NHS Gloucestershire

Maternity Health Needs Assessment

January 2026

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Thank you

The Maternity Service Review Project Board would like to take this opportunity to thank everyone involved in the development of this maternity health needs assessment.

Partners from across the One Gloucestershire Integrated Care System have worked collaboratively over several months to collate and analyse the data presented in this needs assessment, identifying considerations from the emerging findings.

Special thanks to the Maternity and Neonatal Voices Partnership for their ongoing involvement, and finally, we would also like to thank those individuals and communities who took the time to share their insights regarding their experience of local maternity services.

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1. Executive summary

1.1 Introduction

Maternity services in Gloucestershire are facing significant changes that require strategic review. These pressures stem from increasing clinical complexities[1], national guidance and policy changes, shifting patient choices, and workforce challenges. The timing of this work reflects a national focus on improving maternity care, driven by findings from recent independent investigations and reports such as the Ockenden Report, along with the commitment to implement the upcoming recommendations of the National Maternity and Neonatal Investigation, due in 2026. In addition, the NHS 10-Year Plan includes a shift towards wellbeing, ill health prevention, and maintaining health independence, recognising that improving outcomes for pregnancy and the early years requires proactive measures rather than reactive care.

All NHS maternity services in Gloucestershire are provided by a single provider trust, Gloucestershire Hospitals NHS Foundation Trust (GHT), and include antenatal, intrapartum, and postnatal care.

Alongside antenatal and postnatal care, the maternity service provides several birth settings: a consultant-led unit and alongside midwifery unit at Gloucestershire Royal Hospital, two freestanding midwifery-led birth units – Stroud maternity unit and Cheltenham birth unit – and a home birth service. However, Cheltenham birth unit and Stroud's postnatal beds have been temporarily closed since 2022, and the home birth service was suspended for six months in November 2025 while a service review is underway.

1.2 Developing the needs assessment

This maternity health needs assessment has been produced by NHS Gloucestershire ICB through a collaborative and iterative process with a project team, drawing on data from Gloucestershire County Council, Gloucestershire Hospitals NHS Foundation Trust, and the National Maternity Services Data Set (MSDS), as well as mapping local resources. It also includes a dedicated chapter summarising insights collected from both users of maternity services and staff in Gloucestershire.

The purpose of the needs assessment is to identify the health and healthcare needs of the county's maternity population. This includes changes in population health, needs, and inequalities in outcomes and care that need to be considered to support equitable, safe and personalised services that are fit for the future.

The following is a summary of the findings.

[1] Pregnancies may be considered 'complex' for a variety of reasons including pre-existing health conditions, age, social factors, or other factors affecting the pregnancy such as twins. Complex pregnancies will require additional input and specialist care.

1.3 Key findings

Birth rates

The trend in live births in Gloucestershire overall follows the national picture. In 2016 there were 6,739 registered live births, but the rate has decreased since then to just over 5,800 in each of the years 2022-2024. Birth numbers are expected to remain stable until around 2032, before a projected modest increase with district-level variation.

Preconception care

Preconception care is critical to optimise health outcomes for mother and baby, enabling proactive interventions, especially for those with pre-existing health conditions and/or experiencing health inequalities. However, access to good preconception care can be inconsistent and it is essential to consider how it can be more equitable.

Antenatal care

There has been an increase in demand for ultrasound scanning in pregnancy, driven by policy changes, which has resulted in demand outstripping capacity. There is a plan in place to address this, and further work is needed to ensure equitable access. Although there has been some online antenatal education introduced by the NHS, this is not universally accessed. There is very limited NHS-led, face-to-face antenatal education, and feedback from women[2] indicates that having a face-to-face option available would be beneficial.

Midwifery-led and consultant-led care

Gloucestershire has seen a shift away from midwifery-led births towards consultant-led births, again mirroring national trends. More women are giving birth in the consultant-led unit and fewer in midwifery-led birth units, and there are rising caesarean section rates. Caesarean births now slightly exceed spontaneous vaginal births for the first time. The exact reasons for the rise are not fully understood, but are likely linked to shifting demographics, including more women giving birth later in life, higher rates of obesity, and a growing prevalence of pre-existing health conditions. This is in addition to change in guidance to ensure women have an informed choice on mode of birth including caesarean section.

Several factors, including developments in national policy and clinical guidance, have had an impact on induction of labour rates both locally and nationally. The local rate of induction has risen over the last 4 years from 27.5% in 2021/22 to 33.2% in 2024/25, and this is similar to the national average rates.

Postnatal care

Postnatally, outcomes and experiences vary significantly by socioeconomic status, underscoring the need for consistent, high-quality early postnatal care. Systemwide work has strengthened handovers between maternity, health visiting and general practice, and bereavement support has been expanded to cover 7 days a week.

[2] Note on terminology: This document uses the terms ‘women’ or ‘mothers’ throughout. These should be taken to include people who do not identify as a woman, but who are pregnant or have had a baby.

Demographics and impact on outcomes

Although Gloucestershire is broadly affluent, there are pockets of deprivation. The highest rates of deprivation are in Gloucester, followed by the Forest of Dean and parts of Cheltenham. Nearly a quarter of maternity service users are from ethnic minority communities, the majority living in Gloucester, and 11.8% of births in Gloucestershire in 2024/25 were to women whose primary language was not English.

The findings highlight persistent health inequalities. Women from deprived areas and ethnic minority communities face disproportionately poorer maternal and neonatal outcomes and are more likely to have barriers to accessing care, including transport, digital exclusion and communication challenges. Gloucester experiences some of the county's poorest outcomes, shaped by both deprivation and a higher proportion of families from ethnic minority communities.

Local outcome data shows:

- Higher stillbirth and neonatal mortality rates among women in the most deprived deciles and/or among ethnic minorities.
- Babies in the most deprived areas are significantly more likely to be born preterm.
- Asian and British Asian women are more likely to experience third- or fourth-degree perineal tears.
- Women who are of Black, Brown or Mixed ethnicity are more likely to have a postpartum haemorrhage.

National evidence also shows that maternal mortality rates increase with deprivation and among ethnic minority communities.

Health behaviours and impact on outcomes

Inequalities are evident in Gloucestershire across key risk factors and health behaviours:

- Rates of maternal obesity are rising and are particularly prevalent in areas of higher deprivation. Obesity is associated with a higher risk of complications such as gestational diabetes, hypertensive disorders, prolonged labour, and caesarean section, as well as adverse neonatal outcomes including stillbirth and premature birth, and childhood obesity.
- Smoking in pregnancy is more common in deprived areas. Smoking during pregnancy increases the risk of complications such as low birth weight, premature birth and stillbirth and has long term consequences for child development.
- Breastfeeding rates are lowest in Gloucester and the Forest of Dean, and among white British women.
- Timely booking (by 10 weeks) and uptake of antenatal education are lower among women from deprived areas and/or ethnic minority communities.

Maternal age

An increasing average maternal age is likely to result in more complexity. This will be partly from women having pre-existing health conditions and partly from the higher risk of women developing a pregnancy-specific condition. This may lead to an increased need for consultant-led care (including maternal and fetal medicine specialists) and anaesthetic care.

Multiple long-term conditions

More women are entering pregnancy with multiple long-term conditions, increasing demand for obstetric and specialist input.

Mental health

Around one in four women experience a perinatal mental health condition, and referrals are rising to the Specialist Perinatal Mental Health Service, which includes a birth trauma provision. However, referrals to specialist services such as this remain disproportionately low among women from ethnic minority communities and those living in deprivation.

1.4 Insights

A wide-ranging insight programme involved nearly 900 service users, families, staff and community groups. It included targeted engagement with Polish, Black and South Asian communities, Care Quality Commission (CQC) survey results, Patient Advice and Liaison Service (PALS)/Complaints and Friends and Family (FFT) survey data.

The insights reveal an inconsistent experience of maternity care in Gloucestershire: women frequently describe compassionate, skilled care during labour and birth, alongside significant challenges in communication, continuity, and postnatal support. Antenatal insights highlight difficulties accessing appointments, usability and reliability issues with BadgerNet, inconsistent information, and a lack of continuity of midwifery care. Intrapartum experiences are often positive – particularly around staff kindness, responsiveness and safety – yet some women report feeling pressured into interventions, insufficient explanation of procedures, and variation in service availability (including birth units and home birth cover). Postnatally, many families rely on partners and private/community services due to inconsistent breastfeeding support, variable ward staffing, and limited mental health follow up.

Across all insights gathered from women, key improvement priorities consistently emerge: strengthened communication at every stage; more reliable and accessible postnatal care; improved cultural sensitivity and equity of access; continuity of midwifery care; and enhanced breastfeeding and tongue tie services. A key consideration going forward is how to maximise the impact of insight, working with the Maternity and Neonatal Voices Partnership (MNVP), to develop future maternity services that are personalised, accessible and equitable. Despite pressures, the 2025 CQC survey positions Gloucestershire Hospitals Trust as performing ‘Better Than Expected’ in labour and birth, highlighting staff dedication and quality of care, whilst underlining the need for consistency of antenatal information and sustained improvement in postnatal experience.

1.5 Next steps

This needs assessment highlights a number of considerations that will inform the future of our services and the care that we provide. The next step is engaging with communities and stakeholders to develop potential solutions for a maternity service fit for the future.

Ensuring the future sustainability of Gloucestershire’s maternity services will require a model that responds to the changing clinical and demographic needs of women, supports informed

choice, and delivers equitable access to high-quality care. By designing services that reduce inequalities in outcomes, meet the needs of our most vulnerable communities, and create the right conditions for staff to provide safe and compassionate care, we can build a maternity system that is both resilient and truly responsive to the women and families it serves.

2. Introduction

2.1 Purpose of the needs assessment

Maternity services in Gloucestershire are facing significant challenges that require strategic change. These pressures stem from increasing clinical complexities, changes in national guidance and policy, shifting choices for women, and workforce challenges. These challenges are not unique to Gloucestershire.

This maternity needs assessment for Gloucestershire has been developed in response to these challenges. It is used to identify the health and healthcare needs of women. It describes changes in population health, needs and care that need to be considered to support equitable, safe and personalised services that are fit for the future. Throughout this document, there are key considerations which have been developed collaboratively with a steering group through an iterative process. These considerations are intended to inform and shape the next steps in developing potential solutions for a future maternity service model.

The timing of this work reflects a national focus on improving maternity care, driven by findings from recent independent investigations and reports such as the Ockenden Reports (Ockenden, 2020; Ockenden, 2022) and the 'Reading the Signals' Report (Kirkup, 2022), along with the commitment to implement the upcoming recommendations of the National Maternity and Neonatal Investigation. This investigation, of which Gloucestershire is one of the 12 services being reviewed, aims to produce a single set of national recommendations to improve the quality and safety of care across England, reduce inequalities, and promote health equity. The investigation seeks to ensure justice and accountability for families affected by harm or bereavement and embed the lived experiences of women, babies, and families into its work. Baroness Amos published her reflections and initial impressions on the investigation in December 2025 (National Maternity and Neonatal Investigation, 2025). The final report and recommendations are due to be published in spring 2026. In addition, the NHS 10-Year Plan includes a shift towards wellbeing, ill health prevention, and maintaining health independence, recognising that improving outcomes for pregnancy and the early years requires both proactive and reactive measures.

By undertaking this assessment now, the aim is to align Gloucestershire's future services with national priorities, respond to emerging trends in maternal and neonatal health, and ensure that care is personalised, inclusive, and responsive to the diverse communities across the county.

2.2 How the needs assessment has been developed

This assessment has been developed through a collaborative, iterative and evidence-based approach, to ensure that the changing needs of the population were thoroughly understood. The development of the assessment was led by a project team, with representatives with a range of skills from Public Health at Gloucestershire County Council (GCC), Gloucestershire Maternity and Neonatal Voices Partnership (MNVP), Gloucestershire Hospitals NHS

Foundation Trust (GHT) and NHS Gloucestershire Integrated Care Board (ICB). Regular project group meetings ensured ongoing collaboration, regular progress reviews, and focused discussion on data analysis and stakeholder insight. The project team reported into a Gloucestershire Integrated Care System Project Board with Executive Sponsors from GHT and the ICB being accountable for the delivery of the work.

The needs assessment involved a review of national and local data, trends and outcomes, and the views of women, staff and stakeholders. It combines quantitative analysis with qualitative insights from those who deliver and use local maternity services. A variety of local and national data sources were used, including:

- GCC
- GHT
- National Maternity Services Data Set
- Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBBRACE-UK)
- Office for Health Improvement and Disparities (OHID) and Office for National Statistics (ONS)

The most recent data available has been used, but this has sometimes meant using data from different years.

A series of insight sessions were facilitated with a wide range of stakeholders across the Local Maternity and Neonatal System (LMNS). One-to-one and group meetings and interviews were held with clinicians from maternity services as well as staff from other services such as Children's Centres, providing an opportunity to discuss emerging data on births and outcomes and to check whether these patterns aligned with their professional understanding. Stakeholders were invited to comment on whether the data resonated with their experience and to highlight any additional issues or feedback they felt should be considered. In addition, a workshop was held with a broad group of stakeholders to review the data collectively and explore current issues.

To ensure that the voices of women, their families, and staff were central to this assessment, surveys were conducted across these groups. Targeted activities were undertaken to gather diverse insights. Key themes from the survey responses and from engagement activities with women – such as the annual CQC survey and MNVP insights – are included in a dedicated section in this needs assessment.

We have reviewed the insight work to ensure we capture the views of diverse groups that reflect the county's maternity population. As this work develops, a robust Equality and Engagement Impact Assessment (EEIA) will be undertaken to ensure that future service development and improvement is informed by this health needs assessment and the voice of local communities.

Through this approach – combining stakeholder involvement, data analysis, workshops, and surveys – the needs assessment ensures that the findings are comprehensive, evidence-based, and reflective of both local and national priorities.

2.3 Scope of the needs assessment

This assessment focuses primarily on the needs of women during the maternity journey. While partners and families play a crucial role in influencing outcomes, their experiences and support needs – such as inclusion in decision-making, access to information, and mental health support – are acknowledged, and are highlighted in the insight data from women, but not explored in detail here. These areas should be addressed in future work or other complementary assessments.

Similarly, the wellbeing and support of maternity staff are fundamental to delivering safe, high-quality care. National reviews and reports, including the Ockenden Report, the Reading the Signals Report from East Kent, and the report of the All-Party Parliamentary Groups on Baby Loss and Maternity, have highlighted the impact of workforce shortages and pressures on outcomes and experience (Ockenden, 2020; 2022; Kirkup, 2022; All Party Parliamentary Group, 2022). Midwifery and obstetric staffing levels remain a challenge across the NHS, and Gloucestershire is not immune to these pressures. Furthermore, we know that the demographic profile of our maternity workforce does not reflect the diversity of our population, which can influence cultural competence and inclusivity. Although a detailed workforce analysis falls beyond the scope of this document, future service design must prioritise staff recruitment, retention, and support, alongside initiatives to build a workforce that is representative of the local population and equipped to meet the needs of all families.

3. Maternity services

This section provides an overview of the maternity services available in Gloucestershire and examines the wider network of services that work alongside maternity care to support women, babies, and families throughout the maternity journey.

3.1 Overview of NHS maternity services

NHS maternity services in Gloucestershire are provided Gloucestershire Hospitals NHS Foundation Trust (GHT), and include antenatal, intrapartum, and postnatal care.

The maternity services include the following:

- **Midwifery-led care:** for low-risk women, routine antenatal and postnatal care across Gloucestershire's six districts, and intrapartum care at home or in a midwifery-led birth unit.
- **Consultant-led care:** antenatal, intrapartum and postnatal care, including outpatient clinics and day assessment, for higher risk women requiring additional monitoring. These clinics are supported by a range of specialist midwives (for women with additional or complex health or social needs, and include tobacco dependency, substance and alcohol support, safeguarding, bereavement, and perinatal mental health), other health care professionals, a regional Maternal Medicine Network (specialist care for women with significant pre-existing or pregnancy-related medical conditions) and a regional Fetal Medicine Network (specialist care relating to fetal medicine).
- **Maternity triage and advice line:** triage is an 24/7 in-person assessment service at Gloucestershire Royal Hospital, and is available along with a maternity advice phone line for women who are more than 16 weeks pregnant or are recently postnatal and experiencing non-emergency or concerning symptoms.
- **Maternity ultrasound:** routine antenatal scans for all pregnant women and additional scans for women with higher risk pregnancy.
- **Local neonatal unit:** for babies more than 27 weeks' gestation requiring specialist neonatal care.

These services are primarily concentrated in Gloucester and Cheltenham, with limited satellite provision for ultrasound, consultant-led clinics and specialist services across the rest of the county.

3.2 Choice of place of birth

According to NICE (National Institute for Health and Care Excellence) intrapartum care guidance (NICE, 2025a), a choice of where to give birth should be offered which includes home birth, midwifery-led birth unit (freestanding and alongside) and consultant-led hospital birth. Options of where to give birth need to be discussed fully with women and their partners to ensure that informed decisions are made using the most up-to-date evidenced-based information, including risks and benefits, and transfer rates and times.

There is a choice of options for place of birth in Gloucestershire. The full range of choice is not currently available due to temporary closures, but would consist of:

- One alongside midwifery-led birth unit (AMU): Gloucester birth unit in the Women's Centre at Gloucestershire Royal Hospital
- Two freestanding midwifery-led units (FMU):
  - Stroud Maternity Unit at Stroud General Hospital (includes 6 postnatal beds)
  - Cheltenham Birth Unit at Cheltenham General Hospital
- Home birth
- A consultant-led unit in the Women's Centre at Gloucestershire Royal Hospital (intrapartum care in a delivery suite, and a combined antenatal/postnatal maternity ward)

Cheltenham's birth unit has been temporarily closed since 2022, as have the postnatal beds in Stroud maternity unit, both due to midwifery shortages and in order to provide 1:1 care in labour (a key safety metric in maternity care) across services in Gloucestershire. In November 2025, the home birth service was suspended for six months following safety concerns raised by staff. This decision was made after careful consideration to ensure the safety of mothers, babies, and staff.

The key maternity services provided across the county are shown in Table 1:

	Community antenatal care	Antenatal classes	Midwife-led unit	Midwife-led home birth	Consultant-led Unit	Postnatal beds		Community postnatal care (Midwifery, Health Visiting, GP)
						With medical input	Without medical input	
Cheltenham	✓	Online	✓*	✓*				✓
Cotswolds	✓	Online		✓*				✓
Forest of Dean	✓	Online		✓*				✓
Gloucester	✓	Online	✓	✓*	✓	✓		✓
Stroud	✓	Online	✓	✓*			✓*	✓
Tewkesbury	✓	Online		✓*				✓

Table 1: Gloucestershire maternity services and locations by district (as of January 2026).

*Service temporarily closed/suspended

3.3 Other services

Neonatal services

GHT's Neonatal Unit has been classified as a Local Neonatal Unit (LNU) (Level 2 equivalent). It is the largest LNU in the region with 28 cots, of which 12 are intensive care or high dependency and 16 are special care.

Health visiting and perinatal mental health

Gloucestershire Health and Care NHS Foundation Trust (GHC) provides the health visiting service and the specialist perinatal mental health service for women, babies and families across Gloucestershire. These services are actively involved in the LMNS, working closely with other stakeholders to improve the provision of seamless care and minimising the potential for conflicting advice and information to be given to women.

General Practice

Collaborative working between maternity, neonatal, health visiting services and primary care (General Practice, or GPs) is vital to ensure safety and that the needs of women, babies and their families are met. There is a contractual requirement to offer women a maternal postnatal consultation by a GP, carried out between 6 and 8 weeks postnatally.
Locally, there is a well-established maternity/GP forum as part of the LMNS, at which issues are identified and worked through, such as interoperability between IT systems and medical prescribing.

Additional family, voluntary, community and social sector support

Alongside NHS maternity care, Gloucestershire benefits from a range of family support services which provide practical, social, and mental health and wellbeing support for parents and families. These include Family Hubs, voluntary and community sector organisations (VCSOs), and private providers catering for diverse groups with varying needs and demographics.

Family Hubs are a welcoming one-stop for children and young people aged 0-19, designed to give them the best start in life. They offer opportunities for co-location with other partners and are connecting services in communities, making it easier to access services such as baby clinics and support with areas including feeding, parenting, childcare, finances and more.

Collectively, these services all aim to reduce inequalities, promote inclusion, and ensure families receive tailored help during pregnancy and early parenthood.

Maternity services: Key considerations

- Review provision of ultrasound, consultant-led clinics and specialist services across the county to ensure more equitable access where possible.
- While some integrated working has taken place between maternity services and Family Hubs / VCSOs, there is an opportunity to develop a more coordinated and strategic approach.

4. Population and births

4.1 About Gloucestershire

Gloucestershire's Integrated Care System (ICS) footprint covers Gloucestershire's county boundaries, with one ICB, one Local Authority, and two provider Trusts: Gloucestershire Hospitals NHS Foundation Trust (GHT), which provides acute services including maternity and neonatal services, and Gloucestershire Health and Care NHS Foundation Trust (GHC), which provides mental health, learning disability and community services.

In 2024 there were 5826 births registered in Gloucestershire.

The county, situated on the northern edge of the South West region, had a population of approximately 669,380 people in 2024 (Gloucestershire County Council (GCC), 2025a). This is an increase of 1.16% from mid-2023 to mid-2024, in line with the overall England and Wales population growth of 1.16% (Office for National Statistics (ONS), 2025a).

Gloucestershire is predominantly rural, with two main urban centres, Gloucester and Cheltenham. The rural nature of the county presents challenges for transport infrastructure and the accessibility of local services.

While the county is relatively affluent overall – it is in the least deprived 20% of local authorities nationally – significant pockets of deprivation exist, which can be masked by county-level data.

Gloucestershire's population pyramid, shown in Figure 1 below, indicates it has an ageing population – as shown by the wider top half of the pyramid and narrowing base – driven by people living longer and lower birth rates.

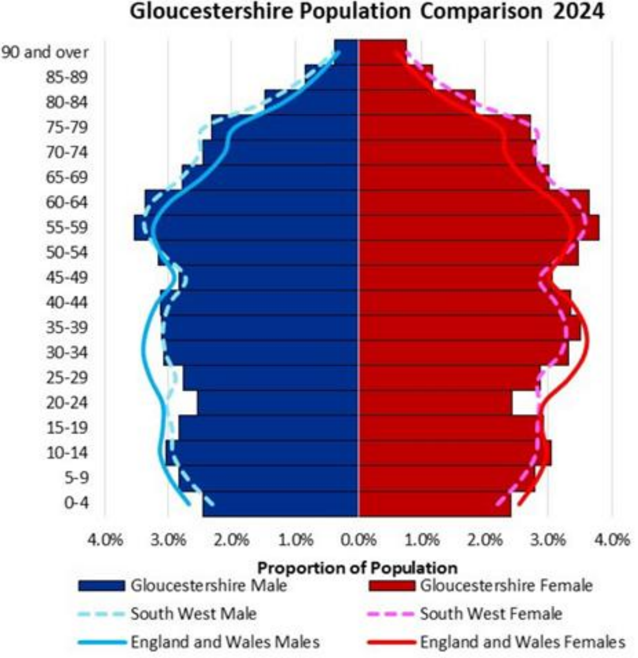
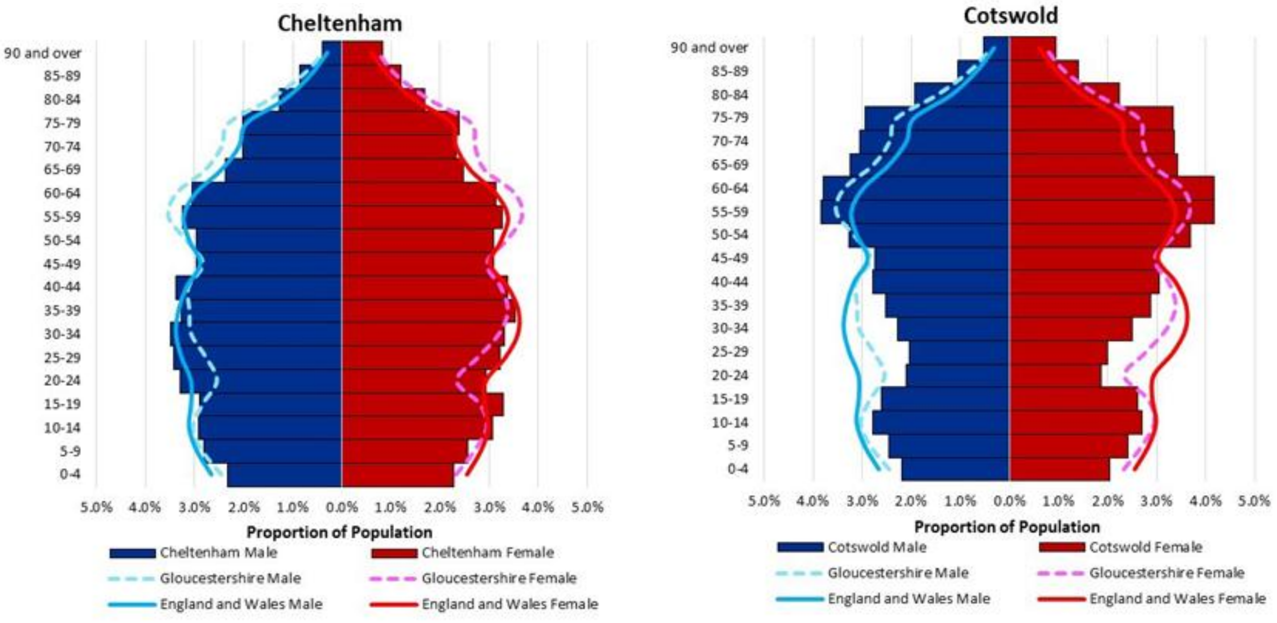


Figure 1: Gloucestershire population structure compared to South West and England, 2024 (ONS, 2024b).

Each district of Gloucestershire has a slightly different profile (see Figure 2 below) with the more urban populations seen in Cheltenham and Gloucester having a lower proportion of the population in the 65+ age groups than the Gloucestershire average, and a higher proportion of the population in the 20-24 to 35-39 age groups.



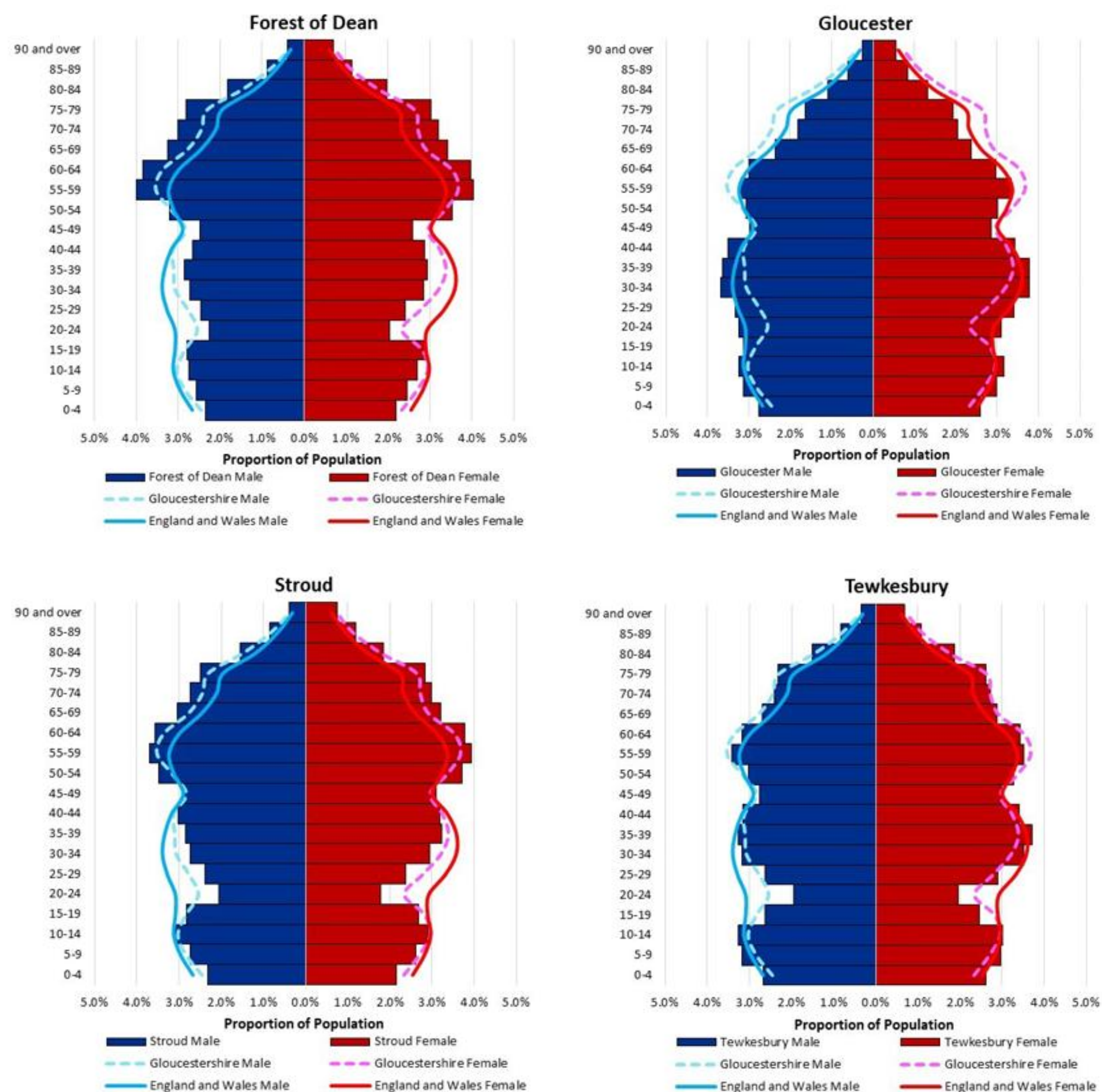


Figure 2: Gloucestershire district population structure compared to Gloucestershire and England and Wales averages for 2024 (ONS, 2024b).

Changes to future district level populations will drive differences in birth numbers. Recent population growth has predominantly been seen in suburban areas between larger towns (e.g. Tewkesbury and south of Gloucester and Stroud). Figure 3 shows the population changes in Gloucestershire between 2017 and 2022, mapped against the potential for new housing increases over the next five years. Future plans for housing[3] show large

[3] The potential housing numbers are based on allocations and commitments. **Allocations** refer to sites identified in local district council plans that are best suited for development. They may or may not come forward for development. **Commitments** refer to situations where planning permission has been applied for and granted. Neither **allocations nor commitments** can absolutely predict future housing.

developments are concentrated around Tewkesbury and Cirencester (as denoted by the stars in Figure 3) – although it should be noted that these are potential developments only.

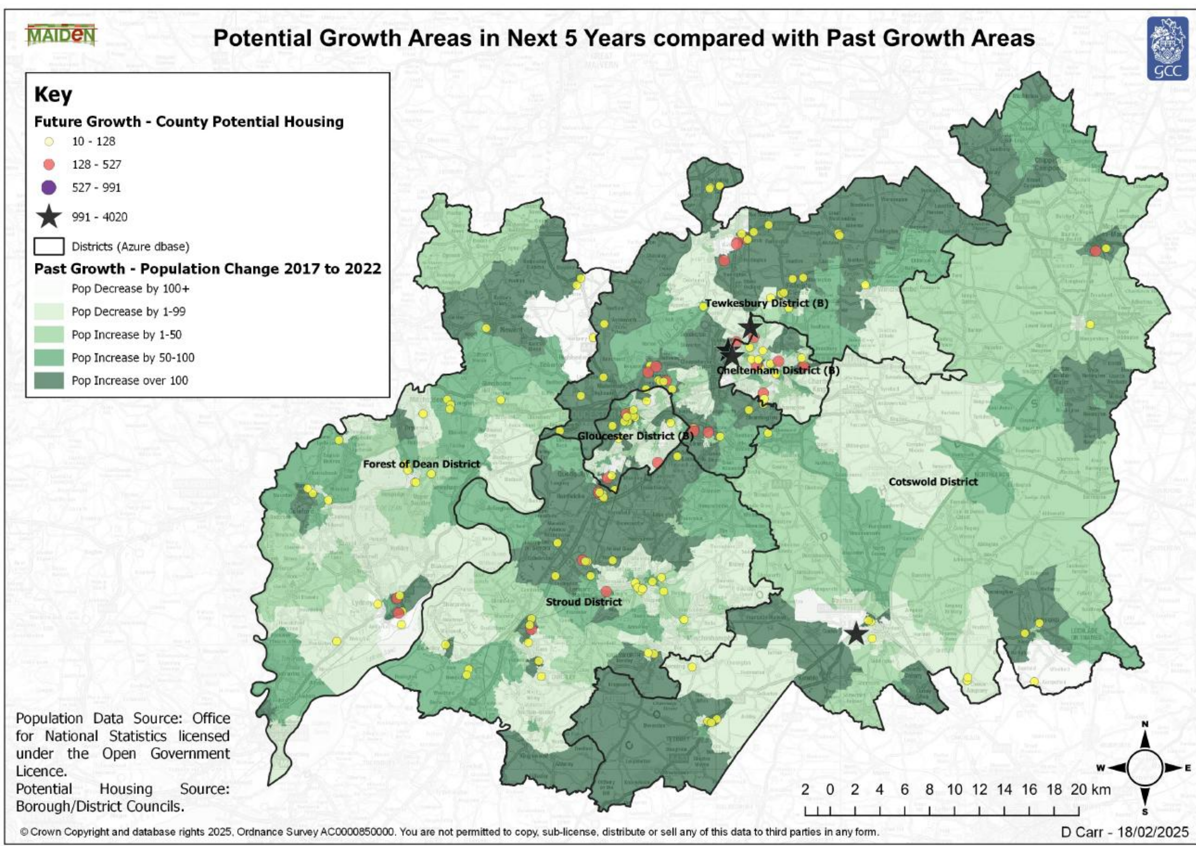


Figure 3: Potential growth areas in Gloucestershire for 2025-29 compared with growth areas in 2017-22 (ONS, 2025b, and Borough/District Councils).

The impact of housing growth is not directly built into national future population projections or forecasts for the numbers of births (see Birth rates, section 4.3). However, housing plans do respond to these projections.

4.2 Fertility rates

As of 2024, the UK's total fertility rate (TFR) stood at 1.41 children per woman, continuing a long-term decline from 1.91 in 2012. The latest population projections suggest that this lower rate will be sustained, with only slight increases over the next 20 years. The forecast TFR nationally is 1.45 in 2047, with variant projections (which provide alternative forecasts to account for different migration levels, among other factors) suggesting a range from 1.25 (low) to 1.65 (high) (ONS, 2025c).

Gloucestershire's fertility rate has declined in line with national averages and was 1.44 in 2024. The data (see Table 2) indicates Cheltenham has the lowest fertility rate at 1.29.

Local Authority	Total Fertility Rate (2024)
Cheltenham	1.29
Cotswold	1.43
Forest of Dean	1.68
Gloucester	1.45
Stroud	1.36
Tewkesbury	1.55

Table 2: Gloucestershire Total Fertility Rate by District (ONS, 2025c).

Projected fertility rates suggest that birth rates in Gloucestershire are likely to be relatively stable in the medium to long term.

4.3 Birth rates

The trend in live births in Gloucestershire overall follows the national picture. Compared with the early 1990s, birth rates in the county were lower in the late 1990s and early 2000s. Higher rates were seen again between 2006-2016, with 6,739 live births in 2016. Since then, rates have decreased and plateaued at just over 5,800 in each of the three years from 2022-24:

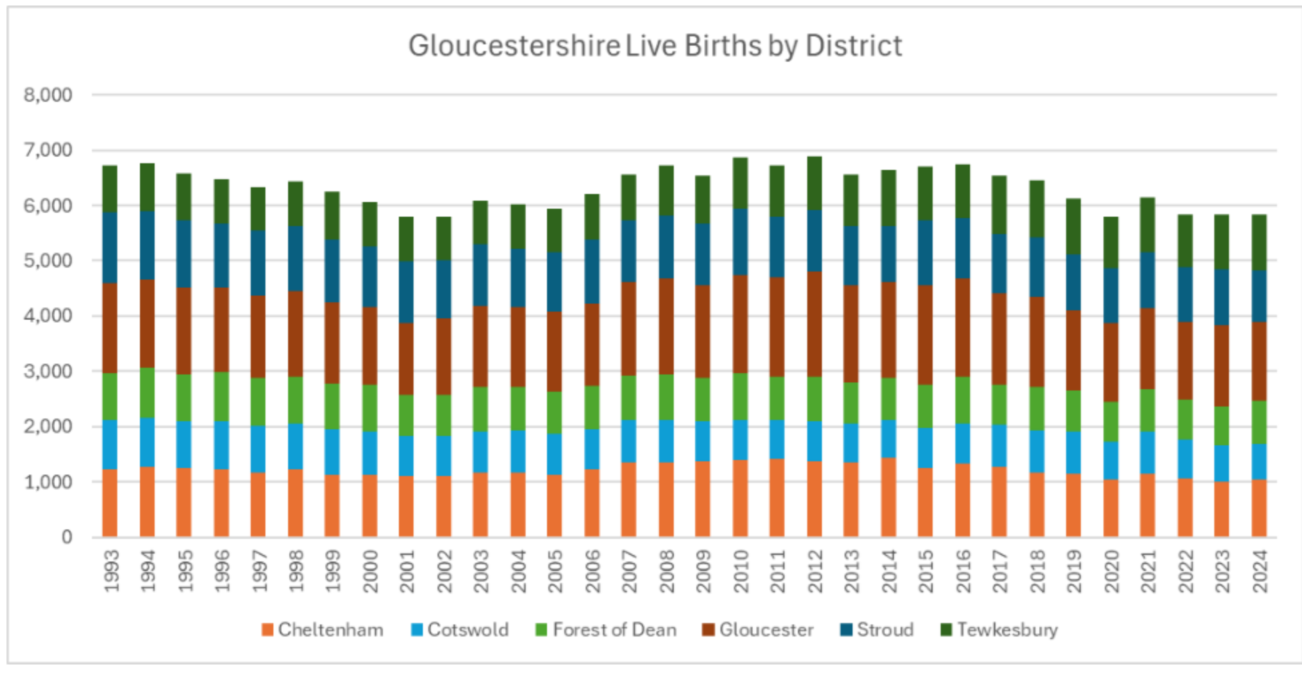


Figure 4: Live births in Gloucestershire, 1993-2024 (ONS, 2025d).

Latest population projections based on the 2021 Census (ONS, Census 2021) and other demographic trend data including the fertility rate projection, suggest that deaths and births nationally will be at similar levels to each other over the next 10 years, with deaths then exceeding births beyond this point. (See Figure 5.) Population growth is expected to be driven by higher international migration, with total fertility rate declining slightly and then stabilising, as outlined in section 4.2. The local level projections for Gloucestershire suggest that at a county level, births will be relatively static until 2032, then there will be a modest

increase (ONS, 2025b). Figures 5 and 6 below show the county and district positions using the principal population projection, with upper and lower limits defined by highest forecast migration, and zero net migration, respectively:

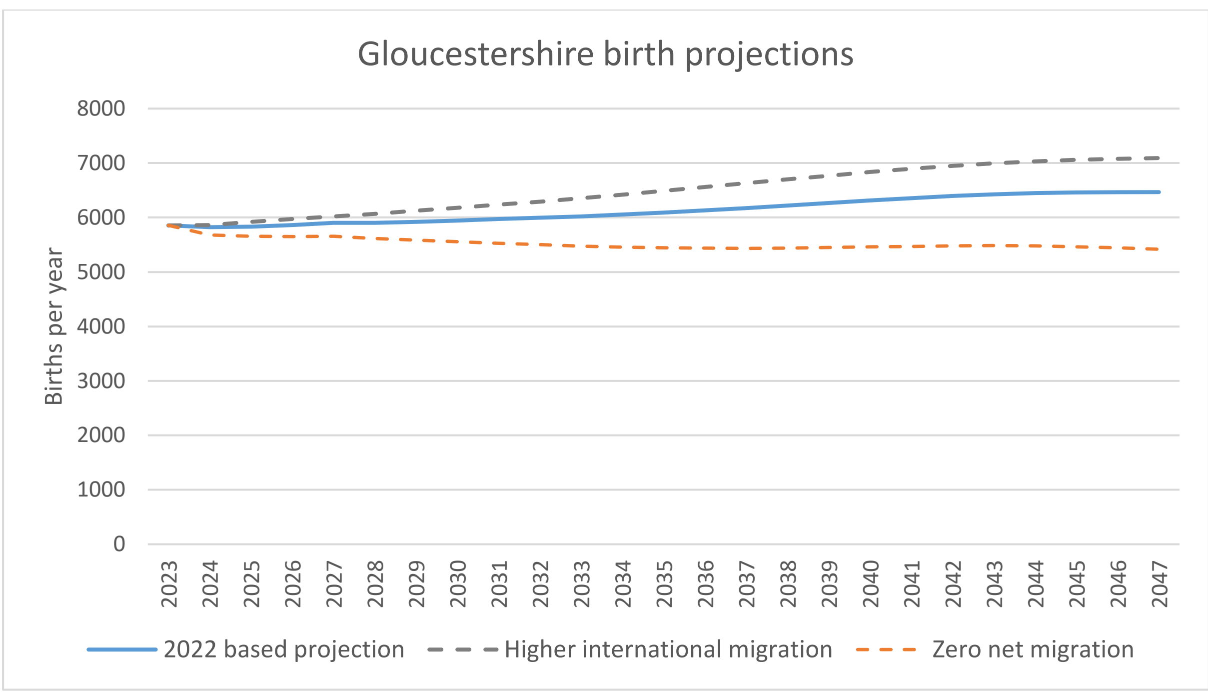


Figure 5: Gloucestershire birth projections. Main projection is the principal projection from the 2022-based subnational projections. Upper and lower bounds indicate projections for high international net migration (upper bound) and zero net migration (lower bound) as forecast by ONS[4] (ONS, 2025b).

[4] Net migration is the difference between the number of people coming to live in the UK (immigration) and the number of people leaving to live elsewhere (emigration), for 12 months or more. When more people are arriving in the UK than leaving, net migration is above zero and so adds to the population. ONS long-term international migration statistics include estimates of immigration, emigration and net migration.

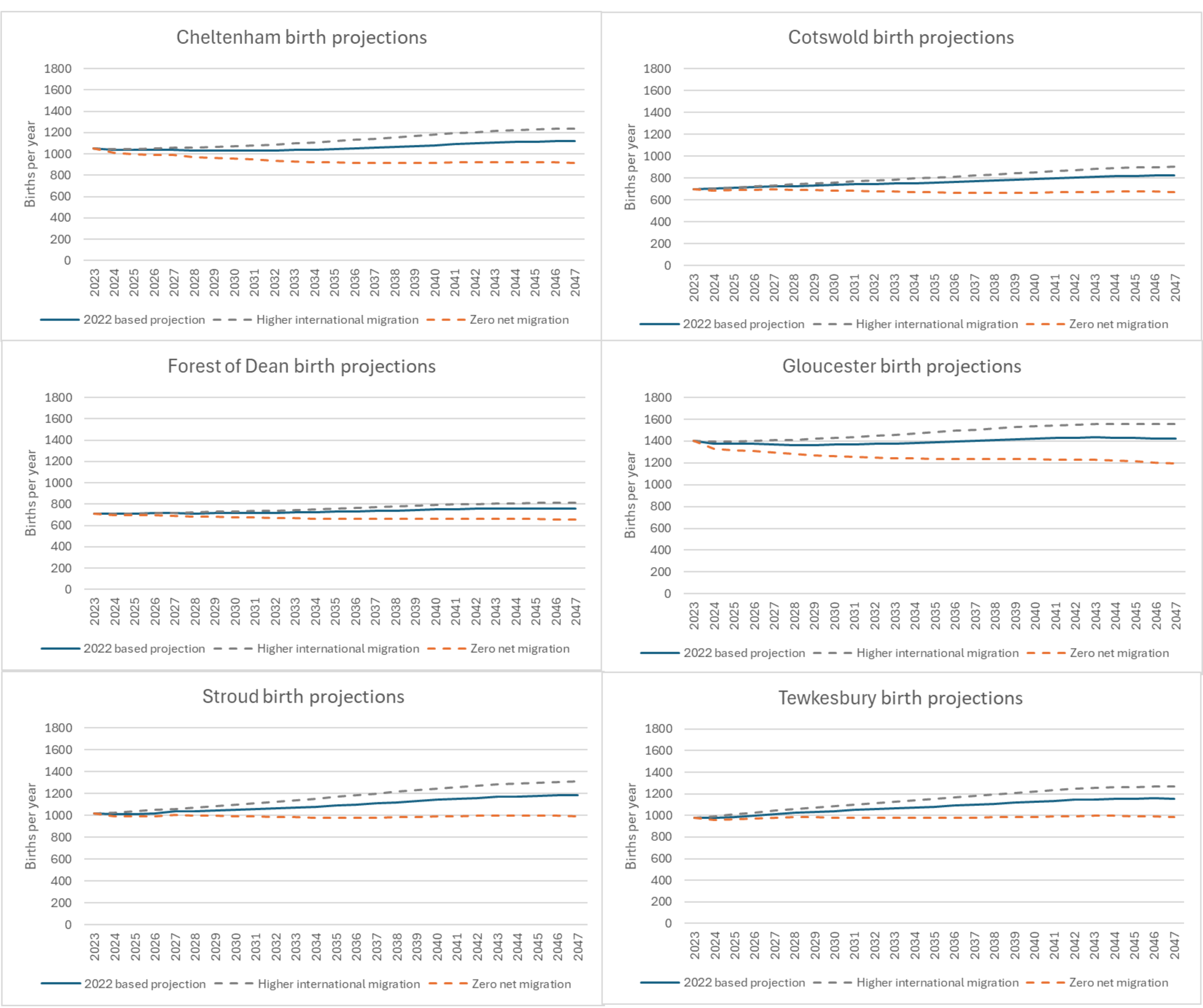


Figure 6: Gloucestershire district birth projections. Main projections show the principal projection from the 2022-based subnational projections. Upper and lower bounds indicate projections for high international net migration (upper bound) and zero net migration (lower bound) as forecast by ONS (ONS, 2025b).

Gloucester continues to be forecast to have the highest number of births, although the greatest increases in birth numbers are seen away from the two urban centres – most specifically, in Tewkesbury, Stroud and the Cotswold districts. See also Table 3:

Local Authority	2023	2032	% change 2023-2032	2047	% change 2023-2047
Cheltenham	1050	1034	-2%	1119	7%
Cotswold	695	744	7%	825	19%
Forest of Dean	712	719	1%	758	7%
Gloucester	1401	1373	-2%	1421	1%
Stroud	1019	1068	5%	1184	16%
Tewkesbury	979	1057	8%	1157	18%
County total	5855	5995	2%	6464	10%

Table 3: Summary of projected birth numbers and proportion changes by district in Gloucestershire from 2023 to 2047 (ONS, 2025b).

Population and births: Summary

Gloucestershire's maternity population sits within a single ICS footprint covering one ICB, one Local Authority and two provider trusts. The county has a mix of urban and rural areas, and although it is generally affluent, there are pockets of significant deprivation. Fertility and birth rates have declined in line with national trends, with overall births expected to remain relatively static until the early 2030s before a modest increase with district-level variation.

Population and births: Key considerations

- Ongoing monitoring of housing and population changes will be required to ensure service provision meets the needs of women in the future.
- Fertility rates are expected to remain stable, so overall demand for maternity services will not decrease (although it may increase). Service configuration should be reviewed regularly to ensure it reflects population changes and continues to meet evolving needs.

5. Birth data and trends

This section provides an overview of birth data and emerging trends in Gloucestershire, drawing on national and local datasets to highlight changes in birth rates, place and method. These data help to contextualise current and future demand on maternity services and identify areas requiring focused attention.

5.1 Midwifery-led births

Women who meet the criteria for a midwifery-led birth (i.e. those who have a low-complexity pregnancy and reach 37 weeks' gestation) – either at home (once the home birth service is operational again) or in a midwifery-led facility – are offered this option. NICE Guidance (NICE, 2025a) recommends that midwives:

- Advise low-risk multiparous women (women who have had at least one previous birth) that planning to give birth at home or in a midwifery-led unit (freestanding or alongside) is associated with a lower rate of interventions and the outcome for the baby is no different compared with a consultant-led unit.
- Advise low-risk primiparous women (women who have not had a previous birth) that planning to give birth in a midwifery-led unit (freestanding or alongside) is associated with a lower rate of interventions and the outcome for the baby is no different compared with a consultant-led unit. Explain that if they plan birth at home, there is a small increase in the risk of an adverse outcome for the baby.

Women with more complex medical and/or social factors in pregnancy are advised to birth in the consultant-led unit. However, women with complexities who want to birth in a birth unit (for example, if they have a BMI of over 30 or have had a previous caesarean section) may be supported to birth at Gloucester birth unit. This would be considered 'care outside of guidance' and would be based on individual circumstances, requiring discussions in the birth options clinic. (See also section 5.7, 'Births outside of guidance'.)

Local position

The proportion of births under midwifery-led care (MLC) (i.e. those in birth units and at home) in Gloucestershire has declined from 28.8% (number = 1669) of all births in 2019, to 16.3% (n=874) in 2024, as the requirement for consultant-led care has increased (see section 5.3 for more on consultant-led care). Figure 7 shows this change:

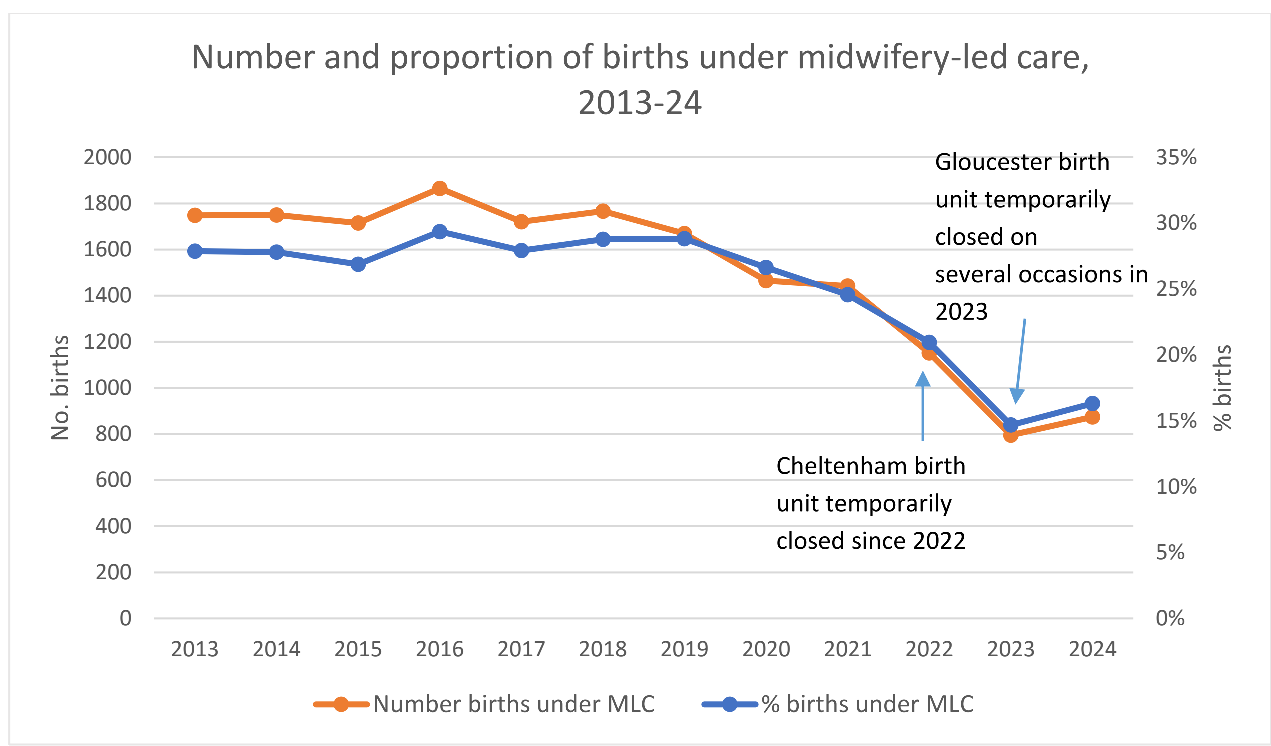


Figure 7: Number and proportion of births under midwifery-led care, 2013-2024 (Local data, Gloucestershire Hospitals NHS Foundation Trust).

5.1.1 Birth units

Local position

Births in the county's birth units overall have declined in recent years, especially since the COVID-19 pandemic. However, it is important to note that the county's birth rate has also declined since 2016, so some reduction in numbers birthing in a birth unit would be expected. The proportion of births in birth units is shown in Figure 8, and Table 4 shows the actual numbers. The data shows the following:

- Birth unit usage was fairly stable until 2020.
- In 2019, 25.9% (n=1498) of all births within Gloucestershire Hospitals Trust were in one of the county's birth units. 16.5% (n=958) of all births were in Gloucester birth unit, 5.1% (n=298) were in Cheltenham, and 4.2% (n=242) in Stroud.
- By 2024, births in the birth units had decreased to 14.9% (n=798) of all births. 13.2% (n=705) of all births were in Gloucester birth unit, 0 were in Cheltenham, and 1.7% (n=93) in Stroud.

As previously mentioned, Cheltenham birth unit has been temporarily closed since 2022 due to midwifery shortages. There were short-term relocations of Gloucester birth unit to the delivery suite throughout 2023, in particular in June and July that year, due to staffing shortages which were seen across the country. This led to the proportion of births taking place in midwifery-led birth units declining steeply that year. As the staffing position improved in 2024, Gloucester birth unit remained open and subsequently the number of women giving birth there began to increase in 2024, although numbers have not returned to pre-pandemic levels.

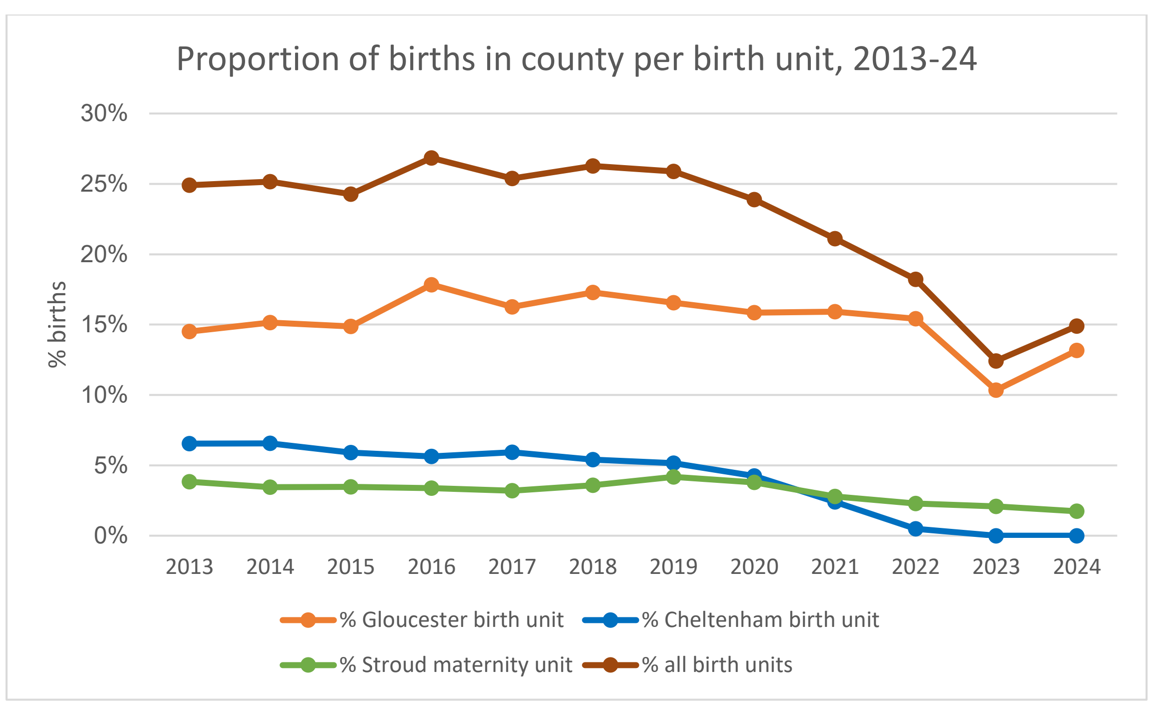


Figure 8: Proportion of births within Gloucestershire Hospitals NHS Foundation Trust taking place in birth units, 2013-24 (Local data, Gloucestershire Hospitals NHS Foundation Trust).

	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
No. Gloucester birth unit	910	954	949	1133	1001	1061	958	872	933	848	560	705
No. Cheltenham birth unit	411	413	377	358	365	332	298	233	141	27	0	0
No. Stroud maternity unit	241	217	222	214	197	220	242	209	164	126	113	93
No. all birth units	**1562**	**1584**	**1548**	**1705**	**1563**	**1613**	**1498**	**1314**	**1238**	**1001**	**673**	**798**
Total births	**6273**	**6297**	**6380**	**6352**	**6159**	**6139**	**5789**	**5501**	**5865**	**5497**	**5418**	**5359**

Table 4: Number of births within Gloucestershire Hospitals NHS Foundation Trust taking place in birth units, 2013-2024 (Local data, Gloucestershire Hospitals NHS Foundation Trust).

5.1.2 Home births

Local position

Data from Gloucestershire Hospitals Trust shows that 1.4% (n=76) of births in the county in 2024 were home births. This is lower than in 2021, where 3.5% (n=203) of births in the county were recorded as home births (see Figure 9). This may represent a trend towards a decreasing number of home births overall, but this discrepancy may also be due to changes in data coding. In particular, before 2023 births recorded as home births may also have included unplanned births outside of the hospital such as babies 'born before arrival' (BBA). Further monitoring of rates of home births in the county is needed to assess for trend.

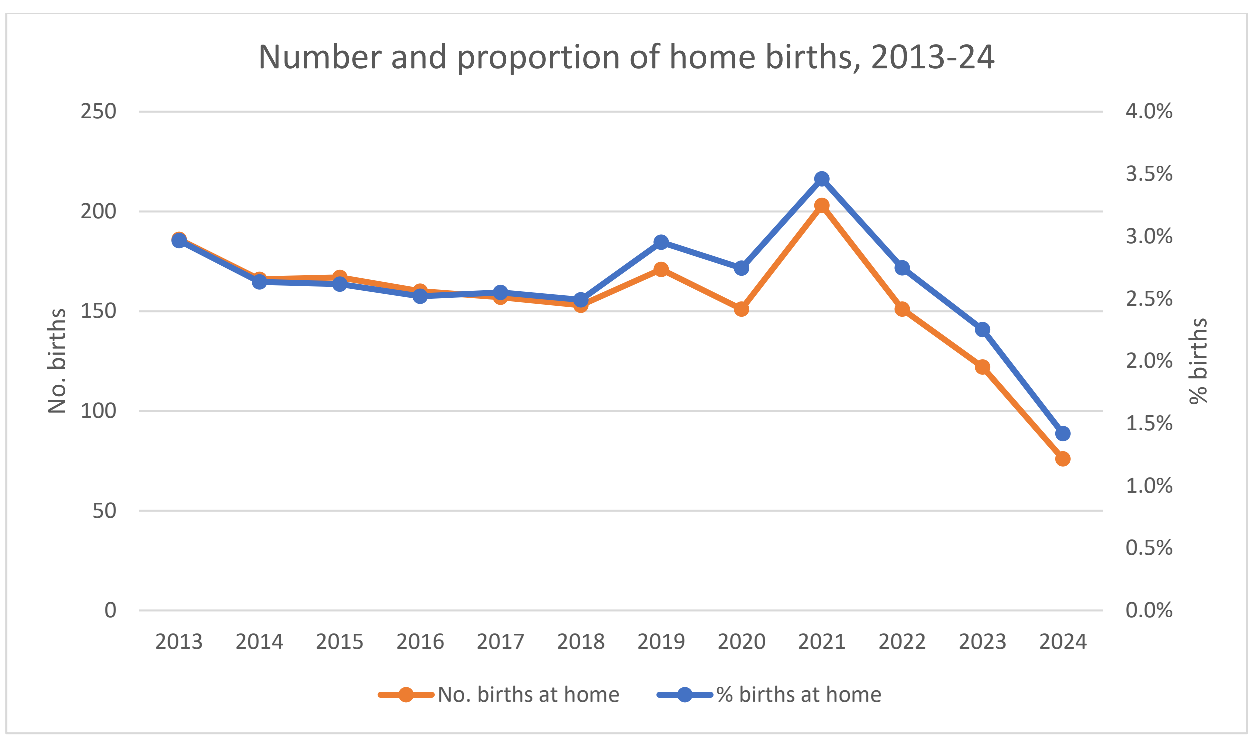


Figure 9: Number and proportion of all births in the county taking place at home, 2013-2024 (Local data, Gloucestershire Hospitals NHS Foundation Trust).

5.2 Transfers from midwifery-led care settings to the consultant-led unit

National position

The Birthplace Cohort Study showed that nationally, for first-time mothers, there was a higher likelihood of transfer to a consultant-led unit during or immediately after birth than for mothers having second or subsequent births (Birthplace in England Collaborative Group, 2011). This is the latest data available for the national position and shows transfer rates of around 45% for planned home births, 36% for freestanding midwifery units, and 40% for alongside midwifery units. Transfers most commonly occur due to slow progress in labour, concerns about fetal wellbeing, the need for pain relief that is not available in the planned setting, or complications requiring obstetric input (NICE, 2025a). For women having a second or subsequent baby, transfer rates are much lower, averaging around 10-13% across all planned birth settings.

Local position

Local transfer rates and wait times are monitored monthly via a birth unit dashboard[5] to identify any issues and pressures. Table 5 shows that in 2024/25, 36.3% of women who started labour in Gloucester birth unit were transferred during or after labour to the

[5] This data was collected manually rather than being validated by GHT through their usual data collection processes and therefore should be treated with caution. Electronic data has been collected on BadgerNet since May 2025; this is being validated and should improve reporting going forward.

consultant-led unit, 27.2% of women who started in Stroud were transferred, and 30.6% were transferred from home.[6]

Transfer from	Total no. births initiated[7]	Overall % and no. women transferred in labour or postnatally to consultant-led unit	% and no. women transferred in labour to consultant-led unit	% and no. women transferred postnatally to consultant-led unit
Gloucester birth unit (AMU)	1052	36.3% (n=382)	30.0% (n=316)	6.3% (n=66)
Stroud maternity unit (FMU)	125	27.2% (n=34)	18.4% (n=23)	8.9% (n=11)
Home	62	30.6% (n=19)	21.0% (n=13)	9.7% (n=6)

Table 5: Number and proportion of women who were transferred from a Gloucestershire birth unit or home to the consultant-led unit at Gloucestershire Royal Hospital, 2024/25 (Local data, Gloucestershire Hospitals NHS Foundation Trust).

Local provision

Gloucester birth unit is located on the same site as the consultant-led unit (on the floor above). If transfer is required from midwifery-led care to consultant-led care, this can be easily facilitated. However, if a concern arises during labour in the free-standing midwifery-led birthing units in Stroud or Cheltenham, women require transfer via ambulance.

The Ockenden Report states that ‘women who choose birth outside a hospital setting must receive accurate advice with regards to transfer times to an obstetric unit should this be necessary’ (Ockenden, 2022).

5.3 Consultant-led births

Local position

The majority of births in Gloucestershire take place in the delivery suite within the consultant-led unit at Gloucestershire Royal Hospital. In 2024, 82.4% (n=4415) of births within Gloucestershire Hospitals Trust took place on the delivery suite, an increase of 11.8% since 2019 (70.6%, n=4086). (Note: there were more births overall in 2013 than in 2024, so although there was a lower proportion of births in the delivery suite in 2013, it was actually a higher number.)

Figure 10 shows how the proportion of births in the different birth places has changed since 2013. (Note the earlier comment in the ‘Home births’ section about the change in recording of home births from 2023.) All rates were fairly static between 2013 and 2019 (other than an apparent drop in delivery suite births in 2017 and an increase in ‘other’ births, but this was

[6] Home birth data is for the period January-October 2025.
[7] Women who started in labour at the specified birth unit or home but may not have actually birthed there.

likely due to the introduction of a new electronic recording system in 2016-17). However, since 2019, delivery suite births have increased, and birth unit births decreased. Possible reasons for this are considered in the following sections.

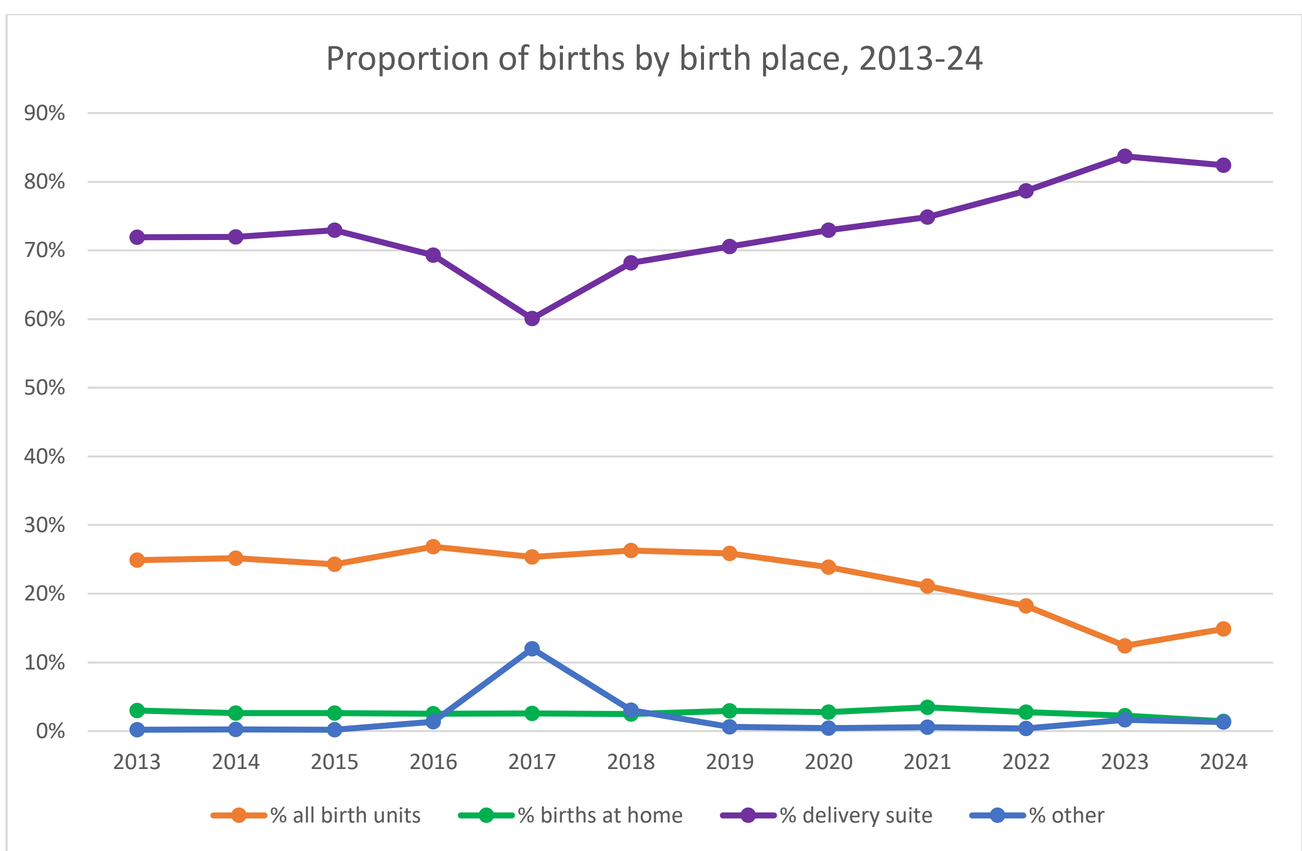


Figure 10: Proportion of births recorded by Gloucestershire Hospitals NHS Foundation Trust by birthplace, 2013-2024 (Local data, Gloucestershire Hospitals NHS Foundation Trust).

	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Birth units	1562	1584	1548	1705	1563	1613	1498	1314	1238	1001	673	798
Home	186	166	167	160	157	153	171	151	203	151	122	76
Delivery suite	4512	4532	4653	4402	3700	4186	4086	4012	4390	4325	4535	4415
Other	13	15	12	85	739	187	34	24	34	20	88	70
Total births	**6273**	**6297**	**6380**	**6352**	**6159**	**6139**	**5789**	**5501**	**5865**	**5497**	**5418**	**5359**

Table 6: Number of births recorded by Gloucestershire Hospitals NHS Foundation Trust by birth place, 2013-2024 (Local data, Gloucestershire Hospitals NHS Foundation Trust).

5.4 Induction of labour rates

Induction of labour is a medical intervention used to start labour artificially, rather than waiting for it to begin spontaneously. It is often used when there are concerns about the health of the mother or baby.

National position

Rates of induction have risen nationally. NHS England (NHSE) reported an increase in rates from 22% in 2011/12 to 33% in 2023/24, but with wide variation in rates between maternity care providers across England. Variation may be influenced by local policies and practice,

application of national guidance, geographical location, and proximity to maternity services for some women (National Maternity and Perinatal Audit (NMPA), 2025a). National guidance includes that published by NICE (NICE, 2021a) and NHSE's Saving Babies Lives Care Bundle (which recommends induction after persistent episodes of reduced fetal movements, widening of the indications to consider induction of labour, and maternal choice) (NHSE, 2025a).

Local position

The local rate of induction is similar to the national average induction rate. There has been an increase in the number of inductions taking place locally in recent years, particularly in the last four years, from 27.5% in 2021/22 to 33.2% in 2024/25 – see Figure 11 (with confidence intervals as shown by the error bars):

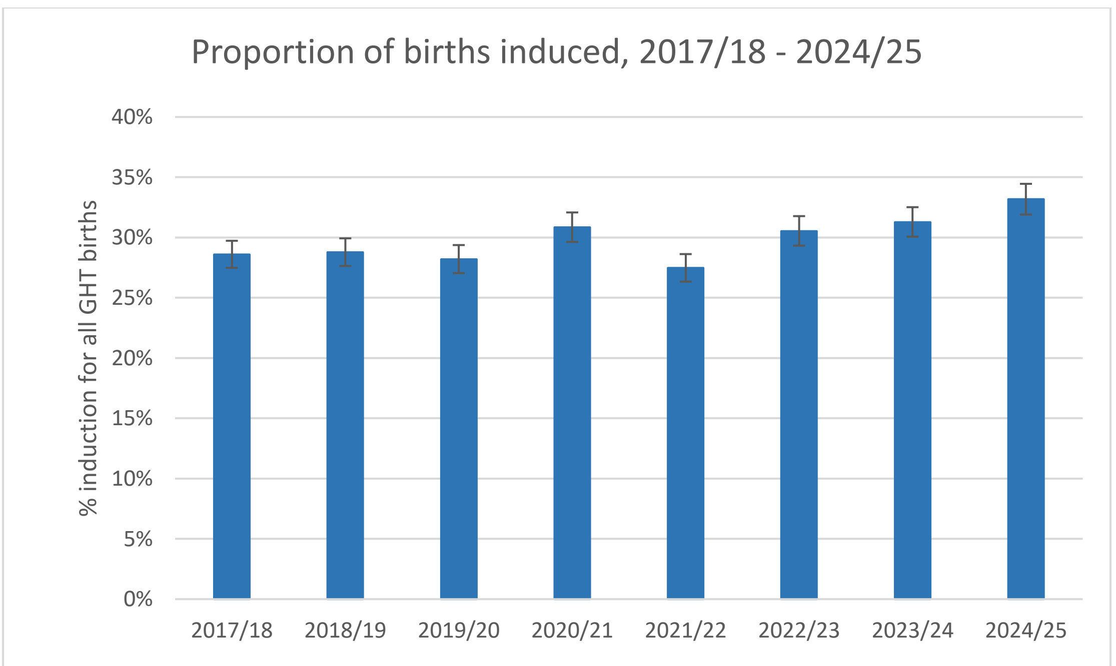


Figure 11: Proportion of births at Gloucestershire Hospitals NHS Foundation Trust where labour was induced, 2017/18-2024/25 (Local data, Gloucestershire Hospitals NHS Foundation Trust).

5.5 Method of birth

Patterns in birth method choice and outcomes can reflect variations in service provision, clinical decision-making, changes to guidance, women's health and age, and access to informed choice.

National position

Data (MSDS, NHSE, 2025b) shows that there has been a change in pattern of birth methods nationally in recent years, with a reduction in spontaneous vaginal births and an increase in both elective (planned) and emergency caesarean sections. Prior to 2024/25, spontaneous birth was the most common method of birth, but caesarean sections outnumbered spontaneous births in 2024/25 for the first time – see Figure 12:

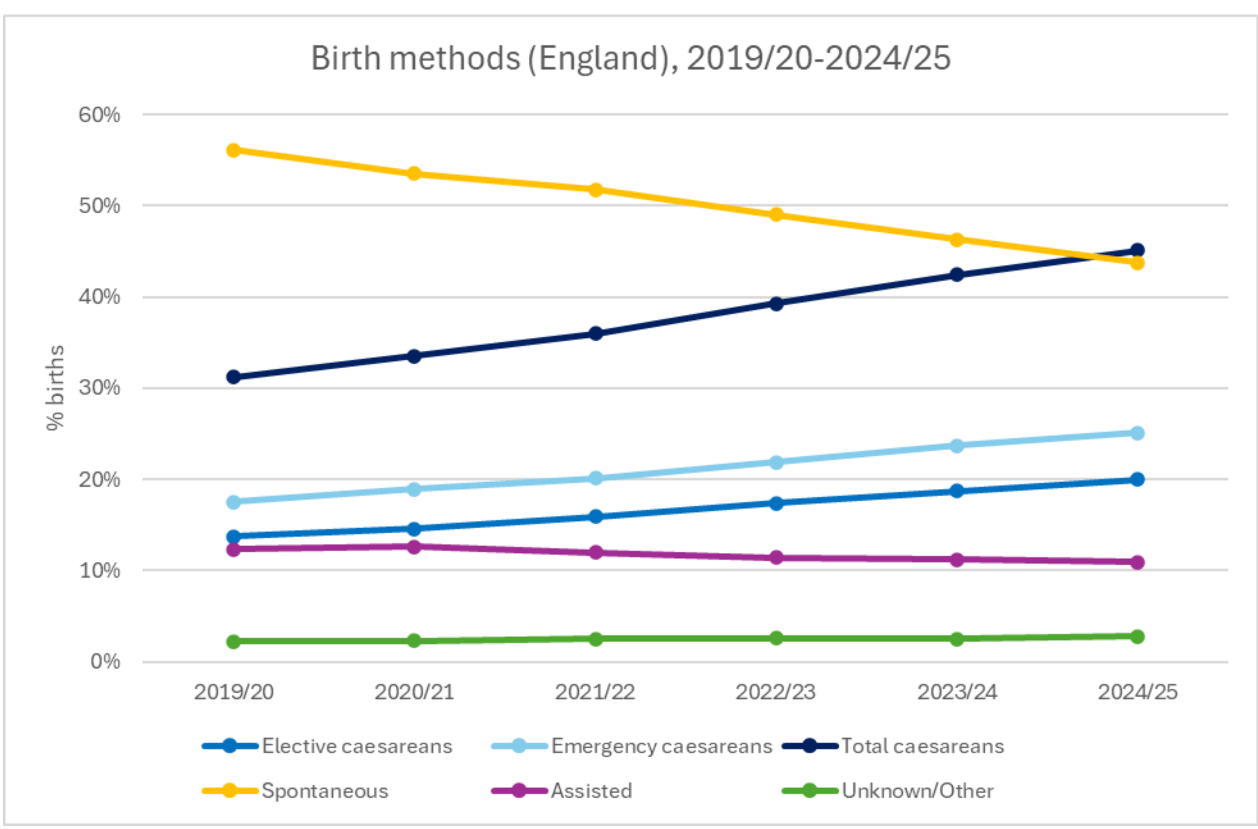


Figure 12: Proportion of births by birth method in England, 2019/20-2024/25 (MSDS, NHSE, 2025b).

Local position

The data for Gloucestershire shows a very similar picture to the national trends (see Figure 13 and Table 7), with a decline in spontaneous vaginal births particularly since 2021/22, and caesarean sections slightly overtaking spontaneous births in 2024/25 (43.4% compared with 43.2%). The next section (5.6) reviews rates of caesarean sections in more detail.

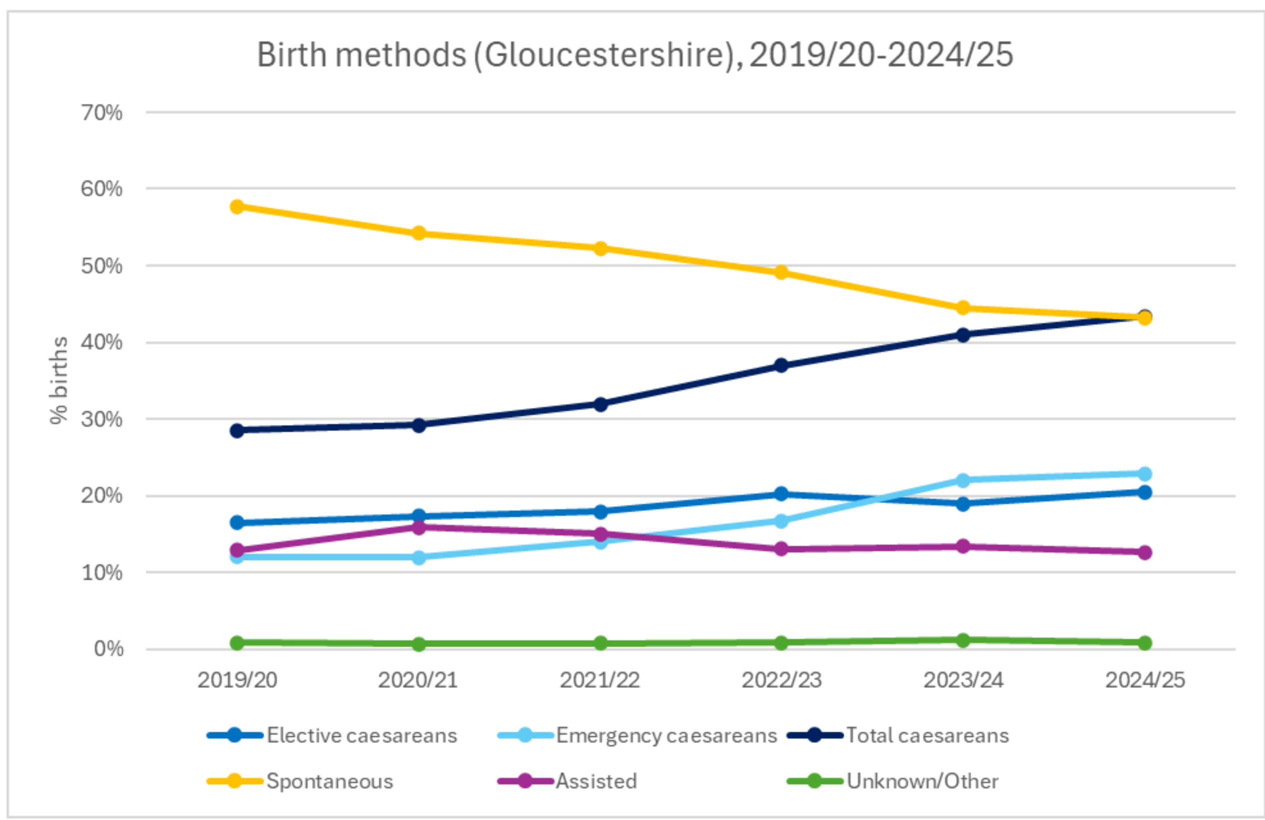


Figure 13: Proportion of births by birth method to Gloucestershire registered mothers, 2019/20-2024/25 (MSDS, NHSE, 2025b).

	2019/20		2020/21		2021/22		2022/23		2023/24		2024/25	
	Local %	National %	Local %	National %	Local %	National %	Local %	National %	Local %	National %	Local %	National %
Elective caesareans	16.5%	13.7%	17.3%	14.6%	17.9%	15.9%	20.2%	17.4%	19.0%	18.7%	20.5%	20.0%
Emergency caesareans	12.0%	17.5%	11.9%	18.9%	14.0%	20.1%	16.8%	21.9%	22.0%	23.7%	22.9%	25.1%
Total caesareans	28.5%	31.2%	29.2%	33.5%	31.9%	36.0%	37.0%	39.3%	41.0%	42.4%	43.4%	45.1%
Spontaneous	57.8%	56.1%	54.2%	53.5%	52.3%	51.8%	49.1%	49.0%	44.5%	46.3%	43.2%	43.8%
Assisted	12.9%	12.3%	15.9%	12.6%	15.0%	12.0%	13.1%	11.4%	13.4%	11.2%	12.6%	10.9%
Unknown/Other	0.8%	2.2%	0.7%	2.3%	0.8%	2.5%	0.9%	2.6%	1.2%	2.5%	0.8%	2.8%

Table 7: Proportion of births by birth method to Gloucestershire registered mothers, and to those in England, 2019/20-2024/25 (MSDS, NHSE, 2025b).

5.6 Caesarean section rates

Reasons for caesarean sections

There are different reasons for caesarean sections (NHS, 2017):

- Emergency caesarean sections: decided on during labour when urgent intervention is needed, commonly due to slow progression, fetal distress, or other complications. These are categorised by urgency.
- Elective caesarean sections: planned procedures, typically scheduled from 39 weeks' gestation, often due to medical indications such as breech presentation, placenta praevia, or previous caesarean.
- Maternal request caesarean sections: chosen by women without a clinical indication. NICE guidance supports this option following informed discussions about risks and

benefits (NICE, 2025b). (These are included under 'elective caesarean sections' in the breakdown of data by birth method.)

Impact

Risks associated with caesareans include increased likelihood of Placenta Accreta Spectrum (PAS), major obstetric haemorrhage, and hysterectomy, as well as complex surgical requirements and multidisciplinary care planning. Higher caesarean rates lead to more women undergoing multiple future caesarean deliveries, which introduces substantial complexity and risk. There is also suggestion of possible associations between elective caesarean and altered risk profiles for certain health conditions later in life (Sandall et al., 2018). Women are provided with information on the risks and benefits associated with caesarean sections.

Global and national position

Globally, caesarean section rates continue to rise, particularly in higher-income countries (Betran et al., 2021). This trend is reflected nationally, with caesarean births increasing from 31.2% in 2019/20 to 45.1% in 2024/25, as shown previously in Figure 13 and Table 7 (section 5.5) (MSDS, NHSE, 2025b).

Although the exact reasons for the increase in caesarean section rates are not yet known, experts have attributed the rise to 'demographic trends, including more women giving birth later in life, rising obesity, and an increase in pre-existing maternal conditions. These factors contribute to more complex pregnancies, particularly among women from ethnic minority groups and those experiencing deprivation' (European Medical Journal, 2025). The 'increasing proportion of pregnancies that are complex' is acknowledged by the Royal College of Midwives (Royal College of Obstetricians and Gynaecologists, 2025a) as a factor in changing birth methods, in particular rising caesarean sections. Furthermore, a significant factor in the rise in elective caesarean sections is likely to have been the recommendation from the Ockenden Report that all NHS Trusts must ensure women have 'access to accurate information to enable informed choice of…mode of birth, including maternal choice for caesarean delivery' (Ockenden, 2020; Ockenden, 2022).

Local position

Rates in Gloucestershire have risen from 28.5% in 2019/20 to 43.4% in 2024/25 (see Figure 14), representing an increase of 14.9%, higher than the national increase of 13.9%.

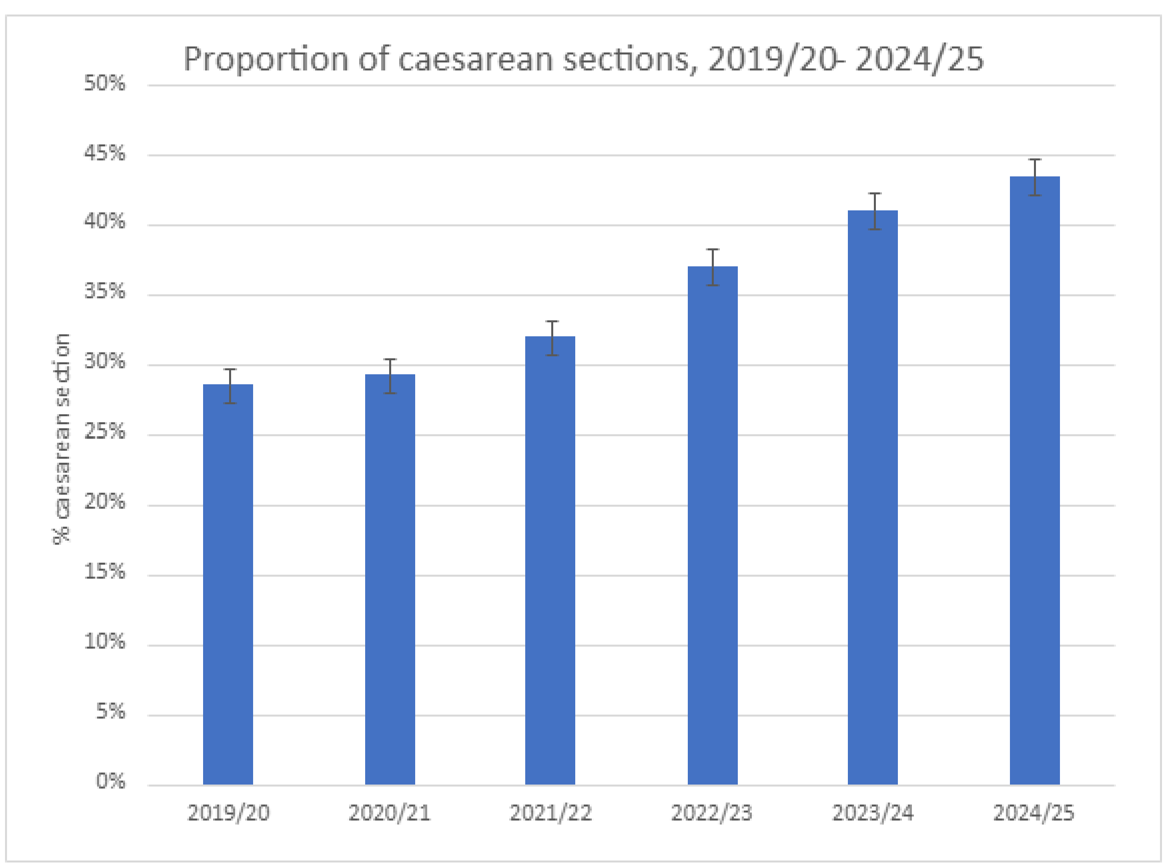


Figure 14: Proportion of all births to Gloucestershire mothers where the method was either elective or emergency caesarean section, 2019/20-2024/25 (MSDS, NHSE, 2025b).

This rise locally has been predominantly driven by *emergency* caesarean sections, which rose by 10.9% between 2019/20 and 2024/25, whereas *elective* caesarean sections rose by 4.0% – see Table 8:

	Emergency	Elective
2019/20	12.0%	16.5%
2020/21	11.9%	17.3%
2021/22	14.0%	17.9%
2022/23	16.8%	20.2%
2023/24	22.0%	19.0%
2024/25	22.9%	20.5%

Table 8: Proportion of all births to Gloucestershire mothers where the method was either elective or emergency caesarean section, 2019/20 - 2024/25 (MSDS, NHSE, 2025b).

However, this pattern of a greater increase in emergency sections compared with elective sections is not the same as the national trend, which saw more of a similar rate of increase between emergency and elective sections: 7.6% increase for emergency sections and 6.3% for elective sections. It is unclear as to the reason for the difference between local and national increases in rates.

Local provision

The continued increase in caesarean section rates has implications for service provision. The current infrastructure in maternity services may not provide adequate support for the rising number of caesarean sections in the future: feedback from local clinicians indicates that rising demand now exceeds the theatre capacity to efficiently manage both elective and emergency caesarean sections with the current infrastructure. As a result, women may experience delays to elective or planned procedures when emergencies take priority. Increasing clinical complexity also contributes to this pressure, as women often require longer theatre time, and this can place additional strain on overall theatre capacity.

In addition to impacting theatre availability, there is an impact on recovery space availability and postnatal care, and on longer-term maternal and child health outcomes. The latter is a growing national concern, and further research and engagement is required to understand how this will impact people and services in the future (Sandall et al., 2018).

Post-operative care for caesarean births is distinct from routine postnatal care and requires specific resources and expertise. Maternity ward staffing models do not necessarily reflect the complexity of post-operative abdominal surgery. This includes the need for surgical nursing and midwifery skills to manage wounds, monitor complications, and administer an increased range of medications.

5.7 Births outside of guidance

A birth outside of guidance refers to a situation where a woman makes a decision or has a birth plan which differs from the recommended care outlined in local or national guidance. Reasons for women choosing to birth outside of guidance are varied, from those with raised BMI wanting to birth in an alongside midwifery-led birth unit, to women requesting care so complex (e.g. breech twins at home) that it is against medical advice. Often women make these decisions due to previous trauma and mistrust of the maternity service (McAllister and Litchfield, 2025).

Impact

Births outside of guidance have resource implications: they often involve longer conversations with women to provide them with all the information they need to help develop their birth plan. In addition, midwives have ‘reported fear of poor birth outcomes or of professional accountability for poor outcome’ (McAllister and Litchfield, 2025).

National position

The National Midwifery Council has reported an increasing number of women making choices outside of standard care pathways (National Midwifery Council (NMC), 2025). This has been recognised by the Royal College of Midwives (RCM) which has recently published guidance for staff (Royal College of Midwives, 2022).

Local position

Data for births recorded as ‘care outside of recommended guidelines’ has been recorded locally only since June 2023 when the new records system (BadgerNet) was introduced, so complete years are available only for 2024 and 2025. Numbers for these years are shown in Figure 15:

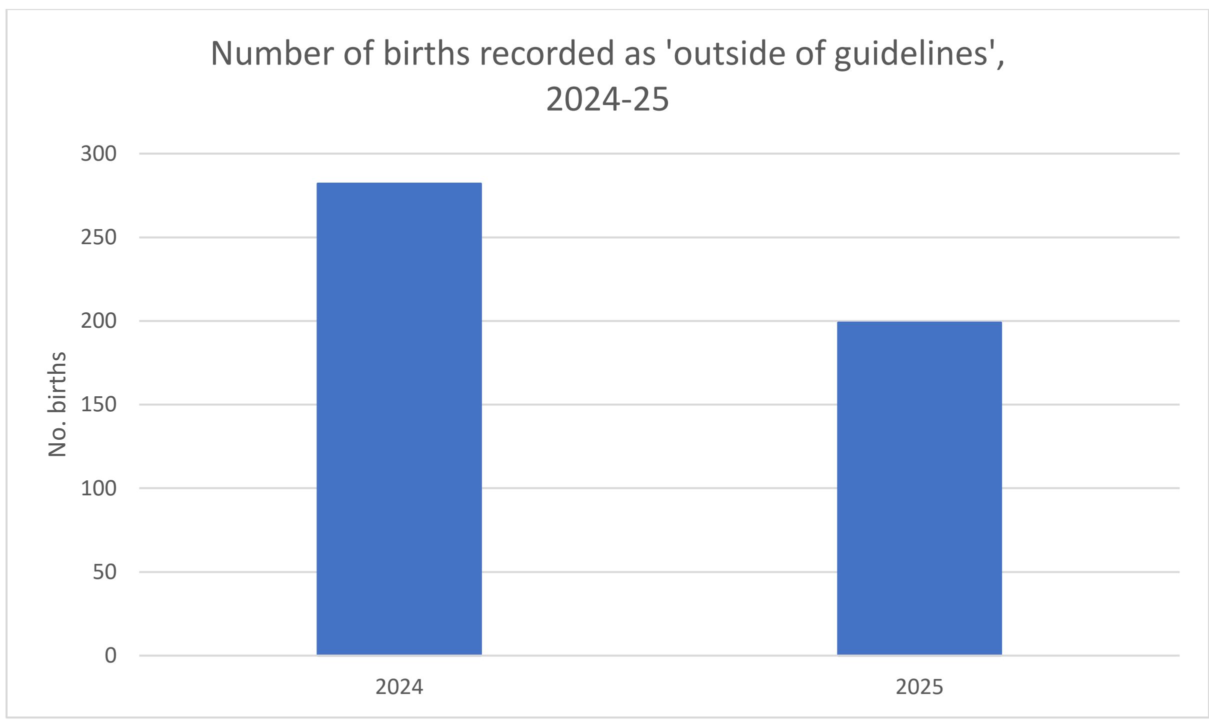


Figure 15: Recorded ‘births outside of guidelines’, 2024-2025 (Local data, Gloucestershire Hospitals NHS Foundation Trust).

The numbers in Figure 15 equate to 5.3% of births in 2024, and 3.9% in 2025.

Local provision

Women in Gloucestershire who are considering requesting care which may be determined as outside of local guidance are referred to the ‘birth options huddle’ by their midwife. This is a meeting of various maternity healthcare professionals to discuss how to support the woman's decision in the safest way possible and make an individualised plan after considering the risks and options.

5.8 Out of county births

Most women from Gloucestershire give birth in the county. Latest figures indicate that fewer than 10% of births to Gloucestershire residents are in out of county settings. The number of women from other areas who come to Gloucestershire is small: around 25 births out of every 1000 at Gloucestershire Hospitals NHS Foundation Trust are to women from out of the county. Figure 16 shows the rate of women from out of county birthing in Gloucestershire, and the rate of women from Gloucestershire birthing out of county.

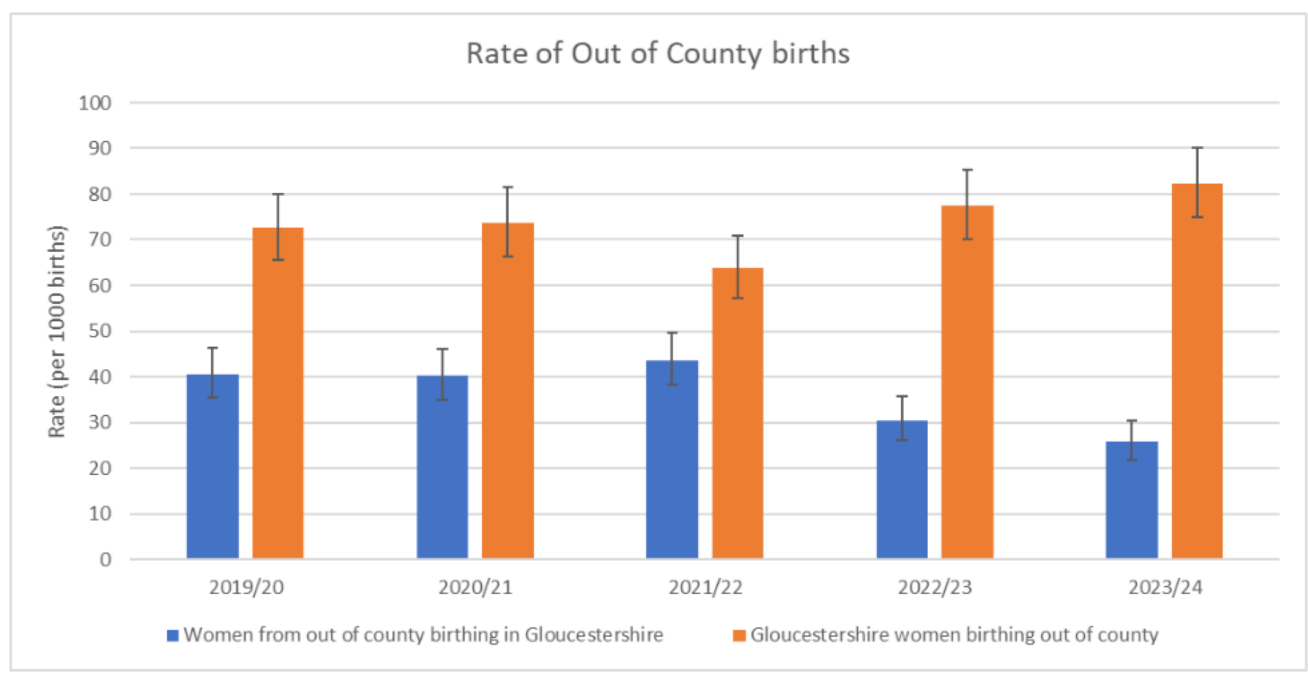


Figure 16: Rates of Gloucestershire registered mothers birthing out of county, and mothers from other counties birthing in Gloucestershire, 2019/20-2023/24 (MSDS, NHSE, 2025b).

Table 9 shows the breakdown of Gloucestershire residents who birthed within Gloucestershire Hospitals NHS Foundation Trust and elsewhere:

Provider	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25
GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST	92.7%	92.6%	93.6%	92.3%	91.8%	90.7%
GREAT WESTERN HOSPITALS NHS FOUNDATION TRUST	3.7%	4.1%	3.1%	3.9%	3.7%	3.0%
NORTH BRISTOL NHS TRUST	1.4%	1.2%	1.3%	1.6%	1.9%	3.1%
OXFORD UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	0.5%	0.5%	0.5%	0.6%	0.5%	0.5%
ROYAL UNITED HOSPITALS BATH NHS FOUNDATION TRUST	0.2%	0.2%	0.2%	0.2%	0.3%	0.1%
SOUTH WARWICKSHIRE UNIVERSITY NHS FOUNDATION TRUST	0.3%	0.2%	0.4%	0.3%	0.6%	0.8%
UNIVERSITY HOSPITALS BRISTOL AND WESTON NHS FOUNDATION TRUST	0.4%	0.5%	0.5%	0.5%	0.4%	0.7%
WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST	0.2%	0.1%	0.1%	0.1%	0.1%	0.4%
WYE VALLEY NHS TRUST	0.1%	0.2%	0.1%	0.0%	0.2%	0.3%
Other	0.5%	0.5%	0.3%	0.5%	0.4%	0.4%

Table 9: Proportion of births to Gloucestershire mothers by hospital, 2019/20-2023/24 (MSDS, NHSE, 2025b).

It is hard to draw conclusions from this data, as although there was an increase in out of county births in 2024/25 compared with 2019/20, and a corresponding decrease in women from out of county giving birth in Gloucestershire hospitals settings, these years are the period covering the COVID-19 pandemic and recovery. There has also been significant attention on maternity settings, quality of care and review of practice nationally, which may be impacting how women assess their options (see section 4.2 for more on place of birth options).

Many factors may be influencing where people choose to give birth, including needing specialist care and whether women live nearer to a consultant-led unit or birth unit in a neighbouring county (taking into account whether neighbouring areas have restrictions on accepting bookings from women out of area). In Table 9, the largest change in proportion of births at any out of county provider has been at North Bristol NHS Foundation Trust, which is

also a tertiary provider of care for premature babies or for those requiring specialist intervention. A recent review of maternity infrastructure by NHSE suggests that specialist care need will continue to rise (NHSE, 2025c).

In November 2025, two neighbouring hospital trusts (South Warwickshire University NHS Foundation Trust and Oxford University Hospitals NHS Foundation Trust) took the decision to limit referrals from expectant parents who do not reside in the counties where the hospitals are based, on grounds of safety and capacity. This will have an impact on choice for women from Gloucestershire.

Without understanding at this stage all the reasons why people are giving birth in out of county settings, we cannot understand if the changes seen over the last five years are likely to continue or stabilise.

Birth data and trends: Summary

Birth patterns in Gloucestershire show a reduction in midwifery-led births, with increasing numbers of women giving birth in the consultant-led unit. At the same time, methods of birth have changed, with rising induction rates and caesarean sections, and the latter now slightly exceeding spontaneous vaginal births. These trends have important implications for the future configuration of local maternity services.

Birth data and trends: Key considerations

- Review birth options, considering changing birth trends to ensure that there is a safe, sustainable service that balances the needs and choices of women and effective use of resources.
- Review the current staffing model to make the most efficient use of clinical resources and meet the needs of staff, and to support the changing needs and choices of the maternity population.
- Review the impact of rising rates of induction of labour on outcomes and on required staffing levels on antenatal wards and the delivery suite.
- Review the theatre and recovery capacity considering rising caesarean section rates. The larger increase in emergency caesarean sections brings a particular challenge due to requirements for rapid access to theatres and specialist staff, placing pressure on acute maternity infrastructure.
- Ensure that postnatal care teams have the appropriate skill mix and training to meet the needs of women recovering from caesarean birth and other complex deliveries. This includes surgical wound management, pain control, medication administration, and recognition of complications, alongside core midwifery skills.
- Develop a care pathway for women choosing to birth outside of guidance so the integrity of women’s choice can be maintained with safe outcomes for mothers and babies, alongside considering the wellbeing of maternity staff.
- Ensure that care can be delivered for all who need it using principles of trauma informed care. This includes making best use of debriefing and counselling services to support those with anxiety around birth and previous birth trauma.

- Regularly review the number of women giving birth outside Gloucestershire or travelling into the county to ensure any changes in acceptance criteria and need for specialist services from other providers are addressed, alongside the resource implications for Gloucestershire maternity services.

6. Preconception, antenatal and postnatal care

This section reviews the preconception, antenatal and postnatal care provided by maternity services in Gloucestershire, along with data and challenges associated with these services.

6.1 Preconception care

Impact

Preconception care encompasses the physical, mental, and social wellbeing of individuals prior to conception, aiming to optimise health outcomes for women and babies. It is a critical opportunity to identify and address risk factors that may influence pregnancy and birth outcomes, many of which, such as obesity, smoking, unmanaged chronic conditions, poor mental health, and exposure to domestic abuse, are present before pregnancy begins. Proactive intervention at this stage can reduce complications, improve fertility, and enhance maternal and neonatal outcomes, particularly for those experiencing health inequalities or social vulnerability (Khekade et al., 2023).

Local support

Women planning a pregnancy are advised to stop smoking and drinking alcohol, maintain a healthy weight, ensure they are up to date with vaccinations, and take a daily folic acid supplement until 12 weeks' gestation to reduce the risk of neural tube defects such as spina bifida (NHS, 2020a). Most women with pre-existing physical and mental health conditions would benefit from a review of their health and medications before trying to conceive. Depending on the type and complexity of health condition, this could be undertaken either within primary care or by doctors with specialist training in maternal medicine.

However, access to preconception advice and support is often inconsistent, and uptake may be influenced by factors such as deprivation, health literacy, cultural beliefs, and previous experiences of healthcare (Public Health England (PHE), 2019). It is essential to consider how preconception care is delivered locally, identify gaps in provision, and explore opportunities for integrated, equitable, and preventative approaches that support individuals before pregnancy begins, particularly those at higher risk of poor outcomes.

Not all pregnancies are planned, so in addition to considering preconception care for women planning pregnancies, it will be necessary to consider support for women who were *not* planning pregnancies and who may have pre-existing health issues or have not changed treatment in line with recommendations (e.g. taking GLP-1), and find that they are pregnant (PHE, 2018b).

Ensuring women's pre-existing medical conditions are well managed prior to pregnancy is a key recommendation of national reviews such as 'Mothers and Babies: Reducing Risk

through Audits and Confidential Enquiries' (MBRRACE) (MBRRACE-UK, 2025a). With rising comorbidity and complexity in the birthing population, resource requirements to enable this pre-pregnancy care and planning are likely to increase.

Preconception care: Summary

Preconception care is critical to optimise health outcomes for mother and baby, enabling proactive interventions, especially for those experiencing health inequalities. However, access to good preconception care can be inconsistent and it is essential to consider how it can be more equitable.

Preconception care: Key considerations

- Review preconception care provision in the county to ensure optimum health and outcomes for women and babies.
- While there are some limited condition-specific examples currently provided for (such as pre-conception care by the endocrinology service for Type 1 and Type 2 diabetes, and support for women from the fetal medicine service who have previously had termination of pregnancy for fetal abnormality (ToPFA)), there will be an increasing demand for wider pre-conception and pregnancy care for those with medical conditions beyond current funding and capacity.
- Explore opportunities for integrated, equitable, and preventative approaches that support individuals before pregnancy begins, particularly those at higher risk of poor outcomes. It is a critical opportunity to identify and address risk factors that may influence pregnancy and birth outcomes, many of which, such as obesity, smoking, unmanaged chronic conditions, poor mental health, and exposure to domestic abuse, are present before pregnancy begins.

6.2 Antenatal care

Antenatal care refers to the routine clinical support, monitoring, and information provided throughout pregnancy to promote maternal and fetal wellbeing, identify risks early, and ensure timely access to appropriate services. It may be delivered through midwifery-led care pathways for those with low-risk pregnancies, or consultant-led pathways for women requiring consultant involvement or additional monitoring. The NICE Antenatal Care Guideline (NG201) provides the national evidence-based framework underpinning this provision, outlining standards for referral, appointment schedules, risk assessment, and personalised support (NICE, 2021b).

6.2.1 Antenatal scans

During pregnancy, women are offered two ultrasound scans at a minimum:

- The first between 11+2 weeks (11 weeks and 2 days) and 14+1 weeks to confirm pregnancy viability, check for multiple pregnancies, and estimate the due date. This scan may also include combined screening for chromosomal conditions (e.g. Down's,

Edwards', and Patau's syndromes), and this is offered to all women whose pregnancy is less than 12+6 weeks.
- A second scan (from 18+0 to 20+6 weeks) screens for fetal anomalies, including heart conditions and limb abnormalities.

Beyond the routine antenatal scans, ultrasound scan access in pregnancy is important for monitoring maternal and fetal health, particularly in complex or high-risk pregnancies.

It can be most appropriate for timely access to ultrasound to be carried out in a consultant-led unit to ensure that holistic review can be provided by the most appropriate healthcare professional, such as an obstetrician. Some routine provision is provided at satellite sites.

Third trimester scanning in the UK increased significantly (around 30%) between 2016 and 2018 due to the introduction of the first Saving Babies' Lives Care Bundle in 2016, which recommended increased focus on reduced fetal movements and fetal growth restriction (Widdows et al., 2018). Ultrasound scan requirements have continued to increase due to subsequent updates to the Saving Babies Lives Care Bundle (NHSE, 2025a) and increasing complexity of pregnant women both locally and nationally.

Local provision

Capacity to meet demand for scanning at GHT has caused delays to women receiving timely antenatal scans. A plan to establish a sustainable future operating model which meets national guidance has been developed by GHT, overseen by the ICB's Enhanced Oversight Group. This group is responsible for overseeing improvements associated with the CQC inspection outcome recommendations.

The plan is in stages, including an interim solution to increase capacity and meet guidance requirements. This involved commissioning a private provider from October 2024 to boost capacity and ensure a seven-day service was established, with capacity flexing to meet key requirements, such as by offering 'urgent' slots for women who have reduced fetal movements. This has improved waiting times and scanning capacity. The plan also includes recruiting a midwife sonographer, and recruiting midwives to train as sonographers, with a timeline to have seven midwife sonographers within the service by 2027. The plan is monitored on an ongoing basis.

6.2.2 Antenatal education

Local provision

The Real Birth Company is commissioned by the NHS to provide free online antenatal education (the 'RealBirth Online Workshop') to all women and their partners in Gloucestershire, with funding until June 2027. Since the launch in July 2024, more than a quarter of pregnant women have taken up the offer of the RealBirth Online Workshop (28.3% of total bookings to GHT maternity services in the period July 2024-April 2025). There is no data describing the balance of first or second and subsequent time mothers taking up the offer of this antenatal education, but the majority of participants are expected to be first time mothers.

Of the 8 languages available, women in Gloucestershire are more likely to take the course in English (97.7% of users). 1.3% of course users have taken the class in Polish, and 1% in the other 6 languages (Arabic, Portuguese, Romanian, Sorani Kurdish, Tamil and Urdu). This is lower than the expected distribution, as 11.8% of women who birthed in Gloucestershire in 2024/25 did not have English as their first language.

There are currently no face-to-face NHS antenatal education classes led by midwives. The lack of locally devised and delivered sessions means that the antenatal education is not specific to birthing options in Gloucestershire. However, there are antenatal education sessions run by the health visiting service: one face-to-face session is offered to women which covers topics such as infant feeding, ICON ('Babies Cry, You Can Cope') (ICON, n.d.), safer sleep, baby brain development, attachment, pelvic health, and information around the local support service 'Dad Matters'.

6.2.3 Vaccinations

Vaccination during pregnancy plays a vital role in protecting both mother and baby from serious infectious diseases. In England, pregnant women are routinely offered vaccines against influenza, pertussis (whooping cough), and, since 2024, respiratory syncytial virus (RSV), ideally to be taken up between 20 and 32 weeks to also give greatest protection to the baby (NHS, 2020b).

National position

Data from the UK Health Security Agency shows that vaccination uptake among pregnant women is variable according to both the type of vaccination and the demographic group, with latest data showing 35% women nationally were vaccinated against flu, 50% against RSV and 66% against pertussis during the winter 2024/25 season (UK Health Security Agency (UKHSA), 2025).

Demographic factors like socioeconomic status and maternal health history significantly impact maternal vaccination rates, with lower rates often seen in more deprived areas and among women who have low confidence in vaccine safety. Mothers who receive pregnancy vaccines are also more likely to get their children vaccinated, highlighting a linked pattern in vaccination uptake (Danchin et al., 2018).

Local position

The local position is not known for all vaccinations, but Gloucestershire coverage for pertussis has recently been in line with the national position:

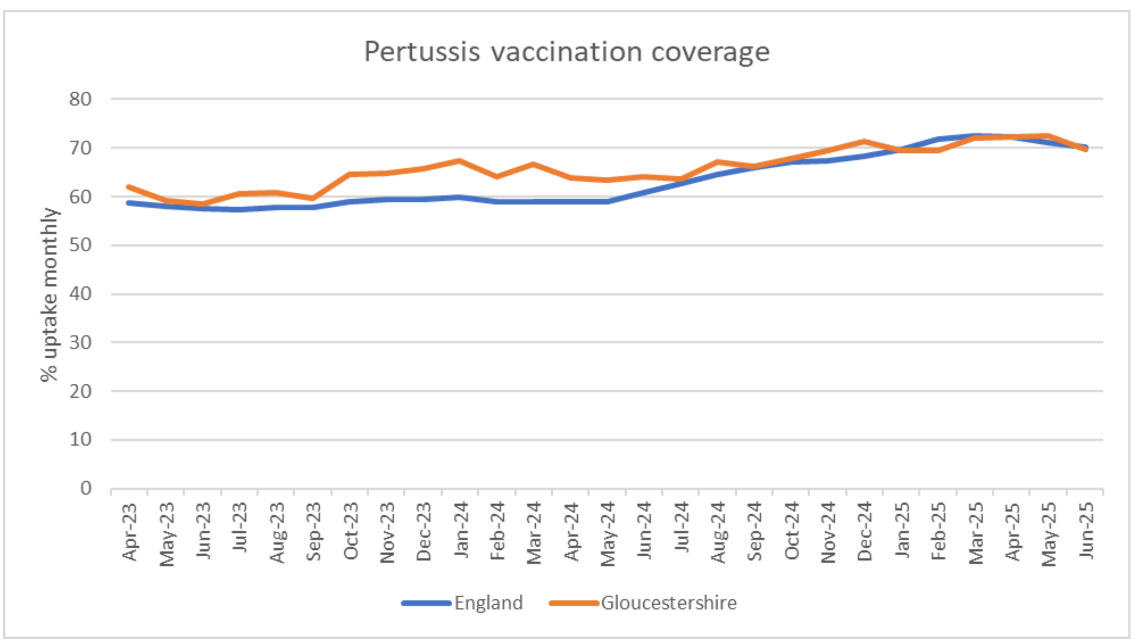


Figure 17: Prenatal pertussis vaccination coverage in England and Gloucestershire, April 2023-June 2025 (UKHSA, 2025).

In 2025/26 (current year), flu and RSV vaccine uptake in Gloucestershire in the maternity population has been higher than the national average, but lower compared to other parts of the South West. The picture in 2024-25 for flu was similar to 2025/26 (RSV not available for 2024/25). See Figures 18 and 19.

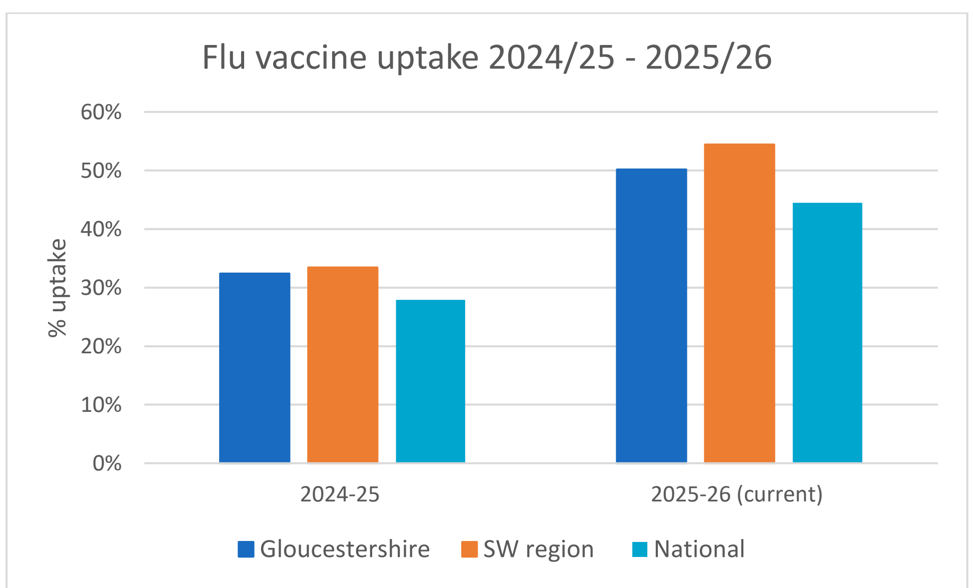


Figure 18: Flu vaccination uptake in maternity population in Gloucestershire, South West region and England, 2024/25-2025/26 (NHS Federated Data Platform, 2026).

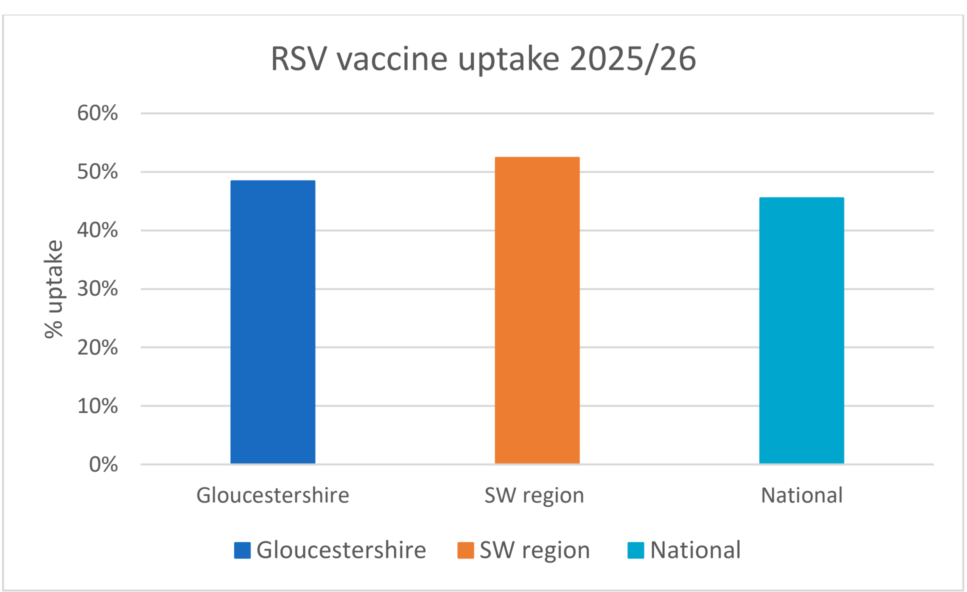


Figure 19: RSV vaccination uptake in maternity population in Gloucestershire, South West region and England, 2025/26 (NHS Federated Data Platform (2026).)

6.2.4 Digital records

Maternity records have been provided digitally via BadgerNet since 2023, and women have access to their records and personalised maternity care plans via the Badger Notes app. The app can be accessed via PC, tablet and phone. Some of the information in Badger Notes can be translated into a number of local languages, and women who are digitally excluded can be supported with access by their named midwife (see section 7.1 for more information on digital exclusion).

The use of electronic records brings significant benefits for service improvement and governance. Digital systems enable efficient data extraction for audits, performance monitoring, and clinical benchmarking, supporting compliance with national standards and local quality improvement initiatives (Barbieri et al., 2023). They facilitate real-time data analysis to identify trends, monitor outcomes, and address inequalities, while reducing reliance on manual processes that can be time-consuming and prone to error. This capability strengthens the evidence base for decision-making and supports continuous improvement across maternity services.

6.2.5 Continuity of carer

Midwifery Continuity of Carer is a model of care where women are supported by the same midwife, or a small team of midwives, throughout their maternity journey, including the antenatal, intrapartum and postnatal periods. The aim is to build a trusting relationship between women and their midwives, improve communication, and provide more personalised and coordinated care, particularly for women with higher levels of clinical or social vulnerability. At present, there are no dedicated midwifery continuity of carer teams operating in Gloucestershire due to challenges staffing the teams.

There is increasing evidence (RCM, 2018) that providing continuity of carer to women in the antenatal and postnatal period results in improved outcomes and experiences, as can including maternity support workers to work alongside midwifery teams working in areas of high vulnerability.

Antenatal care: Summary

Antenatal care encompasses the routine monitoring, clinical assessments, and information offered throughout pregnancy. Scanning capacity is an issue which is being addressed. NHS-funded antenatal education in Gloucestershire is provided online, although uptake could be improved, and there is currently no face-to-face provision. Vaccination uptake for flu and RSV in pregnancy is above national averages. Digital maternity records via BadgerNet support improved access, data quality, and service governance.

Antenatal care: Key considerations

- Address inequalities in routine scanning provision across the county.
- Investigate barriers to digital antenatal education uptake, in particular among women from ethnic minority communities.
- Consider how to improve partnership working with relevant agencies such as health visitors and Family Hubs to deliver high-quality, comprehensive and free face-to-face antenatal education that meets women's needs and supports social connection, reducing reliance on unverified sources.
- Consider how to improve vaccine uptake such as through regional initiatives, address variable access routes, provide staff training to tackle vaccine hesitancy, and consider demographic data and how this impacts uptake.
- Consider enhanced, evidence-based models of care to improve outcomes, including continuity of antenatal and postnatal care, particularly in areas where outcomes are poorer.

6.3 Postnatal care

Postnatal care is provided to women by a range of health professionals. It commences immediately after birth, and maternity services typically provide care until 10 to 28 days, after which care is handed over from community midwife to health visitor. Care should be provided in line with NICE Guideline NG194 for Postnatal Care (NICE, 2021c) and should be personalised to the woman and baby's needs. Women with more complex medical and social needs may require additional support e.g. women with a history of substance abuse, those whose first language is not English, women under 20 and those who experience domestic abuse.

Immediate postnatal care following birth is provided in a midwifery-led unit, a consultant-led unit, or at home following a home birth. Midwifery-led units typically provide a space for immediate recovery and initial care, with an emphasis on facilitating skin-to-skin contact, initiating feeding, and ensuring both mother and baby are well, supporting timely discharge home (typically between 2 and 12 hours) if there are no complications. If a mother and baby

are in a midwifery-led unit and require a longer stay (e.g. for complications, or if the mother or baby needs extra care) they will typically be transferred to consultant-led care, which provides access to obstetric and neonatal expertise as well as other specialist support such as feeding and safeguarding.

National position

A national survey of birth units found that the most common model of midwifery-led care is women being discharged within 6 hours (Whyte et al, 2024).

Different methods of birth require different levels of clinical input, resources, and postnatal support. For example, currently 90% of spontaneous births nationally are discharged within 2 days, compared with 74% of caesarean section births within 2 days – see Figure 20:

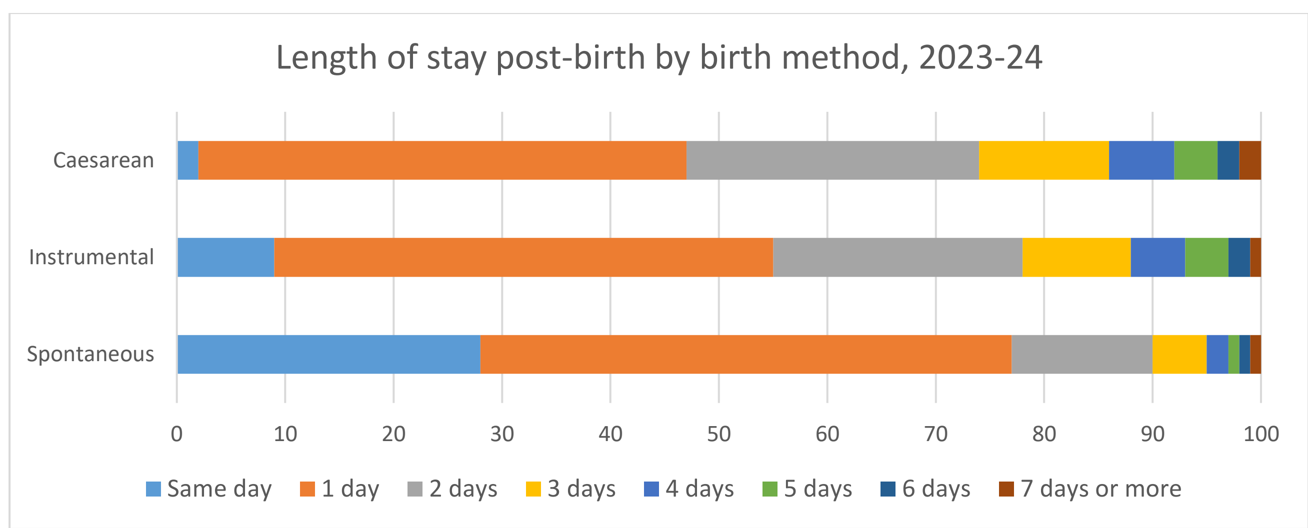


Figure 20: Method of birth and duration of postnatal stay, England, 2023-24 (MSDS, NHSE, 2025b).

National evidence consistently demonstrates that postnatal outcomes and experiences vary significantly by socioeconomic status, with disadvantaged groups more likely to experience poorer physical and mental health outcomes, reduced access to support services, and lower satisfaction with care (MBRRACE Report, 2021).

A national report has highlighted that postnatal care is the period where women express greater dissatisfaction than any other aspect of maternity care. This was evidenced from data over the last 5 years through CQC maternity experience surveys, data gathered by local MNVPs and Healthwatch organisations, and the National Perinatal Epidemiological Unit Maternity Report (NHSE, 2026).

Furthermore, national evidence suggests that uptake and experience of health visiting can vary significantly, influenced by factors such as socioeconomic status, language barriers, and housing stability. These inequalities may result in reduced access to early intervention for vulnerable families, potentially exacerbating health and developmental inequalities (Institute of Health Visiting (IHV), 2025).

Local position

There is an insufficiently detailed understanding of the scale and nature of inequalities in postnatal provision, experience, and outcomes within Gloucestershire, but it is likely that similar patterns of inequality exist.

Local provision

The consultant-led unit is in Gloucestershire Royal Hospital and includes a 46-bed maternity ward which is a mix of antenatal and postnatal beds. Stroud birth unit, in the south of the county, includes 6 postnatal beds which are separate from the birthing rooms and have been temporarily closed since 2022. There are no postnatal beds in Cheltenham or Gloucester birth units.

Before transferring to community midwifery care from the maternity ward or a birth unit, or before the midwife leaves a home birth, a full assessment of the woman's and baby's health and care needs is undertaken. Care is provided in line with NICE Guideline NG194 for Postnatal Care and includes a complete examination of the baby (NHS newborn and infant physical examination (NIPE) screening programme) within 72 hours of the birth, and at 6-8 weeks after the birth by the GP. Before leaving the maternity unit, the woman is provided with information about when to expect the first home visit/contact from a midwife, and who to contact in an emergency. Information also includes what to expect in the postnatal period, and what support is available from both statutory and voluntary services.

For women who have experienced a loss in pregnancy or postnatally, the national recommendation is to provide bereavement services 7 days per week (Ockenden, 2022). In Gloucestershire's maternity service, bereavement care is provided 7 days a week: specialist bereavement services are currently provided Monday to Friday, with bereavement champions providing support at weekends. Previously, a voluntary sector organisation provided free counselling support to families in the county who were bereaved in the perinatal period, although this organisation closed in 2023 and there is currently no other such provision in place.

Postnatal care: Summary

Postnatal care begins immediately after birth and continues for up to 28 days, with care personalised to each woman and baby. Immediate care may take place in midwifery-led units, the consultant-led unit, or at home, with timely discharge common for uncomplicated births, and transfers to consultant-led care on the consultant-led unit when additional medical or neonatal support is required.

Postnatal care: Key considerations

- Ensure consistency and quality in postnatal care, with a particular focus on the early period following birth, both during hospital stay and in subsequent contacts with maternity services. This includes improving communication, timely support for physical and emotional recovery, and equitable access to specialist input where needed.

- Strengthen the pathways of care postnatally (high quality transfer of care from maternity services back to GP), and continue to work with GPs and health visitors to ensure the early postnatal period is meeting the needs of women and babies (including the provision of the 6-week check and that this is delivered in a consistent manner).
- Provision of accessible, coordinated postnatal services that address both physical and emotional health.
- Review the provision of emotional support for bereaved women and families.

7. Demographics

This section explores key demographic factors that influence maternal and neonatal outcomes within our local maternity population. It focuses particularly on deprivation and ethnicity, recognising the strong evidence that these factors shape both access to care and health outcomes for women and their babies. It reviews a number of maternal and neonatal outcomes and inequalities in these outcomes across the county, especially across deprivation deciles and ethnicities.

Alongside deprivation and ethnicity, this section examines a wider set of population characteristics that are essential for understanding local needs and planning equitable, high-quality services. These include language and communication needs, maternal age, mental health, and the prevalence of multiple long-term conditions. Together, these demographics provide crucial context for identifying inequalities, tailoring service provision, and improving outcomes across the LMNS.

7.1 Deprivation

The Indices of Multiple Deprivation (IMD) is a nationally acknowledged measure that combines a number of indicators chosen to cover a range of economic, social and housing issues into a single deprivation score for small areas, each known as a Lower Super Output Area (LSOA). This score helps identify areas where residents may face greater challenges to health, wellbeing, and access to services, and is a key tool for targeting resources and planning equitable service delivery.

The IMD ranks every LSOA in England from 1 (most deprived area) to 32,844 (least deprived area) and divides them into ten categories (deciles) with approximately equal numbers of LSOAs in each.

Impact

Socioeconomic deprivation is consistently associated with poorer maternity and neonatal outcomes across the UK. Evidence from national audits and systematic reviews (Thomson et al., 2021; CQC, 2024) highlights the following:

- Increased risk of adverse outcomes such as stillbirth, neonatal mortality, preterm birth, fetal growth restriction in pregnancy, and babies who are small for gestational age.
- Women living in the most deprived areas continue to have a maternal mortality rate twice that of women living in the least deprived areas.
- Intersection of ethnic minority and deprived population groups: poor outcomes that are seen in ethnic minority communities are more pronounced in the most deprived deciles.
- Lower satisfaction with maternity care and poorer experience for women from more deprived areas.
- Barriers to accessing services are often linked to other risk factors (for example, language, housing instability, and social risk factors).

Poverty and financial insecurity are associated with poorer nutrition, housing instability, and increased stress, which can impact maternal health and wellbeing. In such circumstances, women may be less able to prioritise positive health behaviours, as immediate concerns take precedence. Negative health behaviours are therefore more common in higher deprived areas, where addressing them within the wider context of deprivation is key to reducing inequalities and improving outcomes for mothers and babies (Pinho-Gomes and Mullins, 2023).

Local position

Gloucestershire is in the 20% least deprived counties in England (see Figure 21a) but has pockets of high deprivation. At district level, Gloucester and the Forest of Dean have above-average levels of deprivation compared with England as a whole, although neither are in the 40% most deprived districts nationally (see Figure 21b).

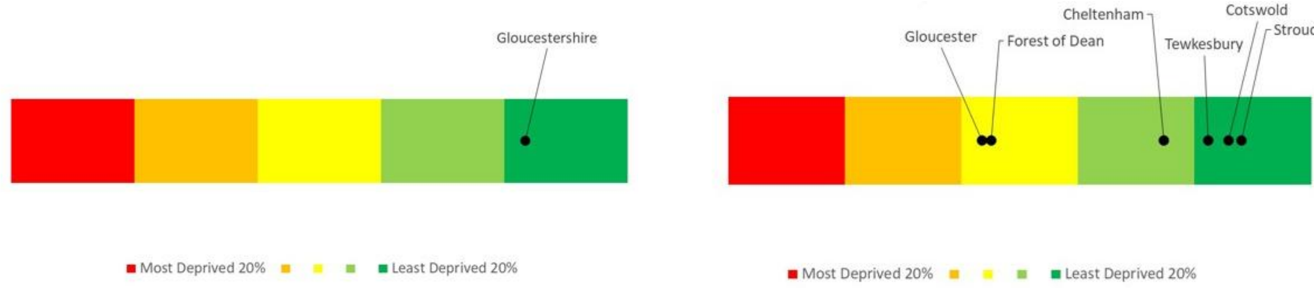


Figure 21:

a) *County Indices of Multiple Deprivation (IMD) rank of average rank in comparison to all 151 English County and Unitary Authorities*
b) *District IMD rank of average rank in comparison to all 317 English District and Unitary Authorities* (ONS, 2019[8]).

However, within the county there are 12 LSOAs which are in the most deprived 10% nationally, accounting for 3.1% of the county's population. Nine of these areas are in Gloucester, two in Cheltenham and one in the Forest of Dean. See Figure 22:

[8] IMD data for 2025 has recently been published but was not available at the time of the analysis for this needs assessment.

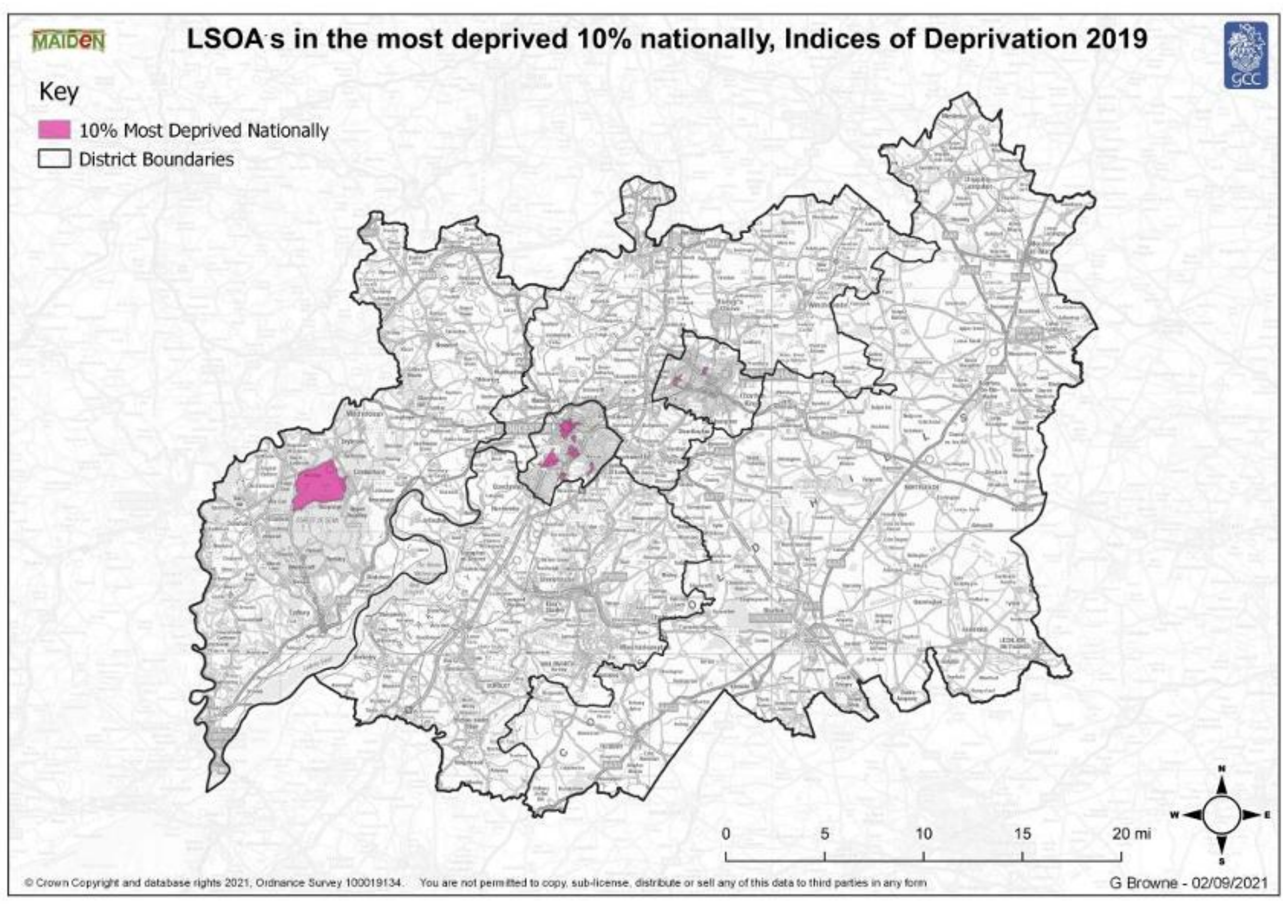


Figure 22: Lower Super Output Areas (LSOAs) in Gloucestershire that fall within the most deprived 10% nationally (ONS, 2019).

Cotswold and Stroud have no neighbourhoods in the most deprived 20% nationally. (The most deprived quintile – top 20% deprivation – is denoted by the darker orange in Figure 23.)

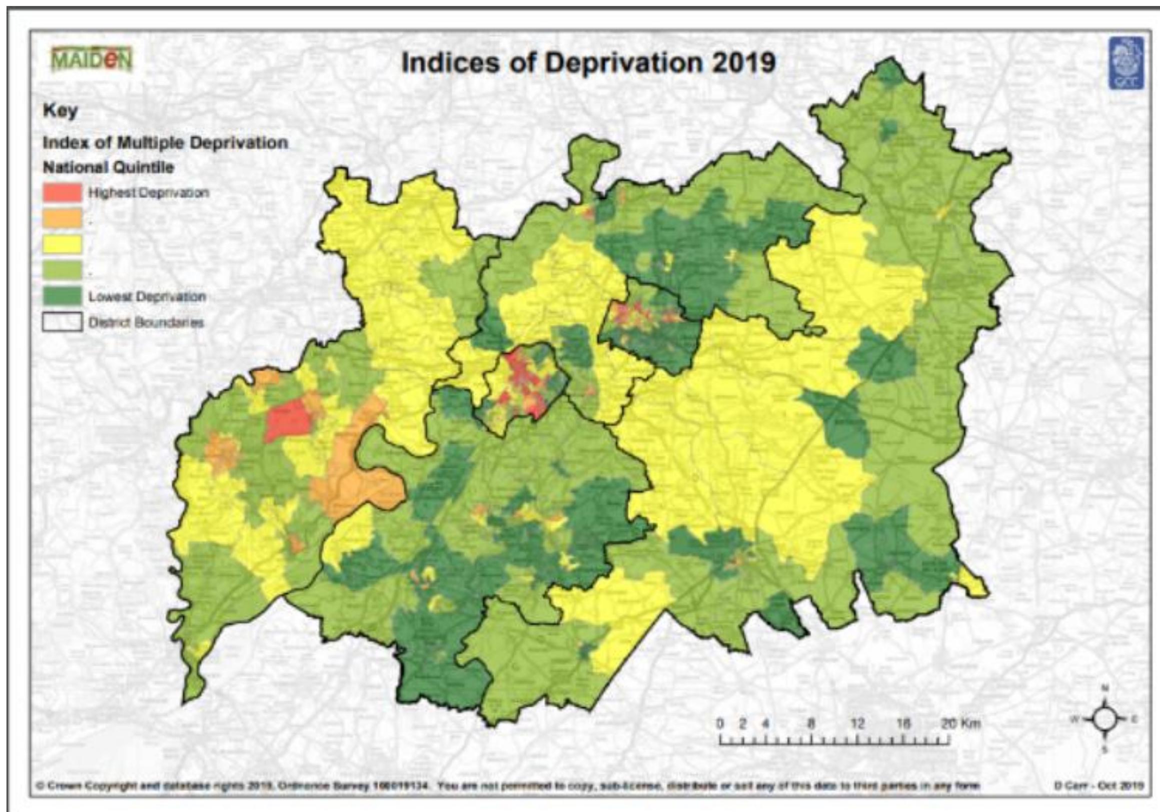


Figure 23: Gloucestershire deprivation map by LSOA based on 2019 Indices of Deprivation (GCC, 2025b).

In terms of births and deprivation in the county (see Figure 24), the general fertility rate in 2023 did not vary strongly by national deprivation deciles – meaning that births were distributed fairly evenly across the deciles.

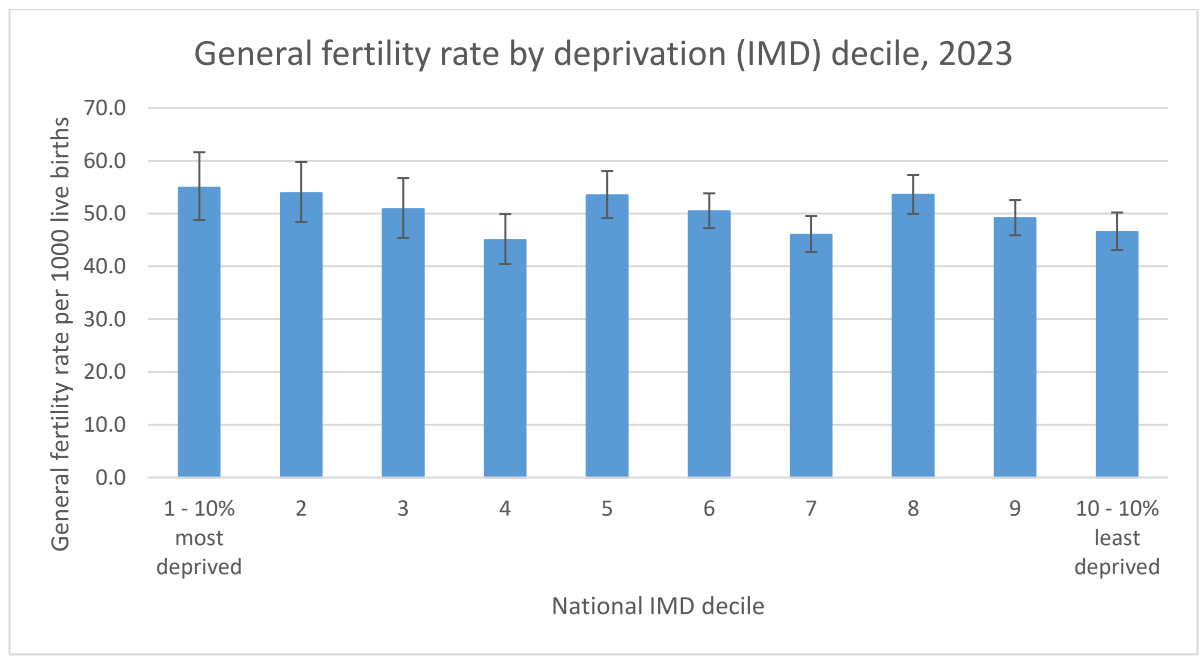


Figure 24: General fertility rate for Gloucestershire by national deprivation decile, 2023 (Indices of Multiple Deprivation, Ministry of Housing, Communities and Local Government, 2019; and ONS, 2024c).

The difference in deprivation across the county highlights the importance of tailoring maternity and neonatal services to meet diverse needs and to ensure resources are targeted where they are needed most.

However, it is important to understand that deprivation is about more than lack of money. It can include lack of access to resources such as education, adequate housing and exposure to negative stressors such as abuse or crime. These social and economic factors influence how women experience pregnancy, access care, and navigate early motherhood, contributing to inequalities in maternal and infant health. Understanding these determinants is key to identifying and addressing inequalities across the maternity pathway.

Some of these socioeconomic factors are considered here, in terms of how they impact access to maternity services and maternal and neonatal outcomes:

Employment is highly correlated to income deprivation – areas with high unemployment often have high income deprivation. Systematic review of maternity research has shown that lower occupational status, especially manual occupations and unemployment, were significantly associated with increased risk of multiple adverse pregnancy outcomes (Thomson et al., 2021).

Education: Lower educational attainment is associated with increased risks of poor maternal and infant outcomes, including delayed care, reduced service uptake, and limited awareness of available support (Mensch et al., 2019). A national measure of education levels showed that Cheltenham ranks in the top 20% (quintile), closely followed by Stroud, Cotswold and Tewkesbury, with Forest of Dean and Gloucester scoring towards the lower end of the scale (in the fourth quintile) (ONS, 2023).

Domestic abuse: Abuse during pregnancy is associated with increased risks of miscarriage, preterm birth, low birth weight for gestation, and poor maternal mental health. Women living in deprived areas, younger women, and those from ethnic minority communities, are disproportionately affected, often facing additional barriers to disclosure and support. Fear, trauma, and instability linked to unsafe environments can reduce engagement with maternity services and increase stress during pregnancy.

Pregnancy is a recognised risk period for domestic abuse, with evidence showing that around 30% of abuse begins during pregnancy and may escalate during the perinatal period (Babazadeh et al., 2025). Locally, Gloucester has significantly higher rates of domestic abuse than other parts of the county, as shown in Figure 25. However, domestic abuse is an under-reported crime, so the figures available are likely to underestimate the true scale of the issue in Gloucestershire.

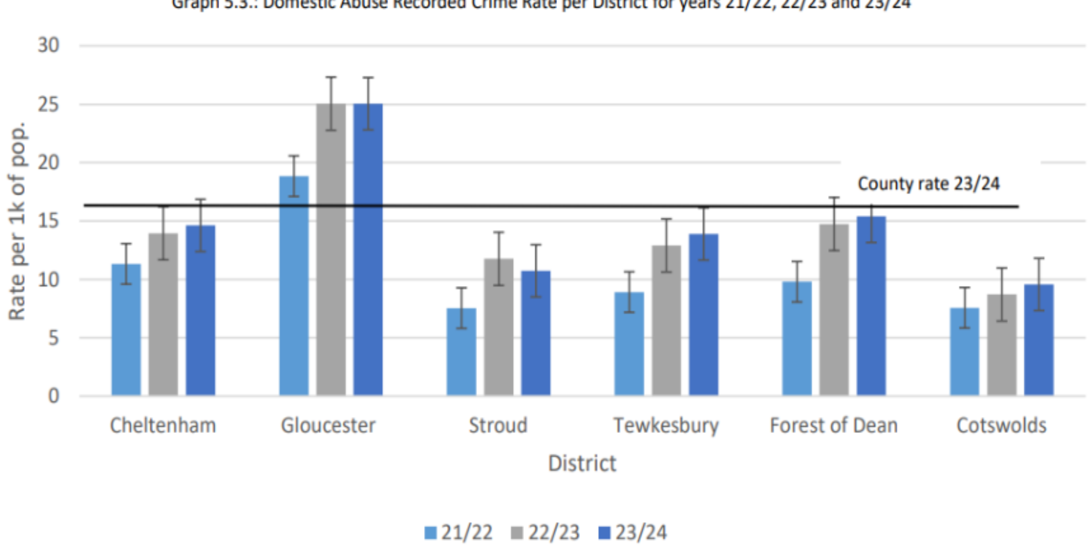


Figure 25: Domestic abuse rate (per 1000 population) for Gloucestershire districts 2021/22 to 2023/24 compared to the county average in 2023/24 (ONS, 2024b).

Homelessness: In 2023/24, Gloucester and Cheltenham had the highest homelessness rates in the county, with Gloucester at 24.4 per 1,000 households and Cheltenham at 13.6, both above the county average. However, homeless households need to approach the Local Authority to be captured in homeless data, so recorded statistics are likely to be an underestimate. Pregnant women experiencing homelessness (rough sleeping, temporary accommodation, sofa surfing, and living in hostels or refuges) may face overlapping vulnerabilities such as ethnicity, experiences of trauma and abuse and caring responsibilities, and they are more likely to struggle with or be unwilling to access antenatal and postnatal care (Lakhanpaul and Svirydzenka, 2024).

Children's safeguarding: The number of referrals to Gloucestershire Local Authority for children under 70 days old (including unborn children) with a safeguarding concern has remained steady over a 10-year period, although there is variation across the county with Gloucester consistently seeing the most referrals and the highest referral rate. Figure 26 shows the referral rate for the years 2020-2024:

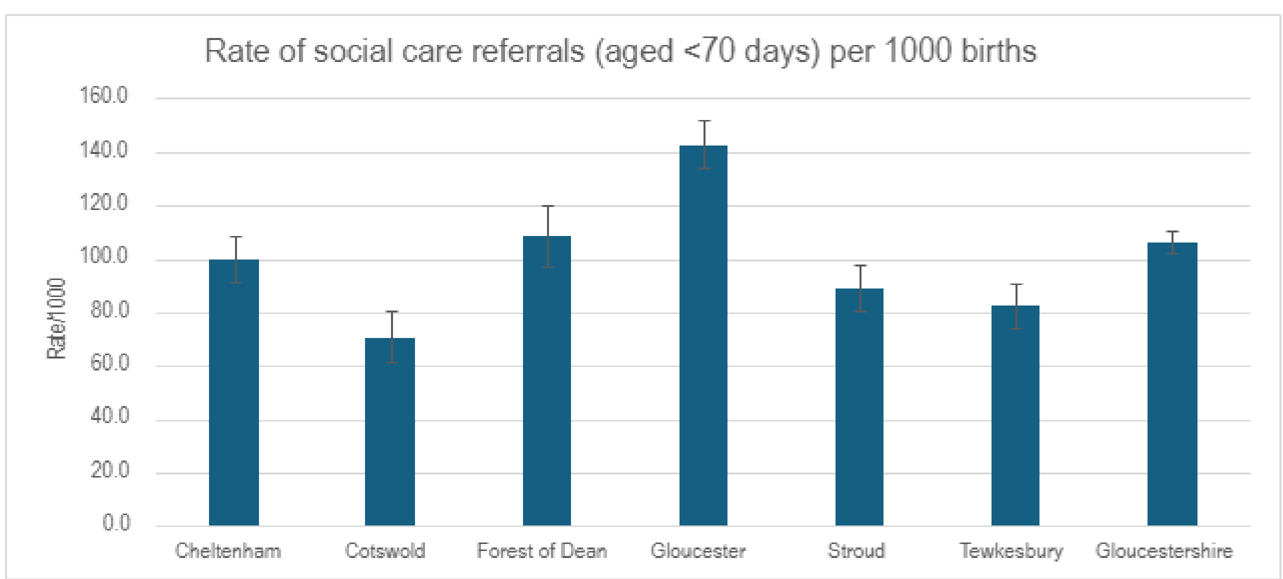


Figure 26: Rate of social care referrals per 1000 births for those aged 70 days or under 2020-2024 by Gloucestershire district (Local Data, GCC – Vulnerable Children Team, 2025).

Severe and multiple disadvantage (SMD) is defined as having three or more vulnerabilities such as housing problems, poverty, mental health issues, substance misuse, social isolation, or experiences of abuse, trafficking or detention. Women experiencing SMD are at the highest risk of poor pregnancy outcomes, including severe maternal morbidity and death. Research by MBRRACE-UK shows that those with SMD are highly overrepresented among maternal deaths, highlighting their extreme vulnerability and the systemic biases they encounter during pregnancy and postnatal care (NMPA, 2025b).

Geographical access: In Gloucestershire, the geography of the county can create barriers for women, due to the rural nature of some areas and potentially limited public transport options. This particularly impacts those without private transport or living in areas of deprivation, with car ownership linked to affluence and implying that those households without private vehicle ownership are more likely to be living with socioeconomic deprivation. There are several areas of the county where access to maternity care hubs (e.g. for antenatal clinics and sonography) would take more than 2 hours if undertaken by public transport.

The local authority has been looking to address accessibility through the updated bus service improvement plan (GCC, 2024). The on-demand bus service, 'The Robin', has now been expanded to include all rural areas of the county and can be used to access maternity services.

Digital access: While increasing digital options may reduce physical barriers to accessing care, the challenge of digital exclusion cannot be overlooked. Digital access is not uniform across Gloucestershire, and the Digital Exclusion Risk Index (DERI) highlights significant variation driven primarily by socioeconomic differences within the county (Greater Manchester Combined Authority, 2025). See Figure 27:

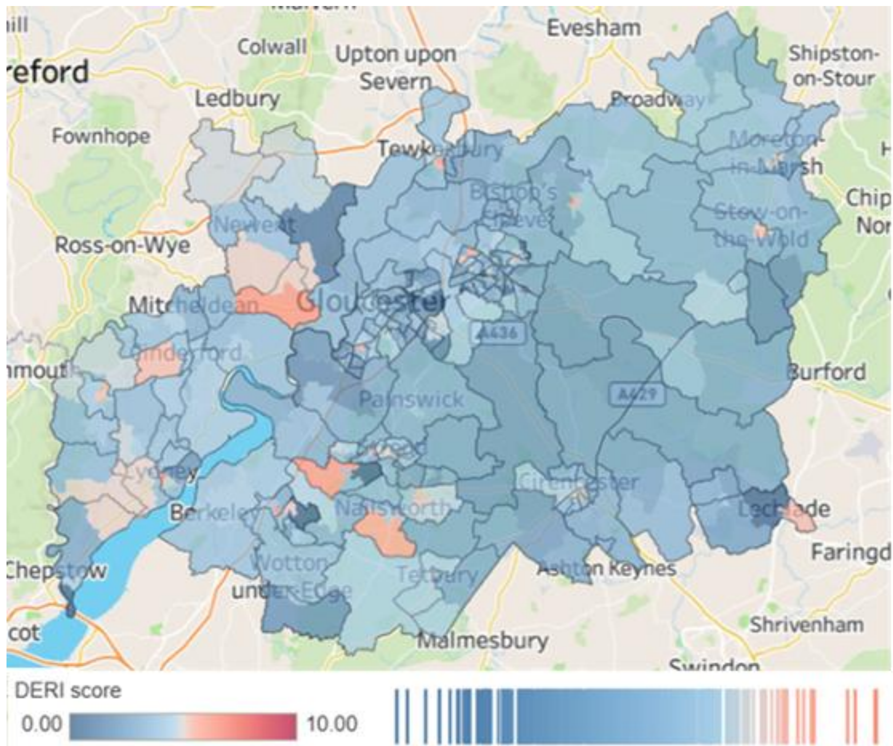


Figure 27: Digital Exclusion Risk Index (DERI) for Gloucestershire (Greater Manchester Combined Authority, 2025).

Women living in areas of higher deprivation, and those with limited digital literacy or access to reliable internet, are at greater risk of exclusion. This can lead to missed appointments, reduced engagement with antenatal education, and difficulties accessing timely advice or support during pregnancy and the postnatal period (NHS Resolution, 2025).

Digital exclusion also intersects with other vulnerabilities, such as language barriers or disabilities, making it essential that digital solutions are implemented alongside inclusive strategies. Care must be taken to ensure that innovations in maternity care do not unintentionally widen gaps in service provision. It is noted that provision of online antenatal education has not been widely taken up, and that the groups least likely to use it may be those with the greatest need.

Local provision

A team of specialist midwives (working in the Vulnerable Women's Team) with extended levels of knowledge and skills provide enhanced support for vulnerable women and act as an expert resource for the midwives caring for these women. Areas of specialism include young parents (under 18s at the time of conception), mental health, domestic abuse, safeguarding, and substance misuse.

In addition to this support from the maternity service, organisations such as Home-Start in the voluntary and community sector support perinatal women across different communities in the county, often based in and reaching out to those from areas of higher deprivation.

In terms of support for digital access, Gloucestershire's maternity service is setting up an offer to provide a device, mobile data, or a SIM card to individuals without digital access, to support them to engage with the service. This support will be vital to reduce barriers to care, promote inclusion, and ensure that all women can access information and services.

Deprivation: Summary

Although Gloucestershire is among the 20% least deprived counties nationally, there are concentrated pockets of deprivation. Deprivation is strongly linked to increased risks of stillbirth, neonatal mortality, preterm birth, and maternal death. Wider socioeconomic factors such as unemployment, low educational attainment, domestic abuse, homelessness, digital exclusion, and limited access to transport, further hinder engagement with maternity services. These intersecting challenges emphasise the need for tailored, equitable service provision that aims to reduce barriers and improve outcomes for women and babies across the county.

Deprivation: Key considerations

- Deprivation varies across the county and is particularly high in parts of Gloucester and the Forest of Dean. This requires targeted enhanced service provision and resource to support a reduction in health inequalities and inequality of outcomes.
- Ensure that information is accessible for women who may face barriers to understanding or receiving it, including those without digital access, or those with lower literacy levels or language challenges.
- Ensure maternity services are equipped to identify and support women experiencing complex social factors such as poverty, homelessness, and/or domestic abuse.
- Improve interagency collaboration between maternity services, other healthcare services, social care, Family Hubs, and voluntary and community organisations, to support women who experience severe and multiple disadvantage to ensure enhanced and joined-up care.
- Improve access to some services e.g. ultrasound scanning and obstetric care. This should be in line with the principle laid in out in the Gloucestershire Joint Forward Plan for services to be "local where possible, centralised where necessary".

7.2 Ethnicity

Impact

Black, Brown and Mixed ethnicity women experience poorer outcomes in maternity than those who are White (Parliament.uk, 2025). For example:

- While the maternal mortality rate for women from Black ethnic backgrounds continued to decrease in 2021-23, there remained a two-fold difference in maternal mortality rates for Black compared to White women. Asian women also had a slightly increased maternal mortality risk compared to White women.

- Miscarriage rates are 40% higher in Black women, and Black ethnicity is now regarded as a risk factor for miscarriage).
- Public Health England's 2020 report found that (preterm birth) is a major cause of long-term infant morbidity. Black mothers, particularly those of Black Caribbean background, are twice as likely to give birth before 37 weeks.
- UK studies show that women from Black, Asian and ethnic minority communities are more likely to suffer from common mental health disorders, yet are less likely to access treatment.

Inequalities in maternity and neonatal outcomes among different ethnic groups are reviewed further in the Outcomes section (7.3).

Local position

In 2024/25, 23.0% of births in Gloucestershire were to women who identified as having an ethnicity that was not white British (MSDS, NHSE, 2025b). This suggests that the composition of the maternity population is more diverse that the general population of Gloucestershire, as the 2021 Census data showed that only 12.3% of the population identified as having an ethnicity that was not white British. There are likely to be three factors underlying this observation:

- According to the 2021 Census, there is a higher proportion of women who identified as having an ethnicity other than white British in the 15-45 year-old age group (17.7%), compared to those aged across the entire population (12.3%).
- Data on birth trends in England published by ONS (ONS, 2024c) shows that the percentage of live births where one or both parents were born outside of the UK is increasing overall. There is also evidence (Wilson, 2019) from some studies suggesting that the total fertility rate is higher among women who are first- or second-generation migrants to the UK compared to women who were not migrant to the UK.
- There is substantial geographic variation in ethnicity across the county, with the areas of highest ethnic diversity being in the urban districts of Gloucester and Cheltenham. These areas also correlate to the areas of the county with the highest proportion of live births.

Figure 28 shows the breakdown of births in Gloucestershire in 2024/25 by ethnicity.

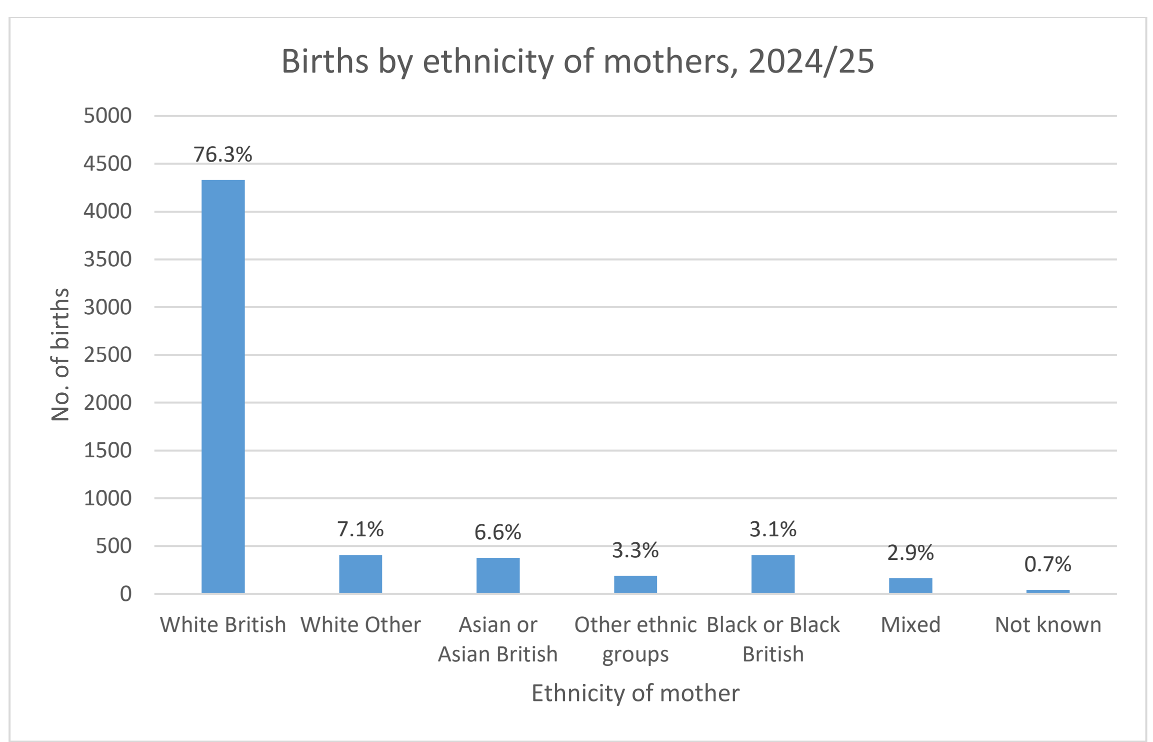


Figure 28: Number and proportion of births by ethnicity to Gloucestershire mothers, 2024-2025 (MSDS, NHSE, 2025b).

With this higher proportion of ethnic minority women among the maternity population than the county's whole population, there will be an increasing need for services to be more culturally sensitive, particularly in Gloucester which has the highest proportion of people from Black, Brown and Mixed ethnicity backgrounds, and Cheltenham which has the second highest proportion. See Figure 29.

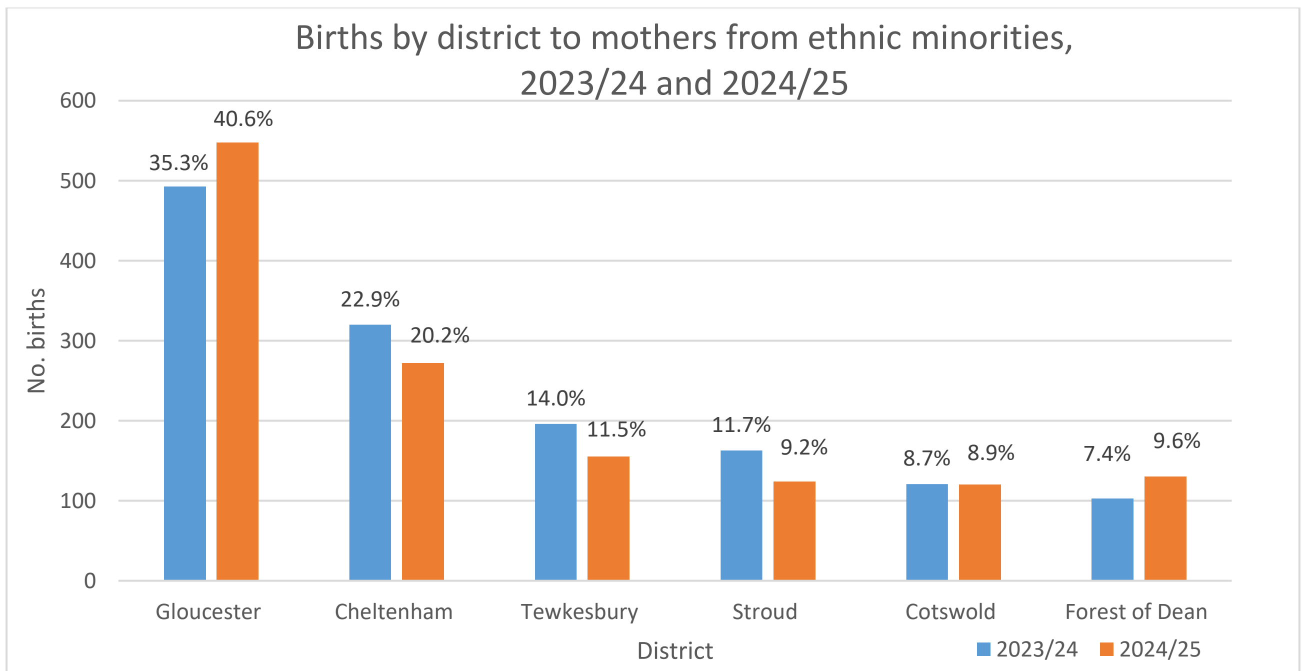


Figure 29: Number and proportion of births to women from ethnic minority communities (excludes all ethnicities other than White British) in each district to Gloucestershire mothers, 2023/24 and 2024/25 (MSDS, NHSE, 2025b).

Local provision

Gloucestershire's LMNS undertook a comprehensive needs assessment in 2022 in response to NHSE's National Maternity Equity and Equality Guidance (NHSE, 2021). Following this, a five-year Equity and Equality Action Plan (2022-2027) was developed and implemented, with a clear focus on reducing health inequalities and improving outcomes for women from ethnic minority communities and those living in areas of higher deprivation. A range of targeted projects and service enhancements have since been delivered and evaluated, as outlined in the 2025 progress report (NHS Gloucestershire, 2025). These include:

- Black Maternity Matters anti-racist staff training
- Creating perinatal support groups for women from ethnic minority communities (Black Mothers Matter, Moments of Motherhood, and Lives of Colour)
- Improved access to interpreting services
- Producing a translated leaflet to explain how to use the Badger Notes maternity app
- Improved ethnicity recording in BadgerNet
- Better monitoring of outcomes by ethnicity and deprivation
- Commissioning of online antenatal education available in different languages (see Antenatal Education, section 6.2.2)
- Commissioning of the pilot of a breastfeeding app ('Anya')

Overall, the work has delivered mostly positive impacts: smoking at delivery rates have fallen; preterm births have reduced; breastfeeding confidence has improved (although the app pilot did not significantly improve breastfeeding rates); ethnicity data recording is much more accurate; and community groups and mental health initiatives demonstrate strong qualitative benefits. Some areas still require further improvement, including stillbirth rates, breastfeeding in certain populations, digital inclusion, and targeted support for groups such as Gypsy, Roma and Traveller families, and these priorities will form the focus of the plan for the remainder of its term, running through to 2027.

Ethnicity: Summary

Ethnic diversity is higher in Gloucestershire among the birthing population than the county's wider population. This must be a central consideration for maternity services, as outcomes for women from ethnic minority backgrounds, especially Black, Asian and Mixed ethnicity women, have been shown to be consistently poorer than for White women.

Ethnicity: Key considerations

- Engagement strategies must be inclusive and tailored to reach communities which may face barriers to accessing care, particularly women from ethnic minority backgrounds and other underserved groups. This includes recognising cultural differences, addressing language and communication needs, and building trust through community-led approaches.
- Ensure that our future maternity service provision:
    - Demonstrates greater cultural sensitivity and is anti-racist and anti-discriminatory in its design and delivery.

    - Tackles the systemic factors contributing to poorer maternal outcomes among ethnic minority communities.
- Takes into account the complexity and inequalities experienced by women from ethnic minority communities (including those who identify as 'White Other').

7.3 Outcomes

Building on the evidence presented in the preceding sections on deprivation and ethnicity, this outcomes section examines how deprivation and ethnicity translate into measurable differences in maternal and neonatal health. The intersection between these and other compounding factors – such as language and communication needs, mental health, and multiple long-term conditions – creates layers of vulnerability that influence clinical risk, access to timely care, engagement with services, and overall maternity experience.

7.3.1 Maternal mortality

Risk factors

Though rare in the UK, maternal mortality remains a significant concern as mentioned previously, particularly among women from ethnic minority communities and those living in deprived areas (MBRRACE, 2025c). The underlying causes of inequalities in outcomes have been found to be complex and multifaceted, and could include preexisting medical conditions, socioeconomic factors, and racism (Brader, 2023).

National position

The most recent MBRRACE-UK report covering 2021-2023 (MBRRACE, 2025a) reveals that, while maternal deaths have slightly decreased since 2020-22, this change is not statistically significant. However, rates remain higher than those reported in 2018-2020 (when COVID-19-related deaths are excluded). Thrombosis and thromboembolism were the leading causes of maternal death during or up to six weeks after pregnancy, while maternal suicide was the most common cause of death between six weeks and one year postpartum. These findings underscore the urgent need for integrated physical and mental health care across the perinatal period. 91% of women who died in this period faced multiple interrelated challenges, reflecting intersectionality of risk where overlapping social, economic, and health-related disadvantages compound vulnerability. The rise in late maternal deaths, particularly those linked to mental health, highlights systemic gaps in postnatal support nationally, especially for women experiencing social care involvement (NMPA, 2025b).

Local position

In Gloucestershire, maternal mortality is monitored through serious incident reviews and the maternity services dashboard. Due to the small numbers involved, trends at a local level are unlikely to show statistical significance. All maternal deaths in England during pregnancy or up to 42 days after the pregnancy ends are reported to and investigated by the National Maternity & Newborn Safety Investigations (MNSI) programme. Recommendations and safety actions are identified for Trusts. Action plans from investigations are monitored through Trust governance processes.

In 2025, an externally commissioned cluster review of local maternal deaths occurring between 2018 and 2022 identified themes that mirror the inequalities seen nationally, including the impact of deprivation, ethnicity, mental health, and access to timely care. This reiterates the importance of monitoring maternal physical and mental health, and of identifying additional risk factors through pregnancy and beyond, such as English not being the first language so requiring an interpreter.

7.3.2 Stillbirth and neonatal mortality

National and local position

In England, the government had an ambition to halve the 2010 stillbirth and neonatal mortality rates for infants born at 24 weeks or over by 2025 (Resolution, Patient Experience and Maternity, Department of Health, 2017). Latest ONS data published in April 2025 covers data up to 2023, and shows that for both Gloucestershire and England, this ambition will require considerable reductions in stillbirth and neonatal mortality rates:

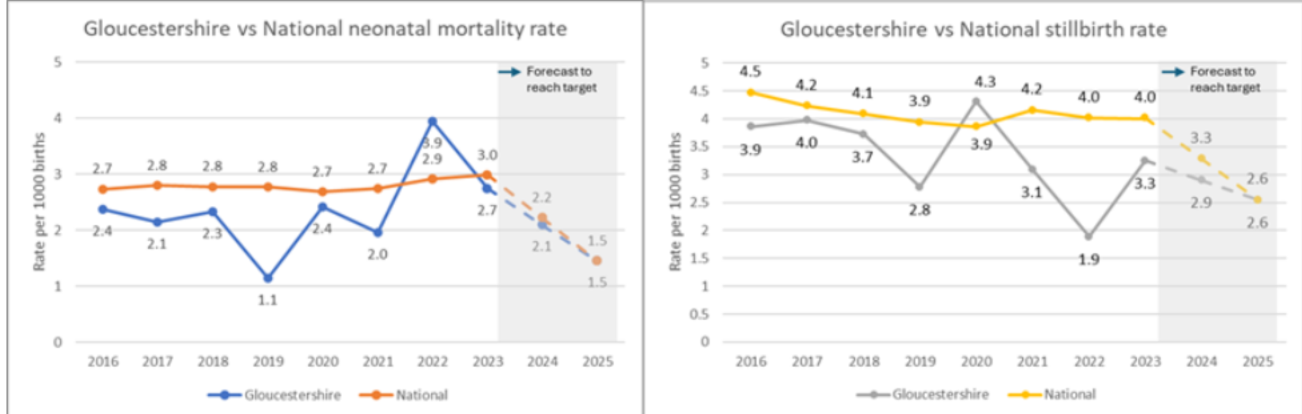


Figure 30: Neonatal mortality and stillbirth rate for Gloucestershire compared to the national average, 2016-2023, and projections shown to 2025 if the national ambitions for improved neonatal outcomes were to be met (ONS, 2025e).

'Perinatal mortality' data is different to the above, as it covers stillbirths and deaths of babies under 7 days (whereas neonatal mortality data is babies who have died in the first 28 days). Gloucestershire perinatal mortality rate is currently below the national rate but has fluctuated in the past few years. MBRRACE reports on perinatal mortality show that GHT stabilised rates are within 5% of peer group trusts, implying no significant differences from hospitals supporting similar numbers of births and with similar population demographics (MBRRACE-UK, 2025b):

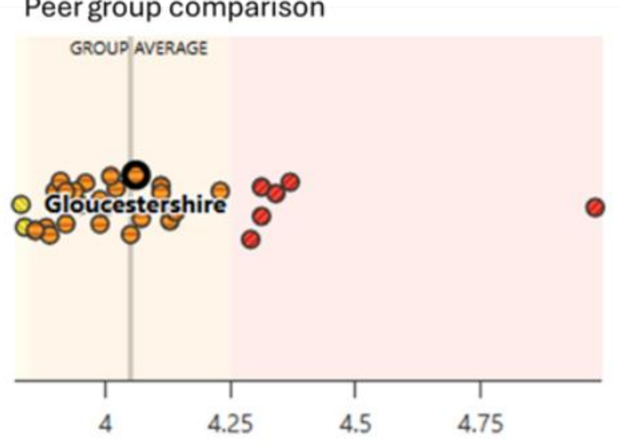


Figure 31: Gloucestershire perinatal mortality adjusted and stabilised to account for population differences, and 2023 position compared to Gloucestershire's peer group (Trusts with similar numbers of births annually, similar levels of neonatal care facilities, similar case mix and complexity and comparable geography/ populations) (MBRRACE-UK, 2025b).

Health inequalities data

Data continues to show persistent inequalities nationally, with higher rates for both stillbirth and neonatal mortality among families from deprived areas and/or ethnic minority communities (NMPA, 2025b):

- Despite an 8% decrease in stillbirth rates for babies born to mothers from the most deprived areas (from 4.60 per 1,000 total births in 2022 to 4.23 per 1,000 total births in 2023), the rates remain much higher than those for babies born to mothers from the *least* deprived areas (2.46 per 1,000 total births).
- Inequalities in neonatal mortality rates by socioeconomic deprivation widened further in 2023. Rates increased for babies born to mothers from the most deprived areas (from 2.38 per 1,000 live births in 2022 to 2.50 in 2023), a rate now more than double that of babies born to mothers in the *least* deprived areas, where the rate decreased from 1.18 per 1,000 live births in 2022 to 1.03 in 2023.
- Stillbirth rates decreased in 2023 for babies of Black and White ethnicity but increased by 9.8% for babies of Asian ethnicity, compared to 2022. Babies of Black ethnicity remain more than twice as likely to be stillborn than babies of White ethnicity (Black: 5.84 per 1,000 total births; White: 2.71 per 1,000 total births). The MBRRACE (2025c) report does not identify a single explicit cause for this increase in stillbirths in Asian babies, but it is likely part of a broader pattern of ethnic and socioeconomic inequalities in perinatal outcomes.
- Neonatal mortality rates decreased in 2023 for babies of all ethnicities, compared to 2022. However, babies of Asian and Black ethnicities continue to have much higher rates of neonatal mortality than babies of White ethnicities (Asian: 2.35 per 1,000 live births; Black: 2.28 per 1,000 live births; White: 1.50 per 1,000 live births).

These inequalities can also be seen in Gloucestershire data, with stillbirth and neonatal mortality rates higher in the most deprived deciles and in ethnicities which are not White British. These are very small numbers, so the differences between groups are not statistically significant. However, the data is included here (see Table 8) as it shows the

same pattern as larger studies where robust associations between stillbirth rates and ethnicity and deprivation have been described (Jardine et al., 2021). The Jardine et al. (2021) study also found that the largest inequalities were seen in Black and South Asian women in the most socioeconomically deprived quintile (see Table 9).

IMD deprivation decile	1	2	3	4	5	6	7	8	9	10
Rate (per 1000 births)	2.9	4.9	4.6	4.1	3.0	2.6	1.8	0.0	1.2	1.6

Ethnicity	White British	White Other	Asian	Black	Mixed	Other	Unknown
Rate (per 1000 births)	1.8	4.4	2.2	4.1	0	2.5	5.0

Tables 8a and 8b: (a) Stillbirth rates to Gloucestershire mothers by national deprivation decile; (b) Stillbirth rates to Gloucestershire mothers by ethnicity; 2020/21-2023/24 (MSDS, NHSE, 2025b).

Stillbirth	Ethnic background: White	South Asian	Black	Mixed and other
Socioeconomic deprivation (national quintiles)				
1 (least deprived)	Reference	33·3% (27·0 to 39·0)	48·0% (41·5 to 53·7)	12·1% (–0·2 to 23·0)
2	–8·6% (–20·9 to 3·6)	38·8% (28·9 to 47·3)	52·3% (43·5 to 59·6)	19·4% (3·8 to 32·5)
3	18·6% (8·6 to 27·5)	45·6% (37·3 to 52·9)	57·6% (50·2 to 63·9)	28·4% (15·0 to 39·8)
4	17·7% (8·0 to 26·4)	45·1% (37·2 to 52·1)	57·2% (50·0 to 63·3)	27·7% (14·4 to 38·9)
5 (most deprived)	30·4% (22·5 to 37·5)	53·5% (47·1 to 59·1)	63·7% (58·1 to 68·6)	38·8% (28·0 to 48·0)

Table 9: Stillbirth rate matrix showing increasing risk of stillbirth in more deprived and non-White ethnic groups (Jardine et al., 2021).

National and local reviews

All late miscarriages, stillbirths and neonatal deaths are reviewed within Trusts using the Perinatal Mortality Review Tool (PMRT). The review involves parents and external clinicians with the aim of standardising reviews, implementing systemic changes, and learning lessons to prevent further tragedies. Some stillbirths and neonatal deaths will also be investigated by MNSI. Stillbirth and neonatal death rates are included as metrics on national and local dashboards to provide benchmarking (as in Figure 31).

In addition, in 2025 the Trust commissioned external reviews of stillbirths from 2023 to 2024, and neonatal deaths from 2020 to -2023. The reviews highlighted the inequalities seen in the data above. An action plan has been developed from the reports, alongside a new GHT perinatal quality dashboard which shows a number of maternal and neonatal outcomes by ethnicity and deprivation. The action plan is monitored through Trust governance processes.

7.3.3 Preterm birth

Impact

MBRRACE-UK, for its main mortality rates, uses a definition of preterm birth as being live births of more than 24 weeks gestation and before 37 weeks, due to legislation in the UK (MBRRACE-UK, 2025a). Preterm birth is a leading cause of neonatal morbidity and mortality and can have long-term impacts on a child's development and health (Quinn et al., 2016). UK research shows increased risks of neurodevelopmental difficulties, including learning disabilities, developmental delay and behavioural challenges, that can persist into adulthood (MBRRACE-UK 2023). Preterm-born individuals also experience higher rates of chronic respiratory disease, cardiovascular problems such as hypertension, and a greater likelihood of ongoing health needs across the life course (MSDS, NHSE, 2025b). UK cohort studies and national audits additionally demonstrate higher risks of mortality and morbidity among those born at earlier gestational ages, reinforcing the importance of early identification, targeted intervention and long-term follow-up for people born preterm (MBRRACE-UK, 2023; ONS, 2025e).

Risk factors

Preterm birth 'is a complex, multifactorial disorder with biological, environmental and social determinants' (Parliament.uk, 2024). Most women who give birth preterm have no apparent risk factors and, in many cases, it is not clear why a preterm birth occurred. There are, however, a wide range of factors that are associated with a higher likelihood of giving birth early. Health conditions that exist prior to pregnancy, such as diabetes, hypertension and mental health problems, can increase a woman's risk of preterm birth. Having a body mass index (BMI) of under 18 or over 35, being at the lower and upper ranges of maternal reproductive age, and health behaviours such as smoking, can be associated with preterm birth, as well as with factors such as multiple pregnancies and infections (Parliament.uk, 2019). Data also highlights inequalities nationally in preterm birth rates, with higher prevalence among women from ethnic minority backgrounds and those living in areas of deprivation (Kayode et al., 2024).

Local position

Review of data since 2019 shows no statistically significant variation in preterm birth prevalence between districts, although Forest of Dean has a consistently higher rate and Stroud a consistently lower rate than the county average. Statistically significant inequalities are evident by deprivation and ethnicity, particularly among babies born in the most deprived decile and those from Mixed ethnicities. See Figures 32, 33 and 34:

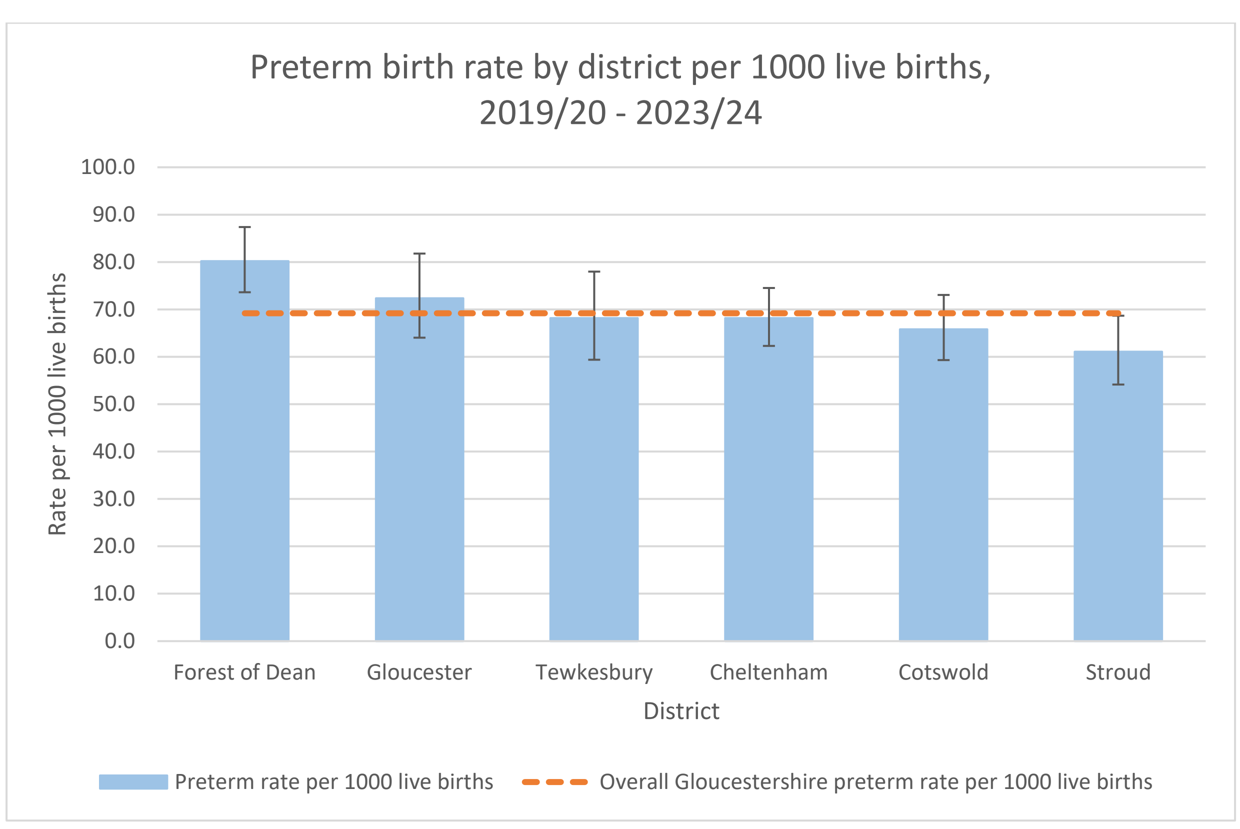


Figure 32: Rate of preterm births to Gloucestershire mothers by district (births from 2019/20-2023/24) (MSDS, NHSE, 2025b).

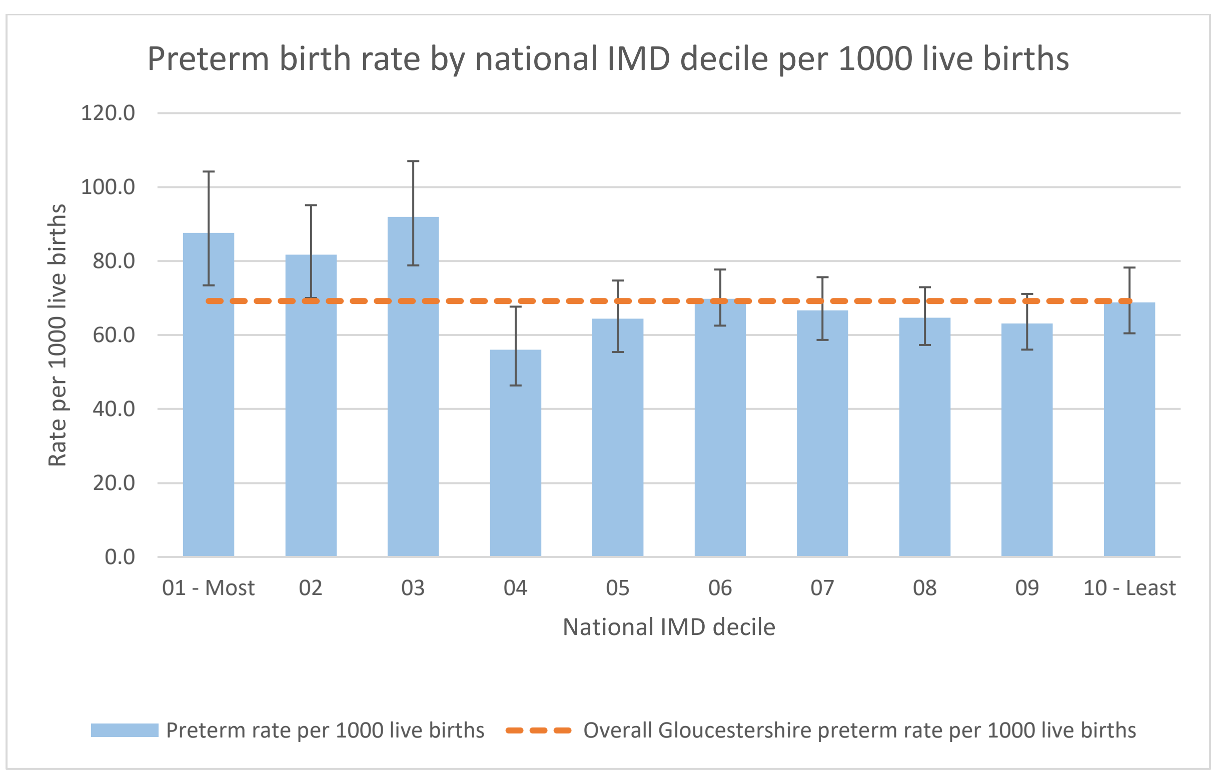


Figure 33: Rate of preterm births to Gloucestershire mothers by national IMD decile (births from 2019/20-2023/24) (MSDS, NHSE, 2025b).

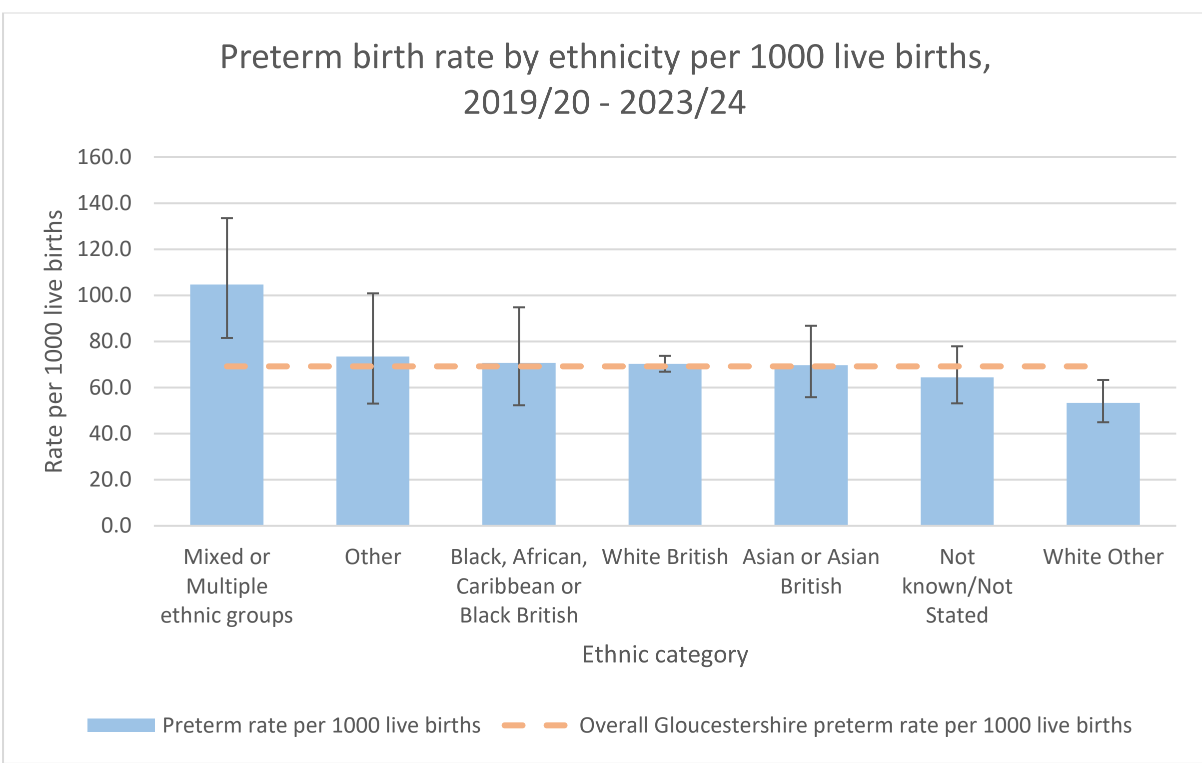


Figure 34: Rate of preterm births to Gloucestershire mothers by ethnicity (births from 2019/20-2023/24) (MSDS, NHSE, 2025b).

Local provision

Working to reduce preterm birth is a national priority, as set out in the Saving Babies Lives Care Bundle Version 3 (NHSE, 2025a). Prevention requires a multifaceted approach including identifying those at risk of preterm birth, introducing preterm birth clinics with specialist expertise for those at risk, and reducing the number of women who smoke. The guidance has been implemented locally.

Targeted interventions in areas of deprivation and culturally responsive care are also required to address inequality in particular demographics. See section 8.2 on smoking cessation.

7.3.4 Low birth weight and small for gestational age babies

Risk factors and impact

Low birth weight (LBW) babies are newborns weighing less than 2,500 grams at birth, regardless of gestational age, and face higher risks of mortality, illness, developmental problems and chronic diseases (World Health Organisation (WHO), 2025). Small for gestational age (SGA) refers to a foetus with a predicted weight or an abdominal circumference measurement less than the 10th centile. SGA at birth is a baby below the 10th centile.

Babies with SGA can be small at all stages of pregnancy but grow following centiles below the 10th centile with no underlying pathology present. SGA with fetal growth restriction (FGR) can be a result of maternal, placental or fetal factors, often involving the placenta not

delivering enough oxygen and nutrients to the baby. This can be due to issues such as high blood pressure, smoking, infections, maternal disease and genetic/chromosomal problems in the baby. (See section 8 - health behaviours and multiple long-term conditions.)

Local provision

The Saving Babies Lives Care Bundle (SBLCB) (NHSE, 2025a) is a key NHSE initiative to provide evidence-based best practices for maternity services to reduce neonatal mortality and morbidity by addressing six key risk factors: reducing smoking in pregnancy; managing FGR/SGA; raising awareness of fetal movements; effective fetal monitoring in labour; preventing preterm birth; and continuous improvement in diabetes management. Gloucestershire maternity service has been implementing the elements of the SBLCB. This has included: a quality improvement project to reduce the number of babies who are born small for gestational age and preterm due to smoking in pregnancy; establishment of a dedicated preterm birth clinic with a specialist preterm midwife and obstetrician; a deep dive into causes and demographics associated with preterm birth; supporting a campaign to raise awareness of the importance of fetal movements; improvements in detection and monitoring of FGR; improved access to timely ultrasound scans for reduced fetal movements; and improvements to management and monitoring of women who have diabetes in pregnancy through a clinic where both diabetic specialists and obstetrician/midwifery support is available in one place. All of these should have a positive impact on the number of babies born with low birth weight and SGA (see section 8.2).

7.3.5 Admissions to local neonatal unit (LNU)

Risk factors

Admission to the neonatal unit is impacted by both maternal and infant health and associated risk factors, with premature and low birth weight babies more likely than term babies to require admission to the LNU.

Local position

Data from 2022/23 to 2024/25 shows that an average of 4.0% of term babies born in Gloucestershire were admitted to the LNU, with just over half (53.7%) of preterm babies being admitted.

Focusing on term admissions to LNU, risk increases with deprivation (see Figure 35), but there is no significant association with ethnicity (Figure 36):

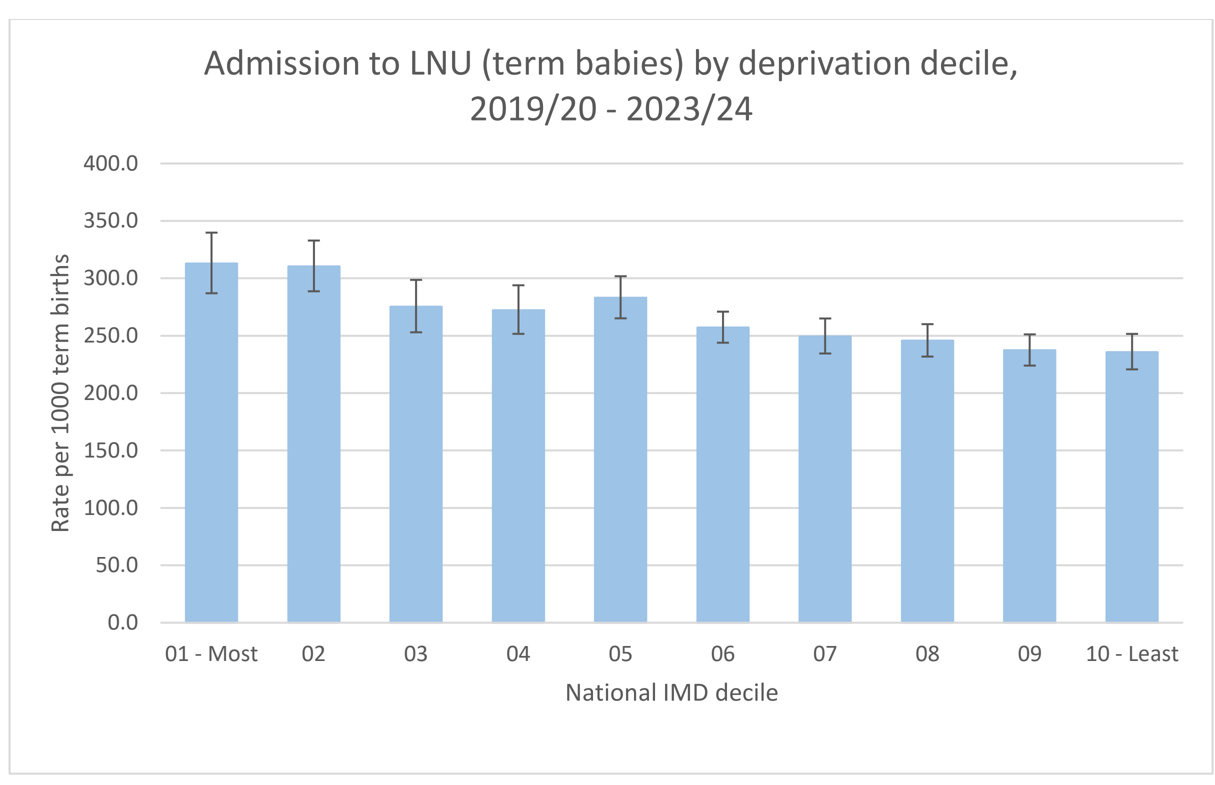


Figure 35: Rate of admission to the neonatal unit by national IMD decile (births from 2019/20-2023/24) (MSDS, NHSE, 2025b).

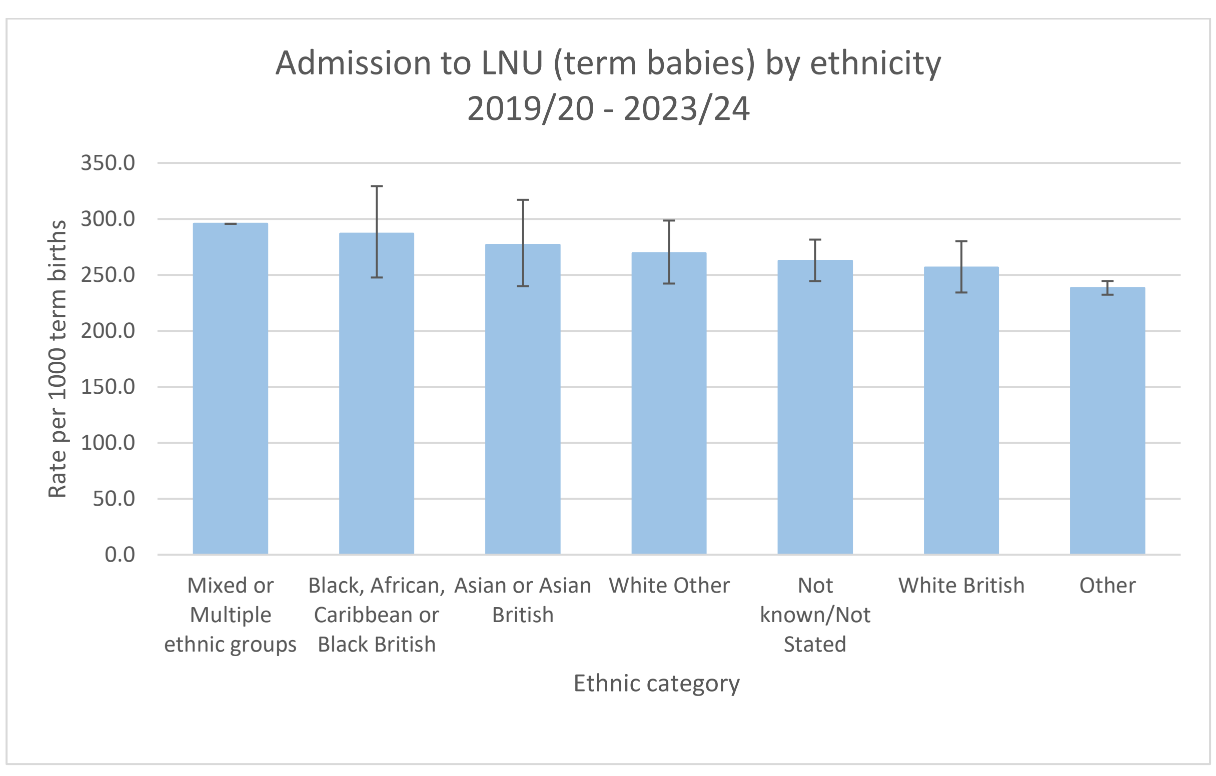


Figure 36: Rate of admission to the neonatal unit by ethnicity (births from 2019/20-2023/24) (MSDS, NHSE, 2025b).

7.3.6 Readmissions

Risk factors

Common reasons for postnatal readmission of mothers include infection, hypertension, and post-operative pain or wound complications (Okorochukwu et al., 2024). A national study found that risk factors for maternal readmissions included minoritised ethnicity (particularly Black or Black British ethnicity), age under 20 years or over 40 years, first time mothers, nonspontaneous vaginal birth modes, and obstetric risk factors including urinary retention and postnatal wound breakdown (Pritchett et al., 2024).

Readmission rates of mothers provide insight into the effectiveness of postnatal support, discharge planning, and the ability of community services to meet the needs of women and newborns following birth.

The most common reasons for *neonatal* readmissions include feeding difficulties (such as poor weight gain or dehydration), neonatal jaundice requiring phototherapy, and suspected or confirmed infections. Other contributing factors can include hypothermia, respiratory issues, and complications related to prematurity (Kardum et al., 2022).

National position

The NMPA reported that the rate of maternal postnatal readmissions in 2023 was 3.08% across England and Wales, a slight decline from 3.3% in 2018-19 (NMPA, 2022 & 2025a). However, rates were increasing prior to 2018-19: a national study found a significant increase in the rate of maternal postnatal readmissions from 2.5% in 2008 to 3.4% in 2016 (Pritchett et al, 2024). The NMPA found that in 2018-19, more women were readmitted after a caesarean section (4.3%) than vaginal birth (2.9%) (NMPA, 2022). (This breakdown of data is not currently available for more recent births.)

High or rising readmission rates may signal gaps in care, unmet health needs, or complications that were not adequately addressed during the initial hospital stay (Pritchett et al., 2025).

Local position

The NMPA report showed that, for 2023, GHT had a maternal readmission rate of 3.0% (NMPA, 2025b). During the 2025/26 financial year, there has been an increasing trend of maternal readmission in Gloucestershire compared with 2022/23-2024/25:

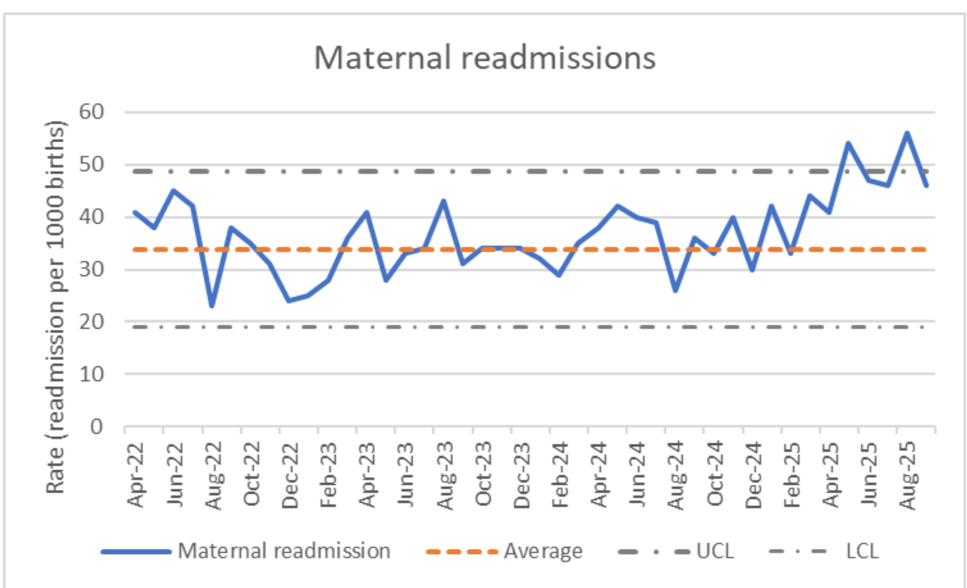


Figure 37: Rate of maternal readmission (within 30 days of discharge) in Gloucestershire per 1000 births (April 2022 to September 2025) (Secondary Uses Service (SUS), NHSE, 2025).

(The UCL (Upper Control Limit) and LCL (Lower Control Limit) are statistically calculated boundaries that define the expected range of normal (common cause) process variation.)

Local neonatal readmission rates have fluctuated around the average over the past three years, with significant increases observed in November 2023 and May 2024, both exceeding 100 readmissions per 1,000 births – see Figure 38:

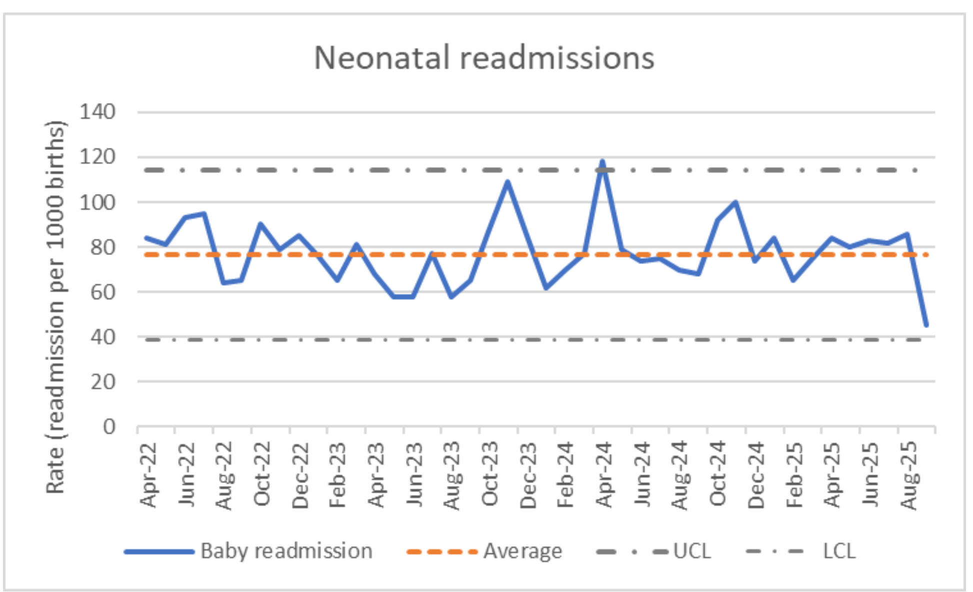


Figure 38: Rate of neonatal readmission (within 30 days of birth) in Gloucestershire per 1000 births (April 2022 to September 2025) (SUS, NHSE).

Neither the local rates for maternal or neonatal readmissions show a statistical difference between IMD deciles and ethnic groups, although this may be due to small numbers.

7.3.7 Perineal tears

Risk factors

Several factors are associated with an increased risk of third- and fourth-degree perineal tears, also known as Obstetric Anal Sphincter Injury (OASI), including: maternal characteristics such as age, and weight gain during pregnancy; neonatal factors like birth weight; and obstetric variables such as induction of labour, gestational age, type of anaesthesia, and mode of delivery, particularly instrumental deliveries. Many of these factors are interrelated and may compound the overall risk (Royal College of Obstetricians and Gynaecologists, 2025b).

National position

The average rate in the UK in 2023 of third- and fourth-degree perineal tears was 3.29% of all women who birthed a single baby vaginally (excluding breech babies) (NMPA, 2025b).

Local position

The Gloucestershire rate for 2023 was higher than the national rate, at 4.4% (of all women who birthed vaginally). Data from GHT covering the whole of 2024/25 and April-August 2025/26 shows no clear association with any particular deprivation decile (though it should be noted that this data includes only term singleton deliveries):

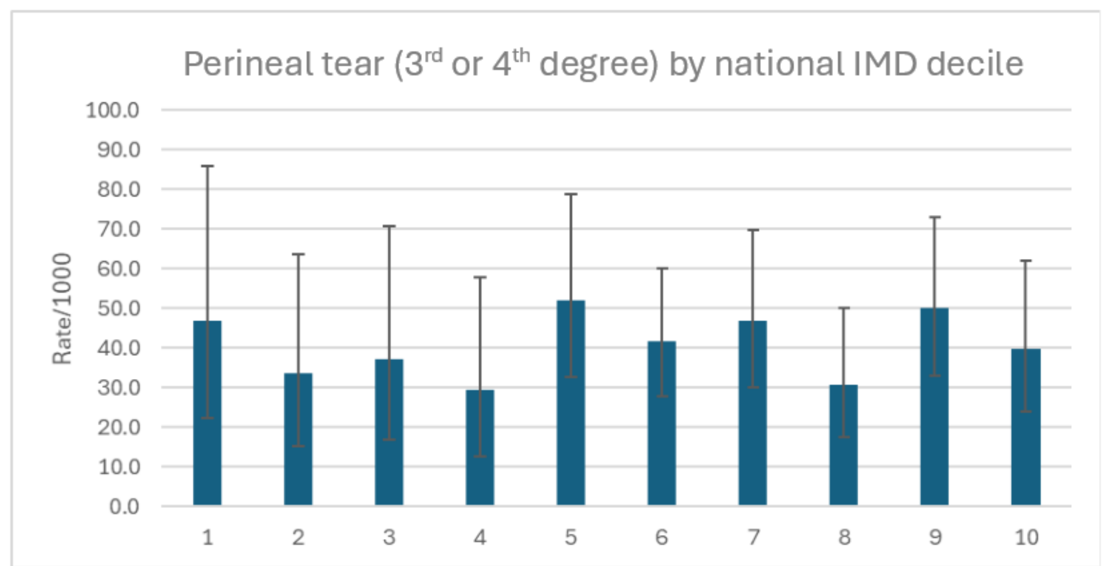


Figure 39: Rate of perineal tears (3rd or 4th degree) per 1000 births by national IMD decile, April 2024-August 2025 (Local data, Gloucestershire Hospitals NHS Foundation Trust, 2025).

Small numbers mean that seeing an impact of ethnicity on likelihood of 3rd and 4th degree tears is challenging; however, in common with wider research (Barca et al., 2021), Asian or British Asian women were more likely to have experienced a 3rd or 4th degree tear than other ethnicities:

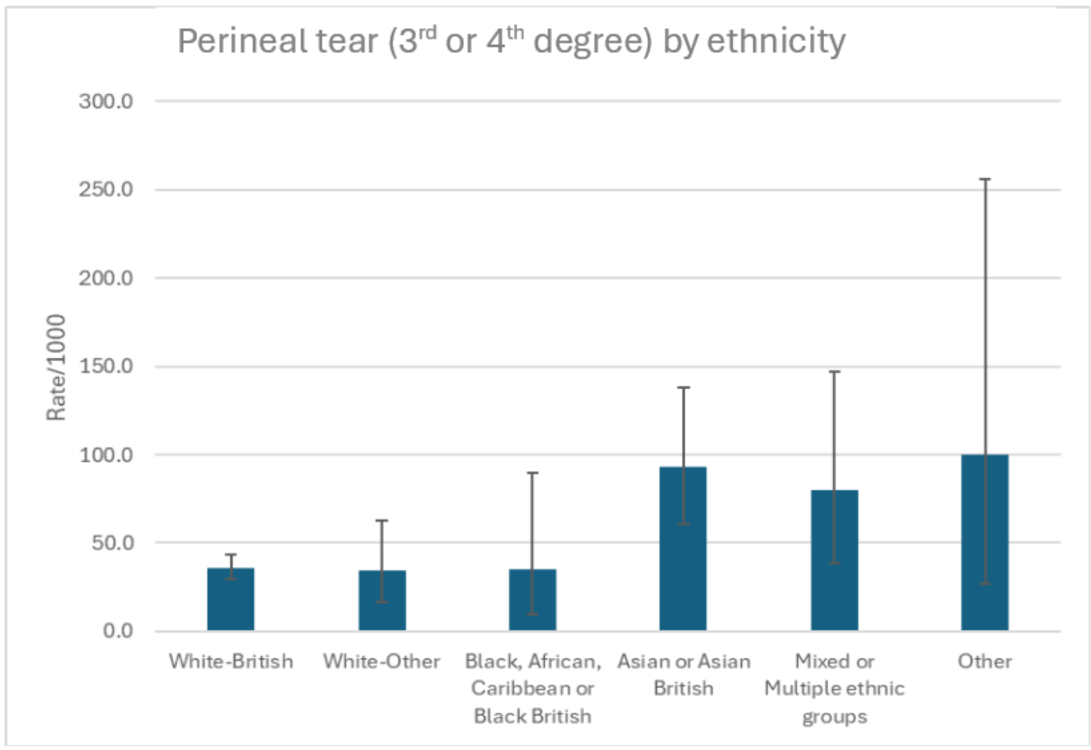


Figure 40: Rate of perineal tear (3rd or 4th degree) per 1000 births by ethnicity, April 2024-August 2025 (Local data, Gloucestershire Hospitals NHS Foundation Trust, 2025).

Local provision

The OASI2 Care bundle was launched in GHT in November 2025 to help reduce all obstetric anal sphincter injuries (OASI) in all groups of women.

7.3.8 Postpartum haemorrhage

Primary postpartum haemorrhage (PPH) is the most common form of major obstetric haemorrhage. The traditional definition of primary PPH is the loss of 500ml or more of blood from the genital tract within 24 hours of the birth of a baby. PPH can be:

- Minor (500-1000ml)
- Major (more than 1000ml). Major can be further divided into:
  - Moderate (1000-2000ml)
  - Severe (more than 2000ml) (RCOG, 2016).

In women with lower body mass (e.g. less than 60 kg), a lower level of blood loss may be clinically significant.

Secondary PPH is defined as abnormal bleeding from the birth canal between 24 hours and 12 weeks postnatally.

Impact

Obstetric haemorrhage is the leading cause of maternal death worldwide, accounting for 20% of all maternal deaths globally according to the World Health Organisation. In the UK,

18 women died from obstetric haemorrhage from 2020 to 2022 (MBRRACE-UK, 2021). Obstetric haemorrhage is also a leading cause of serious maternal morbidity, and the incidence is increasing. The recommendations from the MBRRACE report in 2023 focused on early and regular assessment of blood loss and consideration of concealed bleeding through ongoing assessment of maternal observations and point of care investigations, resulting in prompt recognition of the severity of a haemorrhage and ongoing management (MBRRACE-UK, 2023)

National and local position

Gloucestershire's PPH rate was higher than the national rate for most of 2024/25, but the gap was narrowing later in the year – see Figure 41:

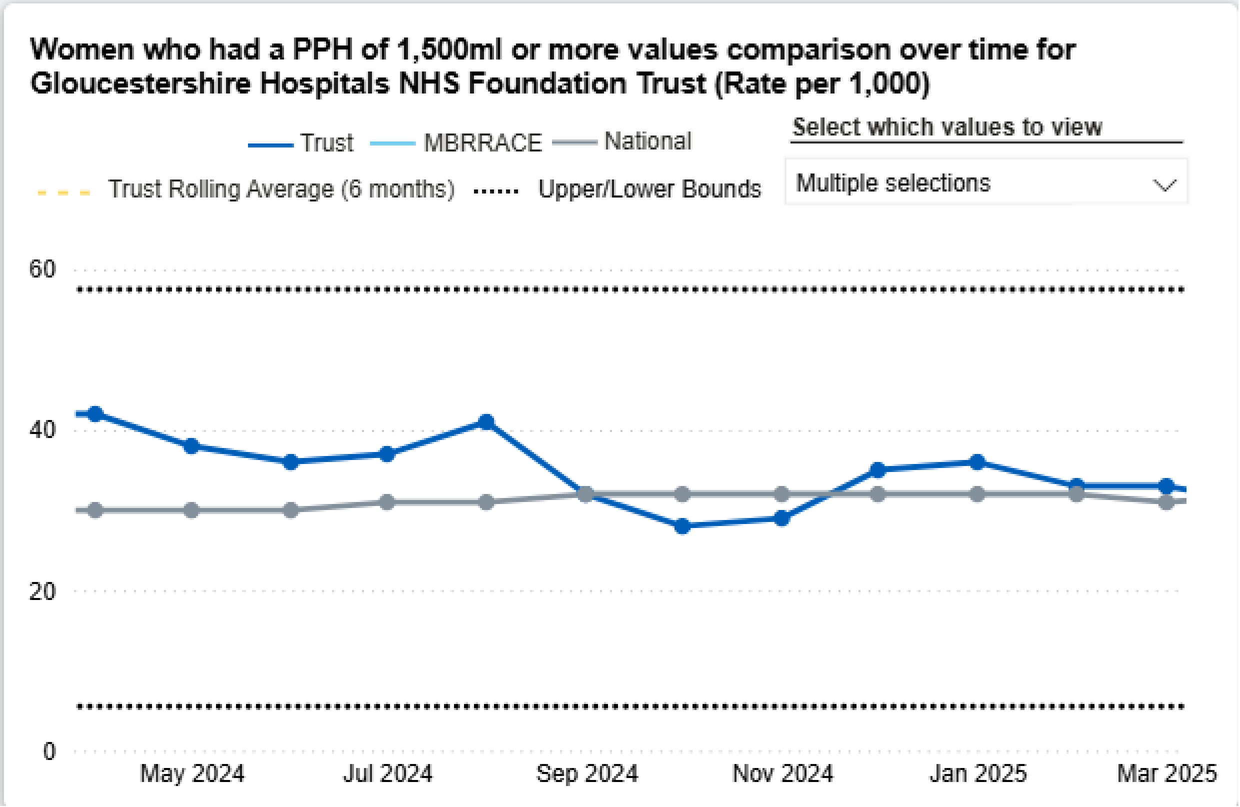


Figure 41: National PPH rate compared with Gloucestershire rate (per 1000 women), 2024/25 (MSDS, NHSE, 2025b).

Across the whole of 2024/25, 3.8% of women in Gloucestershire had a PPH (rate of 38.1 per 1000 women). Across IMD deciles, rates varied rather than showing a consistent pattern at either end of the deprivation scale. By ethnicity, PPH rates were higher in all ethnicities that are not White. See Figures 42 and 43:

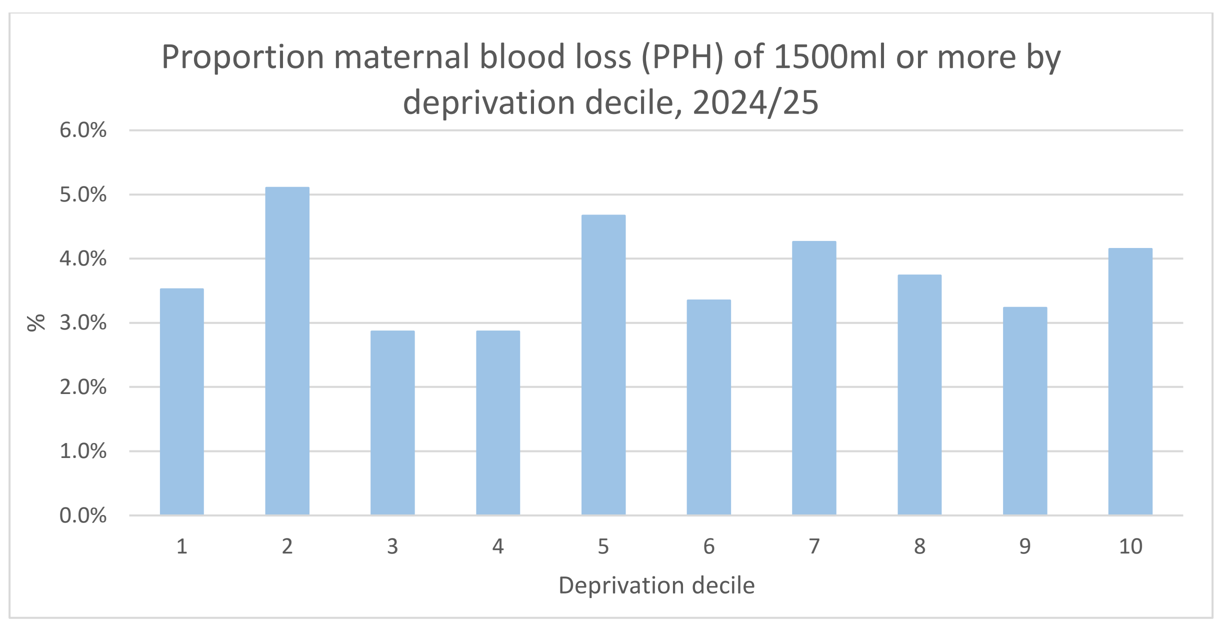


Figure 42: Proportion of Gloucestershire women with PPH by national IMD decile, 2024/25 (Local data, Gloucestershire Hospitals NHS Foundation Trust).

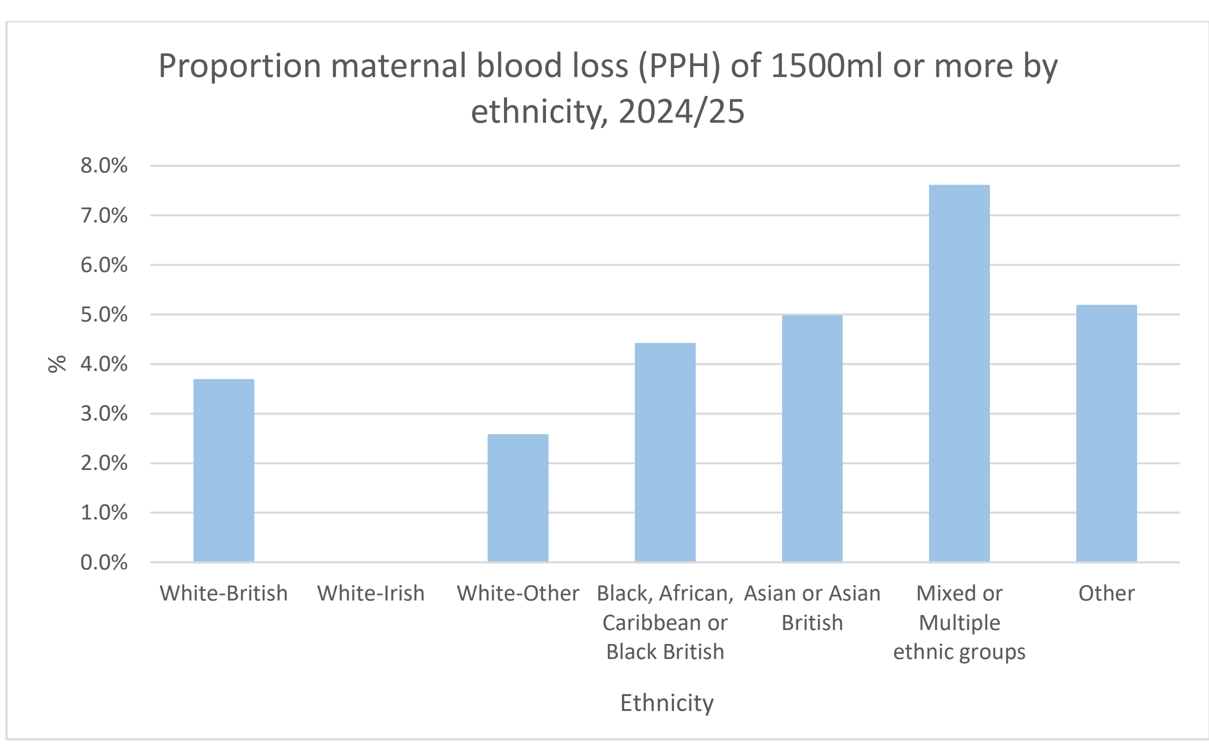


Figure 43: Proportion of Gloucestershire women with PPH by ethnicity, 2024/25 (Local data, Gloucestershire Hospitals NHS Foundation Trust).

Improving PPH care has significant implications for improving health equity. The underlying causes of ethnic inequalities in PPH rates are complex and multifaceted. Women from ethnic minority groups in the UK report poorer experiences of antenatal and intrapartum care, which may be reflected in less attention to risk factors, antenatal symptoms of anaemia, or concerns and symptoms indicative of PPH (Digitale, 2023).

Local provision

The maternity service in Gloucestershire has established a multi-disciplinary quality improvement project team to undertake a deep dive into PPH, implementing a new PPH pathway based on the All Wales OBS Cymru PPH pathway (NHS Wales Wisdom, 2025), with regular meetings to review all cases of PPH.

Outcomes: Summary

The data throughout this needs assessment demonstrates that outcomes are *not* experienced equally across Gloucestershire: women and babies from ethnic minority communities and/or those living in the most deprived areas consistently face a higher risk of adverse outcomes, including stillbirth, neonatal mortality, preterm birth, and complications requiring specialist care.

Outcomes: Key considerations

- Increased maternal readmissions can indicate gaps in care such as in timely follow-up, discharge planning, or early identification of complications. Systematic review of risk factors such as complex pregnancies and caesarean sections, and readmission causes, should inform quality improvement, focusing on preventable factors such as infection control, pain management, and feeding support.
- Review if current postnatal pathways are able to provide adequate early support to prevent avoidable neonatal readmissions. This includes timely feeding assessments, breastfeeding support, monitoring for jaundice, and clear escalation routes for community midwives and health visitors.
- Rates of perineal tears are higher among Asian/British Asian women. Review any work carried out nationally (such as (Olakotan et al., 2025) that could be applied locally to understand and reduce the risk.
- Consider how to reduce postpartum haemorrhage among women from ethnic minorities.
- Consider how we can focus on reducing inequality of outcomes between our different demographic groups.

Following the exploration of deprivation and ethnicity, it is equally important to recognise that other demographic characteristics within our maternity population also play a significant role in shaping maternal and neonatal outcomes. Consequently, the next subsections consider some of these other demographics – namely, language and communication needs, the age profile of mothers, maternal mental health, and the growing prevalence of multiple long-term conditions. Each of these demographics influences how women and birthing people engage with services, how effectively risks are identified and managed, and how outcomes vary across the population. They also intersect with deprivation and ethnicity, often compounding disadvantage.

By examining these demographics in detail, this section provides a more complete understanding of the complexities within Gloucestershire's maternity population. This broader view is essential for planning equitable, personalised services that address the full spectrum of need and work to reduce inequalities in outcomes.

7.4 Language and communication

Impact

Women with limited or no ability to speak and/or read English may encounter barriers when engaging with maternity services and accessing information. This was highlighted in the recent Gloucestershire maternal mortality review. These challenges can include insufficient appointment times due to the need for interpreters, and difficulties in accessing interpreters – especially face to face – due to national challenges. For some languages, there are only one or two individuals nationally who speak it, which makes in-person interpreting extremely difficult. Due to these challenges, staff can sometimes resort to using family or friends to interpret (despite being against NHS guidelines) which can compromise confidentiality and accuracy and potentially create safeguarding issues for the woman concerned. Another risk with using a family member or friend can be the potential for misinterpretation due to lack of proficiency in both languages and/or understanding of medical terminology.

Communication challenges for people with disabilities or who are neurodivergent, including those with hearing, speech, cognitive, or learning impairments, must be considered. These individuals may require alternative formats, such as British Sign Language (BSL) interpreters, Easy Read materials, or augmentative and alternative communication (AAC) tools. Lack of accessible communication for these groups of people can lead to misunderstandings, reduced engagement, and poorer health outcomes.

Local position

The 2021 Census shows that 27,000 people in Gloucestershire (4.3% of the population) did not speak English as their main language. At district level, this rate was highest in Gloucester at 8%, followed by Cheltenham at 6.9%. Forest of Dean and Stroud had the lowest at 1.8%. Gloucester also had the highest percentage of people who either cannot speak English well or English at all (1.5%) and Cotswold and Stroud the lowest (0.2%) (GCC, 2025a).

Figure 44 shows the distribution of people who do not speak English as their main language *and* cannot speak English well or at all. Five LSOAs in the county - all in Gloucester - each have more than 5% of its population in this category, with the LSOA ‘Barton and Tredworth 2’ recording the highest proportion at 9.3%. The areas with the greatest concentration of non-English speakers are primarily in the urban centres of Cheltenham and Gloucester, as well as Cinderford in the Forest of Dean. (GCC, 2025a).

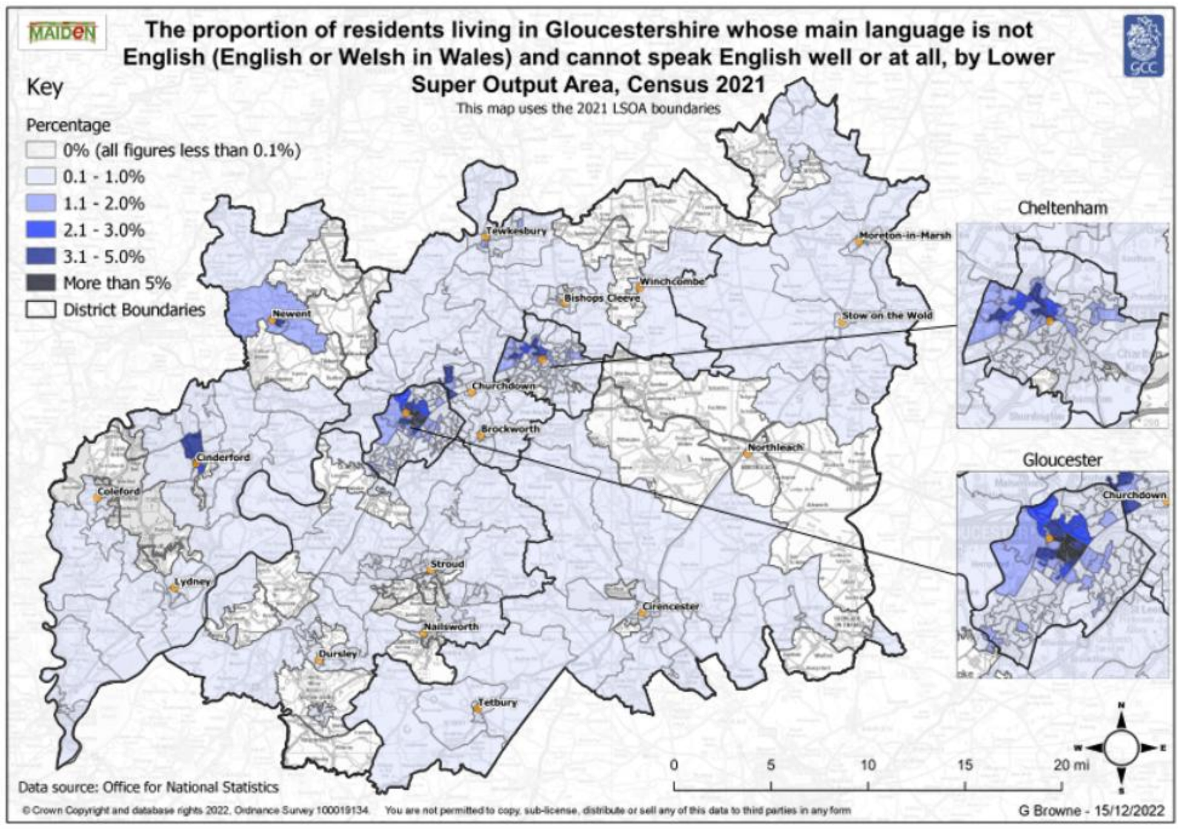


Figure 44: Proportion of residents in Gloucestershire who do not speak English as their main language and cannot speak English well or at all (based on those who answered “4” or “5” to the 2021 Census question regarding language proficiency, where the answer “4” indicates the person cannot speak English well, and “5” indicates they cannot speak English at all) (GCC, 2025a).

This data suggests that overall, women in Gloucester and Cheltenham are more likely to require interpreter support during maternity appointments compared to those in other districts in the county, with a smaller population in the Forest of Dean.

Maternity data shows that more than 1 in 10 women (11.8%) who birthed in Gloucestershire in 2024/25 did not have English as their primary language, further highlighting the importance of interpreter support for the maternity population.

It is important to consider other factors that may mean women encounter communication barriers and challenges. Women with learning disabilities, for instance, often require tailored support, necessitating reasonable adjustments, continuity of care, and advocacy to ensure safe and informed maternity journeys. Likewise, individuals with neurodivergent conditions such as ADHD, or who are autistic, or those with chronic pain or physical disabilities may have distinct needs related to sensory environments, decision-making, and care coordination. Addressing these needs effectively requires collaboration with wider stakeholders and people with lived experience to better understand current service provision and identify opportunities for development.

Local provision

The NHS in Gloucestershire ensures equitable access to healthcare by providing professional interpreting and translation services in line with the Equality Act 2010 and the Accessible Information Standard. The Word360 service provides systemwide interpreting via telephone, video and in person for spoken language and written translations for documents, while British Sign Language support is delivered through Gloucestershire Deaf Association (GDA). Maternity staff should offer an interpreter for all appointments from booking onwards. The aim is to ensure communication needs are met and information is accessible for people who do not speak English or are deaf.

Maternity services at GHT have invested in Wordskii on Wheels (WoWs) – an iPad dedicated to pre-booked and on-demand video interpreting. This can be used for both on-demand and pre-booked interpreting needs. Despite a few occasions where there have been challenges sourcing an interpreter or with poor phone signals, the Word360 and WOW service has made interpreting services far more accessible at the point of care.

Language and communication: Summary

11.8% of births in 2024/25 in Gloucestershire were to women who did not have English as their primary language, and proportions of non-English speakers are higher in Gloucester than in the rest of the county. Other language and communication challenges include those experienced by women who are deaf and/or neurodivergent. It is therefore important to use accessible, culturally sensitive communication within maternity care to ensure equitable engagement and understanding for all service users, particularly those who do not speak English.

Language and communication: Key considerations

- Ensure independent interpreters (as provided by the Word360 service) are provided for those who do not speak or understand English well, or who require disability-inclusive support.
- Ensure information is coproduced and provided in a variety of formats, taking into consideration reasonable adjustments for disability, and cultural sensitivity.
- Consider how best to staff maternity services across the county to ensure appropriate time is available to support women requiring interpreters, especially in Cheltenham and Gloucester where need is greater.
- Aim to identify and address any potential barriers to understanding well before labour begins to ensure safe, personalised care.

7.5 Age of women giving birth

Impact

Older mothers may face higher risks of complications but also tend to have better socioeconomic profiles and access to care.

Women over the age of 35 are more likely to experience pregnancy-specific complications such as gestational diabetes and pre-eclampsia, which increase the risk of adverse maternal and neonatal outcomes. Higher maternal age is also associated with an increased likelihood of chromosomal abnormalities, including conditions such as Down syndrome. These clinical complexities place greater demands on maternity services, requiring enhanced antenatal surveillance, multidisciplinary care planning, and access to specialist obstetric input.

Younger mothers, particularly those aged under 18 at conception, are more likely to experience poorer health outcomes, including higher rates of preterm birth and low birth weight for gestational age, and experience greater vulnerability to perinatal mental health difficulties, indicating increased need for targeted midwifery and perinatal mental health support (Marvin-Dowle et al., 2018; Khashan et al., 2010; WHO, 2024).

National position

The average age of mothers in the UK has been steadily increasing over the past five decades, reaching 30.9 years in both 2023 and 2024 (ONS, 2025d). This shift reflects broader societal changes, including delayed family formation due to extended education, career prioritisation, perceived financial stability, and changes in cultural norms. Births to women under 30 have declined, while those aged 30 and over – particularly in the 35-39 age group – have seen notable increases, with a 2.7% rise in births from 2023 to 2024. Additionally, births to women aged 40 and over continue to rise, suggesting that maternity services must adapt to the needs of older mothers.

Local position

The distribution of births by age of mother in Gloucestershire is similar to the national picture, with Gloucestershire seeing slightly higher proportions of mothers aged over 30 in 2024 than nationally, as shown in Figure 45:

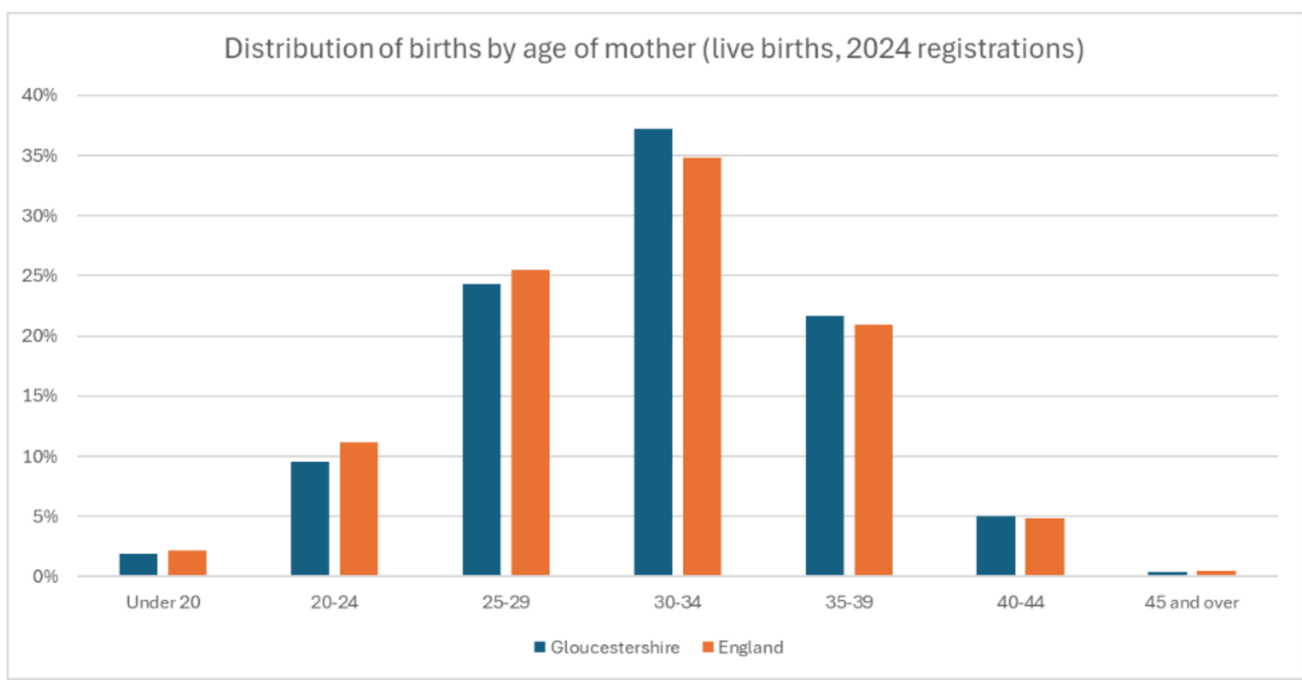


Figure 45: Proportions of birth registrations by age of mother in 2024, Gloucestershire compared to England (ONS, 2025d).

Between 2013 and 2024, the distribution of live births by age of mother in Gloucestershire has seen a slight degree of change. Figure 46 shows that, since 2013, there has been a general decreasing trend in the proportion of births to mothers aged up to 29 years, for each age band. The reverse is apparent for mothers aged 30 and above, where the overall trend is of an increase in the proportion of births each year since 2013.

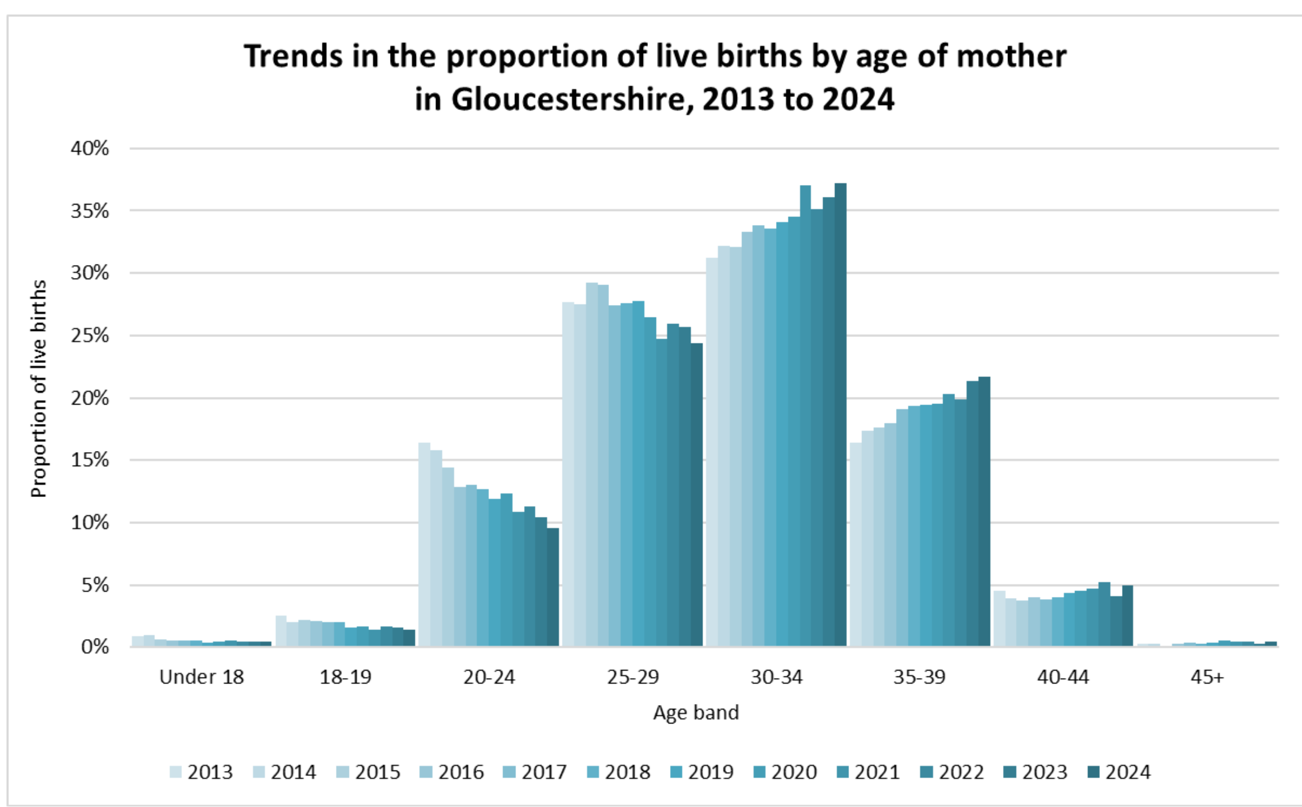


Figure 46: Trends in the proportion of live births by age of mother in Gloucestershire, 2013 to 2024 (ONS, 2025d).

Figure 47 shows that in 2024, nearly two thirds (64%) of all births in the county were to women aged over 30, with higher rates in more affluent districts:

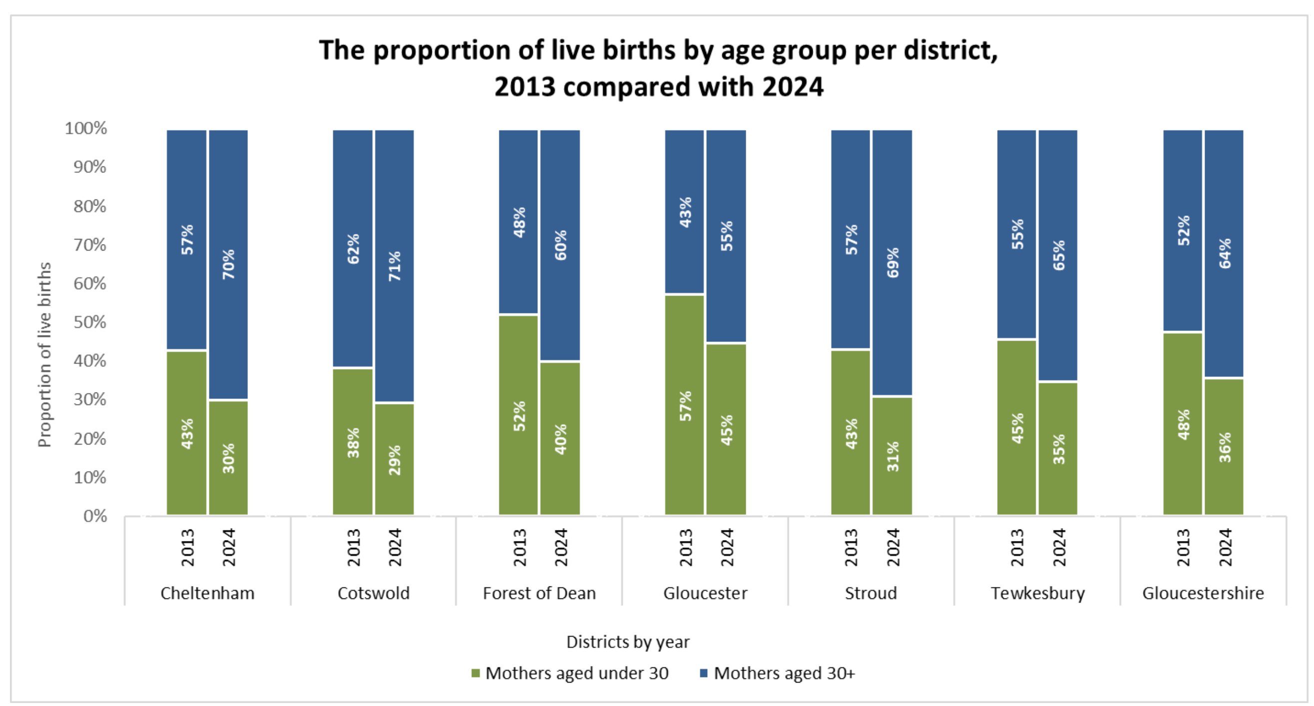


Figure 47: The proportion of live births to Gloucestershire residents by district, grouped by age of mother (mothers aged 18-29 and over 30), 2013 compared with 2024 (GCC, 2025a).

Although the overall number of births in Gloucestershire is expected to remain relatively stable, recent ONS data based on 2022 population projections indicates that the trend of increasing maternal age will persist. Specifically, births to mothers aged 36 or over are projected to rise by 15% by 2032, while total births are anticipated to decrease by 2% compared to 2021 actual figures. By 2047, the number of births to mothers aged 36 or over is expected to be 50% higher than in 2021. While some variation is predicted between districts, all areas in Gloucestershire are forecast to experience a continued shift towards more births to mothers over 30 through to 2047 – see Figures 48 and 49. (Note that numbers of under 20s and age 40+ are grouped rather than shown as individual ages.)

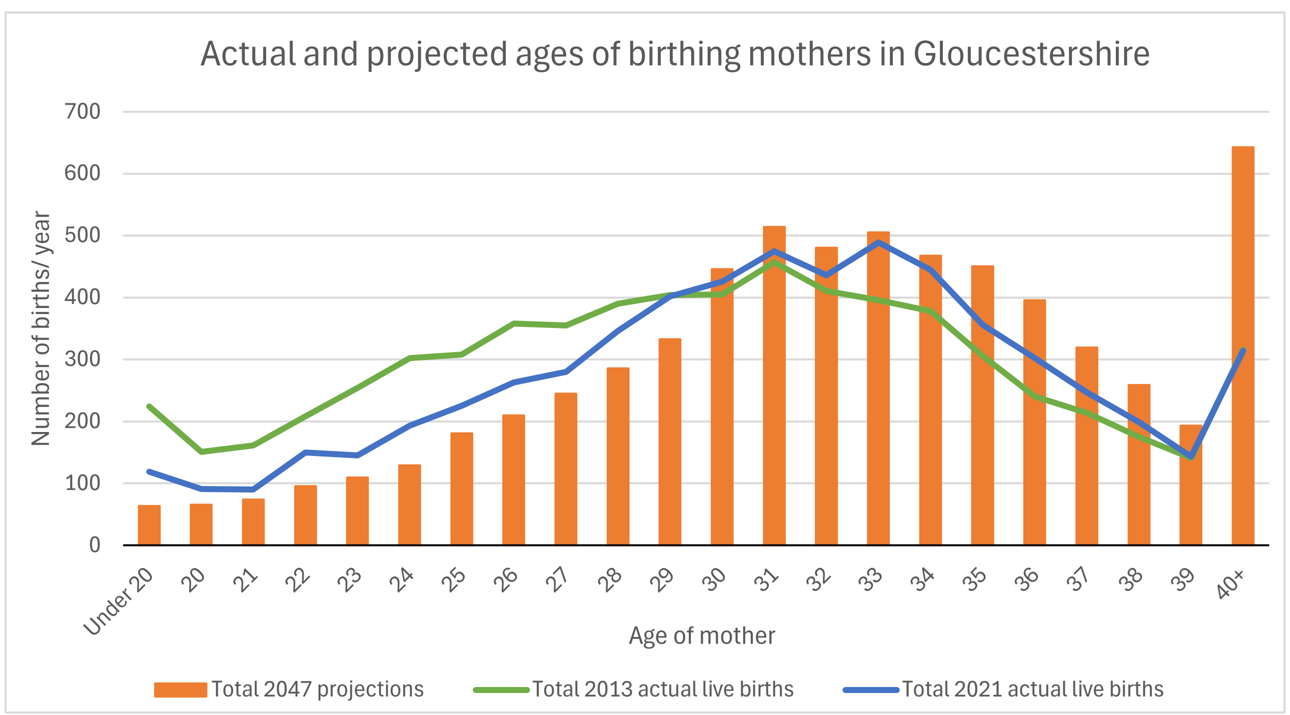


Figure 48: Gloucestershire county-level rates and projections for births by age of mother, comparing actual birth rates in 2013 and 2021 to projections for 2047 (ONS, 2025d).

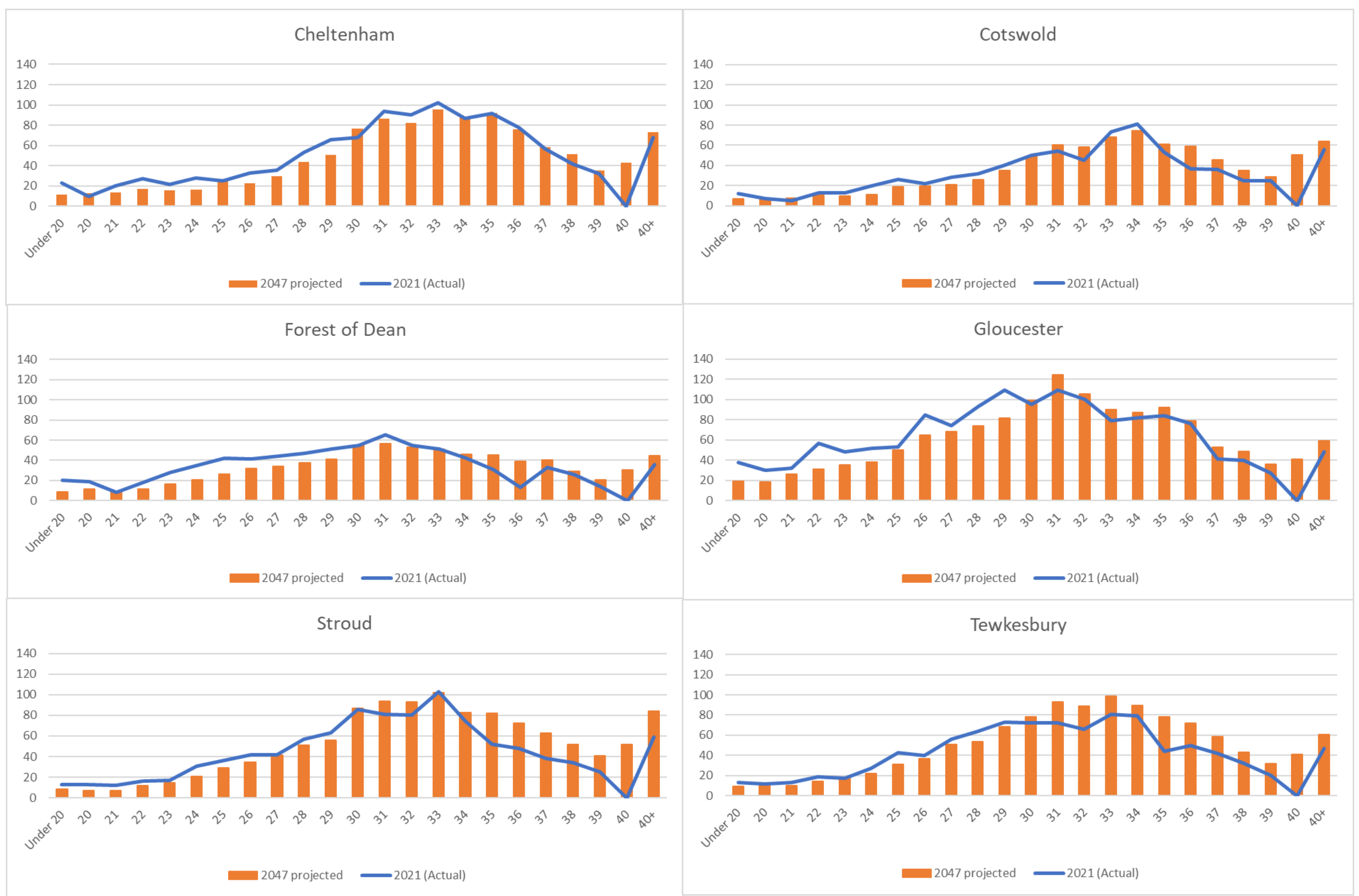


Figure 49: Gloucestershire district-level projections for births by age of mother, comparing actual birth rates in 2021 to projections for 2047 (ONS, 2025d).

Births to mothers under the age of 18 have declined, and latest figures show these account for 0.5% of births in Gloucestershire in 2024. It should be noted that there are variations across the districts in the conception rates to those aged under 18, which may have implications for maternity services.

Local provision

There are a number of ways that younger mums are supported in the county. A specialist midwife for young parents, who is part of the Vulnerable Women's Team within GHT's maternity service, provides training and support to all maternity staff around caring for pregnant women who have conceived under the age of 18 years. The specialist midwife provides three antenatal visits in addition to the universal midwifery care offer, and one additional postnatal visit if required. In addition, there are several weekly support groups for young parents run by the voluntary and community sector - currently in Cinderford, Cheltenham, and Gloucester, with support also available for young parents in Cirencester. The Gloucestershire Teenage Pregnancy Network meets quarterly and brings together all the organisations across the county which support young parents in different ways.

Maternal age: Summary

As the average maternal age continues to rise, maternity services must adapt to manage more complex pregnancies safely and equitably, with appropriate staffing, training, and infrastructure to support personalised and responsive care (NMPA, 2025b).

Maternal age: Key considerations

- Increasing maternal age, and therefore complexity, may lead to an increased need for obstetric care (including maternal and fetal medicine specialists) and anaesthetic care. Service pathways and staffing levels should therefore be reviewed to ensure that safe maternity care can be delivered in the context of increasing complexity related to maternal age.

7.6 Mental Health

Impact

Perinatal mental health (PMH) issues can have profound and lasting effects on women, families, and children. Conditions such as depression, anxiety and birth-related trauma can compromise maternal wellbeing, disrupt family relationships, and hinder bonding with the baby. These challenges often lead to difficulties in infant development, including feeding and attachment, and can also extend beyond the immediate postnatal period, affecting bonding, family dynamics, behavioural and emotional problems later in childhood, and long-term wellbeing (NHSE, 2018; Royal College of Psychiatrists, 2018; NICE, 2020; MBRRACE-UK, 2021).

For some women, birth trauma can also influence future reproductive choices, as it can lead to heightened fear of childbirth, increased requests for elective caesarean sections, or birth outside of clinical guidance. Addressing birth trauma requires proactive identification, timely debrief and psychological support, and integrated care pathways between maternity and mental health services.

These impacts of birth trauma and poor perinatal mental health highlight the need for early identification and integrated support to ensure safe, personalised care, and break the cycle of poor mental health across generations.

National position

Data indicates that PMH conditions affect approximately one in four women in England, with a 25.8% prevalence rate among those who gave birth in 2019 (Office for Health Improvement and Disparities (OHID), 2025a) and there is evidence that mental health prevalence in the maternity population is increasing (NHSE, 2024). Common mental health disorders such as depression and anxiety account for the vast majority of cases, while severe mental illness, eating disorders and personality disorders are seen in 1.2% (combined prevalence) of the maternity population. As outlined earlier in the outcomes

section (7.3), suicide is the leading cause of maternal death between six weeks and one year postpartum.

Data shows that there is likely to be an unmet perinatal mental health need nationally among younger people, those living in deprivation, and/or those from ethnic minority backgrounds.

Local provision

In Gloucestershire, women are asked about their current state of mental health and any previous specialist treatment when booking for maternity care, and are asked again at all antenatal and postnatal appointments, in line with the Gloucestershire perinatal mental health pathway. Women who are identified as having, or being at risk of a recurrence of, a severe mental illness will have a written plan of agreed multidisciplinary interventions and actions to be taken between Gloucestershire's Specialist Perinatal Mental Health Team, midwives, health visitors and GPs, amongst others, and in line with the PMH pathway.

The Specialist Perinatal Mental Health Team (part of Gloucestershire Health and Care NHS Trust) supports women with moderate to severe/complex mental health needs. A joint weekly Obstetric and PMH clinic was established in 2017 at Gloucestershire Royal Hospital to enable women to access both obstetric and specialist mental health support in one place. It is supported by a multidisciplinary team, which includes a lead PMH consultant obstetrician, a specialist PMH midwife, and a maternity support worker, supported by other staff from the Specialist PMH team.

In 2021, the Specialist PMH Team was expanded to further support maternal mental health, and the Birth Anxiety and Trauma Service was established. This service offers specialised trauma-informed psychological support for women with high levels of distress from previous traumatic births, fear of birth, or baby loss. The multi-professional team provides therapy, care planning and support for future pregnancies. Women are able to self-refer or can be referred by a health professional. Referrals to both services have increased each year, mirroring the national picture (Maternal Mental Health Alliance, 2024).

Local position

The Specialist PMH Team saw 835 perinatal women in 2024/25, higher than previous years. This year-on-year rise is likely due to a number of factors including increase in provision, awareness of the services among referrers, and need among women.

In Gloucestershire, White British women are significantly more likely to access perinatal mental health services than all other ethnicities:

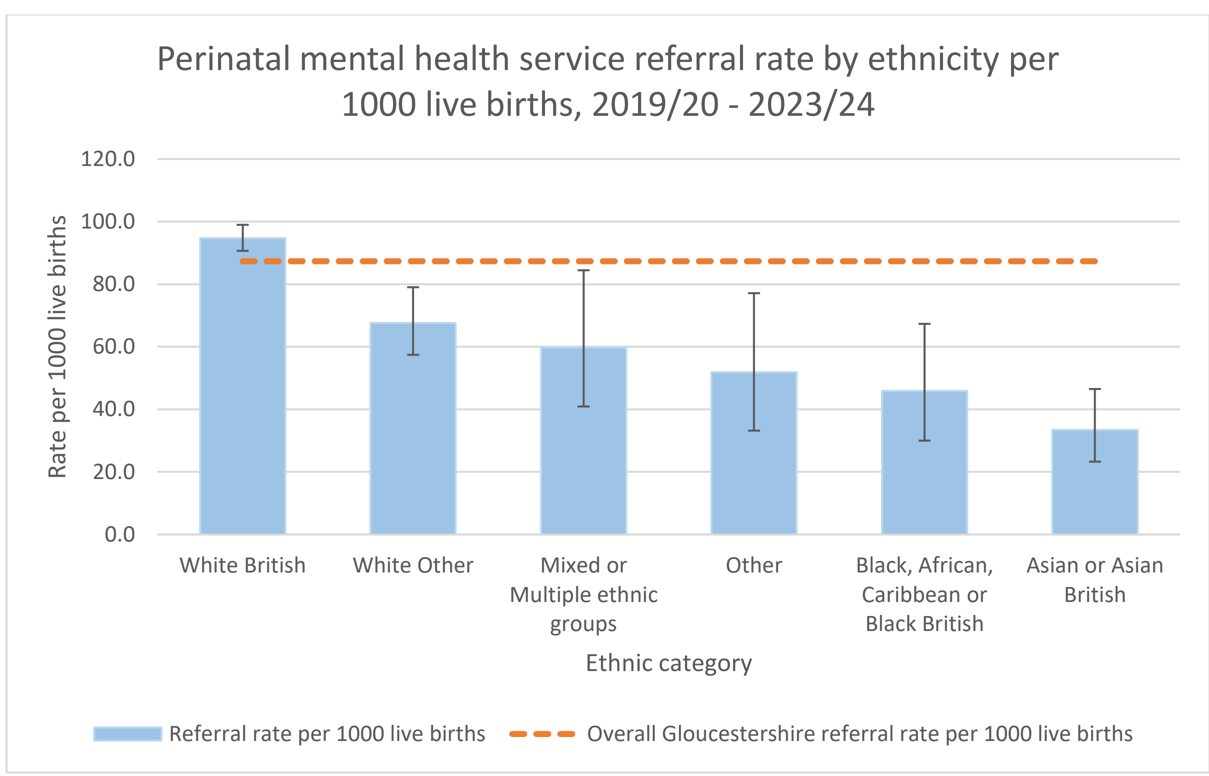


Figure 50: Referrals to the perinatal mental health service by reported ethnicity in Gloucestershire, 2019/20-2023/24 (MSDS, NHSE, 2025b; and Mental Health Services Dataset (MHSDS), NHSE, 2025e).

The Specialist PMH Team has been undertaking a Quality Improvement project since 2024 to improve access to the team for women from ethnic minority communities – particularly those from South Asian communities – through the use of outreach workers. This work has helped to identify and reduce a number of barriers to access.

Data from 2019/20-2023/24 shows no clear deprivation gradient in perinatal mental health service referral rates, although decile 2 has a notably lower rate than the Gloucestershire average. See Figure 51.

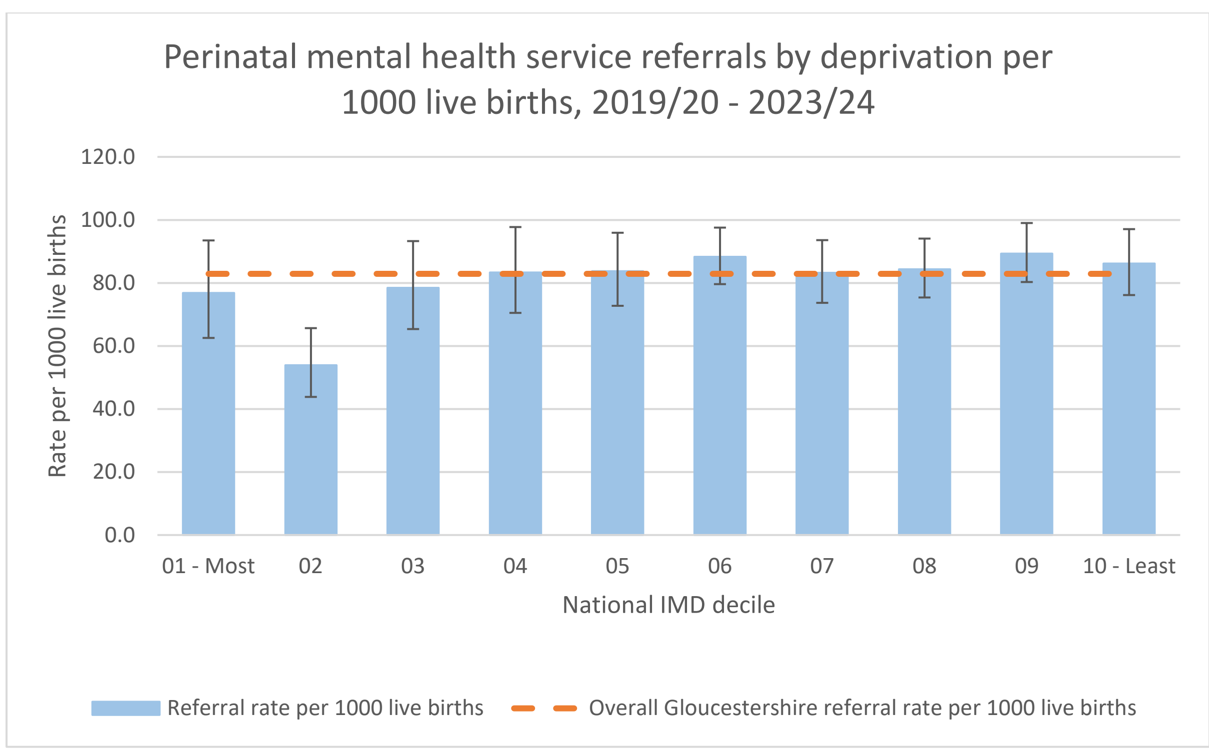


Figure 51: Referrals to the perinatal mental health service by national IMD decile in Gloucestershire, 2019/20-2023/24 (MSDS, NHSE, 2025b).

With regards to age, referral rates were higher among under 20s and 45-49 year olds than other age groups in 2022/23, but broadly similar across most age groups in 2023/24 and 2024/25 – see Figure 52. This suggests no clear, consistent under-representation by maternal age.

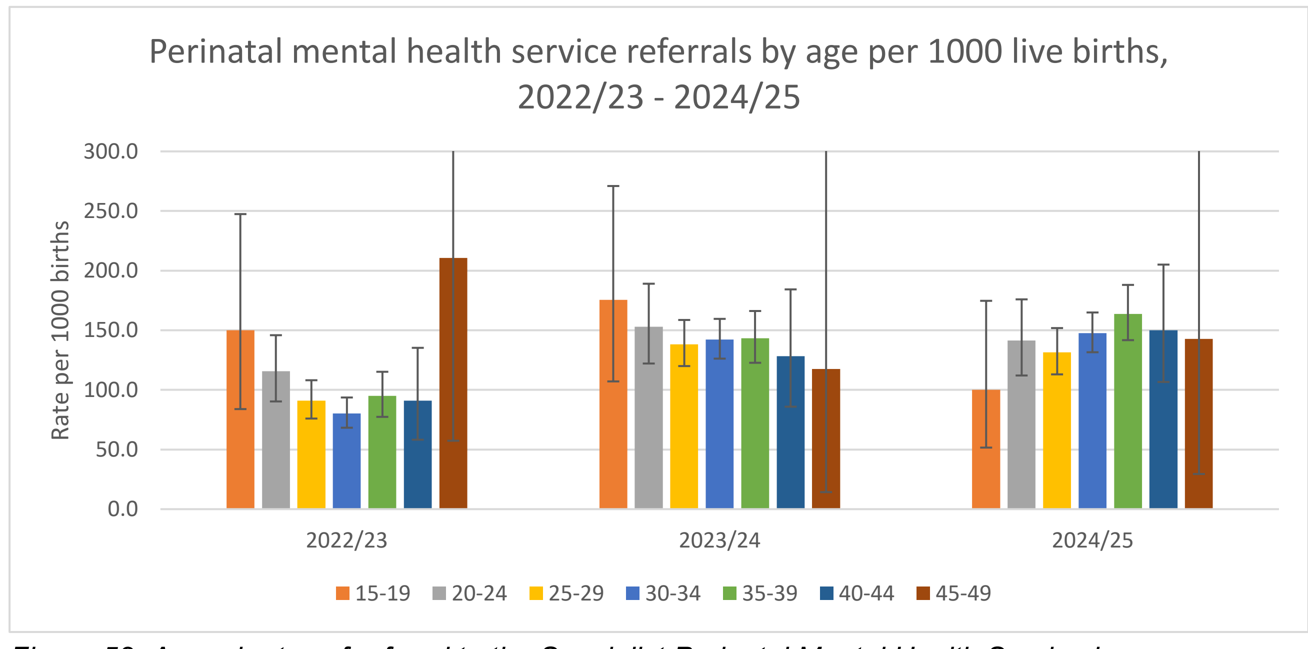


Figure 52: Annual rates of referral to the Specialist Perinatal Mental Health Service by age group in Gloucestershire, 2022/23-2024/25 (MHSDS, NHSE, 2025e).

In addition to pathways and services for women and birthing people with severe/complex mental health needs, consideration has also been given to provision of services for women who may not meet the threshold for referral to specialist services but require support and debrief. In 2025, a Birth Review and Reflect trauma-informed service was established within the maternity service at GHT, initially as a 2-year pilot. Staff have received training on trauma-informed approaches to providing debriefs and an evaluation will be conducted into the effectiveness of the pilot.

The purpose of the Birth Review and Reflect service is to ensure there is a formal pathway back into maternity services for women who want a debrief with a health professional of their birth experience. The service is coordinated by a Birth Review & Reflect Co-ordinator who provides a point of contact for women and refers them to an appropriate senior health professional. Referral numbers to date suggest there is a clear need for this service (258 referrals were made and 231 accepted between the service starting in February 2025, and December of that year), highlighting the need for continued evaluation, investment and workforce development so that all staff are able to provide trauma-informed care.

Mental health: Summary

Perinatal mental health issues have significant and long-lasting impacts on women, babies, and families. Data shows that around one in four women nationally experience PMH conditions, with rising prevalence and clear inequalities affecting younger women, those living in deprivation, and ethnic minority groups. In Gloucestershire, care is provided through a number of services. Data for the county indicates increasing referrals each year and lower rates of access among women from ethnic minorities.

Mental health: Key considerations

- Understand barriers to access to the Specialist PMH Team for women from areas of higher deprivation, and continue the work underway to reduce barriers for women from ethnic minority communities.
- As more women are likely to need support from the specialist perinatal mental health team, the capacity of the joint Obstetric and PMH multi-disciplinary clinic (at GHT) will need to be reviewed to support increasing demand.
- Review the capacity of the Birth Anxiety and Trauma team and maternity workforce development needs to support women in the light of rising referral trends.
- Addressing birth trauma requires early and proactive identification, timely debrief and psychological support, and integrated care pathways between maternity and mental health services to ensure safe, personalised care, and break the cycle of poor mental health across generations.

7.7 Multiple long-term conditions

Impact

The most prevalent conditions among women with multiple long-term conditions include mental health disorders (particularly anxiety and depression), obesity, hypertension, diabetes, and anaemia. These conditions not only affect maternal wellbeing but also increase the risk of complications such as pre-eclampsia, gestational diabetes, preterm birth, and severe maternal morbidity. Women with multiple long-term conditions are over-represented in maternal mortalities nationally (NMPA, 2025b). An epidemiological study of the maternity population (of 37,641 CPRD primary care records accessed in 2018) suggested that 44.2% (95% CI 43.7-44.7%) of women in the UK have multiple long-term conditions. Of these, around 70% had a mental health condition as at least one of the identified conditions (Lee et al., 2022).

Women with multiple long-term conditions are more likely to need consultant-led care in pregnancy and may also need to access care from multiple areas of the maternity service in pregnancy e.g. maternal medicine, perinatal mental health and anaesthetics.

National guidance recommends that women with complex physical and/or psychological long-term conditions receive pre-pregnancy counselling, with health conditions and medication reviewed and optimised wherever possible prior to conception, and coordinated multidisciplinary care across the maternity pathway (NICE, 2025c; RCOG, 2026).

Multiple long-term conditions: Key considerations

- There is likely to continue to be an increase in pregnant women with multiple long-term conditions who will require consultant-led care. These births are likely to be both more complex and require more medical input, including anaesthetics and physicians specialising in maternal medicine, as well as specialist midwives, so training needs and resource will need to be managed appropriately.

8. Wider determinants of health: Health behaviours

It is widely recognised that healthcare itself is only one of the contributing factors to overall health outcomes. While quality and access to healthcare is important to outcomes, there are wider determinants of health which play a much bigger, more critical role in shaping community health (as illustrated in Figure 53), in turn impacting maternity outcomes. These wider determinants tend to be beyond individual control, reinforcing the need for coordinated systemwide action to drive meaningful change. Socioeconomic determinants, such as income, education and employment, have already been considered in this needs assessment. Other determinants which relate to health behaviour, namely obesity, smoking, breastfeeding, and timely booking with maternity services, are reviewed in this section.

To create long-lasting structural change in health outcomes in maternity services, all these wider determinants need to be considered alongside access and quality of care.

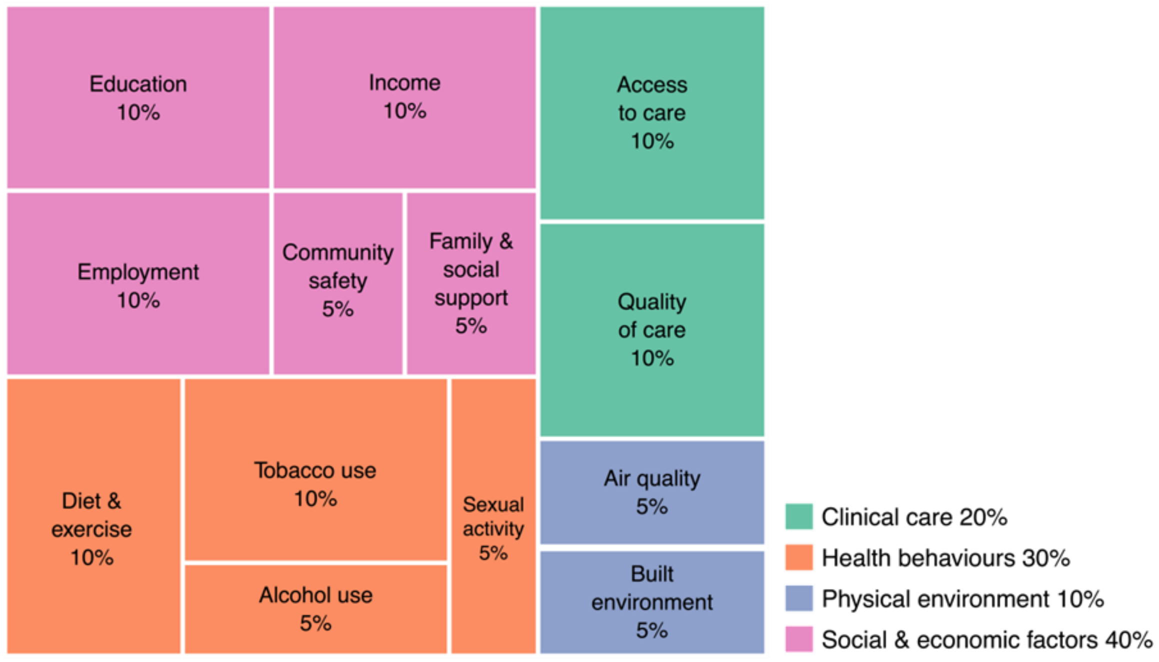


Figure 53: Relative Contributions of a Set of Health Factors to Selected Health Outcomes (American Journal of Preventative Medicine, 2015).

8.1 Obesity

Obesity is a complex problem and has many drivers, most of which are outside of the control of individuals (Vandenbroeck, 2007). Addressing obesity during pregnancy must be embedded within a broader, coordinated approach to healthy living and weight management across the county, involving the ICB, public health, maternity services, community support, and wider system partners.

Impact

‘Obesity’ is defined as having a Body Mass Index (BMI) of over 30, and 'overweight’ is having a BMI of 25-30. There is a substantial body of evidence which links maternal obesity to adverse maternal complications such as gestational diabetes, hypertensive disorders, prolonged or dysfunctional labour, postpartum haemorrhage and maternal morbidity and mortality (Shirvanifar et al., 2024; Abdi et al., 2025). Obesity can also contribute to adverse neonatal complications such as stillbirth, neonatal death, and premature birth, and increased risk of childhood obesity.

National position

Data indicates that nationally, obesity is higher in women than men, is higher in the most deprived communities compared with less deprived communities, and is likely to increase over time (Hancock, 2021). National maternity obesity prevalence is not available, but there are currently around 11 million women of childbearing age (16 to 44 years) in England, of which around 2 million (19%) are obese (Leddy et al., 2008).

Local position

Gloucestershire obesity prevalence (defined by adjusted self-reported height and weight, Active Lives Adult Survey, Sport England) suggests that the county sees no statistical variation to the national trend in the last four years:

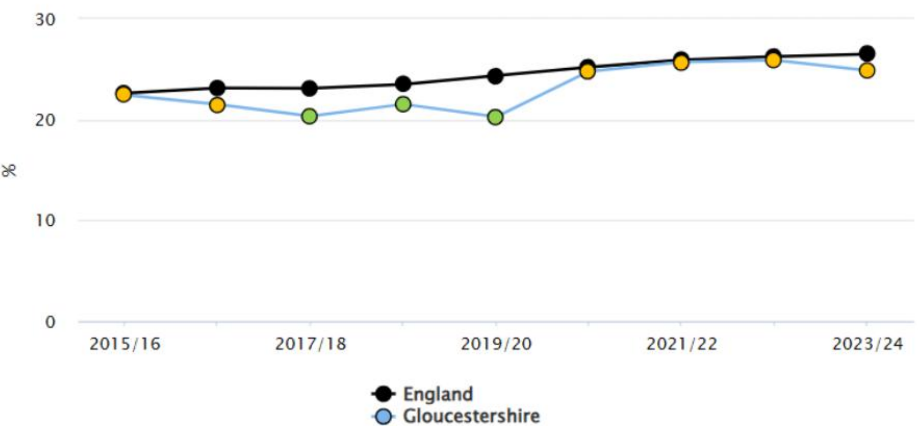


Figure 54: Obesity prevalence in Gloucestershire, compared to the England average where obesity is defined by adjusted self-reported height and weight from the Active Lives Adult Survey conducted by Sport England 2023/24 (OHID, 2025b).

Across the county there is significant variation in the proportion of adults who are obese, with Gloucester in the top third of lower-level authorities in the country for levels of obesity, while Cheltenham is in the lowest 10th (decile). Figure 55 shows the obesity rates in each of the county’s districts, compared with England rates:

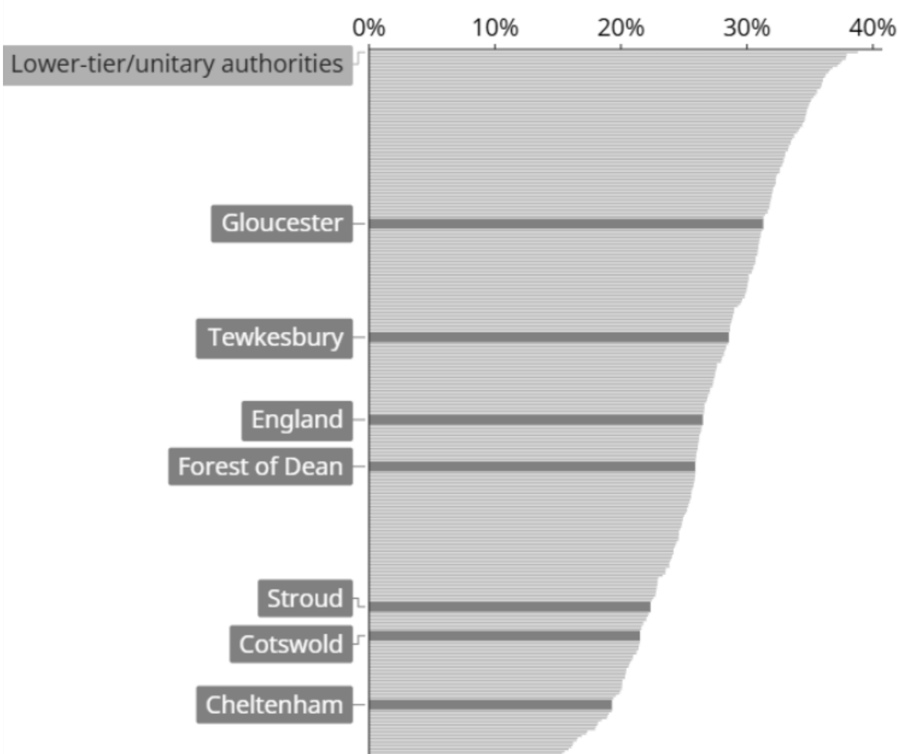


Figure 55: Lower tier/unitary authority variation of the proportion of adults aged 18 and over classified as living with obesity defined by adjusted self-reported height and weight from the Active Lives Adult Survey conducted by Sport England 2023-24. Gloucestershire districts and England average indicated as broader bars. (OHID, 2025b)

Local maternity data shows that in 2024/25, 27.2% of women had a BMI of 30 or above on antenatal booking at GHT. This rate has increased each year since 2020/21, when the rate was 21.0%. There has also been a rise in pregnant women with a BMI of 40 or above, with rates of 2.8% in 2020/21 and 4.6% in 2024/25. Figure 56 illustrates these increasing rates for Gloucestershire women:

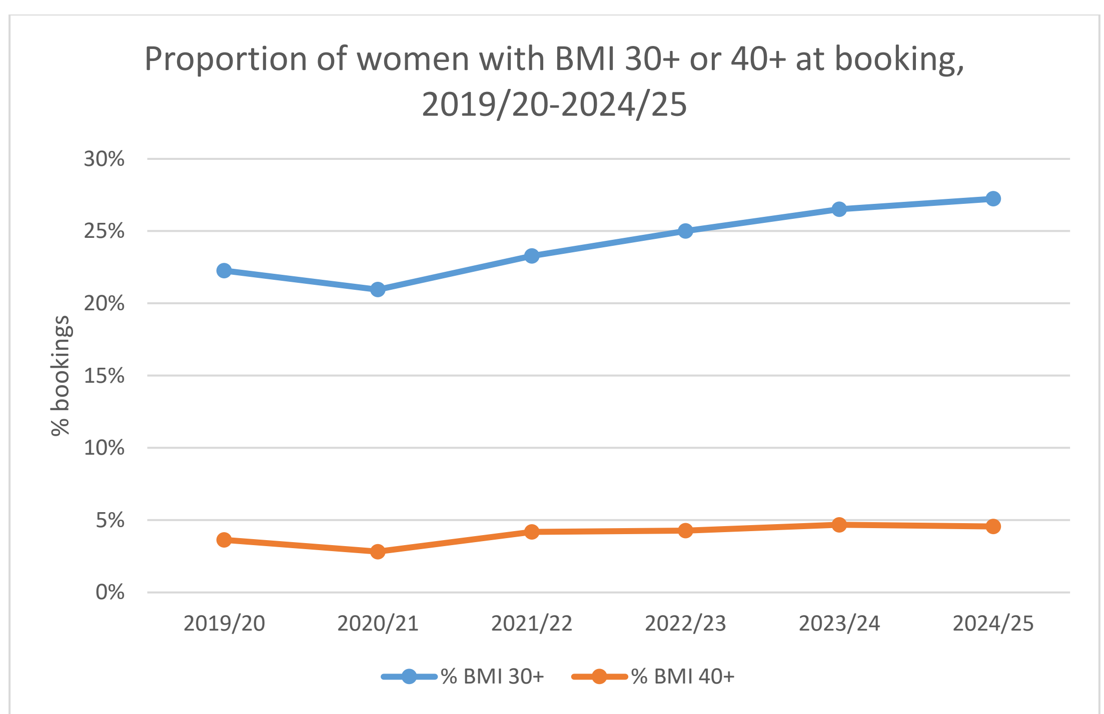


Figure 56: Proportion of women with a recorded BMI of 30 or above and those with a BMI of 40 or above at antenatal booking, 2019/20-2024/25 (Local data, Gloucestershire Hospitals NHS Foundation Trust).

Table 10 shows the *numbers* of women with BMI of 30+ and 40+:

	No. women BMI 30+	No. women BMI 40+	Total bookings BMI recorded
2019/20	1594	260	7159
2020/21	1661	224	7928
2021/22	1562	281	6707
2022/23	1648	282	6592
2023/24	1659	293	6256
2024/25	1734	290	6367

Table 10: Number of women with a recorded BMI of 30 or above and those with a BMI of 40 or above at antenatal booking, 2019/20-2024/25 (Local data, Gloucestershire Hospitals NHS Foundation Trust).

Health inequalities data

Increasing obesity rates suggest there are likely to be higher numbers of complex pregnancies, particularly within our most deprived communities where we currently see higher obesity rates. Figures 57 and 58 show how rates of BMI of 30 and above vary by deprivation deciles and ethnicity in Gloucestershire from 2019/20 to 2024/25. (Note: the red diamond markers in Figures 58 and 59 denote the average rate for BMI of 30 and above for each deprivation decile/ethnicity across all financial years.)

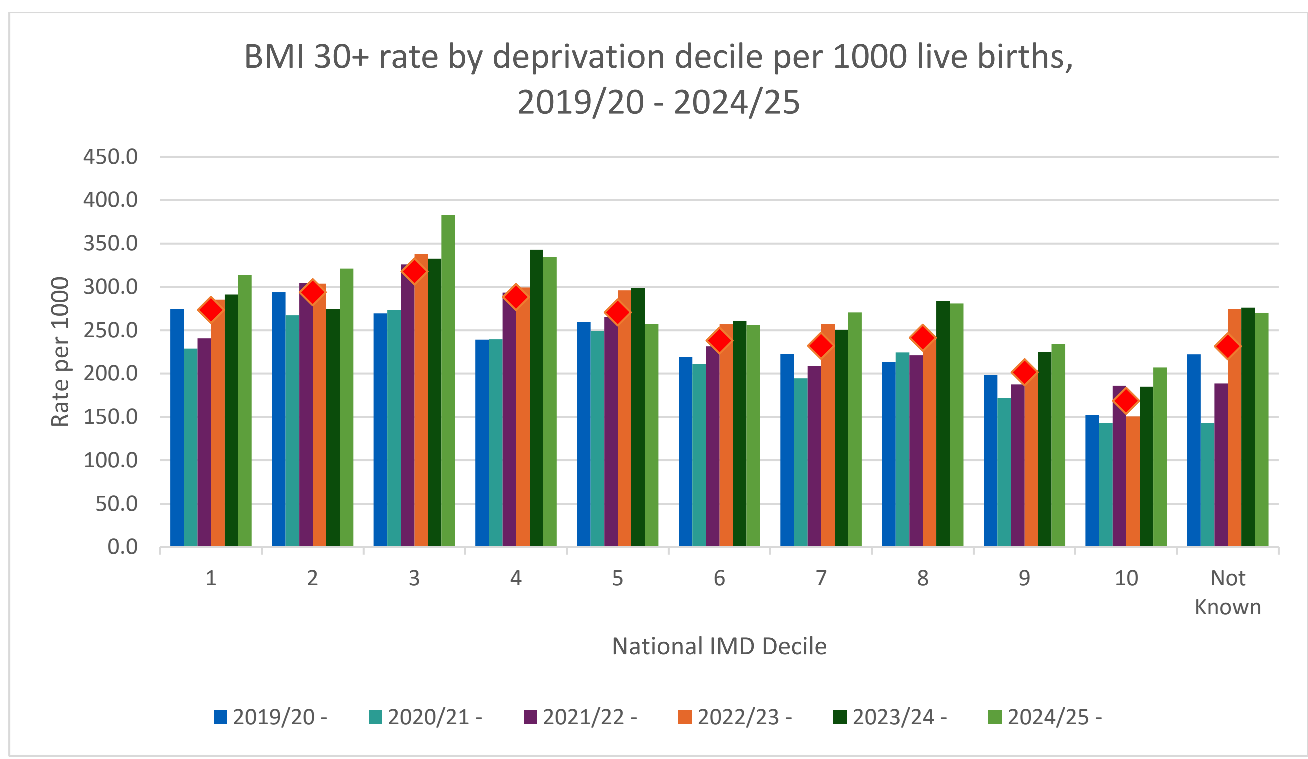


Figure 57: Rate of BMI 30 and above for women birthing in Gloucestershire by national IMD decile, 2019/20-2023/24 (Local data, Gloucestershire Hospitals NHS Foundation Trust).

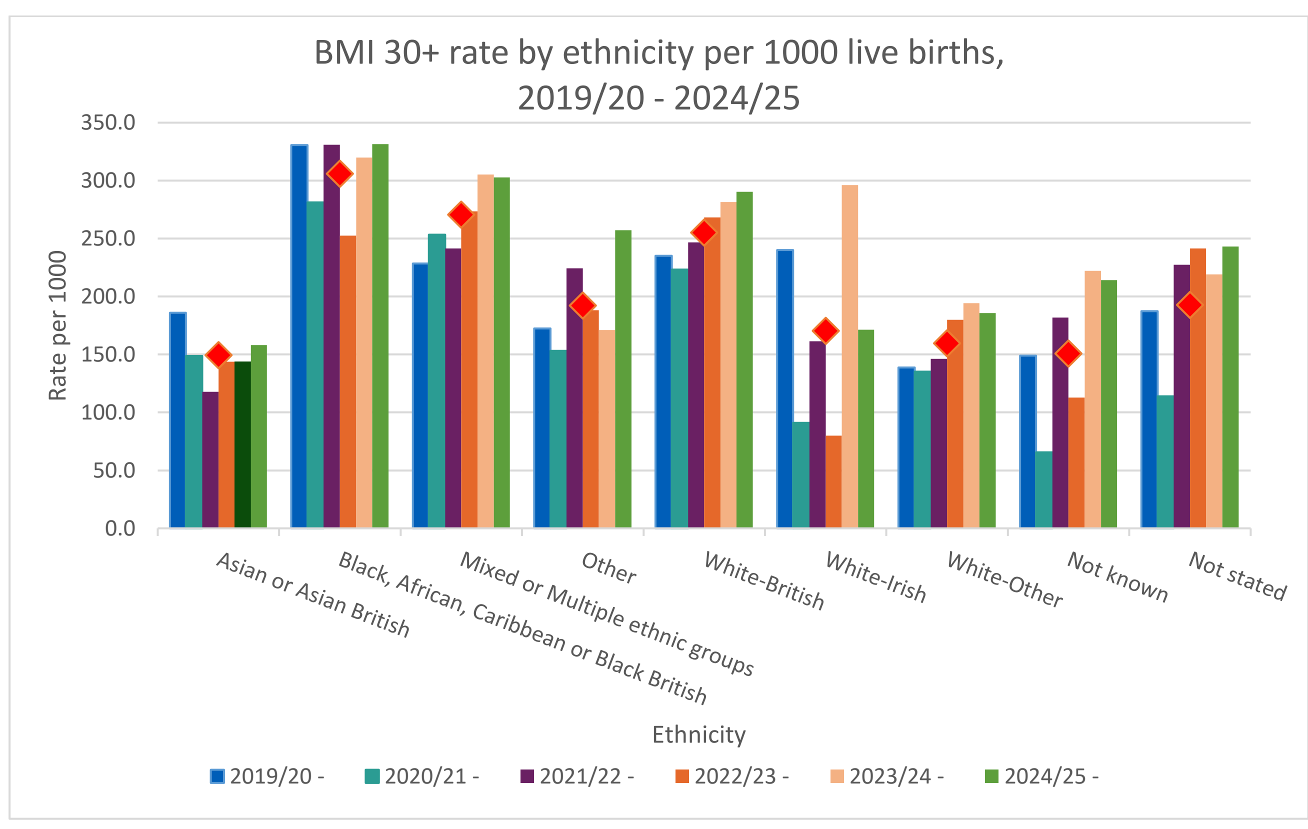


Figure 58: Rate of BMI 30 and above for women birthing in Gloucestershire by ethnicity, 2019/20-2023/24 (Local data, Gloucestershire Hospitals NHS Foundation Trust).

Local provision

The maternity service in Gloucestershire requires all pregnant women accessing antenatal care to have their BMI calculated and recorded at the booking appointment. Women with a BMI over 30 are considered for birth at a consultant unit, and if the BMI is greater than 35, women are *recommended* to birth in a consultant unit. For women with a BMI of more than 35, additional growth scans at 32, 36, and 39 weeks are required. Women with a BMI of more than 40 are referred for an anaesthetic appointment.

Women with a BMI of 30 or over (28 or over for Black and Asian women) are referred to the Healthy Lifestyles Service, commissioned by GCC. The service supports women from 12 weeks' gestation through an eight-week weight maintenance group programme. The group focuses on avoiding excess weight gain in pregnancy, and includes physical activity and nutrition education.

Activity during pregnancy

Physical activity during pregnancy is widely recognised as safe and beneficial for most women, with NHS guidance for pregnant women recommending keeping up normal daily physical activity or exercise for as long as able to do so comfortably (NHS, 2020c). Regular exercise supports cardiovascular health, helps manage weight gain, reduces the risk of gestational diabetes and hypertension, improves sleep and mood, and can ease labour and recovery. Importantly, physical activity also contributes to mental wellbeing and can help prevent or manage perinatal anxiety and depression (Kołomańska et al., 2019).

Weight loss drugs

As yet, it is unclear how the recent NICE Semaglutide guidance as an option for weight management may impact women who are thinking of attempting to conceive (NICE, 2023). Currently GLP-1/GIP agonists are contraindicated for use during pregnancy or breastfeeding (UK Teratology Information Service (UKTIS), 2025). There is a lack of research data on how long women who have been using these medications need to wait after stopping them before attempting pregnancy, and whether their availability will impact the prevalence of obesity in the general and maternity populations.

Obesity: Summary

Obesity is a complex problem and has many drivers. Rates of BMI of 30 or above are higher in the most deprived communities, and Gloucester has the highest rates of all the districts. There is limited provision of support for women to be referred to in the community (beyond consultant-led pathway), especially that is set up to support pregnant women specifically. Increasing obesity rates will impact prevalence of diabetes in our maternity population and require more specialist support.

Obesity: Key considerations

- Addressing obesity during pregnancy must be done as part of a broader, coordinated approach to healthy living and weight management across the county. This should include the work taking place around healthy weight and obesity within the ICB and

Public Health, as well as involving maternity services, community support, and wider system partners.
- Ensure that approaches to weight management including the development of future guidance and practice are trauma-informed and culturally sensitive.
- Future models must anticipate increased prevalence of high-BMI pregnancies and ensure adequate consultant-led capacity and robust care pathways, including dietitians (for example for women with obesity who have had bariatric surgery) and midwife sonography (to support additional growth scans for those with BMI over 40).

8.2 Smoking

Impact

Smoking in pregnancy is a critical public health concern due to its significant impact on maternal and infant outcomes, and is the leading modifiable risk factor for these birth outcomes. Smoking during pregnancy increases the risk of complications such as low birth weight, premature birth, stillbirth, increased risk of sudden infant death and prevalence of respiratory illness due to parental smoking (Bednarczuk et al., 2020), as well as other long-term consequences for child development (Avşar et al., 2021).

Health inequalities

Smoking is a socioeconomically patterned behaviour: people from less advantaged groups are much more likely to smoke, show greater signs of dependence, and experience disproportionate levels of harm from smoking (Hiscock et al., 2012). This inequality is particularly pronounced for smoking in pregnancy. Compared with women from affluent backgrounds, those from disadvantaged backgrounds are not only more likely to smoke before pregnancy, but are also less likely to quit in pregnancy, and among those who do quit, they are more likely to resume smoking after birth (Smoking in Pregnancy Challenge Group, 2018).

National position

In the UK in 2024/25, 6.1% of mothers were smokers at the time of delivery (NHSE, 2025d).

Local position

In Gloucestershire, the smoking at time of birth rate for 2024/25 was 6.9%. Although higher than the national average, the local rate has been steadily declining in line with the national average. The national target for reducing smoking at time of birth is 6% or less by 2025.

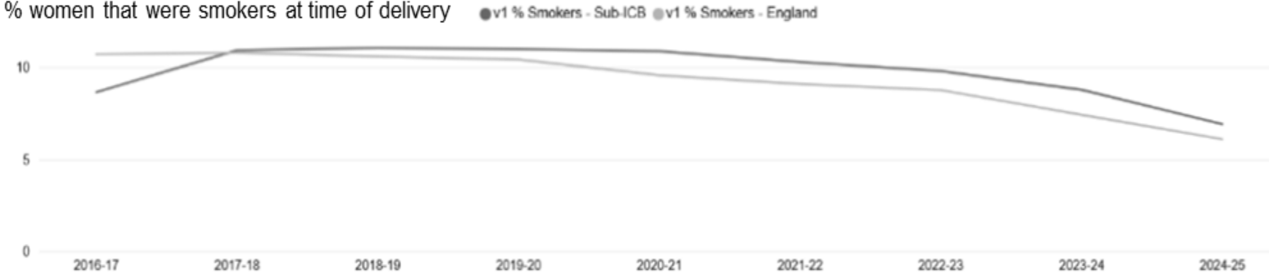


Figure 59*: Proportion of women smoking at delivery, Gloucestershire compared to the England average by financial year* (NHSE, 2025d).

Figure 60 shows that the overall rate of mothers smoking at the time of delivery in Gloucestershire varies significantly by IMD, in line with the expected pattern of higher smoking rates in the more deprived deciles:

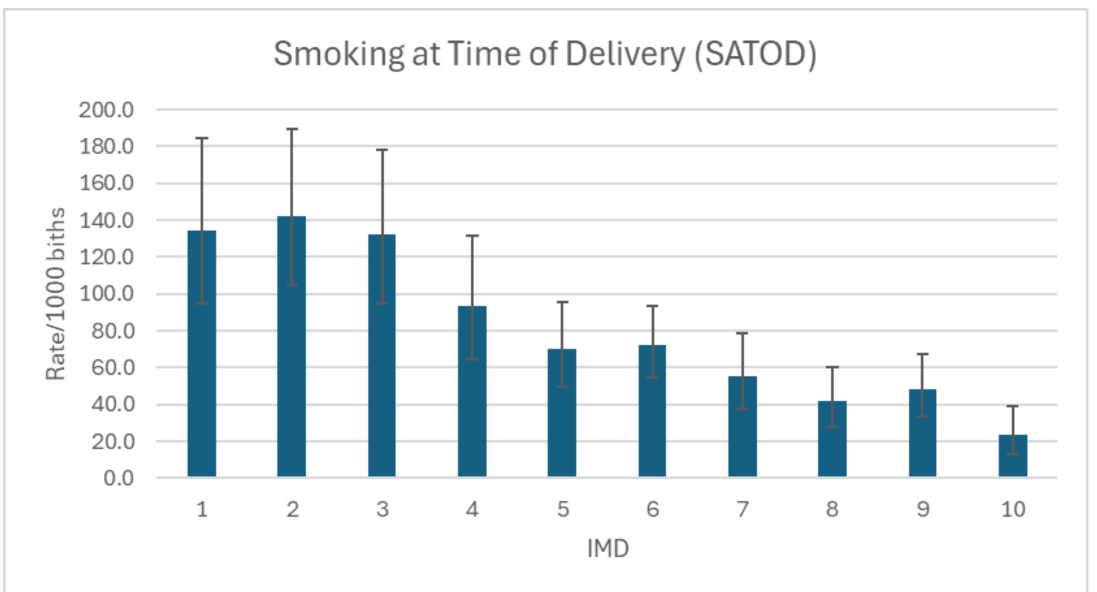


Figure 60: Proportion of women birthing in Gloucestershire smoking at delivery by national IMD decile (2024/25) (Local data, Gloucestershire Hospitals NHS Foundation Trust).

There is no significant difference in smoking rates in specific ethnic groups, although this is likely due to very small numbers:

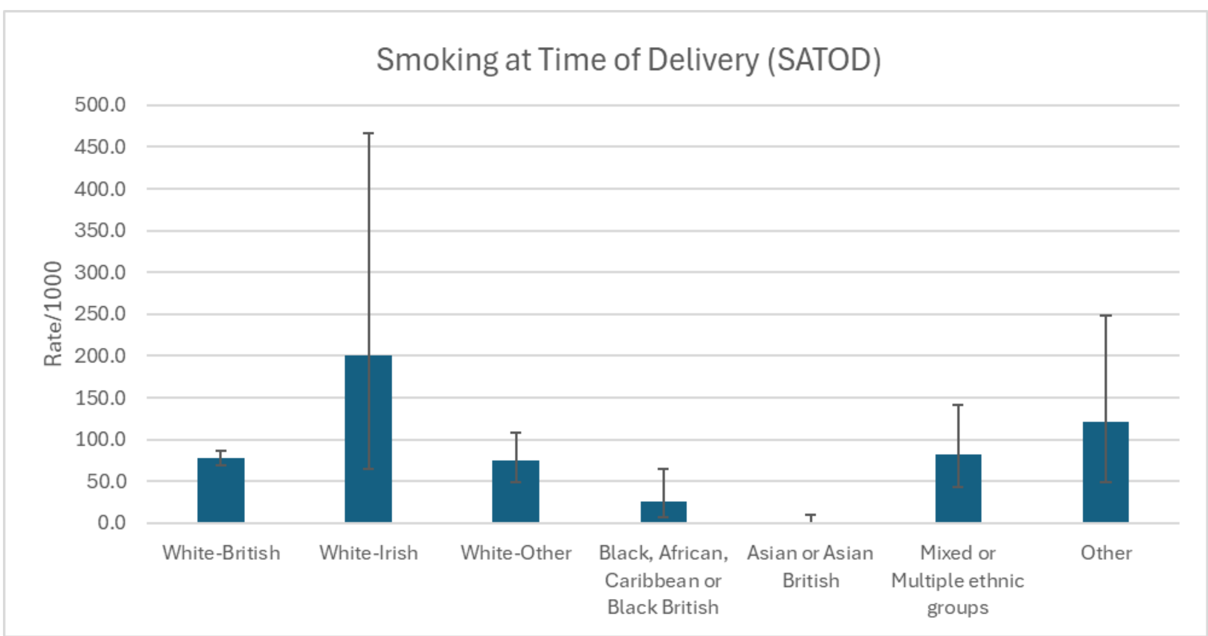


Figure 61: Proportion of women birthing in Gloucestershire smoking at delivery by ethnic group (2024/25) (Local data, Gloucestershire Hospitals NHS Foundation Trust).

National guidance

Evidence has shown that more women quit smoking when they are pregnant than at any other time during their lives (ASH, 2021). NICE has published guidance to support preventing uptake, promoting quitting, and treating dependence. The guidance outlines the support that should be available, which includes monitoring carbon monoxide exposures and referral to Treating Tobacco Dependency (TTD) services. In 2016, the NHS launched the Saving Babies Lives Care Bundle (SBLCB) (NHSE, 2025a) as part of its measure to halve rates of stillbirths and neonatal deaths by 2025, and has subsequently been updated twice. Element 1 of SBLCB v3 – *Reducing smoking in pregnancy* – recommends carbon monoxide testing for all pregnant women at antenatal booking and at 36 weeks, with referral to an in-house (maternity service led), opt-out, TTD service. An in-house Maternity TTD team with experience of the maternity pathway ensures close working relationships between health professionals working within maternity services, and seamless feedback if women are not engaging with the service.

Local provision

In Gloucestershire prior to November 2023, all TTD services for pregnant women were provided by an external provider (Healthy Lifestyles) commissioned by GCC. Healthy Lifestyles provided TTD services for the general population who smoked, and for women who were smoking at the start of pregnancy. Engagement with the service was not measured and therefore numbers of those quitting smoking in pregnancy were difficult to measure.

A proposal to pilot a maternity-specific TTD team delivered by staff within GHT, in line with the recommendations of SBLCB, was approved in November 2023. The TTD maternity team worked within the maternity service alongside maternity health professionals. The pilot was focused on an area of the county where smoking rates and deprivation rates were highest,

which was central Gloucester. The rest of the county continued to be supported by the externally commissioned Health Lifestyles TTD Service.

The introduction of this service aligned with a greater reduction in rates in smoking at time of delivery in Gloucester, and feedback from staff and women is positive. As part of the pilot, the project team was able to improve data collection so that the whole TTD service (maternity in-house and externally-provided Healthy Lifestyles) could be measured against the standards set by SBLCB as part of a Maternity TTD dashboard. Engagement and quit rates can now be measured and reviewed monthly by the teams. Areas for improvement are identified, and the teams are now closely aligned and work as one maternity-led TTD service. Both the internal and external maternity TTD teams provide the use of nicotine replacement therapy (NRT), offer vapes and are part of the national TTD incentive scheme which provides monetary incentivisation to support women to quit smoking in pregnancy. NICE guidelines state that the use of nicotine replacement therapy is preferable to the continuation of smoking during pregnancy (NICE, 2025d).

Smoking: Summary

Smoking during pregnancy increases the risk of complications such as low birth weight, premature birth and stillbirth, and has long-term consequences for child development. People from less advantaged groups are much more likely to smoke. In Gloucestershire, the rate of mothers smoking at the point of delivery is above the national average, but has been declining in recent years, in line with the national average.

Locally, TTD support is provided by an in-house team and an external provider. Engagement and quit rates are monitored and reviewed.

Smoking: Key considerations

- Smoking is closely associated with deprivation: therefore, cessation efforts should be prioritised in the most affected areas of the county. Strengthening collaboration between midwives in these communities and smoking cessation services is essential.
- Smoking cessation should be integrated into maternity and postnatal care to provide consistent support. Building strong links with services that continue into the postnatal period – such as health visiting and wider community support – is critical to sustaining quit attempts.
- Practical support should include assistance with quitting smoking, access to therapeutic interventions, and guidance on managing health conditions.

8.3 Alcohol

Impact

If alcohol is consumed during pregnancy, some will pass across the placenta to the baby. Although the risks to the baby are likely to be low if small amounts of alcohol are consumed before someone finds out they are pregnant, there is no ‘safe’ level of alcohol to drink while

pregnant. Drinking alcohol in pregnancy can affect the growth and development of the baby, and avoiding alcohol altogether is the safest option. Heavy or regular drinking can cause fetal alcohol spectrum disorder (FASD), and the most serious type of harm called fetal alcohol syndrome (FAS). Children with FASD can have learning difficulties, problems with behaviour, physical disabilities and mental health problems, while those with FAS usually have severe mental and physical disabilities.

National and local position

While there is no data available about the prevalence of FASD or FAS in Gloucestershire, studies show that Britain has one of the highest prevalences of FAS in the world (Popova et al., 2017).

Local provision

Recently published guidelines on alcohol treatment highlight the importance of staff in maternity and alcohol treatment services supporting people who are pregnant to reduce or stop their alcohol use as quickly as possible. This reduces the risk and severity of future disability for the baby, as well as risks from alcohol to the mother (Department of Health and Social Care, 2025). NICE quality statements regarding fetal alcohol spectrum disorder (QS204) are as follows:

- Pregnant women are given advice throughout pregnancy not to drink alcohol.
- Pregnant women are asked about their alcohol use throughout their pregnancy, and this is recorded (NICE, 2022).

In Gloucestershire, women are asked and advised about alcohol intake during pregnancy at the booking appointment with the community midwife. The Vulnerable Women's Team at GHT support women who are identified as misusing alcohol in pregnancy. There is a referral pathway to specialist services.

Alcohol: Key considerations

- Assess whether NICE quality standards are being met within the maternity service and consider any additional support that might be needed for women who drink alcohol in pregnancy.

8.4 Breastfeeding rates

Impact

Breastfeeding initiation is a key indicator of maternal and infant health, reflecting both individual choice and the effectiveness of support provided during the early postnatal period. Initiating breastfeeding offers well-established benefits for babies and mothers, including improved immunity, bonding, and long-term health outcomes (Pattison et al., 2019).

Beyond initiation, there is substantial evidence to suggest that breastfeeding provides protection against several childhood illnesses and longer-term health conditions (Masi and Stewart, 2024):

- Gastro-intestinal infection
- Respiratory infections
- Necrotising enterocolitis and late onset sepsis in preterm babies
- Allergic disease
- Type 1 and type 2 diabetes
- Obesity
- Childhood leukaemia
- Sudden Unexplained Infant Death

In addition, women who breastfeed are at lower risk of breast cancer, ovarian cancer and hip fractures, and less likely to have reduced bone density.

There is some evidence that breastfeeding can help with weight loss after pregnancy, with a systematic review finding breastfeeding may reduce postpartum weight retention, but results are inconsistent and the effect is generally small. Longer duration and exclusivity of breastfeeding appear to have a greater impact (He et al., 2015).

Rates of breastfeeding initiation can be influenced by a range of factors including maternal age, education, cultural norms, and the quality of support from healthcare professionals (Vargas-Pérez et al., 2025). Understanding local patterns in breastfeeding initiation is essential for identifying inequalities and informing targeted interventions to improve uptake and sustain breastfeeding across Gloucestershire.

Local position

Data from 2023/24 (see Figure 62) indicates that where a first feed was recorded, Gloucestershire has a higher breastfeeding initiation rate than the national average. However, Tewkesbury, Forest of Dean and Gloucester all have statistically similar rates to the national average, highlighting variation across the county.

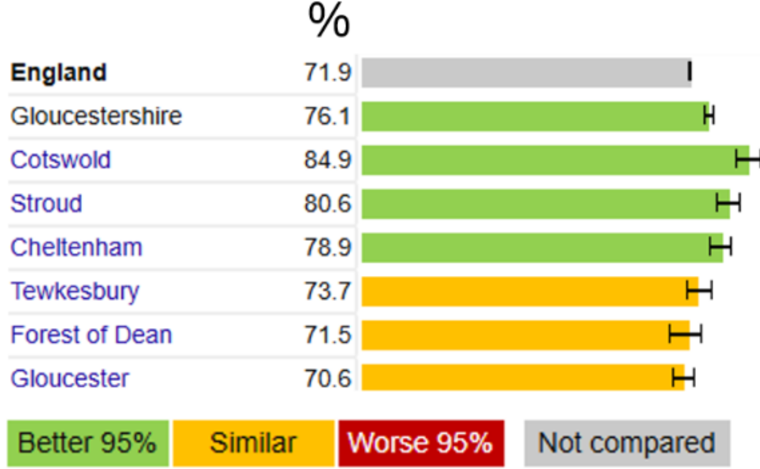


Figure 62: Breastfeeding initiation rates 2023/24 (defined as proportion of first feeds recorded as breastmilk, where first feed was recorded) for Gloucestershire and Gloucestershire districts compared to the national average (OHID, 2025b).

Data for 2024/25 shows that in Gloucestershire there is no significant variation according to deprivation; however, there is a trend to higher rates of breastfeeding initiation in the least deprived deciles:

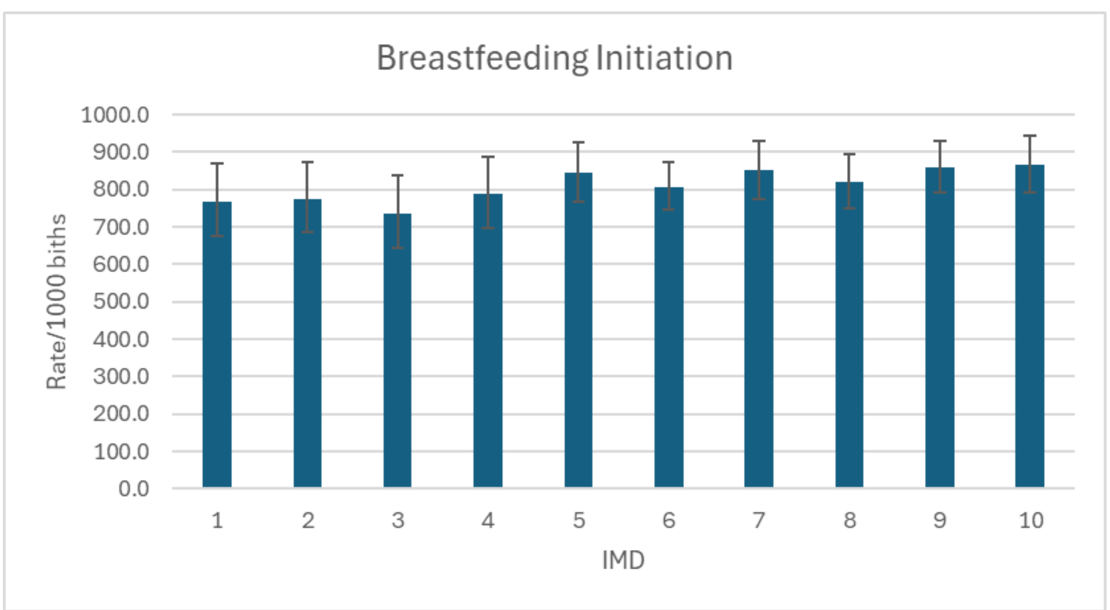


Figure 63: Breastfeeding initiation rates in Gloucestershire in 2024/25 by national IMD decile (Local data, Gloucestershire Hospitals NHS Foundation Trust).

White British women had the lowest rate of breastfeeding initiation for any ethnic group, though only Asian or British Asian women or birthing people had a statistically higher breastfeeding initiation rate:

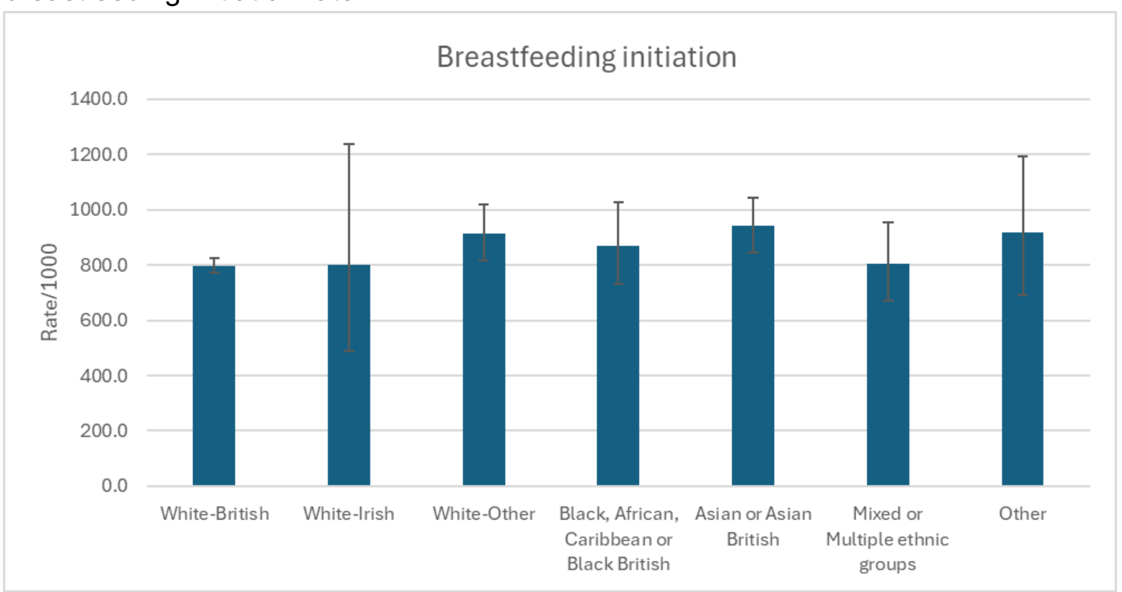


Figure 64: Breastfeeding initiation rates in Gloucestershire in 2024/25 by ethnic group (Local data, Gloucestershire Hospitals NHS Foundation Trust).

GHT is currently (November 2025) reporting a high number of baby readmissions to hospital in the national maternity dashboard, which are related to weight loss and feeding issues (see readmissions section for details). The annual CQC patient maternity surveys highlight women's dissatisfaction with feeding support both on the ward and in the community.

Local provision

The Gloucestershire Infant Feeding Strategic Partnership (GIFSP) provides strategic leadership to improve breastfeeding rates and promote safe infant feeding practices across the county. Its aim is to ensure infant feeding support is delivered consistently and effectively, and is responsive to local needs and health inequalities while adopting collaboration among services and organisations. The partnership offers a forum for sharing best practice, removing barriers to joint working, and using data to monitor child health indicators and inform service development. It aims to continue playing a key role in supporting UNICEF's Baby Friendly Initiative standards by ensuring coordinated action across multiple sectors and services, from Children and Family Centres through to Specialist Infant Feeding services within Maternity.

A number of infant feeding support services are available in the county:

- GHT has an infant feeding specialist midwife who delivers a feeding clinic in a community setting in Gloucester as well as a frenulotomy (tongue-tie) service at Gloucestershire Royal Hospital.
- The maternity service has achieved Baby Friendly Initiative (BFI) stage 3. However, this requires regular reassessment which has been paused by BFI due to the current CQC rating of the maternity service. The neonatal service is currently working towards BFI stage 1 and has a neonatal infant feeding lead in post to support this.
- Community and peer support initiatives such as the 'Black Mothers Matter' and 'Moments of Motherhood' culturally responsive perinatal groups play a vital role in improving uptake and sustaining breastfeeding.

Gloucestershire LMNS has recently worked closely with partners at the Health Innovation (West of England) to pilot the 'Anya' app which provides online breastfeeding and parenting support. The pilot focused on women in Gloucester and the Forest of Dean where breastfeeding rates in the county were lowest. Although the evaluation found that Anya did not have a significant impact on improving breastfeeding rates in these areas, it did serve as a positive tool by offering out-of-hours support for women and helping most users of the app to feel more confident to breastfeed and parent their baby. The areas with highest deprivation saw the greatest improvements, with a 6.8% increase in breastfeeding rates at 6-8 weeks.

Breastfeeding: Summary

Breastfeeding offers many significant benefits. Data indicates that Gloucestershire's breastfeeding initiation rates are above the national average overall, though with variation between districts and higher rates seen among less deprived groups and some ethnic communities, implying potential inequality which can impact both mothers' and babies' health. Persistent challenges remain, including high rates of infant readmissions linked to feeding issues and ongoing dissatisfaction with feeding support.

A range of local services work collectively to improve breastfeeding outcomes, with some evidence of positive impact, particularly in more deprived areas.

Breastfeeding: Key considerations

- Consider how everyone wanting to breastfeed can have the opportunity and the right level of support to enable them to do so.
- Infant feeding support services must be inclusive and responsive to diverse needs and influences, providing tailored messaging and support while also respecting women's and birthing people's choices.

8.5 Late booking

Impact

The first, or booking, appointment is scheduled from 8-10 weeks of pregnancy. Timely access to this initial appointment is crucial for identifying health needs, planning care, and offering early screening. Late booking – defined as attending the first appointment after 10 weeks – can be associated with poorer maternal and infant outcomes such as preterm birth, low birth weight, admission to neonatal intensive care, and maternal morbidity, and may reflect underlying barriers such as culture, language, deprivation, or lack of awareness.

National position

Data (MSDS, NHSE, 2025b) shows that nationally, late booking is more prevalent among women from deprived communities, ethnic minority communities, younger mothers, and those with complex social needs. These patterns reflect broader inequalities in access to care and engagement with services.

Local position

In Gloucestershire, data and service reviews indicate similar trends, underscoring the need for targeted outreach, culturally sensitive care, and improved pathways to support early engagement with maternity services.

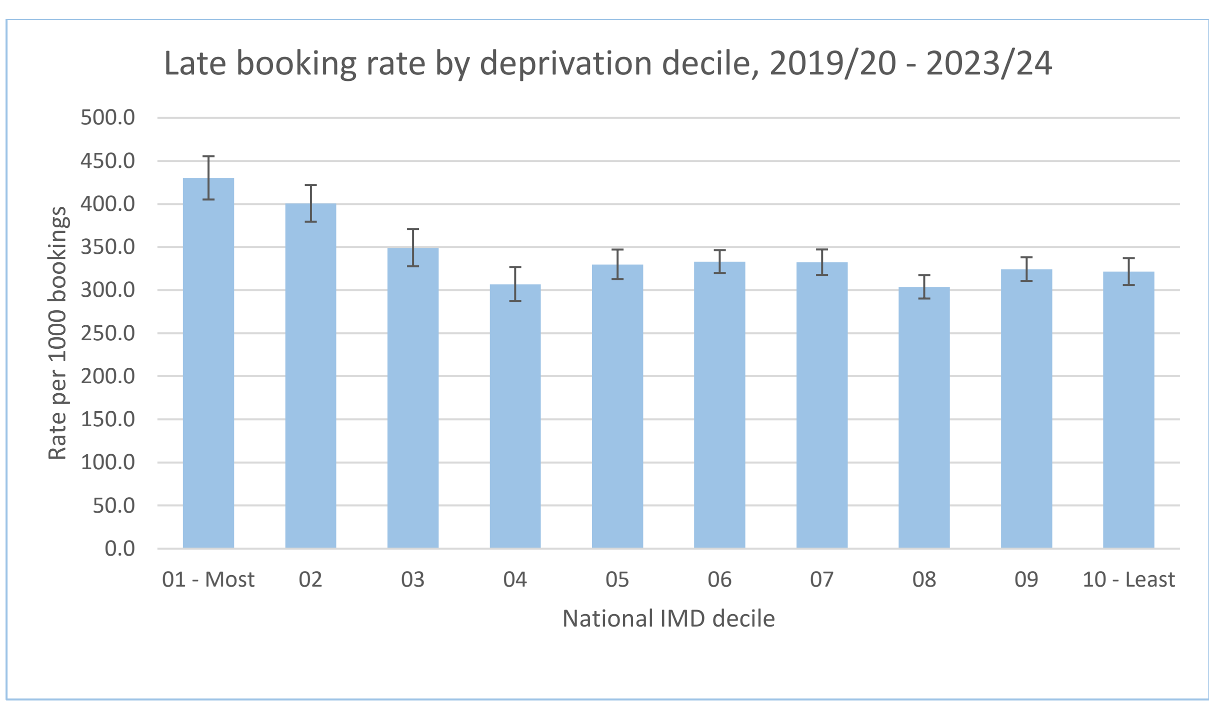


Figure 65: Rate of bookings after 70 days in Gloucestershire (2019/20-2023/24) by national deprivation decile (MSDS, NHSE, 2025b).

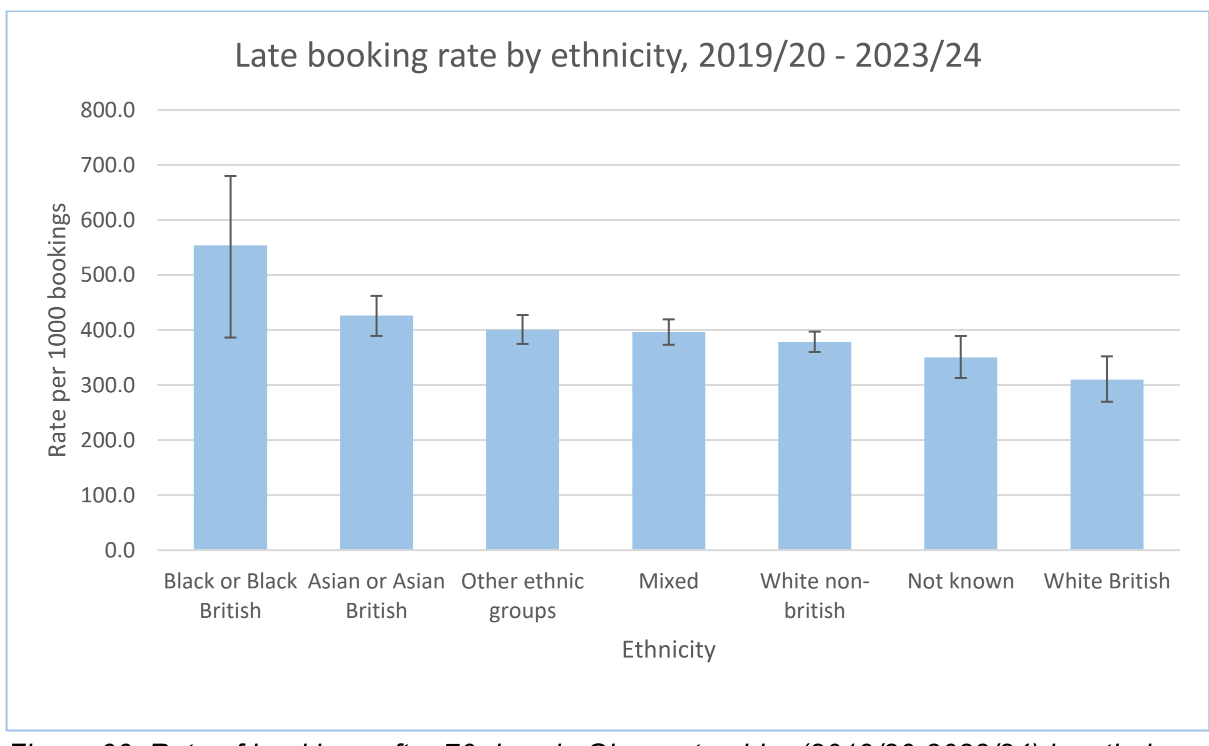


Figure 66: Rate of bookings after 70 days in Gloucestershire (2019/20-2023/24) by ethnic group (MSDS, NHSE, 2025b).

Late booking: Key considerations

- Women from the most deprived deciles and ethnic minority communities are more likely to book their pregnancy after 10 weeks. Further investigation is needed into reasons for this and how rates of booking before 10 weeks can be improved.

- Develop initiatives and campaigns targeted at improving rates of timely pregnancy booking. Initiatives should be co-designed with stakeholders to overcome existing barriers to booking and ensure information and access to services are appropriate.

9. Insights

This section is divided into two parts. Part 1 provides some high-level summaries of the insights gathered through two recent surveys aimed at women and their partners and families. Insight has been broadly collated under the headings of antenatal, intrapartum and postnatal care, and where possible the summary is enhanced by comments which exemplify the feedback. Part 1 also includes summaries of maternity service users' insight collected through other methods. Part 2 provides high level summaries of staff insights gathered through a recent survey, as well as through other methods.

There is a high degree of consistency and repetition between themes identified in the insights shared by users of maternity services (women, partners and family members) and staff feedback. However, it should be noted that in the insight received from staff there is greater focus on operational service delivery arrangements.

Methodology

A mixed methods approach was taken to gathering insight data to support the development of the maternity health needs assessment. The following activities were undertaken:

- A review of existing insight data, including:
    - A report authored by the Gloucestershire MNVP considering the qualitative feedback from the 2024 National CQC annual maternity survey data
    - CQC 2025 annual maternity survey data
- Development and active promotion of local insight surveys
    - Women (maternity service users)
    - Families
    - Staff working in maternity services in Gloucestershire
    - Other partners
- Targeted engagement activities with mothers from groups frequently under-represented in other data collection methods and who are regular users of maternity services in Gloucestershire.
- Drop-ins and interviews with staff working in maternity services in Gloucestershire.
- A sample of existing insight data collected by GHNHSFT (PALS and Complaints themes and Friends and Family Test). It should be noted that gathering insight is a continuous process with regular monthly reporting by the Trust of PALS, complaints and FFT data.

Insight data collected during the development of the maternity health needs assessment has been shared (redacted for personally identifiable information) and discussed with system leaders. In rare instances where comments relate to named individuals they have been reviewed by Executive Leads and appropriate follow up action taken.

Part 1: Service user insight

The following section summarises key themes from all service user insight gathered to support the maternity health needs assessment. It should be noted that there are significant differences in the reported experiences between individual users of maternity services. The

insights presented range from very negative to very positive, with examples across the spectrum selected below to illustrate the key themes.

Who we heard from

Which of the following best describes you?				
Answer Choices			**Response Percent**	**Response Total**
1	Someone who is pregnant		3.27%	26
2	Someone who has given birth in the last year		44.40%	353
3	Someone who has given birth in the last 1-3 years		47.17%	375
4	Other* (please specify):		5.16%	41
			answered	795

* Most respondents who selected other were pregnant and had also had a baby in the last 3 years.

Which best describes you? (NB. If you have given birth in the last 3 years there is a separate survey for you to complete - click here)				
Answer Choices			**Response Percent**	**Response Total**
1	A partner of someone who has given birth in the last 3 years		16.90%	12
2	A family member or friend of someone who has given birth in the last 3 years		12.68%	9
3	Someone who has an interest in maternity care		39.44%	28
4	Other* (please specify):		30.99%	22
			answered	71

* Most respondents who selected other were people who had given birth more than 3 years ago.

Useful information about pregnancy/maternity services and support

Throughout their maternity experience, many users of maternity services reported finding useful information to support them:

Where did you find useful information about pregnancy/maternity services and support? (please tick all that apply)				
Answer Choices	**Before pregnancy**	**During pregnancy**	**After pregnancy**	**Response Total**
Friends and family	27.18% 418	39.34% 605	33.49% 515	1538
My midwife	8.35% 98	60.90% 715	30.75% 361	1174
Staff at my GP practice	14.51% 73	58.45% 294	27.04% 136	503
Gloucestershire Hospitals' website	16.83% 102	57.92% 351	25.25% 153	606
Gloucestershire MNVP	11.54% 30	48.46% 126	40.00% 104	260
Apps e.g. Real Birth Company	15.33% 84	60.22% 330	24.45% 134	548
Badger Notes	5.80% 38	68.85% 451	25.34% 166	655
Other websites (please tell us which ones in the comments below)	21.65% 134	46.37% 287	31.99% 198	619
Social media	24.83% 328	41.64% 550	33.54% 443	1321
Support groups (provided by NHS e.g. antenatal classes)	7.71% 28	68.04% 247	24.24% 88	363
Support groups (not NHS)	11.63% 80	47.82% 329	40.55% 279	688
Other (please describe in the comments below)	18.80% 22	45.30% 53	35.90% 42	117
			answered	817

People valued the opportunity for face-to-face support and peer networks.

“Antenatal classes and the groups where the baby can be weighed were super helpful. Having communities midwives at Gardeners Lane was something I was particularly grateful for as doing the antenatal classes allowed me to meet all the midwives prior to giving birth”.

“Private antenatal classes (because I wanted them in person and to meet mums)”.

> *"I found the support groups moments of motherhood so helpful post birth with helping me to meet other mums and help me with my anxiety of getting out again".*

Whilst online resources, websites and apps were well received by many, there were others who found them difficult to access. Badger Notes also received some criticisms:

> *"As a first-time mother and a professional in education, I understand the importance of accessible, high-quality antenatal support. I also have dyslexia, and I have found that the reliance on e-learning alone significantly limits my ability to engage with and retain essential information. The format presents unnecessary barriers for individuals like myself, who require alternative learning methods to access information equitably".*
>
> *"I found badger notes really hard to navigate. The user experience could definitely be improved to make it easier to find useful information".*
>
> *"I would use badger notes during and after [pregnancy] if it were better. I found it slow, clunky, hard to find information and not engaging to use".*

Maternity care and support

Thinking about the people involved in your maternity care, what is most important to you?				
Answer Choices			**Response Percent**	**Response Total**
1	Access to the same midwife/team before and after giving birth		29.68%	241
2	Access to my usual midwife/team throughout my care, including when giving birth		30.30%	246
3	Skills and expertise of staff at each stage of my maternity care		40.02%	325
			answered	812

Wider support

27% of users of maternity services who completed the insight survey had accessed healthy lifestyle support to stop smoking, maintain a healthy weight and/or have good mental health:

Have you used any services to support you to: (please tick all that apply)				
Answer Choices			**Response Percent**	**Response Total**
1	Stop smoking		7.62%	17

Have you used any services to support you to: (please tick all that apply)				
2	Maintain a healthy weight		17.94%	40
3	Have good mental health and wellbeing		75.78%	169
4	Other (please specify):		12.56%	28
			answered	223

Responses indicated that a combination of timely, personalised, and empathetic support, offered as both an individual and/or group interaction, contributed to a positive experience of services.

When asked what would else would have helped, there were requests for more bespoke support during pregnancy / the postnatal period rather than generic advice and sessions, improved information about the support available, and increased frequency of contact and face-to-face options. There were also specific comments relating to recognition of birth trauma and more proactive support when things don't go well, e.g. miscarriage.

Antenatal care

16.5% of people said they had experienced problems accessing their maternity appointments. Almost all of the problems related to one of the following:

- Lack of contact and poor co-ordination of appointments including frequent cancellations:
  "Appointments were not made and I had to chase with no contact details for my midwife who then left the trust without anyone telling me".
- Poor communication: not receiving notification of appointments, with difficulty getting through to anyone to change times, chase or follow-up appointments, or make enquiries:
  "I made appointments that then didn't show up on different systems. I had appointments made for me then wasn't told. I was told I had to ring different offices/numbers to try to sort out appointments. A variety of issues really that were all quite confusing".
- Problems with Badger Notes:
  "Appointment times on badgernet were sometimes missing or wrong or the app just crashed and wouldn't work".
  "Badger kept on failing during my maternity appointments and staff had to get my physical notes. Badger didn't connect to my diabetes record sufficiently".
- Multiple midwives involved in care and/or periods when no midwife was allocated leaving people unsure who to contact if they had any concerns:
  "My midwife was clearly signed off and wasn't replaced. I kept having different people turn up and say different things, repeat or not cover things and measure differently. All extremely inconsistent and very scary to me as a first time mum pregnant through IVF. I did not feel looked after or safe at all. I didn't know who I should turn to".

"My GP midwife was at capacity and so I was passed around different midwives until 25ish weeks. It didn't give consistency and meant I wasn't always sure where my appointments would be or what I should be doing at those points in my pregnancy".

When asked what would have helped alleviate the problems experienced, suggestions included:

- Consistency of midwife/appointments
- Better communication
- Improved access/appointment system

Intrapartum care

Approx 89% of users of maternity services sharing their insights gave birth at Gloucestershire Royal Hospital. The choice of where to give birth was strongly influenced by the proximity of the unit to home, followed by information from midwives. Other things that influenced choice were previous birthing experiences, reputation and recommendations, availability of specialised care, research and preferences for a particular type of birthing experience.

Where did you give birth?				
Answer Choices			**Response Percent**	**Response Total**
1	Gloucester		89.19%	718
2	Stroud		3.73%	30
3	At home		2.36%	19
4	Bristol		1.49%	12
5	Swindon		1.49%	12
6	Hereford		0.00%	0
7	Oxford		0.00%	0
8	Other* (please tell us where):		1.74%	14
			answered	805

* Respondents were still pregnant or had given birth at other out of county locations.

What helped you choose this place to give birth? (please tick all that apply)				
Answer Choices			**Response Percent**	**Response Total**
1	It is close to home		63.44%	498

What helped you choose this place to give birth? (please tick all that apply)				
2	It is close to where I work		3.57%	28
3	CQC ratings		1.53%	12
4	Advice from friends and family		10.19%	80
5	Advice from other new mums		4.84%	38
6	Visiting the hospital/birthing centre beforehand		10.32%	81
7	Information from my midwife		26.88%	211
8	Information on websites/social media		8.28%	65
9	I didn't choose to give birth there		20.64%	162
10	My own research (please describe what you did):		12.48%	98
			answered	785

Almost 21% (204) of people who took part in the survey did not give birth in the place they had chosen. Most gave the reason for this as either due to pre-determined medical need, e.g. high-risk pregnancy, or because of a medical emergency such as complications during labour.

> *"I had a high-risk pregnancy and required early induction due to cholestasis and pre-eclampsia. Gloucester was where I was under consultancy and I was admitted from there".*
>
> *"I did choose to give birth at Gloucester, that was always my birth plan. However, I was induced due to reduce movements so I had to be in the delivery ward of Gloucester after calling the maternity triage".*
>
> *"I had a consultant led birth and he recommended being in a hospital rather than a maternity mid wife led unit".*

Some people mentioned the lack of availability of their preferred birth centre or home birth options.

> *"I wanted a home birth but there was no home birth cover available due to short staffing".*
>
> *"There was no other choice. Cheltenham and Stroud were both closed".*

Induction

Just over 53% of respondents were offered an induction of labour. Many individuals accepted the induction either immediately or after further consideration. Some had already tried alternative interventions such as stretch and sweep procedures.

Those who accepted induction often did so due to medical advice, personal health concerns, or complications such as high blood pressure, gestational diabetes, or reduced foetal movements.

> *"Induction was required for medical reasons due to cholestasis and pre-eclampsia, so there wasn't really a choice".*
> *"I had to have an induction as my waters broke but I did not go into labour".*

Some people felt well supported and informed about the option for induction.

> *"It was a mutual conversation as I was approaching 42 weeks. I was talked through my options and told I could decide and pick date for it during my next midwife appt. At that next appt we booked it in".*

However, others felt they were not offered a choice and the decision was made for them.

> *"I felt pushed to go with induction rather than a section there were no other options discussed just told I could have induction at a certain date".*
> *"Declined to schedule the induction until a few days after the advised date. And was treated awfully for the next 1-2 hours by a consultant who was trying to convince me to plan an induction when they recommended - didn't feel like the consultant respected that I could make an informed decision. I was open to and understood the risks explained to me but was made to feel patronised and brow beaten".*

Some people who accepted induction went into labour spontaneously before their induction date.

Approx 15% of respondents who were offered an induction declined, preferring to avoid interventions and allow labour to start naturally.

> *"I genuinely don't know anyone who has had an induction that has gone on to have a straightforward labour. I wanted nature to take its course (which it did)".*

Giving birth

Birth method

How did you give birth?				
Answer Choices			**Response Percent**	**Response Total**
1	Vaginal birth		40.90%	326
2	Vaginal birth with interventions e.g. ventouse, forceps		17.57%	140
3	Planned caesarean section		17.06%	136
4	Unplanned caesarean section		24.47%	195
			answered	797

Almost 56% of respondents who reported they had had a caesarean section did so on medical advice. For those who chose to have a caesarean section, the reasons for doing so were varied. Most were influenced by previous traumatic birth experiences or complications, current health conditions or concerns about their baby's health. A small number of respondents chose a caesarean section because they wanted a more predictable birth experience, peace of mind, or had experienced a failed induction of labour.

Approx 12% of respondents chose to give birth in a way that was different from medical advice. The reasons given for this included not wanting an induction of labour, but most cited their own research and informed choice.

> *"After two days after being induced and then having my waters broken I still wasn't in active labour. I was being encouraged to go on the oxytocin drip but knew from my research that this would be very intense, I was already exhausted and vomiting so asked to have a caesarean section".*
> *"Previous birth trauma involving my first born, she was taken to St Michaels [a hospital in Bristol] following hypoxia due to placental abruption and received cooling therapy in the NICU in Bristol. I didn't want to go through that again".*

What went well?

When asked about their overall birth experience, many people reported the empathy, care and attention received from midwives, doctors and other healthcare professionals.

> *"I felt very listened to about my concerns with my baby's movement. The doctors and surgeons I came across during the birth were kind and compassionate. I had the opportunity to hold my baby even though he needed extra support. I had my husband there to support me".*

Effective pain management and when complications arose, the swift and efficient response of the medical team, were valued.

> *"The staff were absolutely amazing and were very quick to change plans when things started to escalate. They were incredibly supportive and I know that they did everything they could for both me, my daughter and my husband".*

Women appreciated the calm and relaxing environment and opportunity to follow their plans and preferences. The safe delivery of healthy babies and the absence of serious complications were, of course, major factors in a positive experience.

> *"Staff in the midwife led unit at the Gloucester Royal were absolutely fantastic. They were calm and containing and empowered me to make decisions. I felt safe in their hands".*
> *"I did it! At home, with support from my husband, doula and 2 midwives. It was exactly as I dreamed it would be. I had my own space and home to move around and I felt fully supported".*

What could have been improved?

Key themes highlighted the importance of communication, support, comfort, and respect as crucial in improving birth experiences.

Communication with people appears to have been lacking in numerous cases, with requests for clear and consistent information about procedures, delays in care and general information about what to expect through labour, birth, and aftercare. Responses show a lack of information about induction and a need for improved information about aftercare for those who have had a caesarean section, including managing stitches and post-birth complications.

> *"Information given by midwives and HCPs postnatally, including about pain relief, was confusing and inconsistent".*
> *Better communication with the Midwifery triage service and across departments. Some of the information during early labour was confusing I.e. when best to come in for assessment.*
> *"I didn't fully understand the induction process and naively went in there thinking we would come home the next day with a baby".*
> *"The communication between staff was sometimes unsettling as they'd talk to each other but not us so we'd have to ask what was going on".*
> *"Better communication and giving me time to ask questions would have improved my experiences immensely. I was never told about the potential side effects of a forceps delivery".*

Some respondents described feeling abandoned and alone, a lack of empathy from clinical staff and not feeling listened to and/or believed.

> *"I didn't feel listened to. I felt pressured until choices. Vaginal examinations were very uncomfortable. I felt patronised and treated like a fussy patient. My birth plan was ignored.*
> *"My midwife was very knowledgeable, polite and informative but she didn't come across very happy/ talkative. I needed that TLC, motherly midwife. One that felt they were invested in my birthing journey- not just turning up to do a job".*
> *"Listening to me prior- I was in labour and wasn't listened too. I almost gave birth on the ward. Declined VE's when I requested them".*

Providing information about, and better access to, pain relief options was noted. More regular checks and clear communication about the health of both mother and baby were requested.

> *"Better aftercare with regards to the c-section. Someone to check wound, advice, do's and don'ts, perhaps even a leaflet would be useful. I felt quite overwhelmed with the situation and anxious about my recovery. I used Google for advice as I didn't receive much at the hospital".*

Postnatally, responses ask for more hands-on support including identification of tongue-tie and support with breast feeding.

> *"It also took 3 days for it to be identified my daughter had a tongue tie (in the context of struggling to feed). Then it ended up being a six week wait for the procedure. We had it done privately in the end".*
> *"After my birth a 95% tongue tie was missed and I was sent home syringe feeding my baby which my community midwives were shocked by and said should never have happened. I didn't receive enough support until I saw my own community midwife 3 days postpartum".*

> *"I asked for breastfeeding support and a tongue tie evaluation - this was refused. Turns out she had a 90% anterior tongue tie".*
> *"Post birth I think it would be good if everybody was offered access to the infant feeding team. I was struggling to breastfed and got limited support (the midwives did their best) but nobody assessed my twins for tongue tie until they were 6 weeks old by which time they were established on bottle feeding".*

Some comments note a lack of privacy and unacceptable levels of noise on the postnatal ward, with specific negative feedback about partners being allowed to stay overnight. Comments also reflected on the inadequate staffing levels in delivery units and wards which led to communication breakdowns and a lack of timely care and support. Whilst people understood these challenges, the comments of staff left some respondents feeling like they were a burden and unable to speak up.

> *"The delivery ward was short staffed, so I had to wait 2 days to be taken down, communication was poor which led to increased anxiety prior to birth. Support on the ward afterwards with regards to breastfeeding was minimal, lack of care due to nurses being stretched".*
> *"There was a lack of staff throughout my stay, lots of waiting without knowing what was happening throughout, lack of aftercare once moved to the ward, little or conflicting communication about discharge".*

If things didn't go well, were you offered support?

When things didn't go well during birth and immediate post-natal care, approximately 65% of respondents said they weren't offered support. The support offered to some included birth review or debriefing sessions meetings with midwives or doctors. Community midwives played a significant role in providing postnatal support, including discussing birth experiences and offering mental health referrals.

Additional themes included:

- Breastfeeding support: There were mixed experiences with breastfeeding support with some reporting inadequate or inconsistent support.
- Mental health support: Several individuals mentioned being referred to mental health teams or receiving support for birth trauma and anxiety.
- Bereavement support: Bereavement midwives provided support to those who experienced the loss of a baby.

What else would have helped?

Overall, when things didn't go well, people suggested that more comprehensive support with better communication and improved resources would have made a difference Many responses highlighted the need for emotional support, including counselling and support groups. Some people reported they felt alone in their trauma and needed more follow-up appointments to process their experiences.

There were also mentions of the need for support in dealing with birth trauma and postnatal depression.

> *"To have felt more supported in my choices before birth as this impacted my decision to delay my induction and led to a poor outcome for me and my baby".*

"More consistent/expert feeding support after birth. I was being assisted by bank staff who openly admitted they knew nothing about breastfeeding and couldn't help me".

Postnatal care

Who supported you after giving birth? (please tick all that apply)			
Answer Choices		**Response Percent**	**Response Total**
1	Partner	96.40%	750
2	Other family member(s)	69.15%	538
3	Friends	39.07%	304
4	Midwife	61.05%	475
5	Health Visitor	48.46%	377
6	Community group	9.51%	74
7	Other (please describe):	5.66%	44
		answered	778

It is clear from the responses that women's partners and other family members are a crucial support element. Many respondents noted that postnatally they received professional NHS support from midwives, visitors, specialists and perinatal mental health teams. Others noted accessing private and community support including doulas, breastfeeding support, tongue-tie specialists and local support groups.

"Midwife- home visits/in clinic visits post birth. Really appreciated it being the same community midwife the entirety of my pregnancy and postpartum. She also provided a birth debrief".

"Lactation consultant (private) provided video consultations which were invaluable in helping us on our breastfeeding journey".

"Lactation consultant at a community group, breastfeeding peer support group, La Leche League website, tongue tie clinic (private) and Osteopath (private)".

If you received any professional support, did you find it helpful?			
Answer Choices		**Response Percent**	**Response Total**
1	Yes, definitely	33.44%	218
2	Yes, to some extent	25.00%	163
3	No	9.66%	63

If you received any professional support, did you find it helpful?				
4	Not applicable		31.90%	208
			answered	652

What worked well?

Responses identified key themes regarding the support that worked well postnatally. The importance of personalised, consistent and compassionate care, both at home and in the hospital, was seen as crucial to supporting new parents effectively.

Home visits: Many respondents appreciated the convenience and comfort of having midwives and health visitors come to their homes. This was particularly helpful for those recovering from childbirth and those with newborns, as it eliminated the need to travel. It also enabled staff to provide practical advice with feeding, pain relief, and managing newborn care.

> *"Midwife home visits and health visitors coming to the house. My first visit I left the house and it was too soon. Having the option for at home helped massively".*
> *"The ability to go home within 4 hours of giving birth to recover and sleep at home. It was amazing to have a mixture of home visits and attending appointments at my local hospital, Cheltenham".*
> *"The midwife visits were really helpful for the first few weeks but would be better to have known when they were going to visit on the day (time wise)".*

Consistent care: Having the same midwife or health visitor throughout pregnancy and after the birth was highly valued. This continuity of care helped build trust and provided a sense of familiarity and reassurance.

> *"Midwife visits from the same midwife I had before I gave birth were really helpful as she knew me well".*
> *"The consistency of the same community midwife pre and post birth made an enormous difference. To have built up a relationship and being able to keep seeing her in those early days means a great deal".*

Communication and information: Clear and consistent communication from healthcare professionals was important. Respondents valued being kept informed about their care and having telephone access to staff who could answer any questions or address concerns. It was also helpful to have information and resources in a written format that could be referred to again at a later time, and signposting to other services.

> *"Being on my own, it was helpful to have the process and order things happened in writing so I refer back to this when I was struggling to come to terms with what happened or remember certain details".*
> *"I was given contact numbers for people to call if I had any questions or concerns, and places to go in person".*
> *"Telephone support when passing large blood clots post birth and when calling with suspected mastitis".*

Breastfeeding support: Numerous respondents highlighted the importance of breastfeeding support, both in the hospital and at home. This included help with latching, addressing tongue-tie issues, and providing guidance on breastfeeding techniques.

"The maternity care assistants were wonderful with helping with breastfeeding".
"Tongue tie specialist resolved 95% tongue tie on day 5 and my baby then fed instantly".
"The breastfeeding support group at the local children's centre was helpful".
"Was referred to the tie clinic quickly and was contacted about a slot very quickly and the staff performing the procedure were knowledgeable, supportive and caring. GBSN is a godsend for anyone struggling with breastfeeding, made the difference between giving up and not".

Emotional support: Emotional support from healthcare professionals, including midwives and health visitors, was crucial. Respondents appreciated when their mental health was acknowledged and supported, and when they were given time to talk about their experiences and feelings.

"My health visitor was brilliant - she was very thorough, took the time to talk and helped with guidance on where to look for postpartum mental health support".
"I also had HV visit prior to birth due to previously struggling with my MH".

Family and partner support: The support from partners and family members was often cited as invaluable. This included help with household chores, emotional support, and assistance with baby care.

"Having my partner to talk to and process trauma".
"Having my partner home also helped massively especially for my mental health".

Local neonatal unit (LNU) and hospital staff: The care provided by LNU teams and maternity hospital staff was highly praised. Respondents appreciated the expertise, kindness, and support they received during their hospital stay, especially in critical situations.

"Post surgery care from midwives was consistent and kind. I found the breastfeeding advice very frustrating - everyone had different and conflicting advice, but I appreciated that someone was on hand 24/7. I really didn't want to leave the hospital".
"Knowing there was support anytime at the Stroud maternity unit is also wonderful!"
"I was able to attend Stroud Maternity hospital to get 1:1 support with breastfeeding".

Being able to use one's own previous maternity experiences to take control

"This was my 3rd child exclusively breast fed and I needed to be left alone to establish breastfeeding and post tongue-tie snip realign positioning. I didn't feel I was given the time or space needed despite baby thriving in all ways except slow weight, undermining my confidence and adding stress".
"I didn't receive any additional support for my first pregnancy so when I knew second baby was struggling to breastfeed I mentioned it a few times to midwife and health visitor at appointments. Once the health visitor made the referral it was relatively quick and straightforward".

"I had to really push to be seen by the frenulotomy nurses - initially being told that breast pain is still normal at 7 weeks (after I had previously fed my other child for 13 months so knew what I had wasn't normal)".

What other support would you have liked?

When asked what other support people would have like postnatally, similar themes were identified. This suggests that there may be significant variation in care provided and/or people's experience of care and support.

Breastfeeding support: Many respondents expressed a need for more consistent and knowledgeable breastfeeding support both in the hospital and at home. This includes assistance with latching, addressing issues like tongue-tie, and having access to lactation consultants.

"One professionally trained lactation consultant or breastfeeding counsellor who had the experience and knowledge to support establishment of breastfeeding rather than multiple midwives or midwife assistants with scant and inconsistent breastfeeding knowledge".

"More breastfeeding support in hospital ESPECIALLY on the children's ward - the lack of breastfeeding knowledge and support on the ward was awful and ultimately stopped our breastfeeding journey prematurely, which I was deeply upset by".

"Whilst feeding support was provided my midwives, it would have been better to have greater support from someone specialising in breastfeeding. In my experience, the breastfeeding the breastfeeding support groups, whilst they have a place, are not equipped to assist with difficulties in supporting to get breastfeeding established, especially when there is an issue such as tongue tie. If it were not for my sheer determination, I most likely would have given up on breastfeeding in those first few weeks".

Mental health and emotional support: There was a significant call for better mental health support, including counselling and check-ins for both mothers and fathers. Some respondents mentioned the need for dedicated mental health sessions and support groups.

"I would have liked mental health support. I would have liked to have been offered counselling. I needed more support at home after the birth with caring for myself and our baby".

"A dedicated pre or postnatal session on mental health. It would have helped me not feel so alone and I would have sought help earlier".

"I feel that more support should have been offered to my husband who experienced an incredibly traumatic event with both his wife and baby needing immediate emergency care at the same time. He was told about 1 support group but unfortunately this ran on a day that he could not attend".

It's been isolating having a c-section and not being able to get out. There's a lot of groups I just can't attend. Maybe an online support group or councillor would have been helpful.

Consistency of care: A recurring theme was the desire for continuity in care. Many respondents felt stressed by seeing multiple different midwives or health visitors, each providing different advice. Consistent care from the same professional was highly valued.

> *"To have had postnatal check-ups with my community midwife and not be seen by the wider team".*
> *"Consistency of midwife post birth. I saw about 7 different midwives all with contrasting advice about how to help my baby gain weight which was very stressful".*
> *"I would have liked a consistent point of contact at the hospital as it felt like I saw hundreds of staff but didn't really know any of them".*

Postnatal care: Respondents highlighted the need for more thorough and frequent postnatal check-ups, including physical health checks for mothers, support with wound care, and more home visits. The offer of a post-birth debrief was frequently mentioned.

> *"A faster assessment for an identified tongue tie. I ended up seeing a private GP due to the proposed 4 week wait time".*
> *"I would have liked a proper rundown of what the C-section actually was and why it happened. I also would have liked to be talked about on how to care for my scar".*
> *"More continuity of care on the ward - due to myself and baby being unwell post birth we had multiple different professionals all coming in to see us at different times (often with about 30mins between) so we never really managed to get proper rest on the ward".*
> *"I expressed my upset and trauma over the birth to the midwives I saw post birth, but I wish I had pushed harder to have the debrief. I feel they gave me no support on this except to direct me to other people".*
> *"I would have liked someone to explain to me why my birth progressed the way it did and help me understand why things went the way they did".*

Communication and information: Better communication and clearer information were frequently mentioned. This includes understanding what to expect post-birth, having clear instructions for postnatal care, and being informed about available support services. More detail about appointment times during the day, rather than just being told to expect a visit at some point during a day, would also have been helpful.

> *"More information on postpartum recovery and what to expect with episiotomy healing and care".*
> *"Leaflets to be given to me when leaving the hospital. A lot of information was given verbally but it can be difficult to retain it after the amount of medication".*
> *"Clearer communication on the processes following birth".*
> *"Text message check-ins".*
> *"A proper in person antenatal class".*
> *"Badger notes could have been more comprehensive".*
> *"Appointment times would be helpful not just knowing days of visits".*

Practical support: Practical help with tasks such as feeding, caring for the baby, and managing postnatal recovery was a common request. This includes help with breastfeeding, understanding baby's needs, and managing physical recovery from birth.

> *"Literally ANY support from the maternity ward would have been appreciated. No water, no support to visit baby, no help with pumping for baby, no wound care, no support around mental health, no food, medication never on time and often not brought at all... any one of these things would have helped".*
> *"Health visitors' advice was inconsistent and at times contradictory- it would have been helpful if HVs were able to signpost effectively to the right services needed".*

Developing services for the future

When developing services for the future, how important are the following? (Responses from people)					
Answer Choices	**Very important**	**Important**	**Not that important**	**Unimportant**	**Response Total**
Services are easy to access	80.56% 634	18.93% 149	0.38% 3	0.13% 1	787
Wider support from community groups	36.91% 289	45.08% 353	16.73% 131	1.28% 10	783
Access to the same midwife during and after my pregnancy	63.87% 502	26.97% 212	8.65% 68	0.51% 4	786
Access to my usual midwife when giving birth	29.94% 235	31.34% 246	33.89% 266	4.84% 38	785
Services provide additional support for those who need it	77.46% 605	21.13% 165	0.90% 7	0.51% 4	781
Services are based on research and evidence (e.g. national guidance)	64.52% 502	31.23% 243	3.73% 29	0.51% 4	778
Skills and expertise of staff at each stage of my maternity care	95.04% 748	4.83% 38	0.13% 1	0.00% 0	787
				answered	789

When developing services for the future, how important are the following? (Responses from partners, family members and other interested parties)					
Answer Choices	**Very important**	**Important**	**Not that important**	**Unimportant**	**Response Total**
Services are easy to access	88.57% 62	11.43% 8	0.00% 0	0.00% 0	70
Wider support being available from community groups	48.57% 34	41.43% 29	10.00% 7	0.00% 0	70

When developing services for the future, how important are the following? (Responses from partners, family members and other interested parties)					
Access to the same midwife during and after pregnancy	64.29% 45	28.57% 20	7.14% 5	0.00% 0	70
Access to the same midwife throughout pregnancy AND when giving birth	45.71% 32	32.86% 23	18.57% 13	2.86% 2	70
Services provide additional support for those who need it	87.14% 61	12.86% 9	0.00% 0	0.00% 0	70
Services are based on research and evidence (e.g. national guidance)	75.71% 53	22.86% 16	1.43% 1	0.00% 0	70
Skills and expertise of staff at each stage of my maternity care	97.14% 68	2.86% 2	0.00% 0	0.00% 0	70
				answered	70

Many responses highlight the importance of comprehensive, compassionate, and accessible care for mothers and their families. Some respondents thought that more should be done to ensure more personalised care and fewer interventions during birth are encouraged throughout pregnancy.

Postnatal support: There is a strong emphasis on the need for better postnatal support, including breastfeeding support, mental health support, and care for mothers recovering from childbirth. There is a strong call for additional training for health professionals, particularly around breastfeeding and lactation support. The need for improved and consistent signposting to community groups and resources was also noted.

"We had conflicting views from hospital staff on breastfeeding techniques and this was difficult to manage and to know what to do - it would be good if there were more standardised messaging and training".

"Increased tongue tie service - waiting 8 weeks for an appointment makes it impossible to breastfeed".

"Service provided for women giving birth needs to be human centric. Mental health is equally as important as physical health and should be better supported immediately postpartum".

"Tongue tie reviews before discharge - I strongly feel that this will help more people to have successful breastfeeding journeys".

"Debrief should be standard after any delivery suite birth".

Compassionate care: The attitude and compassion of maternity staff is highlighted, with many respondents noting burnout and compassion fatigue among staff. There is a call for more empathetic and supportive care, particularly for new mothers and those experiencing mental health challenges. There are some suggestions about mix of staff and additional roles to relieve the workload on midwives.

> *"I felt that the language used by many professionals was coercive and I felt a huge amount of pressure to be induced. I was low risk and had an uncomplicated pregnancy. I felt that at the 41 week mark I was constantly pressured to accept intervention even though I didn't want it".*
>
> *"Nobody - at any point - explained risks and benefits of induction to me such as increased risk of emergency c section, increased risk of complications for myself and baby post birth and increased risk of NICU* [Neonatal Unit] *admission. How can anyone be giving informed consent when they do not have this information explained to them?"*
>
> *"Strongly advise exploring innovative alternatives on the ward after birth. I recognise the national shortage of qualified staff but may be an opportunity to explore breast feeding support workers, breast feeding councillors. Can people be trained up in this area? Could it reduce pressure on midwives on the ward?"*
>
> *"Look at the French model. You have hospital cate for the baby. Then all mums move to another area where you are helped to get settled with your baby, learn to feed and bath the baby. You can stay up to a week. This aftercare might seem a lot but it is proven to improve infant care, mother's recovery, increase breast feeding and reduce readmission and returns to a and e. Get it right the first time and you will get better results".*

Continuity of care: Some respondents call for continuity of care, with the same midwife supporting a woman throughout her pregnancy, birth, and postnatal period. For other the same midwife is less of an issue, but they wanted consistency in support available and advice from all midwifery staff.

> *"I feel extremely lucky to have had the same midwife throughout my pregnancy and postnatal care. It really made a difference".*
>
> *"Continuity of care was a huge factor in the outcome of my birth. The relationship I had built with my midwife meant I trusted her implicitly. She knew exactly what I wanted. Addressed all my worries and ultimately allowed me to achieve the birth that all woman should have the opportunity to experience".*
>
> *"I don't feel that the same midwife throughout was an important factor for me but I do think the standard between the midwives in terms of professionalism and compassion was quite varied".*
>
> *"It would be great to have the same midwife for birth but I realise that is impossible in reality. I think that as long as detailed notes are passed on / written in notes then it should all work out ok".*

Evidence-based practices and informed choice: There is a desire for evidence-based practice and for guidelines to be presented as recommendations rather than rules. Respondents want to be provided with balanced information to enable them to make informed choices about their care.

> *"Often it can feel like women are not treated as capable competent adults with working mental faculties. We are the experts in our bodies and birth should be a*

conversation led by clinicians and their evidence in tandem with women who understand their own bodies. There is a tendency to infantilise or restrict what is shared with women in case it influences their decisions. All facts should be offered and people allowed and trusted to make the best decision for them and their families".

"In regards to being evidence based and following national guidelines, I feel it is important to make people aware that a large part of the guidelines are not actually based on good quality evidence. And that there just isn't enough good quality evidence for a lot of things pregnancy related! There certainly isn't good evidence supporting the high usage of some interventions however they will be implemented due to 'guidelines'. Making more people aware of this and that guidelines are not rules you MUST follow or else…"

"Being open to a women's informed choice and supporting her to birth safely, which doesn't always mean in hospital".

"To actually provide evidence-based information on an individual circumstances vs one size fits all. Provide easier access to information behind NiCE guidelines and NHS information on their website (link the references) so people can make informed choices".

Accessibility and inclusivity: Accessibility to services is essential, with some specific comments about community services, facilities in Cheltenham and Stroud, and support for home births. Many respondents value local, smaller midwife-led centres for their relaxed and calm birthing experiences.

"Ensuring there is a local midwife service available for during pregnancy, birth, aftercare and breastfeeding support. Large acute maternity services are not able to provide the same intimate support as a midwife lead local centre".

"I think a midwife led model of care should be the norm, i.e. services designed to offer this should be expanded and doctor-led care should be accessed when necessary and needed. If a person is low risk they shouldn't have to give birth in a consultant led unit".

"More support for home birthing. If you can't afford a private doula or private health care like we couldn't you run the risk of not being able to access it. We were really looking forward to ours and believed in the science of it".

"Re-open Stroud maternity postnatal beds. I cannot tell you the impact this place had on me during first two births. The care and time staff are able to give us second to none and quite frankly is 100 times better than what can be provided at busy GRH. Breastfeeding support and just looking after a new mum to support her looking after her baby. I'd have gone there in a heartbeat this time".

Facilities for partners and ability for partners to stay on the ward overnight received mixed feedback.

"Consideration for wards to not be overrun with dads sleeping in chairs. I was placed in a ward full of men snoring in chairs not getting up to help their partners with the baby. They were also often in the toilet when I needed to go and kept me awake all night. I know some people need support especially if they have had a section but it actually meant I got even less rest as I was surrounded by unfamiliar men on the ward at a time when I was at my most vulnerable".

“Some support for dads on the ward if you’ve had a traumatic birth or your baby is unwell. There aren’t even basic chairs for them and they’ve had to watch their partner go through the experience and hold it together”.
Additionally, there is a need for services to be more inclusive, particularly for those who do not speak English.
“I feel you need to take a look at the maternity ward. I stayed in hospital for 2 nights and they wanted to keep me further, but I was so appalled with the service I asked to be discharged. I am a British-born woman so have no issue with language barrier etc, but I witnessed people on that ward who are not from here or don’t speak the language [who] were dismissed and I witnessed people struggling with breast feeding [who]were not given any support and left to cry and figure it out themselves”.

Digital tools: Badger Notes received criticism for being clunky and difficult to use. There is a need for better digital tools and improved communication between service users and health professionals.

“Badger notes needs a lot of work. I had the folder with my first baby and it was so much better. All the information was kept in one place and I could easily find the information. However badger notes is hardly ever updated and I can’t find any details from my pregnancy on it or the baby”.
“More staff are needed, clearer communication and checking in. Badger notes is not sufficient, not much (in my experience) was published on there”.
“Badger was not user friendly. My midwife didn’t upload my info (probably didn’t know how or realise it was important to me), whenever she would upload docs for me to read they’d be impossible to find. I didn’t enjoy Badger at all”.
“Digital connectivity- improving BadgerNet”

Information and support*:* Access to good quality information and support in the local community were considered essential throughout the pregnancy and maternity experience.

“Having a simple website to tell you about weigh clinics etc play sessions etc all in one place”
“I find the Instagram pages really useful for info. I think badger notes could be a better app, it’s quite hard to find info on there”.
“Creating a support network/leaflet for mums of courses/groups etc that are available in the area as when I asked no one knew, this could have really helped me in the early days”.
“Antenatal groups were not offered to us by NHS at all but the ones we found privately have been one of the most useful avenues for support that we had after birth”.
“More training in regard to language and communication midwives in hospital are using. Much more signposting to local services and where to access evidence based information for support both in the hospital and after birth”.
“Bring back antenatal classes in the Forest of Dean I felt isolated not being able to meet other women who were having a baby around the same time”.

General insight into maternity care

Overall, what was good about the maternity care you and your family received?

As before, responses highlight the importance of compassionate, personalised, and professional care in creating a positive maternity experience:

Supportive and caring: Many respondents appreciated the kindness, compassion, and professionalism of the midwives and other healthcare staff. They felt listened to, respected, and well-cared for throughout their pregnancy, birth, and postnatal period. Many women had positive experiences during labour and delivery, with midwives and other staff providing excellent care and support.

> *"All the midwives were amazing, couldn't praise them more. I felt safe and my experience was positive. The birthing unit at Glos is a beautiful calming space".*
> *"Community midwife's postpartum - very pleased with the visit frequency, and support and expertise that followed".*
> *"The midwives (2 in particular) cared not only about my physical wellbeing but also my mental wellbeing and advocated well for me".*
> *"The theatre staff during my labour/birth were incredible and made me feel so safe and listened to".*

Continuity of care: Having the same midwife or a consistent team throughout their pregnancy and postnatal period was highly valued. This continuity helped build trust and provided a sense of reassurance and support.

> *"All appointments were timely and we benefited from seeing the same midwife every time (despite not being part of the continuity team!)".*
> *"Continuity of care during pregnancy and after birth".*
> *"My midwife was incredible and she wanted me to have the birth I wanted and advocated for this".*

Personalised care: Women felt that their individual needs and preferences were respected and that they were involved in decision-making about their care. This person-centred approach made them feel empowered and supported.

> *"My decision making despite being against medical advice and birthing guidelines was respected. I was presented with the facts and allowed to make an informed decision".*
> *"I felt listened to and involved in all decision making. I felt safe despite unexpected events in my labour".*
> *"The understanding of my needs and anxieties throughout my stay at hospital. That delivered my healthy baby girl".*

Professionalism and expertise: The knowledge and competence of the healthcare professionals were frequently mentioned. Women felt confident in the care they received and appreciated the clear communication and guidance provided by the staff.

> *"Being able to call triage during pregnancy to discuss concerns. Monitoring in the ward during incidents of reduced movement. The attitude and commitment of the midwives I came into contact with who went above and behind".*

"The midwives (2 in particular) cared not only about my physical wellbeing but also my mental wellbeing and advocated well for me".
"My most recent pregnancy experience was the best out of all three. This was down to continuity of care, trust, knowledge, facts and the ability to finally advocate for myself and understand everything is a choice, with out being made to feel like I was putting my baby or myself at risk. I was given actual statistics for my personal risks".

Emergency and specialised care: The prompt and effective response to emergencies and complications was highly praised. Women felt that they and their babies were in safe hands, and the specialised care provided in situations like the Local Neonatal Unit was particularly appreciated.

"The care in labour was amazing, everything was explained to us before it happened including why it was necessary and the alternatives. We felt safe and calm despite going for a very speedy emergency section".

Postnatal support: The support provided after birth, including breastfeeding support and home visits, was highly valued. People felt that this support helped them navigate the challenges of the postnatal period and provided reassurance and guidance.

"Having breastfeeding support at Stroud Maternity was a lifesaver. The volunteers and midwives there are amazing".
"Great continuity for antenatal and postnatal care. Fantastic extra support groups, through yoga, tea and cake various other opportunities which I have never seen offered in other trusts".

What could have been improved?

These themes highlight the areas where people feel improvements could be made to enhance their overall experience and ensure they receive the best possible care.

Communication and information sharing: Many people felt that communication between staff and people could be improved. This includes better sharing of information, and more consistent advice throughout the pregnancy and postnatal period.

There were also concerns about the lack of information provided about certain procedures, such as induction and caesarean sections and the need for more detailed explanations about what to expect during labour and after birth.

"More information to be given face to face about possible birth methods. The real birth was great, but I think more antenatal classes with that information would be better. I did not realise induction could take up to 3 days".
"Communication could be better. Letters being sent late and a lot of worry in the first pregnancy that could have been stopped by better communication".
"A clearer process for those wishing to birth out of guidelines. Easier access to consultant midwives who make decisions around birth locations".
"Different professionals throughout could have took more time to sit and explain things in a simpler manner, so I had more concrete understanding of what and why things were happening".

“Our consultant care during pregnancy did not feel helpful. Appointments just stressed us out as we did not feel listened to and felt we were being pushed towards certain paths. Communication was not clear and we weren’t provided with evidence for the assertions that were given about our birth choices”.
“Communication, talking to me about what happened in greater detail to allow me to make more informed choices”.
“The way the consultant spoke to me offering me inductions and discussing my other options. I came away feeling anxious, emotional, pressured, sad and uneasy”.
“Advice about C section recovery. A pamphlet or website with specific advice about rehab and recovery, rather than trying to remember what a doctor has told you after you've been up for a day or two trying to birth a baby”.

Staffing levels and attitudes: A recurring theme was the need for more staff, particularly on the maternity ward and during labour. Many felt that the current staffing levels were insufficient to provide the necessary support and care.

There were also comments about the attitudes of some staff members, with some women feeling that they were not treated with the necessary empathy and respect.
“The staff are so overloaded they cannot give the women in their care the time and attention they need”.
“Pre-birth - staffing levels, staffing attitudes, consistent messages rather than conflicting information from different midwives”
“Availability of staff to support with baby once born as I didn't have partner who could stay 24/7 after birth & feel staff relied on them”.
“Treatment and respect in triage”.
“Hospital staff, attitudes towards feeding, consistent advice, compassion for vulnerable women”.
“I felt unsafe during my induction and labour. The staff were so busy that I don't think they were able to give full attention. Similarly with after care, the staff were unable to provide an adequate level of care due to resourcing pressure”.
“Staffing after birth, care and kindness after birth (I understand midwives are very busy but I was made to feel like I was a nuisance asking for pain relief or about excessive blood loss)”.

Postnatal care: Many respondents felt that postnatal care could be improved, particularly in terms of support for new mothers. This includes better pain management, more support with breastfeeding, and more attention to the emotional and mental health needs of new mothers.
“Post birth support in general. Particularly on breastfeeding. Physio support to rehab pelvic floor. Physio assessment should be routine after delivery”.
“Support after leaving hospital and also after being discharged from the midwives. Health visitor support needs to be ramped up”.
“Breastfeeding support, aftercare for parents as well as baby, checking for jaundice, discharge procedure, communication between staff and patients, ensuring pain relief is given regularly and on time”.
“Help with mental health and birth trauma”.
“Aftercare, mental health follow-up a month or so later (I had a section under general anaesthetic) and more information about recovery post section”.

Consistency of care: Several women mentioned the need for more consistent care, particularly in terms of seeing the same midwife throughout their pregnancy. This would help build a rapport and ensure that the midwife is familiar with the patient's history and needs. There were also comments about the need for better coordination between different departments and healthcare professionals including consultant obstetricians, anaesthetists and midwives.

> *"The sheer volume of different people involved in our care, it felt like we were swept away on an uncontrollable tide of health care professionals! No joint up working, no one knew what was happening".*
> *"Prenatal I saw lots of different midwives with no consistency".*
> *"Consistency in care after giving birth once discharged from hospital".*
> *"Whilst I was pregnant we saw the same midwife but after my daughter was born, we had a different midwife each time and they didn't know me or my daughter. We would have preferred to see the same midwife throughout our pregnancy and after birth".*
> *"Communication and standards across teams - I was bounced from community to triage regularly during my 3rd trimester because they don't use the same blood pressure reading technology".*
> *"Communication between staff on the maternity ward. Continuity of care from the same midwife after birth".*

Support for partners: Some feedback highlighted the need for better support for partners, including more comfortable facilities for them to stay overnight. Partners need more recognition and support, particularly during traumatic births or emergency care.

> *"Better support for partners - they go through a lot too plus those chairs were awful!"*
> *"Partners considered and supported- not a just given a chair in the corner".*
> *"Support after birth for my husband could have been improved, so he was not left alone worrying for so long. He was also told very honestly about the situation and my health and I'm not sure how helpful that honesty was at the time when he was alone with our newborn".*
> *"More support for new dads and not just expecting them to know what to do. One lady made my partner feel really uncomfortable as he asked if he could have help changing her bum for the first time".*

Access to support: There were comments about the need for better access to certain support services throughout women's maternity experience. This included antenatal classes, breastfeeding support groups, and mental health support. Some felt that support was not readily available, or easily accessible, to those from all parts of the county.

> *"Stronger engagement with the Health Visiting team in the antenatal period. They were great once my son was born but I don't recall hearing from them during my pregnancy. The health visitor wasn't aware that I had another child despite having previous health visitor appointments for that child".*
> *"More access to antenatal groups (no in person NHS groups available)*
> *The one antenatal class we were offered did not feel inclusive at all. Only dads were mentioned (we are a 2 Mum family) and introductions were skipped. There was also a lot of assumed knowledge which wasn't helpful. I submitted feedback at the time".*
> *"More local access to advice and services like antenatal classes and breastfeeding support groups in the Forest of Dean and other rural areas".*
> *"More information regarding support to access".*

> *"Information early on about antenatal classes, yoga, breastfeeding support".*
> *"Better breastfeeding support. The closest group being 30 mins away and once a week just doesn't cut it".*

Technology: Some feedback mentioned issues with the BadgerNet app, including difficulties accessing information and the app being slow or crashing. There were suggestions for improving the app to make it more user-friendly and reliable.

> *"Badger notes are rubbish and it is so hard to adequately outline your birthing plan. Please find a way to allow mothers to upload attachments. The multiple-choice questions are also not fit for purpose and should be reviewed".*
> *"The BadgerNet app. It was very slow and this put me off accessing info/leaflets opting to instead google for the trusts info/leaflets.*
> *"Communication between hospital and community was poor no one knew what the other was doing or had done, notes often incomplete on badgernet or using systems other services e.g. GP cannot access".*
> *"Get rid of badger notes. The app is useless, always crashes, hard to navigate. I would rather carry round paper".*
> *"I would have preferred access to my full maternity and delivery notes. The Badger app was clunky and incomplete".*
> *"Badger notes could be better. I didn't feel I could see lots of notes like I could previously when I had my other baby and had paper notes. It's a lot harder to find specific things and then when I was locked out at about 30 weeks I never got logged back in again so I didn't have any birth notes or anything which was disappointing"*

Other insights

As well as conducting surveys specifically designed to support the development of the maternity health needs assessment, insights were gathered in other ways to increase the diversity of participants. In addition, insight data collected nationally through the CQC annual Maternity Survey, as well as an example of themes from complaints and Friends and Family Test data collated by Gloucestershire Hospitals NHS Foundation Trust, are presented in this section.

Polish community listening event – 26.10.24

The local ICS partners are involved in engagement activity with underserved communities on a regular basis on a variety of health and wellbeing related subjects. In autumn 2024, members of staff from the ICB and Gloucestershire Health and Care NHS Foundation Trust were invited to join a gathering of Polish families.

The overall experience of maternity services among members of the Polish community in Gloucestershire revealed a number of concerns, particularly regarding the quality of care and support during labour and birth. Many individuals described their experiences as stressful, with a sense of fear or anxiety often linked to negative media coverage around maternity services and others' experiences in Gloucestershire. This fear was compounded by a strong desire to protect the wellbeing of their unborn child, and in some cases, led families to consider, or choose, to give birth outside the county or country, highlighting a serious trust issue in the local system.

A central theme that emerged was the importance of not being misunderstood. Language barriers, cultural differences, and a lack of cultural sensitivity within the maternity services were seen as major obstacles to accessing appropriate care. This misalignment often resulted in feelings of being dismissed, not listened to, or not properly informed, particularly during the most critical time: labour and birth. These issues made it difficult for Polish families to feel safe and respected within the system.

Interestingly, some participants reported positive experiences, but these were mostly postnatal rather than related to the birth itself. Mothers were more likely to express satisfaction with services such as postnatal support once the baby was born, although confusion remained around the role of health visitors. A lack of clear communication about what health visitors do, and how they can support both mother and baby, remains a barrier to full engagement with these services.

Another important aspect raised was the presence of mistrust around vaccines and certain health practices, including concerns related to postnatal practices. These views are often shaped by cultural norms and community narratives and need to be handled with sensitivity. In terms of communication, most Polish residents do not rely on local English-language media such as BBC West or local newspapers to access information about NHS services. Instead, they primarily receive health information through Polish language TV, Polish social media platforms, and community WhatsApp groups.

A mother's story, Autumn 2025

Additional feedback was captured in 2025 in the birthing story shared by a woman from the Polish community in Gloucestershire. To protect her identity, she is referred to here as 'D'.

D reported overall a positive experience of local maternity services. She gave birth to her fourth child earlier this year, but this was her first child born in Gloucestershire. D is fluent in English.

Services here are very different to those in Poland, but in a positive way. Staff had been very kind and she felt well supported. It would have been useful to have some written information about the way services work: what will happen and which professionals you will see at various stages of the maternity pathway. D had been able to research these things online but recognised not everyone would be able to – she suggested this information could be shared with women at their first maternity appointment.

D would have liked to attend face-to-face antenatal classes. She would also have appreciated more support for breastfeeding and noted that her child had a tongue-tie which had gone undetected. By the time it was picked up, she was told it was too late to correct it and she has consequently had this done privately.

She did comment that in the first few days at home, the midwifery team were very short staffed and she had to go to a clinic to access checks on her new baby, rather than having a

home visit. This was really difficult for her and she had to get her husband to drive her to the appointment. She has not had a visit from a health visitor.

Black Mothers Matter – listening event 29.09.25

Representatives from the maternity health needs assessment project team attended a regular meeting of the Black Mothers Matter Group in Gloucester. Together, the mothers talked about the following topics relating to their experiences of maternity services in Gloucestershire.

Accessing information

Attendees reported hearing about Black Maternity Matters via word of mouth, through friends and online. One attendee noted that if she had questions, she would use Google. The group felt that printed leaflets aren't useful and they would all prefer QR codes or online information.

Continuity of carer and rapport with health care professionals

The experience of continuity of carer was varied, with one attendee not having the same midwife more than once and another having the same throughout until discharge to the health visitor. Another attendee noted a lack of relationship with the health visitor, having seen the health visitor only twice and contacted them with a question on only a single occasion.

Access to pelvic health support

Having self-referred to physiotherapy several months ago and receiving no response, one attendee presented to the GP with Pelvic Girdle Pain (PGP). Her GP was unable to find the cause of this and has referred her on to gynaecology as she still has a lot of pain 8 months after giving birth. The woman was induced (pessary) and wondered if this has caused her pain since. Her midwife knew about the PGP but did not refer to the Perinatal Pelvic Health Service. She had not received any support yet. None of the women had heard of the free NHS perinatal pelvic health sessions.

Triage experience

This attendee commented that her experience of triage was fine. She was going to have a vaginal birth after caesarean (VBAC) but changed her mind (she had had a c-section in Nigeria for her first baby).

Birth experience

One woman commented that she did not want anyone touching her during her contractions. A staff member called 'J' was brilliant at ensuring her wishes were listed to. She was monitored due to baby's low heart rate and they were going to perform a caesarean section, but she insisted they check his heart rate again. This time the baby's heart rate was fine and she was allowed to give birth naturally. She felt it was only because of 'J' listening to her that her baby's heart rate was checked again and a caesarean section avoided.

One woman had a scan at 37 weeks, and the scan had shown a heart issue with her baby. She was kept in Gloucestershire Royal Hospital for a caesarean section but it was a week before the procedure was performed; she felt it was unnecessary for her to be kept in that long. She is a single parent and had an older teenager at home who stayed at home by herself that week. The mother queried what would happen to a single parent with another child at home when they need to attend hospital – where would the child go?

Another attendee reported choosing to leave the hospital within three hours of giving birth with each of her four children as she was aware that lots of people were coming in and out of the ward, including men, and this did not allow for a culturally-sensitive space.

Smoking and weight management

One woman noted that no support was offered with regard to support to stop smoking, even though her carbon monoxide was tested at each appointment. However, despite this, she confirmed that she was able to stop smoking on her own.

Another woman who did not know she was pregnant until 16 weeks was referred to the Health Lifestyles Service (HLS) for her weight, but they did not get in touch with her until the week before she gave birth, so she did not think it was worth seeing them at that point. She reported feeling judged by some health visitors and midwives around her baby's weight, being told by one that she was overfeeding her baby even though he was breastfed and she didn't feel a baby can be overfed that way. She said in that situation there was a mother at the clinic with a baby the same size as hers, but that baby's mum 'is very slim' so was spoken to very differently (not judged) by the healthcare professional. She noted she would have taken advice from HLS but is worried about being judged. This woman felt people need to give information in a respectful and non-judgemental way.

Another attendee noted that the HLS service needs to be more culturally sensitive, with someone commenting that the 'lifestyles' in Healthy Lifestyles certainly doesn't include the lifestyles of a Black woman. She said free support for achieving a healthy weight after pregnancy would have been beneficial as she was not overweight enough to get free access to Slimming World or to a gym, but cannot afford to pay for a gym. One attendee echoed this sentiment and several others felt that free access to a gym or other postnatal exercise would be beneficial.

Another woman noted that in Bristol, free swimming is offered to women for the first year after birth.

Best and worst experiences

When asked what their best and worst experiences were, the group was divided on the topic of partners on the ward: while one attendee disliked partners staying due to the noise (conversations and snoring) and the space that they took up, another attendee liked having her partner there. It was commented that partners need to be more aware of others and be quieter.

One attendee noted that she had a Black midwife during labour and wondered if this was intentional, and said this made a huge difference in a positive way. Others didn't have this experience – i.e. didn't have a Black midwife.

Understanding barriers to perinatal mental health services access: Insights from Asian Sub-Continent perinatal women & ethnic minorities, November 2023–April 2024

Over a 6-month period during 2023/24, insights from Asian Sub-Continent (ASC) women living in Gloucestershire regarding the barriers to perinatal mental health services were gathered through focus group discussions, 1:1 conversations and online engagement. Three reports were produced and the outputs are summarised below. Many of the themes align with those identified through listening to women from the Polish and Black communities above.

Stigma and cultural barriers

Perinatal mental health (PMH) remains highly stigmatised in ASC communities. Women feared being judged or misunderstood, especially by health professionals unfamiliar with cultural or faith-based perspectives. There was a strong reluctance to attend anything labelled as a 'mental health' group due to shame or fear of community judgement.

Lack of awareness and understanding

Many women did not initially recognise their symptoms as PMH-related, believing PMH only referred to severe conditions like psychosis. There was limited knowledge of how to access support, especially postnatally, and a lack of continuity between midwives and health visitors.

Trust and safe spaces

Women consistently expressed a need for culturally sensitive, faith-aware, and non-judgemental environments. Groups like 'Marvellous Mums' were praised for offering a safe space where women felt understood without needing to explain their beliefs.

Barriers to accessing services

Long waiting times, lack of drop-in options, and digital exclusion were major barriers. Booking systems requiring early sign-up or online access were seen as exclusionary. Language barriers were often misunderstood and many preferred English materials they could translate with family, rather than formal interpreters.

CQC annual maternity survey

The CQC undertakes an annual survey of women's experiences of maternity services.

CQC survey 2024

In 2024, Gloucestershire MNVP reviewed in detail the results from that year. This is the summary of their review:

Positives

Overall positive care experiences highlighted:

- Fantastic care from individual members of staff
- Positive antenatal care experiences
- Positive care practice by staff in Gloucester birth unit, the consultant-led unit, the Local Neonatal Unit, and continuity of care teams.

Often, even when someone raised a criticism, it was followed by how appreciative they are of staff "who are doing their best despite circumstances."

Women who birthed during/immediately after Covid felt their experience in 2024 was improved in comparison to the past, so wanted to highlight improvements.

Suggestions to improve care were made by a few respondents and included a request for more continuity of care teams and more postnatal checks up to four months after birth.

Negatives

Communication

- Poor communication with service users around appointments, named community midwife, scans, post-surgical advice and feeding support. One service user mentioned wanting more considerations around learning needs – i.e. offering visual aids/easy-read items to help with decision-making.
- Poor communication was observed between staff, especially during shift change, and between departments.
- Lack of shared decision-making/informed consent: respondents often felt updates were not provided often enough in relation to their care such as induction process, pain management, catheter removal, feeding support, and tongue-tie.
- In a few instances, women felt the lack of communication led to their own health worsening or their need for hospitalisation due to poor communication, especially if they had any medical complications during pregnancy.

Poor postnatal care

- Poor pain management, poor responses to buzzers, lack of support around rest and a sense there were not enough staff available if something were to go wrong.
- Feeding support: inconsistent support around feeding newborns both in hospital and at home. Respondents felt there was a lack of training for staff to address any difficulties, including neonatal feeding support at home. Waits for tongue-tie assessment noted to be long and three respondents reported they sought private medical support to address tongue-tie. One respondent felt all staff should be trained to identify tongue-tie.
- Discharge: respondents' experiences of discharge noted a lengthy process held up by newborn check, medications or catheter/venflon removal.

Failure to listen

- When concerns were raised by service users, no explanations were offered or needs were not met because they felt they were not being listened to. *"It took for me to*

have high blood pressure and vomiting to be listened to." Several respondents were not believed they were in labour and felt dismissed.

Lack of respect/compassion

- Staff being dismissive or rude or not respecting an individual's privacy was brought up. Examples included: a cleaner opened a curtain during a woman's pelvic exam, and a consultant telling a service user to "forget about" having a water birth. Furthermore, another service user felt her postnatal care experience lacked compassion and that the choices she made for herself and baby were not suitable.

Staffing

- Staffing concerns related more to the postnatal ward where respondents felt there was an apparent lack of staff to support/check on service users.

Further areas that were highlighted on several occasions included:

- Triage: It was reported that staff could be rude and do not listen when a service user identifies a need for assessment/assistance. It was felt that triage offered inconsistent care.
- The lack of rest for a birthing woman
- The perception of a lack of care for the mother
- Longer hospital stays
- Poor communication: Many understood that emergencies would take precedence over their care but felt more could be done to update those that were waiting.
- Treatment of partners/birth companions was not ideal.

CQC survey 2025

The results for the national 2025 maternity survey were published in December 2025. The national report summarises the experiences 16,755 women who gave birth nationally in February 2025. The survey tells us about their experiences of care provided before giving birth (antenatal care), during labour and birth (intrapartum), and in the 6 to 8-week period following birth (postnatal care).

The survey shows overall improvement nationally in many areas of maternity care over the past year, especially in experiences of communication during antenatal care and involvement in decisions during postnatal care. However, there remain other areas of maternity care where women report poorer experiences, particularly communication during postnatal care.

This year Gloucestershire Hospitals NHS Foundation Trust is noted as one of 12 Trusts in England performing 'Better than expected'[9]. This is because the proportion of women who

[9] Each question overall response is given a score out of 10 and a comparison is also made against other trusts. Each trust receives a rating of 'Much better', 'Better', 'Somewhat better', 'About the same' 'Somewhat worse', 'Worse' or 'Much worse':

- Much better: the trust is much better for that particular question compared to most other trusts that took part in the survey
- Better: the trust is better for that particular question compared to most other trusts that took part in the survey

answered positively to questions about their care during labour and birth, and on the ward after the birth, was significantly above the national trust average. This report and the survey results will be available at the following link: https://www.cqc.org.uk/publications/surveys/maternity-survey. The full results for Gloucestershire Hospitals NHS Foundation Trust can be found here: https://www.cqc.org.uk/provider/RTE/surveys/130.

Questionnaires were sent out between April and July 2025 to women who gave birth between 1 and 28 February 2025. Responses were received from 163 people who had birthed at GHT, and the results are shown in the tables below.

Labour and birth

Patient Response: 9.0/10. Compared with other trusts: Better than expected.

Area	Score (out of 10)	Compared with other trusts
Advice on risks of induction: Being given appropriate information and advice on risks of induced labour	8.7	Better than expected
Advice at start of labour: Receiving appropriate advice and support when contacting a midwife or the hospital	9.2	Better than expected
Being sent home: Not being sent home during labour when they were worried	9.1	About the same
Pain management during labour and birth: Staff doing everything they could to manage pain during labour and birth	8.3	Somewhat better than expected *This result is a significant improvement since the 2024 survey.
Partner involvement: Partners being involved as much as they wanted during labour and birth	9.9	Much better than expected

Staff caring for you

Patient Response: 8.9/10; Compared with other trusts: Better than expected.

Area	Score (out of 10)	Compared with other trusts
Staff introduction: Staff introducing themselves before examination or treatment	9.6	Better than expected
Being left alone: Not being left alone by midwives or doctors at a time when it worried them	8.5	Somewhat better than expected. *This result is a significant improvement since 2024

- Somewhat better: the trust is somewhat better for that particular question compared to most other trusts that took part in the survey
- About the same: the trust is performing about the same for that particular question as most other trusts that took part in the survey
- Somewhat worse: the trust performed somewhat worse for that particular question compared to most other trusts that took part in the survey
- Worse: the trust performed worse for that particular question compared to most other trusts that took part in the survey
- Much worse: the trust performed much worse for that particular question compared to most other trusts that took part in the survey

Raising concerns: Concerns being taken seriously once raised	8.6	About the same
Attention during labour: If attention was needed during labour and birth, a member of staff was there to help	9.2	Better than expected. *This result is a significant improvement since 2024.
Staff working together: Feeling midwives and doctors worked well together during labour and birth	9.0	About the same
Clear communication: Being spoken to during labour and birth, in a way they could understand	9.4	About the same
Involvement in decisions: Being involved in decisions about their care during labour and birth	9.2	Better than expected
Respect and dignity: Being treated with respect and dignity during labour and birth	9.6	Better than expected
Confidence and trust: Having confidence and trust in the staff caring for them during labour and birth	9.1	About the same
Opportunity to ask questions: Having the opportunity to ask questions about their labour and birth	6.9	About the same
Medical history: Staff caring for them during labour and birth being aware of their medical history	7.7	About the same
Kindness and compassion: Being treated with kindness and compassion during labour and birth	9.4	Better than expected

Care in hospital after the birth
Patient Response: 8.0/10, Compared with other trusts: About the same.

Area	Score (out of 10)	Compared with other trusts
Delay in discharge: Discharge from hospital being delayed	6.5	About the same
Attention after birth: If attention was needed after the birth, a member of staff was there to help	7.4	About the same
Information and explanations: Receiving the information and explanations they needed after the birth	7.7	About the same
Kind and understanding care: Being treated with kindness and understanding by staff after the birth	8.7	About the same
Partner length of stay: Partner who was involved in care being able to stay with them as much as they wanted	9.2	About the same
Pain management after birth: Staff doing everything they could to manage pain in hospital after birth	8.5	Somewhat better than expected

As the results from the national CQC were only published in December 2025, the MNVP has not yet had the opportunity to review the qualitative feedback from the survey. Initial analysis by the Trust suggests that themes identified in 2024 can be seen in the 2025 results, but the frequency of negative experiences in these areas may be fewer and less extreme. The following themes are noted:

Positives

- Staff working in the delivery suite, theatre, Local Neonatal Unit and birth unit teams commended.

Negatives

- Staffing levels
- Mixed experiences of antenatal care but specifically appointment availability and consistency of information including conflicting advice from different staff
- Women not being listened to
- Lack of postnatal support (pain, feeding, emotional support)
- Delays to discharge
- Suggestion from women for more support at home post-discharge
- Better communication between teams needed

Complaints, Patient Advice and Liaison Service (PALS) and Friends and Family Test

Gathering insight from people who use services is a continuous process with established mechanisms in place at Gloucestershire Hospitals Trust, which enable people to share their experiences. Key mechanisms for sharing insight are the complaints process, the Patient Advice and Liaison Service (PALS) and the Friends and Family Test (FFT).

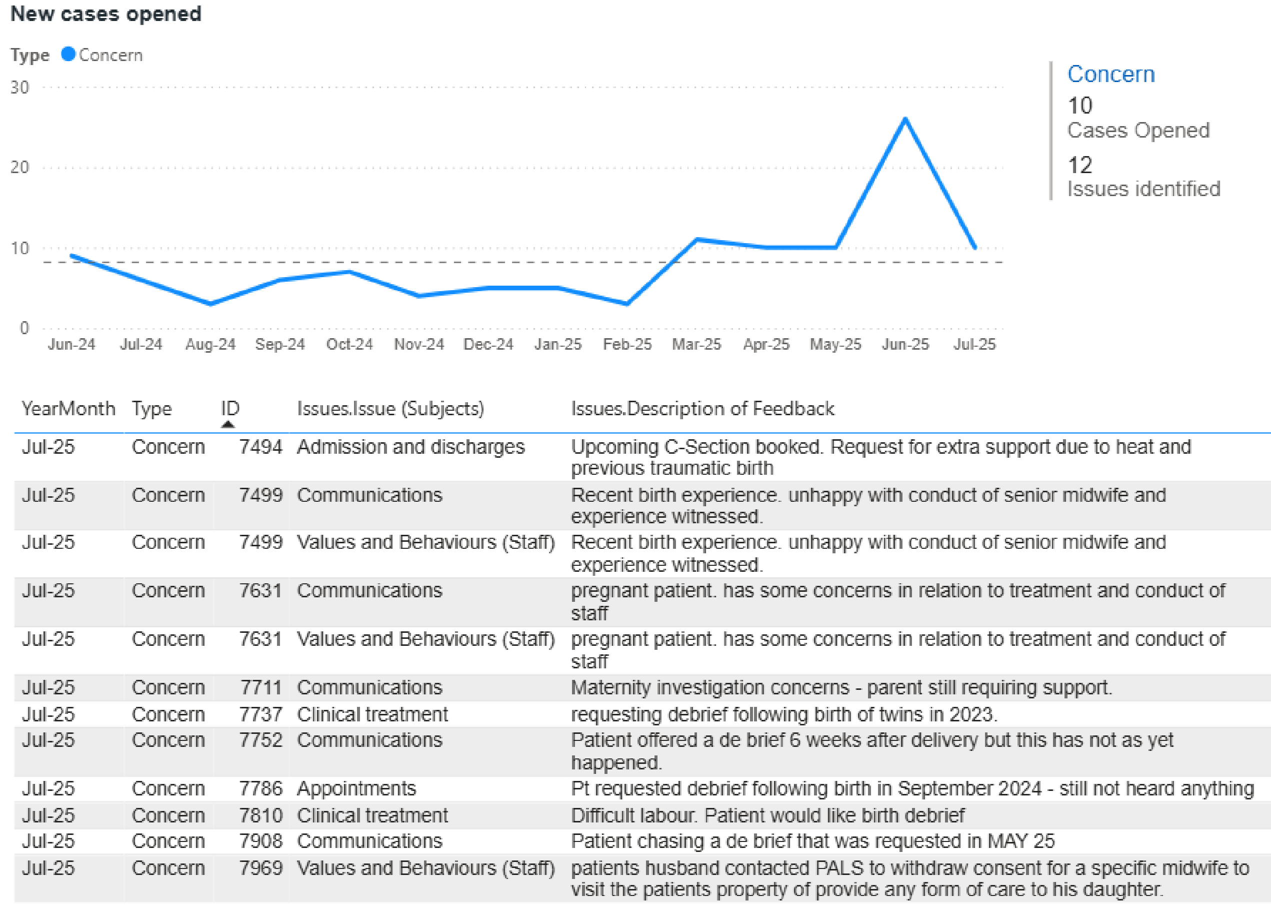
The PALS team speak with staff and support services to help resolve concerns and issues raised by patients and their families. Concerns that cannot be resolved by PALS may be forwarded on to the complaints team. All concerns raised by patients are logged on Datix, a web-based system used for incident and experience reporting, where the key subject of issues raised are recorded to help the Trust to identify and monitor trends and themes in our data. The themes identified help the Trust to understand the concerns and frustrations our patients experience every day and are used to raise awareness of issues and help to identify and support quality improvement activity.

FFT surveys are designed to provide a continuous stream of anonymous feedback about patient experiences when using NHS services. The FFT is available at all times on the Trust website, as well as via a direct SMS messaging service. The Outpatient FFT is sent to patients and services users directly after an attended appointment, and the Maternity FFT is sent out to mothers approx. two weeks post birth and discharge. Responses to the survey are collated together and reported back to the ward or service area on a monthly basis.

Below is an example of one month's complaints, PALS and Friends and Family Test data relating to individual experiences of maternity services in Gloucestershire. The July 2025 report was selected as it most closely coincides with the fieldwork period of the insight surveys, promoted to support the development of the needs assessment.

PALS: Concerns

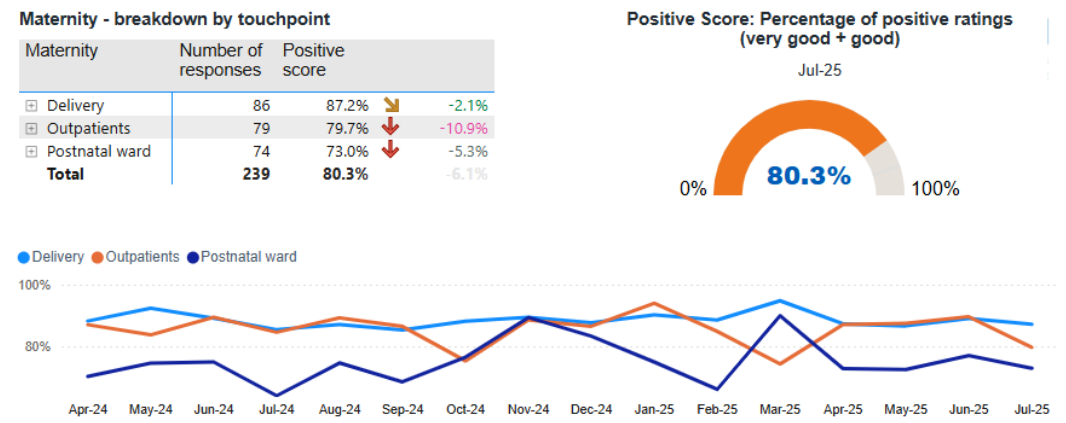
There were 10 concerns raised for maternity services in July 2025. Key themes continue to relate to communication during and after birth – especially when birth outcomes are more complex or considered to be 'traumatising'.



YearMonth	Type	ID	Issues.Issue (Subjects)	Issues.Description of Feedback
Jul-25	Concern	7494	Admission and discharges	Upcoming C-Section booked. Request for extra support due to heat and previous traumatic birth
Jul-25	Concern	7499	Communications	Recent birth experience. unhappy with conduct of senior midwife and experience witnessed.
Jul-25	Concern	7499	Values and Behaviours (Staff)	Recent birth experience. unhappy with conduct of senior midwife and experience witnessed.
Jul-25	Concern	7631	Communications	pregnant patient. has some concerns in relation to treatment and conduct of staff
Jul-25	Concern	7631	Values and Behaviours (Staff)	pregnant patient. has some concerns in relation to treatment and conduct of staff
Jul-25	Concern	7711	Communications	Maternity investigation concerns - parent still requiring support.
Jul-25	Concern	7737	Clinical treatment	requesting debrief following birth of twins in 2023.
Jul-25	Concern	7752	Communications	Patient offered a de brief 6 weeks after delivery but this has not as yet happened.
Jul-25	Concern	7786	Appointments	Pt requested debrief following birth in September 2024 - still not heard anything
Jul-25	Concern	7810	Clinical treatment	Difficult labour. Patient would like birth debrief
Jul-25	Concern	7908	Communications	Patient chasing a de brief that was requested in MAY 25
Jul-25	Concern	7969	Values and Behaviours (Staff)	patients husband contacted PALS to withdraw consent for a specific midwife to visit the patients property of provide any form of care to his daughter.

Friends and Family Test (FFT)

Maternity received 239 FFT ratings in July 2025, with an overall positive score of 80.3% (including delivery rating, postnatal ward ratings, and midwife and obstetrics outpatient ratings).



Maternity - breakdown by touchpoint

Maternity	Number of responses	Positive score	
Delivery	86	87.2%	-2.1%
Outpatients	79	79.7%	-10.9%
Postnatal ward	74	73.0%	-5.3%
Total	**239**	**80.3%**	-6.1%

Outpatient ratings were poorer in July 2025, comments were about long delays to clinic appointments/ultrasounds (mentions of staffing issues), and some poor interactions with sonographers. Several comments described not having questions answered properly or not being given enough reassurance about concerns.

Postnatal ward FFT scores were also lower. However, there were many positive comments about how kind/supportive staff were. Many expressed appreciation for regular check ins and updates.

One theme running through negative comments was expectations surrounding medication and pain relief. Some comments suggest lack of clarity around whether they need to ask for medication or if it should be routinely given, or what is available to them. There were a few comments describing poor communication or lack of information - about what to expect when on the ward, as well as general information about health and what happens next.

Other comments mentioned mixed experiences with breastfeeding support, and concerns over caring for their baby in the heat.

Delivery experiences on the birth unit were very positive – described as supportive, stress free, and ‘magical’. However, there was one comment that mentioned having to stay in the room post birth, which was not cleaned.

There were lots of positive comments about staff on the delivery suite helping to keep them calm and providing reassurance, especially when things did not go to plan, if needing to have an emergency caesarean section, and being kept informed and talked through every step effectively. The negative experiences were when communication was less forthcoming, and some staff members were perceived as rude or not supportive. A couple suggest they were not checked on soon enough when requested. Concerns over staffing were also mentioned.

Part 2: Staff Insight

Part 2 summarises staff insight gathered through a staff survey (summer/autumn 2025) and a series of staff drop-in discussions and interviews.

The first section provides some high-level summaries of the insights gathered through two recent surveys aimed at:

- NHS staff working in maternity services; and
- Staff working in services that interact with / support people and their families.

Insight has been collated to inform the maternity health needs assessment, and as such, this report focuses on general maternity topics, things that currently work well and areas for improvement. Where possible, the summary of insight received is enhanced by comments which exemplify the feedback.

Further insight was provided focusing on operational policy and processes which are outside the scope of the health needs assessment. This insight has been collated into a separate report and used to inform further service improvement work over the coming months.

Which best describes your role?

	Answer Choices		Response Percent	Response Total
1	Healthcare professional/staff working in General Practice		11.57%	14
2	NHS staff working in Gloucestershire maternity services		77.69%	94
3	Staff working in the Local Authority		1.65%	2
4	Staff working in a voluntary, community or social enterprise organisation (VCSE)		3.31%	4
5	Private sector practitioner/staff		0.83%	1
6	Other* (please specify):		4.96%	6
			answered	121

* People who selected other were in other healthcare roles that support people.

What is currently working well in the provision of antenatal, intrapartum and postnatal care?

Staff dedication and care: Responses recognise the commitment and dedication of staff, emphasising good communication withing teams and positive working relationships across different maternity roles and locations. There is mention of specific examples where the

service is working well and providing consistency in antenatal and postnatal care, e.g. Stroud and Forest of Dean.

"Continuity works very well in the FOD through antenatal and postnatal care. midwives have autonomy over their own diaries which promotes happy midwives!"
"At Stroud antenatally we are able to be flexible with appointments, routine or ad hoc for reassurance to suit the birthing people's daily life, from bookings right through to a stretch and sweep. Most of our MCAs [Midwifery Care Assistant] are blood trained therefore able to support the midwives in these clinics, especially if we have a labourer.
Having the unit open as a 24hour service is vital for the intrapartum care here at Stroud, we often have women arrive at full dilatation which means if there was to be any changes within the provision that birth could be a BBA [Birth Before Arrival], For the community, knowing we are available 24 hours a day gives them ease reassurance and choice regarding their birth. We have two beautiful birth rooms that provides the birthing people the calm space they need for their births.
Postnatal care we thrive on what we have been dealt with and that is the sad closure of our beds. So therefore we offer DAY postnatal support up to 28D PN [Postnatally], this ensures that the family feel supported into their new journey of parenthood. Which is when they feel most vulnerable. They can stay at the unit all day to build their confidence before heading home with their baby.
We also offer weighing for babies, to support the CMW [Community Midwives] and MSWs *[Maternity Support Workers]* and if needed SBRs *[screening for jaundice in newborns]* can be taken by the midwives and further support for the families.
We have a great deal of classes available at Stroud for antenatal and postnatal families such as:

- Yoga
- Baby yoga
- Singing
- Tea and cake
- Bump start
- Mother circle

These provide support to the new families that is vital in the upcoming events of having a baby and postnatal bonding"

"The efforts and care and good will of staff. Increase in midwifery staff and also of new roles like ward nurses. New role of Glow appears to work well but I don't know if this has been evaluated. Use of The Good Hope foundation for digital devices and SIMs".
"Practice facilitators for newly qualified midwives. Good doctor and midwife relationship".
"Badgernet is improving communication and documentation amongst HCP's [Healthcare Practitioners]. CMW's [Community Midwives] are trying to provide as much continuity of care".

Improved staffing levels: Success in recruiting to vacancies is noted, although several comments indicate very low staff morale, over-stretched teams and poor pathways/support for women.

"Successful recruitment to full for midwives".

> *"I think that the expertise and experience of workforce is excellent. The drive for improvement, learning and development is at the forefront. But I think the service is just surviving, mainly surviving by the generous effort of frontline staff going above and beyond and taking on workload much higher than they can cope with daily".*
> *"I used to think that women in Gloucestershire received amazing, women centred holistic care, but now it's organisation-centred care, and usually obstetric rather than midwife led. Women in Stroud and Chelt seem to have fantastic continuity from their community teams which is great for these families".*
> "Antenatal and postnatal care is stretched, missed, rarely seeing the same midwife twice. Poor care due to lack of resources, time and staff."

What ideas do you have for reducing health inequalities in maternity care?

Training and education: Responses suggested mandatory training should tackle unconscious bias and foster trust. Further investment in training similar to Black Maternity Matters and more LGBTQ+ awareness is required.

> *"Offer mandatory cultural safety training (not just generic equality modules) to tackle unconscious bias and foster trust".*
> *"Have midwifery/obstetric champions who can lead bite-sized training, case discussions, or awareness campaigns around culturally appropriate care. They can act as a safe go-to for advice when staff are unsure how to sensitively support a patient from a different background".*

Community engagement and support: Inviting community organisations to be more visible on wards was suggested, together with pop-up antenatal clinics in community hubs where underserved groups gather. A number of responses highlighted the need for an improved antenatal offering that is accessible and in-person. Involving community members / 'experts by experience' in the planning and delivery of maternity services was suggested, to ensure services are culturally relevant and responsive.

> *"Pop-up antenatal clinics in community hubs (e.g. mosques, churches, food banks) where underserved groups already gather".*
> *"Inviting community organisations to be more visible on wards. See how positive having Dads Matter has been - if we had that for cultural support etc it would make a huge difference with very little extra work if any for NHS staff".*
> *"We need to make more black and brown women feel heard and welcome from the off. Maybe antenatal (AN) classes aimed specifically at these women, and also aimed at poorer income families who won't be able to afford to attend expensive antenatal education. Our current provision is online AN classes and this is NOT good enough - too easy to not engage at all and these families also don't meet one another and form a potentially helpful support networks like you would with something like NCT for example. This is unfair on families from poorer socioeconomic backgrounds".*

Personalised care: Responses suggest more flexible services to support personalised care and improved continuity of care throughout the antenatal and postnatal periods. A reduction in caseloads would also enable more personalised care for people in deprived areas.

> *"Talk to women and families in local communities or hubs, regularly, to glean what is most important to them for their maternity care and use this information to make policy change. Consider peer support/experts through experience to bridge the gap between professional and service user particular certain vulnerable groups such as young mothers or ethnic minority groups".*
> *"Reduce caseloads of staff who support women with greater needs. Better community-based services so these women can access services more easily eg breastfeeding support and MH support in communities / Children's Centres".*
> *"Localised care approach. We work in a county with very different needs in different areas. Too often change is applied uniformly, rather that taking a local approach".*

Improved support and resources: Specialist leads for diverse ethnic groups was suggested to improve understanding, with dedicated teams for vulnerable women and those with additional needs, along with introducing Maternity Social Prescribers to support pregnant women with non-medical needs.

> *"Improving access to and quality of antenatal care, addressing social determinants of health, ensuring culturally competent care, and fostering community engagement. These efforts should focus on early intervention, personalized care, and addressing specific needs of vulnerable populations, including those from minority ethnic backgrounds and those experiencing poverty and deprivation".*
> *"Introduce Maternity Social Prescribers -professionals who support pregnant women with non-medical needs- like housing, debt, domestic abuse, isolation, or accessing benefits".*
> *"Integrate mental health, housing, and financial support links earlier in pregnancy for vulnerable women".*
> *"Translation services need to be embraced and improved".*

What do you think are the biggest challenges for maternity services in Gloucestershire?

Complexity of care: Increasing complexity in pregnancies and high rates of medical interventions like inductions and caesarean sections are identified as challenging the capacity of services. People who live in the more deprived areas of the county, or have additional needs due to their protected characteristics, often need additional support which is challenging given current resources. More funding and resources are required to enable the provision of good care for all.

> *"Induction of labour rates are too high. Caesarean rates are high. Women's expectations are too high. People only tell the negatives about care but actually their care is good they just want more which we can't give".*
> *"The complexity of obstetric cases. The rising induction and caesarean section rates".*
> *"Lowering our IOL [Induction of labour] and Section rates. Our spontaneous labour and birth rates are much lower than they should be and I've yet to learn about a significant drop in poor outcomes to justify this".*
> *"Increasing birth outside of guidance – need support to help deliver personalised care as this takes time".*

> *"Increased demand and expectations; inability to provide the debrief service needed, which would then potentially also impact on future pregnancies. Smoking and obesity rates".*
> *"Vulnerable women in our area, lack of support for women that is birthing outside of guidance, and the higher management not realising that postnatal beds are not a luxury they are a bare essential in supporting our families in Gloucestershire".*
> *"Women who are high risk having babies that wouldn't have probably 10 years ago".*

Staffing issues: There are significant concerns about staff shortages, lack of experienced staff, and high turnover rates. The high workload and constant changes are causing fatigue and burnout among staff. There is a need for better support and more manageable workloads.

> *"Scrutiny and investigation internal and external which while this is needed is all time consuming preventing other service improvement for the good of families".*
> *"Staffing! We may be at 'full' staff quota but it's quite a junior work force. The constant pressures are forcing experienced midwives out of the job".*
> *"Insecure and overworked staff cannot possibly provide consistent and safe care".*
> *Negative media coverage and previous poor ratings from the CQC have damaged the reputation of the maternity services. This has led to a loss of public trust and increased pressure on staff.*
> *"The media, it's scaremongering women, which in turn in increasing the number of women birthing outside of guidance".*
> *"Improving our services within the required timeframe, without causing burnout amongst staff".*
> *"'Inadequate' rating from CQC has highlighted poor levels of safety and poor management - this has been further highlighted in recent media with Gloucester being named as one of the top 10 worse hospitals for maternity care provision. This cannot be ignored".*
> *"Staff morale, burn out. Continuously loosing experienced staff, who have felt undervalued for a long time".*

Communication and governance: There are issues with communication within teams and with service users. Inconsistent practices and lack of clear guidelines are causing confusion and inefficiencies.

> *"Clear vision articulated to staff and families".*
> *"Unrealistic expectations based on Google and antenatal classes which don't reflect our practice and guidelines. It can cause serious tension".*
> *"Disjointed service: many areas doing different things, lack of consistency across the board. Lack of admin support for teams. Lack of access for women and workspaces [for staff] as centres closed out of term time etc".*
> *"Staff not being listened to. Women and families being enabled to have care outside of trust guidance".*
> *"Significant improvements are still needed in governance processes, in the way that learning is identified and implemented which includes learning from the family directly".*
> *"Communication with women and teamwork".*
> *"Changing workforce mindset to be flexible to work in different areas. Community hub provision".*

What opportunities are there to do things differently?

A range of opportunities to improve maternity services are identified, including addressing systemic issues, enhancing leadership and management, improving staff wellbeing and support, and focusing on woman-centred care.

Responses emphasise the need for increased investment in staffing, resources and infrastructure, including maternity-led care, and a review of medical interventions, e.g. induction of labour, caesarean sections.

Staff support and wellbeing: Improving staff wellbeing and support is a recurring theme. This includes better wellbeing support for staff, listening to staff feedback, and addressing issues highlighted in staff surveys.

> *“Ensuring that at times core staff work in different areas, to keep skills up but also to better understand pressures in different areas”.*
>
> *“Understanding underlying departmental and team culture and seek to find where it does not fit or meet trust values and extensive work on cultural change as well as implementing the recommendations made in numerous reports that have been written about maternity care in recent years”.*
>
> *“Listening to the staff that are doing the job day to day, brainstorming ideas and being open and honest about feasibility and timelines”.*

Communication and team working: Enhancing communication and collaboration within teams and with external partners is seen as crucial. This includes better communication within the service, growing good working relationships with doulas and the homebirth community, and benchmarking with other trusts.

> *“Antenatal women need to be managed better. Ward core midwives should specialise in antenatal and postnatal care to help with the service they provide. Delivery suite / birth unit midwives should be able to then concentrate on intrapartum care or high risk care on CDS. Once a delivery is complete the MCA should attend the delivery - weigh blood loss, help the woman to shower, assist with breastfeeding, etc and build up that rapport so the midwife can complete notes or get a break knowing her patient is with someone who will look after her. The service needs to be streamlined and everyone should know their role in order to contribute to the team”.*
>
> *“More hubs that are open weekends. Working geographically. Better use of MSW's - more of them”.*
>
> *“Change expectations of women right from the outset of what the service provides and the role of the community midwife. What services women can expect postnatally - in terms of face to face care and what they can access themselves”.*
>
> *“Be involved with Family Hubs”.*
>
> *“Creating a team with an appropriate skills mix. Changing how women are allocated to RM, according to location - not GP. Regular team meetings”.*

Service delivery and efficiency: There are several suggestions for improving service delivery and efficiency. This includes streamlining processes, supporting midwifery-led care, creating dedicated clinics, improving triage and continuity, and building a separate induction of labour suite.

"Support MLC [Midwife-led care] as much as possible! Use the forums for talking about innovation and supporting more women to have low risk births rather than the whole discussion being around audit and statistics. Let's look at why GDM [Gestational Diabetes] diet-controlled women aren't back on the birth units in line with national guidance. Let's look at bringing low risk women of all backgrounds to MLU's [Midwife-led Units] for their 36-week appointment to encourage the use of them and remember the birthplace study".

"Build a separate IOL [Induction of labour] suite as some other trusts have done so that these women are separate and take pressure off the AN ward".

"Have courage to invest in our MLC services across county which includes investing in midwives and our future midwives to ensure they are highly skilled in both supporting physiology and recognising & referring deviation from physiology".

"Encouragement and normalisation of births outside of delivery suite. Keeping delivery suite for our poorly and high risk women".

Innovation and flexibility: Encouraging innovation and flexibility within the service is highlighted. This includes supporting QI projects, community transformation, and creating new rotation patterns to grow a more flexible workforce.

"Listening to the staff that are doing the job day to day, brainstorming ideas and being open and honest about feasibility and timelines".

"Quality Improvement projects. Community transformation. Job opportunities. New rotation patterns. Decrease core and grow a more flexible work force. Increase support workers. Increased admin support".

"Learn from other areas to are doing well particularly any that have significantly improved. Improving technology within service, whilst not perfect, data has improved considerably".

Woman-centred care: Focusing on woman-centred care is another key theme. This includes improving antenatal and postnatal care, ensuring transparency for women in the pregnant or birthing community, and supporting more low-risk births.

"A passion for women centred care that supports physiological birth and a drive to reflect on our Induction of labour and caesarean rate and whether this best serves the population we care for".

"To open PN beds again for women, relieving pressure from GRH and improving women's overall experience. Have dedicated clinics on set days? Such as GTTs, vaccinations".

Responses from professionals working alongside maternity services

Although many of the responses above reflect feedback from both staff working within and alongside NHS maternity services, there is some additional feedback specific to professionals in working in other settings.

Appreciation of maternity staff and the support they provide to people.

"Midwife coming to the practice, continuity of midwife, us knowing who our midwife is, good relationship with her".

"Midwives are working so hard and parents are really appreciative of the time they have with them. They value their midwives!"

"Women in our service report feeling well cared for during labour".
"Being able to refer parents to Stroud maternity unit for postnatal support has been brilliant! Can it be extended? Parents really value this option".

Information sharing and referral via BadgerNet has been helpful, although wider access and integration with other clinical systems would be beneficial.
"Unfortunately Badgernet has meant practically as a GP I am not able to view a patients maternity notes anymore. Every single time I have tried the patient has been unable to gain access because of problems with the wifi etc."
"Lack of communication since BadgerNet introduced, a little in the dark about the care ladies are having".

Greater continuity of midwife would support women, particularly the most vulnerable.
"Ensure continuity of care - same MW in practice".
"Continuity of care (the same midwife to work with the family), more midwives to reduce pressures; health professionals to work together, to work in same base so services/colleagues can support each other".
"Continuity of care and/or continued care from vulnerable women's team - women in our service do not always feel they are given the advice and care other 'universal' mums receive".
"More support needed for those who experience traumatic birth".
"Lots of women we work with have had traumatic births, and struggle to have their voice heard due to emergency situation and or their own trauma".
"We are seeing more mums reporting traumatic birth (often due to need for induction/failed induction/c-section.) there is a lot of fear of delivery at a stand alone birth unit and the need for a hospital environment. Homebirth options can be limited".

Opportunities for **improved communication** and more collaborative working with health visitors, GPs and voluntary sector/community organisations.
"More communication, dialogue between services. Emails/ calls with direct information on dates of visits so services are working together to support families/joined up and reduce duplication/workload".
"Still blurred lines over roles of midwife, health visitor and GP as to who does what at times".

Examples of good **collaboration and interagency working**, but more could be done. Shared workspace, co-location of support services and ways to build mutual understanding of pathways/services offered should be explored.
"As much multi-agency working / communication as possible, use of digital services and resources may be increased to help, and perhaps drop-in groups for patients on different subjects".
"Joint targeted AN visits, joint AN classes, communication of families needing an AN contact".
"Shared pathways, clear written guidance/flowcharts/pictorials of which team does what, who to contact when etc. Could an app be used for this?"

Clear appetite from respondents to **work more closely** with community midwifery teams.

"Using the children centres more effectively, to improve dialogue with other services and work together, reducing duplication of work".
"As much multi-agency working / communication as possible, use of digital services and resources may be increased to help, and perhaps drop-in groups for patients on different subjects".
"Designated email address or telephone line that we as GPs can use to raise any queries or alerts to ensure nothing is missed. Sometimes we just want to ensure the midwife is aware of a test result or actioning it, or pass on some information before their next appointment".

Summary of staff feedback from face-to-face conversations with staff working in maternity services in Gloucestershire

A series of staff drop-ins and interviews were held during summer 2025. The following is a summary of the key themes identified by participants.

Complexity

- General comments about the increased complexity of women that staff are seeing.
- Some women are choosing caesarean sections rather than induction.
- Increase in the induction rates and recognition that this can lead to more caesarean sections.
- A move away from spontaneous vaginal births, with some comments about over-medicalising birth.

Staffing

- Works well where there are dedicated staff to provide support to women, undertake routine tests and offer breastfeeding support. Some examples of support staff being under-utilised and de-skilled.
- Some community staff feel their views are 'unheard'. Staff lack space where they can work as a team.

Digital

- Some concerns about BadgerNet and Badger Notes – functionality and opportunities to share information with other healthcare professionals.
- Connectivity issues when working in community/children's centres.

Local services

- Need to improve access to ultrasound across the county.
- Limited opportunities for debrief service for women who have had traumatic birth/bereavement service.
- Improved antenatal support required with face-to-face offer. The lack of face-to-face contact has resulted in some women feeling isolated, unsupported, lack of peer connection. Some felt improved antenatal education might lead to women making more informed choices about their birthing options.
- Some women face real difficulty travelling to appointments – costs, transport, etc. Particularly challenging when they have other young children.

Considerations

Considerations from the insights are listed here:

Using insight (process/infrastructure)

- Pay due regard to the insight presented in this needs assessment.
- Review all considerations presented in this needs assessment in the context of insight considerations; seek alignment and identify discrepancies, discuss and address these.
- Review new insight data on a regular basis to identify any new themes and to note any improvement or deterioration in experiences in any area of maternity service user experience.
- Gathering individual women's stories is an excellent way to share experience insight and can be used to support staff training.
- With the new support arrangements for the MNVP there are opportunities for the MNVP members to be more involved in the review of insight data.
- Given the diverse range of insight data routinely collected and specifically gathered to support this needs assessment, the LMNS can explore work with the local MNVP to review current insight mechanisms and make observations for opportunities for improvements.

Communications

- There is a need for better digital tools and improved communication between patients and health professionals.
- Greater collaboration and interagency working e.g. shared workspace, co-location of support services, opportunities to build mutual understanding of pathways/services offered to be explored.
- Growing good working relationships with doulas and the homebirth community, and benchmarking with other trusts.
- Better sharing of information between staff, and more consistent advice throughout the pregnancy and postnatal period.
- Better coordination between different departments and healthcare professionals including consultant obstetricians, anaesthetists and midwives.
- There were also concerns about the lack of information provided about certain procedures, such as induction and caesarean sections and the need for more detailed explanations about what to expect during labour and after birth.

Inclusivity

- Addressing these considerations requires improved cultural competence among maternity staff, clearer communication, and a more inclusive, respectful approach to care that acknowledges and responds to the needs of the diverse communities.
- Specialist leads for diverse ethnic groups to improve understanding, with dedicated teams for vulnerable women and those with additional needs.
- Introducing Maternity Social Prescribers to support pregnant women with non-medical needs.

- Mandatory training should tackle unconscious bias and foster trust. Further investment in training similar to Black Maternity Matters and more LGBTQ+ awareness.
- Need for services to be more inclusive, particularly for those who do not speak English.
- Awareness of the reluctance amongst some communities to attend anything labelled as a 'mental health' group due to shame or fear of community judgement
- Attention to learning needs e.g. offering visual aids/easy-read items to help with decision making.
- Culturally sensitive spaces and access to spaces, for example presence of male partners.
- Steps to be taken to reconnect and rebuild trust in the local healthcare system amongst some communities.
- Inviting community organisations to be more visible on wards
- Pop-up antenatal clinics in community hubs where underserved groups gather.
- Involving community members/'experts by experience' in the planning and delivery of maternity services to ensure services are culturally relevant and responsive.
- Health messages tailored and delivered in culturally appropriate ways to address concerns without alienating individuals.
- Healthy Living Service to be more culturally aware.
- The need for more targeted communication strategies ensuring that accurate, culturally appropriate messages are shared through the channels the community uses and trusts.
- Reducing language barriers and ways to address the expressed fear of being misunderstood.
- Attention to the cultural differences in parenting styles and health practices.
- Acknowledgement of the need to build trust in the local system; to reduce the number of women choosing to give birth/seeking postnatal support outside Gloucestershire and England.
- Clarity about the role of the midwife post-birth, health visitors and other postnatal support.
- Response to concerns around vaccinations.
- Complexity of care: Increasing complexity in pregnancies and high rates of medical interventions like inductions and caesarean sections challenge the capacity of services. People who live in more deprived areas or who have additional needs due to their protected characteristics, often need additional support which is challenging given current resources. More funding and resources required to enable the provision of good care for all.

Inconsistency in the offer to users of maternity services

- Differences in experiences ranging from negative to positive are influenced by inconsistency in the offer to users of maternity services. Consideration needs to be given to how to ensure and monitor consistency of the offer whilst being responsive to individuals' needs and requirements. Examples:
    - Provision of evidence-based, balanced information to support informed choices about care.

    - Bespoke support during pregnancy/postpartum period rather than generic advice and sessions.
    - Improved information about the support available.
    - Increased frequency of contact.
    - Face-to-face options.
    - Recognition of birth trauma.
- More proactive support when things don't go well e.g. miscarriage.
- Access to support is not equitable to people across all parts of the county.

Staff

- More empathetic and supportive care, particularly for new mothers and those experiencing mental health challenges.
- Failure to listen to mothers.
- Skill-mix of staff and identification of additional roles to relieve the workload on midwives.
- Staff shortages, lack of experienced staff, and high turnover rates. The high workload and constant changes are causing fatigue and burnout among staff. There is a need for better support and more manageable workloads.
- Improving staff well-being and support, including better well-being support for staff, listening to staff feedback, and addressing issues highlighted in staff surveys.
- Encouraging innovation and flexibility within the service; e.g. supporting Quality Improvement projects, community transformation, and creating new rotation patterns to grow a more flexible workforce.

Accessibility and efficiency

- Choice essential, community services, facilities in multiple locations including at home.
- Value of local, smaller midwife-led centres.
- Streamlining processes, supporting midwifery-led care, creating dedicated clinics, improving triage and continuity
- Building a separate induction of labour suite.

Antenatal care

- Consistency of midwife/appointments
- Better communication
- Improved access/appointment system
- A lack of clear understanding of what health visitors do, and how they can support both mother and baby, a potential barrier to full engagement.
- Consistent access to lifestyle support e.g. support to stop smoking.
- Delays to outpatient clinic appointments/ultrasounds.

Intrapartum

- Importance of communication, support, comfort, and respect as crucial in improving birth experiences.

- Clear and consistent information about procedures, delays in care and general information about what to expect through labour, delivery and aftercare.
- Lack of information about induction
- Improved information about aftercare for those who have had a caesarean section including managing stitches and post-birth complications.
- Providing information about, and better access to, pain relief options.
- More regular checks and clear communication about the health of both mother and baby.
- Lack of privacy and unacceptable levels of noise on the postnatal ward
- Adequacy of staffing levels in delivery units and wards and potential impact on communication breakdowns and lack of timely care and support.

Family considerations

- What would happen to a single parent with another child at home when they need to attend hospital
- Think about the pros and cons of partners being allowed to stay overnight for the individual and other people giving birth in the same facilities

Postnatal

- Personalised, consistent and compassionate care, both at home and in the hospital, crucial to supporting new parents effectively.
- Better understanding of what to expect post-birth, having clear instructions for postnatal care, and being informed about available support services.
- Awareness raising of free perinatal pelvic health sessions.
- Earlier identification of tongue-tie.
- More consistent and knowledgeable support with breast feeding in hospital and at home; including assistance with latching, addressing issues like tongue-tie; having access to lactation consultants.
- Mental health and emotional support, including counselling and support groups and check-ins for both mothers and fathers.
- Support in dealing with birth trauma and postnatal depression.
- Home visits: convenience and comfort of having midwives and health visitors come to their homes, eliminating the need to travel with newborn babies.
- More detail about appointment times for home visits
- More thorough and frequent postnatal check-ups up to 4 months after birth, including physical health checks for mothers including support with wound care.
- Post-birth debriefs -increased opportunity and more consistent offer.
- Lengthy process for discharges can be held up by newborn check, medications or catheter/venflon removal.

Continuity of care

- For some, having the same midwife or health visitor throughout pregnancy and after the birth helps to build trust, familiarity and reassurance.

- For others, same midwife is less important than consistency in support available and advice from all midwifery staff.
- Ensure personalised and natural approach is encouraged throughout pregnancy.

10. Conclusion

Overall, this needs assessment has illustrated that while Gloucestershire is broadly affluent, pockets of significant deprivation exist - particularly in Gloucester, the Forest of Dean, and parts of Cheltenham. The data highlights persistent health inequalities, with women from deprived areas and/or ethnic minority communities facing disproportionately poorer maternal and neonatal outcomes and being more likely to have barriers to accessing care.

The key considerations which have been raised throughout this needs assessment are repeated below for ease. They will be used to inform ideas for the future of local services and the care provided. Any proposals for future service development will be co-designed through meaningful engagement.

Key considerations

Maternity services

- Review provision of ultrasound, obstetric-led clinics and specialist services across the county to ensure more equitable access where possible.
- While some integrated working has taken place between maternity services and Family Hubs / VCSOs, there is an opportunity to develop a more coordinated and strategic approach.

Population and births

- Ongoing monitoring of housing and population changes will be required to ensure service provision meets the needs of women in the future.
- Fertility rates are expected to remain stable, so overall demand for maternity services will not decrease (although it may increase). Service configuration should be reviewed regularly to ensure it reflects population changes and continues to meet evolving needs.

Birth data and trends

- Review the provision of place of birth options, in light of changing birth trends.
- Review the current staffing model to make the most efficient use of clinical resources and meet the needs of staff, and to support the changing needs and choices of the maternity population.
- Review the impact of rising rates of induction on outcomes and on required staffing levels on antenatal wards and the delivery suite.
- Review the theatre capacity, staffing and utilisation, in light of rising caesarean section rates. The larger increase in emergency caesarean sections brings a particular challenge due to requirements for rapid access to theatres and specialist staff, placing pressure on acute maternity infrastructure.
- Ensure that postnatal care teams have the appropriate skill mix and training to meet the needs of women recovering from caesarean birth and other complex deliveries.

This includes surgical wound management, pain control, medication administration, and recognition of complications, alongside core midwifery skills.
- Develop a care pathway for women choosing to birth outside of guidance so the integrity of women's choice can be maintained with safe outcomes for mothers and babies, alongside taking into account the wellbeing of maternity staff.
- Ensure that care can be delivered for all who need it using principles of trauma informed care. This includes making best use of debriefing and counselling services to support those with anxiety around birth and previous birth trauma.
- Regularly review the number of women giving birth outside Gloucestershire or travelling into the county to ensure any changes in acceptance criteria and need for specialist services from other providers are addressed, alongside the resource implications for Gloucestershire maternity services.
- Monitor the impact of women not being able to birth out of county on them and on our maternity service.

Preconception, antenatal and postnatal care

Preconception care

- Review preconception care provision in the county to ensure optimum health and outcomes for women and babies.
- While there are some limited condition-specific examples currently provided for (such as pre-conception care by the endocrinology service for Type 1 and Type 2 diabetes, and support for women from the fetal medicine service who have previously had termination of pregnancy for fetal abnormality (ToPFA)), there will be an increasing demand for wider pre-conception and pregnancy care for those with medical conditions beyond current funding and capacity.
- Explore opportunities for integrated, equitable, and preventative approaches that support individuals before pregnancy begins, particularly those at higher risk of poor outcomes. It is a critical opportunity to identify and address risk factors that may influence pregnancy and birth outcomes, many of which, such as obesity, smoking, unmanaged chronic conditions, poor mental health, and exposure to domestic abuse, are present before pregnancy begins.

Antenatal care

- Address inequalities in routine scanning provision across the county.
- Investigate barriers to digital antenatal education uptake, in particular from women from ethnic minority communities.
- Consider how to improve partnership working with relevant agencies such as health visitors and Family Hubs to deliver high-quality, comprehensive and free face-to-face antenatal education that meets women's needs and supports social connection, reducing reliance on unverified sources.
- Consider how to improve vaccine uptake such as through regional initiatives, address variable access routes, provide staff training to tackle vaccine hesitancy, and consider demographic data and how this impacts uptake.
- Consider enhanced, evidence-based models of care to improve outcomes, including continuity of antenatal and postnatal care, particularly in areas where outcomes are poorer.

Postnatal care

- Ensure consistency and quality in postnatal care, with a particular focus on the early period following birth, both during hospital stay and in subsequent contacts with maternity services. This includes improving communication, timely support for physical and emotional recovery, and equitable access to specialist input where needed.
- Strengthen the pathways of care postnatally (high quality transfer of care from maternity services back to GP), and continue to work with GPs and health visitors to ensure the early postnatal period is meeting the needs of women and babies (including the provision of the 6-week check and that this is delivered in a consistent manner).
- Review the provision of emotional support for bereaved women and families.

Demographics

Deprivation

- Deprivation varies across the county and is particularly high in parts of Gloucester and the Forest of Dean. This requires targeted enhanced service provision and resource to support a reduction in health inequalities and inequality of outcomes.
- Ensure that information is accessible for women who may face barriers to understanding or receiving it, including those without digital access, or those with lower literacy levels or language challenges.
- Ensure maternity services are equipped to identify and support women experiencing complex social factors such as poverty, homelessness, and/or domestic abuse.
- Improve interagency collaboration between maternity services, other healthcare services, social care, Family Hubs, and voluntary and community organisations, to support women who experience severe and multiple disadvantage to ensure enhanced and joined-up care.
- Improve access to some services e.g. ultrasound scanning and obstetric care. This should be in line with the principle laid in out in the Gloucestershire Joint Forward Plan for services to be “local where possible, centralised where necessary”.

Ethnicity

- Engagement strategies must be inclusive and tailored to reach communities which may face barriers to accessing care, particularly women from ethnic minority backgrounds and other underserved groups. This includes recognising cultural differences, addressing language and communication needs, and building trust through community-led approaches.
- Ensure that our future maternity service provision:
- Demonstrates greater cultural sensitivity and is anti-racist and anti-discriminatory in its design and delivery.
- Tackles the systemic factors contributing to poorer maternal outcomes among ethnic minority communities.
- Takes into account the complexity and inequalities experienced by women from ethnic minority communities (including those who identify as ‘White Other’).

Outcomes

- Increased maternal readmissions can indicate gaps in care such as in timely follow-up, discharge planning, or early identification of complications. Systematic review of risk factors such as complex pregnancies and caesarean sections, and readmission causes, should inform quality improvement, focusing on preventable factors such as infection control, pain management, and feeding support.
- Review if current postnatal pathways are able to provide adequate early support to prevent avoidable neonatal readmissions. This includes timely feeding assessments, breastfeeding support, monitoring for jaundice, and clear escalation routes for community midwives and health visitors.
- Rates of perineal tears are higher among Asian/British Asian women. Review any work carried out nationally (such as (Olakotan et al., 2025) that could be applied locally to understand and reduce the risk.
- Consider how to reduce postpartum haemorrhage among women from ethnic minorities.
- Consider how we can focus on reducing inequality of outcomes between our different demographic groups.

Language and communication

- Ensure independent interpreters (as provided by the Word360 service) are provided for those who do not speak or understand English well, or who require disability-inclusive support.
- Ensure information is coproduced and provided in a variety of formats, taking into consideration reasonable adjustments for disability, and cultural sensitivity.
- Consider how best to staff maternity services across the county to ensure appropriate time is available to support women requiring interpreters, especially in Cheltenham and Gloucester where need is greater.
- Aim to identify and address any potential barriers to understanding well before labour begins to ensure safe, personalised care.

Age of women giving birth

- Increased maternal age is likely to result in more complexity in the maternity population. This will be partly from women having pre-existing health conditions and partly from the increased risk of women developing pregnancy-specific conditions. This may lead to an increased need for obstetric care (including maternal and fetal medicine specialists) and anaesthetic care.
- Service pathways and staffing levels should be reviewed to ensure that safe maternity care can be delivered in the context of increasing complexity related to maternal age.

Mental health

- Understand barriers to access to the Specialist PMH Team for women from areas of higher deprivation, and continue the work underway to reduce barriers for women from ethnic minority communities.
- As more women are likely to need support from the specialist perinatal mental health team, the capacity of the joint Obstetric and PMH multi-disciplinary clinic (at GHT) will need to be reviewed to support increasing demand.

- Review the capacity of the Birth Anxiety and Trauma team and maternity workforce development needs to support women in the light of rising referral trends.
- Addressing birth trauma requires early and proactive identification, timely debrief and psychological support, and integrated care pathways between maternity and mental health services to ensure safe, personalised care, and break the cycle of poor mental health across generations.

Multiple long-term conditions

- There is likely to continue to be an increase in pregnant women with multiple long-term conditions who will require consultant-led care. These births are likely to be both more complex and require more medical input, including anaesthetics and physicians specialising in maternal medicine, as well as specialist midwives, so training needs and resource will need to be managed appropriately.

Health behaviours

Obesity

- Addressing obesity during pregnancy must be done as part of a broader, coordinated approach to healthy living and weight management across the county. This should include the work taking place around healthy weight and obesity within the ICB and Public Health, as well as involving maternity services, community support, and wider system partners.
- Ensure that approaches to weight management including the development of future guidance and practice are trauma-informed and culturally sensitive.
- Future models must anticipate increased prevalence of high-BMI pregnancies and ensure adequate consultant-led capacity and robust care pathways, including dietitians (for example for women with obesity who have had bariatric surgery) and midwife sonography (to support additional growth scans for those with BMI over 40).

Smoking

- Smoking is closely associated with deprivation: therefore, cessation efforts should be prioritised in the most affected areas of the county. Strengthening collaboration between midwives in these communities and smoking cessation services is essential.
- Smoking cessation should be integrated into maternity and postnatal care to provide consistent support. Building strong links with services that continue into the postnatal period – such as health visiting and wider community support – is critical to sustaining quit attempts.
- Practical support should include assistance with quitting smoking, access to therapeutic interventions, and guidance on managing health conditions.

Alcohol

- Assess whether NICE quality standards are being met within the maternity service and consider any additional support that might be needed for women who drink alcohol in pregnancy.

Breastfeeding rates

- Consider how everyone wanting to breastfeed can have the opportunity and the right level of support to enable them to do so.
- Infant feeding support services must be inclusive and responsive to diverse needs and influences, providing tailored messaging and support while also respecting women's and birthing people's choices.

Late booking

- Women from the most deprived deciles and ethnic minority communities are more likely to book their pregnancy after 10 weeks. Further investigation is needed into reasons for this and how rates of booking before 10 weeks can be improved.
- Develop initiatives and campaigns targeted at improving rates of timely pregnancy booking. Initiatives should be co-designed with stakeholders to overcome existing barriers to booking and ensure information and access to services are appropriate.

The following key considerations are from the insights:

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- Review all considerations presented in this needs assessment in the context of insight considerations; seek alignment and identify discrepancies, discuss and address these.
- Review new insight data on a regular basis to identify any new themes and to note any improvement or deterioration in experiences in any area of maternity service user experience.
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- With the new support arrangements for the MNVP there are opportunities for the MNVP members to be more involved in the review of insight data.
  Given the diverse range of insight data routinely collected and specifically gathered to support this Needs Assessment, the LMNS can explore work with the local MNVP to review current insight mechanisms and make observations for opportunities for improvements.

Communications

- There is a need for better digital tools and improved communication between patients and health professionals.
- Greater collaboration and interagency working e.g. shared workspace, co-location of support services, opportunities to build mutual understanding of pathways/services offered to be explored.
- Growing good working relationships with Doulas and the homebirth community, and benchmarking with other trusts.
- Better sharing of information between staff, and more consistent advice throughout the pregnancy and postnatal period.
- Better coordination between different departments and healthcare professionals including consultant obstetricians, anaesthetists and midwives.

- There were also concerns about the lack of information provided about certain procedures, such as induction and caesarean sections and the need for more detailed explanations about what to expect during labour and after birth.

Inclusivity

Addressing these considerations requires improved cultural sensitivity among maternity staff, clearer communication, and a more inclusive, respectful approach to care that acknowledges and responds to the needs of the diverse communities.

- Specialist leads for diverse ethnic groups to improve understanding, with dedicated teams for vulnerable women and those with additional needs.
- Introducing Maternity Social Prescribers to support pregnant women with non-medical needs.
- Mandatory training should tackle unconscious bias and foster trust. Further investment in training similar to Black Maternity Matters and more LGBTQ+ awareness.
- Need for services to be more inclusive, particularly for those who do not speak English.
- Attention to learning needs e.g. offering visual aids/easy-read items to help with decision making.
- Culturally sensitive spaces and access to spaces, for example presence of male partners.
- Steps to be taken to reconnect and rebuild trust in the local healthcare system amongst some communities.
- Inviting community organisations to be more visible on wards
- Pop-up antenatal clinics in community hubs where underserved groups gather.
- Involving community members/‘experts by experience’ in the planning and delivery of maternity services to ensure services are culturally relevant and responsive.
- Health messages tailored and delivered in culturally appropriate ways to address concerns without alienating individuals.
- Healthy Living Service to be more culturally aware.
- The need for more targeted communication strategies ensuring that accurate, culturally appropriate messages are shared through the channels the community uses and trusts.
- Reducing language barriers and ways to address the expressed fear of being misunderstood.
- Attention to the cultural differences in parenting styles and health practices.
- Acknowledgement of the need to build trust in the local system; to reduce the number of women choosing to give birth/seeking postnatal support outside Gloucestershire and England.
- Clarity about the role of midwife post- birth, health visitors and other postnatal support.
- Response to concerns around vaccinations.
- Complexity of care: Increasing complexity in pregnancies and high rates of medical interventions like inductions and caesarean sections challenge the capacity of services. People who live in more deprived areas or who have additional needs due to their protected characteristics, often need additional support which is challenging

given current resources. More funding and resources required to enable the provision of good care for all.

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- Differences in experiences ranging from negative to positive are influenced by inconsistency in the offer to users of maternity services. Consideration needs to be given to how to ensure and monitor consistency of the offer whilst being responsive to individuals' needs and requirements. Examples:
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- Improved information about the support available.
- Increased frequency of contact.
- Face-to-face options.
- Recognition of birth trauma.
- More proactive support when things don't go well e.g. miscarriage.
- Access to support not equitable to people across all parts of the county.

Staff

- More empathetic and supportive care, particularly for new mothers and those experiencing mental health challenges.
- Failure to listen to mothers.
- Skill-mix of staff and identification of additional roles to relieve the workload on midwives.
- Staff shortages, lack of experienced staff, and high turnover rates. The high workload and constant changes are causing fatigue and burnout among staff. There is a need for better support and more manageable workloads.
- Improving staff well-being and support, including better well-being support for staff, listening to staff feedback, and addressing issues highlighted in staff surveys.
- Encouraging innovation and flexibility within the service, e.g. supporting Quality Improvement projects, community transformation, and creating new rotation patterns to grow a more flexible workforce.

Accessibility and efficiency

- Choice essential, community services, facilities in multiple locations including at home.
- Value of local, smaller midwife-led centres.
- Streamlining processes, supporting midwifery-led care, creating dedicated clinics, improving triage and continuity
- Building a separate induction of labour suite.

Antenatal care

- Consistency of midwife/appointments
- Better communication
- Improved access/appointment system

- A lack of clear understanding of what health visitors do, and how they can support both mother and baby, a potential barrier to full engagement.
- Consistent access to lifestyle support e.g. support to stop smoking.
- Delays to outpatient clinic appointments/ultrasounds.

Intrapartum

- Importance of communication, support, comfort, and respect as crucial in improving birth experiences.
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- Improved information about aftercare for those who have had a caesarean section including managing stitches and post-birth complications.
- Providing information about, and better access to, pain relief options.
- More regular checks and clear communication about the health of both mother and baby.
- Lack of privacy and unacceptable levels of noise on the postnatal ward
- Adequacy of staffing levels in delivery units and wards and potential impact on communication breakdowns and lack of timely care and support.

Family considerations

- What would happen to a single parent with another child at home when they need to attend hospital
- Think about the pros and cons of partners being allowed to stay overnight for the individual and other people giving birth in the same facilities

Postnatal

- Personalised, consistent and compassionate care, both at home and in the hospital crucial to supporting new parents effectively.
- Better understanding what to expect post-birth, having clear instructions for postnatal care, and being informed about available support services.
- Awareness raising of free perinatal pelvic health sessions.
- Earlier identification of tongue-tie.
- More consistent and knowledgeable support with breast feeding in hospital and at home; including assistance with latching, addressing issues like tongue-tie; having access to lactation consultants.
- Mental health and emotional support, including counselling and support groups and check-ins for both mothers and fathers.
- Support in dealing with birth trauma and postnatal depression.
- Home Visits: convenience and comfort of having midwives and health visitors come to their homes eliminating the need to travel with newborn babies.
- More detail about appointment times for home visits
- More thorough and frequent postnatal check-ups up to 4 months after birth, including physical health checks for mothers including support with wound care.
- Post-birth debriefs -increased opportunity and more consistent offer.
- Lengthy process for discharges can be held up by newborn check, medications or catheter/venflon removal.

Continuity of care

- For some, having the same midwife or health visitor throughout pregnancy and after the birth. Helps to build trust, familiarity and reassurance.
- For others, same midwife is less important than consistency in support available and advice from all midwifery staff.
- Ensure personalised and natural approach is encouraged throughout pregnancy.

11. Glossary

Alongside Midwifery Unit (AMU)
A birth unit located within or next to an obstetric unit, offering midwifery-led care for women with low-risk pregnancies.

Antenatal
The period during pregnancy before birth.

Antenatal booking
The first appointment with maternity services, ideally between 8–10 weeks of pregnancy, where initial assessments and plans are made.

Antenatal education
Classes or resources provided to expectant parents to prepare them for pregnancy, birth, and early parenthood.

BadgerNet/Badger Notes
A digital maternity records system and app used in Gloucestershire since 2023, allowing women to access their records and care plans. BadgerNet is for staff, and BadgerNotes is the app for women.

Birth outside of guidance
A situation where a woman's birth plan or choices differ from recommended care outlined in local or national guidance, often requiring additional discussion and planning.

Birth related trauma
Traumatic birth experiences may include emergency interventions, perceived loss of control, inadequate communication, or birth complication resulting in postpartum haemorrhage, or admission of the baby to a neonatal intensive care unit, for example. Birth trauma is associated with post-traumatic stress disorder (PTSD), anxiety, and depression in the postnatal period.

Body mass index (BMI)
A calculation using height and weight (kg/m^2) to categorise body size.

Born before arrival (BBA)
When a baby is born either prior to arrival at the planned place of birth, or before a midwife arrives at a home birth.

Breech presentation
When a baby is positioned bottom or feetfirst in the womb near the time of birth, rather than headfirst.

Caesarean section
A surgical procedure to deliver a baby through incisions in the abdomen and uterus. Can be elective (planned) or emergency.

Care Quality Commission (CQC)
The independent regulator of health and social care in England, responsible for inspecting and rating services.

Confidence intervals
A confidence interval provides a range within which the true value of a measurement is likely to fall.

- **UCL (Upper Control Limit):** The highest expected value within normal statistical variation.
- **LCL (Lower Control Limit):** The lowest expected value within normal statistical variation.
  Values outside these limits may indicate unusual or “special cause” variation.

Consultant-led unit
A hospital-based unit where care is led by consultant obstetricians, suitable for women with higher-risk pregnancies.

Continuity of carer
A model of maternity care where the same midwife or team supports a woman throughout pregnancy, birth, and the postnatal period.

Deciles
Statistical groupings that divide a dataset into ten equal parts, each representing 10% of the population. The first decile is the most deprived 10%, and the tenth the least deprived.

Deprivation (Indices of Multiple Deprivation, IMD)
A measure combining economic, social, and housing indicators to assess levels of disadvantage in small areas.

Digital exclusion
Barriers to accessing digital services due to lack of devices, internet, or digital literacy.

Elective caesarean
A planned caesarean section, usually scheduled before labour begins.

Emergency caesarean
A caesarean section performed urgently during labour due to complications.

Enhanced oversight group
A group responsible for overseeing improvements associated with the CQC inspection outcome recommendations.

Equality and engagement impact assessment (EEIA)
A structured assessment used to evaluate how proposed services or changes may affect different population groups, ensuring fairness, equity, and meaningful involvement of communities in decision making.

Fetal growth restriction (FGR)
A condition where a foetus does not grow to its expected size. Babies with FGR are at higher risk of complications before and after birth.

Freestanding midwifery unit (FMU)
A birth unit not located within a hospital, offering midwifery-led care for low-risk pregnancies.

Gastrointestinal infection
An infection affecting the stomach or intestines, often causing vomiting, diarrhoea or abdominal pain.

General fertility rate (GFR)
Birth rate per 1,000 females aged 15 to 44 years.

Gestational diabetes
A type of diabetes that develops during pregnancy.

Gloucestershire Hospitals NHS Foundation Trust (GHT)
The single provider trust for all maternity services in Gloucestershire.

Home birth
A planned birth at home, supported by midwives.

Indices of Multiple Deprivation (IMD)
A national measure that ranks small areas in England based on factors such as income, employment, education, health, crime, housing and environment, to identify levels of deprivation.

Induction of labour
A medical intervention to start labour artificially.

Integrated Care Board (ICB)
A statutory NHS organisation responsible for planning and funding health services in a local area.

Integrated Care System (ICS)
A partnership of NHS organisations, local authorities, and community partners that work together to plan and deliver joined-up health and care services for a population.

Intrapartum
The period covering labour and birth.

Late maternal death

The death of a woman from direct or indirect obstetric causes more than 42 days but less than 1 year after end of pregnancy.

Local Maternity and Neonatal System (LMNS)
Gloucestershire's Local Maternity and Neonatal System (LMNS) is part of the Integrated Care System (ICS). It is systemwide and includes maternity services, neonatal services, health visiting, perinatal mental health services, general practice, public health, Maternity and Neonatal Voices Partnership, and the voluntary sector.

Local Neonatal Unit (LNU)
A hospital unit providing specialist care for newborn babies who are premature or unwell.

Low birth weight
A baby born weighing less than 2,500 grams.

Lower super output areas (LSOAs)
Small geographic areas used in England and Wales for statistical analysis, each containing around 1,500 people. They enable detailed monitoring of local deprivation, health outcomes and service needs.

Maternal Medicine Network
A regional network of specialist clinicians who support the care of pregnant women with significant preexisting or pregnancy related medical conditions, ensuring coordinated, expert management across services.

Maternal mortality
Deaths of women during pregnancy or within a year of the end of pregnancy.

Maternity and Neonatal Voices Partnership (MNVP)
An independent organisation working with NHS organisations in a local area, to help improve maternity and neonatal care.

Maternity & Newborn Safety Investigations (MNSI)
An independent national programme that investigates certain serious maternity and newborn incidents to identify learning and improve safety across NHS services.

Midwifery-led care (MLC)
Care provided primarily by midwives for women with low-risk pregnancies.

Multiparous (Multip)
A woman who has given birth two or more times.

Multiple long-term conditions
The presence of two or more chronic health conditions in a pregnant woman.

Neonatal mortality
The death of a baby within the first 28 days of life (0–27 days).

Nonspontaneous vaginal birth
A vaginal birth requiring clinical assistance, such as forceps or a ventouse.

Ockenden Report
A national review of maternity services in England, highlighting the need for improvements in safety and quality.

Perinatal mental health
Mental health conditions occurring during pregnancy and up to a year after birth.

Perinatal Mortality Review Tool (PMRT)
A national framework used to review stillbirths, neonatal deaths and late miscarriages to improve learning, transparency and quality of care.

Placenta accreta spectrum (PAS)
A group of conditions where the placenta becomes abnormally attached to the uterine wall, making it difficult to detach after birth. It includes accreta, increta and percreta, with increasing severity and risk of haemorrhage.

Placenta praevia
A condition where the placenta lies low in the uterus and partially or completely covers the cervix, increasing the risk of bleeding and often requiring planned caesarean birth.

Postnatal/postpartum
The period after birth.

Postpartum haemorrhage (PPH)
Heavy bleeding after birth (typically defined as blood loss of 500ml or more), which can be life threatening and requires urgent clinical management.

Preconception care
Health care and advice provided before pregnancy to optimise outcomes for mother and baby.

Preterm birth
Birth before 37 weeks of pregnancy.

Primiparous (Primip)
A woman who is giving birth for the first time.

Quintile
A statistical grouping that divides a population or dataset into five equal parts, each representing 20% of the whole.

Respiratory infections
Infections affecting the lungs or airways, such as colds, bronchiolitis or pneumonia.

Saving Babies' Lives Care Bundle (SBLCB)
A set of NHS England recommendations to reduce stillbirth and neonatal deaths.

Small for gestational age (SGA)
A baby whose birthweight is below the 10th centile for their gestational age.

Spontaneous vaginal birth
A birth that occurs naturally without surgical or instrumental intervention.

Stillbirth
The birth of a baby showing no signs of life at or after 24 weeks of pregnancy.

Sudden unexplained infant death (SUID)
The unexpected death of an infant under one year of age that remains unexplained after thorough investigation.

Term singleton deliveries
Births of a single baby (not twins or multiples) at term—between 37+0 and 41+6 weeks of pregnancy.

Third- or fourth-degree perineal tear (Obstetric Anal Sphincter Injury, OASI)
A severe tear during vaginal birth involving the muscles controlling the anus.

Total fertility rate (TFR)
The average number of children a hypothetical cohort of women would have at the end of their reproductive period if they were subject during their whole lives to the fertility rates of a given period and if they were not subject to mortality. It is expressed as children per woman.

Treating tobacco dependency (TTD)
Services and interventions to support pregnant women to stop smoking.

Vulnerable Women's Team (VWT)
A specialist team of midwives providing enhanced support for women with additional vulnerabilities such as mental health needs, substance misuse, or safeguarding concerns.

Zero net migration
The number of people immigrating to a country equals the number of people emigrating from it, resulting in no overall change in population size due to migration.

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