

**ASSESSING THE IMPACT OF ST GEORGE'S MATERNITY SERVICES ON RACE EQUALITY AND DIVERSITY - (key considerations for Black and Minority Ethnic patients)**

**1. AIM OF THE ASSESSMENT**

To assess how effectively the Trust's maternity and midwifery services reached all sections of our local community, recognises diversity and promotes equality for black and minority ethnic patients, users and their families. As per Race Equality duties, this assessment will need to be built into service improvement activities and into decision making processes within the service.

**1.1 Key areas of focus:-**

- Identifying areas of good practice on race equality and diversity
- Assessing how well race equality, cultural awareness and diversity considerations are mainstreamed into decision making, service delivery, service improvement, into care provided, policies, into clinical practice and the workforce.
- 'Must do' improvements to enable the service reach wider sections of our local community, including marginalised groups and to promote race equality.

**2. METHODOLOGY**

**Quantitative Approach**

- Investigations using data collated by the Trust (on the Euroking and PAS systems)
- Investigations using data from PALS and Complaints service

**Qualitative Approach**

- Interviews/discussions held with staff within the service, managers and patients
  - Community midwives and patients in Tooting Health Centre, Balham Health Centre, Brocklebank, Doddington, Tudor Lodge, Lavender Hill, Lanesborough Wing, Tamil Support Worker. Sixty three (63) women were interviewed over a 6 week period. The following was the women's preference for their ethnicity and also a clear indication of communities the service reached

<b>Ethnicity</b>	<b>Numbers</b>	<b>Ethnicity</b>	<b>Numbers</b>
<b>White</b>	27	<b>White Other</b>	1
<b>British</b>	1	<b>American</b>	1
<b>Latin American</b>	1	<b>Cypriot</b>	1
<b>Polish</b>	1	<b>British Indian</b>	1
<b>Asian</b>	3	<b>Bangladeshi</b>	1
<b>Mauritius Indian</b>	1	<b>Tamil</b>	1
<b>Pakistani</b>	7	<b>Black Caribbean</b>	2
<b>Black African</b>	4	<b>Black Burundi</b>	1
<b>West African</b>	1	<b>South African</b>	1
<b>Not Applicable</b>	1		

- A majority were first time users of the service, however there were several women who had used the service before, or were having second/third or more babies. See **Appendix A** for detailed notes.

- Discussions were held with Head of the Service, Labour Ward Manager, Community Midwives, Midwife Consultant, Ward Manager, Risk Assessment Managers, Team Leaders
- No discussions were held with Consultants within the service and with staff on wards.

### 3. KEY FINDINGS

Both quantitative and qualitative activities found the following. **Appendices A, B, C and D**

- Nearly 50% of service users are from Black and Minority Ethnic (BME) communities **(A)**
- Around 11% of those delivering in STG had a history of mental health conditions, depression being the most common **(B)**
- BME women are less likely to take folic acid, (particularly teenage mothers **(B)** and less likely to attend antenatal classes, the latter affects Muslim women in particular. **(A)**.
- BME women are less likely to take up the offer of having a home birth – cultural reasons may account for this **(A)**
- BME women less likely to complain, language barrier may make access to complaints difficult **(D)**
- BME women more likely to book late in pregnancy than women of white backgrounds. There is also suggestion by some practitioners that some may not have received antenatal care, however this is not well recorded/monitored to enable us identify which particular sections/groups in the community are affected. There is suggestion that they could be asylum and refugee seekers or international visitors. Late bookers or women with no antenatal care are at significant risk as some may have medical conditions **(C)**.
- Teenage pregnancy appears to be higher amongst Black Caribbean women
- Cultural issues and language barriers can make meaningful access difficult, a potential **clinical risk** – this needs detailed investigation
- Very limited information in accessible language available for diverse communities
- Lack of consistency in information provided by GPs when referring patients on – some practices are very poor at providing data on ethnicity, disability, chronic conditions and language requirements.
- Women who DNA most are from out of area, forgotten appointment or may have limited or no English – **Appendix I**
- Need to ensure that post-natal services and labour ward effectively promote dignity and respect for patients.

### 4. GOOD PRACTICE ON RACE EQUALITY AND DIVERSITY WITHIN THE SERVICE

- 48% of the staff employed with the service are from Asian, Black, Chinese and mixed race backgrounds, see **Appendix E**. The diversity of staff within the service mean they have staff who can provide appropriate and sensitive health care.
- Ethnicity monitoring in the service is very good. For 2006/7 and as at July 2007, 97% of outpatient attendances for newborns were recorded, and 93% of inpatient attendances. This has helped this assessment immensely.
- Children and Women's services (Maternity being a key user of the service in this directorate) and Medicine are the highest users of the Trust's Interpreting service as per, Jan - June 2006 reporting.

#### 4.1 Community Midwives

- Described by nearly all the women interviewed as a very good service, made up of staff who listen very well to their patients and offer appropriate and sensitive care

- A team well liked by the women, and in some case, women would prefer to have care provided only by midwife (not shared with GP), also to be followed to labour ward by the midwife.
- They treated their patients with professionalism, with dignity and respect and ensured that any complaints and concerns raised are dealt with immediately.
- Community midwives are involved in rotational activities. Staff in Tooting Health centre for example, skill themselves and move around into other areas eg mental health, teenage pregnancy.
- Lavender Team work 12 hour shifts which allow for many of them to accompany / be present on the labour ward. There is clear evidence (through discussions with women and midwives) that this has a positive influence on the delivery experience. This is very good practice, however as this is not possible in other teams it is not equitable.

#### 4.2 Services for Tamil Women

- WPCT funds the post of a Tamil support worker to work specifically with the Tamil community. This dedicated worker provides language support and healthcare support for the growing Tamil community
- A post-natal Tamil service runs at Tooting – organised by the Health Visitors and complements the service

There will be an audit of the Tamil maternity support post shortly. Initial discussions with the support worker and some users confirm that language specific support and post-natal services for Tamil families have improved access within the open services. There is some evidence from HIMP funding recording, that a separate post natal project targeted at South Asian families has reduced attendance of Tamil families at **A&E** as a result.

### 5. AREAS FOR IMPROVEMENT AND RECOMMENDATIONS

Race Equality and diversity are important to the staff and management teams we talked to. Ethnicity recording is high because the team see the value in making the service equitable for all. The role of the Tamil worker and the discussions being held to introduce some support for Polish women are clear examples of how the service views diversity and its importance to delivering good health services.

The following are some of the recommended areas for improvement around race equality and diversity:-

Areas for Improvement	Recommended activities
<b>Culturally Competent health care - Cultural and faith awareness training for staff and managers</b>	Mandatory sessions – run by Diversity team within input from local faith community.  Rhian Williams, Asylum and Refugee Worker to run session on key regulations and working with hard to reach groups
<b>Improve access to information</b>	Leaflets/Posters (reflect diversity of patients) on maternity services needed in communities, GP practices and around STG – also part of education for communities.  To work with Polish, Pakistani, Muslim and Asylum and Refugee communities in particular, to assess information needs and most effective ways to disseminate within communities, discuss service routes within community. Speak to Mayday who are already doing

	<p>some work on this</p> <p>Speak to Bradford PCT re examples of good practice on language, information and interpreting.</p> <p>To record language, nationality and religion of all patients as part of ethnicity recording.</p> <p>Clear policy need in the service to ensure that translating, or by family members is to be discouraged (esp. if the father is present) as domestic violence goes up by 50% in pregnancies.</p>
<b>Interpreting and Language</b>	<p>Monitor the range of languages spoken by staff in the service – they could support patients during labour and offer support on post-natal ward</p> <p>Older mothers from the local community (to discuss with community and faith groups first) could be recruited and trained to support antenatal and parentcraft classes, information giving session, offer language support during labour.</p>
<b>Delivery of care in different ways</b>	Organise parent-craft and information giving sessions on maternity care, labour within communities/faith settings.
<b>Folic Acid and parent-craft classes</b>	To develop promotional information for BME women on the importance of taking folic acid and attending parent-craft sessions

<b>Late bookers</b>	Develop a better system of recording details of women arriving late to give birth, in particular those who have not had any ante-natal care and which communities they come from to enable the diversity team to work with the communities
<b>Care for Muslim Women/faith communities</b>	Allocate an area within the post-natal ward for mothers to pray. Provide information to mothers about multi-faith services in STG To do some work with faith communities in particular Muslim women, on issues around access, dignity, privacy and set up learning activities for staff.
<b>Staff attitudes – dignity and respect</b>	Address through supervision model and through diversity training. Promoting dignity and respect to be part of cultural awareness training.  To train more staff to carry out observations of care and address issues around dignity, respect and staff attitudes and concerns on diversity
<b>Community Engagement</b>	Identify diversity champion in the service to work with Outreach Facilitator in engaging communities and in mainstreaming diversity and race equality into service and into decision making
<b>Evaluating the Patient Experience</b>	3 - 6 months after patients have used service to send a short questionnaire to them, via GPs or Health Visitors or at home to share their experiences of using service.  Once a month ask a sample of patients on the post-natal ward to tell us what was good and not so good about experiences.
<b>GP Referrals</b>	To develop a template STG wide and work closely with Primary care to ensure that GPs include all relevant information – ie ethnicity, nationality, disability and chronic conditions when referring patients to STG.  To encourage GPs to invite midwives to practice meetings, encourage midwives and Health visitors to meet regularly - share learning, update each other on changes and promote good relations.  Tamil women in particular use GPs from Tamil communities, but do not necessarily get good care. Action needed by PCT to encourage promote better choice by effective use of advocacy/interpreting provision.
<b>Identifying and challenging discriminatory practice</b>	Use of the diversity monitoring form (an anonymous reporting form to identify nursing, clinical, staffing concerns around discriminatory practices and inappropriate behaviours (affecting both patients and staff)  This will enable the service to indirectly capture the concerns of women who do not complain, are unable to access complaints or afraid to – will inform training and educational activities and ensure that service improvements are made/systems tightened.
<b>Staff attitudes and complaints on postnatal and labour ward</b>	Head of service to identify fundamental issues creating poor behaviours/attitudes.  A session with staff to identify unacceptable behaviours and for all to sign up and agree on how inappropriate behaviours and attitudes will

	be addressed. Skill managers and provide them with tools to address inappropriate behaviours
<b>Risk Management</b>	To monitor and report by ethnicity, risk issues within maternity services and assess impact on BME patients. As part of this find out how and if we communicate meaningfully with the women affected, how we ensure if they have understood what is happening to them and why, whether they have understood instructions and can give informed and meaningful consent, particularly to clinical interventions.
<b>Impact Assessments</b>	As per Race equality duties to assess and monitor the impact of policies, strategies, procedures, practices, initiatives and services on diverse patient groups and staff.  Diversity team can offer training to support this process.

### 5.1 Other recommendations

- Seek views/experiences of Consultants/medical staff in future monitoring and assessments
- Food portions seem to be insufficient for some mothers, they felt under-nourished
- Make parentcraft sessions more interesting, interactive and less of a presentation
- Improve time it takes between GP referral to contacting pregnant women
- Improve the environment in some of the clinics – some either very hot or very cold, little to do to while away the time – some clinics have long waiting times. Ensure that antenatal reception clinic in Lanesborough manned at all times, water available, including cups.
- Provide breastfeeding areas around Trust – toilets only place available around Trust.
- Improve communication and working relationship with Health Visitors – in particular where care is being handed over.
- Develop indicators and reporting targets for race equality and diversity within the service.
- Domestic Violence – develop tools to help identify effectively and deal with sensitively, particularly amongst some cultures who are reluctant or afraid to say.
- Patient/Case Notes – need to be referred to all times as some patients who have used service previously found past clinical experiences not taken on board or notes mixed up.
- 1<sup>st</sup> time mothers need more re-assuring on when to present to delivery suite
- To make clearer the pathway for post-natal mothers who present at the Delivery Suite or Gwillam ward when they have an issue after leaving hospital. Ideally, they should present at GP, and then at A&E, not at the ward, however, since they are still under the care of the Midwifery service, mothers are not clear where to go. This is especially in relation to High Blood Pressure.
- Team building exercises and some work needed to enable both midwives and HCA's, in particular on labour ward to recognise and support their mutually dependant roles.

## 6. CONCLUSIONS

There are no huge variations in the experiences of BME women who use maternity services from women of white backgrounds. The service provides good clinical care, community midwifery which is closer to the diverse local communities have good examples of how their service recognises diversity and race equality. The service has some areas it needs to improve in order to raise its profile as a champion of race equality and good customer care.

*Margaret Adjaye, Equality and Diversity Manager, Wilfred Carneiro, Equality and Outreach Facilitator, Rebecca Cronje, SPPr, Public Health* **September 2006**

## **APPENDIX A**

### **INITIAL OUTLINE FOR PATIENT INTERVIEWS AND FOCUS GROUPS**

**Aim:** To have one to one discussions or focus group discussion with maternity service users across Wandsworth.

**Outcomes:** Identify key issues within the service, patient experience of service, good practice and improvements to be made, assess impact service has on diverse patients (BME) patients in particular, quality of care within service and make recommendations

#### **Format**

- Speak to Senior Managers in the Service and with staff within the service, also community midwives.
- Speak to patients and users of service.
- Focus on Labour Ward, Community Midwives, Ante Natal Services and Primary Care (speak to health visitors in PCT), Consultants, Sickle Cell
- Observations of Care
- Sure start teams
- Maternity Services User Group (contact chair for the group who is a PCT member of staff)
- Speak to Rixa and Jacqueline again.

#### **Questions for Staff**

Use Chery's questionnaire/feedback from her thesis. Develop further questions as a result of Health Impact Assessment, Rebecca is working on.

#### **Questions for Patients**

##### General Questions

- Ask them to share experience of using Maternity Services (ante-natal, other care (those who may have chronic conditions, community services, labour ward, after care))
- What was good about service?
- What was not good and why?
- For specific groups, what are some of their key concerns, issues with the service (what did not happen e.g. language, disability but should have happened?)
- Assessment of staff's cultural competencies, knowledge and impact on care received?
- What improvements must we make (no buts on this) in order to improve/sustain equity. What would they like to see done differently?
- Ideas on how this could be done? Who should be involved?

##### Specific questions

- Folic Acid, Home births, Primary Care Access, Communication and Information, Cultural competencies, staff attitudes

These will be questions which will come out of the Health Impact Assessment which Rebecca is working on (including complaints data).

#### **Monitoring for Success**

We have to build into activities a process for monitoring changes we make and ensuring that we make difference to patient lives

## **Wandsworth PCT – PPI Activities as part of Community Nurses Review – January/February 2006**

5 separate PCT locations covered, discussions held with Health Visitors and new mums.  
Same questions asked at each location

### **Antenatal classes**

- Lots of information about the birth but not on the baby
- Use of very old videos and materials

### **Communication**

- Communication issues between midwives and health visitors – examples given of women who have come home, not knowing what services to expect. Some had found out themselves, by contacting GP surgeries and then on to health visitors

### **Other**

- Delivery area excellent
- Post natal ward at STG – overcrowded, slow, lack of staff, pressured, poor attitudes
- Interpreting services and basic communication with those families whose first language is not English
- Inconsistency in services and behaviour of midwives

### **Over arching discussions – A Helleur**

- Attitudes and behaviours of some staff on ward
- Cultural awareness and understanding
- Late bookers
- Asylum and Refugees (late bookers? Challenges in accessing service?)
- Clarity on access to care for asylum and refugees, and international users
- Information in accessible format within communities
- Equitable and meaningful access – as part of this look at experience of different groups who use service – wide variations? Are there inequities anywhere
- Challenges, gaps within service

### **Over arching issues - Rixa**

- Community midwives structured geographically – there are around 50 midwives, short by 12.
- Tamil worker supporting Tamil women (health advocacy, parent education)
- Teenage clinic
- Have Somalian women supported by community midwives
- Eastern European community (3 – 4 Polish midwives)
- Care shared with GPs
- 1st appointment for women is at home – very good to get to know them, issues, concerns etc
- Noted concerns – getting information about service into different communities, letters in English only (some may not always understand), Some communities, not knowledgeable about system and how it works, feedback process, complaints – those with limited language, some cultures not good at complaining/not sure where to go to, health promotion – how much of it is done



### **Steve Hogarth**

- Language and interpreting a big issue for the service – difficult to communicate with woman, with no or limited English in middle of labour
- Cultural awareness training for staff welcomed
- Speak to Liz Stephens, re postnatal care experience
- Do not monitor late bookers at labour ward – there is some data collected and may be an idea to set into motion a process for gathering some data to help identify who late bookers are and from which communities, to enable Wilfred to work with them

### **Discussions with Jacqueline**

- Bookings made through STG and midwives notified accordingly of pregnant women. Scans, bloods etc arranged accordingly. High Risk women seen at STG, low risk ones by community midwives
- Patients are written to and asked to make appointment. If they do not phone then they are discharged after 12 weeks – ARE LETTERS IN ENGLISH ONLY? DO GP'S ALWAYS LET STG KNOW IF WOMEN HAVE LANGUAGE, DISABILITY REQUIREMENTS
- There are some women who book later on in their pregnancy and some who may be coming in to deliver without ante-natal care – will need to be investigated. Rebecca addressing.
- Will provide us with details of women who DNA for July by ethnicity.

## **BALHAM HEALTH CENTRE**

### **Maternity Services**

#### **Patient Interviews - Balham Health Centre – July 2006**

**Care is shared with GP practices**

**W- White patient , B – Black Caribbean BA – Black African I – Indian P – Pakistani S – Somalian, WO – White Other, A – Asian, BI – British Indian, MI – Maurituus Indian**

#### **How did you find out about Service**

W – Went to GP who confirmed pregnancy (her first child) and asked which hospital she would like to go to. Was not happy with care from GP – wasn't given any info. Received letter from St George's very quickly and visit from midwife. Received lots of information leaflets from St George's and midwife also gave lost of info.

W - Lives in Spain with partner. As soon as she found she was pregnant, phoned her GP and instigated discussions with GP and with midwives. Saw Gynaecologist in Spain as well. Her first child. Came down at Easter and was seen immediately on arrival.

W – Saw GP 5 – 6 weeks into pregnancy. Midwives more informative and would have preferred to see them very early on in pregnancy – have good personal touch. Got Emma's diary from GP. GP explained that midwife will contact them and send letter.

WO (Cyprus) – 1<sup>st</sup> pregnancy, came from Cyprus and lives here with husband. Registered with GP and GP given her lots of advice. She has a lot of support, advice and information from her mother, friends and family. She is very early into her pregnancy and this was her first antenatal visit. Is comfortable communicating in English and has no concerns.

A – Seen at 12 weeks by GP. GP gave her a booklet and that was it.

BC – Saw GP when she was 6 weeks into pregnancy. Had lots of leaflets, booklets and information from GP – what to expect, what to eat. Got appointment with midwives 4 weeks after seeing GP and given advice on folic acid, asked about her history, scans organised. Very informative and structured care given.

BA – Nigeria. Was in Nigeria when pregnant. She went to Lanesborough Wing first to register her pregnancy on advice of mother, but advised by team there to see her GP first. Saw GP 20+ weeks into her pregnancy.

BI – through GP at 7 weeks – he gave her the due date and arranged booked. Got a letter when 10 weeks gone for 1<sup>st</sup> scan. Took folic acid when she found out at 7 weeks.

B – She was 3 months gone when she learnt she was pregnant. She went to the Tooting Walk in Centre and not her GP. Preferred to go to WIC. WIC advised her to see GP who then referred her to St Georges. Did not get any information from GP e.g. leaflets etc and did not take folic acid

MI – Spoke to GP at 8 weeks, contact with midwives at 13 weeks, scan at 14. Info from NHS direct and SGH ok. **No**, few days,

#### **Experience of using Midwifery and Maternity Services**

W – Midwife has been very helpful. Has been for an appointment at Bolingbroke which was very convenient as local to where she lives. New GP she has registered with has been great. Scans have been timely.

W – Within 2 days of arriving from Spain midwife came to see her

W – Booked to attend parent craft sessions. Found booking system very good.

A – Service is good all round. Does not attend parent craft classes. Feels she has lots of information and support from family and does not need classes.

BC – Very nice midwives – first visit from midwife was at home.

BA – After seeing GP, had to wait 2 – 3 weeks, before hearing from STG, and particularly after she had booked late, on arrival from Nigeria.

BI – very good service

B – Friendly and informative service

MI – GP not helpful

### **What is/was good about service**

W – New GP – can always get appointment or talk to someone. Midwife has been excellent. Lots of information received from SGH. Appointment at Bollingbroke was good.

W – Excellent – had lots of information from midwife and GP. Well informed on choices. Care very much tailored to her needs. Also when issue identified, it is dealt with immediately e.g. she was referred to Day Unit. Midwives very good at listening.

W – Reassuring service. Notes looked at thoroughly. Consistency in care given, even though she has seen different people on different occasions.

A - Nothing

BC – Service is good

BA – Midwife – attentive, helpful, knows what she is doing, and looks at everything properly. Makes her feel at ease and relaxed

B – Good service

MI- Good midwives

### **What is/was not so good about service**

W – The GP patient was registered with when she became pregnant.

W – Was very concerned about services in STG as she had heard some bad things about midwives from friends. Was pleasantly surprised about the care she receives, and again even though she was based in Spain initially.

BC – Have to wait too long to be seen at antenatal clinic. Probably because this was opportunity

opportunity for women to talk to midwife about concerns, get more information, support, and assurance and discuss issues.

BI – environment at antenatal clinic – unbearably hot and nothing really to do whilst waiting

B – waiting time – 45 minutes wait. Important to stick to appointment times.

MI- GP did not diagnose anaemia till 7 months preg, although complained of tiredness and backache

### **What needs to improve/change about service**

W – Apart from her old GP, nothing. Very happy, very nice team well joined up care.

W - Nothing

W - Could there be a third column in the red booklet which is given to women, for appointments to be recorded, also to tell women where to go. Sometimes not sure if going to GP, Lanesborough or coming to community, also to include who you will be seeing. Sometimes lose appointment cards.

BC – Improve time keeping, have something to occupy themselves whilst waiting (observed by interviewer, no television present, but had lots of reading materials)

BA – Parent craft classes very boring. Would benefit from having more demonstrations – hands on/practical activities/interesting activities. Fell asleep on first visit and has not been back.

### **Good Practice**

- Parent craft lessons offered later on in pregnancy so women do not forget what they have learnt.
- Audit each other's work to ensure that they are meeting needs of patients
- Able to phone labour ward and ask questions

### **Obersavation at Parentcraft Class**

1 midwife, 1 student midwife, 5 mothers / 2 fathers

\* Recap on last session, encouraged to practice birth positions at home

\* Discussion on labour, possible scenarios at 41+3 days

\* Very full flip / chart...??too much written info distracting

\* is all info covered in books supplied by SGH for mothers who do not attend?

\* Aspects of Choice/s for mother in birth process emphasised

\* Engagement from some mothers, all seem interested

### **SUMMARY**

#### **Midwives – Balham Health Centre**

A professional and diverse staff team who offer good services to patients - summary of discussions with patients

The following are based on discussions with 7 midwives from the team

### **About patients and users of service**

- 70%+ are white, middle class women and professionals as well. Articulate and well informed. Buy most books about pregnancy and babies
- Asian (Pakistani and Bangladeshi) and Somalian women
- Indian, Pakistani, however predominant users are young, white, affluent. Know how to access services very well, well read on pregnancy issues, take folic acid, and attend NCT classes, Parent craft.
- Somalian women – there is emergency accommodation nearby for asylum and refugee communities.

### **Communication and Information**

- Everything we give to patients, including letters and bounty packs are in English
- Posters in English feature predominantly white families, will be good to have more posters with diverse patients
- Limited information about midwifery services in communities, what they know is what they find out from GPs and midwives.
- What women need is clarity on process and what happens at each stage and as much as possible midwives try to communicate this across e.g. when is my scan, what happens etc
- Maternity notes and all other information given to women are in English.
- GPs are first point of contact for women and promote services from that end. If you have a woman not registered with GP, how do they find out about the midwifery services and how to access it? What information is available in the communities about the service?

### **Language**

- Once established that patient has language need, language line is used. Service very committed to ensuring that families do not act as interpreters – actively discouraged.
- Sometimes have patients who say they cannot speak English but find they have some level of understanding and use of language

### **How diversity is mainstreamed into service**

- Discussion with patients, GP referrals tell them if there are special requirements
- Own knowledge and experience of communities (this is picked up during their day to day interaction with women and their families), family ties/traditions faith and religion does inform how care is delivered and communication.

### **Diversity Training**

- Not had any training in equality and diversity
- Not had diversity training
- Was part of midwifery training – one of the modules.

### **Culturally Appropriate/Sensitive Health Care**

- No formal training in culturally appropriate health care. What she knows about this is from hands on experience and dealing with a diverse patient group
- No cultural awareness training – knowledge gathered from caring for diverse patients, also her own cultural background
- Not cultural awareness/competency based training.
- Female Genital Mutilation – though midwife may see this as an issue, women who are affected do not always see it – a cultural thing for them. It affects a small group of women though

- Eastern European patients believe in medical model of care and tend to use GPs more for maternity care rather than midwives. This community may not know a lot about midwifery services

### **What is good about service**

- Patients get to know most midwives well
- Go beyond the call of duty. If a woman does not turn up will call her as many times and may even visit at home. Do not get complaints about service – proactive team and very involved in women's care.
- Access to all the support they need, once they get into the service.

### **Home Births**

- Widely available and accessed by women in Balham (**is that monitored?**)

### **Parent craft sessions**

- Asian women in particular Bangladeshi and Pakistani women do not usually attend sessions. May get lots of advice and support from families and may not find parent craft sessions as useful. Black women again may rely on family support and advice. Some of white clients attend parent craft, yoga, NCT classes.

### **GP Referral forms**

#### **5 forms were sampled by interviewer**

- Very basic and sometimes illegible data offered when referring women on
- No data at all on ethnicity, language requirements, special needs, chronic conditions, past medical history and likely impact on care – severe medical conditions never mentioned, though one instance given of a woman who did have a serious condition and this was never passed on to midwife, woman offered details about her condition much later during her care. Concern that if woman had limited English and has chronic condition some information very hard to glean from them and their families and this could have impact on care, as well as health.
- Use of abbreviations a lot – midwives have to ring surgeries for more information/clarity
- contact details for women not always offered – again have to ring GP for information

### **GPs**

Will be good for GPs to invite midwives to meetings. Balham Park Surgery very good

### **Hard to reach groups**

- Not sure there are any. If pregnant you can access service via GPs and midwives themselves.
- No activities in place to reach hard to reach groups – who are they though?

### **Other**

Need more midwives – i.e. more jobs for them

### **Questions for This Team**

Are there women not registered with GPs who come to midwifery service by themselves – who are they, which communities (do we monitor) and how is their care handled – do we get them to register with GPs?

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## **TUDOR LODGE**

**Orange Team – Tudor Lodge. 19<sup>th</sup> July**

**W- White patient B – Black Caribbean BA – Black African I – Indian P – Pakistani T – Tamil, WO – White Other, A – Asian**

### **How did you find out about Service**

T: GP sent her details to the maternity team. All information to date has been through the team who take time to explain. GP advised and patient took folic acid. (1<sup>st</sup> p)

P: GP provided some basic information, other information from family and friends. Information from the maternity team easy to understand (1<sup>st</sup> p)

WO: (South Africa) found she was pregnant in SA, in contact with UK GP at 3 months, information useful and easily understood. Did not always take folic acid. (1<sup>st</sup> p)

WO: (Polish) GP advised on choices of hospitals and about the service. Information useful and has heard good reports about the service and the hospital. (1<sup>st</sup> p)

WB – learnt about her pregnancy very late and has not had a positive experience at all. Referred by GP and this is where things went downhill.

P – Through GP (husband did the interpreting). Wife is Pakistani Dutch. Did not get any information from GP – aware that there is no information in different languages – would prefer to have something in Dutch or Urdu. This is their first pregnancy.

WB – 1<sup>st</sup> baby, took folic acid until 12<sup>th</sup> week on midwife's advice. Given baby pack and has had lot of information. She has also bought her own baby book. GP referred her on. She prefers to be seen by midwives – really likes the care they give.

W – Referred by GP. Did not take folic acid for 1<sup>st</sup> pregnancy, found out late. This is her second baby and did not take it as found out late. She had some tests done and these were lost. As this is her second baby, does not feel need for information. Does not need parentcraft lessons even though there is refresher course.

WB – referred by midwife, this is her 3<sup>rd</sup> pregnancy. Care is shared with GP. Has second baby in STG. Not going to antenatal classes. First time she did NCT. Received bounty pack.

### **Experience of using Midwifery and Maternity Services**

T: GP gives basic information, very good support from the team. No specific issues in respect of diversity

P: GP very busy and advises patient to speak to midwives for any concerns or questions

WO: SA - All services seem OK, difficult to isolate any experiences. The referral letter from the GP for 1<sup>st</sup> scan took 6 weeks to process although she was 3 mts pregnant when presenting to GP. The service as a whole does not seem to be joined-up.

WO: P – 1<sup>st</sup> scan at 7 weeks at STG. This was early as they had to check for Strep. Letter and clinic location not clear, had to ask 4-5 people to find the clinic

WB – This experience is more about the maternity services and not community midwifery. Did not hear from STG about bloods etc. Came to see midwife who was good and who arranged the bloods for her. When she arrived for her bloods, no one knew what was to be done – the person whom the midwife spoke to was not there and had left no messages that she was coming and this was what was needed. It took 5 weeks before fax to STG was acknowledged. She phoned scan people herself and again got contradictory information. It took three weeks for things to be organised, considering she came into the system late in her pregnancy.

P – so far so good – nothing to measure service against as their first pregnancy. Has requested via midwife to have female only care and a female consultant if things were to go wrong. However if this is not possible and situation is dire, will have to accept care from male clinician.

WB – midwifery care is very good. Very nice and friendly midwives. Good communication and lots of information

W – So far so good with 2<sup>nd</sup> baby, but experience with first baby not so good. Has had very good advice and support from midwives. Listen to her and have made sure she has had all the necessary checks.

W – very friendly midwives. Put at ease, can ask questions. She is an older mother and has never felt prejudiced or treated inappropriately. Has had excellent care.

### **What is/was good about service**

T: All good

P: Antenatal classes very good for 1<sup>st</sup> time mother

WO-SA: Seems Good - 1<sup>st</sup> preg, does not know what to expect

WO-P: Always good. Friend has measles, there was very quick follow up from the hospital to track people and for check ups, made her feel secure

WB – midwives very good but has issue with STG staff i.e. booking

WB – well supported by midwives. Can ask questions and feels she is looked after well.

W – Midwives are very good

### **What is/was not so good about service**

P: Clinic always runs late by ½ hour. Lack of staff noticeable. No privacy for handing in urine sample and other tests.

WO-SA: Antenatal classes times not suitable for working timetables, not able to transfer to other classes. In SA family units go together to these classes. Goes to NCT parent craft classes. Choices and support services not fully explained or understood. Not clear who would be present from the team / service at time of birth.

WO-P: Blood results from measles test took long while to arrive



WB – STG booking staff rude and unhelpful – poor communication. GP gave her wrong address and she went to see GP 4 times to change address. This was probably why it took so long for her to hear from STG. Irrespective, her midwife had arranged things directly. She was concerned as she had not heard baby's heartbeat and wanted a scan. She has heard that Kingston and Guildford services very good and is considering moving over.

P – Have to wait too long to be seen sometimes over half an hour. Have attended one parentcraft session and will not be going back. Lots of people there and did not feel comfortable. It was a difficult experience. Being Muslim, did not feel comfortable in that environment. Will prefer to ask midwife questions. Again lack of information in different languages – if it was available this should be helpful.

WB – nothing major, just waiting time.

W – when she had her first baby at STG, she was not offered a bath for 1 week in Gwillam ward. She had a bad experience with the baby and had to see consultant. She had to visit FMU a lot with 1<sup>st</sup> baby, then on delivery not offered a wash. She did not feel able to complain. It was very unpleasant. 1<sup>st</sup> baby 2 week slate.

W – with second baby had to wait a while to be stitched. Was left on her own when she was at STG and it was only when she was ready to deliver when someone came in. It was a busy night and she acknowledged this – she would have liked her husband to be with her, but he was looking after 1<sup>st</sup> child and could have passed on baby to grandmother if someone from STG had rang to say she was about to deliver – she delivered without husband. AS she was left on her own for so long, it was too late to have an epidural which she wanted and which was in her birth plan.

### **What needs to improve/change about service**

Nothing to add for 1<sup>st</sup> 4 clients

Attitude of staff at booking office – rude, and improve communication in maternity services.

Some information in different languages. Parentcraft lessons not always ideal or some communities e.g. Muslim

Offer mother and baby a wash in Gwillam ward.

Make sure we do not leave mothers on own too long in wards. Experience with 2<sup>nd</sup> baby not so good in STG, however midwives very good.

### **Discussions with Midwives**

There are 3.5 midwives instead of 8 for the team. 1 senior midwife who has retired works 0.5 and offers guidance to the team. Office space very cramped with test kits and other materials alongside desks and patient encounters. Other users in open corridor outside  
One midwife co-leads on Domestic Violence Training with Social Services

### **About patients and users of service**

- Kingston Hospital is within 2 miles; about 70% of mothers in this area elect to go there. A % also go to the Portland and Chelsea & Westminster.

- Patient cohort mainly white middle class, small pocket of Somali and Ethiopian community
- Mothers in Roehampton link into Surestart
- A % of teenage mothers

### **Communication and Information**

- All mothers are assessed individually and their medical history is taken into account
- They are offered homebirth choices, more are taking this up
- Combined care with GP;s encouraged
- Link into Health Visitors ASAP
- This is very neccary as they only see the Kingston mothers after they have given birth for 1 visit
- Some GPs are very poor at communicating information about the patient
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### **Language**

- There used to be an internal SGH based interpreting service in the past which was used
- Once it is established that an interpreter is required, they are easy to book although notice is required, telephone interpreting is a last resort
- Some mothers can understand if time is taken to slow things down, therefore more time is allocated in these situations, or the partner may be present
- GPs do not always state language needs in referral letters to midwives

### **How diversity is mainstreamed into service**

- Each user is assessed for individual needs. These are then supplied / delivered to the best of the team's ability
- Use of peer support and other specialist services ( such as Tamil interpreter)

### **Diversity Training**

- Only as part of midwife training

### **Culturally Appropriate/Sensitive Health Care**

- The team takes time to ensure that the users understand all parts of the service delivery
- Help is given to some clients with other social matters (milk tokens, support for re-housing, link with social workers, benefit applications, others)

### **What is good about service**

- The capacity to be flexible to the clients needs, such as home visits, appt times, choice of pathways and services
- Most users of the service will be satisfied, but there are language barriers, even though these are not expressed by the clients

### **Home Births**

- this is offered as an option, although no figures were available

### **Parentcraft sessions\***

1<sup>st</sup> time mothers do take up parentcraft sessions, refresher ones not taken up so much by 2/3 time mothers

**Other comments**

- As the BME population grows, consideration should be given to developing roles such as the Tamil worker into other communities
- Handing over care to HV is not ideal with mothers who do not deliver at SGH as there is no time to form a relationship with them (only 1 visit post-birth)
- More information re Folic Acid could be put into Family Planning Clinics
- Some mothers are reluctant to learn English even though a mother had 5 children, all born in the UK
- Seeing a growing population of Tamil and Somalian women in Roehampton.
- Kingston and Chelsea are capping so women coming to STG

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## **TOOTING HEALTH CENTRE**

### **Discussion with Red Team Midwives – 27<sup>th</sup> July 2006 Tooting Health Centre**

There are 7 midwives in the team. They are a very cohesive team and work closely together. They also do other specialist care apart from community work, also support on labour ward – specialist care – one does mental health (i.e. for pregnant women with mental illness), one runs teenage pregnancy, another on domestic violence. They are encouraged to develop and broaden their experiences and they bring these experiences into the team and share their learning. They know their clients very well.

#### **Patients and Users**

Predominantly white, then Pakistani (Muslim women). Have some communities with limited or no English. Also Polish women.

#### **Communication and information**

There is no information in the community about midwifery services, role and how to access. Teenage pregnancy service promoted in community.

#### **Diversity Training**

Not had any, learnt on the job and their collective experiences which are shared is excellent – this runs across community midwives.

#### **Parentcraft sessions**

Well attended by all cultures. Muslim women and partners do attend and if they have any questions/queries, do stay behind to ask.

#### **Folic Acid**

Taken up more by white women and they tend to read more about it

#### **Home Births**

This is offered and taken up, but predominantly by white women – not by Asian women (just one or two). Cultural reasons may be behind it – e.g. living at home with extended families and also BME women more used to medical model of care.

#### **What women may want to see improved within service**

Appointment times – currently do not have to book to attend antenatal lesson can come in anytime (wait too long)

See same midwife during care

#### **What is good**

A very good team who work together and this is evidenced in care given  
Homebirths – all the midwives involved in the process.

#### **Suggestion**

Midwifery workforce very ethnically diverse with many spoken languages. May be a good idea for the midwives to be used in running parentcraft sessions in their own languages – they have better understanding of the cultures. Concern noted – as professionals encourage integration, however to enable women and families to get better access this is something that could be considered.

### **Question for this group**

How many users with mental illness including GPs, know about midwife who specialises in their care (she works closely with consultant)? Does she do clinics in Springfield? How does she share learning with whole midwifery pool, not just her team? Could midwives who specialise in particular areas be used in training others? How is their learning shared with nursing staff in general? How is the work of midwives promoted in STG and across Wandsworth? Could the service not have a midwife who specialises in cultural issues and ensures that midwives, labour ward etc take on board cultural issues, concerns around privacy, respect and dignity from cultural perspective?

Could experienced mothers not work closely with teenagers and give encouragement, also experienced mothers from different cultural backgrounds, support those from their cultures and with parentcraft sessions?

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### **Experience of using Midwifery and Maternity Services**

**Red Team- Tooting Health Centre ; 27-07-06, Antenatal Clinic 5.30-7.00pm**

**WB - White British, AI – Asain Indian, AP Asain Pakistani, NA – North African, WA – West African, A - African**

### **How did you find out about Service; Folic acid question**

NA – 3<sup>rd</sup> preg, (36 weeks) weeks, given leaflet. Materials easily understood. **Yes**

WB 1- 1<sup>st</sup> preg, Gp – no literature, info from midwife team is good and continues to be useful. Has additional appt with Endocrinologist and Obstetrician. Shared care with GP. **Yes**

AI 1 – 1<sup>st</sup> preg (20 weeks) rige) , GP confirmed preg with test at surgery. RECEIVED Bounty pack, uses other books . **YES**

AP 1 – 1<sup>st</sup> preg, GP no info, (Rushed as client was going on holiday), unclear pathway to service from GP. Uses magazines that have real-life stories for further information. (Maternity book to be collected) **YES**

WB 2- 1<sup>st</sup> preg (30 weeks), Go provided info about SGH (did not confirm preg at surgery), given Emma's diary. Pack from SGH had item missing, tried to get this through the internet and other sources, but no success. **YES**

AP2 – 2<sup>nd</sup> preg, GP pack, SGH info clear. Also uses internet. **NO** – Feeling nauseous

A – 1<sup>st</sup> preg, Direct from midwife team as using Family Planning at clinic, did not read all the info. Family / friends for other info. **Yes**

WB3 – 1<sup>st</sup> preg, Called NHS Direct, GP – Emma's Diary (A3), Maternity (A4), all info useful and accessible. **Yes**

WB4 – 1<sup>st</sup> preg, GP in Streatham (now with Tooting GP), bought book, uses baby, centre.co.uk,

AP3- 2<sup>nd</sup> preg, GP referral to SGH, info pack good. Uses magazines and books from the library.  
**NO** only 1-2 weeks intake

AI2- 1<sup>st</sup> preg, No GP info pack. Referral to SGH ok. Uses internet sites. **Yes**

WB5- 1<sup>st</sup> preg, 1<sup>st</sup> scan at St Thomas, care now at SGH as moved home & doctors. Info from family, internet and other sources. **Yes**

WA- 1<sup>st</sup> preg, Midwife at GP examined and referred to SGH> useful info, little internet info. 1<sup>st</sup> visit to clinic. **Yes**

### **Experience of using Midwifery and Maternity Services**

NA – good service, everyone helpful. Attended parentcraft classes at 1<sup>st</sup> p, found them useful, no time to attend

WB 1- Has additional appt with Endocrinologist and Obstetrician. Shared care with GP. Has lots of appts because of other medical condition Service very good.

AI 1 – Good services, Blood test prompt at SGH (late afternoon), Birth choices offered, (1<sup>st</sup> preg, no information from Mayday)

AP 1- 1st scan too early at 11 weeks, rebooked for 13 weeks.

WB 2- Scanning very interesting likes the teaching hospital element. Midwives very good. Thorough booking in process. Has not been weighed once in the pathway so far.

AP2 – Links into other services at SGH. Cardiologist, Obstetrician.

A- Good service, birth plan discussed

WB3 – Slick and organised

WB4- Shared care. Midwives brilliant, scans and other services good

WA- 1<sup>st</sup> scan very prompt, little waiting

### **What is/was good about service**

WB 1- Service pathway seems very good. Has a friend in Fulham who have different pathway which does not seem so comprehensive. Everything is explained by all professionals. Communications between the services is good. Parent craft classes good. Been made aware of home birth choices. Home visit good

AI 1- Quick responsive services, had bad hay fever, GP prescribed effective medication

A- Easy access, timings convenient

WB 2- Supportive and personable

WB3 – Full health questionnaire. Scan was a positive moment. Home birth option may be considered, but not keen

WB4 – Full Case history, holistic approach. More than one expected in the level of care. Parent craft classes booked for Sept

AP3- Shared care, everyone very supportive. Seeing the same midwife each week > separate visit to labour ward

AI2' Home visit, home birth offered

WB5- Midwives followed up on questions

### **What is/was not so good about service**

AP 1 –1<sup>st</sup> home visit by midwife was missed because client was on the phone and midwife came to the house but did not knock on the door. Midwife suggested that the phone line should not be used, was abrupt. 2<sup>nd</sup> visit good

AP2 – At time of 1<sup>st</sup> del, some staff were not supportive. Toilets were not working

WB4- ! Visit to GP to check urine sample for sugar and infection was not possible as GP had not pre-filled the request form. Efforts to resample and get the test results were unsatisfactory. No one from the GP ever returned calls.

AP3- Would like more than just 1 refresher parent craft classes did not attend 1<sup>st</sup> time round father could not attend. Gap between children (2years) > Baby nor washed for 1-2 days at 1<sup>st</sup> birth, culturally significant. 1st child, HBP difficult birth 4-5 days labour, epidural nor explained, not cared for or reassured, had to wait for doctor to deliver, left traumatised by process

AI2 – More information in early stages. Cousin informed about Early Pregnancy Unit which she accessed and got a scan.

### **What needs to improve/change about service**

AI 1 – It would be good to have the same midwife for delivery

AP1 – Take alternative contact details

WB2 – More after working hour's activity. (E.g. – Mcmillian Way parentcraft classes at 9.30 am, not able to attend)

AP3- More check ups in 1<sup>st</sup> trimester

AI2[ Class , info on different types of scans

WB5- More explanation of procedures at SGH, test results more quickly.

**Final notes**

- (NA – this patient had her 1<sup>st</sup> at Guys and 2<sup>nd</sup> at St Mary’s. Patient switched care from King’s to Guys because she had heard negative comments about the service, esp. in relation to her cultural perspective (Muslim). Baby washing after birth and cleanliness / water is very important to Muslim women in particular for religious traditions)
- It is essential to review the baby cleaning policy after birth.
- 1 Indian woman could not speak English (2<sup>nd</sup> preg), was known to a midwife. Was waiting for her husband to arrive from local shop. Her appt was delayed until his arrival as no interpreter was present. She was interested in my engagement with the other women
- All women highlighted the value of the home visit. In 1 case, this was re-scheduled because the midwife did not knock on the door although the client & partner were at home but on the phone. A mobile number was not used, although available because this contact information was not recorded. Ist midwife was abrupt and suggested that they should have kept the line free so that she could contact them. Full contact information to be taken





## **LANESBOROUGH WING – RED TEAM**

**Ante-natal Clinic, St Georges Hospital 21/7/06**  
**Afternoon clinic: Red Team, Lanesborough Wing**

**WB: White British, WO: White other, AP: Asian Pakistani, LA: Latin American**

### **How did you find out about Service: Folic acid Question**

AP: 4<sup>th</sup> pregnancy at SGH, knew the pathway. **NO**

LA: 1<sup>st</sup> Pregnancy, does not speak English, Sister has baby of 1 year delivered at ST G and translated the questions, pathway identified through sister. **YES** (own observation: I asked if she had been offered an independent interpreter, she was, but saw no need for it. I also got the impression that her sister answered for her, as she had recently had a baby at SHG & the midwives knew her)

WB: 3<sup>rd</sup> pregnancy at SGH, knows pathway. **YES** (The NHS Book was very useful, but this was not the Pink book)

AP: 1<sup>st</sup> t preg, works in obs/gyn at SGH. Information from family taken with a pinch of salt, **YES**

WB: 1<sup>st</sup> preg, Health Visitor in Tower Hamlets, (GP at 7 weeks, midwives at 12), (**Some**: Patchy, but has very good diet, esp. broccoli)

Would have preferred more information generally in 1<sup>st</sup> trimester

WB: 1<sup>st</sup> Preg, GP at 1 month, referred to midwives. used internet and spoke to local pregnant mothers. Also knows friends who work at SGH and recommended the service. **YES**, but not before conception (Changed GP after highly dissatisfied service, formal complaint against practice)

AP: 2<sup>nd</sup> preg, used pathway at SGH, currently 18 weeks, not too much information from other sources. Used Bounty Book in 1<sup>st</sup> P, read it carefully and understood it all, good information in this resource. **Some**

WO: (American) 1<sup>st</sup> preg, GP did not give ant printed information, gave general info and suggested patient looks up on the internet. Information from SGH service in general supports what she knows, comes from large family, and is a biologist. **YES**, after con, good diet

### **Experience of using Midwifery and Maternity Services**

AP: Good GP support, (help from husband and mother)

LA: GP and other services good. Although user does not speak English, does not feel she has any need for interpreter

WB: All services good

AP: No special needs, minimum contact with GP

WB: Used delivery suite for bleed at 25 weeks, no special needs

WB: used some ante-natal classes at SGH, they were good, attends NCT classes. No needs, but question was asked by team

AP: Patient had complications in 1<sup>st</sup> preg at SHG, but feels the team do not always pay attention to her.

(Case history – At 35 weeks, a protein imbalance was diagnosed, but only after the patient was checked for HBP. This was on the same day when a protein test had been done at the clinic and been found negative. The BP nurse re-did the test and was positive. Admitted directly into unit, after 12 days, baby was induced, epidural used, low birth weight. Mother depressed after birth, had no appetite, tried to breast feed, but did not find it easy. One midwife on the birth ward was not helpful and patient found it difficult to be with this person. Eventually, breast feeding started, patient felt better, child doing well)

WO: All services seem OK. No expectations, but will probably be giving birth at another hospital as moving house.

### **What is/was good about service**

AP: GP support for depression after 3<sup>rd</sup> child

WO: Attention to personal service good

AP: Good to have same midwives as last time, would not go anywhere else for service

AP: Midwives very supportive and encouraging

WB: Communication is good within / between the service/s. Service responsive and easy to get hold of

WB: Couple of concerns were taken on and dealt with swiftly

AP: No specific comment, but perception is OK

WO: 1<sup>st</sup> meeting at home was good, it took place at the weekend so husband was present, and it was long but useful

### **What is/was not so good about service**

WB -5: there does not seem to be good communication between GP and midwives. Getting prescriptions is a case in point.

AP-7: Had to wait 3 weeks for results of a blood test, sugar levels 6.3. Patient would have taken measures to help this, but feels results should be communicated more swiftly and not between visits (this is relevant because of case history, my comments)

### **What needs to improve/change about service**

WB-6: Would like to meet the whole midwife team, as she is not sure who will be in attendance. Would prefer more GP shared care

AP-7: Test results communicated faster

Better signage

**My own comments**

It was a very hot afternoon, 4 -5 patients found it difficult to identify the clinic, there was no clear signage. A suggestion was made to put clear directions in letter. No receptionist on duty in main clinic. No glasses at water station.

One patient AP-7 who was late by 1 hour was spoken to loudly to remind her to keep to her appt times, or she may have to re-book in the future. No clear explanation to the delay was identified.

Some mothers covered their urine samples

One patient would have her notes posted back to her

Midwives also had to call GP's to get some further info for patient notes, some were delayed.

No magazines (except 1 baby mag); a fan in the corridor area would have helped if this was possible.

There were good notice board/s. Re back pain classes & mother support at Balham. Deaf patient text line details, link to Surestart Battersea, teenage parents posters, BUMPS clinic, URDU poster from NHS Greater Glasgow. This is good practice that needs to be spread on an agreed format across the service.

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## **BROCKLEBANK**

**Green Team – Brocklebank Health Centre 3<sup>rd</sup> August 2006. Morning Clinic**

### **Experience of using Midwifery and Maternity Services**

**WB- White British, WO- White Other, BC – Black Caribbean, BA- Black African**  
**12 women were questioned, 8 were WB, WO were from South Africa & Argentina. (see note below)**

### **How did you find out about Service / Folic Acid question**

WB1- 1<sup>st</sup> preg, Just moved from Scotland to local area, rang SGH to enquire about service. Was advised to register with GP and offered appt. This is 1<sup>st</sup> visit to register with GP and see the team. **Yes**

WB2- 1<sup>st</sup> preg, Lived in Clapham , moved to Wandsworth, GP did not offer choice. No information so far, uses babycentre.com and book. **Yes**

WB3 – 1<sup>st</sup> preg. GP referred to service, information good. **Yes**

WB4- 2<sup>nd</sup> preg, GP-SGH. **Yes**

WB5- 1<sup>st</sup> preg, GP in Battersea. Sister & mother used SGH service and recommended. No home visit by midwife. Information useful. **Yes**

WB6- 1<sup>st</sup> preg, 22 weeks. Gp –SGH. No information to date except leaflet on 1<sup>st</sup> scan. Has borrowed NHS baby book. **Yes**

WB7- 2<sup>nd</sup> preg. GP-SGH**Yes**

WB8- 2<sup>nd</sup> preg. GP- SGH. Works at QMH. **Yes**

WO-A- 2<sup>nd</sup> preg, (1<sup>st</sup> at Kingston). GP-SGH, offered choice. Info pack good. **Yes**

WO-SA-3<sup>rd</sup> preg (Chelsea & West). GP –SGH, prefers midwife led service. **Yes**

BC- 1<sup>st</sup> preg, GP –SGH, info good. **Yes**

BA- 1<sup>st</sup> preg, GP-SGH. No choices offered by GP, would have liked Chelsea & West. Info good, uses internet. **Yes**

### **Experience of using Midwifery and Maternity Services**

WB2 – No problems so far, little encounter with health professionals as normal pregnancy. Expected a little more contact.

WB4- Being seen a lot less than 1<sup>st</sup> preg, although has HBP and was 5 weeks premature with 4 days labour with 1<sup>st</sup> child. Classified as low risk by team. On this visit was given leaflet and advised to see GP for procedure.

WB5- No home visit or info. This is partly explained by missed appointment and holiday.

### **What is/was good about service**

WB4- Service is responsive

WB5- Scan visit

WB7- 1<sup>st</sup> pathway good through, midwife at labour ward good

WB8- Good on 1<sup>st</sup> child through the pathway

WB8- Now that the teamleader is here, much improvement in service.

WO-A- Home visit by midwife very positive. This is not in the pathway at Kingston where ante-natal visits were conducted at QMH.

BA – will be accessing parentcraft classes.

### **What is/was not so good about service**

WB3 – Notes mixed up at clinic with other mother who had a miscarriage. This was upsetting.

WB5 – Pressure to choose between NCT and parentcraft classes, feels she should have an automatic place on the NHS service which she has now accepted

WB7- Post natal ward and experience not positive. Very noisy, lots of people

WB8- Referral & Notes went missing between GP, SGH and Clinic. She had to book herself directly into SGH for 1<sup>st</sup> scan at 22 weeks. Low risk assessment although late detection of 1<sup>st</sup> breach birth and had anaemia diagnosed at 21 weeks. Client had to make repeated calls to all services and no one called back. Notes were finally found at the clinic on a visit, although clinic maintained that they had not yet received them from SGH. The GP booked the client into Chease & Westminster although the client had requested SGH. It was not clear if the delay in receiving the notes at the clinic was due to the lack of admin capacity at SGH.

WO-SA- Has made repeated inquiries about having stem-cells removed, but does not find any support of discussion within the service. Her husband will consider making the procedure, but she would prefer a clinician to do it as husband will assist in labour. Feels this subject should be opened up in the NHS as is developing in the USA. Has considered private procedure at £1400.

BA- GP care very unsatisfactory, will be changing GP to Brockelbank.

### **What needs to improve/change about service**

WB5- Has only attended some parentcraft classes as works. Would prefer wider option of classes.

WB7- More attention to mothers in the post-natal ward. There is a lot of attention leading up to and including the birth, then almost no contact, feels odd. Transition stages need more attention.

WB8- The pathway of care was not explained in this pregnancy. There should be a leaflet on booking/ about the scans.

WO-A- Post-natal parentcraft classed were accessed by client in Kingston pathway. Not sure if these are available at SGH

BC- Would like option of evening parentcraft classes

**Other notes**

- The waiting area is very small, 8 seats ( but the clinic was busy and mothers did not have to wait too long)
- HCA came out regularly to check , midwives came out to call mothers
- No notice board or info on maternity services given this is a very busy clinic
- A Pakistani mother was present with husband and 1 child. Neither were confident in English, husband assisted wife with translation. They book interpreters when required for NHS services, has a degree of confidence in the service. Is not aware of SGH paying attention to Muslim patients ( would like Halal foods to be made explicit, as can only eat crisps & soft drinks when at SGH. Did not know of prayer room. > this needs broader attention within SGH as a whole. Is very dissatisfied with Wandsworth Interpreting Service.

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## DODDINGTON

### Blue Team: Base – Doddington Health Clinic

#### Visit – St Christophers Clinic. 4<sup>th</sup> Aug 2006

#### \* Informal discussion with HCA and midwives

- There seems to be inequity in the capacity of midwife teams to be present / on call for delivery. Anecdotally, Pink-Lavender team was suggested as being able to be there, but Blue cannot due to staff numbers
- As Extra NICE guidelines are introduced, these increase the time required with visits, leading to potential delays in seeing the midwives
- The role of the HCA was positive and has development opportunities
- A midwife from Surestart Battersea was present, they are able to support mothers that are having services at K&C or other than SGH, reducing travelling times for these mothers

#### 7 women

**AB- Asian Bangladeshi, WB- White British, BA- Black African, BB- Black Burundi**

#### How did you find out about Service/ Folic Acid

AB- 3<sup>rd</sup> preg (prev 2 at SGH) – 1<sup>st</sup> child 8 years ago, 2<sup>nd</sup> – 6yrs ago. Limited English, finds the material difficult to read. Has used interpreting services in the past, but able to manage now. **No** as was not prescribed

WB1- 1<sup>st</sup> preg ( 18 yrs, unplanned preg) . GP at 6 weeks-SGH, no choice offered. Baby package useful, lots of magazines. **Yes**

BA- 3<sup>rd</sup> preg (prev at SGH). Useful 1<sup>st</sup> time round. **Incomplete**

WB2- 1<sup>st</sup> preg. GP-SGH. Had been recommended by friends. Information useful. **Yes**

WB3- 1<sup>st</sup> preg. GP-SGH, offered choice, determined by location. Information useful. Uses internet. **Yes**

WB4 – 1<sup>st</sup> preg. GP-SGH, choice offered. Had originally gone to C&W, but father of child had 2 previous children at SGH, so changed hospital. Info useful. **Incomplete**

BB- 3<sup>rd</sup> preg (previous at KCL and C&W). GP –wanted C&W. Uses Surestart Battersea. Read limited material. **Yes**

#### Experience of using Midwifery and Maternity Services/ parentcraft

AB- At postnatal ward, some nurses were not nice/ impolite. Had C –section. Will only use female doctors unless Emergency situation, will cancel appts if no F is available. **No**

WB1- Feels confident and supported to ask any questions , service reassuring. **Will book in**

BA- Negative post-natal experiences. 1<sup>st</sup> child (6 yrs), team did not check up on her in the labour ward. 2<sup>nd</sup> preg,(4 yrs) very quick delivery, was left alone in the delivery suite for 4 hours, they forgot she was there. Nurses not supportive in ward, 2<sup>nd</sup> child was not awakening to feed and

her breast was hurting and loss of milk, but no support or advice given. Yes – is parentcraft same as ante-natal?

WB2/3/4- All good (**WB2 –No** to parentcraft)

BB- Similar midwife care as earlier services

**What is/was good about service**

WB1- 1<sup>st</sup> Scan very reassuring, no bruising on blood tests. Has friend who is using service at K&C, but has to see midwives in Victoria. Had considered changing service if she was not happy with it to other location/s.

BA- Midwives ante-post natal

WB2- Had scare at 10 weeks, early scan at SGH was reassuring. Staff helpful.

**What is/was not so good about service**

AB- Poor washing facilities, GP long waiting times of 1hr +.

See above comments on delivery & post natal experiences.

**What needs to improve/change about service**

AB- Information in other languages did not know about prayer room or Chaplin services. Would encourage community located information re Maternity Services

BB- Would like same midwife teams to be present at labour, but this team cannot do this. Is very concerned about level of cleanliness throughout SGH, esp. in toilets. Levels at other hospital visibly better. Has heard many negative comments about SGH labour/post natal from Young Mothers group at Surestart Battersea. Prefers female clinicians.

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## APPENDIX B

### INVESTIGATING EQUALITY IN ST. GEORGES MATERNITY

#### **Key Points**

An analysis of information from the maternity clinical database (Euroking) was used to determine whether there was evidence of inequalities within the maternity service. This study looked at folic acid uptake, uptake & accessibility of antenatal classes, meeting labour ward midwife prior to delivery, birth weight and place of birth.

At SGH 53% of women who deliver are 'White'. The next most common grouping is 'Black African' and then 'Pakistani' and 'Black Caribbean'. Women delivering at St. George's is therefore much more ethnically diverse than women who live in Wandsworth (Wandsworth population is 75% white).

The ethnic profile of teenage mothers is *similar* to the profile of all women delivering at St. George's. The main difference is more Black Caribbean women and fewer Asian women deliver at SGH.

1.5% of women giving birth are younger than 18 years.

4.5% of women giving birth are 40 years or older.

BME women are less likely than white women to have taken folic acid pre-conceptually (almost a half of white women compared to a quarter of BME women).

BME women are much less likely to go to antenatal classes than white women. The difference appeared to be about accessibility and personal choice.

More than 80% of homebirths are to 'white' women.

There was no difference in birth weight detected between white and BME women.

**SERVICE** Teenage mothers are the group most likely to attend antenatal classes (95%) but

#### **Aim**

To determine whether there is evidence of inequalities in the maternity service.

#### **Method**

Data was collected from the Euroking database on the deliveries during the 6 months from 1<sup>st</sup> October 2005 to 31<sup>st</sup> March 2006 (because of small numbers for teenage pregnancy 12 months data was used - April 2005 to March 2006). The information on each pregnancy and birth is filled in by midwives at booking and at delivery. The information gathered on women on the Euroking database was used to look for evidence of inequalities. Three population groups who are known to be affected by health inequalities were selected, these are:

1. Black and minority ethnic groups
2. Women who gave a history of psychiatric illness
3. Women under 18 years of age

The 3<sup>rd</sup> group was specifically chosen because St. George's has set up a special service for teenage mothers and therefore it would be interesting to see how well this is helping prevent inequalities.

### **Choosing the Indicators to measure health inequalities and health service provision**

Ideally indicators should be chosen that reflect ACCESS to healthcare, QUALITY of healthcare provision and OUTCOME. However an indicators can only be chosen if there is a way of 'measuring it' and it is important that the indicator serves as a true measure and not influenced by other confounding factors such as medical risk factors (unless they can be controlled for). For example, type of birth might be influenced by medical complications such as high blood pressure which is more common in certain ethnic groups. Examples of possible indicators are shown in Table 1.

Table 1: Indicators to measure health inequalities

<b>Access Indicators*</b>	<b>Quality Indicators</b>	<b>Outcome Indicators</b>
<i>Late booking (&gt;14 weeks)</i>	Taken folic acid	Birth weight
<i>Missed NT test</i>	Attendance at antenatal classes	
<i>Missed screening tests</i>	Has woman met LW midwife previously	
	Place of birth	

\*None of the access indicators can be determined by the database at the moment

(Unfortunately the Euroking database was not able to discriminate between women who had a timely or late screening test or those who booked late. Therefore we were only able to analyse the quality and outcome indicators).

Another problem with the Euroking data base is that it was not possible to correct for simple confounders (such as age). However, the results can lead to questions which can be a starting point for further more in depth research.

### **Rationale for all the indicators**

- a) *Folic acid* – this is a vitamin which should be taken before pregnancy and in the first 12 weeks of pregnancy to reduce the risk of neural tube defects. Recent studies in the US have shown that about 40% of women take folic acid pre-conceptually and that being non-white, lower maternal age, lower educational achievement and unplanned pregnancy are predictors of low use<sup>1</sup>. This indicator therefore reflects knowledge about health and pregnancy in the community, although starting to take folic acid at any stage during pregnancy will also reflect prompting by health professionals.
- b) *Attendance at antenatal classes* – antenatal classes should be available and accessible to all women.
- c) *Has woman met labour ward (LW) midwife previously* – An ideal model of care would be that all women know their LW midwife before the time of delivery. Due to the inability in most cases to plan the time of delivery this is often not possible. For some groups of women this will be more important than others e.g. teenage mothers. Systems to increase the chance of knowing your midwife might be taken up by certain groups not according to need.

<sup>1</sup> Goldberg et al, 2006

- d) *Place of birth* – Most women will deliver in the hospital. There has recently been an increasing demand for home births and is available to a limited number of women. This indicator was only looked at by ethnic group.
- e) *Birth weight* – The 'ideal' birth weight is between 2500-3900g. This is a crude measure of good outcome of antenatal care.

## Results

In the 6 months between October 2005 and April 2006 there were 2227 deliveries. The **ethnicity** and number of the women who delivered in this time is shown below.

Table 2: Ethnicity of women delivering at SGH and ethnicity of Wandsworth

	Deliveries at SGH		Wandsworth*
Caucasian	1170	53%	75%
Black			
Black African	240	11%	4%
Black Caribbean	126	6%	6%
Black other	19	1%	2%
West Indian	7	0%	
Asian			
Pakistani	158	7%	2%
Indian	90	4%	4%
Bangladeshi	25	1%	1%
Sri Lankan	65	3%	
Other Asian	53	2%	1%
Jewish	1	0%	0%
Mixed Ethnic origin	70	3%	
Chinese	26	1%	1%
Unknown	3	0%	
Other	174	8%	3%
<b>Total</b>	<b>2227</b>	<b>100%</b>	<b>100%</b>

\*data from 2001 census

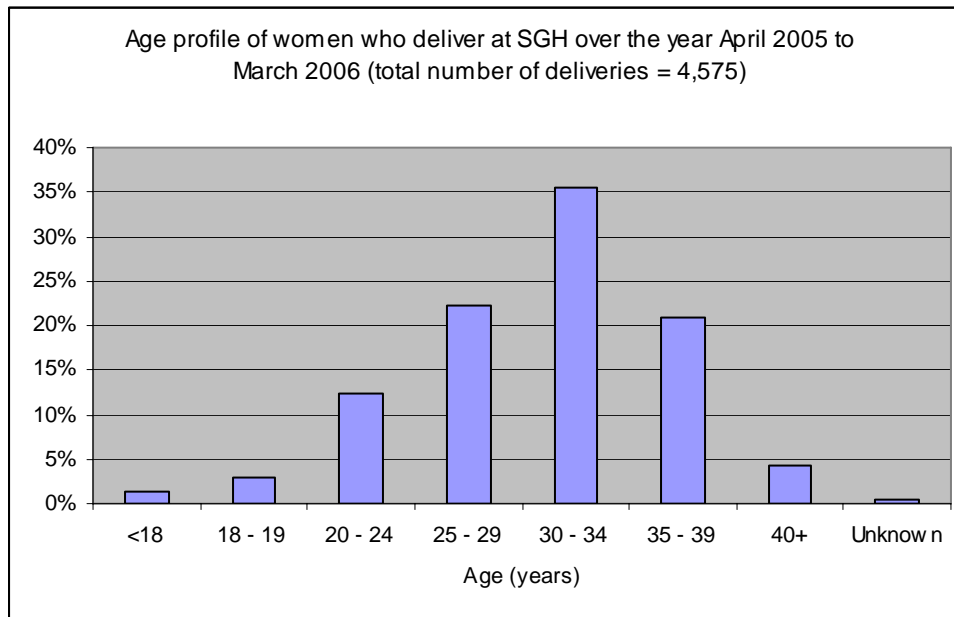
The table above shows that **women delivering at SGH are more ethnically diverse than the population of Wandsworth as a whole**. This is partly because women of child-bearing age are more ethnically diverse than the overall population of Wandsworth and partly because fertility rates in different BME groups are higher than in the Caucasian population. But it is also possible that there are some other explanations why Caucasian women are underrepresented.

Of all the women delivering 252 (11%) gave a history of current or previous **mental health** condition. The most common was depression, 89% of the 252 had depression (some had more than one psychiatric condition).

Due to the small numbers of deliveries the data on **teenage pregnancy** was collected for the 12 month period between April 2005 and March 2006 (age at delivery). During this period there were 4,575 women who delivered and of these 63 (1.5%) were less than 18 years old and 4.5%

were 40 years or older. In terms of obstetric risk profiles women at the extremes of age carry a greater risk than other women.

Figure 1



The ethnicity of teenage mothers is similar to that of all women delivering at SGH as shown in Table 3. The numbers of teenage mothers are small so confidence intervals are given for the percentage. The only ethnic group which might have a disproportionate number of teenage pregnancies is black Caribbean. Pakistan (and Asian generally) has disproportionately fewer teenage pregnancies.

Table 3: Ethnicity of teenage mothers compared to all women delivering at St. George's

	Teenage mothers		Deliveries at SGH	
	n	% (CI)	n	% (CI)
Caucasian	45	55% (44%-55%)	1170	53% (51%-55%)
Black				
Black African	12	15% (8%-24%)	240	11% (10%-12%)
Black Caribbean	11	13% (8%-22%)	126	6% (5%-7%)
Black other	0	0% (0%-4%)	19	1% (0%-1%)
West Indian	1	1% (0%-7%)	7	0% (0%-1%)
Asian				
Pakistani	0	0% (0%-4%)	158	7% (6%-8%)
Indian	1	1% (0%-7%)	90	4% (3%-5%)
Bangladeshi	0	0% (0%-4%)	25	1% (1%-2%)
Sri Lankan	1	1% (0%-7%)	65	3% (2%-4%)
Other Asian	0	0% (0%-4%)	53	2% (2%-3%)
Jewish	0	0% (0%-4%)	1	0% (0%-1%)
Mixed Ethnic origin	9	11% (6%-20%)	70	3% (2%-4%)
Chinese	0	0% (0%-4%)	26	1% (0%-2%)
Unknown	0	0% (0%-4%)	3	0% (0%-1%)
Other	2	2% (0%-9%)	174	8% (7%-9% 7%)

<b>Total</b>	<b>82*</b>	<b>100%</b>	<b>2227</b>	<b>100%</b>
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82 women who were <18 years at booking  
95% confidence intervals given in brackets

## RESULTS OF QUALITY INDICATORS

### a) Folic acid

*The question asked 'have you taken folic acid?'*

Table 4

	<b>Response rate</b>	<b>Took folic acid pre/post or both</b>	<b>Took folic acid pre-conception</b>
<b>Ethnicity:</b>			
Caucasian	75%	94% (92%-95%)	46% (43%-49%)
BME	30%	85% (81%-89%)	25% (20%-30%)
<b>Psychiatric history:</b>			
Yes	68%	88% (82%-92%)	29% (22%-36%)
No	52%	92% (91%-94%)	42% (39%-45%)
<b>Age at delivery:</b>			
<18 years	49%	61% (44%-76%)	0% (0%-10%)
18 -24 years	36%	82% (76%-86%)	8% (5%-12%)
25 - 39 years	54%	93% (92%-94%)	43% (40%-45%)
40+ years	66%	89% (83%-93%)	44% (35%-52%)
<b>All women</b>	<b>53%</b>	<b>92% (90%-93%)</b>	<b>40% (37%-43%)</b>

(95% Confidence Intervals given in brackets)

A problem with the interpretation of these results is that the response rate was to this question was generally poor but significantly worse for the BME than for Caucasians. This was particularly true for Pakistani's; there was only 1 answer from 158 deliveries.

The worst result was from the Black Caribbean/African/Other as only 15% of those who responded took folic acid pre-conception (n=150). However by the end of pregnancy 84% had taken folic acid.

Taking folic acid prior to pregnancy is less common in women with a history of mental health problems. However the proportion of women who end up taking folic acid at anytime before or during their pregnancy is the same irrespective of mental health problems.

None of the teenage mothers took folic acid prior to conception, but 61% started taking it whilst pregnant. They had the lowest rates of folic acid use of all the groups studied.

### b) Antenatal Classes

*The question asked whether the woman attended antenatal classes.*

Table 5

	<b>Response rate</b>	<b>Yes*</b>	<b>No†</b>	<b>Not available</b>	<b>Not required</b>
<b>Ethnicity:</b>					
Caucasian	98%	59% (56%-62%)	3% (2%-4%)	1% (0.8%-2%)	35% (32%-38%)
BME	98%	44% (41%-47%)	7% (6%-9%)	5% (4%-7%)	47% (44%-50%)
<b>Psychiatric history:</b>					
Yes	100%	48% (42%-54%)	4% (2%-7%)	1% (0%-3%)	44% (38%-50%)

No	98%	52% (50%-55%)	5% (4%-6%)	3% (3%-4%)	40% (38%-42%)
Age at delivery:					
<18 years	95%	95%	0%	0%	5%
18 -24 years	96%	56%	8%	6%	32%
25 - 39 years	98%	51%	5%	3%	40%
40+ years	99%	36%	4%	1%	59%
<i>All women</i>	98%	52% (50%-54%)	5% (4%-6%)	3% (3%-4%)	40% (38%-43%)

\* includes hospital classes, community classes, NCT, woman making 'own arrangements', teenage classes, refresher classes

† includes tour only, no class available. (95% Confidence Intervals given in brackets)

More Caucasian than BME women attended antenatal classes. Sri Lankan women had the lowest uptake of antenatal classes, just 28% attended. In the Black African group 33% attended antenatal classes (58% said they were 'not required' and 6% said they were 'not available'). Indian women were the only single ethnic group which had a higher uptake of antenatal classes than Caucasians, as 63% attended.

One percent of Caucasians and 5% of BME women said that an antenatal class was not available. Eighteen percent (n=65) of Sri Lankan women and 8% of Indian women said that an antenatal class was not available.

There appears to be no difference in the attendance at antenatal classes between women with a history of mental health problems and those without. About half of all women attended some form of antenatal class.

The majority of teenage mothers attended antenatal classes and 87% attended the teenage classes. A class was available for all the teenage mothers although 3 decided they were not required. The age group with the poorest uptake of antenatal classes were the 18-24 year olds and 6% of this group said there were no classes available.

### c) Labour ward midwife

*The question asked 'had the woman previously met the midwife caring for her during labour?'*

Table 6

	Response rate	Yes
Ethnicity:		
Caucasian	99%	9% (7%-10%)
BME	98%	7% (6%-9%)
Psychiatric history:		
Yes	98%	8% (5%-12%)
No	99%	8% (7%-9%)
Age at delivery:		
<18 years	100%	10% (5%-19%)
18 -24 years	99%	7% (5%-9%)
25 - 39 years	99%	8% (8%-9%)
40+ years	98%	16% (11%-21%)
All women	99%	8% (7%-9%)

The majority of all women delivering at St. George's have never met the midwife caring for them during labour before. Indian women had the highest rate at 15% (n=90) and Black African the lowest at 3% (n=240).

There was no difference in this indicator between women with and women without a mental health history.

Women at the extremes of age are more likely to have met the midwife before delivery. For young women it is likely to be beneficial to have someone they know with them in labour and steps have been taken by SGH to make this more likely. It is unclear why older women also are more likely to have met their midwife.

## RESULTS OF OUTCOME INDICATORS

### d) Birth weight

*This question recorded the birth weight of the baby.*

Table 7

	Response rate	2500 – 3999g	Less than 1000g
Ethnicity:			
Caucasian	99%	79% (77%-81%)	1% (0.5%-2%)
BME	98%	82% (81%-86%)	1% (0.5%-2%)
Psychiatric history:			
Yes	98%	80% (75%-84%)	1.6% (0.5%-4%)
No	99%	81% (79%-83%)	1.0% (0.5%-2%)
Age at birth:			
<18 years	100%	84% (74%-91%)	2% (0%-8%)
18 -24 years	100%	86% (83%-88%)	1% (0.5%-2%)
25 - 39 years	99%	80% (79%-82%)	1% (1%-2%)
40+ years	98%	76% (70%-82%)	2% (0.5%-4%)
<i>All women</i>	<i>99%</i>	<i>80% (79%-83%)</i>	<i>1% (0.5%-2%)</i>

Overall 80% of women had babies within the optimum weight band (2500-3999g). The figures are suggestive that women over 40 might have the smallest babies, but due to small numbers and wide confidence intervals this can not be certain. The likelihood of having a very low birth weight baby (less than 1kg) appears more likely at the extremes of age. However the confidence intervals overlap and therefore the difference is such that statistically there could be no relationship between maternal age and birth weight at SGH.

There was no difference in birth weight between women with and women without a mental health history.

### e) Place of birth

*This question recorded the place of birth of the baby*

Table 8

	Response rate	Labour ward	Home
Caucasian	100%	92% (90%-93%)	4% (3%-5%)
BME	100%	94% (92%-95%)	1% (0.5%-2%)
<i>All women</i>	<i>100%</i>	<i>93% (92%-94%)</i>	<i>2% (2%-3%)</i>

There were 53 home births in the 6 months period and 43 (81%) of those were Caucasian women. However the percentage of women delivering at home was the same for black Caribbean women as Caucasian women. Apart from this group the BME women were far less likely to have a home birth.



## Summary

### ***Ethnicity***

At SGH's 53% of women who deliver are Caucasian. The next most common grouping is Black African and then Pakistani and Black Caribbean.

- These results are interesting in that there is a huge ethnic difference on whether the question on **folic acid** is being completed by the midwives – *the reasons for this will need to be investigated.*
- From those who responded it appears that almost half of Caucasian women take folic acid at the optimum time (preconception) compared to a quarter of BME women. The differences in preconception folic acid use might reflect better awareness by Caucasians for the need to take folic acid or more unplanned pregnancies in the BME group. More BME women start taking folic acid after conception but still do not reach the uptake of Caucasian women, 94% compared to 85%. *The reasons that certain ethnic groups do not take folic acid in pregnancy should be explored and efforts made to increase awareness and use of folic acid pre and during pregnancy.*
- There is a significant difference between availability and attendance at **antenatal classes** between Caucasians and all the ethnic groups but particularly Sri Lankan and Black African women. Almost half of BME women stated that antenatal classes were 'not required' compared to just over a third of Caucasian women. There may be some cultural reasons for not requiring antenatal classes but there are *significant differences in availability/accessibility of antenatal classes between ethnic groups which should be explored.*
- The majority of women have never **met the midwife who cares for them in labour** before. Indian and Pakistani women were more likely to have met the midwife and Black African and Caribbean women the least likely.
- Almost all deliveries occur in the hospital labour ward. There is currently no facility for midwifery only care at St. George's. There is a significant difference in the number of **home births** between the ethnic groups. Over 80% of the 53 homebirths were to Caucasian mothers, only Black Caribbean women had similar rates (only 5 of the home births did not come from either of these ethnic groups). *The reasons why there were so few home deliveries in the BME community needs to be addressed by critically looking at the process by which decisions are made on accessing home births.*

### ***Mental health history***

At SGH approximately 1 in 10 women give a history of current or previous mental health problem, depression being the most likely disorder. There was no difference in any of the indicators reflecting hospital care between women with a history of mental health problems and those without.

### ***Teenage pregnancy***

Last financial year 63 women less than 18 years and 200 women over 40 years old delivered at St. George's. The ethnicity of teenage mothers appears similar to the ethnicity of women delivering at SGH overall, although there are proportionately more Black Caribbeans and fewer Asian women.

- None of the mothers less than 18 years old had taken folic acid preconception and more than a third never took the vitamin at any point in pregnancy
- Antenatal classes were available to all teenage mothers and 95% took up the opportunity (most attended the special teenage classes).
- Teenage mothers were also more likely than most other women to have met their LW midwife before labour, although overall rates of this are still low.

## **Conclusions**

This study attempted to look at whether there were differences in maternal healthcare being delivered to different groups of women who deliver at SGH. This study concludes that there are some differences between the different populations. In some situations this can be seen as a positive result, for instance it is appropriate that the take up of antenatal classes and availability of antenatal classes is best for teenage mothers who need might be greatest. But it is not appropriate that some BME groups are finding it more difficult to access antenatal classes and are not heeding health promotion advice such as taking folic acid.

The reasons for these differences needs to be explored in a more in depth qualitative analysis but the findings of this study can be used as a starting point for this research.

## APPENDIX C

### INVESTIGATING THE PROFILE OF WOMEN WHO BOOK LATE IN PREGNANCY

#### Key Points

This small study looked at the demographics of the 173 women who booked 'late' for antenatal care in January and February 2006. It demonstrates that women who book late are much more ethnically diverse than women overall who give birth at St. George's.

Overall 15% of women who book do so after 13 weeks.

Women who book for antenatal care outside the optimum period of before 13 weeks are missing out on early ultrasound scans and other screening procedures which are best done early on in pregnancy (e.g. HIV, blood pressure). This might result in a compromise of maternal and/or foetal health.

The women most likely to book late are from BME groups:

- 27% are Black (18% of women who deliver at SGH are black)
- 19% are White other
- 17% are Asian

The women who book late are more likely to have been born outside of the UK, in particular 'black African' women who were born in Africa (most commonly Somalia). Another large group are Sri Lankan's. These groups of women come from countries from which the UK receives refugees and asylum seekers. They are a mobile population who might be transiently resident in and around SGH; they are also likely to have greater health needs and language problems.

Eastern European women, Poland being the most common, also account for a relatively high proportion of late bookers. The number of Eastern European women living in Wandsworth appears to be growing.

St George's maternity service needs to engage with community groups and outreach worker's to ensure that these diverse groups of women are aware of the services offered at SGH and know how to access them in a timely way.

#### Aim of the study:

To identify some characteristics of the women who book late in pregnancy ('late bookers'). For this study a 'late booker' is a woman who books too late to have the nuchal translucency (NT) ultrasound scan (performed at 11-14 weeks).

#### Method

'Late bookers' were identified through the referral records of the foetal medicine unit (FMU). All women who book in pregnancy should have an ultrasound scan during their pregnancy, and therefore unless a woman presents extremely late in labour ward their details should be in this record. Referrals for January and February 2006 were used. These notes often recorded if a woman had been booked elsewhere and was moving into the area, these women were excluded from the analysis. It is likely that this information on some of these women will not have been recorded and they will be included in this analysis. The hospital numbers were used to identify the women's 'ethnic origin' and 'country of birth' from the EPR system.

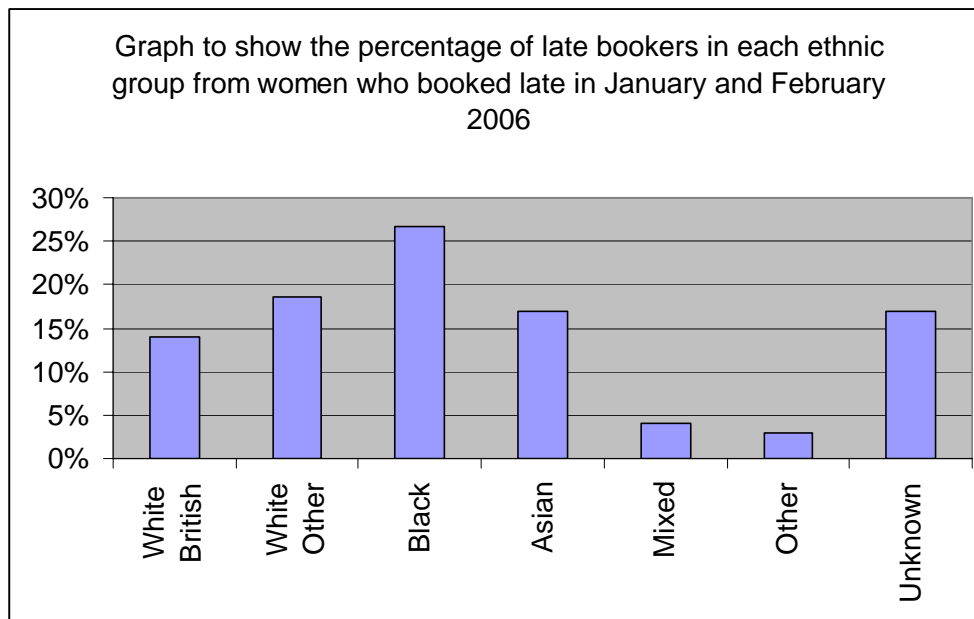
## Results

In January and February there were 1124 referrals to the FMU of which 173 (15%) were identified as 'late bookers'.

The ages of the women ranged from 16 to 42 years, the average age was 30 years (the age was not available on 5 of the women).

The latest 'booking' date was 38 weeks. Sixty five women booked between 20 and 29 weeks and 14 women booked on or after 30 weeks.

Figure 1



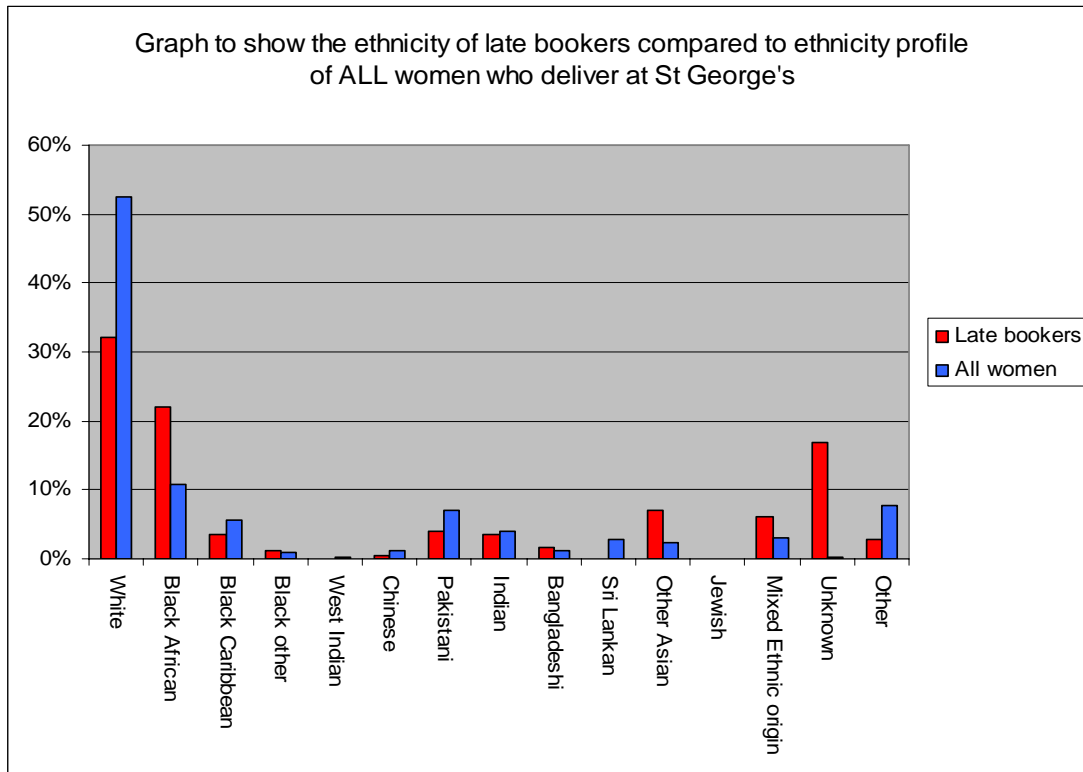
### *Ethnicity of 'late bookers'*

The ethnicity was taken from the hospital computer system. Unfortunately the data was only available for 83% of the women. The number of women in each ethnic group is shown in figure 1.

In terms of numbers, the 'black' and 'white other' ethnic groups make up 46% of all 'late bookers'. These groups are over represented compared to all women who book at St George's. Unfortunately the ethnicity data for all women delivering at St George's comes from a different database which is 100% complete but does not include sub groups of 'white'. However figure 2

does show that 'black Africans', 'other Asians' and 'mixed ethnic' groups are over represented in the late bookers.

Figure 2



### Country of birth

Women who booked late were born in 45 different countries (this information was not available on 32 women). The most common countries of birth were UK, Somalia and Sri Lanka. Of the 140 women on whom there was information on place of birth 95 (68%) were born outside of the UK, 37 (26%) were born in Africa and 18 (13%) were born in Eastern Europe.

Table 1

Country of Birth	Number of late bookers
UK	45
Somalia	9
Sri Lanka	8
Ghana	7
Nigeria	7
Poland	6
Other	58
Unknown	32

Out of those women who were born in the UK 19 (42%) were white British. Interestingly of the 46 women who were defined as 'black' just 5 were born in the UK. Of the 32 in the 'white other' group just 1 was born in the UK whereas 16 were born in Eastern Europe and 5 in Western Europe.

## APPENDIX D

### Details of Formal and Informal Complaints

#### Summary

There are over 2000 deliveries half yearly at SGH and the maternity unit receives about 50 formal complaints per year. This equates to about 2% of women. The majority of people who may be unhappy with some aspect of their care will not go on to make a formal complaint so complaints should be seen as the 'tip of the ice berg'.

It is also true that there are many people who are very happy with the care they have received but never go on to share that formally with the trust.

Complaints therefore do not tell 'the whole story' but there are lessons that can be learnt from them. From the information presented below a common theme is that women who go on to complain have often felt neglected either by being left unattended or by someone not spending time with them, such as to help them with breast feeding. There are also many cases where the attitude of the staff who are supposed to be caring for them was bad. These two areas are probably related and a greater awareness of a patient's fears and respect for their dignity would help address some of these issues.

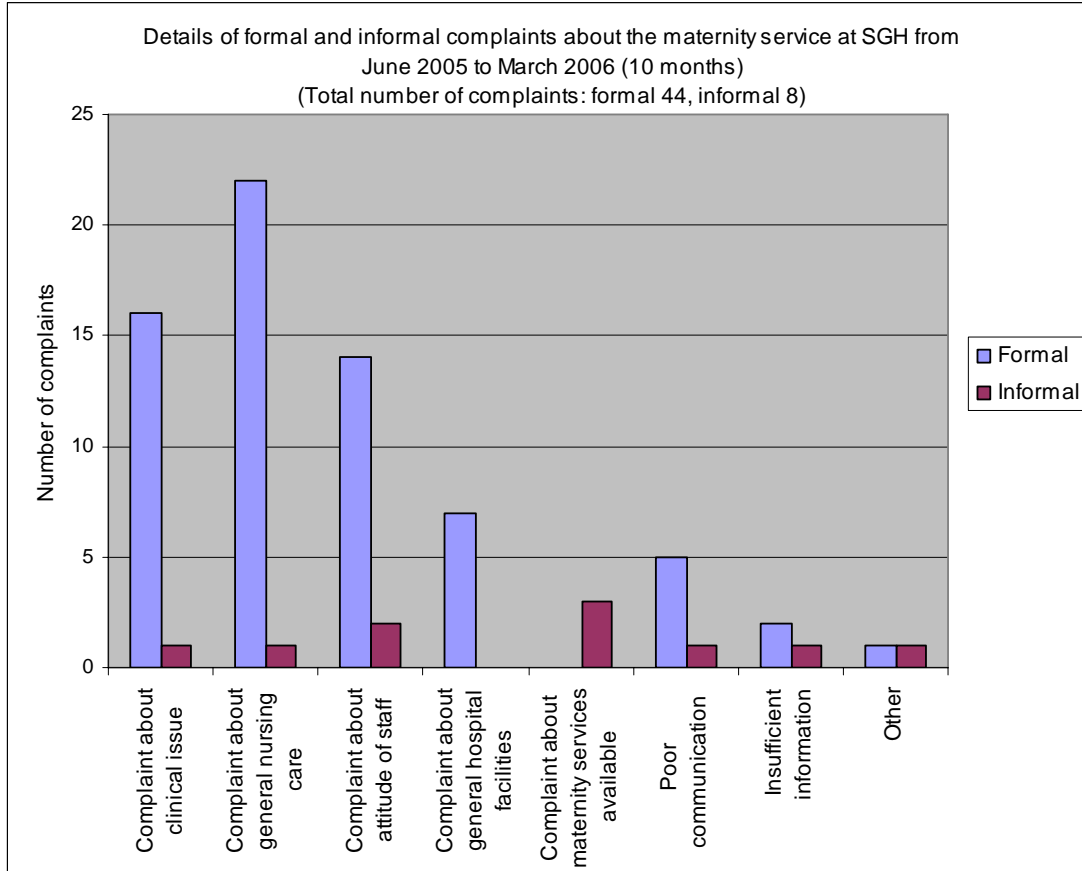
#### Formal and Informal Complaints to SGH complaints department

A summary of complaints for the 10 months between June 2005 and March 2006 is shown in figure 1. There were 44 formal complaints made which contained 66 different issues about which they were complaining. There were only 8 informal complaints (people complaining informally were encouraged to do so via PALS) which contained 10 different complaints.

The most common reason for complaining was about general nursing care. Such as "... patient was left unattended in the delivery suite, not given an epidural till the following morning, her husband had to clear up her vomit, and says she had a horrific experience", "complaint regarding the care given by a midwife" and "concerns about the care and attention given to this young mother especially regarding breastfeeding advice".

There were 11 complaints where the mother had felt neglected by the staff such as "...she was left unattended for most of the time, until she was fully dilated...", "the patient was not assisted with breastfeeding...", "...the patient was having a baby and was supposed to be closely monitored and was left" and "...looked after by a student midwife without supervision...".

Figure 1



Clinical care was the second most common reason such as “complaint about giving birth unattended by a midwife. The husband was told to wait as the midwives were handing over”, “poor epidural control” and “complaint about misdiagnosis of infection during pregnancy”.

The third most common area of complaints was about staff attitude such as “concern about the attitude and care of a midwife” and “attitude of staff in delivery suite and on Gwillim Ward”. These complaints were about the doctors, midwives, theatre staff and staff generally.

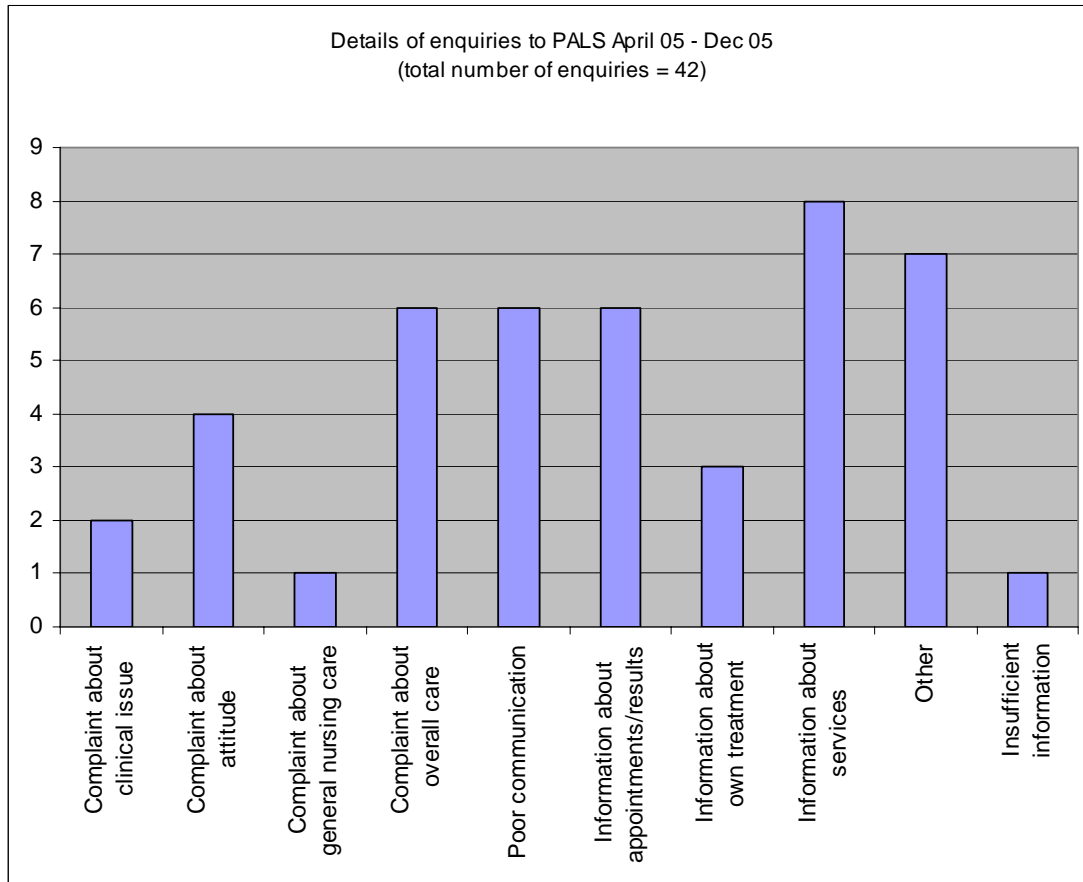
### Details of enquiries to PALS about maternity services in 2005

There were 42 enquiries to PALS which included comments made on 44 different issues, not all of them were complaints. Many of them (17) were after information about their care, appointment or the maternity services generally. This may imply that there is lack of information given to patients and so they have to use PALS for this purpose.

Examples of peoples request for information were “wanted to know scan date”, “wanted to know whether hospital had her referral”, “wanted information about EPU”, “information on LW tour”(x3).



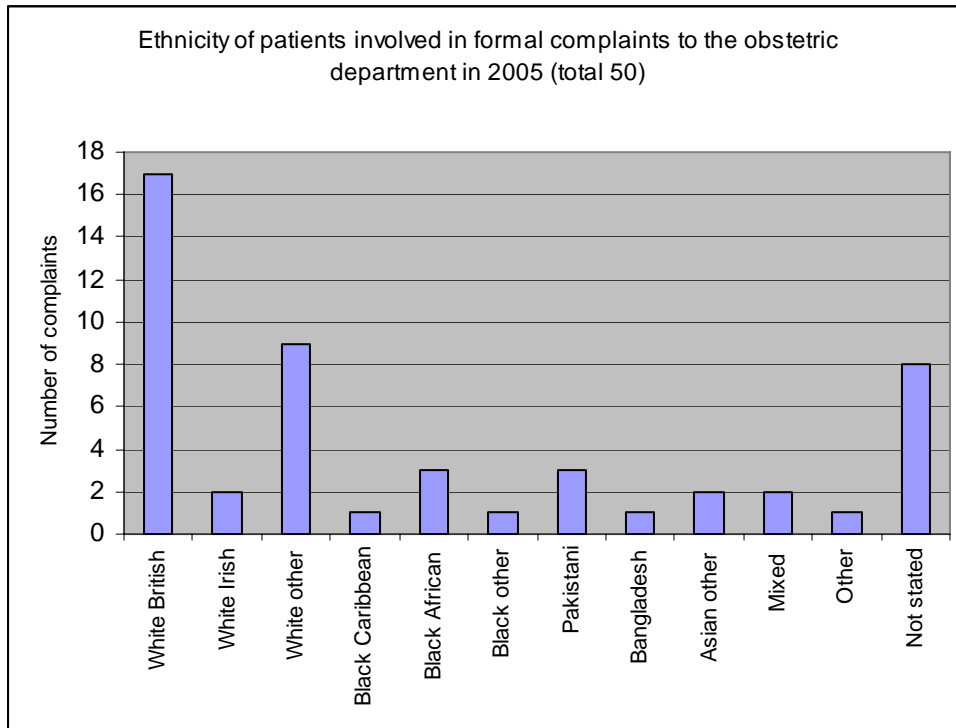
Figure 2



### Ethnicity of patients involved in complaints

Those people most likely to complain are white British (32%). This is not unexpected since this group are the largest single ethnic group using the maternity service. The white group overall make up 53% of maternity patients and 56% of complaints. Black Africans make up 11% of deliveries at SGH but only 6% of complaints. The numbers are small and ethnic group is not available on 8 people so it is possible that the people complaining are representative of all women using the maternity service.

Figure 3



## APPENDIX E

**Breakdown of Staff by Gender / Band & Ethnicity over the following areas  
Community Midwives / Delivery Suite / Geillim / Dakin Ward & Neonatal Unit**

Gender	Band	Ethnicity					
		Asian	Black	Chinese/Other	Mixed Race	Unknown	White
Female	Band 5	4	3	1	1	6	11
	Band 6	19	33	11	4	15	47
	Band 7	5	16	5	1	7	19
	Band 8a	0	0	0	0	0	3
	Band 8b	0	0	0	0	0	1
Male	Band 5	1	0	0	0	0	0
	Band 6	1	0	0	0	1	1
	Band 7	0	0	0	0	0	1
	Band 8a	0	0	0	0	0	0
	Band 8b	0	0	0	0	0	0

## APPENDIX I

### MATERNITY SERVICES

#### DID NOT ATTEND - DNA's Sample data from Maternity Services

There were 62 DNAs for July 2006, 7 for Teenage Clinics, 25 for Midwifery follow ups, 23 for Consultant appointments, and 7 Booking appointments. DNAs by ethnicity are summarised as follows

White British	13 DNAs and from postcodes, 5 were out of area
White Other	9 DNAs and 6 out of area
White Irish	2 DNAs and both out of area
Black African	11 DNAs, 7 out of area
Black Caribbean	7 DNAs and 6 out of area
Other Ethnicity	1 DNA
Asian Other	3 DNA and 1 out of area
Mixed	4 DNA and 2 out of area
French	1 DNA out of area
Sri Lankan	2 DNA out of area
Bangladeshi	1 DNA out of area
Pakistani	2 DNA 1 out of area
Arab	1 DNA
Afghan	1 DNA out of area
Refused to state	4 DNA 2 out of area

Majority of those who DNA do turn up eventually and are seen.

#### **Observation**

Ethnicity recording above does not follow 16+ coding.

#### **Challenges**

Women who do not turn up for appointments could have severe medical concerns or issues and may need urgent scans/care. Some women however who have eg suffered from a condition previously and no longer see it as a threat, may opt not to turn up for appointments.

#### **Possible Reasons for DNA**

- Out of area (top most reason) – they may be receiving care elsewhere.
- Forgotten
- English as a second language

#### **Areas**

Women from the Merton and Lambeth areas appear to DNA most.