



*The Royal College of*  
**Midwives**



**Better Births**

# Understanding Experiences in Hospital-Based Maternity Settings

A Better Births Summary

November 2015

SUMMARY

## Summary

Evidence-based guidelines have been developed for midwife-led units (RCM, 2012) in line with the research. There is, however, a limited knowledge-base on the application of these findings to the acute maternity settings such as labour wards and delivery suites in the hospital-based maternity settings.

Design is often used as a creative approach to problem solving. Following further analysis on the use of design approaches to inform service and physical designs within public sector and health care, a research projects was initiated in collaboration with the Design Council. The goal was to identify potential opportunities to improve aspects of the experience using design, grounded in an evidence base, and to start to outline briefs for subsequent phases of work. This summary presents an overview of the findings from the research phase in hospital-based maternity settings.

The project started with an initial scoping of the research literature, observations and interviews in two maternity units and wider consultations within midwifery. A total of 8 themes and 38 insights were identified. These could be grouped into three main headings namely, *understanding and interpreting information, what people really value, and the moments that stick*. Three opportunity areas for improving experiences in hospital-based maternity settings were also highlighted. These are presented with the context, the problem specification, and opportunity questions.

*Opportunity area 1: Preparing for the birth experience*

*Opportunity area 2: 'Transition points' in the birthing experience*

*Opportunity area 3: A continuous journey to prepare for pregnancy and parenthood*

There are additional resources from this project to be made available for use in education, learning, and research agendas. As for practice and policy within maternity, the findings and opportunities highlighted in this summary can be developed into design briefs for local, regional or national applications of design in maternity care. This work continues under the Better Births Initiative led by the Royal College of Midwives through a collaborative effort.

## **Background**

The research literature has highlighted the importance of ambient environments and the feeling of control and safety (Lock and Gibb, 2003). The care environment can be associated to reduced use of pain relief and more active positions for labour and birth (Hodnett et al., 2009). In addition, there are findings associated with the impact on the workforce working maternity care. This includes a greater likelihood of staff staying in ambient rooms facilitating one-to-one births (Hodnett et al., 2009) and differences in communication styles depending on the areas (Foureur et al., 2010).

Evidence-based guidelines have been developed for midwife-led units (RCM, 2012) in line with the research. There is, however, a limited knowledge-base on the application of these findings to the acute maternity settings such as labour wards and delivery suites. Given that majority of women choose to or need to use acute maternity settings, closing the gap in the knowledge base and influencing service design and physical spaces is an essential next step.

Following further analysis on the use of design approaches to inform service and physical designs within public sector and health care, a research projects was initiated in collaboration with the Design Council. The goal was to identify potential opportunities to improve aspects of the experience using design, grounded in an evidence base, and to start to outline briefs for subsequent phases of work.

This summary presents an overview of the findings from the research phase in hospital-based maternity settings. The detailed insights and themes identified aim to inform the next steps for improving experiences in at a local and national level as well highlighting areas for future research and development. This work continues under the Better Births Initiative led by the Royal College of Midwives through a collaborative effort.

## **Describing the hospital maternity care setting**

Care for women during pregnancy and immediately afterwards can be provided safely in a number of settings including the home, community settings, freestanding midwife-led units, as well as hospitals. The hospital setting for labour and birth as well as antenatal and postnatal care has been changing over decades and there are provisions for midwife-led units to be located in hospitals.

Starting with the booking appointment and this introduces the woman to maternity services. There are also sonography (scanning) services, day assessment units, and inpatient facilities for the antenatal period. Most units have a triaging system to assess women on admission in labour. In the current context, the majority of women give birth in hospitals and mainly in obstetric units (see NAO, 2012; ISD, 2014). The role of co-located or alongside midwife-led units (also known as birth centres) and freestanding units within the community has also increased over the years (NAO, 2012, RCM, 2013). For established labour and the time of birth, privacy is available across all types of units. Midwives and maternity support workers provide most of the care in midwife-led units with a team of obstetricians, anaesthetists, operating theatre staff, neonatal nurses, and paediatricians in the obstetric units, including labour ward and delivery suites. There are many other healthcare staff who contribute to the smooth running of the maternity units, for example, this includes staff within housekeeping and facilities management.

Postnatal care is provided in a ward setting for those who have accessed obstetric care. In obstetric units, there is usually a transfer to a shared area whilst women and their newborns are awaiting the appropriate checks and care planning. In midwife-led units, there is a decreased chance of transfer to another area during the postnatal period as the space is designed to accommodate labour, birth, and immediate postnatal periods. For most women, discharge from the hospital will take place within a few hours of having a baby based on the complications experienced during birth.

## **Starting with understanding the experience**

Design is often used as a creative approach to problem solving. Working with the Design Council, the research phase was initiated with an overview of the published literature. Two design researchers were involved in the initial scoping exercise to understand what influences the experiences of accessing and utilising maternity care in the UK.

This was then followed by primary qualitative research with families, midwives, and clinicians in two different sites between May and June 2015. Units were invited to participate through online recruitment and targeted invitations. The focus for the data collection was on two mid-sized hospital units in England providing around 3,500 to 4,500 births per year. They typically had six to eight rooms in the delivery suite, and co-located midwife-led units also known locally as birth centres. The primary research was conducted at various times during the day and night, and within various settings throughout the maternity context. Approximately 50 hours was spent on activities including observations and interviews.

The approach taken included

- Observational studies and semi-structured interviews with families who access services, midwives and other professionals to gain insights about their experiences.
- Mapping flow and movement through physical spaces
- Experience mapping throughout their service to build a picture of patterns of joy and frustration
- Analysis of findings to understand the impact of the environment on people's experiences and the working culture within different settings.

During synthesis, the findings were distilled into several key themes and presented at initial stages to an internal team at the Royal College of Midwives. An interactive session was also held at the Normal Birth Conference 2015 held in the UK for wider consultation in June 2015. Initial findings were also tested with student midwives and hospital units as part of learning and study days on the topic of better births.

A total of 8 themes and 38 insights were identified as part of the analysis (Annex 1) and these were presented in line with the continuum of care. The detailed findings will be made available as part of learning, service design and improvement resources through the Better Births Initiative. For the purposes of this summary, the insights and themes are presented as an overview under three main headings and following this, three opportunity areas are presented to support how these insights can be made actionable.

## Findings section 1. Understanding and interpreting information

This theme brings together the perceptions of the women and partners as well as the staff. These relate to the provision of care, navigation through the care system, and the decisions that are taken and how they are taken.

The first insight presented was titled 'there is so much new information to take in' with reference to the booking appointment. The description provided is that this is the first and longest appointment for women starting on their maternity journey, the information can feel irrelevant and hard to relate to. Fathers and birthing partners are reliant on women to invite or share information with them. It seems that information is provided at a time that is convenient for the service and not necessarily for the pregnancy.

*"It's terrible ain't it. I don't know how the women retain all the information." (Midwife)*

*"Leaflets, not always great, some good midwives would signpost websites. But I don't know about that, I'm just a HCA." (Healthcare Assistant)*

A set of insights related to expectant parent(s) navigating through the hospital space at the time of labour. The description is that this is not always obvious and does not take into account the experience of anxious parent(s) to be. There is a reliance on others in the waiting room or to actually go into the triage space to get assistance. The environment is not conducive to the needs of women or partners who are waiting. Little consideration had gone into how it feels to arrive at an empty reception desk and what it's like to sit uncomfortable, uninformed and unstimulated for hours in some cases. The only information on the walls seemed repeated and unhelpful, and often not considered for those who are waiting in those spaces (e.g. details about a placenta trial and cancer fundraising). There are times when emergency alarms sound throughout the space and waiting parents are silenced whilst witnessing emergencies and sharing a waiting area space with women of varying service needs.

*"First time I have seen someone sat at that desk all day!" (Waiting Father)*

*"At night, how do people know where to go?" "Ah, we see them coming!" (Triage staff)*

*"People get cross if they are waiting and they're uncomfortable. If there are no seats, people stand." (Ward clerk)*

*"There are times where, in the same space, one women is huffing in labour and another one is bleeding and worried they may have lost their baby." (Midwife)*

The observations highlighted the differences in the philosophy of care, the way information is shared, as well as professional preferences and priorities. For example, the birthing pool was a big draw towards the midwife-led units with women valuing the option to use the pool and also have water babies. With fewer pools in this area, mothers felt lucky if they were able to use it, as it was on a first come, first served basis. It also seemed pools were synonymous with low risk. In the obstetric areas, a water birth is possible only in unique cases. From the perspective of the staff, there were differences on whether they approved of or wanted to use the pool as part of the care they provided.

*"[BC] I love the look of it. The experience of it looked good and I wanted a water birth - but the doctors had their reasons." (Mother)*

Similarly, the right position of the bed in delivery suite or lack of a bed in the birth centre was highlighted in the observations. There were a number of views presented in the course of the study and some of the self explanatory quotations are shown below.

*"Wouldn't have used the bed anyway, quite painful to lie down. Better to be upright and active. I would never lie down." (Mother, Birth Centre)*

*"Where they want beds? Differs from doctors to midwives." (Healthcare Assistant)*

*"If curtains are not drawn you can see in and onto the beds – apparently there was a memo from upstairs about patient dignity/ confidentiality. So much controversy." (Housekeeping, Delivery Suite)*

*"We've always had beds in this position. They're a prominent feature. It is difficult in an emergency if the bed has to be moved. To get to the lady that needs assistance quickly - it could be a problem." (Medical Clinician)*

*"We are very confident – we can move the bed in 2 seconds if we need to " (2nd year student midwives)*

*"I don't think we should use the word 'allow'. We need to be supporting women in their choices – as long as they understand the risks. Concentrate on what the woman wants." (Midwife)*

*"Occasionally asked whether we can let a high risk lady birth in a low risk place. I have to advise. I'd give them figures for outcomes in our hospital. And define risks for individual patient. A lot of women expect the perfect baby. Perfect delivery with no interventions. Disparity in expectation. You may need intervention to get your perfect baby." (Obstetrician)*

With the insight statement 'environment is less of a focus for obstetric teams', it was reported that most of the more risk-focussed staff (including midwives, clinical staff, doctors, anaesthetists, theatre sisters) are used to providing care in a very clinical environment. A more home like environment was not something they spoke of with much importance or interest. When women are introduced to a room in the birth centre, they are invited to make the space their own, bring things in, to move and adjust furniture and play music. This philosophy is less apparent in the delivery suite. Some birth centre midwives felt that some staff didn't notice changes to the environment and so could not appreciate them.

*"What's the difference, to me it's the same?" (Obstetrician)*

*"Well it's more family orientated down there [Birth Centre] – the environment, the double beds" (Mother)*

*"I go down [Birth Centre] if there's an emergency – I am very case orientated that's just me." (Obstetrician)*

In the final stages of care within the hospital setting, the postnatal period plays an important role giving an opportunity to round off information provision and understand the experiences. It was important for women to connecting back with the staff who had provided the care during labour and birth and this was also valued by staff.

*"Verbal handover as well as written (handover nurse – staff on ward). Always at side of bed so women can contradict/ question what we say." (Midwife, Postnatal Ward)*

*"Consultant came to us the next day and apologised for his decision." (Mother)*

*"My mum said I was swearing, had to apologise to my midwife the day after" (Mother)*

*"The next day I'll go up and see how they got on – if the shift changed over whilst they were in labour." (Midwife)*

*"Midwife pops up to see you day after before you go home." (Mother)*

## Findings section 2. What people really value

One of the insights for the early stages of care states that ‘what women and partners feel is important on arrival’. This is about their expectation to be panicking when they arrive, some want staff to take over responsibility, others want to remain in complete control. What is valued by expectant women is knowing that they will be supported and not feel like a burden. Women also want to know that their birth partners know what is going on and are not getting in the way. The physical space has an impact at the time of arrival, as does prior knowledge of where they would be when they go into labour. Some had their preconceptions challenged, finding out that it was calm and there was not screaming

*“Clean. Spacious. Relaxing. Calm (as you can be) fresher and cleaner decoration.” (Mother)*

*“They love a good preview...It helps put their minds a rest.”(Midwife)*

*“They said it was very busy, but you wouldn’t know. No women screaming, no babies crying. That surprised me, expected to hear drama - like ‘One Born Every Minute’.” (Expectant mother)*

*“[The maternity ward tour] calmed my partner down a bit, he’s not as panicky.” (Expectant mother)*

There were many appealing features of the birth centres including the extra touches for lighting and environment, the birthing pool, proximity to delivery suite or theatre, and the whole family being able to stay after the birth. The use of the equipment, including the birthing balls, was incredibly valuable to women. Nearly all mothers and fathers mentioned the importance of having the partner stay in the postnatal period regardless of where they give birth.

*“Chose to go to BC as it’s ‘best of both worlds’. It’s not as dramatic then if you have to transfer to DS or ward.” (Mother)*

*“When we arrived towels were rolled up. It was calm and relaxed. Like a hotel” (Mother)*

*“Yeah, we weren’t really expecting things like that in hospital” (Father)*

*“Brilliant having the lights off and the twinkly ones, made such a difference. Couple of candles too. Spa feel in the room with the pool even though I didn’t get in. No hospital bed makes it nicer.” (Mother)*

*“It wasn’t nice, no; getting kicked out, straight away” (Father)*

*“It’s nice dads get to stay, especially for first time mums.” (Mother)*

With the insight ‘Midwives, there if you need them’, it was reported that most women involved in the research who had a straightforward birthing experience in the birth centre commented on the fact that they didn’t feel there were too many interruptions. They valued the knowledge that the midwife was nearby (as did their partners), but unless they really needed a midwife, they got on with it themselves.

*“Midwife left us to it really, checked heartbeat until the end. Sometimes I wasn’t even aware she was there” (Mother)*

In contrast, one of the insights also pointed to a perception that once the doctor needs to get involved you are less in control. For the birthing partners, a major concern was whether the midwives were around. However, the visibility of midwives was reduced in the birthing centre and desks were often left unattended. After the birth, facilities to support women were also considered as much as those made available during labour. Lots of the women commented on the desire to freshen up directly afterwards and the use of the shower was most appreciated at this point.

*“I’m waiting to go up to the ward to have a shower, I do feel a bit gross.” (Mother, Delivery Suite)*

*“I struggled in the bath afterwards. Be better to have a shower or a walk in shower with a seat. I really wanted to freshen up straight away.” (Mother, Birth Centre)*

### **Findings section 3. Moments that stick**

Triage is used to identify women who are in established labour and ready to be admitted. It is appreciated by staff and families and has alleviated traffic and workload for the delivery suite. Where women have arrived to the unit in early stages of labour, being asked to return home can cause anxiety.

*“Triage has made a massive difference.” (Midwife, Delivery Suite)*

*“Between February 1st and February 29th 2015, we had 3000 calls to triage.” (Midwife, Delivery Suite)*

*“I was not prepared at all. We’d just been for a meal. I had my hair extensions and heels on. Didn’t have my notes. At about 2.30am the midwife asked, “will you be able to get the notes.” (mother)*

*“He didn’t want to leave, he didn’t want to miss anything.” (Mother)*

*“Worst experience ever. I came in four times and was sent back home again. Like I was speaking to a brick wall. They don’t want to keep you. It didn’t feel like they were keeping a close eye.” (Mother)*

Memorable experiences were also formed when transfers were required from the birth centre to the delivery suite or to theatre. This is summarised in the insight statement 'pace of delivery suite differs hugely if you've come from a midwife-led unit'. In particular, lack of communication, speed of change and the immediate contrast between care settings was memorable. For example, during transfers, women and partners remember experiencing lags or gaps in communication. This was often reported as the most stressful bit of their journey with recognition from all women, partners and the staff.

*"The transition from low to high risk is not ideal - contrast is so great, I am not convinced this is best for women." (Obstetrician)*

*"As I was transferred, there was no rapport with the midwife [in delivery suite], I don't know her name." (Mother)*

*"I was wheel chaired into obs and it all changed then, contractions turned into pain then." (Mother)*

The insight statement 'some sense of control' also points to differences in the environment stating that there tends to be more people, equipment, noise, brighter lights and the language and tone staff use is different. For women who start in the delivery suite, they are aware it was the consultant's opinion that they should be in delivery suite, and there is a sense that the consultant will make the decisions during the labour too. It was suggested that junior consultants are more likely to intervene than those with more experience. A few women felt rushed during transfer and once in delivery suite. One mother remembered pushing and being aware she was under a time pressure because it was at changeover time, and she didn't want to be introduced and get to know a new midwife at that stage.

*"Seemed like they were in a bit of a rush to get you out [of the delivery suite]". (Mother)*

*"It's so frustrating. Suddenly got consent forms thrown at me, people explaining things thoroughly but fast. All of a sudden things change quite quickly. Had to leave husband behind (Mother)*

*"You're scared. You don't know what's happening. You go from a dark room just the two of you, to a fully lit room with ten people. The language is different. People taking your clothes off you. You feel like a piece of meat. Never had any surgery before or nothing." (Mother)*

Two of the insights describe memorable touch points based on full awareness of the sounds and the physical space. The first, 'heightened senses, what can you hear?', is presented for going from a space that's quiet with a midwife popping in and where you feel in control, to a space where there are lots of staff around, you feel less in control and you start to hear things that sound scary. You then rely on your other senses to interpret the situation. There are then contrasts in approach across the unit where the midwife in the birth centre might ask "how are you feeling", but in the delivery suite they might start telling you what to do. "With my last one, it was horrible, unprofessional, she told me to 'hold on' whilst she was doing her paper work at the back of the room.

*"You hear things: 'There's meconium in there', 'Get the crash team in here'. I think the midwife must have seen my face 'cause they explained that it was 'just in case'. They were really good at explaining. I heard crying from quite far away. I had to say to [husband], 'Is that her?'"*  
(Mother)

With the insight statement on 'senses are heightened, what can you see?' the observation is that from the bed you can often see a clock, and drawers full of equipment for the staff, there is a big light above the bed and multiple bins. The space does not feel like your own; it is full of things that you feel like you cannot touch. In certain circumstances, women and partners are reliant on others to tell them what's happening.

*"There's a chart on the wall that I could read from the theatre bed, it said:*

- *Time knife to skin: 7.01*
- *Time of birth: 7.05*

*Only 4 minutes. That was the first time I had seen her time of birth. Which was quite nice. ..then the consultant showed me her in her hat and towel." Mother*

*" [the room] was quite big, comfortable, all equipment you need in there. The bed was alright, I was just focussed on the baby." Mother*

Partners in the delivery suite and during emergencies can find the experience bewildering /or can feel bewildered and result in a sense of being out of control. For example, in preparation for theatre, partners waiting for the mothers are told to put scrubs on and wait for staff to bring them in. This can take differing amounts of time, and partners are often left wondering whether their partners are alright. Given that this is also when women express the need to have their birthing partner with them, these necessary actions can result in women being at the centre of a whirlwind and partners seem powerless.

*"I think we were delayed by paperwork, but the midwife kept disappearing" (Mother)*

*“I only found out about anaesthetic when she was in recovery, they didn’t mention general till then.” (Dad)*

*“We’ll come back and get you” they said to him. I didn’t have him with me during prep. It wasn’t nice. I kept my eyes closed the whole time.” Mother, from midwife-led unit to delivery suite*

This observation continues to the time of postnatal care in the wards where partners are not allowed to stay. Birthing partners are usually asked to go home and the mother is left alone with the baby. Partners and mothers all commented on how this was difficult for a few reasons: bonding, ability to cope physically after having surgery, dealing with stress post birth. The immediacy of the change was memorable for women at a time that they still needed to be cared for.

*“I had just been through 18 hours of labour, tried to achieve a vaginal birth. But it didn’t happen. Tried special forceps, still problems. Then recovery maybe another hour.. Her oxygen was low. Then heel prick. All this before going to ward...Then everyone disappears and you can’t reach anything!” Mother, Postnatal Ward*

The last insight statement presented was on the ‘After thoughts service’ which seeks feedback from women and their partners. A poignant note is that during the time of shadowing and data collection, there was no mention of the Maternity Services Liaison Committee. Although women have the opportunity to review their notes, this does not take into account the emotional impact.

*“Very few women voice disappointment or anger directly after giving birth. Usually happens during and after support and care – that’s where they voice it. Don’t refer very often (but it’s available).” (Midwife)*

## **Working towards design briefs in maternity**

The findings from this research phase resulted in the identification of three opportunity areas. These are presented as the context, problem specification, and statements to initiate ideas and design briefs that can be implemented as part of local, regional or national efforts in maternity services. Although home births and freestanding birth centres were not included in this study, the opportunity areas do highlight the need to engage in a continuous journey of preparation for pregnancy, the birth experience and parenthood. This could be translated to all maternity care settings.

## **Opportunity area 1: Preparing for the birth experience**

Expectant mothers are provided with a considerable amount of information which can feel hard to relate to, irrelevant or inconsistent in tone. New parent(s) may not have a good sense of what the hospital environment looks and feels like, therefore being able to see the space beforehand is an important step for parent(s) to prepare themselves for giving birth. The next interaction with the hospital environment may be triage, which can provide a vital moment for expectant parent(s) to get ready for the birth, though expectant parent(s) also experience anxiety when they arrive earlier than expected for admission.

### **Problems**

Information may be provided at the time convenient for the service, not the individual, potentially leaving expectant parent(s) feeling overwhelmed with information and/ or a mismatch of the questions they have and the answers they need. There is an inconsistency of tone, on the one side striving to empower expectant mothers about choice whilst attempting to manage expectations by warning about risks. People arriving too early in triage are made more anxious at being asked to return home in instances that they are not in established labour.

### **Opportunity questions**

How might we present information to expectant parent(s) in a timely and consistent way?

How might we strike a balance between empowering and realistic to put women's and their partners' minds at rest about the birthing experience?

How might we build a clearer understanding and reduce differences between birth environments?

How might we improve the triage experience to inform and reassure expectant parent(s) at whatever stage of labour?

## **Opportunity area 2: 'Transition points' in the birthing experience**

There are several important transition points in the experience of giving birth: entering triage, admission, transition between birth centre and the delivery suite or theatre, postnatal and discharge. Expectant parent(s) experience the anxiety when moving between these stages, as environments, personnel and their perceived amount of choice shifts. For example, when women are transferred out of the birth centre and into delivery suite or theatre, often it's a rapid transition from a comfortable environment where the woman is encouraged to be in control to a more frenetic environment where the medical clinician takes control. The environment changes from one that feels more homelike to a very clinical, noisier one. These shifts could continue right through to the home and beyond which can have an impact upon the parents' sense of empowerment and control.

### **Problems**

Often the lags and gaps in communication between transfers are experienced as the most stressful part of the journey. For others, the sense of suddenly being rushed and out of control is an anxious time, and they feel powerless. Necessary parts of the transition, such as the urgent need to sign consent forms, or for partners to scrub up ahead of surgery, as well as the absence of staff at times when people may have questions about what is about to happen, can add bewilderment to the process. The transition to postnatal wards can present problems where there is not the support or information to deal with the stress of the birth and bonding with and caring for the new baby.

### **Opportunity questions**

How might we look at the journey through each stage, especially the 'entry point' to a new environment?

How might adjustments be made to the aspects of the environment that are causing avoidable anxiety?

### **Opportunity area 3: A continuous journey to prepare for pregnancy and parenthood**

Expectant parents have a number of interactions with the health service during pregnancy and birth, as well as access to other advice services such as external antenatal classes, and friends and family. The end-to-end experience from early pregnancy to early parenthood can be experienced as a bumpy journey. Rather than a steady nine months of gradual preparation for each stage of pregnancy, birth and early parenthood, information and support may feel either overwhelming or lacking, or contradictory (e.g. information from external antenatal classes or health service messages versus the stories from friends and families). The lack of continuity of information in this journey of support does not provide the best starting point for becoming a parent.

#### **Problems**

The initial 'booking' appointment can leave expectant parents feeling overloaded with information at an early stage of pregnancy. Parents may be signposted to a range of websites and leaflets which they are left with to digest themselves. Some of the information available may not be consistent across professionals such as the use of birthing pools and hypnobirthing. The birthing experience may often be anticipated as a hurdle to overcome with less attention on its marker as the starting point in your role as a parent. New parents may feel that the support starts to disappear after the birth, a crucial moment in bonding and caring for your new baby

#### **Opportunity questions**

How might we develop a consistent tone of voice with pregnant women to offer well-paced advice and empowerment at each stage of their journey?

How might we equip people so they feel well-informed and empowered through their whole experience of pregnancy and birth?

How might we allow for individual needs and preferences to be considered at each stage of the journey from early pregnancy to early parenthood?

How might the role of key professionals and personal advisors at each stage of the journey be re-imagined?

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## Annex 1. The themes and insights on understanding experiences in hospital-based maternity settings

Theme		Insight
1. Antenatal	1.1	There is so much new information to take in
	1.2	Hypnobirthing and antenatal classes – balance of informing and petrifying
	1.3	Previewing the space before giving birth was really valued
	1.4	What women and partners feel when they arrive is really important
2. Where to give birth	2.1	Professionals have a huge influence on parents' choice of the birth environment
	2.2	Appeal of birth centre - comfortable but help never too far
	2.3	Perception that a birth centre is nice, but delivery suite is the right thing in certain cases
	2.4	Importance of having a birthing partner present throughout
	2.5	General perception: if you are low risk you have more options
	2.6	The pool is a big attraction
3. Triage	3.1	The concept
	3.2	Arrival – everything is memorable
	3.3	Navigation
	3.4	The environment
	3.6	Witnessing emergencies
4. Birthing centre	4.1	Midwives, there if you need them
	4.2	Understanding of the benefits of active birth
	4.3	Spa feel is one of the main appeals
	4.4	Connection between not seeing the doctor and having a lovely experience
	4.5	Environment is less of focus for obstetric teams
	4.6	Sounds
	4.7	Appropriate facilities to freshen up being really important
5. Transfers	5.1	Communication
	5.2	Poor experiences

Theme		Insight
6. Delivery suites	6.1	Pace of delivery suite differs hugely if you've come from a midwife-led unit
	6.2	Some sense a 'loss of control'
	6.3	Senses are heightened – what can you hear?
	6.4	Senses are heightened – what can you see?
	6.5	Focus on safety of baby,
	6.6	Privacy
7. The bed	7.1	Women only seemed to comment on the bed, or lack of, in the birth centre
	7.2	There are two different opinions when it comes to the right position of the bed in the delivery suite
	7.3	Those who set the rooms up are aware of conflict, but tend to go with the medical clinicians
8. Postnatal ward	8.1	Arrival to ward
	8.2	Communications
	8.3	Environment
	8.4	After thought service



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SUMMARY