



House of Commons
Health Committee

Inequalities in Access to Maternity Services

Eighth Report of Session 2002–03



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*Report, and formal minutes together with oral
and written evidence*

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The Health Committee

The Health Committee is appointed by the House of Commons to examine the expenditure, administration, and policy of the Department of Health and its associated bodies.

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Footnotes

In the footnotes of this Report, references to oral evidence are indicated by 'Q' followed by the question number. References to written evidence are indicated in the form 'Ev' followed by the page number.

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Summary

Care for mother and baby throughout pregnancy and the early postnatal period can have a marked effect on the child's healthy development, on resilience to health problems encountered later in life, and on the woman's health and experience of motherhood. Disadvantaged women are more likely to die in childbirth, or shortly afterwards, and their babies are more likely to be born with low birth weights. Disadvantaged women are also less likely to initiate and sustain breast feeding, which helps to perpetuate health inequalities.

Addressing these inequalities involves the development of appropriate services for different groups of people. We learned about some examples of excellent practice in meeting the needs of minority ethnic groups, asylum seekers, homeless people, those who live in poverty, those from the travelling community and those who are affected by domestic violence—some of which were directly attributable to Government initiatives such as Sure Start.

Across all of these areas it was clear to us that the development and implementation of good practice was generally achieved by particular individuals or teams who acted on their own initiative in response to need in their local areas. It was also clear to us that this good practice was rarely taken up in other areas, or indeed shared across the health service. This is deeply disappointing because it means that families across the country are not getting access to the services that they need, and that instigating good practice in different areas involves wasteful duplication of effort by the NHS.

In particular, we were shocked to hear that in many parts of the country there were insufficient numbers of specialist Mother and Baby Units for women suffering from severe mental health problems after the birth of their babies. We were also frustrated that after the recommendations of our predecessor Committee, and of *Changing Childbirth*, so little progress had been made towards fulfilling the needs of women and families affected by disabilities.

During our inquiry we identified some basic communication problems which prevented some women from gaining access to appropriate care throughout pregnancy and the postnatal period. We heard that when homeless people were moved from one area to another or when asylum seekers were dispersed, information on maternity care — including test results — was often lost, along with any sense of continuity of care. Our report recommends action by the Government to ensure that there is a proper flow of information between maternity services in different areas. We also recommend that the Government's policy on dispersal of asylum seekers should take into account the needs of pregnant women and new mothers, and that the development of one-to-one or continuity of carer schemes should be a particular priority for maternity services which care for women and families from disadvantaged groups.

We identified problems with access to interpreting services, for people who do not have English as a first language, and for those who are deaf. We recommend that steps should be taken to provide qualified interpreters, including British Sign Language interpreters. We

are concerned that too many maternity services depend on relatives to interpret, which may be appropriate in some circumstances but not in others. For women who suffer as a result of domestic violence, relying on partners to interpret can conceal the problem, and may ultimately be extremely dangerous.

Throughout our inquiry we heard that a particular experience of maternity services varied a great deal according to the attitude of individual members of maternity care staff. Prejudice in relation to class, race, or disability profoundly affected a woman's experience of pregnancy, birth and motherhood. Staff who care for families at such an important and sensitive time must have access to specialised training and support in these issues. We also recommend that trusts consider recruiting healthcare assistants from different cultures and communities and training them to provide advocacy support as a further means of addressing the needs of particular communities. We recognise that the voluntary sector has a valuable role to play in tackling inequalities and is often better able than the health service to represent the needs and interests of particular groups. We recommend that the health service should ensure that this sector is properly supported.

1 Introduction

1. Care for mother and baby throughout pregnancy and the early postnatal period can have a marked effect on the child's healthy development, on resilience to health problems encountered later in childhood, and on the woman's health and experience of motherhood. Yet some of the most disadvantaged and vulnerable women, who have the greatest need of care and support throughout pregnancy and the early stages of motherhood, are less likely to receive the same quality of care as other women. In some cases, they do not gain access to services at all. We are concerned that inequalities in access to appropriate services may contribute to the maternal death rate amongst unemployed families, which was found to be 20 times higher than that for women in the highest two social classes.¹

2. On 12 December 2002 we appointed a Maternity Services Sub-committee to undertake a series of short inquiries. In our first inquiry we set out to establish a picture of maternity services as they are provided across the country. In this inquiry we focus on the inequities and inequalities which might prevent access to appropriate services. Our third and final inquiry will examine the role of choice in a woman's experience of maternity services.

3. We were assisted by the four specialist advisers who helped us during our inquiry into provision of maternity services: Dr Susan Bewley from Guy's and St Thomas' Hospital, Professor Lesley Page from the Royal Free Hospital, Professor Alison Macfarlane from City University and Professor Martin Whittle from the University of Birmingham. Once again we wish to express our gratitude to them for their assistance.

4. In formulating our terms of reference we were all too aware that there were many more groups of disadvantaged women than we would be able to list, and that some women experienced multiple disadvantages which affected their access to care. We chose a range of disadvantaged groups in order to explore a number of access problems and solutions, and if possible, to draw together common factors which might contribute to full access to appropriate care and advocacy services. We recognise that there are also specific issues to be addressed in the provision of appropriate services for other groups, such as very young mothers, women with HIV/AIDS and women with drug addictions.

1 *Why Mothers Die 1997-1999: The Confidential Enquiries into Maternal Deaths in the United Kingdom*, RCOG Press, 2001

5. On 28 March 2003 we announced the following terms of reference:

The Sub-committee will examine inequalities in access to care for pregnant women and for parents and babies from disadvantaged groups. The Sub-committee will consider the provision of appropriate care and advocacy services for:

- *Those from minority ethnic groups*
- *Refugees and asylum seekers*
- *Those who do not speak English as their first language*
- *Those who live in poverty*
- *Those who are homeless*
- *Those who live under threat of domestic violence*
- *Travellers*
- *Those with severe mental health problems*
- *Those with severe learning disabilities*
- *Those with severe physical disabilities*

6. In addition to the memoranda submitted for our first inquiry, we received 13 which focused exclusively on inequalities in access to maternity services and contributors included individual maternity care teams as well as professional bodies and charitable organisations.

7. We set out to explore a range of perspectives in our programme of oral evidence and we sought views from researchers in the field, organisations campaigning to improve access and services, national organisations for specific groups, community organisations serving a local population, and maternity care staff working to develop and provide specialised services. We heard from nine witnesses over two evidence sessions, held on 13 and 20 May 2003. We took evidence from witnesses representing the Maternity Alliance, the National Perinatal Epidemiology Unit (NPEU), the Disabled Parents Network (DPN), Women's Health and Family Services (a community health advocacy organisation based in Tower Hamlets, London), Queen Charlotte's and Chelsea Hospital, London, and Newham Healthcare NHS Trust. We are extremely grateful to all those who submitted written and oral evidence.

2 Disadvantaged groups and access to maternity services: the current situation

What evidence is there that disadvantaged groups do not have full access to maternity services?

What evidence is available and what are the gaps in knowledge?

8. All of those who contributed to our inquiry attested to the existence of inequalities in access to maternity services. The Royal College of Obstetricians and Gynaecologists (RCOG) told us that:

Maternity care is available to all women in the UK but there is no doubt that there are inequalities in access to care: some women do not take advantage of the services provided and others find it difficult to access the care or do not find that the services meet their needs.²

9. Jenny McLeish, Social Policy Officer at the Maternity Alliance indicated two ways in which women encountered inequalities in access to maternity services:

One is actually in getting through the door, whether that is through physical access or through knowing about the services; and the second thing is the inequality of access to a good service when they are actually with the carer, whether they get a proper service, whether they get a decent and humane, kind service.³

10. Diane Jones, a consultant midwife at Newham Healthcare NHS Trust, also argued that disadvantaged groups encountered inequalities in access to care owing to a lack of awareness about available services. She told us that women who were “more aware ... and ... more assertive and know how to access health care are able to do so far better than others.”⁴ Lesley Spires, Head Midwife for One to One and community midwifery services and Birth Centre Manager from Queen Charlotte’s and Chelsea Hospital agreed that “it is one thing to provide the service but it is another thing for that woman to know that the service is there.”⁵

11. While these statements reinforced the conviction with which we undertook this inquiry — that some women did encounter barriers in terms of contact with maternity services and in terms of gaining access to appropriate care and support — we also heard that both qualitative and quantitative evidence on inequalities in access to care was limited. The National Perinatal Epidemiology Unit (NPEU) asserted that “without good evidence about who the maternity services fail to reach and whether some categories of women and babies get poorer care, we are not in a position to make sensible changes to services.”⁶

2 Ev 56

3 Q 17

4 Q 93

5 Q 94

6 Ev 3

12. The Department of Midwifery at City University, London drew to our attention its research on maternal and perinatal health statistics which attempted to determine the extent to which access to health care could be measured for specific groups in the population. In outlining this work, the Department of Midwifery assessed the state of current resources for analysing inequalities in access to care:

Data and statistics that are routinely available for maternal and perinatal health care in England are inadequate for measuring the level of access to maternity and neonatal services for groups within the population including minority ethnic groups and socially disadvantaged groups. Lack of complete and valid recording of ethnic group is compounded by the absence of reliable socio-economic data on mothers and their babies, making any comparisons of inequalities in health outcomes along with any assessment of equity of access for vulnerable groups, impossible.⁷

13. Given the burden of data collection currently imposed on midwives we are concerned that this process should not become any more time-consuming. However, when we examined the collection of maternity care data as part of our first inquiry, we heard evidence that maternity service planners and providers were impeded in their work by lack of data on the socio-economic and ethnic status of pregnant women, and on relevant pregnancy and child health outcomes.

14. We recommend that detailed socio-economic and ethnic data should be recorded in a standardised way in all national datasets and that analyses of these data should be routinely published as well as being made available to researchers for more detailed analyses.

15. Several of our witnesses suggested that one important gap in knowledge about inequalities in access to maternity care has been created by the lack of information on women who give birth to their babies without having booked any maternity care at all. Carolyn Roth, a member of the management committee of Women's Health and Family Services, and a researcher at City University, London, told us that she had been involved in a small survey which attempted to collate figures on the number of women who arrived at hospital in labour without having received any kind of antenatal care. Of the 33 units surveyed, nine were able to respond and it was found that about 4% of women had received no antenatal care whatsoever.⁸ Overall, in reporting that very few maternity units could produce the relevant figures, Carolyn Roth told us that this was symptomatic of a wider problem:

It is a theme that runs through a lot of the issues regarding access to services which is what is not encountered does not count. In other words, if you cannot actually enumerate what the dimensions of the problem are it is actually very difficult to identify shortcomings in the service.⁹

7 Ev 71

8 Q 153

9 Q 96

16. Systematic reviews by the NPEU found “surprisingly little recent evidence about patterns of attendance at antenatal care for different social groups.”¹⁰ The exception to this was a study undertaken in the mid-1990s which suggested that on average, women from South Asian backgrounds started maternity care later and made fewer visits than white women. The NPEU also found evidence that South Asian women might be up to 70% less likely to receive prenatal testing for haemoglobin disorders and Down’s Syndrome. Some of the work in this area suggested that South Asian women might be less likely to be offered testing.¹¹

17. According to the NPEU, information about social and ethnic differences in access to postnatal and infant care was even more limited although evaluations of initiatives such as Sure Start¹² and the Teenage Pregnancy Strategy might enhance the evidence base, as the NPEU explained:

For example, comparison of Sure Start areas with control areas may help to understand whether and how midwives and health visitors target their care to those in most need, and what difference it makes.¹³

18. We asked our witnesses whether there was any correlation between poor access to care and areas of general social deprivation. We heard that access often depended on the work of particular projects, and of particular individuals in improving access for disadvantaged groups. Christine Gowdrige from Maternity Alliance told us that:

this kind of accidental way in which particular midwives come along and create specialist services shows that provision is extremely haphazard ... I do not think that it is based on geography as such although there are obviously issues around rural areas, but it is more based on chance.¹⁴

19. A great many of the examples of specific projects to improve access which were drawn to our attention during this inquiry, were based in areas with large communities of women from disadvantaged groups. We recognise, however, that the needs of disadvantaged women living in areas without such identifiable communities, might not be identified. Christine Gowdrige, Director of Maternity Alliance, told us that access “is much more of a problem for an asylum seeker in an area which is not identified as an area of deprivation than it would be for one living in North London which is.”¹⁵ Even if services were accessed, according to the Centre for Nursing and Midwifery Research, in such areas “midwives were deskilled and individual clients often received a poorer service.”¹⁶

20. Jo Garcia, from the NPEU, pointed to a lack of evidence on possible links between poor access to care and general deprivation in a particular geographical area. She told us that little work had been done that examined services “in terms of ... the level of staffing or spending or comparing places in terms of women’s views of care.” Ms Garcia went on to

10 Ev 3

11 *Ibid.*

12 <http://www.dfes.gov.uk/surestart/>

13 Ev 3

14 Q 7

15 Q 10

16 Ev 61

say that it was “not always easy” to ascertain whether differences in access to care were related to resources, or to the “attitudes and structures” inherent in a particular area or service, but she told us that she was unaware of any research which compared spending on maternity services in the poorest areas with that in the more affluent areas.¹⁷

21. It may be that maternity services are less inequitable than other health services because of the regular pattern of antenatal and postnatal visits that midwives conduct. However inequalities remain a serious issue, particularly given the impact that a positive experience of appropriate care can make in this critical period of individual and family life, and the powerfully negative effect that inequalities can have on every aspect of life.

22. If maternity services are to meet the needs of disadvantaged women, babies and families, the evidence base on which policy decisions and service developments are made must be expanded. We recommend that the Department commission programmes of quantitative and qualitative research so that an accurate assessment of the extent to which women who do not gain full access to maternity care can be made, the reasons for inequalities and inequities established and further action taken to address these inequalities.

What can be learned from the Confidential Enquiries into Maternal Deaths?

23. While maternal deaths are now very rare, policy makers and services providers draw on the investigation of these cases when considering those factors which may contribute to adverse pregnancy outcomes other than death. In 1952 the Department (then the Ministry of Health) established the Confidential Enquiry into Maternal Deaths in the United Kingdom (CEMD). Since then the Enquiry, a centrally-directed self-audit for health professionals involved in maternity services, has been undertaken at intervals, and its findings incorporated into Government health policy and obstetric practice.¹⁸

24. The latest report, *Why Mothers Die 1997–99: The Confidential Enquiries into Maternal Deaths*, as well as finding that the maternal death rate amongst women in the group where neither the woman nor her partner had a stated occupation was 20 times higher than that for women in the highest two social classes, extended the scope of the investigation to include consideration of the wider aspects of health and health inequalities in relation to maternal deaths.

25. *Why Mothers Die* indicated that for women from some minority ethnic groups the risk of maternal death was twice that for white women. Of the cases of maternal death investigated by CEMD, more than 25% of women from minority ethnic communities either first made contact with the maternity services when they were more than five months pregnant or missed four or more routine appointments. A large number of the women from ethnic minority groups spoke little English and in many cases, family members acted as interpreters. *Why Mothers Die* reported on several cases where children

17 Q 10

18 *Why Mothers Die 1997–1999: The Confidential Enquiries into Maternal Deaths in the United Kingdom*, RCOG Press, 2001

were used to interpret intimate personal or social details of the mother, and vital information was not communicated.¹⁹

26. CEMD also found that a disproportionate number of women from the travelling community were likely to die. By evaluating a range of factors that may have played a part in cases of maternal death *Why Mothers Die* illustrated not only the relationship between social exclusion and poor pregnancy outcomes, but also that late, sporadic or inadequate care was another common factor.

27. Jenny McLeish, Social Policy Officer at Maternity Alliance, told us that the links made in *Why Mothers Die* between poor access to care and maternal death represented:

the most extreme end ... the tip of the iceberg where the mother actually dies as a result of lack of access to care. Working backwards from that, I think you can hypothesize fairly confidently that there will be other poorer outcomes going on that are harder to pick up in the pattern but ... less drastic consequences for the same problem.²⁰

What is the Government doing to help disadvantaged women gain access to maternity services?

What is the role of maternity services in the context of the Government's Health Inequalities Strategy?

28. In 1997 the Government commissioned the *Independent Inquiry into Inequalities in Health*, chaired by Sir Donald Acheson. The Inquiry listed support for mothers with very young children as one of three top priorities. It also emphasised the importance of making early interventions to improve health and of a focus on the health of mothers and young children in addressing infant mortality. The Inquiry pointed to the need to break the “intergenerational cycle” of health inequalities and identified this as a long term aim.²¹

29. *The NHS Plan*, published in July 2000, made health inequalities a priority in order to tackle the ‘inverse care law’, which suggests that those in greatest need are least likely to receive the health services that they require.²² The Department outlined the implications of the *Plan* for maternity services:

this means knowing where pregnant women are and how they want and need their care delivered and configured. It means understanding the local patterns of disadvantage and exclusion; and designing services that reach out to ensure those most in need have prompt access to the support they need.²³

30. The *NHS Plan* described the health of mother and baby at the very beginning of the baby’s life as being the foundation for health throughout life but noted the wide variation

19 *Why Mothers Die 1997–9, The Confidential Enquiries into Maternal Deaths in the United Kingdom*, December 2001, p 22

20 Q 5

21 *Independent Inquiry into Inequalities in Health: Report* (Chairman: Sir Donald Acheson), TSO 1998

22 Tudor-Hart, Julian, “The inverse care law”, *The Lancet* 1971, pp 405–12; Department of Health, *The NHS Plan: A plan for investment, a plan for reform*. Cm 4818, July 2000, para 13.8

23 Ev 42

in infant mortality rates across the country and in terms of social class and ethnic origin. Babies born to fathers in unskilled or semi-skilled occupations have a mortality rate 1.6 times higher than those in professional or managerial occupations and children of women born in Pakistan are twice as likely to die in their first year than children of women born in the UK.²⁴

31. *The NHS Plan* set targets for reducing smoking in pregnancy as it can be associated with poor birth outcomes. With the help of specialist smoking cessation services as part of antenatal care, the Government aimed to reduce by 55,000 the total number of women who smoke in pregnancy by 2010.²⁵ The *Plan* also stated that while mental health services were not always sensitive to the needs of women, women were more likely to suffer from mental health problems (particularly anxiety, depression and eating disorders) and that 10–15% of women experience postnatal depression after childbirth. As a means of focusing on the mental health needs of women, the Government directed that services should be redesigned to ensure the availability of women-only day centres across the country.²⁶

32. In August 2001 the Government published *Tackling Health Inequalities—Consultation on a Plan for Delivery*. One of the six priority themes in the consultation document was the need to produce a sure foundation for health through healthy pregnancy and early childhood. *The Results of the Consultation Exercise*, published in July 2002, listed suggestions for action on the theme:

- Developing more targeted support for maternal health and the health of developing babies, with specific emphasis on maternal nutrition before, during and after pregnancy
- Reducing the incidence of low birth weight babies by tackling smoking and poor diet
- Promoting and supporting breastfeeding
- Developing parenting skills through family support services and life skills programmes
- Improving access to maternity services, including antenatal classes for disadvantaged groups, those with physical disabilities, learning disabilities, and non-English speaking women
- Increasing professional support for identifying and tackling postnatal depression, a key indicator of maternal health, and improving training on domestic violence.

33. The consultation also revealed that professional and lay support in communities was seen as crucial to providing proper support in pregnancy and early childhood, but that a great many respondents had concerns about resources, capacity and training and development.²⁷

34. This consultation was used to inform the Government's cross-cutting spending review on health inequalities which took place over summer 2002. Among the priority

24 Department of Health, *The NHS Plan: a plan for investment, a plan for reform*. Cm 4818, July 2000, para 13.15

25 *Ibid*, para 13.19

26 *Ibid*, para 14.33

27 *Tackling Health Inequalities: the results of the consultation exercise*, DOH, July 2002, paras 3.6–8

interventions likely to make a major impact on the infant mortality target and on early years development, the review identified reducing smoking in pregnancy, increasing breastfeeding rates, improving diet and enhancing support for families. As part of the review, targets set by *The NHS Plan* on increasing life expectancy (by geographical area) and infant mortality (by social class) were combined into a single Public Service Agreement (PSA) by 2010 to reduce inequalities in health outcomes by 10% as measured by infant mortality and life expectancy at birth. This target has also been incorporated in the National PSA for Local Government.²⁸

35. *The Priorities and Planning Framework for the NHS, 2003–2006*, published in October 2002, afforded health inequalities a high profile and set targets to support progress towards the main PSA aim, including two targets which had direct relevance to maternity services:

- to deliver a one percentage point reduction per year in the proportion of women continuing to smoke throughout pregnancy, focusing especially on smokers from disadvantaged groups [the Department reported that smoking throughout pregnancy decreased from 23% in 1995 to 19% in 2000 in England]
- to deliver an increase of two percentage points per year in breastfeeding initiation rate, focusing especially on women from disadvantaged groups [the Department reported that breast feeding initiation increased from 68% in 1995 to 71% in 2000 in England and Wales].²⁹

The main findings of the health inequalities consultation and of the spending review have been used in the Department's ongoing work in leading on the development of an All-Government Delivery Plan on health inequalities.³⁰

36. However, the RCOG made clear to us its disappointment that in light of the findings and recommendations of CEMD, the targets set for Strategic Health Authorities and PCTs in the *Priorities and Planning Framework 2003–2006* “included so little” that was relevant to “improving maternity care and outcomes”:

The College is concerned that this may delay, through lack of resources, any positive planning for change in service provision.³¹

37. A great many of those service providers who contributed to our inquiry described their involvement with Government programmes such as Health Action Zones, Neighbourhood Renewal Funds and Sure Start. Diane Jones, a consultant midwife from Newham Healthcare, told us that the community focus of Sure Start complemented caseload midwifery schemes:

Part of our strategy comes through from working with the community groups, bringing them together on what the priorities are for the community rather than health care professionals deciding what is necessary for the community.³²

28 *Health Inequalities: summary of the 2002 cross-cutting review*, DOH, November 2002, para 24

29 Ev 44

30 Department of Health, *Tackling Health Inequalities: a programme for action*, 2003 (published after our inquiry).

31 Ev 56

38. However, we heard that maternity services encountered problems in tapping the resources offered by such initiatives:

You need to find out who the key people are who make the decisions about the funding and that can be very, very difficult ... the balance tends to shift, one moment it sits in social services, then it is with education or the PCT. You have to have an awareness of these issues.

In the majority of cases you are not informed that there are these things going on, you have to go out and find it and if you are not clued up as to where to go that can be very difficult. Once we have got in there it has been great. It is just about finding the right places to go.³³

39. Another problem drawn to our attention was the short-term nature of the funding allocated to projects. While such funding afforded services an opportunity to undertake innovative work, Lesley Spires from Queen Charlotte's and Chelsea Hospital told us that it was difficult to recruit staff for short-term programmes, "even if some of them go on for four years."³⁴ As Carolyn Roth, from Women's Health and Family Services told us:

There is a constant insecurity about not only sustaining the work but also the continuity of employment for the people who are working on the project.³⁵

40. We recommend that the Department provide PCTs and acute trusts with relevant and timely information to enable maternity care teams to use the opportunities and resources offered by the Government through projects and initiatives such as Sure Start, to recruit more staff and provide specialised services for disadvantaged women and their families. We further recommend that the Department should ensure that best practice be shared in relation to these centrally-funded projects. We further recommend that the Department should ensure that best practice be shared in relation to sustaining the work of a project after the allocated funds have been used.

How will the Children's National Service Framework address inequalities in access to maternity services?

41. The Development of a National Service Framework (NSF) for Children was announced in February 2001. According to the Department:

In the new architecture of the NHS the setting of national standards through the NSF will be the most effective way of ensuring consistency of service provision to all groups of women, including those who use the current services least, and quality in a devolved health care system; whilst at the same time continuing to allow local health systems to develop a 'best fit' ... the maternity module will develop national standards of care to cover the provision of antenatal, intrapartum and postnatal

32 Q 115

33 Q 132 (Diane Jones, Newham Healthcare); Q 132 (Maggie Elliot, Queen Charlotte's and Chelsea Hospital)

34 Q 136

35 Q 135

services; and will look at how to make maternity services more flexible, accessible and appropriate for all, including the socially disadvantaged.³⁶

42. The maternity module of the NSF is being developed by the Maternity External Working Group (EWG) and a sub-group has been appointed to work on inequalities and access. In an interim report issued in April 2003, the EWG made a number of recommendations on access to maternity care:

- From pre-conception to post-birth all women need to have appropriate access to community, hospital and/or specialist services, including women with:
 - Healthy and uncomplicated pregnancies
 - Complicated pregnancies due to medical, psychological or social reasons; and
 - Ethnicity, poverty or social exclusion issues—e.g. prisoners, women with enduring mental health problems, women with disabilities, and women from transient populations
- This can be helped by: setting standards of care to reduce health inequalities; recognising cultural diversity and providing appropriate communication and support; and by providing flexible services, for instance considering innovative approaches for women who have difficulty accessing services.³⁷

43. The Department told us that the sub-group had identified two key questions in relation to inequalities in access to maternity services: how do services find hard-to-reach women; and how do services respond when these women do attend? The Department told us that in addressing these questions the sub-group would look at examples of good practice at local level, and at ‘care pathways’ that describe the journey of pregnant women through maternity services. The aim would be “to provide individual and personal care for each woman, without making assumptions about her needs from her appearance, her ability to communicate or her past history.”³⁸

44. The interim report on the development of the NSF has generally been received with enthusiasm. Jo Garcia, from the NPEU, welcomed the promotion of care pathways in the NSF. These, she told us, would:

help midwives to think about the sort of additional needs women might have and, even beyond that, help the service to think about how it might reach women ... help make care more individualised without putting rules on by saying exactly what sort of care should be provided.³⁹

45. The RCOG endorsed the recognition in *Emerging Findings* that providing appropriate services for women from disadvantaged groups would involve development of the skills of the maternity care workforce, and of lines of communication between health care and

36 Ev 57

37 *Getting the right start: National Service Framework for Children—emerging findings*, chapter 4

38 Ev 46

39 Q 83

social care professionals, and between services and the women who use them. However, in the context of the shortages of maternity care staff which were drawn to our attention during our first inquiry, the RCOG told us that it was concerned that “effective implementation and change will only be possible with appropriate and additional training and education for health and social care professionals” and that this had resource and staffing implications.⁴⁰

46. We welcome the interim findings of the Maternity External Working Group, and look forward to seeing the work of the sub-group appointed to examine inequalities and access. The difference for women and families will depend on the identification of effective strategies and the Government ensuring that the implementation of these strategies is achieved.

3 What are the barriers to access for disadvantaged women and their babies?

Minority Ethnic Groups

47. The latest Census found that the minority ethnic population of the United Kingdom in 2001 was 4.6 million (7.9% of the total population). Access to and use of public services by this group is an increasingly important consideration for service providers and policy makers. The Department identified access to maternity services as a particular problem for minority ethnic groups, given the CEMD findings that women from minority ethnic communities were more likely than white women to contact maternity services late in pregnancy, and to miss routine antenatal appointments.⁴¹

48. In 1994 the Commission for Racial Equality (CRE) launched the *Race Relations Code of Practice in Maternity Services* which explained how the Race Relations Act 1976 applied to maternity services, offered guidance on how to eliminate racial discrimination from the provision of services, and provided examples of good practice.

49. The evidence we have heard suggests that guidance and training for midwifery staff can vary a great deal between, and even within, maternity care teams. Diane Jones told us that staff took part in a “trustwide diversity programme” but that there was no special training for the maternity care team, and that “policing who has attended and who has not and has it made any difference to the way they practise is very difficult to evaluate.”⁴²

50. The RCOG argued that the underlying problems in relation to access to maternity care for ethnic minority groups were lack of understanding of cultural differences and barriers to communication.⁴³ The RCM identified the following factors as obstacles to progress:

- institutionalised racism
- a reluctance on the part of young women from ethnic minority groups to become midwives [partly owing to the poor experiences of older midwives from minority ethnic communities]
- complacency in areas with small ethnic minority populations
- a general reluctance to address the sensitive issue of race.⁴⁴

51. Awareness of, and sensitivity to, cultural differences, are key elements in the provision of appropriate maternity care for women from minority ethnic communities. There may be fundamental differences between the kind of maternity care or birth a woman could

41 Ev 47

42 Q 167

43 Ev 58

44 Ev 64

expect to have according to the traditions of her community, and that which she is likely to have in this country.

52. Diane Jones from Newham Healthcare NHS Trust told us that women from some minority ethnic communities were unaware of the fact that a home birth would be attended by a midwife, who would then record that the birth had taken place. This, Ms Jones explained, could seem “very alien”. In some cases, even when explanations were attempted, the process was seen as:

an authority coming in wanting to take the baby away ... it was misconstrued as something terrible that we wanted to do which pushed them further away from us.⁴⁵

53. This kind of gap in understanding and communication between some minority ethnic groups and the maternity services, which creates anxiety and fear, is likely to have a profoundly detrimental effect on women’s experiences of pregnancy, labour and of the postnatal period. All of our witnesses called for stronger lines of communication between disadvantaged women and the maternity services to be established. Two proposed strategies for enhancing these lines of communication were: to recruit women from ethnic minority communities into the maternity services; and to ensure that women from ethnic minority communities who used the maternity services were properly consulted.

54. However, our witnesses told us of difficulties in recruiting women from minority ethnic communities into the maternity services. Maggie Elliot, Head of Midwifery and General Manager at Queen Charlotte’s and Chelsea Hospital, described this difficulty in terms of increasing minority ethnic representation in all aspects of maternity services:

We have a high Somali population and from that group of women it is hard even to get representation on things like the Maternity Services Liaison Committees, let alone to encourage those women to go and do midwifery training.⁴⁶

55. The Royal College of Midwives (RCM) noted the finding of a survey, carried out in 1998 by Maternity Alliance and the CRE, that a quarter of maternity units had no formal channels for consultation with minority ethnic groups.⁴⁷

56. We recommend that the Government investigate the RCM’s concerns relating to the recruitment of midwives from minority ethnic communities. Action to promote the recruitment of midwives from ethnic minority communities could include the identification of ‘champions’ from minority ethnic communities which may help to inspire some younger people from these communities to pursue careers in maternity services.

Refugees and asylum seekers

57. In 2002 there were 85,865 applications for asylum in the UK and by March 2003, 92,685 asylum seekers were receiving assistance from the National Asylum Support

45 Q 174

46 Q 128

47 Ev 63

Service. In the first quarter of 2003, the main countries of origin for those seeking asylum were Iraq, Somalia, Zimbabwe and Afghanistan.⁴⁸ Asylum seekers constitute a diverse group and patterns of migration shift frequently.

58. In its evidence on access to maternity services for refugees and asylum seekers, the Department stated that anyone with an outstanding application for asylum in the UK was entitled to full use of the NHS, including maternity services, without charge. However, the Department also acknowledged that “pregnant asylum applicants may be in a particularly vulnerable condition.” Several of the reasons given by the Department for this vulnerability also represent factors which prevent asylum seekers from making contact with maternity services: their future in the UK will not be certain, they are unlikely to have family or friends around them for support, and they may not be able to speak English.⁴⁹

59. As My Diep, a Community Health Worker from Women’s Health and Family Services explained, women who are recently arrived “have very little knowledge about the health services in this country compared to ... their own country.”⁵⁰ She also pointed to cultural and religious differences which had to be taken into account.

60. Research undertaken by the Maternity Alliance identified some of the particular problems encountered by asylum seekers in gaining access to, and in making full use of, maternity services. A great many of the women surveyed by the Maternity Alliance had not been given any information about the kinds of services and support available to them. While most women who did gain access to maternity care were satisfied with their antenatal care, and while half told the Maternity Alliance that their experiences in hospital were positive, half of the women surveyed were subject to “indifference, rudeness and racism.” Owing to their circumstances, these women “felt powerless to challenge hostile attitudes and fearful of the consequences if they attempted to do so.”⁵¹

61. We were concerned in particular for those asylum seekers whose future in the UK is uncertain, and who are detained pending decisions on their applications. In a written answer to a parliamentary question, the Minister of State for Citizenship, Immigration and Community Cohesion outlined the Government’s policy on detention of pregnant women seeking asylum:

Pregnant women are not normally considered suitable for detention under the Immigration Acts unless there is a clear prospect of early removal from the UK and medical advice suggests no question of confinement prior to this. In addition, women in the early stages of pregnancy may be detained briefly at Oakington Reception Centre as part of the fast track asylum process. Statistics for the number of pregnant women detained under the Immigration Act powers are not available.⁵²

62. However, we have heard evidence that some asylum seekers have been unable to gain access to maternity care as a direct result of detention. The Maternity Alliance told us of

48 *Quarterly Asylum Statistics*, Home Office, March 2003. <http://www.homeoffice.gov.uk>

49 Ev 47

50 Q 169

51 Ev 3

52 24 October 2002 416W (Anne Campbell MP)

interviews conducted with four women who were detained while pregnant or with a young baby. The Maternity Alliance concluded from these interviews that the health care centres within detention centres did not provide care to meet the needs or wishes of pregnant women. Where hospital care was needed, detention centres were responsible for escorting women to appointments but the Maternity Alliance identified one instance where a detention centre did not provide this service. Movement between detention centres disrupted women's care, and in one case a detention centre did not forward blood test results to a pregnant woman who had been released.⁵³ Jenny McLeish from Maternity Alliance told us that although midwives visited detention centres, they did so without interpreters, and that detention centres did not provide interpreting services.⁵⁴

63. Dispersal of asylum seekers constitutes another barrier to access to care. Jenny McLeish told us that dispersal could happen at very short notice, interrupting maternity care:

the agency responsible for dispersal will not give details to external agencies such as the health services of where people are going. So, it is very much down to the individual to try and contact the health service, if they can speak the right language, to tell them that this is happening and for notes to be passed on.⁵⁵

64. Pregnant asylum seekers are at a particular disadvantage when seeking access to maternity services if those services are not aware of their needs, or even aware that asylum seekers have been dispersed to the area. Health professionals who see pregnant asylum seekers for the first time at very short notice and who are not equipped with adequate information or resources, can themselves find the experience upsetting and frustrating. Jo Garcia from the NPEU told us:

In relation to asylum seekers if there is a sudden change in the need in a town, in some cases, the maternity services will pick it up very fast ... and will be prepared ... in other cases, the midwife may find herself face-to-face with someone without the warning and knowledge.⁵⁶

65. Any support system for asylum seekers should provide specifically for the needs of pregnant asylum seekers, new mothers and their babies. We recommend that the Government take steps to ensure that pregnant women and new mothers should not be detained for any prolonged period, and that accommodation centres should provide a gateway to maternity services for pregnant asylum seekers.

66. Better communication between maternity and child health services and accommodation providers during dispersal is needed to ensure that members of maternity care teams are forewarned of the arrival of asylum seekers who will need their services and that their test results and notes are forwarded.

53 Ev 4

54 Q 44

55 Q 51

56 Q 15

67. In considering asylum seekers for dispersal special attention should be paid to the support needs of pregnant women and new mothers since separating them from any support network at this time could be especially detrimental to families.

Those who do not speak English as their first language

68. People who do not speak English as their first language need advocacy and interpreting services to help them to understand what services are available to them, and to help them to participate in decisions about their care. We noted a broad agreement amongst contributors to our inquiry that interpreting services should be provided by specialist staff. Informal interpreters, such as the woman's partner, relatives or friends, or bilingual but untrained NHS staff may not be able to interpret what a woman wants to say or describe to a midwife or obstetrician (and vice versa) and a woman cannot maintain a confidential relationship with her carers under these circumstances. Both of these factors may prevent women from gaining access to the maternity care that they need.

69. However, we heard that lack of resources often limited the interpreting services available to pregnant women and that hospitals kept in-house lists of bilingual staff, or asked women's relatives or friends to interpret as a substitute for professional services. Drawing on the results of the Maternity Alliance/CRE survey which found that over one fifth of maternity units provided information only in English, and that two out of every five units relied on friends and family to interpret (even when consent for a medical procedure was required), the RCM told us that in relation to facilitating access to services for those who do not speak English, "these challenges are not being met by maternity services as currently configured."⁵⁷

70. The Maternity Alliance reported that there was no recognised pay structure for interpreting work within the health service, nor was there any national organisation to represent and co-ordinate the activities of language support service providers. Language support services were often funded on a short-term basis, through schemes to support ethnic minority groups.

71. Language Line Limited is a private sector interpretation service used by public sector organisations such as NHS Direct, the UK Immigration Service, and the National Asylum Support Service, and by various NHS trusts and PCTs across the country. In its written submission to our inquiry, Language Line emphasised the role of professional interpretation services in improving access to maternity services, and in the provision of appropriate care. Language Line told us that language services could be used alongside advocacy services, with "an impartial, vetted interpreter" who would guarantee confidentiality and accuracy. Language Line also told us that it accumulated a body of knowledge about the cultural attitudes of different communities in relation to health services, and that language service providers could "prove invaluable in conveying to ethnic minority customers concepts which do not necessarily exist in their cultures, for example, national health numbers or the NHS itself."⁵⁸

57 Ev 64

58 Ev 53

72. Throughout our inquiry, we heard evidence of problems with using Language Line as a means of communicating with pregnant women who did not speak English. In some instances, staff members were discouraged from using the service on the grounds of cost.⁵⁹ Language Line itself noted inconsistency in use of language services and stated that it was:

essential that all frontline staff who come into contact with health service users should be educated about when it is appropriate to utilise language services and how to maximise the benefits to both the recipient and provider of the service.⁶⁰

73. Jenny McLeish from Maternity Alliance told us that maternity care supported by “Language Line with a man [at the end of a telephone line] in Australia” could be “quite an appalling prospect for some women” and that in some cases women chose their own partners to act as interpreters.⁶¹ City University argued that telephone translation was inappropriate in acute situations.⁶²

74. Although services for pregnant women and mothers who do not speak English as their first language can be inconsistent and inadequate, we heard that most maternity units were “reasonably good at getting some kind of communication going in the hospital and at antenatal clinics.” Hospitals in some areas drew up lists of bilingual or multilingual staff who might be called upon to help women when specialist services were not available. However, Jenny McLeish told us that “in the community there is very rarely access to interpreting services so, when the midwives go for their postnatal visits, they are left with sign language and trying to write things down.”⁶³ Where advocacy and interpreting services are available in the community, it may be the case that a woman will lose access to them, and to the benefits of continuity of care, if she goes into a maternity unit. For example, the advocates from Women’s Health and Family Services in East London work exclusively in primary care and cannot follow women into hospital.

75. Lesley Spires, from Queen Charlotte’s and Chelsea Hospital, confirmed that maternity care provided in the community involved using family members as interpreters. She said that the caseload approach to maternity care, where a midwife would get to know women and families in their own homes and ascertain “the relationship between the family members and the dynamics within the family”, helped to ensure that this did not compromise a woman’s ability to make herself understood or to ask questions.⁶⁴

76. Pregnant women and mothers who do not speak English as their first language are rarely represented on Maternity Services Liaison Committees or on policy making bodies inside the maternity services, and so as the Maternity Alliance told us, “linguistic minority communities still face difficulties in raising these issues and in lobbying for resources.”⁶⁵ We examine the issues of how representative MSLCs are below at Chapter Four.

59 Ev 70

60 Ev 54

61 Q 43

62 Ev 70

63 Q 44

64 Q 112

65 Ev 5

77. Given the high incidence of domestic violence in pregnancy, relying on relatives to interpret for women can be extremely dangerous. All maternity services should ensure that the use of relatives as interpreters does not deny women the opportunity that maternity care provides to report domestic violence or to discuss other concerns such as mental health.⁶⁶

78. Interpreting and advocacy services are a vital component of appropriate maternity care for women who do not speak English as their first language. However, we are concerned that local service planners do not recognise this in their budgets, and in particular that there is so little provision for need in the community and out-of-hours in hospital-based units. We recommend that local maternity services take steps to ensure the development of on-site out-of-hours interpreting and advocacy services and that better use is made of telephone interpreting services. We further recommend that staff running antenatal classes and undertaking postnatal visits should have access to advocacy and interpreting services.

79. Ideally, interpreting services should be provided, in the community and in the hospital, by specialist interpreters and advocates, rather than by family members, friends, or by other staff. However, we endorse the attempts made by maternity care staff to find interpreters when specialist services are not available. Bilingual and multilingual staff working in PCTs and acute trusts should have the opportunity to develop their interpreting skills. We recommend that the Department commission work to develop appropriate training courses and qualifications in interpreting for non-specialist staff.

Those who live in poverty, and those who are homeless

80. Women living in poverty have poorer health outcomes than others. Babies born to women in manual social classes are one and a third times more likely to be born with a lower birth weight than babies born to women in non-manual social classes.⁶⁷ Children born into poor families will also suffer from a higher infant mortality rate and generally have poorer health.⁶⁸

81. Attending antenatal appointments and classes may be costly and difficult for women who live in poverty where affordable and convenient public transport is lacking. The NCT argued that “this discourages those who would most benefit from being seen by health professionals attending appointments.”⁶⁹

82. We also heard of the financial difficulties facing those who had to travel long distances to be with their babies in Special Care Baby Units. The extra financial burden on low-income families might pose particular difficulties at this time. Currently help with the

66 We discuss the prevalence of domestic violence in pregnancy, and its implications for maternity services below at paragraphs 97–9.

67 New Policy Institute/Joseph Rowntree Foundation, www.poverty.org

68 *Supporting poor families: briefing paper*, Rogers, C, and McLeod, M, National Family and Parenting Institute and End Child Poverty, 2002

69 Ev 74

expense of visiting is restricted to people who receive income support or job seeker's allowance.

83. Christine Gowdrige, Director of Maternity Alliance, told us that in some areas health visitors were not pro-active enough in providing support for women and babies living in poverty—their approach to care was to say “Get in touch if you have a problem.”⁷⁰

84. Access to health service provision for women and families who have become homeless and who are living in temporary accommodation can be fraught with difficulty, not least because it can vary dramatically between different areas. The Maternity Alliance found that:

The services a family received were generally determined less by need and more by luck with respect to the level and quality of what was available in the locality in which they were living.⁷¹

85. In our last inquiry, into provision of maternity services, we heard that most women gained access to maternity services through their GP. However, a great many women who are homeless struggle to gain access to GP services. The Maternity Alliance told us that over half of the women they surveyed did not have a GP in the area where they were temporarily housed, because they had chosen to remain registered with a GP in the area where they had last been securely housed. Seeing a GP could then involve substantial travel and expenditure.

86. Without access to maternity care through a GP in the community, most homeless women tend to receive their maternity care at hospitals. Jenny McLeish from Maternity Alliance told us that:

They do not get the community care because they never get through that route to the community midwives, who are probably better placed to form relationships and give them support ... so they are really disadvantaged.⁷²

87. The Maternity Alliance found that women's expectations of antenatal care were low, but that while they did not expect any social support or maternity care designed to cater to their particular needs, “their concerns for their pregnancy all related to their social circumstances.”⁷³

88. Access to care after the birth of a baby can also be problematic for homeless women, as a hospital midwife told the Maternity Alliance. She described the “frustrations and anxieties” of hospital staff who discharged women into the care of local Homeless Persons Units (HPUs) but who then had great difficulty finding out from HPUs where the women and their babies were living.⁷⁴

70 Q 71

71 Ev 4

72 Q 72

73 Ev 5

74 *Ibid.*

89. This difficulty in maintaining contact with women who move from place to place can be compounded by lack of communication between social services in different areas.⁷⁵ Lesley Spires told us that:

we do have a lot of problems about going across social services boundaries. If you need to be in contact with social services then once a woman moves out of one area into another that [contact] seems to break down. Unless the midwife is following that woman through, the other services do not seem to do that ... you are going to lose women if they do not have the confidence to keep in touch with the midwife or the services they are getting.⁷⁶

90. We were also concerned to hear of individual social workers giving mothers the general impression that it would be easier to take a baby away and care for him or her, rather than work with the family to keep them together. We recognise that in extreme cases social workers do have to recommend that babies are taken away from parents but this experience suggests that more needs to be done to ensure that social workers are trained to understand and respect the sensitivities of homeless and disadvantaged families so that it is clear that families will be kept together where this is possible.

91. Although there are ways in which maternity services, and social services, can be adapted to meet some of the needs of pregnant women and mothers living in poverty, the RCM argued that:

The problems lie beyond the maternity unit and helping to give the children of women who live in poverty a better start in life must be about the wider anti-poverty agenda and helping the financial circumstances of the mother.⁷⁷

92. Those responsible for rehousing pregnant women and women with young babies should be able to pass information on to maternity and health visitor services where women wish for these services to be provided. Currently methods of passing on information are inadequate and the situation needs to be improved. We recommend that the Department should assess the difficulties faced by low-income families who have to spend long periods visiting their babies in Special Care Baby Units and that the Department should then take steps to ensure that sufficient financial support is provided so that these families can meet travel and other costs.

Those from the travelling community

93. Women from the travelling community may not gain full access to maternity services for a variety of reasons. Those who move from one official stopping place to another have little chance of receiving continuous antenatal or postnatal care. Every move means that a woman has to seek out local health services where professionals might not have access to her medical records. Travellers who reside in the same place throughout their pregnancy

⁷⁵ For a wider discussion of this issue see Health Committee, Sixth Report of Session 2002–03, *The Victoria Climbié Inquiry Report*, HC 570.

⁷⁶ Q 186

⁷⁷ Ev 65

and the postnatal period may face hostility from the local population and from some health professionals when they seek maternity care.⁷⁸

94. Jenny McLeish from Maternity Alliance told us that the travelling community was “unpopular ... seen as resistant to services” and Christine Gowdrige reported that when the Maternity Alliance sought funding for an initiative designed to improve services for travellers, one potential funder responded by saying that the project was “a waste of money.”⁷⁹ She went on to illustrate the need for funding and for specific projects to help women and families from the travelling community as she told us of the results of a survey of the provisions maternity services made for women from the travelling community. The response from one unit was “we rent out car seats.”⁸⁰

95. Lesley Spires from Queen Charlotte’s and Chelsea Hospital, London identified women from the travelling community as a group “who traditionally do not attend for antenatal care.” She went on to cite as a reason for this non-attendance “that barrier where women feel they cannot trust the professionals.”⁸¹ We are concerned that prejudice on the part of health service staff has perpetuated this mistrust.

96. The Department assured us that the Children’s NSF would examine how to make services more accessible for travellers, and that it was funding the Maternity Alliance project which would involve consultation with women and with health professionals to produce guidance on service delivery and provision of information.⁸²

Those who live under threat of domestic violence

97. Some 12% of the women whose deaths were reported in the latest CEMD had disclosed that they were subject to domestic violence. All of the evidence we received on this aspect of our inquiry stated that domestic violence often starts or intensifies when a woman is pregnant.

98. Violence during pregnancy is associated with premature birth, low birth weight, fetal injuries to limbs and organs, placental abruption⁸³ and premature spontaneous rupture of the membranes.⁸⁴ However, women who are subject to domestic violence may be reluctant to come forward for care, may have a partner who prevents them from attending, or prevents them from participating fully in discussions at antenatal appointments. They may be reluctant to disclose abuse if they have fears about confidentiality. It was also pointed out to us that it was no good for staff to identify domestic violence if nothing could be done to help women facing this problem.

99. We believe that domestic violence is substantially under-reported and that the true scale of the problem remains unknown. We endorse the RCOG’s call for further

78 Ev 6

79 Qq 76–7

80 Q 10

81 Q 95

82 Ev 50

83 Placental abruption is the formation of a blood clot behind the placenta.

84 Rupture of the membranes is a term used to describe the breaking of the sac of amniotic fluid surrounding the fetus; BMA, *Growing up in Britain: ensuring a healthy future for our children*, 1999

research into the prevalence of domestic violence, and into effective models of intervention. All maternity services need to have access to support services, to which they can refer those who are suffering from domestic violence. All women should have ready access women's refuges so that maternity services can protect women who disclose domestic violence from further abuse.⁸⁵

Those with severe mental health problems

100. *Why Mothers Die* provides worrying evidence that some women with mental health problems do not gain access to appropriate maternity care. In working with the Office for National Statistics to identify deaths that previously would have passed unrecognised by the Enquiry, CEMD found that information on maternal deaths from mental illness had been subject to "a large degree of under-ascertainment". However, in terms of the deaths which were recognised, when all deaths up to one year from delivery were taken into account, suicide was the leading cause of 'indirect' death (death from a medical condition exacerbated by pregnancy) and also the leading cause of maternal deaths overall.⁸⁶

101. The RCM told us that access to maternity care for women with severe mental health problems was compromised by a "lack of specialist practitioners available to childbearing women with mental illness" and by a lack of co-operation between mental health and maternity services, which meant that pregnant women with mental health problems might be cared for by general psychiatrists, without support or care from midwives.⁸⁷

102. The RCM cited a lack of specialist facilities as one of the main barriers to access to appropriate maternity care for women with severe mental health problems:

There are entire counties without mother and baby units, requiring midwives and mental health professionals to refer to larger cities some distance away. This compromises care, safety, and the well-being of mothers and babies. Where there is no alternative to separation, subsequent maternal and infant bonding can be compromised.⁸⁸

103. We also heard a disturbing account of how lack of communication and co-operation between mental health services and maternity services could jeopardise short and long term health outcomes for mother and baby:

Most mental health teams do not recognise postnatal depression at all ... if a woman displays some bizarre behaviour she cannot go to the mother and baby unit, so she is separated from the baby and admitted to a mental health hospital, which is going to exacerbate her problem because she is not with the baby.⁸⁹

104. Carolyn Roth from Women's Health and Family Services said that, along with colleagues at City University, she had identified access to maternity services for women

85 Ev 58

86 *Why Mothers Die 1997–99: The fifth report of the Confidential Enquiries into Maternal Deaths in the United Kingdom*, RCOG Press, 2001, p 27

87 Ev 67

88 Ev 67

89 Q 196

with mental health problems as an area requiring further research and sharing of good practice: “at the moment we do not know what midwives are doing with respect to the social and mental health needs of women, we do not know what they ought to be doing.”⁹⁰

105. All trusts should ensure that maternity and mental health services work together to provide proper support for women during pregnancy and the postnatal period. We believe that the Department should give high priority to addressing the problem of inadequate provision of mother and baby units in some parts of the country. Mental health trusts should appoint lead practitioners to ensure that care for these women is properly co-ordinated.

Those with severe disabilities

106. Women who have physical or mental disabilities or impairments, face barriers to access to appropriate care even before they or their partners become pregnant, because they are not seen as prospective parents by those around them. During a consultation with 150 parents with disabilities (which was funded by the Department), the Disabled Parents Network (DPN) gathered evidence of the effect of this attitude on parents’ ability to gain access to services. One parent said “I had no sense that support and acceptance would be available” and another reported:

The message coming to me since I was a baby was, you can’t do and you can’t be ... I never thought that I would be a parent. It meant that when I did get pregnant I had no idea what was going on.⁹¹

107. The Maternity Alliance portrayed a particularly bleak situation for women with learning disabilities:

the possibility of motherhood is often discouraged, active decisions to become a parent are unsupported and resources to prepare and support the future parents are unavailable.⁹²

108. In its written submission to our inquiry, the Department recognised that “disabled people, when choosing to become parents, often face negative attitudes, an inaccessible environment and support which is inappropriate.”⁹³ The RCOG further acknowledged that in terms of maternity services, “ensuring that people with learning disabilities have equal rights ... is a particular challenge.”⁹⁴

109. Prospective parents with physical disabilities have particular need of specialist maternity care. A woman’s pregnancy may be affected by her impairment, or her impairment by her pregnancy. However, just as pregnant women and mothers with mental health problems may receive care from two discrete groups of health professionals,

90 Q 195

91 *It shouldn’t be down to luck: consultation with disabled parents*. Disabled Parents Network, 2003, p 15

92 Ev 6

93 Ev 52

94 Ev 59

disabled people often struggle to negotiate a package of care which takes into account all of their circumstances.

110. Providing this package of specialised care for a woman can be a difficult task for maternity care staff. The RCOG told us that:

Obstetricians and midwives are at a disadvantage because they may only encounter women with a particular disability infrequently and do not have the chance to become an expert in management of the particular problem nor the resources to provide optimum care.⁹⁵

111. Although we fully understand that obstetricians and midwives and indeed GPs and health visitors cannot hope to have ready knowledge of all disabilities and their implications for pregnancy, we were dismayed to hear that some women with disabilities are denied any sort of continuity of care because health professionals are so eager to refer them to others. Simone Baker, Vice-Chair of the DPN confirmed that lack of expertise on the part of health professionals could reinforce barriers to access to care in that “everybody washes their hands of their responsibility and the person who pays the price is the disabled mother-to-be.”⁹⁶

112. The DPN cited examples of instances where maternity services might easily fail mothers with disabilities and their babies, and where barriers to access were simple but fundamental. These included reports of visually impaired women struggling with feelings of disorientation at antenatal clinics because staff did not take account of their disability, and of deaf mothers, family members and friends who were unable to gain access to maternity wards or units which operated intercom systems.⁹⁷

113. As an active member of her local MSLC Simone Baker (along with the lay chair of the committee) overcame a fundamental barrier to access to appropriate maternity care by securing the purchase of height-variable cribs so that women with disabilities could reach their babies by themselves. However, the cost of the cribs was met by a private company rather than by the trust, and Mrs Baker was not aware that this example of good practice in providing appropriate care for disabled parents and their babies had been spread beyond her local area.⁹⁸ The height-variable cribs were not much more expensive than other cots and they were also of benefit to mothers who suffered from back pain, and to those recovering from surgery.

114. Although women may require care specific to their particular disability or impairment, women with all kinds of disabilities may encounter the same barriers to access. The DPN told us that:

It is usually structural and attitudinal barriers that ‘disable’ women during their contact with maternity services and these are often generic regardless of the nature of an individual’s impairment (lack of physical access, lack of information in accessible

95 *Ibid.*

96 Q 58

97 Ev 2

98 Q 62

formats, negative attitudes of staff, lack of adaptive baby equipment, lack of appropriate means of communication etc.).⁹⁹

115. The DPN told us that in particular, disabled parents (most notably those with learning difficulties) appear to have very limited access to, or even knowledge of, antenatal education and postnatal support groups. One mother described the first 18 months of her baby's life to the DPN as "a nightmare ... I have lurched from one crisis to the next."¹⁰⁰

116. Information that is provided to expectant parents should be made fully accessible to all groups of people with disabilities, including those with physical or sensory impairments, people with learning difficulties or long-term illnesses and people with mental health problems.

117. Maternity units and services should be made accessible to all groups of people with disabilities. We recommend that the Department set up systems for best practice to be shared so that people with disabilities do not have to struggle to make their views known in every area before improvements are made. For example, the obvious success of height-variable cots in one area should automatically be picked up by other units. We have little confidence that this happens now.

99 <http://www.disabledparentsnetwork.org.uk/latest.htm>

100 *It shouldn't be down to luck: consultation with disabled parents*. Disabled Parents Network, 2003, p 15

4 How can barriers to access be overcome?

Assessing the needs of disadvantaged women and their babies

118. Policy makers and service providers alike are impeded in their work to improve access to maternity services for women from disadvantaged groups by the weakness of the evidence base. The needs and wishes of these women are not known and so services are ill-prepared to meet them. Christine Gowdridge from the Maternity Alliance told us that “a lot of the evidence on which services have been planned has been skewed by the fact that they have not necessarily asked the right women.” In particular, she pointed out that user surveys often did not include women whose first language was not English because services could not “afford to survey them.”¹⁰¹

119. However, there is much that maternity care teams can do at local level to gain an understanding of the needs of disadvantaged women and their babies, and also to strengthen their relationships with different communities.

Consultation at individual level

120. In the first instance, maternity services should engage with women, and respond to their needs as individuals at the earliest opportunity. The RCOG argued that women with learning disabilities should have access to pre-pregnancy advice, and that women should be involved in planning the “packages of care and support” that would be necessary to enable them to bring up a child.¹⁰²

121. The RCM emphasised the importance of involving women in their care at the earliest possible stage so that services and equipment could be adjusted to meet their needs:

Adjustable equipment will increase the independence of women with disabilities and will reduce staff workload, therefore the right equipment and forward planning are crucial.¹⁰³ Prior to admission the woman should be given an opportunity to visit the maternity unit and check that facilities are appropriate to her needs, including familiarising her with the environment and giving her an opportunity to meet other staff.¹⁰⁴

122. Simone Baker from the DPN agreed that women should be closely involved in all decisions about their maternity care. She emphasised the importance of assessing and then responding to a woman or a family’s need over acting on assumptions. Mrs Baker told us

101 Q 2

102 Ev 59

103 For further discussion of how planning, involving patients themselves, can reduce staff workload and unnecessary hospital stays, see Health Committee, Third Report of Session 2001–02, *Delayed Discharges*, HC 617.

104 Ev 68

that “a disabled person does not need you to do everything for them, they need you to wait to be asked.”¹⁰⁵

Consultation at community level

123. *Changing Childbirth* tackled the issue of access to maternity care and recommended that every District Health Authority should have a Maternity Services Liaison Committee (MSLC) with user representation reflecting the ethnic, cultural and social mix of the local population. Involvement of users in planning and evaluating services was proposed as a way of improving access and developing appropriate service provision.¹⁰⁶ Jo Garcia from the NPEU told us that MSLCs “have been fantastically useful and they are also the place where women using the service can have a real input ... it is very often a layperson chairing the committee and they have been incredibly important.”¹⁰⁷

124. We were encouraged to hear this endorsement of MSLCs. As part of our first inquiry, into Provision of Maternity Services, we heard from service users representing 15 maternity units across the country. Nearly all of the service users were members of their local MSLCs and as such they spoke with confidence about a range of work being carried out to ensure that maternity services took full account of women’s needs and wishes.

125. However, we heard from other quarters that women in some areas were not adequately served by active MSLCs, despite the publication of Department of Health guidelines on the role and organisation of MSLCs.¹⁰⁸ The RCOG told us that although these guidelines were intended to “emphasise the role and place of the MSLC” across the country, the activity levels and efficiency of MSLCs continued to vary widely.¹⁰⁹

126. Some of our witnesses concurred with the RCOG that MSLCs found it difficult to find appropriate lay and user representatives from minority and disadvantaged groups.¹¹⁰ One factor which might partially explain this difficulty is the financial burden of arranging childcare and/or travelling to MSLC functions, and in a written submission to our inquiry, the Centre for Nursing and Midwifery Research at the University of Brighton called for service users to be paid for formal participation at events such as trust meetings.¹¹¹

127. Jo Garcia told us that it was “difficult to get ... any reimbursement for lay people on the committees”, and further that this and every other aspect of the running of MSLCs depended “entirely on the local health authorities’ approach.” She told us that reforms to restructure the health service, namely the transition to PCT-led commissioning, could threaten the effectiveness, and even the existence, of MSLCs:

In some places, they are continuing to function well but in other places, the change in service structure means that it is not clear where they should be based. There is a lack of clarity right now about what they should be doing ... all the learning and

105 Q 59

106 Department of Health, *Changing Childbirth: report of the Expert Maternity Group*, 1993

107 Q 23

108 Department of Health, *Maternity Services Liaison Committees: guidelines for working effectively*, 1996

109 Ev 57

110 *Ibid.*

111 Ev 61

skills and confidence that has been built in gradually with these committees and lay people need to be kept in order that that role can continue.^{112,113}

128. User involvement is vital to the effective planning of services and monitoring of access to care. We recommend that the Department should ensure the continuation of MSLCs in the context of NHS reforms. The role of MSLCs in relation to the Patient Advice and Liaison Service (PALS) and in relation to new patient forums and other mechanisms to involve the public in health service provision needs to be clarified. The expertise of the Commission for Public and Patient Involvement in Health should also be used to support MSLCs.¹¹⁴

129. Even where MSLCs operated on a secure organisational basis, we heard that some still failed to represent or even register the experiences of women from disadvantaged groups. Diane Jones from Newham Healthcare told us that although local MSLCs could play significant roles in maternity services:

The service users' representation does not actually reflect the Newham population. What we tend to have are women from the NCT group, many middle class white women who run the MSLC, so it does not accurately reflect other women from the community.¹¹⁵

Maggie Elliot from Queen Charlotte's and Chelsea Hospital described the problem in the starkest of terms: "you are not going to get somebody that is subject to domestic violence on the MSLC."¹¹⁶

130. Jenny McLeish from Maternity Alliance argued that service planners needed to acknowledge that current provision was not based on an accurate profile of local communities, and take immediate steps to rectify this:

If an area is really serious about hearing the views of its full local population and reflecting them, they cannot simply rely on voluntary committees and groups of people who are confident to come to groups and speak the language of the group in doing that ... they have to do much more by way of local health assessments and needs assessments to work out who they have in their population who is not being heard.¹¹⁷

131. Maternity services in some areas have recognised that women from disadvantaged or marginalised groups may not be able to make a case for specialist care through mechanisms such as MSLCs. Diane Jones told us that other ways of "hearing the voices" of disadvantaged women were being explored, and Maggie Elliott commented that Queen Charlotte's and Chelsea Hospital used their complaints system, inviting those who made complaints to become involved in service development. She reported that the service had

112 Q 23

113 We also refer to problems of discontinuity in our Ninth Report of Session 2002–03, *Choice in Maternity Services*, HC 796.

114 For further discussion of patient and public involvement in the NHS see Health Committee, Seventh Report of Session 2002–03, *Patient and Public Involvement in the NHS*, HC 697.

115 Q 158

116 Q 191

117 Q 25

made contact with a Somali woman in this way. In general, she told us, “you tend to have to go out to these women as opposed to them coming to you.”¹¹⁸

132. Outreach work is a key factor in making an assessment of the views and needs of disadvantaged groups. Diane Jones emphasised this in telling us that the maternity service at Newham was proactive in seeking entry to established community forums where staff could seek views on maternity care, and in developing cassette tapes to raise awareness that women could make their views known to the maternity services.¹¹⁹

133. MSLCs can be a powerful way of involving users in planning and developing maternity services but it is important that MSLC membership reflects the ethnic and social diversity of the local population as far as possible so that the needs of disadvantaged groups are accommodated. Lay members of MSLCs should at least be reimbursed for the child care and travel costs incurred when they attend meetings.

134. We were encouraged by the work of service providers who actively sought the views of women and families from disadvantaged groups by becoming involved in forums established by minority communities, and we are keen to ascertain whether this work could be replicated in other areas. We recommend that the Health Development Agency should gather and disseminate evidence of best practice in this area.

Training staff to provide appropriate care

135. Another strategy to ensure that maternity services provide appropriate care for the whole community involves the promotion of awareness of the needs of disadvantaged groups through specific training programmes.

136. In order to provide an appropriate level of care, the Centre for Nursing and Midwifery Research argued that:

Midwives need more support and training ... trusts, supervisors and educationalists need to recognise that this work is challenging and that it needs extra resources, to undertake training of this sort.¹²⁰

137. Maggie Elliott from Queen Charlotte’s told us that existing training programmes for midwives working with disadvantaged women were “excellent” but that enabling midwives to undertake the courses could be difficult, owing to lack of resources and flexibility in terms of staffing. She insisted that in-post training was essential, even if student midwives now received training in meeting the needs of disadvantaged women and babies:

Certainly students who come out of midwifery education programmes will have had that education, one hopes, during their training, but it is all the midwives who trained 20 years ago that we need to get to as well.¹²¹

118 Q 161

119 Q 162

120 Ev 61

121 Q 125

138. The Centre for Nursing and Midwifery Research told us that the involvement of service users who were themselves representatives of a specific group or community, as “expert educators”, greatly enhanced student learning, and “the development of empathy.”¹²²

139. Simone Baker from the Disabled Parents’ Network endorsed this view in telling us how she spoke to trainee midwives about her own situation and experience¹²³ but she acknowledged that “a lot of mothers would not want to do that.”¹²⁴ Jenny McLeish from Maternity Alliance told us that where a woman’s experience had been particularly distressing, she might be reluctant to recount it or to answer questions about it, and that a more sensitive approach in these instances might be to support the woman in compiling a case history which could then be made available for discussion.¹²⁵

140. Domestic violence is a particularly sensitive area in relation to training of maternity care staff, not only because pregnant women and new mothers may be reluctant or unable to discuss abuse, but also because members of staff may themselves have been subjected to domestic violence. According to the RCM, maternity care staff require the support of policies and guidelines in caring for women who are affected by domestic violence¹²⁶ and the RCOG incorporated guidance on identifying abuse and managing care for those affected in its Trainee’s Log Book.¹²⁷ The Department acknowledged this requirement in 2000 as it published *Domestic Violence: a resource manual for Health Care Professionals* but while we understand that the guidance was widely welcomed, neither the RCOG nor the Maternity Alliance could judge how widely the manual was being used.¹²⁸

141. Because of the particular sensitivity and importance of maternity services we recommend that trusts should ensure that maternity care staff and PALS officers have access to sufficient opportunities for training with particular reference to the problems of mothers with disabilities or mental health problems, those from minority ethnic communities, those who live in poverty, and those from other disadvantaged groups. If there were to be a ‘specialist’ in maternity units to help such mothers, service users might not suffer from the ignorance and prejudices of some staff that were reported to the Committee.

142. We were encouraged to hear examples of good practice in promoting access to specialised services and continuity of care for women and families from disadvantaged groups through guidance and training programmes. However, our witnesses expressed doubt that this good practice could be spread unless sufficient resources were made available to create opportunities for recruitment and training of midwives in adequate numbers. Maggie Elliott from Queen Charlotte’s and Chelsea Hospital told us that “we are

122 Ev 61

123 Q 59

124 Q 60

125 Q 38

126 Ev 66

127 Ev 58

128 Ev 58; Q 84 (Christine Gowdridge)

not able to do as much as we would like to do because we just do not have the resources and staffing to do it.”¹²⁹

Providing specialist services in hospital and in the community

143. In the course of our inquiry we heard evidence of innovative practice in improving access and service provision for women and families from disadvantaged groups and we list several examples of such practice below. We note that, as a great many of our witnesses told us, much of the specialist work undertaken with disadvantaged communities is driven by small teams of committed staff or is even “the result of one individual being concerned.”¹³⁰

144. We are keen to see the good practice implemented by these teams and individuals, spread across the country. While local projects are, by necessity, inextricably linked to their specific groups, communities and areas, the principles which inform the projects (for example, the provision of targeted and continuous care in an appropriate environment) may be applied elsewhere.

Good practice in provision of targeted services

Access to appropriate care for those from minority ethnic groups

145. Although women from minority ethnic groups who live in areas where the minority ethnic population is low may face greater difficulties in gaining access to maternity care than women in other areas, we heard that in some cases individual services, or individual midwives, rose to the challenge of meeting women’s needs:

they are so motivated because this is the first person they have encountered in that situation and they feel really compassionate and get really involved and they have the most fantastic personalised service.¹³¹

146. The RCOG went on to cite examples of good practice in the provision of services to meet the needs of specific groups, such as special clinics for African women affected by female genital mutilation based at the Whittington Hospital, London, Guy’s and St Thomas’ Hospital, London, and at the Central Middlesex Hospital. The RCOG also drew attention to an open access family planning service in Wandsworth where the minority ethnic population also had direct access to midwifery services.¹³²

Access to appropriate care for those from the travelling community

147. Maternity services at Queen Charlotte’s and Chelsea Hospital identified travellers as a particular group of women who did not attend for antenatal care, the barrier to access being a lack of trust between travellers and health professionals. Lesley Spires outlined the rationale behind a project to improve access to care for travellers:

129 Q 123

130 Q 7 (Christine Gowdrige)

131 Q 50 (Jenny McLeish, Maternity Alliance)

132 Ev 58

If ... [the women] get to know individual professionals then they are more likely to trust the service that they are getting and to access it and to believe in the people who are giving it.¹³³

148. ‘One to one’ midwives developed such strong relationships within the travelling community that a visit to the site became “more of a social event, people come and say hello.” Lesley Spires was keen that the success of the One to One project should be replicated elsewhere:

I think it is an achievable aim to go and address the issue of the travelling community, particularly the worst ones with poor attendance. If you are providing care in the community you have 100% attendance rate and that is what we got.¹³⁴

149. We recommend that local health services should liaise with local authorities and other agencies to update information about traveller sites within their areas. User representatives from local travelling communities should be involved in planning any special measures for service provision. We further recommend that PCTs should identify a co-ordinator for travellers, to facilitate transfer of health records, especially maternity records and notification of health professionals.

Access to appropriate care for women who live under threat of domestic violence

150. As Jenny McLeish from Maternity Alliance argued, maternity services “cannot act alone” in tackling domestic violence. Other support services, and safe places, must be available so that the maternity care team can refer women for specialist help. However, maternity services could work to improve care for women subject to domestic violence by ensuring that:

all midwives are equipped with whatever local knowledge there is to support women effectively, to know how to ask women in a non-threatening way, and to make sure that all women are seen without their partner at least once.¹³⁵

151. The Maternity Alliance described how some services had been driven to use unconventional techniques to give women an opportunity to disclose domestic violence. In one case, the maternity care team suspected that a non-English speaking woman, was at risk of domestic violence. The woman’s husband acted as her interpreter and so the maternity care team arranged for a professional interpreter to “go and hide in the women’s loo” in order that the woman could speak freely.¹³⁶

152. Diane Jones, a consultant midwife based in Newham, explained to us that discussion of domestic violence could contribute to a positive experience of maternity care:

they are not offended by it, they are actually quite glad that somebody is asking those questions. It is just a forum for them to speak about what is happening in their lives.

133 Q 95

134 Q 187

135 Q 78

136 Q 78 (Jenny McLeish, Maternity Alliance)

They may not want to do anything about it but the fact that somebody has listened to them in a non-judgemental way shows women, the few I have had contact with, it is beneficial.¹³⁷

153. As part of its work on domestic violence the Government should ensure that the Department of Health addresses the issue in the context of maternity services across the country. For women who have been abused and raped, there may be particular issues which need to be addressed in maternity services. We recommend that the Department should take steps to ensure that special training programmes are made available to all maternity staff across the country so that women subject to rape and domestic violence receive appropriate care.

Advocacy and interpreting services

154. Specialist interpreting and advocacy services, which enable women from disadvantaged groups to understand what is available to them, to participate in planning their own maternity care, and to gain access to health and social services, provide a model for maternity services. The principles of advocacy work can be used in meeting the needs of women who are disadvantaged for all kinds of reasons, not just those from minority ethnic or cultural groups, or those who do not speak English. Interpreting and advocacy services extend beyond “making medical procedures understandable to women” into “establishing a forum or a vehicle for women to express their own needs.”¹³⁸

155. My Diep, a community worker, interpreter and advocate for women from some of the Asian communities in East London, confirmed that her work involved more than an interpreting service for women but that she was also engaged in “explaining the health care system in the country to them and encouraging them to use the services, and how to use the services.”¹³⁹

156. We heard from the Maternity Alliance that according to findings of recent research, the services of advocates, helped women to make fuller use of the maternity services:

They felt more confident and reassured, able to ask questions and make choices and reported positive experiences of maternity care when supported in this way.¹⁴⁰

157. However, we also heard concern that such positive outcomes were difficult to achieve, and that service providers themselves encountered barriers to access in relation to maternity services. Diane Jones, a consultant midwife from Newham noted that in an area where approximately 60 core languages were spoken it could be difficult to provide access to health advocates. She reported that the trust was undertaking work to recruit healthcare assistants from different communities, and to train them to provide advocacy support.¹⁴¹

137 Q 191

138 Q 106 (Carolyn Roth)

139 Q 169

140 Ev 6

141 Q 113

158. Advocates may be impeded in their work by the extension to them of negative attitudes towards disadvantaged women and families. Carolyn Roth from Women's Health and Family Services told us that:

Advocates have had experience of being treated rather disrespectfully themselves by health professionals, so there are even attitudes that are projected onto the group of workers that are actually negotiating services on behalf of women. I think there is a need for awareness on the part of health professionals about the needs and backgrounds and the lives of the people that they are serving ... somehow it has to be valued as an essential part of the care that the women are getting rather than an optional extra which can be dispensed with if it does not suit the professional.¹⁴²

159. We recommend that all maternity services should consider recruiting healthcare assistants from minority ethnic communities, and developing training programmes so that these assistants can provide advocacy support for women and families.

Working with the voluntary sector

160. We heard throughout our inquiry that a great many health professionals did not have expertise in providing maternity services for those from disadvantaged groups, and that they lacked specialist cultural or, in the case of women with disabilities, physiological and medical, knowledge. Simone Baker from the DPN told us that health professionals such as GPs could not be expected to be able to provide immediate advice in all cases but she pointed to peer support groups and voluntary sector organisations as valuable sources of the information required by prospective and new parents.¹⁴³

161. The RCOG highlighted the importance of the work undertaken by organisations outside the NHS:

Many of the patients have contact with voluntary sector organisations and self-help groups who can advise and anticipate the problems that may be encountered and it is important that the doctors and midwives take advantage of the help that is available.¹⁴⁴

162. Perhaps the most important role of these organisations is to provide a direct service to women and families. Simone Baker underlined the value of a direct specialist service to those who have urgent need of advice and support. She argued that while peer support and voluntary organisations should not replace statutory service provision:

Volunteers, grass roots organisations ... can react much quicker than statutory service providers. In the case of somebody who is pregnant or who has just had a baby and might have a disability, and, on top of that, might just have become a single parent, they are not really going to want to sit around and wait three weeks for an appointment, they are going to need some help immediately.¹⁴⁵

142 Q 168

143 Q 56

144 Ev 59

145 Q 68

163. All health professionals, including PALS officers, who become involved with a disabled mother who is either planning to become pregnant, receiving fertility treatment or who is already pregnant, should know how and where to obtain specialised information about the problems with pregnancy, delivery and baby care associated with particular impairments.

164. In order to provide an appropriate level of care for disadvantaged women and families, health professionals should have ready access to expert information, and to sources of further support. We recommend that the Health Development Agency should collate available research and evidence on work with disadvantaged groups, and create a central database of voluntary organisations working at local and national level.

Working with other health and social services

165. In examining the barriers which prevent disadvantaged women and their families from gaining full access to maternity care, we heard that for a great many disadvantaged groups, care can be fragmented if health and social services professionals do not collaborate in providing care during pregnancy, childbirth and the postnatal period.

166. In a great many cases, care for pregnant women with severe mental health problems forms a vivid illustration of the fragmented and incoherent approach to provision of maternity services which can prevent women from receiving the care and support that they need. Jenny McLeish from Maternity Alliance described this problem and went on to suggest one step towards a solution:

You have one group of people who know a lot about mental illness and nothing about maternity and another group who know a lot about maternity and nothing about mental illness. Actually, what you have to do is get them round a table once a month and then they can provide really good care ... it is about liaison between the different agencies involved in someone's life.¹⁴⁶

167. Lesley Spires described as "fortunate" the way in which the maternity care team at Queen Charlotte's was able to communicate with the mental health team in the trust. Diane Jones reported that at Newham, the maternity service was "trying to come to some agreement" with the mental health team on issues related to postnatal depression.¹⁴⁷

168. The RCOG felt that the problems of mental health provided another example of the case for effective co-ordination of inter-agency care¹⁴⁸ and outlined how the 'inter-agency' approach to provision of maternity care could be used to help women from other disadvantaged groups:

The [minority ethnic] groups provide examples of the requirement for multi-professional education of carers and identification of specific health and social carers

146 Q 64

147 Qq 194-96

148 Ev 58

to be lead professionals and to use their added knowledge to act as a resource for the whole team.¹⁴⁹

169. Southampton University Hospitals Trust told us that they had addressed the issue of poverty and homelessness “as part of the maternity services strategy”. Midwifery group practices were established in areas of socio-economic deprivation and these practices worked in partnership with Sure Start projects. According to the Trust, this partnership promoted inter-agency work to tackle issues such as housing, benefits, domestic abuse, mental health, smoking cessation and other aspects of culture or lifestyle which might prevent a woman from gaining full access to maternity services.¹⁵⁰

170. Simone Baker confirmed that, like women from other disadvantaged groups, “what most disabled parents would love” in terms of access to maternity services would be an integrated approach to care:

Some kind of cohesive joined-up service provided to them that involved everybody in their maternity care, so GP, health visitors, midwives and ... social services.¹⁵¹

This approach to care, which would involve the social services at an early stage might help to alleviate the anxiety felt by some disabled parents and parents-to-be about intervention by social services.

171. An identified ‘lead’ professional, appointed to oversee care for women with disabilities would be able to provide practical and logistical support, allowing a pregnant woman to focus on her health and on that of her own baby. Simone Baker described the role of this professional as:

Somebody working with you right from that very early stage and actually saying “don’t worry about the cot, I’ll sort that” or “don’t worry about your husband coming to stay with you.”¹⁵²

172. The RCOG identified the appointment of a Disability Advisor at Liverpool Women’s Hospital NHS Trust as an example of good practice and recommended that:

it may be appropriate for each tertiary centre to appoint a midwife co-ordinator for women with disabilities in the region, to act as a consultant and a resource for advice.¹⁵³

173. We recommend that local maternity services should appoint a lead health professional to ensure that women and families who have needs specific to physical or mental health, or social circumstances are provided with appropriate services. The role should involve liaison within a multi-disciplinary health and social care team, provision of care for individual women, advice on plans and policies within units, co-ordination

149 Ev 58

150 Ev 62–3

151 Q 55

152 Q 57

153 Ev 59

of advocacy and interpreting services, including British Sign Language, and training and support for colleagues.

Providing continuity of care

Continuity of carer

174. There is evidence that one-to-one support during pregnancy can improve physical and mental health by helping disadvantaged women to cope with their difficult circumstances. Our attention was drawn to one study which reported that women who were supported in this way were less likely to feel unhappy during pregnancy and six weeks after birth they were more likely to be breastfeeding, less likely to have introduced solid food too early, less likely to be feeling physically unwell, and their babies were less likely to have had worrying health problems.¹⁵⁴ A follow-up study found that the benefits of these health outcomes could still be perceived in the children seven years later.¹⁵⁵

175. During our inquiry witnesses identified as models of good practice in supporting pregnant women and mothers with mental health problems, those which provided continuity of carer, one-to-one midwifery, or midwifery provided by a small group of midwives. Jenny McLeish from Maternity Alliance told us that this kind of service, where the same midwife or midwives would “see the woman right from the beginning, see her at home, deliver her baby and then follow her up at home”, would enable maternity services to monitor the woman’s mental health throughout the pregnancy and to detect and respond to any problems.¹⁵⁶

176. Lesley Spires, Head of the One to One midwifery group based at Queen Charlotte’s and Chelsea Hospital confirmed that:

If women in these groups do have a named midwife they can identify with there is going to be a more trusting relationship between them and more disclosure in these kinds of situations and also better co-ordination of the other services they require.¹⁵⁷

177. Maggie Elliot, Director of Midwifery and General Manager at Queen Charlotte’s emphasised that the One to One scheme was a community-based service, with “one midwife providing total care”. For the women served by the scheme (young mothers-to-be, and women from the travelling community amongst others), access to continuity of carer was “not just a concept [but] ... a reality.”¹⁵⁸ However, Mrs Elliot also reminded us of the impact of midwifery shortages on community midwifery care, as described to us by witnesses to our first inquiry:

What currently happens is that at times of high workload because of the safety issues the staff from the community tend to go to labour wards, so there is a shift of

154 “Social and psychological support during pregnancy”, Elbourne et al, in *Effective Care in Pregnancy and Childbirth*, ed Chalmers et al, OUP, 1989

155 “Social support in pregnancy: does it have long term effects?”, A. Oakley, *Journal of Reproductive and Infant Psychology*, vol 14, pp 7–22

156 Q 64

157 Q 94

158 Q 101

resources from the community to the labour wards. Where we are, our community service is probably one of the least resourced parts of the service. Yes, we need more midwives, we absolutely do. If we had more midwives we could provide more caseload practice to individual groups which would vastly improve outcomes.¹⁵⁹

178. Maternity teams which have developed community-based continuity of carer schemes for women from disadvantaged groups, have been successful in improving access to maternity care and in achieving positive health outcomes for mothers and babies. We recommend that providing continuity of carer schemes for women from disadvantaged backgrounds should be a particular priority for maternity services.

Woman-held notes

179. Where it is impossible to provide continuity of *carer*, some degree of continuity of *care* may be preserved by the use of woman-held notes which would allow health professionals access to a woman's medical history, to information about any pre-existing conditions which might affect her pregnancy, and about the maternity care (or lack thereof) that she had received. The RCM argued that beyond the vital function of passing on medical and health information to maternity care staff, woman-held notes could also help a pregnant woman to become involved in discussing and making decisions about her own care:

all pregnant women ... should be invited to carry their own notes and take a full and active role in decisions about the nature of their care. Women should be asked what they want included in notes about their condition so that this information does not have to be continually repeated to new carers.¹⁶⁰

180. Diane Jones told us that use of woman-held notes was effective in helping to sustain care for women from transient populations because women were "more than likely" to bring their notes with them when they made contact with maternity services in a new area.¹⁶¹ Women themselves may be less likely to lose their maternity records than hospitals.

181. However, we are aware that maternity services in some areas do not provide woman-held notes and a written submission to our inquiry from the Centre for Nursing and Midwifery Research identified further problems with the current system. According to the Centre, the value of woman-held notes in encouraging women to become actively involved in their maternity care was diminished because they were "rarely adapted to meet the literacy and comprehension needs of women with learning difficulties and those for whom English is not their first language." The Centre raised the concern that this problem could be exacerbated by the introduction of the Electronic Patient Record (EPR), which could lead in turn to the development of a "digital health divide."¹⁶²

182. Although the use of woman-held notes does not address the problem of identifying and reaching those women who do not make any contact with maternity services, they

159 Q 140

160 Ev 68

161 Q 181

162 Ev 61

are a valuable way of passing on information which may be crucial to the provision of appropriate care for women from transient populations and for women who see a variety of health professionals during their maternity care. Given the concerns expressed by witnesses during our first inquiry in relation to maternity care records, and to the Electronic Patient Record (EPR) in particular, we recommend that the Department should clarify whether the EPR will affect the use of woman-held notes and how it will be adapted to facilitate provision of appropriate services for disadvantaged women and their babies.

5 How can maternity services help to reduce health inequalities?

183. Health inequalities can be reinforced during pregnancy and the early life of a child and it is during this period in particular that the ‘intergenerational cycle’ of inequality is perpetuated. However, the provision of appropriate maternity care may help to break this cycle by promoting the health of mother and baby, and by helping disadvantaged women and families to gain awareness of, and access to, available services.

184. We heard a great deal of evidence which emphasised the key importance health during the very early stages of life has on long term health outcomes. The Department told us that children born to women from disadvantaged groups are more likely to be affected by pre-term labour, intrauterine growth restriction, low birth weight, low levels of breastfeeding and higher levels of neonatal complications.¹⁶³ The Maternity Alliance asserted that exposure to poor material conditions in early life, including *in utero*, is detrimental to health not only in the short term, but also in adult life, regardless of adult socio-economic status.¹⁶⁴ The NCT told us that there was growing evidence of the effect of poor mental health during pregnancy and in the postnatal period on the relationship between mother and baby, and on the baby’s future mental health and wellbeing.¹⁶⁵

185. In terms of promoting the general health and wellbeing of women and babies, Jenny McLeish from the Maternity Alliance told us that “some of the most helpful things that the maternity services can do or try to do are not related to obstetric outcomes.”¹⁶⁶

Smoking cessation

186. In particular, Ms McLeish identified support for smoking cessation as an intervention which would promote health and wellbeing beyond pregnancy and the postnatal period. Although disadvantaged women are more likely to smoke, and less likely to stop smoking in pregnancy, Ms McLeish argued that “people do seem to be more motivated when they are pregnant than at other times and it is seen as this great opportunity.”¹⁶⁷

187. Diane Jones, a consultant midwife from Newham Healthcare, reported on the outcome of a smoking cessation project at Newham. In the first year of the project, 39 women were referred. Of those 39, 30 stopped smoking, and all 30 were still non-smokers four weeks after the birth of their babies. This success rate was the result of “intensive ... one-to-one support” for women who wanted “the support to quit.”¹⁶⁸

163 Ev 45

164 Ev 4

165 Ev 76

166 Q 15

167 *Ibid.*

168 Q 151

Breastfeeding

188. Babies fed on formula milk are five times more likely to be admitted to hospital with gastro-enteritis in their first year,¹⁶⁹ twice as likely to develop atopic eczema, wheezing and ear infections, and five times more likely to have urinary tract infection than babies who are breastfed for at least four months. For premature babies, there is evidence that breast milk reduces the risk of the serious bowel disease, necrotising enterocolitis. The NCT argued that breastfeeding “saves lives as well as reducing hospital costs” and that it was “one of the simplest and most effective ways of improving the health of our children.”¹⁷⁰

189. The NCT reported that the decision to breastfeed was related to age, social class and mother’s education, meaning that children most at risk of poor health (owing to poor housing, overcrowding, parental smoking and other social factors) are least likely to be breastfed. According to the *Infant Feeding Survey 2000*, breastfeeding rates in England are amongst the lowest in Europe, with only 28% of babies receiving any breastmilk at four months of age.¹⁷¹

190. The NCT told us that many women felt that their access to support “vanished” at the end of their care from a midwife, and called for “a better way of making the transition to health visitor care” which would involve “more integration, more overt support for breastfeeding from health visitors (many of whom may need further training in this regard) and emotional support for women themselves.”¹⁷² Jenny McLeish told us that work to provide this kind of service was under way:

a lot of money, energy and time is now going into trying to assist disadvantaged women to start sustained breastfeeding even in a culture which is quite opposed to it because that would then give their child some sort of improvement on the chances that they would otherwise have had in terms of health.¹⁷³

191. Provision of support for smoking cessation and for breastfeeding represent two interventions which can improve a woman’s experience of maternity care, and the long-term health outcomes for women and babies. Women from disadvantaged groups may need specialist support in these areas. We recommend that health visitors and midwives undertake training, and that they work closely with peer groups and volunteers, to provide this support. We further recommend that the Health Development Agency issue guidance to PCTs on best practice in smoking cessation and breast feeding support for women from disadvantaged groups. There should be a flexible approach to the transition to care provided by health visitors, to allow mothers to work with whichever health professional they feel is best placed to support them.

169 “Protective effect of breastfeeding against infection”, P W Howie et al, *British Medical Journal* 300 (1990), pp 11–16

170 Ev 73

171 *Ibid.*

172 *Ibid.*

173 Q 15

A wider public health role for the maternity services?

192. In April 1999 the Prime Minister launched *Making a Difference: the nursing, midwifery and health contribution*, which outlined the Department's proposals to expand the role of the midwife to include more involvement with women's health and with public health in general. This expanded public health role would accommodate support for breast feeding and smoking cessation, and also early identification of women affected by domestic violence or by postnatal depression.

193. Given the success of maternity services in some areas, in terms of helping women to stop smoking and to initiate and sustain breast feeding, proposals for a wider public health role for midwifery staff constitute a recognition that maternity services can act as a gateway to other services. The Centre for Nursing and Midwifery Research at the University of Brighton argued that midwives were crucial to the success of wider schemes to tackle health inequalities:

The role of the midwife puts her in a unique position since she often enjoys a greater level of acceptance by clients than do other professionals such as health visitors and social workers. Because of this, teams working directly, and holistically, with disadvantaged clients have much to gain from incorporating midwives.¹⁷⁴

194. Jo Garcia from the NPEU explained how Maternity services provided “a fantastic opportunity to reach women”, particularly those who might not otherwise use the health service or who might have difficulty in gaining access to it:

if you are thinking about encouraging ... [a woman] to use child services, it may be ... that if she has a good experience with maternity care and feels she can trust the midwives and the health visitors, then maybe for her, using child services, knowing who to ask would be made easier.¹⁷⁵

195. In fulfilling the wider public health role envisaged for them, midwives need training to overcome negative attitudes and prejudice, and support as they take on the challenge of caring for women and families who are difficult to reach. The Maternity Alliance suggested that training to improve access to services for disadvantaged women and to promote their general health and wellbeing, was not yet sufficient. Jenny McLeish told us that for midwives:

The public health agenda is getting there, but it has not really penetrated; it has not permeated their [the midwives'] culture. They do not have any time for reflective practice once they are on the busy wards doing their work.¹⁷⁶

196. Carolyn Roth from City University argued that the proposed expansion in the public health role of maternity services had not been recognised by service planners:

The demands on the midwifery service have increased. It has absorbed an enormous amount of new things that we have recognised that we need to do to respond

174 Ev 61

175 Q 15

176 Q 19

appropriately to women's needs and yet the service has not expanded to the same extent and there is invariably more demand than the ability to respond to it and women do suffer because of that.¹⁷⁷

197. We recognise the potential of midwives, and of maternity services, to play an expanded role in promoting public health. However, maternity care staff must have access to appropriate levels of training and support if they are to be effective in this role. We recommend that the Department should facilitate the implementation of the proposals in *Making a Difference* by making a detailed assessment of the training and support needs of staff who provide maternity care.

6 Conclusion

198. While the work of the *Confidential Enquiries into Maternal Deaths* has drawn attention to the vulnerability of women from disadvantaged groups to the severest complications in pregnancy and childbirth, the extent to which women and families from these groups suffer through lack of access to appropriate maternity care, has not fully been assessed.

199. A great many of those who contributed to our inquiry pointed out that an attempt to tackle this very issue was made 10 years ago. The RCOG reiterated the recommendation by *Changing Childbirth* that regular monitoring of uptake of maternity care should be carried out to identify those women not seeking care or taking advantage of the services available so that a strategy for improving access could be developed. In relation to the work undertaken by *Changing Childbirth* on access to maternity services, the RCOG asserted that “had these recommendations been implemented then it may not have been necessary to re-visit the issues of access to care again now.”¹⁷⁸

200. We are aware that maternity services in some areas have striven to make contact with women from groups and communities for whom access to maternity care is problematic, and to cater to their needs. Lesley Spires from Queen Charlotte’s and Chelsea Hospital summed up the strategy deployed by maternity services to tackle inequalities in access to care by means of identifying needs and forming connections with communities and their existing support structures:

It is important to understand the groups that we are providing the service for. That is about networking with organisations that serve those groups ... and to network with the leaders of that particular society so that you understand their needs and you are not making assumptions about what you think they need, because that can be hugely different from what we presume. Each group has different priorities and different needs.¹⁷⁹

201. Service providers such as those at Queen Charlotte’s and Chelsea Hospital have found that the best way to make and maintain contact with women from disadvantaged groups is to reach out to them in their own communities, and to develop trust and understanding by providing continuity of care and carer throughout pregnancy and the postnatal period.

202. There is strong evidence, however, that such good practice in providing services which are sensitive and responsive to the particular needs of different groups, is not widespread. In the context of maternity services for women with disabilities, the NCT told us that there is often a tendency in a medicalised system for women with additional needs to be treated as ‘high-risk’. This is true for women from all disadvantaged groups, particularly if they first make contact with maternity services at a late stage in their pregnancies and/or they are unable to understand information given by maternity care staff, or to make themselves understood. These women are more likely to undergo monitoring and even medical

¹⁷⁸ Ev 57; Department of Health, *Changing Childbirth: report of the Expert Maternity Group*, 1993

¹⁷⁹ Q 102

interventions, which may not be wanted or needed. We endorse the view of the NCT that women should feel that they are in control of their own bodies and of decisions about their care, or able to choose when and to whom to delegate some of that responsibility.¹⁸⁰

203. The evidence we have heard during this inquiry suggests that many disadvantaged women do not have this sense of control. In some cases disadvantaged women feel that owing to their particular circumstances or status, maternity and social services focus exclusively on the health of their babies, to the detriment of their experience of pregnancy and birth. Women may feel that they are given access to support for smoking cessation or breastfeeding, that they are given attention, purely for the benefit of their babies. Women with disabilities may feel that services pay attention to them, because they see their unborn babies or new infants as children at risk. In fulfilling a wider public health role maternity services must retain the goal of providing women-centred care.

204. It may be that for disadvantaged women a lack of control over the care that they receive, and a lack of awareness about their choices, constitute a barrier to access to appropriate maternity care. The DPN told us that :

Women with disabilities are not always given the same choices as other parents, for example, decisions about the type of birth or anaesthesia and mode of delivery are taken by professionals without adequate discussion with the woman or her partner. Informed choice is often not an option for women with disabilities due to assumptions and decisions made by professionals.¹⁸¹

205. All that we have heard about the relationship between the ability (or lack thereof) to make choices and decisions about aspects of maternity care, and access to appropriate care, will inform our work as we go on to examine choice in maternity services.

206. We have seen excellent examples of good practice in maternity services across the country. The biggest frustration for the Committee has been in hearing reports that this best practice is not shared across the NHS. The Department must find ways of saving maternity services the wasted effort of 'reinventing the wheel' on each of these issues. Methods must be found to ensure that best practice can be shared across the country.

180 Ev 76

181 www.disabledparentsnetwork.org.uk/latest.htm

Conclusions and recommendations

1. We recommend that detailed socio-economic and ethnic data should be recorded in a standardised way in all national datasets and that analyses of these data should be routinely published as well as being made available to researchers for more detailed analyses. (Paragraph 14)
2. If maternity services are to meet the needs of disadvantaged women, babies and families, the evidence base on which policy decisions and service developments are made must be expanded. We recommend that the Department commission programmes of quantitative and qualitative research so that an accurate assessment of the extent to which women who do not gain full access to maternity care can be made, the reasons for inequalities and inequities established and further action taken to address these inequalities. (Paragraph 22)
3. We recommend that the Department provide PCTs and acute trusts with relevant and timely information to enable maternity care teams to use the opportunities and resources offered by the Government through projects and initiatives such as Sure Start, to recruit more staff and provide specialised services for disadvantaged women and their families. We further recommend that the Department should ensure that best practice be shared in relation to these centrally-funded projects. We further recommend that the Department should ensure that best practice be shared in relation to sustaining the work of a project after the allocated funds have been used. (Paragraph 40)
4. We welcome the interim findings of the Maternity External Working Group, and look forward to seeing the work of the sub-group appointed to examine inequalities and access. The difference for women and families will depend on the identification of effective strategies and the Government ensuring that the implementation of these strategies is achieved. (Paragraph 46)
5. We recommend that the Government investigate the RCM's concerns relating to the recruitment of midwives from minority ethnic communities. Action to promote the recruitment of midwives from ethnic minority communities could include the identification of 'champions' from minority ethnic communities which may help to inspire some younger people from these communities to pursue careers in maternity services. (Paragraph 56)
6. Any support system for asylum seekers should provide specifically for the needs of pregnant asylum seekers, new mothers and their babies. We recommend that the Government take steps to ensure that pregnant women and new mothers should not be detained for any prolonged period, and that accommodation centres should provide a gateway to maternity services for pregnant asylum seekers. (Paragraph 65)
7. Better communication between maternity and child health services and accommodation providers during dispersal is needed to ensure that members of maternity care teams are forewarned of the arrival of asylum seekers who will need their services and that their test results and notes are forwarded. (Paragraph 66)

8. In considering asylum seekers for dispersal special attention should be paid to the support needs of pregnant women and new mothers since separating them from any support network at this time could be especially detrimental to families. (Paragraph 67)
9. Given the high incidence of domestic violence in pregnancy, relying on relatives to interpret for women can be extremely dangerous. All maternity services should ensure that the use of relatives as interpreters does not deny women the opportunity that maternity care provides to report domestic violence or to discuss other concerns such as mental health. (Paragraph 77)
10. Interpreting and advocacy services are a vital component of appropriate maternity care for women who do not speak English as their first language. However, we are concerned that local service planners do not recognise this in their budgets, and in particular that there is so little provision for need in the community and out-of-hours in hospital-based units. We recommend that local maternity services take steps to ensure the development of on-site out-of-hours interpreting and advocacy services and that better use is made of telephone interpreting services. We further recommend that staff running antenatal classes and undertaking postnatal visits should have access to advocacy and interpreting services. (Paragraph 78)
11. Ideally, interpreting services should be provided, in the community and in the hospital, by specialist interpreters and advocates, rather than by family members, friends, or by other staff. However, we endorse the attempts made by maternity care staff to find interpreters when specialist services are not available. Bilingual and multilingual staff working in PCTs and acute trusts should have the opportunity to develop their interpreting skills. We recommend that the Department commission work to develop appropriate training courses and qualifications in interpreting for non-specialist staff. (Paragraph 79)
12. We were also concerned to hear of individual social workers giving mothers the general impression that it would be easier to take a baby away and care for him or her, rather than work with the family to keep them together. We recognise that in extreme cases social workers do have to recommend that babies are taken away from parents but this experience suggests that more needs to be done to ensure that social workers are trained to understand and respect the sensitivities of homeless and disadvantaged families so that it is clear that families will be kept together where this is possible. (Paragraph 90)
13. Those responsible for rehousing pregnant women and women with young babies should be able to pass information on to maternity and health visitor services where women wish for these services to be provided. Currently methods of passing on information are inadequate and the situation needs to be improved. We recommend that the Department should assess the difficulties faced by low-income families who have to spend long periods visiting their babies in Special Care Baby Units and that the Department should then take steps to ensure that sufficient financial support is provided so that these families can meet travel and other costs. (Paragraph 92)

14. We believe that domestic violence is substantially under-reported and that the true scale of the problem remains unknown. We endorse the RCOG's call for further research into the prevalence of domestic violence, and into effective models of intervention. All maternity services need to have access to support services, to which they can refer those who are suffering from domestic violence. All women should have ready access women's refuges so that maternity services can protect women who disclose domestic violence from further abuse. (Paragraph 99)
15. All trusts should ensure that maternity and mental health services work together to provide proper support for women during pregnancy and the postnatal period. We believe that the Department should give high priority to addressing the problem of inadequate provision of mother and baby units in some parts of the country. Mental health trusts should appoint lead practitioners to ensure that care for these women is properly co-ordinated. (Paragraph 105)
16. Information that is provided to expectant parents should be made fully accessible to all groups of people with disabilities, including those with physical or sensory impairments, people with learning difficulties or long-term illnesses and people with mental health problems. (Paragraph 116)
17. Maternity units and services should be made accessible to all groups of people with disabilities. We recommend that the Department set up systems for best practice to be shared so that people with disabilities do not have to struggle to make their views known in every area before improvements are made. For example, the obvious success of height-variable cots in one area should automatically be picked up by other units. We have little confidence that this happens now. (Paragraph 117)
18. User involvement is vital to the effective planning of services and monitoring of access to care. We recommend that the Department should ensure the continuation of MSLCs in the context of NHS reforms. The role of MSLCs in relation to the Patient Advice and Liaison Service (PALS) and in relation to new patient forums and other mechanisms to involve the public in health service provision needs to be clarified. The expertise of the Commission for Public and Patient Involvement in Health should also be used to support MSLCs. (Paragraph 128)
19. MSLCs can be a powerful way of involving users in planning and developing maternity services but it is important that MSLC membership reflects the ethnic and social diversity of the local population as far as possible so that the needs of disadvantaged groups are accommodated. Lay members of MSLCs should at least be reimbursed for the child care and travel costs incurred when they attend meetings. (Paragraph 133)
20. We were encouraged by the work of service providers who actively sought the views of women and families from disadvantaged groups by becoming involved in forums established by minority communities, and we are keen to ascertain whether this work could be replicated in other areas. We recommend that the Health Development Agency should gather and disseminate evidence of best practice in this area. (Paragraph 134)

21. Because of the particular sensitivity and importance of maternity services we recommend that trusts should ensure that maternity care staff and PALS officers have access to sufficient opportunities for training with particular reference to the problems of mothers with disabilities or mental health problems, those from minority ethnic communities, those who live in poverty, and those from other disadvantaged groups. If there were to be a 'specialist' in maternity units to help such mothers, service users might not suffer from the ignorance and prejudices of some staff that were reported to the Committee. (Paragraph 141)
22. We recommend that local health services should liaise with local authorities and other agencies to update information about traveller sites within their areas. User representatives from local travelling communities should be involved in planning any special measures for service provision. We further recommend that PCTs should identify a co-ordinator for travellers, to facilitate transfer of health records, especially maternity records and notification of health professionals. (Paragraph 149)
23. As part of its work on domestic violence the Government should ensure that the Department of Health addresses the issue in the context of maternity services across the country. For women who have been abused and raped, there may be particular issues which need to be addressed in maternity services. We recommend that the Department should take steps to ensure that special training programmes are made available to all maternity staff across the country so that women subject to rape and domestic violence receive appropriate care. (Paragraph 153)
24. We recommend that all maternity services should consider recruiting healthcare assistants from minority ethnic communities, and developing training programmes so that these assistants can provide advocacy support for women and families. (Paragraph 159)
25. All health professionals, including PALS officers, who become involved with a disabled mother who is either planning to become pregnant, receiving fertility treatment or who is already pregnant, should know how and where to obtain specialised information about the problems with pregnancy, delivery and baby care associated with particular impairments. (Paragraph 163)
26. In order to provide an appropriate level of care for disadvantaged women and families, health professionals should have ready access to expert information, and to sources of further support. We recommend that the Health Development Agency should collate available research and evidence on work with disadvantaged groups, and create a central database of voluntary organisations working at local and national level. (Paragraph 164)
27. We recommend that local maternity services should appoint a lead health professional to ensure that women and families who have needs specific to physical or mental health, or social circumstances are provided with appropriate services. The role should involve liaison within a multi-disciplinary health and social care team, provision of care for individual women, advice on plans and policies within units, co-ordination of advocacy and interpreting services, including British Sign Language, and training and support for colleagues. (Paragraph 173)

28. Maternity teams which have developed community-based continuity of carer schemes for women from disadvantaged groups, have been successful in improving access to maternity care and in achieving positive health outcomes for mothers and babies. We recommend that providing continuity of carer schemes for women from disadvantaged backgrounds should be a particular priority for maternity services. (Paragraph 178)
29. Although the use of woman-held notes does not address the problem of identifying and reaching those women who do not make any contact with maternity services, they are a valuable way of passing on information which may be crucial to the provision of appropriate care for women from transient populations and for women who see a variety of health professionals during their maternity care. Given the concerns expressed by witnesses during our first inquiry in relation to maternity care records, and to the Electronic Patient Record (EPR) in particular, we recommend that the Department should clarify whether the EPR will affect the use of woman-held notes and how it will be adapted to facilitate provision of appropriate services for disadvantaged women and their babies. (Paragraph 182)
30. Provision of support for smoking cessation and for breastfeeding represent two interventions which can improve a woman's experience of maternity care, and the long-term health outcomes for women and babies. Women from disadvantaged groups may need specialist support in these areas. We recommend that health visitors and midwives undertake training, and that they work closely with peer groups and volunteers, to provide this support. We further recommend that the Health Development Agency issue guidance to PCTs on best practice in smoking cessation and breast feeding support for women from disadvantaged groups. There should be a flexible approach to the transition to care provided by health visitors, to allow mothers to work with whichever health professional they feel is best placed to support them. (Paragraph 191)
31. We recognise the potential of midwives, and of maternity services, to play an expanded role in promoting public health. However, maternity care staff must have access to appropriate levels of training and support if they are to be effective in this role. We recommend that the Department should facilitate the implementation of the proposals in Making a Difference by making a detailed assessment of the training and support needs of staff who provide maternity care. (Paragraph 197)

Formal minutes

Thursday 10 July 2003

Members present:

Mr David Hinchliffe, in the Chair

Mr John Austin
Mr Paul Burstow

Dr Doug Naysmith
Dr Richard Taylor

The Committee deliberated.

Draft Report (Inequalities in Access to Maternity Services), proposed by the Chairman, brought up and read.

Ordered, That the Chairman's draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 206 read and agreed to.

Summary agreed to.

Resolved, That the Report be the Eighth Report of the Committee to the House.

Several papers were ordered to be appended to the Minutes of Evidence.—(*The Chairman.*)

Ordered, That the Appendices to the Minutes of Evidence taken before the Committee be reported to the House.—(*The Chairman.*)

* * * * *

[Adjourned till Thursday 17 July at 10 am.]

Witnesses

Tuesday 13 May 2003

Page

Jo Garcia, Institute of Education, University of London (formerly of the National Perinatal Epidemiology Unit), **Simone Baker**, Vice-chair, Disabled Parents Network; and **Christine Gowdridge**, Director, and **Jenny McLeish**, Social Policy Officer, Maternity Alliance.

Ev 7

Tuesday 20 May 2003

Lesley Spires, Head Midwife, One to One Community Midwifery and Birth Centre Manager and **Maggie Elliott**, Director of Midwifery and General Manager, Queen Charlotte's and Chelsea Hospital, **Diane Jones**, Consultant Midwife, Newham General Hospital, Plaistow; and **Carolyn Roth**, Management Committee Member, Women's Health and Family Services Group.

Ev 27

List of written evidence

1	Disabled Parents Network	Ev 1
2	National Perinatal Epidemiology Unit	Ev 2
3	Maternity Alliance	Ev 3
4	Queen Charlotte's and Chelsea Hospital	Ev 24
5	Diane Jones, Newham Healthcare NHS Trust	Ev 25
6	Department of Health	Ev 42
7	Language Line Ltd	Ev 53
8	Royal College of Obstetricians and Gynaecologists	Ev 56
9	Centre for Nursing and Midwifery Research, University of Brighton	Ev 60
10	Southampton University Hospitals NHS Trust	Ev 62
11	Royal College of Midwives	Ev 63
12	Department of Midwifery, City University	Ev 69
13	National Childbirth Trust	Ev 72

Reports from the Health Committee since 2001

The following reports have been produced by the Committee since the start of the 2001 Parliament. The reference number of the Government's response to the Report is printed in brackets after the HC printing number.

Session 2002–03

First Report	The Work of the Health Committee	HC 261
Second Report	Foundation Trusts	HC 395 (Cm 5876)
Third Report	Sexual Health	HC 69
Fourth Report	Provision of Maternity Services	HC 464
Fifth Report	The Control of Entry Regulations and Retail Pharmacy Services in the UK	HC 571
Sixth Report	The Victoria Climbié Inquiry Report	HC 570
Seventh Report	Patient and Public Involvement in the NHS	HC 697
Eight Report	Inequalities in Access to Maternity Services	HC 696

Session 2001–02

First Report	The Role of the Private Sector in the NHS	HC 308 (Cm 5567)
Second Report	National Institute for Clinical Excellence	HC 515 (Cm 5611)
Third Report	Delayed Discharges	HC 617 (Cm 5645)