

... tell me more ...

Engaging Women - A Different Approach

by Stephanie Stanwick and Noemi Fabry

'As Midwives we hear women's stories all the time, taking notes of the things that are important to 'us'. This time I was listening for the bits that were important to 'her'.'



tell me more
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ENGAGING WOMEN—A DIFFERENT APPROACH

Engaging women in East London on the future of their Maternity Services

by Stephanie Stanwick and Noemi Fabry

As midwives we hear women's stories all the time, taking notes of the things that are important to 'us'. This time I was listening for the bits that were important to 'her'. It reinforced the close relationship between women and midwives.

Executive Summary—the Tell-me-More approach to public consultation

1. BACKGROUND Key Facts

Maternity Services across London are facing significant challenges: an increase in the number of births together with a highly mobile and diverse population. This combined with the difficulty in retaining and recruiting staff provides significant tensions when trying to develop high quality responsive services.

The Health Care Commission's 2007 review of Maternity Services, which included a comprehensive survey of women's experiences of the service, judged all but one London unit as either 'fair' or 'least well performing'. The review highlighted that providers are struggling to offer the kind of care women expect and that the aims of a woman-centred maternity service offering access and choice are not in line with the reality of the patients' experience.

2. AIMS

This report had two distinct aims:

- 1) To describe a different engagement process which was undertaken in order to inform the development of a local maternity strategy. This approach used a detailed analysis of interviews with vulnerable women who had recently delivered, providing a snapshot of their recent experiences of ante-, postnatal and intra-partum care.
- 2) To describe the benefits of working with clinicians to do this work, and demonstrate how this approach can fit into a service improvement approach through a continuous PDSA (Plan, Do, Study, Act) cycle.



3. METHODS

There are challenges to developing effective interventions and representative measurements of healthcare experience and this was demonstrated in the Picker Institute's comprehensive review of *Patient-focused interventions* (2006). Clinical staff are overwhelmingly responsible for the experience patients have, and if we expect that experience to improve, it is the staff themselves who should have an opportunity to hear and understand the impact their work has on patients.

Consultation is a continuous process of service assessment based on patient experience, and the aim is to build internal capacity to establish an effective and continuous feedback system. This draws on women's willingness to reflect on their experiences and ensures that their views are easily accessible to frontline staff who are then in a better position to recognise and implement improvements in services.

The midwives' training was adapted from Nancy Kline's work on the Thinking Environment® for an incisive leadership, focusing on two central elements: Attention and Limiting Assumptions.

By using 'systems thinking' approaches the focus of the consultation is shifted from specific activities and interventions to concentrate on the service's purpose and how that can be best achieved.

Midwives undertook 32 interviews with women during April 2008, the majority of whom were using facilities at two local Children's Centres. Women from some of the more, 'hard-to-reach' sections of the diverse local population were contacted, establishing and using local networks.

4. RESULTS

The themes which emerged demonstrate that *Continuity of the carer* - is more important for vulnerable women, and that *Postnatal Care and Support* is significantly lacking.

Most women find the transition from the birth environment to the postnatal environment difficult. This was strongly reflected in women's comments. They feel that during labour decisions are often taken on their behalf and at times information on their and their baby's care is not sufficiently shared with them.

However once they exit the delivery suite and go into the postnatal ward they are expected to get on with it, and to know how to look after the baby, especially how to breast feed with very little support and information. They recognise the pressure midwives are under but to them it feels there is an overwhelming focus on a quick discharge rather than effective care.



5. RECOMMENDATIONS

The emphasis of recent policy is on creating a stronger local voice when developing health and social care services and doing so within an effective commissioning framework which requires regular feedback and staff involvement as well as patient engagement.

This report shows that regular patient feedback and engagement can become an integral part of the delivery of care in a cost effective way, and such a model can bring significant additional benefit by strengthening core staff skills.

This engagement can provide a continuous, consistent, and reliable dialogue with in-depth feedback which is fundamental to service improvement.

This dialogue is even more important when we are seeking to improve the care of those women who are most vulnerable and reluctant to engage with maternity care.



Introduction

Enterprise for Communities Ltd was commissioned to engage with local women who have been recent users of the local maternity services and to capture a snapshot of their experiences. We also explored the development of a sustainable approach for continuous consultation with users of the service.

As a priority for the work, the PCT was seeking the views of the most vulnerable and marginalised women in the area, for example women who are asylum seekers or refugees, women who do not speak English, women with physical or sensory disabilities, very young women, women who misuse alcohol or other substances and women experiencing mental health problems. Considerable time and attention was given to contacting women from some of the more, 'hard-to-reach' sections of the diverse local population.

Despite the slow start in gaining permissions and access there has been an overwhelmingly positive response from women, community leaders and professional advocates wishing to contribute to the consultation and to share their experiences and knowledge. In the groups contacted the majority of women have responded positively and expressed an appreciation for this opportunity.

Although by analysing and evaluating the comments we have gained a strong sense of what is important to local women, in the main we have not made any specific recommendations on how to immediately address these. Instead it was decided to dedicate this report to the voices of the interviewed women, allowing their comments to stand for themselves.

This report has two distinct but complementary aims:

- 1) To inform the development of a new Maternity Strategy with a detailed analysis of interviews with women who have recently delivered: capturing a momentary snapshot of women's recent experiences of ante-, postnatal and intra-partum care.
- 2) To explore the rationale behind working with midwives rather than use outside interviewers, and demonstrate how this approach fits into the larger context of service improvement through a continuous PDSA (Plan, Do, Study, Act) cycle.



I. Background: PATIENT-CENTRED-CARE

Health care is not just another service industry. Its fundamental nature is characterized by people taking care of other people in times of need and stress. Patients are ill, families are worried, and the ultimate outcome may be uncertain.

Stable, trusting relationships between a patient and the people providing care can be critical to healing or managing an illness. The people who deliver care are the health system's most important resource (*Crossing the Quality Chasm: A New Health System for the 21st Century* (2001). Institute of Medicine, Washington D.C.).

Over the past two decades a fundamental paradigm shift has taken place within the health care sector, marked by the growing recognition that to further improve health care a radical change is required. This is a shift away from a doctor, technology, hospital and disease-centred health care service towards one that is able to put the patient's experience at its heart.

Section 11 The Health and Social Care Act (2001) reflects this shift in policy, making consultation with patients and the public a legal requirement for all service providers.

Seddon (2008), describes a need to shift the focus of public services away from measuring professional activity towards creating value for customers, patients and improving their experience of public services. This is also indicated in the Review of Maternity Services undertaken by the Health Care Commission (2008), which was conducted in collaboration with the Picker Institute, who have been at the forefront of research in patient-centred care (PCC).

All health care providers struggle with putting the patient at the heart of their work. Particularly when balancing the needs of 'ordinary' patients with patients who are vulnerable and are facing complex social factors. Providers also find it difficult to adequately assess the demands imposed on their services when the type and frequency of the demands made are so variable limiting the service's ability to respond flexibly and promptly.

I.1. Health Inequity in Maternity Care

In 1998 in his Inquiry on health inequalities, Lord Acheson identified Maternity Services as among the NHS Services most affected by inequity. Subsequently repeated reviews of maternal death have highlighted the direct correlation between high social risk and adverse maternal outcome.

The most recent report, *Saving Mothers' Lives* (2007) again concludes that only by better understanding vulnerable women's 'demands'—where and how they can be best cared for—can we help ensure that Maternity Services are adequately able to respond to the changing needs of the most vulnerable women in their area.



The midwifery summary which accompanies the report, recommends that midwives urgently strengthen their understanding of their professional responsibility and their decision making capacity to ensure that they are able to adequately respond to the needs of these, most vulnerable women who default from care.

For the maternity service there is a greater urgency to consult patients and citizens than most other NHS services. By definition all sections of the population are affected by it at some time during their life. Especially in London with a highly mobile population, it is crucial that the service has its ear to the ground and is able to recognise quickly and respond flexibly to the changing needs of its local population.

Although some improvements e.g. cleaner facilities, will equally benefit all women, others need to be flexibly tailored to accommodate the specific needs of some women. The working reality of most midwives on the frontline in central London is that they will frequently have to make quick decisions on how to appropriately address the complex social needs of the women they are caring for within the limited resources available locally.

1.2. Evidence Base for Patient-Centred-Care

While there is wide acceptance among health care providers of the inherent value of patient-centred-care, there is a similarly universal recognition of the challenge in establishing a solid evidence base on how to successfully implement and effectively measure it.

However there is one area of research where clear evidence of the benefits of a patient-centred approach to care is slowly accumulating: patient participation. Especially those professionals striving to improve the management of chronic conditions such as diabetes, have discovered how putting the patient and their complex social and health needs at the centre of their care can not only improve outcomes but also increase efficiency (the notion of the 'expert patient'). The Agency for Health Care Research & Quality (2005) reported that effective implementation of patient-centred-care can successfully reduce both under and over use of medical services thereby ensuring that services are used by those in the greatest need.

The limited available research into patient-centred-care in maternity services is largely focused on breastfeeding. When considering the complexities of establishing a solid evidence base for successful involvement of patients and the associated methodological challenges this is unsurprising.

However when considering that the greatest single indicators of risk in maternity care are late booking and non-attendance, there is a powerful incentive for effectively putting care women at the centre of their care, and this has been reinforced by recent policy documents and guidelines such as Maternity Matters (DH 2007).





In order to affect the care outcomes for the most vulnerable sections of the local population, and to improve the service's ability to respond to these needs, a more in depth understanding of what women demand of their care has to be at the heart of service improvement. The King's Fund, (2008) describes the lack of information on adverse outcomes, and the fact that such outcome measures in maternity are only broad indicators of safety.

Furthermore as the quality of the birth experience has lasting effects on mothers, babies and families, we have to reassess the merit of more qualitative measures of the patient experience as being equally or more important, particularly in an environment where outcome data is lacking.

2. Tell-me-More

2.1. Program Design and Methodology

This project set out to tackle these complex methodological and practical challenges in an attempt to explore viable ways of consulting with a broad range of women and move towards a more women-centred design of maternity care.

Our approach is based on an understanding of consultation as a continuous process of service assessment based on patient experience, thereby departing from the established model in which consultation with patients and citizens is an intermittent disruption of the normal path of care. Our aim was to develop a viable and sustainable model of continuous consultation whereby local women and their families can engage in an open 'conversation' with those providing their care and where consultation is central to the delivery of the service:

The service's capacity to respond to the changing demands of the local community is strengthened by:

- **Placing the needs of women at its heart** and
- **Building on existing infrastructure.**

Seddon (2008) describes 'systems thinking' in the public sector and its potential for service improvement. He focuses his attention on the sector's capacity to effectively respond to the continuously changing demands of its users (i.e. the public). The benefit of using a systems thinking approach to service design is that by its very definition it places those using the service at its heart, thereby mirroring the health sector's stated ambition of moving towards a more patient-centred system of care. By adapting 'systems thinking' and using it to provide the theoretical base we are developing a systems approach to service improvement centred around the patient's experience.



By focusing on the service's purpose rather than activity, on how it creates value rather than spends resources, on the bigger picture of the flow cost rather than the unit cost, Seddon reflects a shift in management paradigm in line with the shift in the health care paradigm discussed earlier. This provides a management framework for implementing the necessary steps towards a more women-centred model of maternity care.

'Systems thinking' recognises that problems are not departmentally shaped and that successful solutions have to reach beyond individual areas. For example: when a dehydrated baby is readmitted to A&E because his mother left hospital unable to feed him, the flow cost of the care for mother and baby rises significantly, despite the potential savings in the mother's initial postnatal care. In our study 2 of the 32 women interviewed described how their baby had to be readmitted due to dehydration.

This indicates a lack of capacity to adequately respond to a woman's demand for postnatal care, and calls for further review and testing of assumptions about women's' expectations and needs.

Our approach is to build internal capacity, so that rather than rely on outside consultants and /or elaborate and time consuming data analysis over a long period of time, we help to establish an effective and continuous feedback system. This draws on women's willingness and enthusiasm to reflect on their experiences and ensures that their views are easily accessible to frontline staff, who as a result are in a better position to recognise the need for, and to effectively implement changes.



2.2. The Training—Midwives

We initially trained six midwives who were recruited from all three areas of the service: Community Care, Labour and Postnatal Ward. More recently another five midwives joined the programme. There is currently a pool of eleven midwives trained to conduct feedback interviews with women.

The unrelenting pressures on midwives' time—e.g. the requirement to provide multiple sets of records—has created conditions where to listen to a woman's experience of pregnancy, birth and new motherhood, in a continuous dedicated way, is an exception rather than the norm of midwifery practice. We have become accustomed to a culture of care in which the filing of large quantities of data takes precedence over the gathering of quality information.

Without the ongoing support of the midwifery managers helping to ensure that the nominated midwives were able to dedicate their time and energies to the programme this work would have been inconceivable.

We adapted our training programme from Nancy Kline's groundbreaking work on the Thinking Environment® for an incisive leadership, focusing on two central elements of her work: Attention and Limiting Assumptions:

1) Attention is the gateway to creating a people-centred health care environment in which professionals, as much as patients and their families, are able to generate sustainable long-term solutions. It is clear from the comments analysed in this paper that at the core of much of women's dissatisfaction with their maternity care lies a fundamental lack of attention. This takes a variety of shapes and forms reflected in the quotes and reproduced here under Findings.

The following quote from a new mother effectively illustrates the experience of profound inattention and its impact:

my midwife never used my name (the student did and that was better)- she also didn't pick up on a lot of stuff in the birth plan: water, position etc. I remember I was shouted at to push and felt I had to apologise because I wasn't pushing 'well enough.'

A large section of our training was devoted to exploring how to give attention and create an environment of ease and encouragement in which women are able to relax and effectively relate their care needs within the pressured environment of the ward.

One of the participating midwives, with two decades of midwifery practice described the following encounter during one of the follow-up training days:

A woman in the second trimester of pregnancy was sent from A & E to labour ward complaining of stomach pain. It was an especially busy day and the midwife was in charge of coordinating the ward at the time. She explained to the patient that she would be unable to examine her immediately. But that once she is finished with her current task, in about 20 minutes she would be able to examine her. The patient was reassured and waited. During the consultation that followed the midwife gave her, her full, undivided attention.

What she then heard is difficult to comprehend: The young woman had lost a previous pregnancy a year ago to the day. Both her parents had also died during that year, leaving her without their valued support. In addition after her sister became the victim of domestic violence, murdered by her husband, she was left with caring responsibilities for her three children.

This pregnant woman had been sent from A&E. Her handheld notes did not contain any of these family circumstances. Understandably, she had never been asked if any members of her family had been victims of homicide and she has never before in all her contact with health professionals felt enough trust to relate these significant aspects of her life. Clearly she was a vulnerable woman with multiple risk factors, only previously nobody had paid enough attention to her to listen.

The midwife who described this consultation was a highly skilled professional with considerable experience in looking after vulnerable women. She champions a woman-centred approach to care. Nonetheless when telling us of this incident she credited the training with helping to remind her of the importance of attention, of generating an environment in which the woman felt assured of her undivided attention; disregarding all the other seemingly urgent demands on her professional time.

Similarly other participating midwives again and again paid tribute to the training programme for helping to strengthen their consultation skills and helping to improve their daily practice:

Being made aware that giving the clients a short opportunity to express themselves makes a big difference. I have tried it and it works!

2) Limiting Assumptions. Our work on assumption is directly correlated to that on attention. To pay full attention to someone requires us to suspend judgement, suspend our assumptions about that person—to stop finishing their sentence for them. Using the previous example: confiding difficult, distressing aspects of one's personal life to a stranger, even a healthcare professional, needs courage. If the patient senses that the person facing her is judgemental and has preconceived views about the circumstances of her life, there will be very little reason for her to relate anything sensitive.

Groopman (2007) provides an effective exploration of the significance and dangers of assumptions in medical practice. Research evidence is frequently represented as Gaussian distribution (or bell curve), engraining the assumptions which constitute the foundations of clinical decision making. It is this model of thinking, built on assumptions about mean averages, which is the basis of screening programmes for example.



Groopman provides the caution that although useful in general terms for the population as a whole, for the understanding of individual patients and their illness, such bedrock assumptions can be highly dangerous. Groopman describes how the assumptions about the average age for heart attacks can lead to a highly experienced consultant in emergency care misreading the undeniable signs of heart attack in a fit 38-year-old Canadian lumberjack.

2.2.1. Consultation—Strengthening Core Midwifery Skills

The skill set developed for conducting the interviews remains within the core workforce, enabling the local service provider to continue to hear women's views, continuously monitoring the impact changes in the service have on women. In addition it strengthens midwives' understanding of their patients' needs and ensures that their decision making and leadership skills are firmly embedded in an in-depth understanding of the local population.

Midwifery care for a highly mobile, exceptionally diverse and vulnerable population is to a large extent dependent on recognising and responding to the signs of unforeseen, unexpected complications. It is about continuously questioning and revisiting strongly held assumptions.

Such a readiness to regularly revisit assumptions about patients and their needs, is not only important for positive clinical outcomes but also central to how women experience their care, especially those women who feel marginalised. Street workers or HIV positive women explained during our recruitment conversations their reluctance to engage with the maternity service because of their fear of being judged: their fear of encountering health professionals, midwives who are judgemental about them, their babies and their life circumstances.

2.3. Interviews—The Women

2.3.1. Recruiting Women

By effectively working with advocates and community leaders and creating easily accessible and available opportunities for feedback interviews, we were able to ensure that the interview findings are highly relevant for the Maternity Strategy Consultation.

Within the limited time frame of our pilot, we proactively approached hard-to-reach groups of women. We were welcomed by a local African women's group, a group supporting HIV positive women, as well as by a Kurdish refugee group. We also spoke to some women with substance abuse problems as well as with teenage parents.

Although links were established with advocates working with women suffering domestic violence, bereavement and mental health issues, and with Travellers, due to the time frame of the consultation and the special vulnerability and marginalisation of the affected families, interviews needed to be arranged with great sensitivity. We did not feel it appropriate to arrange interviews with women receiving such targeted support, so we are unable to comment on the experience of those women using these specialised services, although clearly some of the interviewed women had experienced some of these issues (e.g. two mothers discussed suffering with mental health problems and one mother described losing a twin).

The midwives conducted 32 interviews during April 2008. Along with the women from the above community groups, the majority of these interviews were with women who were using facilities at two local Children's Centres.

These Centres were selected as their staff were very supportive of the project. They helped us to recruit women for interviews by welcoming us into their breastfeeding drop-in, as well as into the baby massage class, and the 'stay and play' sessions. They offered us interview rooms and childcare facilities as well as interpreters for the interviews.

2.3.2. Selection for Interviews

The women were self-selecting. After explaining the aim of the project they were invited to give their names and asked if they were interested to be interviewed by a midwife. In the groups we visited with children under one more than 50% of the women (in some groups all women) added their names to our list. In the sessions for older children, (two and above) 25% of mothers still showed interest in participating.



Our high response rate is indicative of local women's desire to help improve their maternity service and to share their experience of pregnancy and motherhood. Midwives who conduct postnatal home visits and those regularly leading breastfeeding drop-ins are acutely aware of women's appreciation of opportunities to debrief and feed back and to discuss their experiences.

Interviews were arranged with the women on our list to fit around the participating midwives schedule and the women's time availability, ensuring that the interviewing midwife was not involved in the women's care. The selection of interviewees was random although there was a slight bias towards breastfeeding mothers as two of our recruitment groups were breastfeeding drop-in services.

We decided against asking women to fill out ethnic monitoring forms as we felt that this could have inhibited participants from freely discussing their stories. This approach seems to have been justified where women themselves were suggesting that their treatment might have been prejudiced by their cultural or social backgrounds.

In addition to the African and Turkish women who were specifically targeted through their community groups, the midwives also interviewed four Afro-Caribbean, one Asian and one Croatian mother. The majority of women had one child but some women told us about previous children with one mother having given birth at the same hospital five times during the past ten years. In addition the midwives interviewed women with a previous history of mental illness and drug abuse.

Women were invited to explore their experience of the maternity services at their own pace, focusing on what was most significant to them—using an open storytelling approach, which built on the midwives' training in the Thinking Environment. Trust is crucially important not only for one-to-one consultations and interviews, but also for a successful overall consultation process.

Only when women feel that they can confide in professionals will we hear those important stories, which require particular attention, and use this feedback to effectively improve the service for all. The interviewing midwives were amazed at how much could be discovered in this way. Despite some women having difficult stories to tell, the midwives were surprised by the women's readiness to acknowledge and appreciate the positive aspects of the service.

This is how one of the midwives involved in the project described her learning:

As midwives we hear women's stories all the time, taking notes of the things that are important to 'us'. This time I was listening for the bits that were important to 'her'. It reinforced the close relationship between women and midwives. It revealed how pressure and the need to de-brief are tightly bound together.



2.3.3. Debriefing—An Additional Benefit

The interviewing midwives were struck by how many women told their story in tears despite having given birth months ago. Such feedback sessions can never replace formal counselling or a robust complaints procedure, but it is a much welcomed opportunity for women to find willing and supportive listeners and this can have a lasting positive impact on women's early experience of motherhood.

During the past decade a number of Health Trusts have explored the potential of debriefing women with traumatic childbirths. Birth Afterthought, the debriefing program at the John Radcliffe Hospital in Oxford has been established since 1994. Sheehan (2007), in a recent review of this service found that those midwives involved "almost incidentally became clinical leaders" as a result of hearing about women's experiences through debriefing episodes. Generally it was found that those services led by midwives rather than counsellors were more beneficial in terms of feedback to health care staff and that the clinical leadership of those involved was extremely effective.

Locally there is no formal structure in place, for women to debrief their experience of childbirth. Informally the midwifery managers make every effort to respond to women's need to debrief traumatic experiences, which often means that prompted by a formal or informal complaint senior managers meet with the affected woman and her family to hear their views.

However a formal complaint will preclude an effective debriefing in the counselling sense, because the legal process takes over and employment issues become paramount. Naturally, individual midwives, especially those working in the community, often find themselves listening to women's experience of birth. However they are not allocated specific time for this and therefore the debriefing process puts an extra pressure on an already stretched service.

Ayers, et al, (2006) reported that the vast majority of Hospital Trusts in England have no established formal approach to debriefing and described how this puts additional demands on senior managers' time in responding to such requests. In addition this means that only the more vocal patients who insist on or demand an opportunity to debrief are able to do so, thereby denying an opportunity for feedback to more disadvantaged or vulnerable women.

Our approach offers effective, informal debriefing opportunities which can be easily accessed by all women as a beneficial side-effect of the consultation process.





2.4. Reporting

To help ensure that women felt relaxed enough to discuss their stories freely, the interviews were not recorded. However all women were asked if they wanted an opportunity to write comments on postcards and they were encouraged to record their suggestions and concerns on tape after the interview. Women freely took up this opportunity and all the direct quotes in this report are from either of these two sources.

To help inform the maternity strategy we undertook a detailed, systematic analysis and critical evaluation of the postcards as well as women's recorded messages. Using traditional text analytical methods, we developed the common themes from the interviews and contextualised them.

Judging from the responses to our two presentations at maternity strategy meetings, this approach has proved to be an effective tool for capturing the feelings among users of the maternity service and for gaining a deeper understanding of the very diverse needs within the local communities, and this is appreciated by senior managers. This report offers a useful baseline for future assessment and provides an opportunity to share the results of the interviews between providers and commissioners of the service.

In methodological terms there is great value in focusing in close detail on a small sample of diverse experiences as this can help ensure a better understanding of the complex interlinking of women's individual life circumstances and how they are affected by the way the service is delivered. This is an opportunity to view the service, as women might perceive it.

As we were not working with set questions and the women discussed aspects of their care according to their own priorities, a very detailed and time consuming analysis of all comments had to be undertaken before thematic similarities could be extrapolated. We feel that the outcome; the richness of the information we were able to gather, has justified an approach which prioritised the accessibility and openness of the process, ahead of easy reporting.

We would argue that although such reports are an invaluable resource for in depth analysis of the service, it is not necessary to record all interviews in this way as it can detract from one of the central aims of this work which was to develop a continuous engagement and reflection process which supports the focus for a more woman-centred model of care.

3. FINDINGS—First Interview Round (April 2008)

3.1. BREASTFEEDING

Breastfeeding was among the issues most frequently raised. Taking into account that half the recruited women attended breastfeeding drop-ins at the two participating Children's Centres, this was to be expected. But the lack of breastfeeding support was also raised by a number of mothers who were unable to, or chose not to breastfeed their babies.

The majority of mothers were extremely keen for additional breastfeeding support. Some said they had received no information or support on the postnatal ward.

On the other hand one HIV positive mother was reproachfully asked why she was not breastfeeding? This further compounded her sense of being made an example of 'by staff with attitude' and clearly demonstrates the importance of approaching all women with sensitivity, respecting their individual circumstances.

SKIN to SKIN INITIATION

- *I felt if I hadn't asked on delivery suite the 1st feed wouldn't have happened:*
- *Breastfeeding support immediately after birth should be standard. Midwife should observe feeding before discharge.*
- *Being offered Formula when asking for help to breastfeed is insulting.*

POSTNATAL BREASTFEEDING SUPPORT

Praise

- *Good to have lactation specialist for difficulties feeding.*
- *Was great to have the one to one support at home afterwards—particularly help with establishing breastfeeding.*
- *A nurse placed baby on bed with me to feed + sleep—it was the best thing she could have done—I didn't know it was allowed.'*

Room for Improvement

- *Something as simple as getting food into him ended up with him in hospital for four days.*
- *Breastfeeding advice should be in line with hospital policy of 'breast is best.'*

- *Better post-natal support, particularly for first time mums, so they leave hospital with confidence in caring for their newborn.*
- *Ward Nurses' demeanour different (from Theatre staff) busy ward—seemed less approachable. Not good for breastfeeding teaching.*
- *There needs to be more information about breastfeeding before birth: technique, positions, pain free feeding—I found it so painful to start with.*
- *More mention about the practical aspects of feeding needed before the birth.*
- *I was overwhelmed by responsibility for feeding—needed someone to show me how. I felt the midwives were rushed off their feet but also lacked the skills to show me.*
- *Aftercare felt a little rushed would have appreciated more help with breastfeeding at hospital.*

Breastfeeding in NICU

- *Facilities for parents (on Neonatal Intensive Care Unit) are inadequate—'the expressing room: '2 chairs, 2 pumps & 2 sterilisers—its not enough (there are 40 babies). I got 40-50ml of breast milk a day and their reaction was 'not enough'. The breastfeeding woman was only there 1 day a week. What good is that? My baby needed breast milk and I couldn't do it. I gave up in the end. They need a dedicated breastfeeding supporter and a full time counsellor for all the stressed out parents.*

3.2. FOOD

Women consistently told us how after a difficult delivery there was insufficient or no food available and that they were not aware of the need to pick up their own food from the trolleys. Often, if delivering at night, they were left with nothing to eat until lunch if they forgot to get their breakfast. This was especially the case outside visiting hours when they were left without the help of family or friends until much later in the day.

The hospital does not provide formula milk (in line with baby friendly initiative) and women are encouraged to breastfeed their babies. After the extreme physical demands of labour sufficient healthy food is paramount in helping women feed their babies and begin their new roles as mothers well nourished and strengthened. In addition a generous availability of fruit can improve digestion and help to reduce constipation post delivery. For vulnerable women who lack the support of friends and family and solely rely on the food provided by the hospital this of course is of even greater importance.

In addition to its scarcity women found the quality of the food disappointing:

- *Food disgusting.*
- *Food is dreadful + portion sizes too small.*

- *Bad Food.*
- *Unclear about breakfast routine by the time I understood to pick up food from trolley, trolley taken away.*

The Orthodox Jewish Community provide a regular provision of fresh kosher sandwiches to the maternity wards. These are always available. A similar provision should be aimed for to ensure that all women in the care of the maternity service are well nourished.

3.3. CLEANLINESS

Along with breastfeeding, cleanliness was among the most frequently raised issue. The following remarks are a representative summary of women's general comments:

- *The hospital could definitely be cleaner!*
- *Improve cleanliness of bathrooms—make sure the bins are emptied and don't run out of toilet paper!*
- *Had to change own sheet.*
- *Toilets disgusting*
- *The bathrooms were awful—I learned to go straight after the cleaner—but it was still blood-stained—AWFUL!*
- *Ward. which was dirty + scary*

Several women found it distressing that sanitary towels were not readily available when they asked for them. They felt unnecessarily reprimanded for not having enough provision and for having friends and family sent to the supermarket to purchase the necessary pads. Again for more vulnerable, isolated women without families and friends nearby this is not an option.

One patient (after surgery) was greeted on the ward by being told not to mess up the toilet. This is how she described what happened:

- *I was told to clear up. Don't leave blood everywhere, everyone always leaves blood everywhere. I thought to my self ok I try not to. As I undressed myself I realised that I was absolutely covered in blood... I just took my trousers off and it just went everywhere. I just felt so guilty for that mess. But actually I had no control over it...I can imagine that it must be a nightmare keeping those toilets clean. I can appreciate that but at the same time I didn't really need to feel guilty for the mess...And as things progressed I realised more and more that I was incontinent...*

Similarly a patient with an incontinence problem was devastated by the way medical staff ignored her incontinence problem and the lack of basic care she experienced.

- *After they finished they didn't discuss their findings with me but they both left the room and I was left with nothing on on my bottom half and the bed raised so that I couldn't get off and I could not get to the buzzer to press it and baby started to cry... Eventually I managed to get up and as I got up again blood poured out and again I was incontinent. and so I was in a complete mess and I still didn't know what to do....all over the floor. And then I managed to clean myself up and then the Midwife came in and said 'oh don't worry we will clear it up later' but than a visitor came 'and it was my Pastor from Church. He was just terrified because there was blood everywhere and...it was a really embarrassing situation and it took nearly four hours until they came and cleared up and I could use the bed again...*

An HIV infected woman said that it is common for staff to publicly ask women in that category (HIV positive) to wash the bathroom after use.

Dirty toilets and rooms not only impinge on women's experience but can also have implications for care. As one of our interviewees, an intensive care nurse as well as a new mother summarised:

- *I was concerned about infection control issues. The mattress was taped together— blood on ceiling + a nurse didn't use aseptic non/touch technique when administering medication into my epidural IV port... ward again infection control issues ...changing catheter bag...non touch technique not practiced*

3.4. CARE

GAPS between PROVIDERS:

The greatest gaps in care, causing the most anxiety, generally occurred in the overlap between and during handover between various areas.

- *'Inconsistent care. Varying information.'*
- *'Gap in care from confirming pregnancy with GP to Midwifery care!'*
- *Doctor/midwife interaction visibly strained.*

One mother, who described herself as 'squeamish' about needles (she had needle phobia), suffered unnecessary anxiety due to lack of clarity about responsibilities between GP and the hospital. She was sent back and forth from GP to hospital continuously dreading the blood test, and never receiving clear information when and where it would take place.



MIDWIFERY CARE at its best:

Women commented positively about the care and attitude of individual midwives.

- *I love the midwife system. They were professional, warm & helpful.*
- *Antenatal care excellent, thorough. Midwife wonderful to visit.*
- *Convenience & continuity of care at Children's Centre was good.*
- *Hospital midwife + care was great.*
- *Good phone support about coming in for the birth.*
- *Most staff were friendly & engaging*
- *Children's Centres invaluable—my community midwife team were really good.*
- *Met community midwife—inspired confidence. Lovely demeanour of all three Midwives.*

CONTINUITY of CARER:

A significant majority of women felt that the single most important improvement to their care (once obvious issues such as cleaning had been resolved) could have been achieved by ensuring that they could see the same midwife throughout their care. Recognising a familiar face at a time of stress can help women gain confidence in their new role as mothers as well as reassure them in times of uncertainty.

- *I remember feeling immense relief seeing the antenatal midwife for postnatal care once I was home.*
- *Do not underestimate the importance of continuity of care ante and post birth.*
- *Continuity of midwife is important*
- *Antenatally-care under midwife good would have been nice to see same midwife each time though.*
- *Would have been good for same midwife to do the home visits—as saw some different ones—home visits vital as difficult to get out with new baby.*
- *I would have liked to have the same midwife throughout my pregnancy!*
- *I had an awful time on Gynae Ward. The MW support was good but continuity would have been better*
- *Ideal would be having one midwife for all your care.*



CHOICE: Mother's Suite / Home Birth

One of the more reassuring and positive outcomes of these interviews were the significant number of women who praised the strong support they experienced in their choice of birth place. Again the women commented on this without being prompted on the subject. This is a positive reflection on community midwives' commitment to offering choice to women.

- *Support surrounding homebirth was very good and MW attending provided good care but lacked in providing information and advice re baby being in OP pos.*
- *Home Birth planned—everyone really supportive. It did not happen.*
- *I planned a natural birth with no drugs and at home, but it ended in an emergency C Section. But it was not a bad experience due to all the care and support.*
- *For a long time no one seemed bothered about my wanting a home birth... 'will sort that out later...' After a few hiccups I was finally well supported in this choice. After starting at home my labour stopped and a shared decision was made to be induced in hospital. I felt very supported with all events.—progression decisions etc. this led to a forceps delivery—not the birth I had planned but I was very happy with everyone's attitude and involvement.*

The following two contrasting comments clearly demonstrate how a lack of regard for women's wishes can have a lasting negative impact on a woman's experience of birth.

- *Using the birth pool in the mother's suite really helped my experience of birth and midwife were great.*
- *Using birthing pool + feeling more in control would have improved my experience.*

At times we are so focused on the service at large that we lose sight of the crucial importance an individual Midwives' ability to build successful partnerships with women and their families, has on shaping a mother's experience of pregnancy, birth and new motherhood.

- *When I got in my midwife never used my name (the student did and that was better- she also didn't pick up on a lot of stuff in the birth plan: water, position etc. I remember I was shouted at to Push and felt I had to apologise because I wasn't pushing 'well enough': I just saw the scissors-no discussions. If things would have been managed differently they might not have been needed. The stitches were horrendous...*

Women are painfully aware of the level of attention individual members of staff afford them.

- *Postnatal care disappointing however some individuals were amazing and showing great dedication.*
- *Labour care varied, dependent on midwife.*

Similarly teenage parents felt so strongly about 'their' Children's Centre midwives that they thought if they could have been reassured that they would be looked after by 'their' midwife, they would have been confident to deliver at home.

STAFF ATTITUDE

Along with the lack of continuity of carer, women expressed concern about the general attitude of staff. While acknowledging the work of dedicated individuals, the majority of women interviewed expressed disappointment over the general lack of care and support they experienced.

Unfortunately positive comments such as these were the exception:

- *Positive delivery care... didn't expect hospital delivery to be positive.*
- *Delivery staff all very nice. Good handover to ward midwife.*

Being passed from pillar to post: some members of staff unwilling to take responsibility for patients' needs; having to address a simple request for toilet paper to five different staff members; is highly frustrating and can unnecessarily undermine the women's experience of their care. Some women clearly felt that this related directly to low staffing levels and that their care directly suffered from a lack of midwives.

- *More respect of women in labour – listen and take seriously. More staff and space!*
- *Better staffing levels to allow midwife more time to 'care'.*
- *I felt I didn't want to be a burden asking staff to help- that's how I felt on ward. I felt some were not forthcoming with care.*
- *After having my baby I did feel like I was quite 'forgotten'. Getting discharged took ages.*
- *Hardly saw anyone' 'staff unapproachable'.*
- *Better post-natal support, particularly for first time mums, so they leave hospital with confidence in caring for their newborn.*
- *Left on my own post this emergency (baby's heart rate fell & mother in shock) at times in powerful labour without pain relief. had to ask for pain relief at times—forgotten about.*
- *Lack of respect as a patient on ward requiring rest (security & midwife chatting in the middle of the night).*
- *Depersonalisation generally in aftercare.*
- *Harsh and not nice.*
- *Not treated as human 'Lack of Humanity'*
- *Staff are just doing their job.*
- *All I was looking for was Guidance, Compassion and good Communication.*



- *One support worker was very unhelpful—she wouldn't get toilet paper or help me empty my catheter bag because 'it's not my job'.*
- *No sympathy when asked for help.*
- *More respect & dignity from medical staff performing examination—better management of incontinence.*
- *Important reassurance.*

3.4.1. Summing up Women's Views on Care

The themes which emerged demonstrate that:

- Continuity of the carer is more important for vulnerable women
- The value of postnatal care and support.

Most women find the transition from the birth environment to postnatal environment difficult. This was strongly reflected in women's comments. They feel that during labour decisions are often taken on their behalf and at times information on their and their baby's care is not sufficiently shared with them.

However once they exit the delivery suite and go into the postnatal ward they are expected to get on with it, and to know how to look after the baby, especially how to breast feed with very little support and information. They recognise the pressure midwives are under but to them it feels there is an overwhelming focus on a quick discharge rather than effective care.

3.5. Un-booked Women

3.5.1. Women with Substance Abuse

There were three women with issues of substance abuse, who met in a peer support group for mothers and pregnant women, They indicated that the majority of women in their situation, especially those who are also street workers, do not seek medical care during their pregnancy. These highly vulnerable women with complex pregnancies (due to the very nature of their life circumstances), often arrive un-booked and in advanced labour on the delivery suite without medical notes. This is further compounded by insufficiently skilled staff, unable to recognise the signs of addiction or understand its effect on women and their babies.

They felt that the work that the substance abuse specialist midwife was doing was invaluable and her efforts enabled them to receive antenatal care. However they also felt that one person was insufficient because their own lives are unpredictable as are their needs, and emergencies occur any time of the day or night. This makes the planned absences of a single midwife providing this service particularly difficult for the affected women.

One Mother described how she diagnosed her baby's withdrawal symptoms. She arrived in hospital un-booked and in labour. The midwife in charge did not diagnose the baby's continuous screams as symptoms of his withdrawal. When the Mother recognised the reasons for her newborn's distress, she drew staffs' attention to his condition. She felt that staff had insufficient skills in recognising and addressing the signs of drug dependency.

This lack of understanding of substance dependency can have very severe medical consequences. One mother on a methadone programme was wrongly told to stop breastfeeding her baby. As a consequence her newborn suffered severe withdrawal symptoms and had to be admitted to the Neonatal Intensive Care Unit (NICU) where she remained for several weeks. Only a few days later when she was no longer able to breast feed, was she told that the original advice had been unsound and that breast milk would have been the best way to slowly wean her daughter off methadone.

3.5.2. African Women with Positive Status

The African women we spoke to from Rise Community Action told us a very similar story. The stigma of HIV often means that HIV positive women once diagnosed no longer attend antenatal appointments. Women either have no antenatal care or decide to attend clinics further afield. For these women anonymity is paramount and ensuring that no one within their community or their family learns about their positive status can be crucial for their and their baby's future.



Small things such as the requirement to attend clinics at the hospital rather than being seen in the community have big implications. Women with positive status who are required to attend the antenatal clinic in hospital feel singled out, having to explain to friends and family why they are not being cared for in the community.

For other women the move to more community-based care has been helpful. Their reluctance to engage with medical services is further compounded by a cultural attitude within African communities, which does not consider pregnancy and birth a medical matter requiring hospital care.

Anecdotally, other health professionals such as health visitors, echoed the issues and concerns about the number of un-booked women highlighting it as a significant problem. There are no reliable figures currently on the number of un-booked women delivering at the hospital, as the current system is unable to differentiate between a woman who received antenatal care outside the area and is delivering at the hospital for medical or personal reasons, and those local women who have not received antenatal care anywhere.

Besides the obvious health risks to mother and child, looking after women whose medical history is unknown represents a considerable additional demand on staff charged with the difficult responsibility of providing safe care.

3.6. Complaints

Two Turkish women approached us wanting to tell their stories. They were the only women who used the word 'racism' and suggested that racial prejudice might have played a part in their treatment. It is difficult when these issues are raised by such a small number of women. However other members of the Turkish Women's Group also reiterated this.

It is important that women and their families who feel that the service is treating them in an unequal and unfair way, have recourse to a simple easily accessible complaints procedure. This is not the experience of these women who were interviewed.

One woman's story

One woman, during her second trimester of pregnancy, went to the hospital's assessment unit in pain only to be sent home by the Registrar. She lost her baby during the subsequent weekend at home. When she later returned with her husband to enquire why she had been discharged and requested to see her notes, the Registrar on duty refused to hand out the notes or give out the name of the Doctor responsible for discharging her the previous week. She then asked for an advocate to help her make a complaint and again she was refused and told that she spoke sufficient English to make a complaint herself. She left the hospital not understanding what had happened and feeling that because she was Turkish and unable to express herself in English she had been denied the right to make a complaint.

Although this is clearly an extreme case, there appears to be a general sense among the Turkish women we spoke to that they do not receive equal treatment and that staff are often prejudiced towards them and culturally insensitive.

The story of another Turkish Mother

Unlike the majority of women in the Turkish community this mother was born and raised in London and is a well educated and highly articulate English speaker and as such she was able to make a formal complaint about the treatment she experienced at the hands of an individual midwife.

During the birth of her second child two years ago she felt unsupported and at times threatened by the midwife in whose care she was. She felt there was no opportunity for her or her husband to draw attention to her treatment and only when an instrumental delivery became necessary and the doctor arrived did her care improve.

Previously, with her first child she had an uncomplicated, positive experience at the same hospital. She felt that with sufficient support and care, the instrumental delivery would not have been necessary and she could have been saved a traumatic birth experience. Despite wanting to have more children she is now terrified of another labour. Her postcard said,



- *As human beings we all have the right to Compassion; Respect; Professionalism; Humanity; Basic Care. But we should not have to tolerate Disrespect, Hurt, Discrimination, Isolation, Racism.*

To her, the formal response to her written complaint appeared dismissive and was not followed up. She felt the midwife's version of events was accepted in an unquestioning way and that her concerns were dismissed out of hand.

These two women's experience of the complaint procedure are not unusual within the NHS. Coulter (2006) undertaking a review of Department of Health complaints systems found that:

- *It is unclear how, and difficult to pursue, complaints and concerns.*
- *Complaints don't seem to get a fair hearing*
- *Patients don't get the support they need when they want to complain.*
- *The process doesn't provide the redress patients want*
- *There does not seem to be any systematic process for using feedback from complaints to drive improvements in services.*

This further highlights the urgent need to establish effective informal channels of communication through which women can air their concerns, enabling management and staff to respond quickly and efficiently to issues as they arise.



4. Evaluation and Recommendations

4.1. Public Engagement—Commissioning Framework

The emphasis of recent policy is on creating a stronger local voice when developing health and social care services and doing so within an effective commissioning framework which requires regular feedback and staff involvement as well as patient engagement. DH (2006)

One of the central benefits of this project has been to develop a viable approach in which regular patient feedback as well as citizen and staff involvement can become an integral part of the delivery of care in a cost effective way.

We have also highlighted the additional benefit such a model can bring by strengthening core midwifery skills, while offering a welcome opportunity especially for those women with difficult maternity care experiences.

One woman following an unsatisfactory response to her complaint, felt the interview session had helped her rebuild her trust in the midwifery profession, offering her a new opportunity to re-engage with the service.

4.1.1. Un-booked Women

This first round of 32 interviews evaluated in this report are an effective first step towards engaging with local women. To ensure continuous quality improvement of the service it is crucial that women and their families who use the service have opportunities to feedback their experiences to those delivering maternity care.

A continuous, consistent and reliable dialogue is even more significant in improving the care of those women who are more reluctant to engage in a formal way with maternity care and who at times remain un-booked throughout their pregnancy.

We were able to interview women who during previous pregnancies had not sought antenatal care or who were aware of other un-booked local women. This remains a concern so that improvement in the care of these most vulnerable women can be made . The details and life stories behind these figures in our view warrant further attention.



4.1.2. Peer Support

Vulnerable groups of women might benefit from peer support groups similar to the successful model of labour supporters from the Orthodox Jewish community. A number of Turkish as well as some of the HIV positive African women expressed an interest in establishing a mutual support structure for pregnant women and mothers within their communities, to help improve their maternity experience. We would also suggest that the issue of additional maternity specific training for advocates should also be explored.

4.2. Staff Involvement

The training and support of local midwives to listen to, and effectively capture patients' experiences contributed significantly to:

- Establishing an informal midwife peer support network across different areas of work (labour, postnatal and community care).
- Strengthening midwives' ability to understand and address women's individual needs more effectively.
- Helping staff to access valuable real time information on the service.
- Creating an early warning system of service issues
- Offering effective channels to raise concerns.

The participating midwives have appreciated this opportunity to train with colleagues from different areas of the service and especially valued the chance to reflect on their practice in a safe group of peers. It has led to informal cross-departmental support, helping to improve the understanding of the constraints and possibilities for these areas.

It has also led to the midwives involved gaining a better and more comprehensive understanding of women's actual experience of the service, from the first sign of pregnancy to becoming a mother, rather than focusing on just one isolated aspect of women's care. This strengthens team work and facilitates communications, which in turns reduces the risk of vulnerable women and their babies slipping through the referral system between different areas of care.



4.3. PDSA Cycle—Recommendation

This work has been positively received by participating midwives, local women as well as managers of the service. It fills a gap in the service on four different levels:

- Providing opportunity for continuous public engagement.
- Strengthening core skills within the workforce.
- Providing valuable information about the experience women have of local service which should support a service improvement approach based on a PDSA cycle.
- Offering a viable, informal debriefing opportunity for local women.

Managers have expressed an interest in continuing this work not only because of the positive effect on the practice of participating midwives, but also because it has opened up channels of communication between women and midwives which can only benefit the service.

During our work with the Trust we have been acutely aware of the clinical pressures on frontline staff. We have seen how difficult it is for clinical managers to ensure that staff are able to attend study days. However the skills of these eleven specially trained midwives are an ongoing source of expertise for the Trust in gaining further understanding and feedback about the services they provide to women.

4.3.1. Interviews

Our recommendations are based on a recognition that effective, continuous service improvement needs to be based on dialogue between clinicians, patients and commissioners. By working in this way with specially trained and supported midwives, this dialogue can be beneficially embedded within the core service.

A single midwife interviewing in this way for a half-day a month, would provide 10 sessions over the course of the year and gain feedback from 30 women, and the eleven currently trained midwives could interview over 300 women in the course of a year. Providing continuous and highly relevant feedback to the local maternity service.

4.3.2. Outreach

Our outreach work has been crucial to the success of this approach. It is important to recognise that whereas regular interviews can more easily be arranged alongside regular breastfeeding drop-ins or health visitors' clinics. It is far more time consuming to arrange interviews with more vulnerable women especially those who are most reluctant to engage formally with the health service. However when women feel confident that they are being





listened to and that their opinion matters, they are keen to contribute to the improvement of the services.

4.3.3. Findings

This report is only one approach to documenting and disseminating the findings of the interviews. Although there are clear benefits in making a written report available, by helping to ensure that commissioners, providers, as well as the public, have convenient access to information, its impact can be limited.

Such a report based on in-depth interviews, which focus on women's individual experiences rather than requiring them to answer set questions, is time consuming. It entails lengthy evaluation of written and spoken material in order to synthesise the emerging themes.

In order for this approach to develop as a continuous dialogue and feedback process it needs to be incorporated into every day midwifery practice and team meetings. Such meetings could help midwives to gain a more in-depth understanding of issues facing local women in their care, helping to create a continuous cycle of service improvement firmly rooted in the reality of patient's experience and the delivery of care.

However we also realise that we are not best placed to find or suggest solutions (an assumption in itself). Indeed the fundamentals of our approach would indicate that solutions need to be found by the midwives themselves and tested and developed in a way that produces the greatest benefit and value. We would urge them to do this within a PDSA approach.

5. Some Concluding Remarks

Enterprise for Communities Ltd., has built on the initial approach described in this report. This engagement and enquiry approach is called 'Tell-me-More', and seeks to generate ownership, influence and control for the local clinical community. It invests and develops the skills of staff, helping to build different relationships between clinicians, patients and their families, strengthening relationships across and within different groups of clinicians

The 'Tell-me-More' approach is a sound foundation for a sustainable and effective clinical community which values its most important resources, people. It contributes to developing and transforming care through enquiry and understanding, helping to create a flexible and responsive system. 'Tell Me More' is the copyright of Enterprise for Communities Ltd.

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Noemi Fabry - Independent Consultant and Associate of Enterprise for Communities Ltd

Noemi Fabry received a summa cum laude for her Master Thesis on Perception and Representation from the University of Berlin. During her academic career she taught numerous courses on Interpersonal Communication and the interrelation between subcultures and mainstream culture in American Society. Since moving to London in 2000 she established a parent-run after school support group in Camden Town, ran a Community Centre in one of the most diverse and deprived Wards in England, while contributing to her local community as a school governor and the Treasurer of an alternative health charity for women offering counselling and other support. For the past five years she has worked independently as a researcher and a consultant writing on storytelling and complexity in organisations.

Her work with Nancy Kline has involved leading, developing and establishing an inter-generational Mentoring Group at the RCN working with Senior Executives within the Health Service. During the past four years she has increasingly become engaged in the Health Service, consulting with pregnant women in Holloway Prison, and developing a unique approach to obtaining women's views of maternity services in central London. She has combined the passion of a campaigner with the analytical mind of an academic. She is currently conducting a number of public consultations in the Islington Sure Start areas.

Neslyn Watson-Druée - contributed to the training of midwives on this project pioneered discovery interviews in 1986 as part of her MSc Dissertation at King's College, London University: 'Perspectives on Health Needs of African and Caribbean Women in Britain'. Later in her inaugural role as Chair of the Race and Ethnicity Committee of the RCN she facilitated feedback interviews in a drive to improve the pre and post registration education curriculum for nurses and midwives around the quality of care to patients. Since then she has among others worked with Forest Health Care Trust and St Georges Hospital Midwifery Service helping nursing and midwifery services respond to the needs of the diverse communities they serve.

Judy Oliver of Oliver and Company, and Pip Hardy – Director of Pilgrim Projects and the Patient Voices website also contributed to the training

Stephanie Stanwick - Director Enterprise for Communities Ltd.

Stephanie Stanwick has had a long NHS career, with 5 years as a Chief Executive and 5 years as a Director of Commissioning – a total of 10 years contributing at Board level. She joined the private sector in 2005 leading service and business development and supporting PFI. She has excellent business and organisational skills and really enjoys leading and managing multi professional teams. She has particular skills in complex change management, strategic service redesign, and service improvement bringing a strong value based approach to managing and developing people. She has considerable experience in building relationships to support strategic alliances, and in programme and project management to ensure performance and delivery. She coaches and supports Trainee Consultant Practitioners in service improvement and is supporting the development of a service improvement programme in Cambodia. She is also a Trustee/Director of the Avenues Trust caring for people with mental health problems, and people with a learning disability in the community.



Tell Me More ...
Engaging Women—a Different Approach
Stephanie Stanwick & Noemi Fabry

How can you engage women in the design of maternity services so that their needs are met in a better way?

Maternity services are facing significant challenges, an increase in the number of births together with a mobile and diverse population.

This report describes a different engagement process developed by Enterprise for Communities Ltd, to help inform the development of a local maternity strategy. It relies on the woman's willingness to reflect and draw on their own individual experience and ensures that these views are easily accessible to front line staff. It describes the benefits for clinicians being supported to do this work and using it as an integral part of service and quality improvement through a PDSA cycle (Plan, Do, Study, Act). This approach helps build capacity and skills locally so that maternity services can establish an effective and continuous feedback system – establishing a stronger local voice for women for use within a service commissioning framework.

A copy of this report is available as a download

from...<http://www.archive.org/details/EngagingWomen-aDifferentApproach>

Or a full pdf version is available by emailing enquiries@e4com.eu

Interested in finding out more then please contact stephstanwick@e4com.eu





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