COI / NHS London

Satisfaction with maternity services in London amongst seldom heard audiences

QUALITATIVE RESEARCH REPORT

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CONTENTS

1. BACKGROUND AND RESEARCH OBJECTIVES

1.1 Background

Government policy outcomes for maternity[1] are dependent on the successful engagement of and support provided to women and their partners before, during and after pregnancy and birth.

Quantitative evidence[2] suggests that satisfaction with maternity care is lower in NHS trusts in London than in other parts of England: in fact 19 of 27 of London-based trusts have been identified as 'least well performing'. With quantitative evidence demonstrating that satisfaction levels were lower than average in London, NHS London felt that there was a clear need to identify and address the needs of women accessing maternity services in the capital.

The national quantitative survey identified a number of groups who responded more negatively to questions about the quality of care before, during and after birth. These groups were:

- Younger women (i.e. under 30 years old);
- Women from black and minority ethnic groups (to questions about care during labour and birth);
- Women with a self-reported disability;
- Single women (i.e. those without a husband or partner).

NHS London wanted to understand further the expectations, experiences and needs of these women and their partners in London. However, the projects primary purpose was to hear from those who were least likely to have engaged with the national survey. It was important to include groups of particular importance to NHS London due to their higher levels of poor

[1] Maternity *Matters: Choice, access and continuity of care in a safe service,* April 2007
[2] Healthcare Commission (now Care Quality Commission), *Towards better births: A review of maternity services in England,* July 2008 (fieldwork conducted in 2007)

outcomes and/or higher incidence within the population of London. When discussed collectively, these groups are referred to as 'seldom heard' throughout this report.

The overall purpose of the research was to identify opportunities to transform women's experience of maternity services in London.

1.2 Research Objectives

NHS London wanted to understand women's experience of maternity services:

Primary research objectives:

- **To explore the current maternity journey** in order to understand what elements feed into expectations of the service
    - Identifying differences in experience for specific groups
- **To gauge overall satisfaction;** and satisfaction with different elements of the current maternity journey – from preconception (where relevant) to birth
    - Identifying what elements feed into satisfaction for specific groups
- **To identify ways to improve maternity service design**, delivery and satisfaction

Secondary research objectives

- **To understand the role of choice** in maternity – particularly the choice of hospital

    - Identifying how mothers and their partners/families can best be empowered to make meaningful choices about their maternity care

- **To understand the role of communications**

    - To identify how information is currently being accessed/utilised
    - To identify how mothers and their partners/families can best be informed and supported – particularly in terms of pre conception and pregnancy

Audience-specific research objectives

- **Partners**: to understand and explore the relationships that exist in different 'seldom heard' groups, exploring similarities and differences in terms of experience and opinions, as well as joint decision making.

- **Healthcare Professionals**: to provide contextual understanding in terms of attitudinal, behavioural and cultural characteristics of each 'seldom heard' group prior to primary research being undertaken.

2. RESEARCH METHOD AND SAMPLE

2.3 Research method

A qualitative approach was adopted, due to the need to explore and understand the range and nature of views, experiences and behaviours amongst women from seldom heard groups.

A mix of qualitative interviewing approaches were employed, including:

- depth interviews;
- friendship paired depth interviews (two respondents);
- and triad interviews (three respondents).

The individual or small group format was designed to ensure that respondents felt confident and comfortable to articulate their views about very personal experiences.

The fieldwork schedule was structured as follows:

1. **Health Professionals**: Initially, **12 depth interviews** (1 hour duration) were conducted with health professionals involved in delivering maternity services to 'seldom heard' groups.

2. **Women**: Subsequently, **12 two-part customer journey depth interviews** (each of 1 hour duration) were conducted with women from 'seldom heard' groups expecting their babies within 3-4 weeks. These pre and post birth interviews were designed to capture a sense of 'real time' maternity experience.

3. **Women**: **24 depth and 24 pair depth or triad interviews** (all 1.5 hours duration) were conducted with women who had given birth within the past 6-8 weeks.

4. **Partners**: In addition, **12 depth interviews** (1.5 hours duration) were conducted with fathers whose babies had been born in the past 6-8 weeks. Four fathers were partners of women taking part in the friendship pair/triad interviews.

5. **Two observation days** were undertaken at centres attended by 'seldom heard' groups. A series of 15-20 minute conversations were conducted. These sessions were designed to capture more informal data.

The research method was designed to achieve robust qualitative findings, corroborated by different interview approaches. The majority of mothers interviewed in the friendship pairs/triads were asked to recall their experience of maternity services retrospectively (albeit within the very recent past: all had given birth within the previous 8 weeks). Their retrospective views were supported by:

1. The experience of mothers currently using maternity services. Our 12 'customer journeys' provided us with 'real time' evidence that the themes to emerge from the friendship pair/triad sample were current. In addition, these interviews allowed us to focus on antenatal experiences which tended to be overshadowed by labour, birth and post natal experiences for the majority of the sample. However, the same 'U' shaped satisfaction curve (as described in section 4) emerged across the customer journey sample.

2. The experience of mothers captured in much less formal interview setting, at groups in the community. Once again, these shorter interviews confirmed that the themes to emerge from the friendship

pair/triad sample had not been 'hot-housed' (i.e. artificially exaggerated due to the interview format).

2.2 Sample

The qualitative sampling was purposive (i.e. non-random) and designed to reach particular 'seldom heard' groups. As in all qualitative research, the sample sought to reflect, rather than represent, the relevant research population (as defined below by NHS London).

Per audience: 1 x customer journey, 2 pair depths/triads with mothers, 2 depth interviews and/or triad with mothers, 1 x depth interview with fathers

Teenage parents
Parents with disabilities
Parents seeking asylum
Traveller parents
Single parents
African parents
French speaking African parents
Caribbean parents
Pakistani parents
Bangladeshi parents
Somali parents
Turkish parents

In addition:

- 1 x depth interview with **health professionals** working with each of the communities (12 depth interviews in total);
- 1 day at a baby clinic and 1 day at a Sure Start centre which generated 20 x 15 minute informal 'conversations'.

Overall, we gained a perspective on **maternity services across the capital** (including services in North West, South West, North Central, Outer North East, Inner North East and South East).

2.3 Recruitment criteria

The mothers' sample included:

- Those in their last trimester of pregnancy and those who have given birth in the past 6-8 weeks;First-time and second-time pregnancies (biased towards those pregnant for the first time); A spread across the spectrum of 'planned' and 'unplanned' pregnancies;
- Women with different birth experiences (e.g. Caesarean section);
- Women with different medical needs (e.g. pre-eclampsia, liver function problems, MS);
- A mix of partnered and single mothers.

The fathers' sample included:

- Those living with the mother of their child and those not living with the mother of their child;
- All were in contact with their child's mother during the pregnancy and were present at the birth of their child.

The health professional sample included: community and hospital-based midwives, with a mix of respondents from other professions (community nursery nurse, Doula, family support worker). The findings from the health professional sample are included in section 6 of this report.

2.4 Recruitment

The recruitment was challenging. Not only was the recruitment criteria extremely specific i.e. capturing an interview with parents within 6-8 weeks of

the birth of their baby, respondents needed to be drawn from 'seldom heard' communities.

We collaborate with experienced community-based recruiters with whom we have established relationships during our research on behalf of the Birth and Beyond and Child Promotion Programme teams at Department of Health. They used a range of techniques to engage respondents, for example publicising the research in community venues via leaflets and posters and working with community workers to generate interest and promote trust.

In order to engage those unlikely to have experienced the research process before, all interviews were conducted in home or familiar community settings. Where necessary, interpreters from within the community also provided a familiar point-of-contact. Interview set up (i.e. location, time and support required i.e. translators) was respondent-led.

2.5 Ethics

Ethical review by NHS REC was not necessary in this case, due to the project being focused on service evaluation. However, all Research Managers and Research Practitioners within the COI framework are members of the Market Research Society and bound by its Code of Conduct.

At the most basic level, any participation in projects is voluntary (informed consent), and respondents are assured confidentiality and anonymity. Care is taken to ensure that research is positioned in a manner than enables potential respondents to decline to continue their participation at any point if they wish. This applies equally to NHS staff as well as to members of the public.
All respondents were left with an information leaflet[3] with contacts for help and advice (agreed by NHS London), once the interview was completed.

[3] See appendix 3

3. ANALYSIS

Qualitative analysis is based on evidence of recurring themes – and exceptions to these themes. The following qualitative findings therefore indicate the range of views of parents and health professionals regarding maternity services (antenatal, delivery and postnatal). Since qualitative approaches do not measure, the findings are not statistically representative.

A content analysis approach was employed in order to ensure a consistent and robust approach to analysis. Researchers listened back to the audio recordings of their interviews, writing detailed notes, including quotes. Listening to tapes (rather than reading transcriptions) generates much richer detail in terms of the tone and temperature of the discussion.

Each researcher collates the findings in their notes under headings mirroring the question areas in the topic guide. The analysis process responds to respondent feedback: as new themes emerge, additional headings are included. The findings under each heading are assessed in terms of: frequency of mention, content, tone and emphasis. Key themes are drawn from the findings. This report draws together the findings, highlighting the key themes.

4. MANAGEMENT SUMMARY

The satisfaction curve was 'u' shaped. Across the 'seldom-heard' sample, satisfaction with antenatal care and postnatal care at home was consistently high. It was hospital care that was routinely the cause of most dissatisfaction, particularly postnatal care in hospital.

4.1 Expectations

- A majority of first time parents reported that they did not have expectations of maternity services. (Most – but not all - second time

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parents felt that they knew what to expect, based on previous experience).

- Two key assumptions were made about maternity services:

1. Service users (whether first or second time parents) expected *"to be treated well".* There were many examples of hospital experiences from across the 'seldom heard' sample where service users felt that this expectation had been disappointed. Not feeling that the service 'cared' was the major theme to emerge from this research.

1. An ongoing relationship with a midwife *throughout* the maternity journey was a consistent expectation across the 'seldom heard' audience, particularly amongst first-time parents. Typically, satisfaction was higher amongst those who felt that they had an ongoing relationship with a midwife and lower amongst those who did not.

- Overall, when service users were aware of what to expect from maternity services, satisfaction tended to increase. When not aware of what to expect, satisfaction tended to decrease.

- In future, maternity services should consider whether and how to manage service users' expectations. It will be particularly important to make service users aware of what to expect from hospital services during labour, birth and post-natal care, since this was currently the major source of dissatisfaction.
- For those new to the UK, the service has the opportunity to set expectations. For those born in the UK, services can start managing expectations at the first point-of-contact (currently the GP) and by improving attendance at antenatal classes.

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- Attendance at antenatal classes was low across the seldom-heard audiences, particularly amongst teenage, single, Pakistani/Bangladeshi and traveller groups, as well as mothers from large families e.g. Turkish and African. A minority who had attended antenatal classes felt that they had been a positive and useful experience.

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4.2 Satisfaction

Common factors influencing satisfaction across the seldom heard audience	
Common theme	**Audience specific requirements**
The need for maternity services to engage with groups of service users in a way that demonstrates an understanding of their cultural needs	In particular: • Becoming 'part of the family' for African parents-to-be; • Providing age appropriate care for teenage parents-to-be; • Offering single mothers-to-be a sense of recognition; • Demonstrating sensitivity to the cultural preferences of Bangladeshi and Pakistani parents-to-be; • Engaging with traveller mothers-to-be 'on their terms'.

The need for maternity services to communicate effectively with different groups of service users from across the seldom heard audience	In particular: • Generally improving clarity and direct style of communication preferred by Turkish, African Caribbean and African audiences; • Clear communication regarding choice for the African, Bangladeshi/Pakistani and African Caribbean audiences; • Maintaining an ongoing dialogue with those seeking a particularly close relationship with maternity services (teenage and single mothers-to-be). • Encouraging dialogue and offering reassurance to Somali parents-to-be; • Ensuring that Bangladeshi and Pakistani parents-to-be feel sufficiently informed; • Listening to the needs of parents-to-be with disabilities so they feel more in control.
The need for maternity services to engage more service users from seldom heard audiences with antenatal services (i.e. antenatal classes)	In particular: • Encouraging women with experience of child rearing to attend e.g. Turkish and African mothers-to-be; • Offering antenatal classes which will appeal to different groups e.g. 'mum only' (for single and teenage mothers-to-be) or 'women only' for (Pakistani/Bangladeshi mothers-to-be) or 'at home' (for traveller mothers-to-be).

The need for maternity services to offer practical support to enable seldom heard groups to engage with maternity services	In particular: • Offering single mothers-to-be convenient options for accessing services; • Links to wide-ranging social support for Turkish parents-to-be; • Improving clarity of communication between Turkish, French African and asylum seeker audiences, by involving interpreters where necessary.

- The commonly voiced desire for an ongoing relationship with a midwife was an expression of the wish to improve communication between those providing and using maternity services.

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- In order to fulfil expectations of improved communication without an ongoing relationship with a midwife, the service will need to synthesise a dialogue. This will involve linking different face-to-face interactions along the maternity services pathway, supported by written information.

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- Sensitivity to feeling 'judged' when using maternity services was a theme across the 'seldom heard' audiences. In this context, cultural misunderstandings could be taken to heart and negatively influence satisfaction. Whilst there were examples of cultural misunderstandings, on other occasions women seeking to explain poor experiences chose to suggest that the service had treated them unfairly, due to their cultural background. Health professionals acknowledged that tension between cultural beliefs and professional advice was likely to be a factor influencing satisfaction.

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- Currently, awareness and understanding of choice varied – particularly between first (less informed about health services) and second (more informed about health services) generations. Health professionals reported that expectations of choice are generally increasing.

- However, the full range of options need to be publicised for the benefit of the least informed amongst the 'seldom heard' groups - otherwise most assume that choices do not exist.

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- Overall, choice emerged as having the potential to increase satisfaction amongst seldom-heard audiences, particularly African and African Caribbean. Trusted relationships with health professionals encouraged service users to value choice.

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- If feeling unsupported regarding choice (i.e. if opportunities to make choices were communicated ineffectively or choices made were not perceived to be respected) the ability to make choices tended to become less meaningful.

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- In future, expectations about choice need to be managed in order to avoid conflict and disappointment (and therefore the suspicion that being offered choice is not meaningful).

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- Choice needs to be communicated effectively by promoting opportunities to make choices, as well as defining the limits of patient choice (i.e. when patient choices may or may not be available or when choices were clinical, rather than patient choices).

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- Ultimately, a majority felt that satisfaction was more likely to grow from being treated with dignity and respect, rather than being offered choice.

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5. MAIN FINDINGS – SERVICE USERS

A qualitative assessment of satisfaction has been derived from a comparison of expectations of maternity services and experiences of maternity services.

- Section 5.1 describes overall expectations of maternity services for the sample as a whole;
- Section 5.2 describes the key experiences which influenced satisfaction with maternity services for each 'seldom heard' group;
- Section 5.3 draws together the key experiences which influenced satisfaction for the sample as a whole.

5.1 Expectations

5.1.1 Expectations

Across the sample, first-time parents consistently reported that they did not have expectations of maternity services. It was clear that this group simply did not know what to expect, and that their expectations of maternity services were therefore largely 'unformed':

"Because I was quite young, I didn't know what I could have or what to expect." (Teenage mother)

"We just went in there, we didn't know what to expect. We knew nothing at this point." (Bangladeshi father)

"It's my first time so I didn't know what I was supposed to do." (Pakistani mother)

"I didn't really expect anything because I did not know what was going to happen or what could happen." (Traveller mother)

"I felt really emotional when I found out. I was happy about it, but because it wasn't planned it was a very daunting thought and I just didn't know what to expect." (Mother with a disability)

In the absence of knowing what to do, many expected to be 'told':

"I did not really know anything. It's all really new. You are not really thinking, 'am I entitled to this?' Whatever they did I just assumed was right." (Single mother)

"I expected the midwife to tell me what to expect because I'd never been pregnant before." (African mother)

"I didn't know. I didn't really have many expectations. I just thought they'd do their job." (Pakistani father)

A majority of second time parents tended to feel that they knew what to expect from maternity services, based on previous experience:

"As I'd had a baby before I knew what to expect. The same questions were asked and the same things happened at the scans." (Traveller mother)

"I think pretty much you just get on with it." (Turkish mother)

"It's our second child, so we didn't really get that into it [written information received]." (French African mother)

However, a minority of second-time mothers were keen to point out that the experience of a second child is not the same as the first:

"I really wanted to go to antenatal classes. It had been five years since my last baby and I wanted to go to classes. I was at a different hospital with my

son and I wanted to find out how things are different here." (Mother with a disability)

"I was more inclined to go [to antenatal classes] this time because it was my second child. When it's your first child, the pregnancy just hits you." (Pakistani mother)

"I felt that their [the midwives'] attitude was different with my second pregnancy. They assumed – wrongly – that I would know what to do." (Pakistani mother)

Typically, fathers-to-be had expectations on behalf of their female partners, rather than expectations of their own experience. There was a spectrum of involvement, from the most engaged with maternity services (for example, African and French African) and the least involved (teenage, first-generation Pakistani and traveller). In fact, a lack of involvement was considered appropriate for traveller fathers:

"Partners don't really get that much involved. Women just have to get on with it. They are there, but if you have any worries, you go to your friends or family to help you out … you just have to crack on with the baby and do what you need to do." (Traveller mother)

The point at which fathers tended to become involved in the journey was labour and birth. For example, some traveller fathers were present at the hospital, but not necessarily at the birth itself. A lack of awareness regarding what to expect during labour and birth contributed to dissatisfaction (as discussed in section 5.1.3 and 5.1.4).

5.1.2 Common assumptions

In the absence of specific expectations, first-time parents across the sample made two broad assumptions:

1. **The first assumption was that they would be 'treated well' when using maternity services. Second-time parents also shared this assumption. By being 'treated well', parents meant being cared for as a person and with dignity and respect. Expressed below are examples of what is perceived as not being treated well (all of which refer to hospital experiences):**

   *"I know that everyone can't be all smiling and cheery every time they go to work, but in that profession you have to have **a bit more courtesy**." (Turkish mother)*

   *"They were really horrible some of them. If you were screaming or crying they would **tell you to be quiet**. There wasn't much support. It's not an easy thing giving birth. I think the staff should **be more friendly**." (French Caribbean mother)*

   *"The thing that would have made all the difference is if people had been **a bit nicer** ... Having the baby is the main event, so **you want everyone to treat you well** so you don't have to worry. That's the place where there needs to be the most improvement." (Single mother)*

   *"The midwives on the labour ward are not that nice. They just want to get the baby out. **They don't even ask you how you are feeling**." (African mother)*

   *"**They were proper rude**. I felt like crying [after allegedly being told to 'pull herself together and stop moaning']." (Teenage mother)*

*"I think the **staff need to treat people how they would like to be treated and not like a number** … You can't just do the health thing and forget about the people." (Bangladeshi mother)*

*"I would like midwives to be more concerned about their patients. They are always so busy and they don't spend enough time on the ward looking after the babies and the new mothers … I think they should either employ more or talk to the ones they have to change their attitude. When you have just had a baby your mind is not 100% and you need more care. **They should be more concerned about you**." (Mother with a disability)*

The most critical comments were from those who felt physically neglected (as opposed to emotionally neglected) during their time in hospital:

"Personally I think it was disgusting how the midwives were treating her … I found two asleep in a room. I wanted them to see my girlfriend because she was in the bed covered in blood and poo and stuff." (Teenage father)

"In one bathroom there was only hot water, and when we went to another bathroom there was only cold water … That's just a basic thing. And I was pouring with blood … and I was calling the midwife and she wasn't coming and the water was cold so I couldn't get in the bath." (Turkish, teenage mother)

"The next day I was still bleeding. It didn't want me to get up and they wouldn't tell me why. My mother-in-law came down and threatened to take them to court and that is when everyone came down and started to explain what had happened and that I had lost a lot of blood and it was really very serious. They had had to give me two bags of blood. But if she hadn't been there I don't know what would have happened." (Caribbean mother)

2. **The second assumption, based on hope rather than expectation, was that they would have an ongoing relationship with a midwife throughout the experience:**

"I didn't expect to see so many midwives. I would have really liked to have had one midwife that I could have built a relationship with, rather than seeing different faces all the time … Because I had different midwives, it's difficult talking about what's going on with your body." (Single mother)

"It would have been nice to have her [the midwife] all the way through, because you build a relationship. She had been with me a long time and it would have been nice to have her right through [the labour]." (Traveller mother)

"I read lots of magazines that said I would have one midwife, or at least one that you will see regularly. But it's not like that at all." (Teenage, African mother)

"I just assumed that the midwife would be there. I mean, she's the one that knows you." (Teenage mother)

"We were really struggling throughout … If we had a midwife she would have explained everything. That is what I was told by a friend. But in reality I was struggling at every step." (Bangladeshi father)

The role of service users and maternity services were consistently characterised by all across the sample (whether first or second time parents): maternity services were perceived as the source of guidance and reassurance; and women were perceived themselves as those seeking guidance and reassurance.

5.1.3 Managing expectations

The role of service users and maternity services were consistently characterised by all across the sample (whether first or second time parents): maternity services were perceived as the source of guidance and reassurance; and women were perceived themselves as those seeking guidance and reassurance.

When service users across the sample were told what to expect from antenatal services by health professionals (typically midwives or GPs), outcomes tended to be more satisfactory:

"It's daunting, like homework. But during the pregnancy I knew what was going to happen because I got it [lots of information] so early." (Single mother)

"She [the GP] told me how everything would work from now on. I didn't expect so much information on the first day, so that was good." (Bangladeshi mother)

"My doctor explained who a midwife is, what they do and how they will help. She told me about the different scans and the tests I would have. She told me about all the important things … the midwives really made an effort and explained things slowly and made sure I understood. They were very patient with me." (Pakistani mother)

"I was very lucky to have the same midwife. It makes a big difference because she knows you from the start and understands your history … I used to get so happy to meet her every time and so was she … She knew me well and knew what I was going through and explained the changes that were happening to me and my baby so nicely. I don't think you can get the same quality of care if you are seeing different midwives." (Pakistani mother)

In transactional analysis[4], parents would be described as engaging with services in their 'child' alter ego state. The response from maternity services was expected to be as a 'parent'. If maternity services failed to respond as a 'parent' – i.e. guiding and caring - first-time parents often felt disappointed.

Consequently, when not told what to expect, satisfaction tended to decrease:

"My whole pregnancy is like a blur to me. It just sort of happened, and I didn't know what to expect, with any of it." (Teenage mother)

"The nurse was really snotty with me [because she missed the doctor]. I have been going to the hospital [to visit her baby in SCBU] every day for the last six weeks and nobody has ever told me about doctors' rounds." (Mother with a disability)

"We didn't have a midwife because the hospital was dealing with it [pregnant with twins], so we felt lost. We didn't have a midwife. Every time we called they said, 'go to emergency'." (Bangladeshi father)

In future, maternity services should consider whether and how they could manage service users' expectations. To manage expectations, services will need to communicate clearly what parents-to-be can and cannot expect from maternity services.

5.1.4 Verbal communication

Health professionals consistently were regarded as the 'official' source of information during the maternity service journey. As discussed in section 5.1.1 and 5.1.3, there was a strong preference for being told what to expect by health professionals, by fathers as well as mothers:

[4] Transactional analysis is a social psychology developed by Eric Berne, MD (d.1970). Over the past four decades Eric Berne's theory has evolved to include applications to psychotherapy, counselling, education, and organizational development. For more information, please refer to http://itaa-net.org/

"We did not have anyone to sit down with us properly, so it would have been nice to have someone tell us what was going on and what was to be expected because I didn't know whether I was coming or going." (Turkish father)
"I thought we would be told what will happen in the rest of the pregnancy." (Pakistani father)
A minority of service users from seldom heard audiences (and particularly the African and African Caribbean audience) expressed their frustration about not being clearly told what to expect: *"They [maternity services] just constantly say that 'everything will be fine'. You need reality checks along the way." (French African mother) "All I got from the midwife was, 'don't worry, everything will be fine'. They should really talk about the reality of labour and birth instead of all the fluff they say." (Turkish mother) "Your friends kind of tell you like it is. With the NHS they have to stick to their kind of protocol. I prefer people that keep it real." (Caribbean mother) "I think it could have been explained a bit more what was happening. You were just told the bottom line, you were not told the implications and that sort of stuff." (Caribbean father)* This group of women wanted to be engaged in an 'adult to adult' conversation which they felt had been lacking from their experience.

Overall, the seldom heard audience was looking for maternity services to adopt a parental advising/guiding role, but communicate in an 'adult-to-adult' tone.

5.1.5 Written communication

The various written resources provided by health professionals were often mentioned and very much valued as a source of information. As well as regular recall of the bounty pack and The Pregnancy Book, a range of other resources mentioned included: Emma's Diary, Birth to Five, a well woman pack, a filofax style resource about benefits, even a CD about breast feeding and a DVD:

"The diary was very useful. It really helped me throughout. This was my first pregnancy and I didn't know what to expect. I would read the diary if I wasn't sure about something or if there was a change in my body that I didn't understand. It explained about what changes I could expect and prepared me for it." (Pakistani mother)

"The pregnancy book is really detailed and quite compact." (African mother)

"I read the pregnancy book and then if I was still concerned I'd ask the midwife." (Somali mother)

"I still look at it [the pregnancy book] now. I find it quite useful, because there is information in there about diet and the baby's development." (Caribbean mother)

"They do offer you a lot of information. It is up to you whether you want to take it. I took it all!" (Turkish, single mother)

"It [postnatal bounty pack] had everything you need to know and everything you need to get started." (Single mother)

A small minority complained that they had not received enough written information from health professionals:

"My sister was given a booklet from her midwife which had pictures and showed the changes that will take place every week. It showed how the baby will grow and what changes happen in the body. I didn't get anything like that from my midwife." (Pakistani mother)

"They never told me anything when I went for the scans or the test. All they said was, 'here are your results'. So I thought, what is the point of seeing

them if they are not going to tell me anything. I decided to manage on my own." (Pakistani mother)

Whilst 'official' communication with health professionals and 'official' information provided by health professionals were well regarded and valued, word-of-mouth advice from family and friends was often more influential:

"If I did need some kind of additional support I would contact my parents and talk to them, rather than some random stranger." (Caribbean father)

"They [family] are like a rock to us." (Turkish father)

"I know I shouldn't focus on that [a story about a friend's sister giving birth in a hospital toilet] but that was a close friend's sister so you know it's not made up." (Turkish mother)

"My mum knows absolutely everything." (Single mother)

"It's an extended family – and a very close family." (African mother)

Overall, the 'seldom heard' sample was likely to rely on verbal and written communication from health professionals and verbal communication from their friends and family.

5.1.6 Antenatal classes

Across the 'seldom heard' sample, the most unsatisfactory part of the maternity services journey was consistent: labour, birth and post-natal care in hospital. It emerged that many did not know what to expect from the hospital experience, mainly because many had not sought out information about how services support labour and birth services nor attended antenatal classes:

"I didn't like it that we did not go over my birth plan with the midwife because after I had my baby they were asking me questions but I didn't know what they meant. This should have been discussed with me before I gave birth." (African mother)

I think it is really wrong that you are rushed out of hospital. I mean, you have just had a baby and you can't even get up because you are so weak." (Single mother)

Labour and birth was typically attended by fathers, who also reported that they did not know what to expect:

"I didn't know. I didn't really have much expectations. I just expected it to be straightforward. I just thought they'd do their job." (Pakistani father)

"You expect that someone will stay with you the whole time [during labour] just in case of anything … but no one did. We were anxious and I was a little bit scared really." (Turkish father)

Many from across 'seldom heard' sample reported that they had not attended antenatal classes. There were a range of reasons why:

- **Most single mothers and some teenage mothers had not attended antenatal classes for fear of feeling 'judged':**

  "I was going to get up and leave … but I'm so glad I stayed because now I know what I want and what I don't want. You have all these weird thoughts and now I realise I was being a drama queen!" (Single mother)
  "I didn't really want to go to the groups on my own. I just thought, what is everyone going to think of me?" (Single mother)

"It felt like 'I am the young one'. I thought, 'oh my gosh, everyone here is over 30!" (African, teenage mother)

"I didn't want to know what was going to happen." (Teenage mother)

- **Many Bangladeshi and Pakistani respondents claimed that they felt antenatal classes were either unnecessary (due to the antenatal care already being provided) or inconvenient.** Only a minority articulated their view that 'mixed sex' antenatal classes were off-putting, a view substantiated by an evaluation of the Parenting, Birth and Beyond antenatal education programme conducted by Research Works Limited on behalf of Department of Health. This study found that for the Pakistani community, pregnancy was considered a private matter (for example, mothers reported being expected to 'hide' their bumps in public and fathers did not want to see another woman's bump). For both the Pakistani and Bangladeshi audiences, strong private support networks could become a barrier to using formal 'public' services.

- **Traveller mothers also tended to claim that they had been too busy to attend antenatal classes.** Most worked late into their pregnancies. Some also found that travelling schedules made attending community based antenatal classes inconvenient. Traveller mothers were also more likely to take advice from people within their community: *"I went to my mum for what to do because she has six children."*

- **Often, women from large families (e.g. Turkish and African) felt that they already had sufficient experience of child rearing and that antenatal classes would therefore have little to offer:**

"I have a little brother and sister and my sister had babies when I was 15. I know the basics like bathing and making a bottle and because I live with my aunt I have lots of help." (Turkish, teenage mother)

"For me, sitting with others, they will just give me their own experience. But every child is different." (French African father)
"My sisters all had babies and I was always looking after them." (French African mother)

Antenatal classes offer an opportunity to start managing expectations. The minority who had attended antenatal classes felt that it had been a positive and informative experience:

"I found that [the antenatal classes] useful. We could talk about being a first time dad … a guy had a few kids and spoke about the birth and what we were to expect." (African father)

" … run a bit more efficiently and they would have been great, but I'm glad I went to them." (African mother)

"They [the classes] were fun and informative." (African mother)

"They were great. Everything they taught me stuck with me." (African Caribbean mother)

"I thought they were brilliant. They gave you so much information that I didn't know. Things I thought I knew, but didn't … I've already got a friend who is pregnant and I have told her she has to go to the antenatal classes." (Single, teenage mother, who attended with a friend)

A small minority acknowledged that they had missed a useful opportunity which would have assisted them during labour:

"I had my legs wide open and everyone was shouting at me because I was refusing to push because my mum wasn't there and I didn't know how to push because I didn't go to antenatal classes." (Teenage mother)

"I didn't know how to breathe when I was in labour and I wished I had gone to those classes." (Traveller mother)

"With my first pregnancy I didn't go to antenatal classes because nobody told me about it and also I didn't understand why they were important. I wish I had gone because I would have dealt better with my labour. I didn't go to the class because I didn't know what the class was for." (Pakistani mother)

In future, maternity services should consider how to improve attendance at antenatal classes. Antenatal classes tailored to specific audiences (e.g. single mothers, teenage mothers and women-only groups) were often suggested:

"You feel quite lonely anyway, so I wish they would just bear in mind that some of us are single mothers." (African Caribbean, single mother)

"I would have liked classes for young mums. I just felt like a little girl having a baby. A lot of people think, 'what are you doing with your life?' and they judge you." (Turkish, teenage mother)

5.2 Satisfaction

Overall, the satisfaction curve was 'u' shaped. Across the 'seldom-heard' sample, satisfaction with antenatal care and post-natal care at home tended to be high:

Antenatal:

"When you have your first child and you have two people entering something new, when someone [GP] gives you advice, it really lifts you up." (French African father)

"My midwife told me a lot during our [antenatal] appointments. She was really helpful." (Somali mother)

"She got a lot of support from her midwife before the baby was born." (Teenage father)

"The midwives were brilliant, the staff were fine, apart from the c-section experience." (Mother with a disability)

"I was pretty happy with the [antenatal] service. There was lots of support. I can't say I have any complaints really." (Single mother)

"The staff and midwives at the surgery are more friendly and helpful. I would prefer them any day to the ones at the hospital. The ones at the hospital look as if they are ready to fight with you. They are all so aggressive that it makes you feel so terrified." (Pakistani mother)

Postnatal:

"She [the health visitor] has been great at checking up on us." (African Caribbean mother)

"She [the health visitor] was very different from the hospital staff. She had all the time in the world for me." (Turkish mother)

"The breast feeding support really helped. If I hadn't had that, I wouldn't be as satisfied as I am now." (African mother)

"I feel that the midwives were OK, but the health visitor is in a different league. They have given me so much information. They seem to understand what I am feeling and I feel so much more confident to ask them questions. I didn't have this relationship with my midwives." (Bangladeshi mother)

"That was nice having the health visitor come around, checking the baby and weighing him to make sure he was all right." (Traveller mother)

"At home they answered our questions. They weren't rushed and they advised more about breastfeeding. It was more reassuring." (African father)

It was hospital care that was the cause of most dissatisfaction, particularly post-natal care in hospital (as described in section 5.1.2).

5.2.1 African parents

This group included those from both first and second generations from a range of African countries. There was a mix of both first and second time parents aged between 19 and 38 years old, who were either with a partner or married. Both students and those currently on maternity leave were included. The key themes to emerge from a thematic analysis of the experiences of African parents were:

1. Becoming 'part of the family'

   All valued the familial (and church-group) support and information they received during pregnancy and new parenthood. If services were not perceived to be part contributing to this positive support and information network, experience of maternity services could prove

disappointing: *"My family and friends were doing what I expected from the NHS [providing information during pregnancy]." "I had to learn things on my own. I wish I had had that support system there."*

African parents-to-be were keen to engage with services and expected services to engage with them – positively. Experience of maternity services was variable: some felt that services had engaged with them as individuals experiencing a positive life event, others did not. When services engaged with enthusiasm, satisfaction tended to increase: "*She was like my sister, part of the family."* When services did not engage with enthusiasm, satisfaction tended to decrease: *"As a young mum [20 years old], people look at you as if you should be sad that this is happening to you. Why?"*

Overall, the positive style of engagement preferred was considered most likely to be delivered by an ongoing relationship with a health professional throughout the pregnancy journey.

2. <u>Choice</u>

African parents-to-be tended to see themselves as 'customers' of the service: *"[Post-natal care]: It's like the support after you buy a product."*

When choices were communicated well, satisfaction tended to increase: *"I definitely valued the choices. If things had been normal then I would have had my water birth."* When choices were communicated poorly, satisfaction tended to decrease: *"She [the midwife] said it like hospital birth was the only option. It wasn't until later on [30 weeks] that I found out about the other ways."*

Choice was typically well received by African parents-to-be, who felt that choice – if clearly communicated by a health professional - had the potential to improve their future experience of maternity services.

5.2.2 Teenage parents

This group comprised first time and parents aged between 16 and 19. They were mainly single and included students, those who were unemployed and those who were on maternity leave from their jobs. The key themes to emerge from a thematic analysis of the experiences of teenage parents were:

1. Age-appropriate care

Teenage mothers wished to be treated in an age-appropriate manner.

When teenage mothers felt that their age had been taken into account (in terms of the way in which they were treated) satisfaction tended to increase: *"I like the service because they gave you a lot of advice, help and information about how you would be feeling."* When teenage mothers felt that their age had not been taken into account, satisfaction tended to decrease: *"They weren't patient at all and they were not considerate of our age." "It's like they expected only women who had had 5 children and knew what they were doing to be coming in to hospital."*

In future, being treated in an age appropriate manner was felt to involve:

- **Providing close attention:** *"They left me on the ward, screaming."*
- **Involving the family support network:** *"My mum had to leave just because of their stupid visiting hours. They kept saying, come on, it's your baby. You have to look after it now. It was really scary."*
- **Being perceived to respect opinions and choices:** *"I didn't feel*

like they were paying any attention to what I was saying."

2. Ongoing relationships

Overall, teenage mothers wanted to have a close relationship with services.

When this preference was met, satisfaction tended to increase: *"I was happy that I got one midwife because it really helped me with what to expect."* When this preference was not met, satisfaction tended to decrease: *"I would have preferred to have the midwife who was supporting me to be there. It was too busy and too many mothers to attend to."*

Consequently, those who had used services designed for younger mothers were the most satisfied amongst this audience. There were several good examples of services tailored to teenagers which had successfully engaged this audience: *"You talk about how you are doing and they give you lots of advice. It was really supportive with education and finding colleges and stuff. It's been really good and you get to meet other girls who have had babies as well." "I didn't feel I was being looked down upon by the midwives, but there were a lot of older women there [antenatal appointments in hospital] and I wondered if they felt I was too young and shouldn't be having a baby … maybe it was all in my mind, but I just didn't feel comfortable and this place [for younger mothers] was another way for me to feel comfortable..."*

5.2.3 Single parents

This group were all separated from the fathers of their babies. All were in their 20's and included both first or second time parents. Most were

unemployed. The key themes to emerge from a thematic analysis of the experiences of single parents were:

1. Convenience

Overall, single parents-to-be aspired to a service which would actively support them to look after their baby by themselves. For single parents coping by themselves with pregnancy and new born babies, convenient options made a big difference.
Currently, experience of maternity services was variable.

Inconvenience had contributed to dissatisfaction: e.g. having to pay for parking, paying for scan pictures, having to go to different clinics for different things, having to wait for midwives: *"It's really annoying [to have to go to different clinics]. I can't see why the same doctor who is weighing him can't check his eyes too."*

In future, antenatal and postnatal maternity services should consider how convenience could contribute to satisfaction. For example, visits from the Health Visitor were not only convenient (in one's own home), but also provided the personal style of care which single women valued.

2. Recognition

As a group, single parents were particularly sensitive to not feeling recognised as in need of support.

Currently, there were many occasions when single parents reported feeling overlooked, or at worst, neglected. If not recognised by services, satisfaction tended to decrease: *"I asked someone to look at him because I thought he was going blue and she said, 'who are you?'*

"I've taken the time to make an appointment. The least they can do is not rush about like I'm an inconvenience." "I felt neglected. It was awful. I was all alone and it felt like no one was there." "They thought I was making it up. When they finally checked me in the morning I was 8 centimetres. I pressed the button and no one came. All night … no one came."

In future, successful face-to-face communication was identified as a way of increasing satisfaction amongst this audience.

3. Ongoing relationships

As a group, single parents aspired to a more 'intimate' relationship with services. Relationships were perceived to be a key element of a successful service experience.

There were many occasions when single parents reported that they felt the service had been 'impersonal': *"It was too impersonal. It made me feel that no one really knew me. They only knew me from a computer screen. I had to keep repeating myself." "They see people having babies all the time. They don't look at it as being as hard as it is for each mother. They just treat everyone the same. But everyone has different problems."* When supported by a relationship with a health professional, satisfaction tended to increase: *"At last, some one [the health visitor] seemed to care."*

In future, single parents felt that an ongoing relationship with a health professional throughout the maternity journey was the most likely to deliver the personal service they desired.

5.2.4 Bangladeshi/Pakistani parents

Clear attitudinal differences emerged between those born in the UK and those born in Bangladesh or Pakistan. Those born in Bangladesh or Pakistan tended to be more satisfied with NHS services, based on feeling 'grateful' for what they received. This group were much less likely to challenge health professionals:

"I'm grateful for the NHS. Where I come from, people don't have the NHS and they don't have the help we have." (Bangladeshi mother)

"I had heard about services in this country. I knew that they would look after me well. They really care a lot in this country." (Pakistani mother)

Those born in the UK were much more confident (both in terms of language and willingness to challenge health professionals). This greater sense of confidence stemmed from a greater awareness of what they could expect from maternity services.

In future, maternity services should consider how to communicate to non British born Bangladeshi and Pakistani parents what services are available to them. For example, the term 'antenatal class' was not universally understood: *"I didn't know what antenatal classes were. I thought that antenatal classes and the antenatal clinic were the same thing. It was our first baby so we didn't know about these things." "My midwife gave me a leaflet about antenatal classes. I thought that this meant the clinic in the hospital where you go for blood tests. I had no idea about classes, so didn't really think twice about it."*

Pakistani and Bangladeshi respondents were a mix of first and second generation, first and second time parents and were aged between 19 and 36. They were either married or with a partner and the majority were on

maternity leave. The key themes to emerge from a thematic analysis of the experiences of Bangladeshi and Pakistani parents were:

1. Appetite for information

Bangladeshi and Pakistani parents-to-be tended to be information-hungry.

When information was forthcoming, satisfaction tended to increase: *"It's good to know everything so that you can do your own research." "I found out what the offered online so that I knew what was available to me."* If there was a perception that insufficient information had been provided, satisfaction tended to decrease: *"They are not very good about giving you information. They think you should know or that you shouldn't even ask!" "I was so disappointed after my first visit because I was expecting my midwife to give me a lot of information about my health, diet and what I should do during my pregnancy. My husband even took the day off for the appointment. It was such a waste of time."*

In future, maternity services should consider how to improve their dialogue with Bangladeshi and Pakistani women. Proactively initiating conversations is likely to discourage Muslim women from making negative assumptions about maternity services. For example, there were several who accused maternity services of not expecting them to speak English. This perception was based on a belief that services would make judgements about women wearing the hijab: *"I have a huge issue with my birth … because of the way I look they assume I can't speak English." (Pakistani mother)*

2. Choice

Overall, Bangladeshi and Pakistani service users were also keen to make choices and wanted to feel adequately supported to make these choices. A feeling that one's choices were not being supported could become a cause

of frustration: *"They say you can take this and that but they don't actually give you an explanation as to what the advantages and disadvantages are."* At best, being offered choice was empowering: *"It was really good to have the choice. I think every woman should be given the choice because then they will be satisfied with the outcome." "It was up to me whether I wanted to go home that night or stay overnight, just to get a bit of rest. I think that was much better."*

In future, maternity services should consider ways of managing expectations about choice. Preparing for the types of choices service users may want to make is likely to prevent serious clashes at critical times: *"I was given the third degree for making that decision [not to have stitches] … they said you're probably going to bleed and die!" "I was told my child would die unless they used forceps … and I actually said, 'let it die', I was so angry at them'.*

3. Cultural sensitivity

Whilst Pakistani and Bangladeshi service users did not want services to make assumptions about them, they hoped that services would demonstrate cultural sensitivity, particularly regarding gender.

For example, whilst the option to discuss abortion was appreciated, it was pointed out that this is a difficult conversation to have with a male GP: *"You can almost feel the chauvinism."* For example, male partners from certain communities (e.g. Pakistani, Bangladeshi and French African) may not want to become involved in more intimate issues: *"He felt obliged to [cut the cord] … he wanted to stay at my head. They just handed him the scissors expecting he'd want to do it." (Bangladeshi mother)*

Although reticence to engage with men delivering services was not an overt driver of dissatisfaction, there was evidence that the option to access what were understood to be culturally 'approved' services (e.g. women-only

antenatal classes or services delivered at Children's Centres) would be likely to increase engagement with maternity services in future.

5.2.5 Traveller parents

This group included those who were either married, living with their partners or separated and included both first and second time parents, as well as those who were unemployed or on maternity leave. The key theme to emerge from a thematic analysis of the experiences of traveller parents was:

1. Engagement on 'our terms'

Overall, traveller parents very much wanted their interaction with maternity services to be on their own terms.

Satisfaction tended to increase when services respected women's decisions, particularly in relation to breastfeeding: *"She never made me feel like I had to breastfeed. I didn't want to feel that I'd be a failure if I couldn't do it."* Satisfaction tended to decrease if health professionals were perceived to be pursuing their own agenda: *"They make you feel like you are making the wrong choice. But at the end of the day, it is your choice [whether or not to breastfeed]. They should tell you the pros and cons, they shouldn't be making you feel like you are a terrible person and not doing the best for your baby." "Women have been having babies for centuries, so what's the big deal? I was lead to believe I had broken every rule in the book [by presenting at 6 months pregnant]."*

In future, services should consider how to provide acceptable 'medical' advice and support for new mums, whilst respecting strongly held views about pregnancy and childrearing.

Engagement 'on our terms' is likely to involve contact via statutory appointments (e.g. checks and scans), with little additional contact. Traveller mothers-to-be reported that they were unlikely to attend antenatal classes: *"We were working in the burger bar. We didn't have time to go to antenatal classes."* There was little appetite for more engagement with services, which women from traveller communities did not feel was necessary.

If services wish to encourage traveller women to engage with maternity services to a greater extent, out-reach work is likely to be required. Traveller women explained that they were much more comfortable and relaxed in their own homes: *"I wanted to do a dance when it was finished! You kind of put yourself in their hands really. It's nice to have your body back afterwards." "Communication at home was better because it was a more relaxed atmosphere."*

Alternatively, maternity services could continue to provide written information to read at home, which was typically well-received: "*That was nice because you could look at it and see how far gone you are and what the baby is like at that stage. I liked that book [Emma's diary]. And it has got stuff in it you can look at now as well."*

5.2.6 Disabled parents

This group all described themselves as having either a physical or mental impairment and were aged between 26 and 42. They included a mix of first and second time parents who were either single, married, cohabiting or with a partner. The key themes to emerge from a thematic analysis of the experiences of disabled parents were:

1. Individual needs

Disabled parents' experience of pregnancy and birth tended to have been complicated physical impairments and mental health issues.

Satisfaction tended to decrease when maternity services did not demonstrate an understanding of individual circumstances and failed to plan around individuals' needs: *"When I said it was my second baby, they said they only bath first babies and that I would have to do it myself. I was really sad because I was in a lot of pain [post-Caesarean] and couldn't bath my baby. I explained to my physio … and she said that they had to help me because of my condition [arthritis]." "They were unsympathetic and unhelpful. I had to literally beg for pain relief. The pre-eclampsia is painful and then I had the Caesarean and I was in a lot of pain with that too. They would say 'oh we're too busy, or we have to get the keys. It could be three or four hours by the time I got any."*

Satisfaction tended to increase when maternity services demonstrated that they understood that they understood the individual's circumstances. For example, one service arranged cabs to collect and return home a Somali mother to be with MS. By contrast, in another case, a new single mother with depression and post-Caesarian was concerned about coping at home with a new baby whilst caring for her father who has very limited mobility.

Overall, disabled parents wanted maternity services to appreciate that their disabilities had an impact on their individual needs during pregnancy, labour and birth. In future, maternity services should consider how women with disabilities can be encouraged to feel more in control by planning around their individual needs.

2. Listening

The way in which women with disabilities felt that services should arrive at an understanding of their needs was by listening.

Currently, dissatisfaction was being driven by a feeling of not being heard: *"I asked one of the other women on the ward, why is no one coming to attend to me? I am in pain and I need my pad changing and my baby needs feeding but I cannot reach her. I need help, what do I do?" "I was just in so much pain and no one was listening." "One midwife didn't listen to me when I was telling her that I wasn't feeling right. This was up until the last day, before I had my C-section."*

In future, maternity services should consider how listening may enable them to learn how to satisfy individual needs.

5.2.7 African Caribbean parents

This group included a mix of first and second generation, were all first time parents and were aged between 25 and 31. They were either working part time, self-employed or on maternity leave and were either single, with a partner or separated. The key themes to emerge from a thematic analysis of the experiences of African Caribbean parents-to-be were:

1. Clear communication

Overall, African Caribbean parents expected maternity services to communicate clearly with service users.

When communication was successful (i.e. when individuals understood and were comfortable with what was and would be happening to them), satisfaction tended to increase: *"She brought in leaflets, she clarified everything that I did not know. She was excellent." "They were really*

reassuring and I did feel that they kept me informed. I really felt that they cared about me and how I felt." When communication failed, satisfaction tended to decrease: *"It took forever to get an appointment [for liver tests]. They wouldn't listen and just kept hanging up the phone. It was like a knife. It wasn't until I started bleeding that they realised it was for real. It shouldn't get to that point."*

In future, African Caribbean respondents felt that clear communication would be facilitated by a consistent reference point (e.g. an ongoing relationship with a midwife): *"If you have a good midwife it can really change your whole experience."*

2. Choice

Choice was very much appreciated by African Caribbean parents-to-be.

Making choices was generally perceived as empowering and had the potential to increase satisfaction: *"I was really pleased when I got the letter saying that they had accepted me, even though I was out of their area."* Other examples of choices made included respondents who chose to have a 3D scan (privately) and to change midwives. Not being offered choice did not cause dissatisfaction, but offering choices had the potential to increase satisfaction in future: *"Being able to choose the hospital would have boosted the whole experience for me."*

In future, a positive relationship between maternity services and African Caribbean parents could commence with the presentation of a choice of hospitals.

5.2.8 Turkish parents

This group included a mix of first and second generations from Turkey and Cyprus. Their ages ranged between 17 and 35 and included a mix of first and second time parents. They were either unemployed or on maternity leave and either married, in a relationship, single or separated. The key themes to emerge from a thematic analysis of the experiences of Turkish parents were:

1. Wider support needs

Turkish parents-to-be interviewed for this study had complicated circumstances including: housing problems, those seeking asylum, unemployment, difficult pregnancies and poor English.

When feeling supported with their personal situation, satisfaction tended to increase. For example, one teenage mum had an ongoing relationship with her midwife who had supported her to find housing: "*They have been really supportive. I was talking to my friend the other day and she said she felt really supported as well. At the antenatal classes, everyone got on really well and everyone was acting as if the midwives were their friend … They just made you feel really comfortable. They get you into practical work and I just feel they have been very good.*" Another teenage mother had a midwife who offered to speak to her father who was unhappy about her pregnancy.

In future, maternity services should demonstrate understanding of the range of issues the Turkish audience face and consider how to provide links to other sources of support.

2. Clear communication

Currently, service users felt that communication between themselves and maternity services was often poor.

Poor communication (particularly when individuals did not understood and nor felt comfortable with what was and would be happening to them), tended to encourage a perception that services lacked empathy and, as a result, satisfaction tended to decrease: *"She did not really explain anything. I didn't know what she was doing [20 week scan]." "All she said was, don't worry, everything will be fine. They should talk about the reality of labour and birth instead of all the fluff they say. They could have said 'your baby is in a weird position and you may experience this or that …"*

On several occasions, conversations had become antagonistic and dissatisfaction tended to increase: *"One actually shouted at me saying 'What do you expect from a student midwife?" "She [the midwife] said 'it does hurt, no one said it wouldn't hurt'. She was so rude. A lot of them had no patience saying things like 'you are going to have to deal with this for the next 18 years, so stop complaining.'" "I felt very uncomfortable, lying there in all that blood. They didn't come, so my husband and mum changed the sheets, but they were rude and complained about it."*

In future, services should consider how to initiate conversations with Turkish parents-to-be. For example, a number of service users reported that they did not feel that choices had been presented as choices: *"You can give people choices, but with a rude attitude, what's the point of that?"*

5.2.9 French African parents

The French speaking African group included a mix of first and second time parents aged between 26 and 34. All were on maternity leave and they were either married, single or had a partner. The key themes to emerge from a thematic analysis of the experiences of French African parents were:

1. Engagement

Some new French African mothers had struggled to cope with a new born baby away from their family support networks: *"I was very tired. I found it very hard. I didn't know what to do. But I am very happy I had him. I had family over who came to help me, but it's not easy." "My mum is not alive and I have no one to support me, so it was really nice. The midwives were lovely."*

Those with positive relationships with their midwives and those who were encouraged to attend antenatal classes felt more prepared for parenting and satisfaction with maternity services tended to increase: *"I felt active and strong." "I was satisfied with the way they were and all the advice. It was really encouraging."* For those without ongoing relationships, satisfaction with maternity services tended to decrease: *"The health visitor only came once and she could see I wasn't OK because I started crying. She asked me how I was feeling and I told her I felt depressed and she didn't come again. She told me they are very busy, so next time I had to go to the drop in. She didn't call again to see if I was OK, and I wasn't OK."*

In future, maternity services should consider how to encourage French African parents-to-be to engage with antenatal services. For example, French African parents-to-be typically did not expect antenatal classes to be useful to them, given that they tended to have considerable experience of child rearing.

2. Clear communication

English language skills were limited for some amongst this group.

Ongoing relationships with midwives had encouraged service users to ask for clarification when needed, which increased satisfaction: *"You may have gone*

to school and learned English, but a lot of the technical stuff you only know in French." A direct style of communication was also preferred. Mothers-to-be from this group tended to want to know what to expect, rather than being reassured: *"Can you imagine! Nobody told me what was happening … [whilst waiting for a Caesarean]."* Overall, French African parents-to-be struggled to appreciate the concept of choice. Those with some experience of the service were more confident to discuss choices they might like next time, for example choosing appointment times with health visitors (who currently 'drop in', which can be inconvenient).

Appetite for making choices was currently low amongst this audience, but experience was creating more of a demand for making choices in future, which has the potential to increase satisfaction.

5.2.10 Somali parents

This group comprised both first and second generation respondents who were either married or with a partner. There was a mix of first, second and third time parents. The key themes to emerge from a thematic analysis of the experiences of Somali parents were:

1. Reassurance

Overall, Somali parents-to-be expected to take pregnancy and birth in their stride: most had raised siblings. Typically, this audience valued maternity services which would enable them to enjoy the experience of pregnancy, labour and birth whilst remaining anxiety-free.

Feeling uninformed tended to create anxiety amongst an audience who were unlikely to challenge health professionals. For example, one respondent spent two weeks worrying about a low level of fluid around her baby: *"She just said, 'oh, come back in two weeks'. I would like to know what's going*

on. It's my body and my baby." Another wanted to know more about what was happening to her baby in the womb: *"I was worried about the baby getting wrapped in the cord."*

Those with ongoing relationships with midwives tended to feel that they had a source of reassurance, and were therefore more satisfied with maternity services: *"My midwife told me a lot during our appointments. She was really helpful."* Without this ongoing source of reassurance, satisfaction tended to decrease: *"I've had five different midwives. I saw one twice. They're nice but you don't see one enough to have any relationship with them."*

In future, maternity services should consider how to provide this group of service users with an ongoing source of reassurance.

3. Encouraging dialogue

At times, Somali parents were reticent to ask questions about their babies.

Satisfaction tended to increase when maternity services encouraged parents-to-be to become involved in a dialogue about their babies. For example, choices (although unexpected) were well received and provided an opening for involving parents in decision-making: *"I think the choices are really excellent."* Choice had the potential to increase satisfaction amongst the Somali audience, who currently tend to be content with what they receive.

Maternity services should also consider how to encourage Somali parents-to-be to participate in a dialogue about their babies. Similarly, maternity services should consider how to invite Somali parents-to-be to make choices. Although Somali parents-to-be will be willing to make choices, they are unlikely to proactively ask to make choices themselves.

5.2.11 Asylum seeker parents-to-be

This group comprised those aged between 20 and 28 years old and included a mix of first and second time parents. They were all unemployed and were either married or single. The key theme to emerge from a thematic analysis of the experiences of parents seeking asylum was:

1. Interpretation

The frustration of not being able to make themselves understood was the main driver of satisfaction for those amongst the asylum seeker audience.

For example, one Turkish father, struggling with English and new to the UK was never offered an interpreter. During labour, when his wife was in pain, he approached staff to ask for pain relief. He reported that he had felt dismissed and was, as a result, dissatisfied with how he had been treated by staff, whom he described as 'unpleasant' and 'uncaring'. Another Afghani mother-to-be was provided with an Iranian interpreter who spoke a similar dialect. When provided with an interpreter who could speak her dialect, satisfaction increased.

Once asylum seeker parents had accessed services, satisfaction increased. For example, one Chinese mother-to-be was diagnosed with maternal diabetes and was immediately offered monitoring, choice and breast-feeding advice. She was impressed with the service.

Asylum seekers clearly felt vulnerable when accessing maternity services. In future, maternity services should consider how to ensure that those seeking asylum are provided with interpreters and are guided through the process in terms of: what services are provided and how do I access them?

5.3 Common factors influencing satisfaction

Common factors influencing satisfaction across the seldom heard audience	
Common theme	**Audience specific requirements**
The need for maternity services to engage with groups of service users in a way that demonstrates an understanding of their cultural needs	In particular: • Becoming 'part of the family' for African parents-to-be; • Providing age appropriate care for teenage parents-to-be; • Offering single mothers-to-be a sense of recognition; • Demonstrating sensitivity to the cultural preferences of Bangladeshi and Pakistani parents-to-be; • Engaging with traveller mothers-to-be 'on their terms'.
The need for maternity services to communicate effectively with different groups of service users from across the seldom heard audience	In particular: • Generally improving clarity and direct style of communication preferred by Turkish, African Caribbean and African audiences; • Clear communication regarding choice for the African, Bangladeshi/Pakistani and African Caribbean audiences; • Maintaining an ongoing dialogue with those seeking a particularly close relationship with maternity services (teenage and single mothers-to-be). • Encouraging dialogue and offering reassurance to Somali parents-to-be;

	• Ensuring that Bangladeshi and Pakistani parents-to-be feel sufficiently informed; • Listening to the needs of parents-to-be with disabilities so they feel more in control.
The need for maternity services to engage more service users from seldom heard audiences with antenatal services (i.e. antenatal classes)	In particular: • Encouraging women with experience of child rearing to attend e.g. Turkish and African mothers-to-be; • Offering antenatal classes which will appeal to different groups e.g. 'mum only' (for single and teenage mothers-to-be) or 'women only' for (Pakistani/Bangladeshi mothers-to-be) or 'at home' (for traveller mothers-to-be).
The need for maternity services to offer practical support to enable seldom heard groups to engage with maternity services	In particular: • Offering single mothers-to-be convenient options for accessing services; • Links to wide-ranging social support for Turkish parents-to-be; • Improving clarity of communication between Turkish, French African and asylum seeker audiences, by involving interpreters where necessary.

5.4 Cultural misunderstandings

Examples of cultural misunderstandings from across the 'seldom heard' audience illustrate how isolated incidents can be taken to heart and influence

satisfaction with the service as a whole:

- For example, after ringing several times to secure an appointment, a health visitor made an inappropriate remark to a new Bangladeshi parent about 'the floor probably being dirty anyway' when asked to remove her shoes.

- For example, a health visitor was allegedly at a loss regarding how to respond to a question about circumcision asked by a new African parent.

Whilst there were examples of cultural misunderstandings, on other occasions women were simply confused about why their hospital experience had been so poor, and chose to suggest that the service had treated them unfairly due to their cultural background:

"Sometimes I think that because I am a black woman and I am young, those two combined did not make a very good mixture. I was not offered the right things and I didn't feel welcomed. It's like if you are not a 30 year old woman with a husband and a house and a dog, then you are classed as not intelligent enough to be worth their time." (African, teenage mother)

In some cases, accusations of prejudice were fuelled by existing sensitivities to feeling 'judged':

"I didn't get the feeling she [the midwife] liked me very much because I'm a single, teenage mother." (Teenage mother)

"They made me feel like I was neglecting the baby. I felt judged and ashamed." (Traveller mother)

"My wife felt that she was being ignored due to the colour of her skin. She wanted a pillow, but the staff gave the pillow to a white patient." (African father)

However, there were those who chose to make their own judgements about members of staff from an African background, whom a small, but significant, minority identified as 'brusque'. No other ethnic groups were singled out for comment:

"I know a lot of African people and I do know what they are like, but some of them are so rude." (Single mother)
"For some reason there are a lot of black people in the NHS and I'm not being racist or anything but they are bit rough." (Bangladeshi mother)
"I think they have to let them know that it is part of their job to be polite. It's the older ones. I'm an African person as well. I don't know why this is happening. It's an African thing where if they are caring for you they feel they have authority over you." (African mother)

A small minority articulated their view that understanding is required from both service users and service providers:
"NHS staff should be trained to understand that people with different accents are not stupid. They should not with-hold information or dismiss you because they think you can't understand." (French African mother)
"[Referring to his perception that staff were 'a bit abrupt']: They have a lot of African staff in there. It might just be their nature, but I think it's just their culture. I used to take it personally, but you realise that it's just their culture …" (Caribbean father, separated from single mother)

5.5 Choice

5.5.1 Awareness of and attitudes towards choice

Awareness of options offered by maternity services to service users was limited to: birthing options (including home birth and water birth), pain relief and which hospital (or birthing centre) to have the baby in. Generally, the opportunity to make choices was well received:

"The choice of labour is important because she'll definitely choose a different birth next time." (Father, separated from single mother)

"I was really pleased when I got the letter that they had accepted me, even though I was out of their area." (Caribbean mother)

"It's good to have choices because everyone wants to do things differently, especially when you have so many cultures." (Single mother)

The choice that most felt that they would like to make was to have the same midwife throughout the maternity journey:

"I'd like to have my own doctor and midwife all the way through because they will know what is going on." (Mother with a disability)

"I would have liked one person I could contact from the start to the end. Someone who could tell us what will happen at the next stage and what we could expect. Someone who could help us when things were going wrong at the hospital." (Bangladeshi father)

The range of choices service users felt that they would like to make was much broader and included:

- to be able to say in hospital longer
- can my mum stay overnight?
- discounted parking
- all appointments in one place
- private rooms
- home visits to assist with breastfeeding
- to be able to take a hot water bottle

Whilst many across the 'seldom heard' sample were keen to embrace choice, equally, there were some who did not want to make choices. These included younger mothers who preferred to follow the guidance offered by maternity services:

"At the time I had a lot on my mind, so I just wanted to have the baby, that's all!" (Turkish, teenage mother)

"In labour, I don't think you really have the choice that you want because they know best." (Traveller mother)

"No, in the end we didn't have any choice, but they were the experts and they did the best for us so I was quite happy about that. They made the right decisions and we have a lovely boy." (African Caribbean father)

"Maybe I should have pushed for it [choice] myself, but there is so much going on and I was so worried about so many other things at the time." (Single mother)

Although broadly welcomed, there was agreement that choice was not more important than being treated with dignity and respect:

"It's not about choice, it's about people. They should give them training and they should be more tolerant." (French African mother)

"It's not about choice, if people are there for her and supportive, that's the most important thing." (French African father)

"I would rather the NHS give me better staff than loads of choices." (Bangladeshi mother)

"I want the choice to have more and nicer staff." (Mother with a disability)

"I had a choice of hospital and all that, but the main thing is that the staff have got to be nicer." (Turkish mother)

"I don't care what hospital I can choose, it's about the people that are in the hospital and the way that they treat you." (Teenage mother)

"I don't know if choice is the big thing ... I think that the things that they already offer they should improve upon by giving a good service, rather than create lots and lots of choices." (African Caribbean father)

5.5.2 Current communication of choice

Word-of-mouth information from friends and family was beginning to encourage service users to ask questions about choices:

"One woman [at the antenatal class] did not say nice things about hospital X, she preferred hospital Y... we started worrying that we weren't doing the right thing." (African father)

"I was quite well informed because I have lots of friends who have had babies and they told me I should ask to go to hospital X and told me what to expect." (Caribbean mother)

Currently, service users relied upon health professionals to inform them about choices via face-to-face interactions:

"I think it could have been explained a bit more what was happening because you were just told the bottom line, you are not told the implications and that sort of stuff." (Caribbean father)

"They could have told me more, but in the end those decisions are mine and I made them based on what I thought." (Somali mother)

"There is always something new coming out and you don't get told. They need to keep you informed." (Single mother)

"They need to tell you what to expect and what your choices are. When you don't have a child, you don't know." (French African mother)

The importance of health professionals informing women about the opportunity to make choices became clear in two ways:

Firstly, where service users assumed that choices were not available, largely due to a lack of awareness:

"No one told me what my choices were. I did not even know I had a choice and I didn't know what to ask so I just went along with it really." (Teenage mother)

"The information should be there if you want to take it up … you should be offered the same choices as everyone else." (Caribbean mother)

"I didn't care really, but I would rather have gone to hospital X but I didn't know you could choose." (French African mother)

And secondly, when service users failed to distinguish between patient choices and clinical decisions:

"My wife said she didn't want one [an epidural] beforehand, but she was in pain and they just kept saying I should sign the paper … I wasn't convinced when I came out that I had been given the best advice … She was in pain and you don't want to see that … maybe if I was better informed I might have done things differently." (Pakistani father)

"They pushed the choice of whether or not to have an epidural on to me and did not give me a choice. They said, 'you need it'." (Teenage mother)

"They wanted to use forceps and I refused and they weren't happy with me making that decision … they just want all the control." (Pakistani mother)

Trusted relationships with health professionals clearly encouraged service users to value individual choices and the choice process*: "They encouraged us to make choices … it was reassuring, we listened to their advice." (African father)* Equally, there were some who reported that they felt that the opportunity to make choices had not been valued by health professionals:

"They offered us loads of stuff, but when it came down to it, there was no follow up and you just forgot about it." (Teenage mother)

Some service users felt that their choices had not been respected, which tended to decrease satisfaction and, at worst, serious clashes ensued:

"… she told me that there were not enough staff … if they gave me an epidural they would have to attend to me and there were not enough staff to do that. They left me for about an hour and another midwife came in and again I asked her because the fact that they didn't have enough staff wasn't

my fault. I was in pain. They were forcing me on to gas and air, but I didn't like it. It made me dizzy and sick." (French African mother)

"I do feel that they bully you into breastfeeding really." (Mother with a disability)

5.5.2 Future communication of choice

To encourage service users to make choices, maternity services need to consider how to publicise the range of options available. Otherwise many assumed that these choices do not exist:

"To me it would have made a difference. It would have improved my quality of care. At least we should be given the information to be able to make the choice. I would have liked to have a choice of hospital, choice of having a birth plan, choice of where I can see my midwife." (Bangladeshi mother)

"The choices aren't really put out there. They're there, but not really promoted to us." (Pakistani mother)

"I would have chosen another hospital if they had offered me a choice. They just told me that I was going to have the baby at [hospital X]. I didn't know I had a choice in this matter." (Pakistani mother)
"I would have liked to have had a choice of hospitals. I would have chosen the one in X because I have heard that the service there is much better than in Y. I have heard that the staff there are very friendly and are very helpful." (Pakistani mother)

"I didn't know until afterwards that you could choose what hospital to have your baby in." (Mother with a disability)

In future, many service users felt that they needed support in order to make choices. Maternity services should consider how best to support women to make choices in order to increase satisfaction:

"It would be nice to get a few leaflets about different hospitals because I don't really know about them." (Turkish mother)

"They didn't tell me any of this stuff. I didn't know it existed to ask about it." (Pakistani mother)

As well as promoting opportunities to make choices, maternity services need to be clear about the extent of patient choices available (i.e. when patient choices may or may not be available or when choices become clinical, rather than patient choices). Clear communication will be required to promote informed choice. For example, when making a patient choice about where to have one's baby, women will need to know that epidurals cannot be delivered at certain midwifery led units.

6. MAIN FINDINGS – HEALTH PROFESSIONALS

Healthcare professionals provided an important contextual understanding of 'seldom heard' groups in terms of describing the range of attitudinal, behavioural and cultural characteristics. Their feedback provided the research team with insights into the various 'seldom heard' communities, including some of the challenges they have faced.

6.1 Expectations of maternity services

Overall, health professionals felt that expectations of maternity services were increasing: generally, as well as across 'seldom heard' groups. Their common view was that women's expectations of maternity services were now greater

than ever before and that government policy (particularly regarding choice) was driving expectations upwards: *"People have this idea that they'll get one midwife. Expectations seem to be worse at the moment." (Community based midwife)* Another community based midwife described women's expectations of maternity services as *"desperately unrealistic"*, and suggested that the government was communicating messages which the service were not always able to meet.

Health professionals identified three different groups of service users within the 'seldom heard' audience, each with differing expectations of maternity services. It was the 'newly arrived' group who generated most feedback.

1. Integrated

Overall, health professionals felt that women who had been living in Britain for a longer period of time (for example from second or third generations i.e. those born in the UK) were more likely to have developed expectations of maternity services. This group were described as more confident in their engagement with the service and more likely to ensure that their expectations were met: *"Second and third generations are much more outspoken, they know how to get what they want and which channels to go through to get what they want … they know their rights." (Community based midwife)* *"Second generation black African girls are much more difficult to advise. Older women from that community are more accepting." (Community based midwife)*

2. Traditional

Health professionals identified groups who, although well established in the UK, they felt were more likely to operate largely within their traditional culture e.g. Pakistani and African. This group were considered less likely to have pre-conceived expectations of maternity services when compared to the group

described as more 'integrated'. It was suggested that the cultural beliefs of service users from this group were likely to influence satisfaction with maternity services, as described in section 6.2.2.

3. New arrivals

Health professionals identified a third group: those newly arrived in the UK. On the whole, they felt that this group were typically less likely to have preconceived expectations of maternity services. For example, it was reported that some appeared to have very low expectations, influenced by familiarity with a lack of provision at home (for example, African women and women seeking asylum): *"To my knowledge I've never had anyone appear disgruntled." (Community based midwife)*

This observation is supported by comments from newly arrived service users themselves: *"For me, seeing the way it happens here was surprising and something nice. It's like bonding with your child when it's still in the womb." (French African father) "In Nigeria when they have a baby it is very different to here. It is harder. They don't give you nothing." (French African mother) "I had no idea about services here. When I got pregnant I found out that the doctors do the check up, they do tests in hospitals and that the quality of care in this country is very good. My sister-in-law told me about it because she has children here." (Bangladeshi mother)*

Health professionals explained that, in their experience, a lack of knowledge about how services operate could contribute to dissatisfaction with maternity services amongst new arrivals. For example, one midwife recalled receiving numerous complaints about housing because newly arrived mothers mistakenly believed that maternity staff could influence housing decisions.

6.2 Cultural factors influencing satisfaction

6.2.1 Language

A key theme to emerge from a thematic analysis of the feedback from health professionals was language barriers. Health professionals described how their inability to communicate with women often created a barrier in terms of:

- **Firstly, their ability to deliver the best service possible.** If women had little or no ability to speak English, health professionals reported that they often felt that they were not meeting their needs. For example, they explained that without clear communication, it can be difficult for them to recognise when women are in pain, when they are asking for something, what concerns they may have and how they are feeling: *"You can give them care, but you feel like it's not as good as it could be. It's difficult because of the language." (Community based midwife)*

- **Secondly, women getting the most out of the maternity services.** Whilst health professionals typically felt that most women do not necessarily *expect* to be addressed in their own language, they felt that it was likely that some service users feel at a significant disadvantage when speaking English (if it is their second language). This concern was supported by a number of women from 'seldom heard' audiences for whom English was a second language: *"Now when I look back, I think it would have been good if they had an interpreter because I would have understood what they were saying and could ask questions. I wouldn't have been so nervous … I felt that they will get more angry with me because I can't speak English well and take time to ask questions. I decided to keep quiet and suffer." (Pakistani mother) "My husband speaks fluent English, so he was the one speaking to the doctor. I struggle with understanding English, so I*

prefer my husband is with me because I can ask him to explain things to me properly later on." (Bangladeshi mother) "My husband could not explain to me in Bengali what the doctor was saying because his Bengali is limited." (Bangladeshi mother)

Overall, health professionals felt that maternity services are now better equipped to meet different language needs than ever before. For example, they cited the implementation of hospital advocates for (most) communities, as well as translators. However, they still felt that the language challenge was significant, as described by the issues raised below:

- It was reported that some hospitals are trying to manage the needs of service users speaking up to 48 different languages;
- Whilst translators are available (as well as midwives speaking a range of languages) it was reported that this need was not always met: *"The staff or translators are not always available … we're so stretched we can't always meet the needs of everybody." "You just have to do your best with what you've got." (Hospital based midwife)*
- When translators are available, it was described how appointments can run significantly over time, leaving other women having waiting to be seen: *"It is very important that there is an interpreter, it means we can give them better care from the start … although it can mean that appointments usually have to last longer." (Community based midwife)*
- Independent form filling was also identified as a difficulty for many women. It was explained that fully completed forms are an important tool which enable health professionals to understand any particular issues or requirements that individuals may have;
- Leaflets written in English were also identified as another reason why women who do not understand English may feel at an overall disadvantage when it comes to receiving information. It was reported that each service user could not be supplied with the same information.

Overall, health professionals consistently perceived language barriers as key factors likely to be influencing satisfaction across the 'seldom heard' audience.

6.2.2 Cultural beliefs

Another key theme to emerge from a thematic analysis of the feedback from health professionals was cultural beliefs. Health professionals described how differences in belief can create conflict and tension between maternity staff and service users. The following describes examples of when such tensions may emerge between health professionals and service users from different 'seldom heard' audiences:

- **From experience, health professionals felt that it was particularly difficult to engage African women with maternity services.** They described how African women are more likely to 'book in' late, may travel overseas without warning, and are more likely to be resistant to undertake screening tests (for religious and/or cultural reasons), despite strong recommendations from staff keen to check for abnormalities.

  It emerged that resistance to advice can create unease amongst health professionals, who could also appreciate that African women may feel that they are being asked to co-operate with or pushed into a procedure they do not wish to undertake: *"We expect people to book in by about 12 weeks, 3 months, but sometimes they come in at 30 weeks."*

  Women from the African and French African samples reported that they were keen to engage with maternity services, and wanted services to engage with them positively. The combined feedback suggests that tensions may arise from the differing expectations of service users and service providers.

- **Evidence of tension between health professionals and women from the African Caribbean community was also identified.** It was reported that some first generation Caribbean women travel to the UK to have their babies, then return home after labour. From a health professional's perspective, this arrangement was less than ideal: it was explained that they have an obligation to deliver babies, yet feel concerned that the mother and baby have not been cared for during the rest of the pregnancy.

- **Health professionals also acknowledged that tension may be created by Pakistani women feeling uncomfortable if seen by a male member of staff; or if a male member of staff enters their room.** Whilst health professionals felt that female staff may be preferred by many women (regardless of cultural background), they felt that Pakistani women showed greater discomfort in this situation. This factor was considered likely to contribute to their satisfaction with their overall maternity experience: *"They might be more uncomfortable with a male doctor entering their room than another woman might be." (Hospital based midwife)*

- **The specific difficulty of asking Pakistani families to limit the number of visitors post-labour was another example of where preferences may be in conflict.** It was suggested that telling new mothers that some visitors need to leave may well be a driver of dissatisfaction. However, from a staff perspective, there is a limit to the number of visitors a person can have at any one time.

- **It was reported that asylum seekers' approach to parenting can cause concern, particularly since few were felt to take interest in advice and typically asked few questions.** A range of behaviour was recalled as problematic, for example, 'sterilising' bottles in the sink, wrapping babies in too many blankets and applying

traditional eye make up soon after birth*: "It's often guess work with these women." (Community based midwife)*

To increase satisfaction amongst this audience, health professionals felt that they needed more time to build relationships: "*We do try and spend more time with these people but you often can't because you still have another 9 people waiting to see you."*

Overall, the tension between cultural beliefs and health professional advice was identified as a factor potentially influencing satisfaction with maternity services.

6.2.3 Cultural misunderstandings

A number of community based health professionals were able to reflect on how service users and service providers may misunderstand each other. For example, a doula explained that some African and African Caribbean women may become frustrated if wanting to give birth in a certain position not recognised by health professionals; a nursery nurse explained how African women want to be supported and listened to, but may simply be unaware of the services available that will do so: *"I just really want to project what is out there for mums because they don't always know." (Community Nursery Nurse)* (By contrast, a hospital midwife described how she made assumptions about access to wider services: *"I'm assuming that these women are aware of the service available throughout their pregnancy, but I don't know because I only deal with them at the labour stage");* and a community midwife acknowledged that more time was often needed with women from 'seldom heard' groups, but that: *"Some midwives concentrate on all the negative things that the woman is doing wrong, rather than taking one thing at a time and building up trust with them." (Community based midwife).*

There were occasions when a minority of health professionals expressed their frustration with the difficulties of providing maternity services to women from a diverse range of ethnic and cultural backgrounds. For example: *" They [women from ethnic backgrounds other than British] receive a better service and they will still complain…Even if the government pumped another £5 million pounds into the NHS they would still complain." (Community based midwife) "You get women who want to get booked in as early as possible and have all the tests done but there is no urgency with them [African Caribbean women]." (Hospital based midwife)*

In these isolated cases, women who did not speak English were sometimes referred to as a group (i.e. 'these women'), as opposed to their specific ethnic or cultural background. Similarly, women speaking English, settled in the UK and white were sometimes referred to as 'Caucasian'. Overall, community based health professionals were more likely to speak confidently about the various different communities with which they worked. The minority who appeared to feel less confident about the extent to which the service was currently satisfying women from seldom-heard groups were hospital based.

Any comments which may not reflect an appreciation of diversity stemmed from the frustrations of trying to deliver a quality service whilst working under pressure and feeling overwhelmed: *"We're so stretched, we can't always meet the needs of everybody…you've just got to do the best with what you have." (Hospital based midwife) "There's a massively rising number of births … so capacity is stretched to breaking point." (Community based midwife)* All health professionals were committed to providing the best service possible, but were finding it increasingly difficult to do so. In this context, the increasing complexity of cross-cultural communication had become yet another pressure with which health professionals had to contend.

6.2.4 Hard-to-reach women

Another key theme to emerge from a thematic analysis of the feedback from health professionals was audiences perceived as 'hard-to-reach'. Difficulty engaging women was identified as a factor potentially influencing satisfaction, given that a lack of engagement was considered likely to limit the extent to which women could feel satisfied with maternity services.

- **It was reported that women from the Pakistani community were amongst the hardest-to-reach, particularly those who had travelled from Pakistan and entered into an arranged marriage.** Health professionals described how this group of women tended to have little independence from their husbands and rarely had other family members living in the UK. Caring for this group of women was described as challenging. For example, while a minority of mothers-to-be articulated that 'mixed sex' antenatal classes were off-putting (as discussed in section 5.1.6), health professionals revealed that husbands could forbid attendance at antenatal classes. Interestingly, amongst the 'seldom heard' sample it emerged that Bangladeshi fathers were more likely to be involved than Pakistani fathers, amongst whom second generation fathers were the most likely to become involved.

  The effectiveness of the care maternity services were able to provide this group of women was questioned: "*They are very much at the mercy of their husbands." (Community based midwife) "We can tease out from these women their home situation and try to offer a much better standard of care … if the women are in an abusive environment their health is more at risk … but this abuse is usually hidden." (Community based midwife)*

- **Health professionals also identified Turkish women as 'hard-to-reach'.** Once again, health professionals were concerned about the health and well being of this of group women and their babies, given that they typically found it difficult to access them without the intervention of their husbands: *"We need to really be able to speak to their [Turkish] representatives and encourage these women somehow that we are there for them." (Community based midwife) "Many of these women are scared to come forward because they think we'll get in touch with the Home Office and that the Home Office will get involved in their situation…but it's nothing to do with that, we need to give these women care." (Community based midwife)*

  This feedback reflects the feedback from Turkish mothers-to-be who felt that their relationship with maternity services was limited by poor communication.

Overall, health professionals felt that many of the core factors driving satisfaction (e.g. basic provision of maternity care, access to information, communication, choice, continuity of care and post-natal support) were difficult to deliver to 'hard-to-reach' women.

6.3 Choice

Across the health professional sample, there was an appreciation that, in theory, choice is a way of improving women's experience of maternity services. However, in practice, health professionals commonly felt that unrealistic expectations about choice can drive dissatisfaction with maternity services.

Health professionals claimed that women did not always consider safety and risk factors that may arise as a result of their choice - most notably with home births: *"The government give all these messages about the choices women*

have - for example where they can have their babies and things - but in reality this is difficult to meet." (Community based midwife) Maternity staff explained that they have a duty to foresee any risks with women's choice of birth setting and, in some cases, may advise against what women have chosen. In such cases, the tension created by health professionals advising against choosing certain options was felt to be a potential driver of dissatisfaction.

As a group, health professionals were also of the opinion that they are working under more pressure than ever before, due to rising birth rates and greater choice offer. For example, there were several health professionals working in popular services which were now overloaded: "*In recent years we've seen a huge increase in the number of bookings for people who live a long way away from us because we have a good reputation … and we're busier now than ever because of that NHS choice." (Hospital based midwife)*

The impact of choice on the provision of care was identified as a potential driver of dissatisfaction: *"There simply isn't the infrastructure to support this whole choice thing … there's a massively rising number of births, for example, my hospital unit was designed for 3.5 thousand births a year and we're pushing up to 6 thousand … so capacity is stretched to breaking point." (Community based midwife)*

6.4 Suggested improvements

Whilst health professionals agreed that maternity services are working hard to meet the needs of women as effectively as possible, there was a number of suggestions which health professionals felt would boost satisfaction.

- **A greater number of staff was a reoccurring 'ideal'.** Most commented on pressure they felt that maternity services are under and felt that more maternity staff would enable the service to meet the

needs of women from 'seldom heard' groups. For example, more time could be spent with service users at all stages of the pregnancy and after birth. In addition, it was suggested that teams dedicated to particular groups of 'seldom heard' women were more likely to meet their needs.

- **Continuity of post-natal care was another suggested area for improvement which health professionals felt would reduce dissatisfaction with the service:** "*Continuity is really important for these girls." (Community based midwife)*

- **Ideally, health professionals felt that maternity services should be able to offer links to other sources of support.** Health professionals were particularly conscious that certain groups were generally vulnerable (e.g. asylum seekers, Pakistani and Turkish women). It was recommended that all services provided for vulnerable adults should work more closely with the maternity services to ensure that these women do not 'slip through the net': *"I just really want to project what is out there for mums because they don't always know." (Community nursery nurse)*

- **Greater access to maternity services was suggested**, both in terms of access to the 'booking in' and routine appointments (e.g. outside working hours or at home) and access to information (i.e. leaflets in a range of languages): *" It's all money though I suppose to implement these things." (Hospital midwife)*

7. RECOMMENDATIONS

➔ **Service users generally did not feel that they knew what they could expect from maternity services**

- Actively manage expectations of maternity services (i.e. what the service will and will not provide) from the first point-of-contact, particularly in terms of communicating:
  - The pathway users will follow, as well as the individual points-of-contact;
  - The role of the *range* of health professionals they will encounter;
  - Their role and responsibilities as service users.
- In particular, actively manage expectations of hospital services during labour, birth and post-natal care, including the roles and responsibilities of new parents and staff.➔ **Many did not know what they could expect from maternity services because they had not accessed antenatal/preparation for parenthood services**

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- Actively manage expectations by improving attendance at antenatal preparing for parenthood services, particularly for teenage, single, Pakistani/Bangladeshi and traveller groups, as well as mothers from large families e.g. Turkish and African.
  - Promote the availability of antenatal/preparing for parenthood services that will appeal to particular groups (e.g. 'mum only' or 'women only' groups or other outreach work);
  - Communicate the value of antenatal/preparing for parenthood services (particularly in terms of preparation for labour and birth) to increase relevance amongst those who feel that they already have sufficient experience of caring for children.➔ **Actively manage expectations of maternity services generally and hospital services in particular by:**

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- Addressing the (false) assumption that all service users will have a single midwife dedicated to their care throughout their maternity service journey
  - Explain that service users will see a number of midwives;
  - Support the impression of a 'joined up' service by maintaining communication between different health professionals and points-of-

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contact along the maternity services journey.➔**Hospital care was routinely the cause of most dissatisfaction, particularly postnatal care in hospital**

- Transforming the experience of hospital care will involve:

– Improving the tone of communication between health professionals and service users so that service users feel that they are being treated with dignity and respect;

– A renewed focus on person-centred care which demonstrates an understanding and appreciation of diversity (rather than equality).

➔ **Transforming the experience of hospital care will involve a renewed focus on person-centred care which demonstrates an understanding of diversity (rather than equality);**

- To do so, health professionals will need support. Already working under considerable pressure, the scale and complexity of the cross-cultural communication task can feel overwhelming: – Health professionals need to feel empowered with the skills and language to enable them engage confidently with a wide range of service users, with the support of translators;

– In particular, health professionals will require support to negotiate difficulties that can arise when cultural beliefs conflict with professional advice.

➔ **Choice has a role to play in increasing satisfaction**

- To contribute to satisfaction, clear communication about choice is required:

– Opportunities to make choices and become involved in decisions about care need to be promoted, supported and respected by health professionals (for example, choice of hospital and other choices that may be available e.g. seeing the midwife as first point-of-contact);

– Informed decision-making needs to be supported with clear information;

– The types of choices available need to be clearly explained i.e.

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- the patient choices/flexibility the service offers, as well as the limitations of the patient choices available;
- the scope of patient choice i.e. the difference between patient choices and clinical decisions.

6. APPENDIX 1: NHS London Maternity Services Topic Guide (women and partners)

1. INTRODUCTIONS AND EXPLANATIONS

- Introduce self and Research Works Limited, an independent market research agency
- This is a consultation exercise – NHS London (the Strategic Health Authority for London) are seeking the views of new parents and parents-to-be about maternity services in London
- Explain confidentiality and ask permission to record the session

2. WARM UP

- Respondents to introduce themselves: family and employment status
- Current stage in pregnancy or post-natal?
- How are you feeling about maternity/parenthood?
- Who is supporting you during your pregnancy/new parenthood? *Probe: friends, family, social networks*[5]

3. UNDERSTANDING OF 'MATERNITY SERVICES'[6]

- What services does the NHS provide for pregnant women?
- Who delivers these services? *Probe knowledge of people involved other than midwives*
- What choices does the service offer pregnant women?[7]
- From who or where did you gain this knowledge about services and choices? *Probe: family, friends and social networks*

[5] MISB suggestion: throughout the interview we will probe to understand the relationship between the service, users, and their support network
[6] MSIB suggestion: understanding is the basis for expectations, against which satisfaction is measured.
[7] MSIB comment: the importance of assessing awareness of choice, prior to expectations and satisfaction

4. MATERNITY JOURNEY EXERCISE

Explain that we are going to work through an exercise that will help us to understand what is important to you during your maternity care.

Present respondents with the 'maternity timeline' and ask them to point out their personal contact points with services, building on the existing timeline. MODERATOR – NOTE CONTACT POINTS ON A3 TIMELINE IF RESPONDENTS ARE NOT COMFORTABLE WRITING THEMSELVES.

5. EXPECTATIONS

Now we will revisit the points we have outlined and discuss what you <u>expected</u> from services at this point and put these on the timeline. For each point, prompt with the following questions:

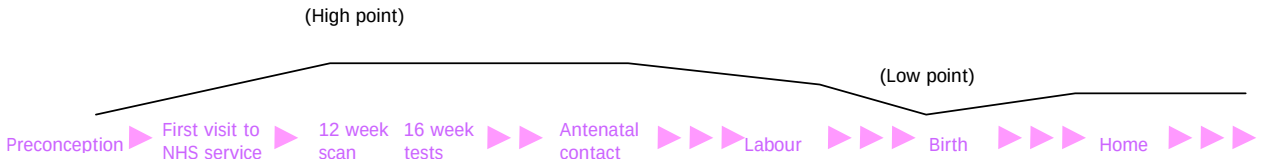
- What did you expect from the service at this point?
- What had led you to expect this? *Probe if needed: things you had heard from friends/family, the media? Previous experiences? Other?*
- Did you expect to be offered choices at this point? Why/not?
- If so, what choices did you expect to be offered?[8]

6. EXPERIENCES OF SERVICE AT EACH POINT

Now we are going to discuss your experiences at each of your contact points – and how these experiences matched up to your expectations. First, I would like to get a sense of whether each point was a 'high point' or a 'low point'.

[8] MSIB comment: the importance of establishing expectations of choice

Moderator, ask respondents to guide you to draw a journey line. For example:



Provide respondents with illustrative stimulus to place on the timeline in order to show their thoughts and feelings at each contact point. Explain that they can do this using pictures, colours, thought bubbles or whatever else they would find useful. Assist them to illustrate the timeline using these tools by working through the following questions with them:

- How would you describe your experience at this point?
- Who else was with you? What were you and they thinking/feeling?
- How did the service you received at this point match up to your expectations? *Prompt: were your expectations met, exceeded or disappointed?*

- What choices (if any) were you offered at this point?
- To what extent were these choices useful/meaningful to you?
- What choices would you have liked at this point?
- Why would these have been useful/meaningful choices?[9]

7. OVERALL EXPERIENCE OF SERVICE

- **Overall rating**: what rating would you give services out of ten? *MODERATOR – NOTE ON TIMELINE* Would this rating change during the course of the timeline? If so, how?

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[9] MSIB comment: expectations assessed against satisfaction with choices offered.

- **Overall choice**: Did your view about the benefit of being offered choices *change* during the course of the timeline? If so, how? *Probe: did you value being offered choices more at certain points in the timeline? Where there certain points when being offered choices felt less relevant?*

- **Overall, primary care**: or those who received antenatal care from primary care services: how satisfied were you with the service you received from primary care?
- For those who did not receive antenatal care from primary care services: would this appeal to you? Why/why not?[10]
- Would you like to be able to access a midwife (rather than a GP) as your first point of contact?
- How did the post-natal care you received in hospital compare to the post-natal care you received at home?[11]

8. COMMUNICATIONS

- Typically, who do you ask for advice during pregnancy/new parenthood? *Probe social support network, friends, family*

Ask respondents to pull out the information they have brought along which they received from NHS services so we can discuss what role they play in the maternity journey. For each point on the journey, ask:

- What information did you receive? *(ask respondents to show any written information they received)* What verbal information did you receive?
- What role did information play, if any, at this point?
- How did you feel after receiving this information? *Probe: did it help, hinder, other?*

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[10] MSIB comment: satisfaction with PC services and potential appeal of PC service delivery
[11] MSIB comment: differences in post-natal care in hospital and at home will emerge during the analysis process

- Did you receive any information about choices? If so, what?
- Did you feel that you had ongoing relationships with health professionals? If so, did your relationship with these professionals encourage you to make choices or appreciate the choices being offered?[12]

9. IMPROVING SERVICES (MINUTES)

If respondents have not spontaneously described what they felt should be done to improve services (in terms of design, delivery and satisfaction), ask the following:

- What could have been done to make you more satisfied with services (looking specifically at the low points on the journey)?
- Would being offered a choice have improved your experience? If so, what choices would you like to have been offered?

10. GAUGING SATISFACTION (MINUTES)

Sort exercise: *Provide satisfaction measures from quantitative study. Ask respondents to sort all measures in order of relevance and importance. Explore as respondents organise their measures:*

- *Why have you placed this measure in this place?*

Once the list is complete, check the measures with respondents:

- *Is there anything missing from these measures?* (If so, add on new cards and position in the sorted measures)
- What would you simply remove (remove)

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[12] MSIB comment: chart how views about choice may change during the maternity journey and how the communication of choice may affect satisfaction with choices offered

APPENDIX 2: NHS London Maternity Services
Health Professional Topic Guide

1. INTRODUCTIONS AND EXPLANATIONS (5 MINUTES)

- Introduce self and Research Works Limited, an independent market research agency
- This is a consultation exercise – NHS London (the Strategic Health Authority for London) are seeking the views of new parents and health professionals about maternity services in London

Explain that we will be asking new parents (mothers and fathers) about their experiences of maternity services across London in the next month. Before meeting new parents from a range of different audiences (younger parents, single mothers, African, parents from the Caribbean, Pakistani, Bangladeshi, Somali, Turkish and Traveller communities, new mothers with disabilities and new mothers who are seeking asylum) we would like to enlist your help about the issues these audiences may raise in relation to their experience of maternity services.

- Explain confidentiality and ask permission to record the session

2. WARM UP (10 MINUTES)

- Name and role e.g. midwife, doula, community nursery nurse, family support worker etc
- How long working in this role?
- Which hospital/areas they cover and the specific population groups covered?

Explain that we are speaking to the respondent as a health professional with specialist knowledge of working with new parents from the [write in audience] _____ community/group.

3. INFLUENTIAL FACTORS (15 MINUTES)

Explain that we are going to explore the factors which effect the experience that this community/group have of maternity services in London.

- **What are the key issues you face with delivering care to this community/group of mothers?**

- Please identify any specific **cultural factors** you feel have an impact on this community/group's experiences of maternity services (moderator, note). *For each, ask:*

    - Why is this factor important?
    - What effect does it have on new parents' experience of maternity services? *Probe: positive and negative effects?*
    - In what ways could the negative effects be reduced?

- Please identify any **shared attitudes** you feel have an impact on this community/group's experiences of maternity services (moderator, note). *For each, repeat questions above.*

- Please identify any **common behaviours** you feel have an impact on this community/group's experiences of maternity services (moderator, note). *For each, repeat questions above.*

- Overall, how would you describe your professional relationship with this community?

4. EXPERIENCES OF CARE (15 MINUTES)

Now we have discussed the factors this community/group of new parents bring to their experience of maternity services, I would like to explore what a good standard of care would mean to this community/group.

- What do new parents from this community **typically expect** from maternity services? What leads them to have these expectations?
- How do their expectations compare with the service they receive? *Probe: do their expectations tend to be exceeded or disappointed?*

- How do you think members of this community/group would rate their experience of maternity services? *Prompt: overall, would they be more or less satisfied 'customers'?*
- With which elements are new parents from this community/group typically more and less happy? Why? (Note)

5. IDEAL SERVICE (15 MINUTES)

Please describe what an 'ideal service' would look like for this particular community/group of new parents. Taking the elements with which this community/group of new parents are unsatisfied:

- How could these elements of dissatisfaction be addressed?
- What, for this community/group would contribute to improving standards of care? *Probe, for example: improved waiting times, consistent service from the same professional, accessibility (times and/or location), cleanliness, communication, quality of medical advice, specific cultural understanding and support, choice, other.*

APPENDIX 3: Maternity Services February 2010

Sources of information for help and advice

	Maternity Support
1.	www.nhs.uk **Tel: 0845 46 47** This site helps you make choices about your health, including pregnancy and birth, through to the practical aspects of finding and using NHS services.
2.	www.cowandgate.co.uk/ Whatever's on your mind about pregnancy or being a mum, find helpful advice from our experts as well as tips and support from other mums and mums-to-be.
3.	www.sidelines.org/ Sidelines is a non-profit organization providing international support for women and their families experiencing complicated pregnancies and premature births.

	General Health
1.	http://www.bootschangeonething.com Whether your goal is to lose weight, stop smoking, get healthier-looking skin or enjoy a healthier lifestyle, what you need is right here at your fingertips. Has easy-to-follow, interactive Action Plans, online support and the latest advice all just a click away…
2.	www.direct.gov.uk Direct.gov.uk is a government website providing information on public services all in one place. The website provides information in areas including education, employment, money and benefits, health and rights.

	Sexual Health
1.	www.brook.org.uk / **Tel: 0808 802 1234** (Monday to Friday, 9am-5pm) 24-hour information line **Tel: 020 7950 7700** Brook is a provider of free and confidential

	sexual health advice and services, specifically for young people under 25.
2.	http://www.nhs.uk/Livewell/sexualhealth/Pages/Sexualhealthhome.aspx **Tel: 0845 46 47** This NHS Choices site gives information on different aspects of sexual health for adults and children

Benefits, housing, employment rights, discrimination, debt and tax	
1.	http://www.adviceguide.org.uk/index.htm Citizens advice bureau information on a wide range of topics, including benefits and housing, employment rights and discrimination, debt and tax issues
2.	http://www.direct.gov.uk/en/MoneyTaxAndBenefits/index.htm Provides information and advice on a range of benefits, tax credits, taxes, pensions and debt management.

THANK YOU AGAIN FOR TAKING THE TIME TO COMPLETE THE SURVEY