detail the pattern of enquiry for the above five categories across maternity services.

Table 17: Breakdown of Inequalities Sensitive Questions By Maternity Unit

Maternity Service/ ISP Enquiry	Alcohol Use	Drug Use	Money and Housing Matters	Domestic Violence	Female Genital Mutilation
PRMH Mainstream	9 (56%)	8 (50%)	4 (25%)	5 (31%)	2 (12%)
PRMH WRHS	17 (89%)	19 (100%)	10 (53%)	11(58%)	0 (0%)
SGH	4 (100%)	3 (75%)	1 (25%)	2 (50%)	1 (25%)
QMH	9 (100%)	8 (89%)	3 (33%)	2 (22%)	1 (11%)
Clyde Mainstream	4 (100%)	3 (75%)	2 (50%)	1(25%)	0 (0%)
Clyde SNIPS	8 (100%)	8 (100%)	7 (87%)	6 (75%)	0 (0%)

Table 17 shows women were more likely to be asked about alcohol and drug use than 'money and housing matters' or 'domestic violence'. Women attending the two special needs maternity services, WRHS and SNIPS have a consistently higher occurrence of being asked about each category (excluding FGM).

Only four women in the whole sample were asked about Female Genital Mutilation. All of these women were from either BME or Asylum Seeker categories of vulnerability. Only two women out of the six asylum seekers were asked about FGM, and within the whole BME group within the sample (as defined by 'ethnicity') only four (20%) were asked about FGM. The one woman in the sample however who had actually experienced FGM was not asked about this antenatally and it was only mentioned within the interview in the context of this being revealed during delivery.

Seventeen women (28%) in total from the whole sample were asked about all four areas (FGM is excluded due to the very small number of women being asked about this and the cultural relevance of this enquiry). Again women within WRHS and SNIPS were more likely to be asked about all four areas. Otherwise, very low numbers of women within mainstream maternity care services were being routinely asked about all these areas.

It should be noted that responses to all enquiry within this section of the survey is dependent on the recall of women remembering being asked these specific questions. For some women, this involves quite a time lapse and for all women, recall is likely to be affected by the relevancy of the topic to each individual woman.

Table 18: Enquiry into all four areas across Maternity Services

Maternity Service	No. women asked about ALL four areas	(%)*
PRMH Mainstream	3 (out of possible 16)	19
PRMH WRHS	6 (out of possible 19)	32
SGH	1 (out of possible 4)	25
QMH	1(out of possible 9)	11
Clyde Mainstream	1(out of possible 4)	25
Clyde SNIPS	5 (out of possible 8)	62

Results: Qualitative Data

Introduction

All qualitative data were analysed for emergent themes. As referred to in the earlier section, the qualitative responses given by women did not always match the numerical satisfaction rating they gave. As such, these qualitative data have been analysed independently of the scoring data to reveal factors associated with satisfaction and factors associated with dissatisfaction with the care received.

The approach to data collection means most narrative occurs within the context of describing a specific stage of the care pathway. However, in analysing the data, the main themes that emerged were found to be cross cutting and described factors occurring across different stages of care. The following findings are therefore presented thematically. However, in the interests of context-setting and transparency, some reference to stage of care is also provided.

Findings are presented within the following sections:

- Accounts regarding Inequalities Sensitive Practice
- Women's perceptions of being treated differently because of their vulnerability
- Accounts regarding Inequalities Insensitive Practice
- Data on practice within specialist services WRHS/SNIPS
- General themes associated with satisfaction and dissatisfaction of care

Accounts of Inequalities Sensitive Practice

This section presents data on satisfaction with services suggestive of sensitivity on the part of the maternity services to the specific – sometimes multiple - needs that the women have.

The first main theme which emerged within this category was around maternity staff taking an active role in supporting women holistically.

Accounts from seventeen women in the sample are contained within this theme, twelve of whom received care from the specialist services of WRHS and SNIPS. The remaining five attended other services: PRM mainstream service (n=3), SGH (n=1) and Clyde Mainstream service (n=1).

Several of these women (many of whom were experiencing domestic abuse) described how midwives provided emotional support and practical help with their wider lives. This often arose from the midwife actively enquiring into the woman's wider circumstances, which led on to increased support for the woman. For example, one of the women experiencing domestic abuse was receiving care through WRHS and described how the midwife had taken an active role in helping her find safe accommodation:

"I had to leave my partner and be put into a mother and baby unit and my midwife helped me talk to the people who ran the mother and baby units and social work. They asked loads of family questions that helped me." **(S51)**

A second woman with a history of depression, and also experiencing domestic abuse described how active enquiry by the midwife had helped her disclose her experience:

"I think it's important (to be actively asked about wider issues). If they hadn't asked me (about domestic abuse) then I might not have said anything and it was one of the reasons for my depression...it's not just the woman's health but the baby's health at the same time." **(S49)**

This same woman also felt well supported in relation to her experience of depression through increased accessibility to her midwife, a sense of feeling cared for, and good interdisciplinary communication to enhance her care and support:

"she (midwife) really, really looked after me well...had a bit of depression while I was pregnant so made sure she kept in touch...gave me her number to phone if I needed help...got me in touch with the physio (for pelvic pain) and said to others at the hospital about depression to see everything was okay...saw psychiatrist. With a past history of depression the midwife wanted to make sure I was set up in case..." **(S49)**

Several other women linked their experience of support closely to a perception of feeling cared for and having a good rapport with their midwife:

"very friendly midwives...helped with problems...either give you information or contact somebody for you..." **(S7)**

"couldn't get a better midwife...personal care...takes an interest in you...Midwife's attitude great...she got alongside you." **(S19)**

One particular woman's story is described below as it provides a very clear example of how several factors combined to create a very positive outcome for one vulnerable young woman. It highlights the positive impact of sensitive enquiry around domestic abuse, the midwife's knowledge of services to refer to, and the midwife's skill in assessing exactly how much support she needed to provide to enable the woman to access the extended support required to make a real difference in her life.

This young woman (age 20 years) described how the community midwife she had initially consulted very sensitively enquired about her wider circumstances and suggested she see the specialist midwife team. The specialist midwife's subsequent enquiry supported the young woman to disclose her history of domestic abuse and current homelessness. She described how the midwife built a relationship with her over time and explained about Women's Aid and how they could help. At a later consultation the midwife enquired again whether she had contacted the agency. When the woman described feeling too frightened to contact them, the midwife strengthened her support by assisting her more actively in making contact with them. The woman saw this as a pivotal point for her: "have gone from strength to strength since then". Women's Aid organised temporary accommodation for her then a permanent flat and supported her with emotional, financial and housing issues.

She also described how the midwife continued to support her with individual birthing tuition and helped her find wider support within the community. She experienced this as a strong support in overcoming social isolation, and support in preparing for birth as she felt unable to attend the mainstream antenatal classes which many couples attend:

"informed me of aquanatal classes to meet other expectant mums...befriending as I was a single parent... helped me get other friends...one-to-one birthing classes to prepare you for labour and parenthood which was worked out at my own level as a single person"

This woman reported being very satisfied with her care which she described as meeting her individual needs and as sensitive in its approach. The example also illustrates the positive outcome of a midwife carefully pacing and gauging the level of support required, increasing this as necessary:

"(specialist midwife) *understood my needs very well...(they were) not in yer face...after a time I felt able to disclose...staff not only provide information about services but take the next step...tell me what it is they (Women's Aid) do and offer to come with you."*

Another participant remarked on how she perceived such wider support as important to not only the woman but also to her unborn baby:

"...it was the midwife that helped me get a new house as I was in an abusive relationship...all questions are important as what surrounds you affects your pregnancy." **(S39)**

Other elements of practical support from midwives were also valued. These included receiving help with organising the baby's birth certificate **(S17)**, making phone calls on the woman's behalf, linking with other agencies including social work and the dentist and help with re-housing.

A small number of women also mentioned the importance of accessibility of staff antenatally, describing an arrangement where they could phone if they needed the midwife or support. Whilst the women did not feel the need to use this facility much, knowledge of this availability was perceived as very supportive.

"quite a lot of support and care. I suffered from a lot of postnatal depression so she says anytime just to phone her...phoned her once but knowing that she was there was great." **(S48)**

The importance of good inter-agency communication in ensuring the type and the level of care and support they needed was also highlighted by some. This included an asylum seeker support agency linking a woman who had no knowledge of maternity care in the UK into maternity services, and another woman described how she perceived communication between agencies as supportive:

"I think it is good that they share information as you get the level of support you need and things are seen from different angles." **(S39)**

The key elements with all these women in relation to practice were:

- Importance of the relationship with their midwife and sensitivity in enquiry of wider issues
- Gauging the right level and type of support needed and facilitating access to other appropriate agencies
- Enhanced availability and accessibility of staff
- Supportive communication between departments and between agencies

Another minor theme expressed by three women and related to inequalities sensitive practice, involved women feeling that their individual requests and needs related to their particular social circumstances, were listened to by staff and effort was made by staff to meet this need. This included one BME woman requesting to be looked after by female staff if possible due to her faith, and feeling satisfied that the staff listened to this request and tried to meet it. Another drug using woman specifically did not want other women in labour suite to know that she was using methadone. She communicated this to staff and felt "they dealt well with it" **(S52**) and another who specifically mentioned feeling satisfied with the interpreting service offered, particularly during labour.

A further example from the sample is described below as again this demonstrates how several elements of inequalities sensitive practice came together to provide a high standard of care for this particular woman.

One woman (aged 35 years) with a long history of mental health problems, reported being very satisfied with the care she received within a mainstream maternity service. She reported how the same midwife looked after her throughout her pregnancy and established a good and trusting relationship with her. The midwife stayed with her and undertook any procedures during pregnancy and delivery, and the woman reported feeling very positive about how well managed her care was.

"I didn't go to any groups as I was quite inhibited but had a lot of care from the midwives...lots of scans to check on growth...the midwife was wonderful...things were done very discreetly and with a lot of sensitivity and respect. When I went to the hospital they put me in a separate room so I didn't need to be in the waiting room as large spaces spooked me."

When a case conference was arranged to overview her care, she again felt involved and supported in the experience:

"There was a group arranged during pregnancy where different agencies came together to discuss how things were going...case conference...make sure I was getting the support I needed and everyone had the same information...really quite intimidating but knew everyone there...support worker came to the house to pick me up and took me in the car...showed me about, told me where the toilets were and took me in to the case conference then took me home. Felt really well supported.

Within labour suite she described how she was attended by staff she knew and received lots of information and explanations by medical and nursing staff about what would happen which reduced her anxiety. She also reported receiving the right level of support and care in the postnatal ward before being transferred to a psychiatric ward, which had been pre-arranged to ensure the right package of care:

"midwives showed me how to fill out the baby's chart and explained everything...showed me how to feed. I was given all the 'this is what you do – do you want me to show you and then you can do it later'. So very supportive...midwives in and out chatting to me and telling me how beautiful he was...arranged for a single room...doing everything they could to keep me stress free.

She reported how this care continued when she transferred to the psychiatric ward, with midwives visiting daily and communicating well with psychiatric staff. This good communication and care continued on discharge home until transferred to the health visitor.

This example highlights several elements of sensitive practice including:

- Continuity of midwife care antenatally and for delivery
- Highly individualised care and sensitive interpersonal communication
- Good awareness of the woman's support needs across staff and appropriate responses to those needs
- Good communication between departments to provide holistic care
- Good interagency working and involvement of woman in processes and decision making

Women's Perceptions of Insensitive Practice

This section describes the body of data which contained narrative describing women perceiving their experience of care to be a consequence of their particular social circumstances e.g. as a drug user or asylum seeker. This category does not involve concrete or 'objective' examples of practice which we can confidently call 'insensitive practice' but rather different perceptions of care that was felt to be insensitive.

Again, these data arose within the context of the three different stages of hospital care – antenatal, delivery and postnatal. The perceptions arose for women being cared for within mainstream service settings and for several women using the WRHS. In total, 13 separate respondents provided qualitative responses on this theme.

The majority of these data came from drug users who perceived that they were being judged and/or treated differently because of their drug use. In addition, there were two BME women who also felt discriminated again on the grounds of their ethnicity.

The following quotes reflect the range of comments made:

"didn't feel the staff bothered with me...thought it was because I was on meth...(staff) showed the other women where to get stuff like nappies but didn't tell me where things were...had to find them myself." **(S1, Post natal section)**

"because I was on the methadone I felt decisions were being made for me. People could have been a bit more helpful." **(S56, Antenatal section)**

"told the midwife the baby was coming and she walked out the room...see if you are on methadone you get treated so different." **(S25, Labour Section)**

Two of the women described how they perceived service provision within the WRHS post natal ward to be different to that in the mainstream postnatal wards, believing they received a diminished level of care on the basis of the type of service:

"we got our meals last and were not asked what we wanted...I think it was because we were on a methadone ward." **(S57, post natal)**

"patients (in the main post natal ward) pressed a buzzer and asked the midwives to pull their curtains round.... you would not be allowed to do this in Ward 71 (WRHS ward)." **(S25, post natal)**

A further two women within the sample described how this perception of being treated differently on the basis of their drug use extended to their partners also:

"...felt the midwife was looking down on me...staring at my partner cause he was falling asleep...she thought he was fu' o' it but he was just tired." **(S55, Labour section)**

"...partner felt he couldn't visit much...was working a lot and afraid of visiting when tired in case they thought he was on something." **(S5, post natal section)**

The two BME women who come into this category perceived being treated differently on the basis of their ethnicity and culture. One woman felt an individual member of staff in the post natal ward was *"very friendly"* towards the other women in the ward, but ignored her. She made sense of this on the basis of her ethnicity. The second BME woman felt that midwives acted with *"annoyance"* and *"nervousness"* to her practice of covering her face. **(S22)**

Accounts of Inequalities Insensitive Practice

There were a number of stories emerging from the data which come into a different category. These are specific examples which describe more factual and therefore stronger evidence to suggest that negative experiences were associated with the women's particular needs or vulnerability. These examples emerged more strongly amongst women from the BME category and those experiencing domestic abuse.

Several BME women described how requests they had made to staff in relation to their cultural or religious needs were not met:

"asked for Halal meat...they said it would take 3 to 4 days to get this. Then the midwife offered an omelette but it had ham it in. All I could eat was a yoghurt." **(S24)**

Another woman in this category described difficulties antenatally in having her cultural practices respected. She recounted not being warned beforehand that she would be consulted by a male doctor, or given time to cover her face before he entered the room:

"I did not have time to cover my face...doctor talked to his papers...no eye contact and told me what I already knew...confirmed I might not get a female doctor." **(S22)**

This same woman went on to describe how her request to close the consulting room door because of the presence of men outside was initially refused by the midwife and she had to go on to explain the cultural significance of this to her before the midwife conceded.

Another BME woman commented on *"being stitched"* by a male doctor which she found very embarrassing, and would have preferred a female member of staff to do this. It is not clear from the data whether she actively requested this. **(S33)**

Three women commented on communication issues in relation to their need for interpretation services. One woman who spoke French said she felt a lack of confidence in the skills of the interpreter provided by the hospital. Another reported not having an interpreter, but instead relied on her husband to interpret for her. It is unclear in this case whether interpreter services were ever actually offered **(S20)**

Related to the theme of communication, several BME women experiencing domestic abuse provided stories describing a sense of isolation and lack of support.

In one striking example, a BME woman who reported experience of Domestic Abuse, described relying on her husband to act as an interpreter for her. At times when he did not attend appointments or the hospital with her she found it difficult to communicate with staff and understand what was being said. This woman reported not being actively asked about domestic abuse, and described how she would like to have been offered an interpreting service:

"communication not good. When father (her husband) came to the ward he was told everything and then told me. Most of the time I didn't know what was happening and was worried...had no family contact and isolated from family. Would like interpreter just to come for 2-3 hours to help me understand and to speak about my problems." **(S34)**

When the interviewer enquired about the wider support offered by midwives, the woman commented:

"I would have like to have spoken alone to the midwife, with an interpreter, about domestic violence"

"felt very alone" **(S34)**

Another two BME woman experiencing domestic abuse had not been proactively asked about this, and related a similar desire for midwives to have taken an interest in their wider circumstances and offer more support:

"midwives didn't really understand what was going on (domestic abuse)*. Would have been happy if midwives had asked more questions about circumstances... didn't ask about problems at home....I would have liked midwives to ask about home situation as that might have helped me do something about it"* **(30)**

These combined factors of poor communication and lack of active support in meeting their multiple needs creates a strong sense of isolation coming from the reports of their care, whilst in hospital and also on discharge. One woman expressed a strong need which was not met, for additional support on discharge due to her isolation. This BME woman had also experienced domestic abuse and had fled from her husband:

"midwives (community) *just came five minutes. I would have liked to have an extra five minutes especially to someone who is alone...when someone with me I feel confident and safe. Feel as if I am not a good mother when I am alone...I would like more time with the midwife and the health visitor. I needed someone to talk to, to give me strength. I feel no self respect, nothing"* **(46)**

A further two women described not being asked about wider issues in their lives despite having a noted history of particular difficulties. One reported not being asked about postnatal depression despite having a previous history of this. Another with a history of alcohol problems reported staff having little interest in this:

"maternity services should have up-to-date information on alcohol. As a woman who had had a drink problem I was not asked about current drinking. I brought up that I had been a drinker in the past but the topic was not picked up again during the pregnancy." **(27)**

Another key theme emerging within the realm of inequalities insensitive practice lies within experiences women have had where there has been insensitivity around their particular circumstances within direct communication with a member of staff. Earlier we have presented data on staff talking or behaving in ways that were *felt* to be insensitive but for which tangible examples were not provided. However, a few other examples existed within the data where there was more evidence to illuminate actual encounters.

One such woman reported being dissatisfied with her encounter with an anaesthetist during labour, who when having difficulty accessing a vein, is reported as saying *"that's what you get for injecting drugs"* resulting in the woman feeling *"quite upset at what he said and the way he said it."* **(8)**

One woman in the sample who was an asylum seeker had previously experienced female genital mutilation. She had not been asked about this antenatally and describes how the midwife attending her in labour responded:

"the midwife looked horrified when she saw the FGM... the look on her face said it all." **(15)**

This same woman also reported being given contraceptive advice in an insensitive manner:

"before discharge...was given information about contraception...felt provocative." She reported the midwife as saying *"we don't want you coming back here every year, you need to do something about this."* **(15)**

Related to this theme of communication, one woman in her thirties, reported an experience which she viewed as insensitive and a lack of care with confidentiality. The woman's mother had been her birthing partner, and whilst in labour suite:

"the doctors took mother aside and told her how much methadone I was on – Mum thought I was on a lower dose." **(S7)**

The woman felt this was inappropriate of the doctor and breached her right of confidentiality.

Finally, one Chinese woman whose relatives worked irregular working hours reported how staff wouldn't accommodate this around visiting times. Whilst this is a very individual account within the data, it highlights how sticking with mainstream practice resulted in real isolation for one woman.

WRHS Service

WRHS and SNIPS are the two specialist maternity services within Greater Glasgow and Clyde, providing maternity care to women with complex needs.

Much of the data describing elements of these specialist services has been included in earlier sections in relation to inequalities sensitive and insensitive practice as the issues raised were not specific to any particular maternity unit or ward. In addition however, there were a few other themes which emerged specifically in relation to the specialist service provided by WRHS.

The two themes which emerged specifically in relation to WRHS were around lack of choice in being referred to this service for their care, and women's experience of the post natal care provided within the WRHS ward.

Thirteen women recounted experiences of their care within the WRHS ward. These were a mix of elements of dissatisfaction and satisfaction with care provided. Some women had experience of receiving post natal care from both the WRHS ward and a general post natal ward, having been moved between the two and provided comparisons.

Descriptions of satisfaction with the ward were described in quite general terms and centred around staff being *"supportive"* in their care and approach with the women:

"the staff in Ward 71 (WRHS ward) were brilliant... always helpful...easy to talk to if you were worried about anything...didn't belittle you or make you feel stupid." **(S19)**

Women who experienced care from the WRHS ward and a general post natal ward generally preferred the care received within the specialist ward, feeling staff were more attuned to their circumstances:

"(mainstram ward) *was a total nightmare...they made you feel as if you were stupid...staff didn't show you where things were or let you know what you should be doing... made to feel different from the other women in the ward. The day after...moved into ward 71...much better...staff brilliant."*

Several women who were not actively using drugs however, felt unhappy with the experience of having to share a ward with other women who were actively using. One in particular felt stigmatised by the association of being cared for within the WRHS:

"I think (WRHS ward) should be done away with...should just be in mixed wards as a lot of people are stabilised on methadone. Didn't use to tell people who my doctor was as if they knew it was (WRHS) they would think less of me...stigma in that name...could risk you relapsing going in there...women and partners full o' drugs and alcohol." **(S31)**

Some of these women also reported being dissatisfied with the experience of being around women who were using drugs, trying to care for their babies, and three women reported experiences of women using drugs within the ward environment of the toilets and smoke room:

"staff must have been walking about blind as people were using on the wards and in the toilets and they were on meth. I caught someone using in the smoke room. A few females nearly dropped babies on the ward cause they were out of it." **(S54)**

"a couple of other patients using on the ward and I went to staff with my concerns and I felt that staff didn't believe me...need to take people seriously when you have concerns about people using...want to be taken seriously." **(S39)**

One other woman reported being asked to leave on her sixth post natal day because of staff's suspicion of her using drugs. She recounts being denied a urine test to confirm this, and one conducted by her addictions worker being clear:

"went to the centre and had a urine and it was clear...the midwife phoned and apologised for getting me kicked out of hospital because my social worker and addictions worker complained to the hospital." **(S57)**

A small number of women described feeling dissatisfied with their lack of choice in receiving care from WRHS. One woman in particular initially resented this policy although ultimately felt it had been beneficial to her, but suggested there should be better communication to women about this decision. This theme of women being involved in decisions about their care continues within the following section on more general factors associated with satisfaction and dissatisfaction:

"I was told after the scan that I would need to attend WRHS as had previously been on drugs...I was pissed off as I didn't have a ragin' drug habit....I was just told I was goin' to Ward 71 (WRHS ward) *nae debate...I would like to have been more involved in the decision...if they could just explain more why you are going to that ward – just in case you have a relapse or anything...special care for your particular needs...better for you and the baby."* **(S18)**

The only remaining issue to emerge from the data in relation to the specialist services was in relation to accessibility. Three women described having to travel some distance to receive their maternity care. For two of these women this was in relation to attending specialist service clinics, whilst for the third it meant delivering within a maternity unit which was some distance from her own community, meaning few visitors during her hospital stay. (S55, S44, S9)

Women receiving their post natal care from the WRHS clearly have mixed experiences. For some, it provided much needed support in the post natal period and was perceived as being distinctly different and more attuned than the general post natal environments. For others however, there was more of a sense of not belonging within the service and a dissatisfaction in sharing their post natal environment with women who were actively using drugs.

Themes Linked With General Satisfaction & Dissatisfaction of Care

This section represents the majority of the overall qualitative data captured within this review. Several key themes relate to women describing factors linked to their experience of being either satisfied or dissatisfied with elements of the care they received.

The data described here however, does not contain sufficient evidence to provide a measure of confidence that the experiences women are relating have a direct bearing on their particular social circumstances, or could be regarded as 'inequalities' sensitive or insensitive practice. For this reason, the findings may have relevance to the wider population of maternity service users. However, the accounts provided do raise the question as to whether staff perception of client social status influences the nature and quality of their response. This is an area requiring further research.

It is worth noting that the majority of respondents had a mixed experience of care, with their questionnaires capturing elements of both satisfaction and dissatisfaction. There were only a small number of women who felt wholly satisfied or wholly dissatisfied with every element of the care they received.

The balance of the qualitative data appears weighted towards descriptions of dissatisfaction. This however, must be interpreted with care. Often when women were reporting on a 'satisfied' experience, there was less substantive description than when reporting on their dissatisfaction. This would be expected generally, that one would have more substance and detail to report within a care experience which was negative or unsatisfactory.

Again, the data within this section were captured within the questionnaire via 'stage of care pathway' but in analysis, themes emerge in a more cross cutting pattern and are presented as such. Where a theme or sub theme has particular relevance to one stage of the care pathway this is highlighted.

Accessing Maternity Services

The first group of data described here captures views expressed by women feeling satisfied or dissatisfied with accessing maternity services.

Within this, a small number of women described being satisfied with elements of access, explaining that they received much of their antenatal care at their GP surgery which suited them, with one respondent saying that she particularly valued being able to receive a scan there.

Three other women however, described missing out on midwife led, antenatal care and support. Two of these women from the 'BME' category described not knowing what to expect from maternity care in this country and therefore not realising that they were missing out on care being offered. One of these women had been told by her GP that he would care for her and only later did she realise she had missed out on midwife led, antenatal care and the extended support she may have received there. She also reported not understanding some of the terms she heard, such as 'parentcraft' classes. She described feeling unprepared and lacking information:

"GP...didn't seem to know who was responsible for my care...had no preparation for labour or parenthood. Just accepted that this is the way it is. There is a presumption that people know what happens in pregnancy and what to expect from services. As a first time mother I don't know any of this." **(S36)**

Again, the second BME woman in this category, received no antenatal care from her initial scan until 36 weeks gestation. At this stage she attended her GP for a minor complaint when he realised she had not been receiving care and immediately referred her. This woman again described how she did not know what to expect from maternity services so did not perceive this as abnormal at the time. **(S29)**

The third woman discovered her pregnancy late and delivered early, leaving a small window for antenatal care. She was referred to the maternity services by her GP at 6 months gestation and went into labour at 7 months, without having been booked for care. She felt that she should have been seen quicker than she was.

Another three women described constraints which affected their access to maternity care: one could not manage the times of the antenatal classes whilst another two reported having to travel a long distance to the hospital for antenatal care.

Dissatisfaction with Waiting Times and Appointments

There was a group of data from women expressing dissatisfaction with specific elements of service provision and administration. This was mainly around dissatisfaction with waiting times, particularly for antenatal scans and appointments and a difficulty in getting appointments organised. One other woman expressed dissatisfaction with her experience of induction arrangements, reporting long waiting times and receiving poor information on what was happening.

Provision of Information

Receiving adequate information at various stages of their care was highly valued by women in the sample. Antenatally, women valued information to prepare them for birth and parenthood, support through attending antenatal classes, and for three women, being well informed when they experienced complications antenatally:

"had a lot of problems antenatally....baby had a hole in his heart and had to get a lot of tests. Had support with everything that was going on especially with all the health concerns of the baby...had information and was kept informed...fully explained if I didn't understand." **(S41)**

Two BME women also described valuing the written information they received antenatally. Two other women specifically mentioned having a tour of the labour suite antenatally, informative and supportive.

Six women also specifically described the importance of receiving information during labour:

"had blood clots and bleeding...went into labour at 6 months...people were trying to explain everything and be positive, supportive and reassure." **(S32)**

Again the theme of information arose strongly within women's experience of dissatisfaction. Six women experienced dissatisfaction with a lack of information antenatally with another specifying a need for more information in Urdu. For some women this lack of information antenatally was perceived as being based on an assumption that, having other children, they did not have information needs, although it was also present for a number of women having their first babies, and feeling there was a lack of information and preparation of what to expect:

"there is a presumption that because you have previous children you are an expert by now and don't need any more (information)." **(15)**

This theme also arose within the context of postnatal care described later and is closely linked to the need for individualised care to assess each woman's information and support needs.

This area of dissatisfaction around a lack of information again emerged strongly within the context of the labour ward. Women related a number of labour experiences where they felt unsupported in a variety of ways, and specifically in relation to not being kept informed or events and decisions:

"baby not moving...third or fourth day in hospital and on monitor for 2 to 2 and a half hours at a time...most people only for half an hour. Didn't tell me why they were concerned. On monitor for prolonged periods but no one telling me why...totally alone...wanted to know everything that was happening...if patient is on her own then they should be kept informed of progress and concerns. ..knew something was up but was excluded from the discussion." **(S35)**

"just left and told it would happen in its own time. Did not get enough information about what to expect...not listening to me and giving me options...they could speak to me about why it is so sore...tell me I would be fine, explain things, give encouragement." **(S13)**

Again, within the post natal area the theme of insufficient information arose for many women. This often centred around not being told what to expect in terms of post natal care and not being oriented to the post natal ward, for example not being shown where to get nappies or baby milk, and not being shown where to go for meals. One BME woman described how she missed out on meals:

"basic orientation to the ward was not given..didn't know where to go for meals or for a drink so missed lunch and tea. This kind of information should be given on admission to the ward" **(S21)**

As well as a *lack* of information creating dissatisfaction, there were a number of examples within the data of women reporting being misinformed. Again this occurred at each stage of the care pathway.

Within the postnatal period this was related to receiving mixed messages and contradictory information from staff around caring for their baby, and in one case, receiving misinformation about visiting times. Within labour suite, women described this theme in the context of again receiving contradictory information and instructions from staff, for example with a change over of midwives:

"one midwife told me to push and then another one told me not to push...staff changed for tea breaks and told me two different things." **(S42)**

Within the antenatal stage of care, there was one striking example reported by one asylum seeker woman where she recounts being advised to abort her pregnancy after receiving blood test and scan results for foetal abnormalities:

"consultant told me that it was definitely a Down's Syndrome baby and wanted to abort the baby (told this at 6 months gestation). Staff said it would be best for me to have an abortion as I was a young woman and was in difficult circumstances. I said I wanted to keep the baby and we prepared ourselves for an unhealthy baby but the baby was born perfect." **(S13)**

With this example however, it is difficult to tell if this is misinformation or misinterpretation, but it highlights the need for clarity and checking understanding with women when conveying complex information.

Interpersonal Communication

This next main theme emerging from the data is closely linked to the issues around provision of information, but occurs at the more interpersonal contact level and centred around four main sub themes of:

- Involvement in Care Decisions
- A Sense of Being Listened to
- Style of Interpersonal Communication
- Miscommunication

Involvement in Care Decisions

Several women reported an experience of this in relation to feeling satisfied with their care. This was particularly relevant for women in the antenatal and labour stages of care.

"very quick delivery. Midwife very good....kept me informed and involved in decisions especially about the haemorrhage and asked my permission even though I was half out of it." **(S24)**

"Brilliant...they don't do anything without asking you first." **(S38)**

Conversely this theme appeared in relation to women's experience of dissatisfaction in care, particularly within labour suite. Two women specifically described staff not sticking to their birth plan, with one feeling "pushed" into a natural birth which was not her wishes. Several other women felt unsupported in labour including not feeling involved in decisions about their own birth experiences:

"they weren't bothering with me as a person...weren't really caring about me...just about the baby getting born...(I) was being told what was to happen rather than being asked." **(S7)**

"there were two midwives mainly looking after me. Kept giving me an internal and then the other one would give me one straight after but didn't explain 'til way later that she was a student. Only asked if it was okay if she examined me after they had done it a number of times." **(S59)**

Another woman who was admitted for induction which ended in an emergency Caesarean Section recounted a similar experience:

"going ahead with everything and not consulting...felt terrified...partner tried to ask questions but was told 'wait just now'...kept putting him off. Just told baby was in distress...not supported enough or told what was going on." **(S56)**

Not Feeling Listened To

This sub theme emerged strongly in relation to women's dissatisfaction with their care during labour.

Fifteen women (25% of the whole sample) described a sense of not feeling listened to by staff when in labour. This centred around accounts of feeling staff did not listen to the woman's actual experience in relation to pain, need to push and request for episiotomy. The following quotes reflect the range of experiences recounted by women:

"Arrived with baby on its way out could feel it coming... told the midwife the baby was coming and she walked out of the room...she only came back when my partner shouted the cord is round it's neck...the midwife did not really listen to me" **(S25)**

Another woman (asylum seeker) recounted her experience of the baby coming:

"the midwife, maybe she was new, but she wasn't listening to me...(I) told her that the baby was coming but she said no and put me on my side with my legs together...but couldn't lie like that so turned on my back and the baby shot out. My husband had to catch it." **(S15)**

"wouldn't give me pain relief. Asked for an epidural and was told anaesthetist not available...kept asking for pain relief but didn't get it...told I was doing fine without it." **(S7)**

One respondent requested an episiotomy in second stage of labour as she had required one three times previously:

"midwife in charge told me she had twenty two years experience and no one she had delivered had required an episiotomy. I felt very uncomfortable and in a lot of pain...birth plan was not adhered to, no pain relief given and was told a direct 'no' to episiotomy." **(S22)**

This respondent reported sustaining a problematic perineal tear as a result.

Midwives and medical staff have to make clinical judgements about the timing of administering analgesia during labour, amongst many of clinical judgements about care and delivery. We cannot tell from the accounts what these decisions were. However, it is clear that women were unhappy with the care received, and again did not seem to have adequate explanation or information about the care decisions being made.

Three other women recounted that they felt their concerns were not being taken seriously within the antenatal and community stages of care. These were around concerns about their babies, for example, poor weight gain.

Miscommunication

Two women also described a mismatch between the information they saw written in their notes and their actual experiences. One woman described how her notes recorded she "refused" skin contact with her baby after birth while her recollection was of the baby having the cord around its neck and not being offered to hold her baby. **(S3)**

Another woman reported her notes saying she was "not interested" in antenatal classes but had no recollection of being offered such classes. **(S15)**

As one woman highlighted, such recording is important as it has bearing within the information appraised around decisions about child protection at a later date.

Style of Interpersonal Communication

Some of the significance of this sub theme has already been described within the results on inequalities sensitive/insensitive practice, but appears again here in a more generic sense. Again, these data relate to women's experience at all stages of the care pathwayy, with the approach and communication style of staff being associated with the woman's experience of feeling satisfied or dissatisfied with their care.

Thirteen women described elements of staff communication style being supportive within the antenatal period:

"they get to know you as a person"

"friendly atmosphere"

"ask about you and your family"

"they sit and speak to you for about half an hour"

The majority of these women had received care from the specialist services.

Within labour suite this theme emerged again where women highly valued a style of communication which was *"friendly", "helpful", "reassuring"* and helped alleviate anxiety and fear. The importance of supportive communication was also raised in the data relating to care on discharge. One woman, where drug use was recorded as a pertinent social factor, described the importance of the midwife's communication in helping her gain confidence when she returned home:

"I think the midwife made excuses to come and see me! Came to see me if in the area. They kept praising me and the more I was praised this made me feel better (about myself) and wanted to prove I could do it." **(S38)**

Several women related dissatisfaction with the general staff attitude within labour ward, although many of these accounts were related to other elements of communication described in earlier sections such as feeling involved and having information. One woman recounted being "shouted at" by the midwife during labour, whilst another three felt unhappy with the manner in which they were told they should not use an ambulance to bring them to hospital in labour. One woman, from a disadvantaged community who was recruited through the addictions service reported her experience:

"My sister-in-law phoned an ambulance (I had wanted to go on the bus)...I was having contractions but was told by staff (at the hospital) that I wasn't having contractions and that I had wasted an ambulance journey and someone could have died from a heart attack".

On examination this woman was found to be 7cm dilated and delivered shortly thereafter.

Individualised Care

Another cross cutting theme emerging from the data was women's dissatisfaction with a lack of individualised care, particularly with their post natal hospital care.
These data had several dimensions:

- Women feeling that staff made assumptions about their confidence and competencies post natally
- Staff not checking on an individual basis what women's support needs were postnatally
- Perception of a lack of resources and availability of staff to provide care and support

These are summarised within the following quotes from women:

"pretty much left to our own devices...didn't ask me how I was doing or if I needed any help...but they did ask when I planned to go home." **(S59)**

"I forgot how to bath my baby...another patient showed me how to bath the baby. I had totally forgotten how to make up bottles. I think if it had been my first baby I would have been really depressed." **(S52)**

"felt anxious and unsure about looking after baby...felt very tired...would have liked more support." **(S34)**

"no support with baby care...midwives made the presumption that you knew what to do and were confident. Need an approach that enquires about competence rather than assumes you can manage bathing, feeding etc." **(S22)**

" I was terrified even though I had had two babies... assumption was that I could manage." **(S7)**

"staff work too long hours. Staff seemed stressed and tired by the end of shift." **(S10)**

"staff didn't spend enough time helping. Things were asked for but never happened." **(S33)**

Three women who were within a single room also reported feeling isolated by this arrangement, whilst another BME encountered difficulty when she requested a single room. Again these data seemed to relate to staff not checking out individual women's individual support needs and preferences for care.

The issue of continuity of care was specifically raised by several women. Where continuity of care, particularly midwife contact, was present women highly valued this. Examples included satisfaction with seeing the same midwife antenatally, which offered the opportunity to develop a stronger relationship. This was also relevant to care on discharge and seeing the same community midwife for the remainder of their post natal care on discharge. One woman who specifically valued continuity described how the midwife who had cared for her in labour then came to visit her in the post natal ward to talk through and explain some complications which had arisen during delivery.

Several others voiced dissatisfaction with a lack of continuity in care, with this appearing at various stages of the care pathway.

A small number of women (n=6) commented on wishing that community midwives had visited either more frequently or for a longer period. These women were satisfied with the care they received, but felt in need of more support when back home, often arising from a sense of isolation or anxiety. Another one woman however felt the community midwives visited too often. When these accounts are examined there is no evidence within the data that proposed frequency of visits was discussed with the woman, or planned in relation to her individual needs.

Sense of Feeling Unsupported

Much of the circumstances described above resulted in women feeling unsupported within specific periods of their maternity care. This theme of feeling unsupported appeared elsewhere also, with women feeling unsupported with infant feeding and being left alone whilst in labour:

"I buzzed for help with feeding during the night but midwife said 'you just need to try and persevere with it' and walked away." **(S3)**

"asked them to teach me with breast feeding...only one midwife patient with me. The rest of them come to help you then say 'hold on a minute, I'll be back' and then didn't come back. I was so desperate to breastfeed my son...seems like they all run away when I ask them." **(S46)**

Three women also reported feeling unsupported in their anxiety postnatally around having to leave their babies alone whilst going for meals.

One woman summed up several of the above elements around lack of individual care and support within one description:

"need to check how mothers feel about how they are doing...women feel inadequate if they don't know what to do...hadn't breastfed before but got no help...left to get on with it...make assessments with mothers...be encouraging and reassuring if required. Felt sorry for new mums who didn't feel competent. They need care, guidance and support." **(S27)**

Feeling unsupported in labour has already been highlighted in previous sections, but conversely, where women had the constant presence of a midwife during labour this was highly valued. They reported valuing having a midwife with them to give reassurance, comfort and alleviate anxiety. Women reported feeling dissatisfied with being left alone whilst in labour and feeling unsupported by this:

"kept leaving me in the labour suite...Kept walking away from me. Didn't stay in the room...kept going out and in the room." **(S3)**

"first half (of labour) no very good...the first midwife never really looked after me...left me mainly to get on with it." **(S60)**

Partner Involvement

Where women had a partner, the opportunity for them to be involved in care was a factor influencing their satisfaction with care. Reference to partner did not always mean the father of the baby, but for some women was another family member or support partner. This theme arose within the antenatal stage of care with women valuing their partners receiving information, being involved in care and informed of progress. It appeared most strongly however in relation to care in labour. Women felt satisfied when their partners were allowed to be present with them throughout, kept informed of progress and care decisions. One respondent particularly valued being allowed to have both the baby's father and her sister present during labour.

Where women reported feeling dissatisfied with partner involvement within labour this often centred on a feeling that partners were not given enough information, particularly in relation to complications arising. One other woman felt dissatisfied that her mother, whom she had as her birth partner, was not allowed to be with her in the pre-labour ward which increased her sense of isolation:

"my mother was my partner but because she wasn't a male partner she was not allowed into the pre-labour ward during partner visits. Other women were sitting with their partners and I was sitting alone reading magazines." **(S26)**

In this instance a ward routine designed to be sensitive to the needs of couples, if strictly adhered to, can be experienced by single Mums as discriminating and exclusive.

Interagency Communication

Eight women described being very satisfied with the sharing of information between agencies and the support they received from other agencies. Where women were satisfied with this they viewed it from the perspective of agencies being there to support them and their babies with sharing of information a necessary part of this. A number of women within the 'drug alcohol user' category of need particularly mentioned feeling supported by addictions services:

"everything kicked in pretty quickly once the drugs service found out I was pregnant." **(S6)**

"had ma back up at first but now know I needed their help...couldnae hae done it maself. Addiction worker was brilliant." **(S18)**

"drug worker helped me when I was pregnant...I could talk to them." **(S51)**

There were several women who had contact with a number of agencies and had a mixed experience of feeling supported. Three women did not like the practice of information regarding them being shared between agencies. One described how her social worker and drugs worker had assured her 'confidentiality' but then shared information. For some of the women there seemed a need for more clarity on boundaries and the meaning of confidentiality and information sharing. For a small number of others their dissatisfaction lay with agencies not communicating between one another enough to provide support needed, or feeling that they used out of date information to base decisions on. Some women also described interagency communication and support deteriorating once care was handed over from the specialist maternity services to community based social care agencies.

Conclusions

The survey provides important insights into women's feelings and experiences of maternity care with associated implications for service delivery. Before we summarise these, it is important to acknowledge some of the limitations of the exercise.

Lack of comparison data means it is difficult to say with confidence that much of the practice described within this review is inequalities sensitive or insensitive, or in fact relevant to the wider population of maternity service users. Research is required to investigate this aspect of care in more detail

Encounters related would also be better contextualised if related to accounts from staff on their experience of caring for women with complex needs.

Much of the qualitative data are centred around accounts of negative experiences or dissatisfaction with care. But this must be interpreted with care as there are likely to be several influential factors. Firstly, women may simply have more to say about a negative experience. Secondly, their reporting will have been influenced by their method of entry to the review and how the exercise was described to them. For example, they may enter the interview with an expectation that the interviewer is particularly interested in hearing about dissatisfaction. Women who volunteer themselves into such a review may also do so because they have more to say around dissatisfaction. However, these factors were moderated within this particular survey by all women receiving a £15 token for participation, and a full explanation by the interviewer of the importance of also hearing about good experience and practice.

The data however provide many positive examples of inequalities sensitive practice with staff meeting women's individual needs, providing and accessing other additional support as needed and communicating sensitively with women. Furthermore the whole data set provides a real sense of the vulnerability of many of the women in the sample, which comes through strongly in their stories across all categories.

One prominent dimension of this is a sense of isolation which manifests in a number of ways such as communication difficulties experienced, and lack of support. But across all categories the sense of women feeling like an 'outsider' comes across strongly. Many of the women already come from marginalised communities or experience marginalisation through their vulnerability, and this is evident also when they enter the maternity service care pathway. There are many examples of women's increased sensitivity to being excluded or treated differently, and how they often perceive interactions from this perspective. Services need to develop practice specific to these groups of women which is sensitive to this position, inclusive in nature and responsive to the complexity of their needs.

One group of women who particularly stand out within this sample are those from BME communities who are also experiencing domestic abuse. This category of women provides a strong example of the women with multiple and complex needs which the government wishes to better support through inequalities sensitive service provision. At the moment, these women are not automatically included within a specialist maternity service, yet experience very real isolation through communication difficulties, a lack of any support network and the isolation of secrecy surrounding women experiencing domestic abuse. There are several striking examples of inequalities sensitive practice within the sample which made a significant difference for these women, and examples where there have been real missed opportunities.

The review raises an interesting perspective around the argument for separate specialist in-patient services, particularly evident in the accounts of women receiving care from the WRHS over against mainstream care. There was a real mix within the data of women's satisfaction and dissatisfaction with such a service. There are examples of how women being treated separately, while in hospital, can continue/deepen their existing perception of 'being different' and separate, but this is offset by many examples of women receiving more attuned care which they needed. However the provision of specialist community based services for women with significant additional needs is almost universally welcomed and valued by service users. A cross cutting theme here is women wanting to feel involved in their care and decision making, and not to feel like passive recipients of care.

Given the purpose of the Inequalities Sensitive Practice Initiative is to improve practice and women's perceptions of care, it is important to recognise the validity of all comments made by women, even when these are based around their perceptions rather than concrete examples of practice.

Another strong theme emerging from the review is the experience of women feeling unsupported postnatally within hospital with several reports of women feeling unconfident and unsupported in caring for their baby and establishing infant feeding. Much of this data is not described within the sample as being directly related to their vulnerability or additional need, which may indicate that this is one area which may be an issue for the more general population of maternity service users. However the importance and significance of early intervention in parenting support for family and child health, particularly in relation to infant mental health and wellbeing, has particular relevance for women identified as having additional needs. Building resilience through the provision of social and emotional support and through the development of maternal competence in basic child care and parenting skills, has added importance for these women who experience added anxiety and often real isolation. Many of the stories relate a lack of basic postnatal care at a time when in fact these women need added support to facilitate early bonding with their babies.

There are other specific findings which have more direct implications for informing inequalities sensitive practice.

Within the sample there was a minority of women across units routinely being asked all ISP questions, yet almost all women being positively disposed to midwives enquiring about their wider lives and circumstances. Women related that they perceived this as supportive, particularly if done within the context of a supportive interaction with the midwife. Further investigation is required to ascertain the reasons why midwives are reluctant or unable to explore these wider social issues which are so pertinent to the future health and wellbeing of mother and child.

Underpinning any inequalities sensitive approach is the quality of interpersonal communication and relationship building which can be instrumental to the woman accepting extended support. Midwives need to be primed to women's sensitivities around being 'different' and entering maternity care with expectations of being treated differently. Learning and development opportunities may be required to support staff understanding of the social determinants of health and the development of the skills needed to identify and support women who have additional needs relating to life circumstances and low social status.

References:

NHS Greater Glasgow & Clyde (2008) Planning and Priorities Guidance.

Rosengard, A., Laing, I., Ridley, J. and Hunter, S. (Jan 2007) A literature Review on Multiple and Complex Needs. Scottish Executive.

Scottish Executive (September 2006) Multiple and Complex Needs Initiative Information Leaflet, www.scotland.gov.uk/Topics/People/Social-Inclusion/17415/mcninfo]

Maternity Services User Survey

1. Profile of maternity service

1.1 Have you used the maternity services in the last 3 years?	Yes	No	Don't Know		
1.2 In which year did you have your last baby?	2007	2006	2005	2004	
1.3 In which maternity unit did you have your baby?	Princess Royal Maternity Hospital	Southern General Hospital	Queen Mother's Hospital	Clyde (circle which of these three)	1. Paisley 2. Inverclyde 3. Vale-of-Leven
1.4 Who did you see mainly for your antenatal care?	Community Midwives	Hospital Staff	** Womens Reproductive Health Service (WHRS)	Special Needs in Pregnancy Service (SNIPS)	
1.5 How many weeks pregnant were you when you first booked for maternity care?	8 - 15 Weeks	16 - 20 Weeks	21 - 25 Weeks	More than 25 weeks	Don't Know

** NB: The WRHS service may be better known as Dr Hepburn's clinic

2. Satisfaction with antenatal care

2.1 On a scale of 1-5 where 1 is not at all satisfied and 5 is very satisfied how satisfied were you with the care you received?

1 2 3 4 5 **Please circle as appropriate**

Explore why this score was given

2.2 Did you feel you got enough information about pregnancy and what to expect from the maternity services?	Yes	No	Don't Know
2.3 Was the information you received in a form that you could understand and was acceptable?	Yes	No	Don't Know
2.4 Did you feel that you, were involved and included in decisions about your care?	Yes	No	Don't Know

Comments:

2.5 On a scale of 1 to 5 how satisfied were you with the attitude and approach of the staff you came in contact with during your pregnancy (that's before the baby was born)?

1 2 3 4 5 **Please circle as appropriate**

Explore why this score was given

2.6 Have you any suggestions as to how care in the antenatal period could be improved?

3. Satisfaction with care at delivery/in the labour suite?

3.1 How satisfied were you with the care you received at the time of delivery?

1 2 3 4 5 **Please circle as appropriate**

Explore why this score was given

3.2 Did you feel you got enough information about labour and the options for your care?	Yes	No	Don't Know
3.3 Was the information you received in a form you could understand and was acceptable?	Yes	No	Don't Know
3.4 Did you feel that you were involved and included in decisions about your care?	Yes	No	Don't Know

Comments:

3.5 How satisfied were you with the attitude and approach of the staff looking after you?

1 2 3 4 5 **Please circle as appropriate**

Explore why this score was given

3.6 Have you any suggestions as to how care in the labour ward could be improved?

4. Satisfaction with care in the ward after the baby was born?

4.1 How satisfied were you with the care you received in the post-natal ward?

1 2 3 4 5 **Please circle as appropriate**

Explore why this score was given

4.2 Did you feel you got enough information about your care and the care of your baby on the postnatal ward?	Yes	No	Don't Know
4.3 Was the information you received in a form you could understand and was acceptable?	Yes	No	Don't Know
4.4 Did you feel that you were involved and included in decisions about your care?	Yes	No	Don't Know

Comments:

4.5 How satisfied were you with the attitude and approach of the staff looking after you?

1 2 3 4 5 **Please circle as appropriate**

Explore why this score was given

4.6 Have you any suggestions as to how care in the postnatal ward could be improved?

5. Satisfaction with care on return home?

5.1 How satisfied were you with the care you received when you returned home?

1 2 3 4 5 **Please circle as appropriate**

Explore why this score was given

5.2 Did you feel you got enough information about looking after yourself and your baby at home?	Yes	No	Don't Know
5.3 Was the information you received in a form you could understand and was acceptable?	Yes	No	Don't Know
5.4 Did you feel you were involved and included in decisions about your care and the care of your baby?	Yes	No	Don't Know

Comments:

5.5 How satisfied were you with the attitude and approach of staff looking after you?

1 2 3 4 5 **Please circle as appropriate**

Explore why this score was given

5.6 Have you any suggestions as to how care on return home could be improved?

6. Satisfaction with wider support: Midwives

6.1 Did midwifery staff take an interest in your life? Things like: relationships with your partner or family, responsibilities at home or for caring for others?	Yes	No	Don't Know
6.2 Were any particular needs you had, for example in relation to your home situation, or a disability or your culture or faith, or sexual orientation, talked about and met?	Yes	No	Don't Know
6.3 Were you asked about the following issues?			
Alcohol use	Yes	No	Don't Know
Drug use	Yes	No	Don't Know
Money and housing matters	Yes	No	Don't Know
Domestic violence	Yes	No	Don't Know
Female genital mutilation (female circumcision/cutting)	Yes	No	Don't Know
6.4 Is it generally acceptable to you to be asked questions of this nature? (Explore)	Yes	No	Don't Know

Comments:

How satisfied were you with the level of involvement of your partner, or close family, in decisions about your care?

1 2 3 4 5 **Please circle as appropriate**

Explore why this score was given

7. Satisfaction with inter agency working

7.1 Before you were pregnant did you get support or care from health or social care services?	Yes	No	Don't Know
7.2 Could you tell me what services?	Social work	Addictions	Other
7.3 Did any other social care services become involved in your care during your pregnancy?	Yes	No	Don't Know
7.4 Could you tell me what services?	Social work	Addictions	Other
7.5 Who referred you into these services?			
7.6 Did you have any concerns about information being shared between agencies?	Yes	No	Don't Know

Comments:

7.7 How satisfied were you with inter-agency working around your care during pregnancy and childbirth?

1 2 3 4 5 **Please circle as appropriate**

Explore why this score was given

7.8 How satisfied were you with the attitude and approach of the staff supporting you from these services?

1 2 3 4 5 **Please circle as appropriate**

Explore why this score was given

7.9 Have any suggestions as to how this aspect of your care could have been done better?

8. Satisfaction overall

8.1 Is there anything else at all that you would like to add about your experience of care during pregnancy and childbirth?

8.2 Is there anything else that might have made your experience of care during your pregnancy better?

9.1 AGE	
9.2 POSTCODE	

	YES	NO	DON'T KNOW
9.3 Would you describe yourself as having a disability?			
9.4 Would you describe yourself as an asylum seeker/refugee?			

9.5 ETHNICITY **(CODE ONE ONLY)**

White

Scottish.....**1**

Other British.....**2**

Irish.....**3**

Other White background (specify).....**4***

Mixed (specify).....**5**

Asian, Asian Scottish or Asian British

Indian.....**6**

Pakistani.....**7**

Bangladeshi.....**8**

Chinese.....**9**

Other Asian, Asian Scottish or Asian British background (specify).....**10**

Black, Black Scottish or Black British

Caribbean.....**11**

African **12**

Other Black, Black Scottish or Black British (specify) **13**

Any other ethnic background (specify).....**14**

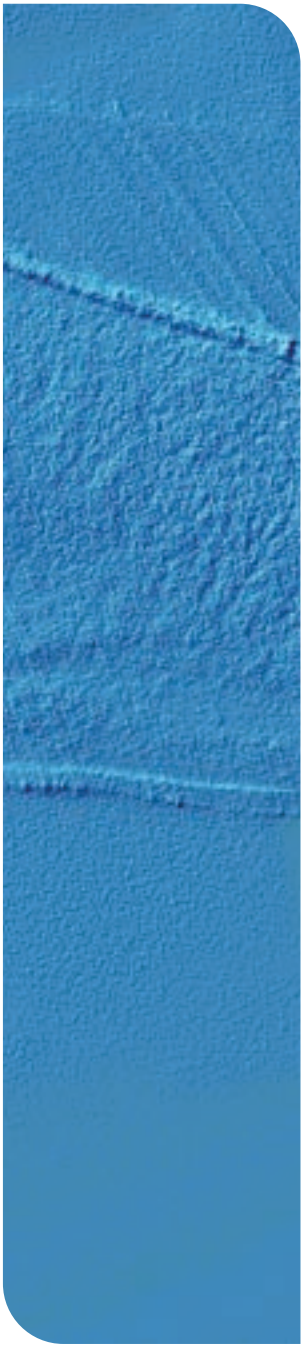
Refused.....**15**

* Gypsy/Travellers should be encouraged to record their ethnic group under 'Other White – specify'

If anything further comes to mind, that you would like to let us know, please contact Anne Bryce. (Provide information leaflet with contact details and give voucher).

Thank you for taking part in this customer satisfaction survey. The information will be used to inform the development of maternity services in Greater Glasgow and Clyde. While the information gathered will be treated in confidence participants who would like to stay in contact and receive reports from the project are welcome to do so. Please leave your name and contact details with the interviewer.

Notes:



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