

Support Overdue: Women's experiences of maternity services

2017



The National Federation of Women's Institutes (NFWI) and NCT

The National Federation of Women's Institutes (NFWI)

The National Federation of Women's Institutes (NFWI) is an educational, social, non-party political and non-sectarian organisation. It was established to ensure that women are able to take an effective part in their community, learn together, widen their horizons, improve and develop the quality of their lives, and together influence local, national, and international affairs on issues that matter to them and their fellow members.

Founded in 1915, the NFWI is the largest voluntary women's membership organisation in the UK with some 220,000 members in over 6,300 Institutes across England, Wales, and the Islands. The NFWI has a long history of undertaking educational work and campaigning on a diverse range of issues. The first NFWI mandate was passed in 1918 and since then the organisation has accumulated a wide-ranging portfolio of policy concerns on a local, national, and international level. The NFWI resolution process means that members play a central role in defining policy and bringing issues onto the organisation's national agenda.

NCT

NCT is the UK's largest charity for parents, offering support from the start of pregnancy until their child's second birthday, a period we call the first thousand days. For 60 years we have provided essential information, helped create friendships between new parents and advocated on their behalf to make the UK more parent-friendly. We do this through our UK-wide network of 325 local branches, antenatal and postnatal courses delivered to nearly 100,000 new parents each year and the information available via our website and free helpline.

Our campaigning achievements include pressing to allow fathers into the delivery room; the labelling and then banning of Bisphenol A in baby bottles; reducing unnecessary interventions during childbirth; influencing the Equality Act in Britain and the Breastfeeding etc. (Scotland) Act 2005 to protect women breastfeeding in public.

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Foreword



At the 2012 NFWI Annual Meeting, WI members passed a resolution calling for urgent action to address the chronic shortage of midwives. As with all WI resolutions, this resolution stemmed directly from the concerns put forward by a WI member, who was also a midwife. A sustained baby boom, increasing case load complexity, and pressures on NHS finances had resulted in a maternity service that was stretched to the limit.

This was not the first time that WI members shone a spotlight on maternity care. In fact, we passed our first resolution on maternal health in 1925, with many more following in subsequent years. Those early resolutions galvanised public opinion and shaped some of the features of maternity care that we take for granted today - such as ensuring the availability of analgesics during labour and the right of all women to receive antenatal care.

Much more has changed for maternity care and for women during the WI's 101 years, but our members' commitment to a maternity service fit for purpose has not wavered. As our recent centenary survey of members revealed, most believe that the NHS has improved at meeting the needs of women, but maternity services remain a key area of concern, especially for younger members.

Our *Support Overdue* (2013) report, based on research carried out jointly with NCT, was firmly rooted in women's experiences of their care and presented a picture of a maternity service struggling to cope with under-resourcing and unable to deliver on its ambitions. The years that followed have seen a sustained focus on maternity care in both policymaking and in the media. We now have the first ever NICE safe staffing guidance for maternity settings and, most recently, the National Maternity Review report - *Better Births* - has outlined a blueprint for the future shape of maternity care in England.

We partnered with NCT for a second time to produce this report which again places women's experiences at the heart, celebrating the outstanding care that the majority of women experience and the special role midwives play in delivering that care at every stage. It also, however, reveals much cause for concern. Too many women experience care that is unsafe, are denied choices, or are forced to turn to other parts of the NHS to access the services they need. Too many told us that systemic staff shortages left maternity units overstretched and midwives unable to provide high quality care.

In *Better Births* we have an inspiring vision to which our maternity services can and must rise. To meet these aspirations we must ensure our midwives are adequately supported and teams are fully staffed.

I hope that this report will serve as a clarion call to decision-makers to recognise the indispensable role that midwives play in supporting mothers, their babies and families, today and in the future.

A handwritten signature in black ink that reads "Janice Langley". The signature is written in a cursive, flowing style.

Janice Langley

NFWI Chair

Executive Summary

This report presents the findings of the NFWI's and NCT's second survey of women's experiences of maternity care, providing insights into key aspects of the experiences of 2,500 women who gave birth in England or Wales in 2014, 2015, and the first half of 2016. Since the publication of our last maternity services report in 2013, the maternity policy landscape has changed significantly. Most notably, the National Maternity Review report – *Better Births* – has recommended significant changes to how maternity services are organised.

These findings are intended to both provide a useful benchmark for how women's experiences of services have changed since 2013 and to inform the work of the Maternity Transformation Programme Board as it oversees the implementation of the reforms outlined in *Better Births* and the NHS in Wales as it lays out its strategic vision for how the maternity service fits within its Prudent Healthcare agenda.

There are many reasons for optimism. Women are generally positive about the maternity care they receive and told us that on the whole their care was respectful and members of staff were supportive and trustworthy. Encouragingly, we found that digital technology can improve women's experiences and help midwives fulfil their public health mandate, which will pay rich dividends in years to come.

The findings do, however, also give us serious cause for concern and continue to show that policy aspirations with regards to choice and personalisation are simply not being met. Compared to our findings four years ago, we can report scant progress in measures meant to ensure better clinical outcomes, such as continuity of carer, and even more worryingly instances where standards have declined by considerable margins.

In this survey we added questions pertaining to what NICE describes as 'red flag events' - indicators of dangerously low staffing levels, such as women not receiving one-to-one care during established labour or experiencing an undue delay in a time critical activity, such as receiving pain relief. The findings showed, shockingly, half of all women surveyed experienced a red flag event.

The provision of postnatal care remains patchy, with no change in the percentage of women - roughly one in five - who were not able to see a midwife as often as they required post-birth. Of the women who were unable to see a midwife as often as they needed to, a third reported that this resulted in a delay in a health problem for them or their baby being diagnosed and 29% said they were forced to seek help from their GP, walk-in centre, or A&E.

As the Maternity Transformation Programme considers how to best implement the recommendations in *Better Births* over the coming years, we hope that this evidence base will help bring those aspirations for safer and more personalised care into reality.

Key findings and recommendations

1. Workforce opportunities and challenges

Findings

- 50% of women report experiencing at least one of the NICE identified red flag events that we polled for during their intrapartum care
- 17% of applicable women did not experience one-to-one care from midwives during established labour
- 31% of women who required or received pain relief experienced a delay of 30 minutes or more in getting it while they were in labour
- 15% of applicable women said their immediate post-birth care, such as washing or suturing, was delayed
- For 24% of women who required other services (either before or following the birth), their midwife was unable or unavailable to make a timely referral
- 28% of women who required medication either during or following the birth experienced a delay in getting a prescription or a delay in receiving it

RECOMMENDATIONS

1. We urge maternity providers to take immediate action to ensure that their maternity staffing complements are complete and they are able to feedback to Clinical Commissioning Groups/ Local Health Boards on their unmet workforce needs. In order to do so:
 - i. Every provider must implement NICE Guidance on safe midwifery staffing for maternity settings (2015) which calls on them to, among other measures:
 - Review their midwifery staffing establishment at board level at least every six months.
 - Ensure that their maternity service has procedures in place for monitoring their midwifery staffing establishment.
 - Ensure that their maternity service has procedures in place to adequately monitor midwifery red flag events and respond to them in an appropriate manner.
2. The Maternity Transformation Programme's 'Transforming the workforce' work stream must urge early adopters to prioritise the development of a decision support-tool to determine what an adequate midwifery staffing establishment looks like within a continuity of carer model of midwifery staffing. This includes providing clarity on the role of supporting staff and taking into account workforce uplift, training needs, and staff wellbeing.
3. The Government must scrap plans to remove bursaries for student midwives in England as this will only exacerbate the midwife shortage.
4. The Government must clarify how it will ensure that the UK's decision to leave the EU does not result in further pressures on midwifery staffing and midwifery support workers, and will not harm the overall aim of addressing the 3,500 gap in England's midwifery workforce.
5. The Welsh Government must prioritise maternity staff planning in order to ensure student midwife numbers continue to rise and the health service is able to adequately replace midwives who retire.

2. Delivering continuity

Findings

- 89% of women see between one and six midwives during the antenatal period, with most seeing between one and four
- Women who see between one and four midwives during the antenatal period report a better quality of antenatal care than women who see five or more
- 88% of women had never before met any of the midwives who looked after them during labour/birth
- Around two-thirds of the women who did know their midwife say that knowing their midwife allowed them to feel more relaxed, more confident, and safer

RECOMMENDATIONS

1. We endorse *Better Births*' call for a continuity of carer model of midwifery staffing, with small teams of four to six midwives taking shared responsibility for a woman's care or caseload. We call on the early adopter sites to lead the way in developing models of this type of care-giving that can be adapted by other sites. However, we call for clarity on:
 - How midwifery staffing levels will be monitored and planned within this model?
 - What percentage of midwives will need to remain as core staff?
 - How will midwives be supported to transition to this type of working?
 - How will the provision of all types of continuity be assessed?
 - How will the experiences and views of women on continuity be incorporated into workforce planning?
2. We urge the Maternity Transformation Programme to commission research into levels of continuity of carer at every part of the pathway in order to determine a benchmarking rate to achieve *Better Births*' goal of increasing levels of continuity of carer by 20% year-on-year from 2018/2019.
3. We urge the Welsh Government to consider the emerging body of evidence regarding the clinical benefits of midwife-led continuity of care models and incorporate those findings into its maternity strategy.

3. Providing personalised care

Findings

- 55% of women were presented with options about where they would give birth, made a decision and then had that decision achieved
- 46% of women said that homebirth was a realistic option for them, down considerably from 68% in 2013
- 44% of women only had one birthplace option
- 14% of women were told where they had to have their baby, despite their preferences
- 58% of women said they understood risks relating to their individual circumstances and were able to discuss them openly

RECOMMENDATIONS

1. We strongly endorse *Better Births'* recommendation that Clinical Commissioning Groups make available maternity services that offer the option of homebirth, midwife-led unit, or hospital.
2. We urge providers to investigate ways to increase the uptake and sustainability of their homebirth services. Trusts and boards should, as a minimum:
 - Commission an external evaluation of their homebirth services
 - Review homebirth models of care currently being deployed, such as at Birmingham Women's NHS Foundation Trust
 - Develop and pioneer homebirth continuity of carer models that safeguard midwives from burn-out
3. We urge providers to enable women to exercise genuine choice of birthplace by ensuring that adequate facilities, staff, and units are in place to accommodate their decision.
 - i. Providers need to agree a local menu of birthplace choices that are available to the different groups of women within their remit and these options and how women can access them must be clearly communicated to service users. Where trusts or boards fail to provide certain options, genuine alternatives must be put in place.
 - ii. We urge the Maternity Transformation Programme's 'Harnessing digital technology' work stream to include in the development of the digital maternity tool functionality that will allow women to fully understand their birthplace choice options in their local area.
4. Our findings show that over 40% of women do not understand 'risk' as associated with their own circumstances and women report that a poor institutional understanding of 'risk' has hindered their decision-making about their own care. We urge the Maternity Choice and Personalisation pioneers to develop a tool that can adequately explain to women the level of care that they require and remind the pioneers that workforce planning must take into account the time needed for midwives and others to explain this fully.
 - i. The Maternity Transformation Programme must clarify how the approximately 55% of women who annually require complex or intermediate levels of care will still benefit from *Better Births'* personalisation agenda. In particular, we would like clarity on how these women will benefit from the NHS Personal Maternity Care Budget.

4. Postnatal care

Findings

- 18% of women did not see a midwife as often as they required postnatally, which is no change from four years ago
- 36% of women who were not able to see a midwife as often as they required postnatally say that it caused them a great deal of concern; a further 32% say it caused them a small amount of concern
- 31% of women who were not able to see a midwife as often as they required postnatally say that it resulted in a delay of a health problem (for them or their baby) being diagnosed and treated
- 29% of women who were not able to see a midwife as often as they required postnatally say that they went to their GP, A&E, or walk-in centre instead

RECOMMENDATIONS

1. We endorse *Better Births*' recommendation that, as per NICE Guidance, women should see a midwife as often as they require postnatally. To facilitate this:
 - i. We recommend that as a minimum standard all women should receive a postnatal home visit by their midwife at least twice. Any subsequent midwife-led postnatal appointments should be conducted at a time and place most convenient for the woman and her family. The location of each woman's postnatal visit should be discussed as part of her personalised care plan.
 - ii. Commissioners need to agree a locally specific acceptable average number of postnatal visits that is appropriate for their population, which should be monitored and updated annually. This average should be based on annually collected feedback from service users about the frequency and quality of their postnatal care contacts.
 - iii. Women should know or have previously met their postnatal midwife, which means that the midwife must be the woman's 'named' midwife or a member of the small team of midwives that is responsible for her.
 - iv. Providers must use an accredited workforce planning tool to make sure their staff complements are adequate for all parts of the pathway, including the postnatal period.
2. We endorse the Mental Health Taskforce's call to provide 30,000 more women with access to specialist perinatal mental health services annually by 2020/2021. In order to facilitate this, we urge commissioners to devise and publish a regional perinatal mental health strategy to ensure that referrals to these services are appropriate and timely.
3. We call on the Welsh Government to urgently review the provision of care for women requiring inpatient mental health care. This is likely to be best provided for with a mother and baby unit, but a more localised approach can be adopted if shown to optimise care. This solution should be in place within three years.
4. We call on NHS Improvement to investigate the full cost of postnatal care, both to maternity services and the wider NHS, and take appropriate steps to adapt the tariff to better reflect the resources required to deliver safe, efficient care at this crucial time.

5. Using digital technologies

Findings

- 34% of women are using a specific digital technology, such as an app for their mobile phone or tablet, based on their own research or recommendations from others
- 65% of women who used digital technology used it to track milestones, such as when their baby kicked or when they had contractions
- 32% of women who used digital technology used it to access information about diet, alcohol, smoking, or other health issues
- 5% of women who used digital technology used it to book their antenatal appointments
- 5% of women who used digital technology used it to access their maternity records or notes
- Women whose midwives used or encouraged them to use specific digital technologies report a better quality of antenatal and intrapartum care

RECOMMENDATIONS

1. We urge the Maternity Transformation Programme's 'Harnessing digital technology' work stream to prioritise the development of a holistic digital tool that includes the types of functionality that is available via independent apps as well as NHS 'patient portal' features. The tool must be available in multiple languages and across multiple hosting platforms.
2. We endorse *Better Births*' recommendation that health professionals use electronic, interoperable maternity records that women can access and input data into and ensure that support is available to enable women to take advantage of these tools if they wish. We urge the Maternity Transformation Programme's 'Harnessing digital technology' work stream to formulate a national standard for interoperability in maternity records which can be adapted locally or regionally as providers see fit.
3. We urge Commissioners to invest in the development of IT systems for their providers which can be used for the electronic monitoring of unit and homebirth service closures/suspensions, staff levels, staff rotas, red flag events, and the availability of facilities.
 - i. A crucial component of this will be to invest in tools that allow midwives to work more efficiently in the community within the new continuity of care models recommended by *Better Births*. We, therefore, urge providers to develop an electronic training or support tool for midwives as they transition to this type of working and ensure that midwives have protected time to master the learning curve.

“There is nothing more important than how we are born. We have forgotten this simple fact for far too long” – Alice Walker, writer, in praise of the work of midwives

Introduction

In 2013 a collaboration between the National Federation of Women's Institutes (NFWI) and NCT galvanised a national conversation about NHS maternity services with a report that investigated the state of the midwifery workforce, the effectiveness of maternity service modelling, and the personalisation of maternity care.

With this second survey of women's experiences of their maternity care, the NFWI and NCT are moving the conversation on by providing further insights into key aspects of the experiences of 2,500 women who gave birth in England or Wales during 2014, 2015, or the first half of 2016.

The intention and outcome of the survey is to provide a useful benchmark from which to track and assess changes in maternity service provision over time. To achieve this we have repeated some of the questions we asked in the 2013 edition of *Support Overdue: Women's experiences of maternity services*.¹ Both the NFWI and NCT remain committed to placing women's voices front and centre and we do so here with a view to informing NHS England's Maternity Transformation Programme as it enacts the reforms laid out in the National Maternity Review report - *Better Births* – and the NHS in Wales as it lays out its strategic vision for how the maternity service fits into its Prudent Healthcare agenda.

This report takes as its starting point that investing in maternity services is one of the wisest financial decisions that a national healthcare service can make.² High quality maternity care helps women and their families lead healthier lives and ensures that babies are physically and emotionally prepared to grow into healthy children and adults.³

It is also one of the most effective mechanisms for reducing intergenerational health and socioeconomic inequalities. The reverse is true of substandard maternity care, which sets the preconditions for 'untold and recurring costs for society' at great personal injury to the women, their babies, and families who the service has failed.⁴ If health inequalities are to be tackled and if NHS England's commitment to a preventative public health programme is to be achieved, the funding and delivery of maternity services must be prioritised.⁵ When commissioners make the mistake of, in the words of Alice Walker, 'forgetting' the relevance of pregnancy and birth to long-term health, social, and economic outcomes across society, they short change the people in their care and NHS budgets in the long-run.

Since *Support Overdue* (2013) was published the landscape of NHS maternity service policy has changed in very meaningful ways, but demographically the service user and the way the service user interacts with the system has remained largely the same. According to the latest available data, having a baby is still the most common reason for hospital admission in the UK⁶ and the birth rate is still higher today than it was all throughout the 1990s and early 2000s.¹ Experts now predict that the birth rate will not fall substantially until 2030.⁷ Maternity services have also continued to become safer. Maternal and neonatal deaths continue to decline in both England and Wales⁸ (although they still compare poorly to some other high income countries) and last year the still-birth rate fell to its lowest level since 1992.⁹

¹ There were 697,852 live births in England and Wales in 2015, an increase of .4% from 2014.

As we found in our previous report, most women in England and Wales continue to enjoy a very high quality maternity service today, but exceptions and unacceptable variations in quality remain. Evidence from maternity experience surveys and from the National Audit Office, among others, continues to show that choice in maternity care remains an aspiration rather than a reality for many women, postnatal care is failing, the maternity pathway is dangerously fragmented and unable to deliver continuity of care, and midwives are run off their feet trying to plug gaps in the service due to understaffing.¹⁰ There is a real fear that despite prescriptive, evidence-based clinical guidance from NICE and robust policy documents like *Maternity Matters* (2007)¹¹ and *Midwifery 2020* (2010),¹² these problems are no closer to being solved than they were when *Changing Childbirth* first recommended more choice, continuity, and control for women in maternity care back in 1993.¹³

Part of the new consensus outlined in NHS England's Five Year Forward View (5YFV) was that the NHS needed to adopt 'new care models' to support the delivery of healthcare in the community and a key part of this strategy was developing a modern maternity service that would be able to facilitate women's choices.⁵ The 5YFV cited our finding that although only 25% of women wanted to give birth in an obstetric unit, over 85% of women actually did so. The 5YFV agreed with our assertion that this was counterproductive and clinically irresponsible and pledged to commission a major review of maternity services to reform how maternity care is delivered. The National Maternity Review report - *Better Births: Improving outcomes of maternity services in England* – was published in February 2016 and is bold in its vision for a 'safer, more personalised, kinder, professional, and more family friendly' maternity service delivered by well-supported and highly performing staff.⁷

Better Births makes seven overarching recommendations regarding personalised care, continuity of carer, safer care, postnatal care and perinatal mental health care, multi-professional working, working across boundaries, and the payment system. Taken together, *Better Births* is a 'radical' departure from current practice and has the potential to completely transform how midwives and other professionals deliver maternity care, how women experience the maternity pathway, and how women exercise choice. It is beyond the scope of this report to discuss all of these areas; however, we do situate every

chapter of this report within the context of *Better Births'* recommendations.

The newly inaugurated Maternity Transformation Programme Board is now responsible for driving forward the implementation of *Better Births'* recommendations. The Programme has established nine work streams on a range of topics, such as 'transforming the workforce' and 'supporting local transformation.' The Programme has recruited 36 Clinical Commissioning Groups and one NHS Trust to serve in seven clusters as Maternity Choice and Personalisation Pioneers to develop and test new approaches for how to improve personalisation in maternity care and, at the time of writing, was in the process of recruiting volunteer localities to serve as 'early adopter' sites to test the overall suite of reforms. The national roll out of the reforms is due to begin in 2018, but CCGs are expected to build *Better Births'* recommendations into their Sustainability and Transformation Plans for 2016-2021.

The overall strategic maternity policy in Wales is unchanged since *Support Overdue* (2013), but the wider strategic healthcare framework in Wales has altered. The All Wales Maternity Strategy report – *A Strategic Vision for Maternity Services in Wales* (2011) – issues twelve recommendations to guide maternity service reconfiguration in Wales with the aim of providing woman-centred care, encouraging positive lifestyle decisions, ensuring women have choice of place of birth, and employing a highly trained workforce to meet the holistic needs of women and their families.¹⁴ Since the strategy was published, the National Assembly for Wales Public Accounts Committee reported that significant progress has been made, but issued further recommendations to drive forward the implementation of the report's vision.¹⁵ The Welsh Government continues to review the strategy to make sure it is fit for purpose and has decided in the wake of *Better Births* to not amend it. Instead, the NHS in Wales will be looking at how to deliver high quality maternity care in the context of its Prudent Healthcare agenda, which aims to personalise the health service in ways that are fiscally responsible, clinically advisable, and locally appropriate.¹⁶

The questions we asked in this survey were done so with a pointed recognition of this changing policy context and with a view to adding women's voices to areas of stated priority for the Welsh and Westminster Governments moving forward. With the exception of Chapter 4

(on postnatal care) this report is structured thematically with the understanding that these themes are in no way discrete or mutually exclusive. The first chapter focuses on the midwifery workforce and safe staffing levels, predominantly in intrapartum care, but across the whole pathway. The second chapter assesses how midwives are providing continuity of care and seeks to determine which aspects of continuity matter most to women. The third chapter considers how maternity services are providing personalised care and unpacks the ways in which having or not having genuine choices influence outcomes for women. The fourth chapter looks at the provision of postnatal care services and the final chapter analyses how women are, or are not, interacting with digital technology to plan their care.

Throughout this report we make frequent use of policy documents that only have practical implications for England as opposed to Wales or the UK as a whole, the most obvious being our repeated references to *Better Births*. We did so with the belief that the issues identified in these policy documents, the trends elucidated, the goals aspired to, and the principles expressed have merit that extends beyond borders and provide opportunities for learning to anyone interested, as we are, in improving women's experiences of their maternity care.

Methodology

In April 2016, WI and NCT members were invited to complete an online Survey Monkey questionnaire regarding their maternity care. Only women who had given birth in 2014, 2015, and 2016 were eligible to complete the survey; eligibility was assessed by the first question. Paper copies were also distributed to members on request. The survey comprised 17 questions in total. Due to logic streams, no woman that completed the survey answered more than 16 questions or less than 13. The questions were a mixture of multiple choice, rating scale, and free-text. Quotes cited throughout the report were taken directly from those free-text responses.

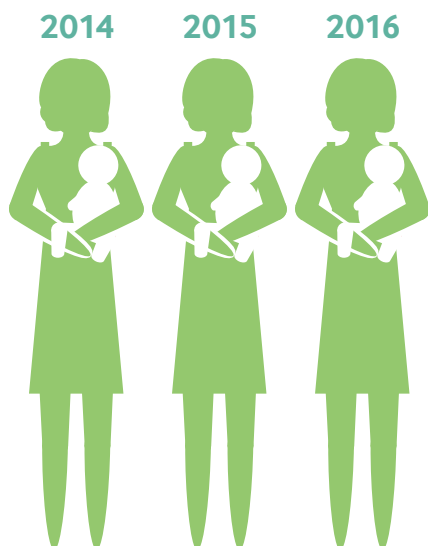
Eight of the questions were repeated exactly from our survey of women's experiences conducted four years ago, the findings of which were published in *Support Overdue: Women's experiences of maternity services* (2013). The unique questions asked this year were posed with a view to informing the work of the Maternity Transformation Programme as it takes forward the recommendations outlined in *Better Births* and the NHS in Wales as it monitors its maternity strategy. With that in mind, the questions were designed to shed light on areas of priority work identified by *Better Births* and the Welsh maternity strategy, such as staff organisation, postnatal care provision, the use of digital technology, how women experience continuity, and how midwives are delivering or can better deliver personalised care.

The sample

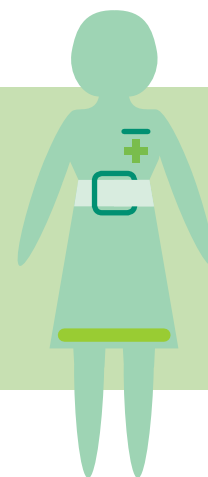
Over 3,600 women started the survey and just fewer than 2,500 completed it. Seventeen per cent of the respondents who began the survey were immediately disqualified because they indicated that their most recent birth was prior to 2014, which was outside the scope of this survey. The findings are based only on the 2,493 completed responses. Fifty-four per cent of respondents that completed the survey accessed it via the WI link collector and the remaining 46% used the NCT link collector, suggesting that the final survey respondents were almost evenly divided amongst the WI and NCT memberships.

Thirty per cent of the respondents answered in relation to a birth in 2014, 48% answered in relation to a birth in 2015, and 22% answered in relation to a birth in 2016. The majority of respondents (55%) were first time mums, 36% of respondents were mums who had given birth for the second time, with the remainder answering the survey in relation to the birth of their third or more child. We instructed respondents to answer questions in relation to their most recent birth experience only.

A majority of respondents gave birth in the South, with 29% of women being from South East England, 14% from London, and 11% from South Central England. Twelve per cent of women responded from the North West of England region. Only 3% of respondents were from Wales. In order to keep the survey as short as possible, we did not ask respondents about their age, ethnicity, income level, or any other additional demographic information.



1. Workforce challenges and opportunities



“*The Hon. Lady is absolutely right; we need more midwives*”

– The Secretary of State for Health Jeremy Hunt, in response to a question about maternity units closing their doors, 15 October 2015

Staffing in context

The Royal College of Midwives (RCM) estimates that NHS maternity services in England are operating with a shortfall of 3,500 full-time equivalent midwives.¹ Even though the number of midwives has steadily increased and the shortage has improved since *Support Overdue* (2013) highlighted a gap of 5,000, it is abundantly clear that the size of the midwifery workforce has simply not kept up with the demographic it serves.¹ It is a testament to the skills and commitment of midwives and other staff that even amidst this shortfall, key maternity care outcomes across the UK continue to improve.²

Workforce shortages are by no means unique to midwifery; our ‘missing midwives’ dilemma takes place within the context of clinical staff shortages across the entire NHS that show little sign of abating.³ Additionally, while the full implications of the result of the EU referendum are still not yet clear, the decision to leave the EU has the potential to further harm efforts to recruit and retain adequate staff numbers across the entire NHS.

While midwifery staff complements face the challenges experienced by the wider NHS, many of the underlying causes of the midwife shortage are, however, completely unique to midwifery and the essential ‘shop front’ service it provides to hundreds of thousands of women each year. Unlike other specialists, midwives coordinate care that is predicated on guiding mostly healthy people through a natural life event that does not always require medical intervention. In maternity care, the stakes are also higher as the health and wellbeing of women during pregnancy and birth can critically influence the development of their babies, so poor maternity care can adversely impact the health and life chances of the woman and her baby for years to come.⁴ These, among other factors, differentiate the maternity service.

While different trusts and boards face their own local challenges, broadly speaking we face a midwife shortage due to the following key factors:

- *The Baby Boom.* There were just over 100,000 more babies born in 2015 than there were in 2001. The baby boom of 2002-2012 may have settled down, but recent figures suggest that the birth rate will not drop to 2001 levels in the foreseeable future and there was actually an increase of nearly 3,000 births in 2015 compared to 2014.⁵
- *Complexity of care.* Midwives coordinate care for women today who may have more complex health and social needs than in the recent past. According to a recent study of women who gave birth in 2011, 55% were classified as ‘higher risk’ according to how NICE intrapartum care guidance classifies case-mix levels.⁶ Midwives need to spend more time managing their and their families’ needs.
- *Recruitment and retention challenges.* While the number of midwives has risen over the past decade, the RCM has characterised this increase as a ‘short-term sticking plaster.’⁷ This is because 98% of the increase in staff numbers over the last decade has been in midwives who are older than 50. Older and more experienced midwives are important sources of expertise and they play an indispensable role in training new midwives. There is a real worry, however, that they are not being replaced quickly enough after they retire, as Heads of Midwifery (HOM) report that they have problems recruiting experienced (Band 6 or above) midwives.⁸

¹ The RCM based their calculations on the latest data published by the Office for National Statistics which showed that there were 697,852 live births in England and Wales in 2015.



A lot of the time my midwife didn't have the time to help, but she always made the time. I felt they were extremely stretched and like swans - graceful on the top, but paddling like mad under the water



– Second time mum describing her most recent birth in 2016, Yorkshire & the Humber

Although in recent years the number of student midwives in England has increased, the RCM maintains that these numbers must be 'scaled up' and worries that the cuts to bursaries for student midwives that are due to take place from 2017 will dent recruitment even further.⁹ Wales faces its own recruitment challenges as well since the number of midwives in training fell by 10% in 2014/2015.¹⁰

- **Staff burn-out.** Staff burn-out is a problem across the NHS, but there is evidence that midwives feel more over-worked and under-resourced than the average clinical NHS member of staff. Midwives are so over-worked that a clear majority (63%) do not have enough time to use the toilet during their working hours and most (57%) report that they have to neglect some tasks because there is too much for them to do. Almost half (48%) say they feel stressed every day or most days due to workload, staff shortages, not having enough time to do their jobs, and missing their breaks.¹¹ This compounds the recruitment and retention problems facing the workforce.
- **Public Health Challenge:** The midwife's remit has also expanded in recent years, putting further pressures on her time. The Westminster and Welsh Governments have both classified the perinatal period as a 'golden opportunity' to improve women's health and to help women and their partners make lasting, positive lifestyle changes.^{12,13} Midwives have embraced this challenge, with some training in specialist roles such as perinatal mental health, to meet all the needs of the women they care for. Additionally, over the last decade women have been empowered to self-refer to midwives, which has meant that more and more women now see a midwife as their first point of contact rather than their GP.¹⁴ Midwives welcome these opportunities, but it does mean that their workload and training requirements have increased.

What is the impact of staff shortages on quality of care?

The impact of staff shortages on quality of care has been difficult to quantify, particularly with regards to safety. The Francis Report (2013) into the failings at Mid Staffordshire Foundation Trust acknowledged that inadequate staffing levels led to the delivery of unsafe care.¹⁵ Other reports have been more hesitant to suggest a direct relationship between the two, instead arguing that with regards to maternity, safe staffing is less about numbers than it is about 'getting the right people, in the right place, at the right time.'¹⁶ Regardless, most agree that staffing complements must be both full *and* appropriately organised to deliver safe and high quality care.

Many maternity units across England and Wales use the workforce planning tool Birthrate Plus to organise and plan their staffing complements. Birthrate Plus is based on the needs of women and babies and is robust, credible, and supported by the RCM. It has a long track record in enabling managers to measure the work and time involved in providing high quality maternity services and translating this into staffing numbers. It has now been endorsed by NICE as a workforce planning tool that can assist with implementing the recommendations in the NICE Guidance on safe midwifery staffing.

Through FOI requests our 2013 report found that no region in England and Wales met the Birthrate Plus ratio.¹ The National Audit Office corroborated our findings the next year, reporting that the NHS was failing to meet the Birthrate Plus ratio a clear majority of the time.¹⁷ Today HOMs report that staffing levels continue to be of great concern to them, with 30% indicating that their 'funded establishment was not adequate for their organisation.'⁸ Worryingly, 11% of HOMs said that inadequate funding and staffing shortages forced them to reduce services and 75% reported that community based staff often have to be redeployed from antenatal and postnatal service to the labour and delivery suite.⁸ This means that services in the community, such as homebirths, are less likely to be on offer and the quality of crucial postnatal care eroded.

These findings are reinforced by evidence from surveys of women's experiences that find units are understaffed and the workforce along all parts of the pathway is overstretched. *Support Overdue* (2013) showed that basic standards of care and long-established policy goals were continually being undermined because of a shortage of midwives. Women told us in 2013 and they told us again this year that staff shortages impacted every stage of their care, from their ability to form a relationship with their midwife, where and when they received their care, how or if they were able to make choices about their care, and how confident or vulnerable they felt as they transitioned into motherhood.

NICE guideline on safe midwifery staffing for maternity settings (2015)

Following the recommendations in the Francis Report, NICE published its first guidance on safe midwifery staffing for maternity services.¹⁸ The Guidance recommends a minimum staffing ratio for women in established labour, but – citing a lack of evidence and local variations – does not recommend a minimum staffing ratio for other areas of maternity care. The Guidance aims to provide a blueprint for trusts and boards to systematically review their midwifery staffing needs, calculate an appropriate staffing establishment, and develop and monitor changes in their workforce.

NICE recommends that as part of workforce planning, midwives need to monitor 'red flag events.' According to NICE:

'A midwifery red flag event is a warning sign that something may be wrong with midwifery staffing. If a midwifery red flag event occurs, the midwife in charge of the service should be notified. The midwife in charge should determine whether midwifery staffing is the cause, and the action that is needed.'¹⁸ Some red flags include:

- Missed or delayed care or delayed time critical activity (for example, a delay of 60 minutes or more in washing or suturing)
- Missed medication during an admission to hospital or midwifery led-units
- Delay of more than 30 minutes in providing pain relief
- Any occasion when one midwife is not able to provide continuous one-to-one care and support to a woman during established labour
- Delay in being referred to other services

What does *Better Births* say about staffing?

Staffing and the needs of staff are at the heart of England's National Maternity Review. *Better Births* sets out a bold vision for staffing models, advocating a continuity of carer model of midwifery staffing where a woman's named midwife will be part of a small team of four to six midwives that will work together to provide continuity for each woman and break down barriers between care in the community and care in hospital or maternity unit. This new model of staffing seeks to organise maternity care in such a way that women will be much more likely to know or have previously met the midwives caring for them during labour and birth. Additionally, in order to better deliver personalisation, safety, and care 'that wraps around the whole woman,' *Better Births* recommends that antenatal and postnatal appointments be extended by 10 minutes, the time for which will need to be accounted for in future workforce planning.

Better Births concludes that in order for its vision to be realised 'staffing levels across the local maternity system have to be adequate' and staff will need to receive the necessary training and support to transition to this type of working. *Better Births* contends that in order to deliver these changes 'a significant increase in the midwifery workforce is not required' because it takes the view that increases in staff will do little to assure continuity of carer and the real lever for change will be how effectively existing staff are deployed. *Better Births* does not share the details of the modelling performed to determine an appropriate staffing establishment nor does it recommend a caseload per midwife ratio, instead recommending a wide range of 30-40 births per midwife based on international caseload averages. *Better Births* is not prescriptive about how these teams must work in practice and instead charges its early adopter sites with the task of piloting new locally specific workforce organisational structures.



Our findings

We wanted to find out if women experienced safe staffing during labour and birth, so we asked them to reflect on whether they had experienced red flag events during their intrapartum care. Some of the red flag indicators will most likely be better understood or measured by midwives and other healthcare professionals rather than the maternity service user herself, so we did not poll for those.ⁱⁱ Instead we asked the respondents to consider whether they had experienced five specific NICE identified red flag events that we believed they would have been able to monitor (which we listed in the previous NICE guideline section) and then we assessed their time on the maternity pathway through that prism. The results are striking and suggest staffing complements on labour wards are in crisis and that for a significant portion of women, these shortages are leading to unsafe care.

In total, 50% of the women we polled experienced at least one NICE identified red flag event that we polled for during their intrapartum care. We found that this is a broad, systemic failing, with red flags occurring evenly across most regions rather than a 'postcode lottery.'

- 17% of applicable women did not experience one-to-one care from midwives during established labour
- 31% of women who required or received pain relief experienced a delay of 30 minutes or more in getting it while they were in labour
- 28% of women who required medication either during or following the birth experienced a delay in getting a prescription for it or a delay in receiving it
- 15% of applicable women said their immediate post-birth care, such as washing or suturing, was delayed
- For 24% of women who required other services (either before or following the birth), their midwife was unable or unavailable to make a timely referral



31% of women
who required or received pain
relief experienced a delay of
30 minutes or more in getting
it while they were in labour

ⁱⁱ Some of these red flags include: delayed recognition of and action on abnormal vital signs, delay of two hours or more between admission for induction and beginning of process, full clinical examination not being carried out when presenting in labour.

For the 50% of women who experienced red flag events during labour and birth, their overall experience of their maternity care was significantly worse than the sample as a whole

One-to-one care: Recommended by NICE, one-to-one care during established labour and birth is regarded as the gold standard in intrapartum care for its many proven benefits for women and their families. Failure to deliver it is also one of the most obvious signs that staffing levels are inadequate or poorly organised. *Support Overdue* (2013) found that 80% of women received one-to-one care during labour and birth. Our findings this year show a small jump to 83% of women. While a welcome increase, it is clear that there is still some way to go until trusts and boards get their workforce planning right to ensure that women are continuously supported throughout their labour and birth. As the following charts demonstrate, women that did not receive one-to-one care during labour experienced a markedly poorer quality of care during the antenatal, intrapartum, and postnatal periods than the sample as a whole.

Antenatally

My preferences about where and from whom I received antenatal care were acknowledged and acted upon

Whole sample

51%

Women who did not receive 1:1 care in established labour

33%

Even if I had not met them before, the midwives I saw had read my notes and knew my history

Whole sample

39%

Women who did not receive 1:1 care in established labour

20%

Midwives had the time to listen to my concerns and answer my questions

Whole sample

60%

Women who did not receive 1:1 care in established labour

29%

During birth

I was able to make decisions in partnership with midwives, other staff, my birth partner, and family

Whole sample

69%

Women who did not receive 1:1 care in established labour

35%

If a loved one of mine were giving birth, I would want them to receive the same level of care that I got

Whole sample

71%

Women who did not receive 1:1 care in established labour

24%

Postnatally

In the weeks following birth, I did not see a midwife as often as I needed to

Whole sample

18%

Women who did not receive 1:1 care in established labour

32%

What women said about staffing

Staffing was the third most common issue women identified when we asked them to comment about the quality of their care overall. Nearly all of the comments indicate that they believe maternity services were understaffed or that their midwife was over-worked and very busy. The women did not isolate a single part of their care when discussing these issues; rather their comments suggest that understaffing is a common thread that runs throughout the entire care pathway.

Many women spoke in very positive terms about how although their midwife or midwives were over-worked, they were still able to deliver a very high quality of care because of their expertise, professionalism, and commitment to the women in their care:

'In hospital following a C-section, the staff on the ward were incredible, despite being critically understaffed.'

'I was extremely pleased with the level of care with both of my births. The midwives were all fantastic and all completely run off their feet, yet never let on that they felt busy!'

During the antenatal period, women were most likely to link staffing shortages or issues with staff organisation with a lack of continuity of carer, saying how the two often went hand in hand and negatively impacted their care:

'I had so many different midwives looking after me during all stages of my pregnancy that I felt it was difficult to build a trusting relationship with any of them.... It did concern me a little bit as I was worried that I would not be cared for properly due to their workload. They also openly told me (in a friendly way) that they were understaffed which made me even more concerned...'

'Due to changes in midwives at my antenatal appointments and lack of knowledge/time, my gestational diabetes was missed.'

During labour and birth women commented in high number on many of the various red flag events that we polled for, often linking them to staff shortages:

'I was induced and having contractions for eight hours in an antenatal ward as there wasn't a midwife available to give me one-to-one care in the delivery suite. It was humiliating and degrading. I wished I could have fought to get better care but I could hardly get out a sentence between contractions.'

'The person giving me the stitches made it clear to me how busy she was and botched the stitches. One and a half years later and that piece of tissue is still sore.'

'Due to severe shortages in midwifery staff, my antibiotics were delayed each time by at least two hours or a dose was forgotten entirely.'

'I felt very lucky with the majority of my care however things like pain relief were taken out of my hands. I was offered an epidural, but that offer was subsequently retracted due to staff shortages.'

'After giving birth I was left for 12 hours in the bed I gave birth in without being washed because I needed surgery. I was told there was not enough staff which is why I had to wait.'

During the postnatal period, women were most likely to express disappointment with their experience in the postnatal wards and with breastfeeding support. A number of women with mental health problems also commented on the poor support they received:

'The poorest level of care was in the post-natal ward when they were short-staffed, changing staff wouldn't know my history/situation. I was unsupported with breastfeeding and made to give baby a bottle and frequently forgotten for things like painkillers and dinner.'

'Though the staff themselves were (on the whole) friendly and knowledgeable, there were simply not enough of them and my postnatal depression was missed until my health visitor was involved.'

“ *The workforce is the greatest risk to implementation, but also the greatest opportunity* ”

– Sarah-Jane Marsh, Chair of NHS England’s Maternity Transformation Programme,
Oral evidence to the House of Commons Health Select Committee Maternity Services Inquiry, 28 June 2016

Summary

As *Better Births* emphasises, adequate staffing is key to the implementation of its wide-ranging proposals for maternity services that are ‘more personalised, kinder, professional, and more family friendly.’ Both the RCM and the Government are clear that there is a shortage of midwives and that the shortage leads to poor and unsafe care for women and low workplace satisfaction for midwives. Due to retirement trends and cuts to funding for midwifery bursaries, the shortage looks to only get worse as birth rates hold steady.

Fifty per cent of women who completed our survey experienced at least one red flag event during their intrapartum care, which suggests that staffing levels in labour wards are at crisis point. While there is no doubt that some or even all of the red flag events can be pre-empted by smarter workforce planning and organisational structures which promote continuity at every stage, our findings indicate that the maternity service has not yet reached the adequate staffing complement that is necessary to ensure that happens.

As the Chair of NHS England’s Maternity Transformation Programme Sarah-Jane Marsh commented, the workforce is the greatest challenge to implementing the reforms outlined in *Better Births*, but it is also the greatest opportunity. Our findings suggest, however, that this opportunity will be lost if ending the midwifery shortage is not prioritised.

RECOMMENDATIONS

We call on the Government to commit to ending the midwifery staffing shortage to ensure that teams and units are fully staffed.

1. We urge maternity providers to take immediate action to ensure that their maternity staffing complements are complete and they are able to feedback to Clinical Commissioning Groups/ Local Health Boards on their unmet workforce needs. In order to do so:
 - i. Every provider must implement NICE Guidance on safe midwifery staffing for maternity settings (2015) which calls on them to, among other measures:
 - Review their midwifery staffing establishment at board level at least every six months.
 - Ensure that their maternity service has procedures in place for monitoring their midwifery staffing establishment.
 - Ensure that their maternity service has procedures in place to adequately monitor midwifery red flag events and respond to them in an appropriate manner.
2. The Maternity Transformation Programme’s ‘Transforming the workforce’ work stream must urge early adopters to prioritise the development of a decision support-tool to determine what an adequate midwifery staffing establishment looks like within a continuity of carer model of midwifery staffing. This includes providing clarity on the role of supporting staff and taking into account workforce uplift, training needs, and staff wellbeing.
3. The Government must scrap plans to remove bursaries for student midwives in England as this will only exacerbate the midwife shortage.
4. The Government must clarify how it will ensure that the UK’s decision to leave the EU does not result in further pressures on midwifery staffing and midwifery support workers, and will not harm the overall aim of addressing the 3,500 gap in England’s midwifery workforce.
5. The Welsh Government must prioritise maternity staff planning in order to ensure student midwife numbers continue to rise and the health service is able to adequately replace midwives who retire.

2. Delivering continuity



I was lucky to have the same small team of midwives throughout my pregnancy and birth, which enables you to build a relationship with them all, and in turn you really know that they believe in your ability to safely birth your baby (just as I did at home). Knowing that makes it easier in labour and a much more positive experience



– First time mum who gave birth in 2014,
South West.

Continuity in context

Midwife-led continuity of care models are workforce organisational structures which allow for women to receive care by one 'named' midwife or a small team of midwives, either throughout every stage of their care or for discrete stages (such as the antenatal period) only. This type of midwifery care is provided within an overarching multidisciplinary structure, where midwives consult other medical professionals if necessary, but assume primary responsibility for coordinating women's care. Evidence suggests that midwives who want to work within a continuity model find this way of working 'extremely satisfying'.¹ There is no one 'right' way to provide midwife-led continuity and different maternity systems strive to achieve it utilising different approaches, such as caseloading or working in teams. Regardless of how staffing rotas are organised, the underlying goal is 'to ensure safe care based on a relationship of mutual trust and respect in line with the woman's decisions.'²

Various studies have proven that not only do women want continuity, but also that continuity of midwife-led care leads to better clinical outcomes for women and their babies. Most significantly, the Cochrane Review (2016) found that women who received midwife-led care were more likely to give birth without costly interventions and were less likely to experience preterm births or lose their baby in pregnancy or in the first month following birth.³ If the NHS wants to meet its target of halving the rates of stillbirths and neonatal deaths by 2030, with a 20% reduction by 2020, then maternity providers must prioritise continuity of midwife-led care.⁴

Continuity of midwife-led care has been shown to result in improved outcomes including:

- women are seven times more likely to be attended at birth by a known midwife
- 16% less likely to lose their baby
- 19% less likely to lose their baby before 24 weeks
- 15% less likely to have regional analgesia
- 24% less likely to experience pre-term birth
- 16% less likely to have an episiotomy⁵

The CQC survey of 20,631 women published in 2015 concluded that continuity of carer was a key indicator of a positive maternity experience in both the antenatal and postnatal periods⁶ and the Green Templeton report highlighted that women who received midwife-led continuity of care were more positive about their overall birth experiences than those who did not.⁷ This type of care also pays particular dividends for women with more complex health or social needs or who find services difficult to access. Therefore, the impact of continuity of care in ensuring good clinical and experiential outcomes for women increases as women's care needs become more complex.

These studies show that providers need to not only take into account 'risk' in terms of the clinical category of each individual pregnant woman, but also in terms of the risks of not being able to guarantee that women are cared for within a continuity model.

Delivering continuity has proven to be a challenge for providers. Despite the recommendation from NICE and the Department of Health that pregnant women should be cared for by a 'named' midwife,⁸ studies have consistently shown that a significant percentage of women are not assigned one and that, while continuity during the antenatal period is improving, seeing only one midwife or a small group of midwives antenatally remains the exception rather than the norm.^{6,9} Additionally, only a small minority of women are likely to know or have previously met the midwives caring for them during labour and birth and a significant percentage of women will have never met the midwife or midwives caring for them during the postnatal period.

Workforce modelling to improve women's experiences of continuity also has its challenges. This is in part because women experience and midwives provide continuity in varied ways. Broadly generalising, continuity in care has three main components: management, informational, and relational.¹⁰ Management and informational continuity work to ensure that professionals providing care together communicate facts and value judgements to each other in a timely manner and that they communicate consistent and complementary information and value judgements to those they care for. Relational continuity refers to consistency of care provider, where the patient is able to form a trusting and therapeutic relationship with their caregiver or small group of caregivers.

The challenge for maternity providers is to ensure that all three types of continuity are being delivered, whilst the midwifery workforce is protected from burnout. Indeed, the CQC found that standards like 'knowing my medical history,' and 'I received consistent advice about feeding my baby' (signs of good management and informational continuity) were just as important as seeing the same midwife (relational continuity) in determining how satisfied women were with the quality of care they received.⁶ The 2015 Scottish Maternity Care Survey found that for some women 'team midwifery' functions as a good substitute for seeing the same midwife, suggesting that there is no 'one size fits all' model for how to deliver continuity.¹¹

This is perhaps why researchers have been unable to definitively recommend a standard model for providing midwife-led continuity of care. There is some uncertainty, they claim, between what kind of continuity matters most to women and what women value most in their care.¹² The task, therefore, for maternity planners is to facilitate models of care-giving which provide all of the types of continuity that individual women want in order to increase their satisfaction and ensure better clinical outcomes for them and their baby within localised systems that are responsive to the needs of the workforce and the population they are serving.

What does *Better Births* say?

Recognising that continuity facilitates genuine choice and helps ensure safety, *Better Births* recommends a continuity of carer model of midwifery staffing in order to achieve its larger personalisation agenda. This is, as *Better Births* acknowledges, a 'radical' departure from current models of working. Under this new model, which utilises principles from both caseload care and team care, women will have a 'named' midwife who is part of a small team of four to six midwives. Midwives can work within a 'buddy' system, where another midwife can step in the event that a woman's named midwife is unavailable. Each team of midwives will be supported by an identified obstetrician. Under this model a woman will be cared for during labour and birth by her named midwife, or a midwife from the team that she has already met. Once the rollout of *Better Births'* recommendations begins in 2018/19, the aim is to increase continuity levels by 20% year on year.

88% of women did not know their midwife before they went into labour

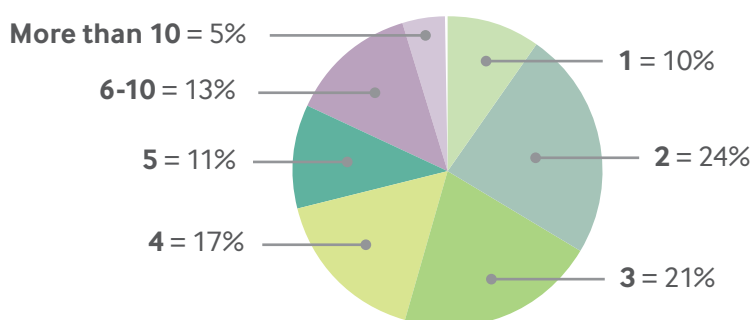


Our findings

We asked women about various different aspects of continuity, including the number of midwives they saw antenatally, whether or not they had met the midwives who cared for them during labour and birth, and what kind of relationship they were able to develop with their midwives.

Eighty-nine per cent of women we surveyed saw between one and six midwives during the antenatal period, with most of those (72%) seeing between one and four. This means that providers are not too far away from achieving the continuity of carer aims as outlined in *Better Births*, albeit within systems that rely too much on the 'goodwill' of midwives to plug the gaps in provision rather than ones which embed continuity, and the resources required to deliver it, as a matter of course.

Q: How many midwives did you see during your antenatal appointments?



Some regions, however, are underperforming. Women in London are less likely to experience continuity, with 16% seeing more than six midwives. Women in the North West are the least likely to experience continuity of carer, with 19% seeing more than six midwives, 10% of whom see more than 10 midwives antenatally.

Our findings suggest that the task for the Maternity Choice and Personalisation Pioneers will be to formulate a continuity of carer staffing model which will improve continuity for the women who are not getting it at all, while not decreasing the levels of continuity adversely for the majority of women who are already getting it. Our subsequent analysis of how quality of care is correlated to continuity of carer demonstrates that this will depend, as Chapter 1 emphasised, on staff numbers as well as how they are organised.

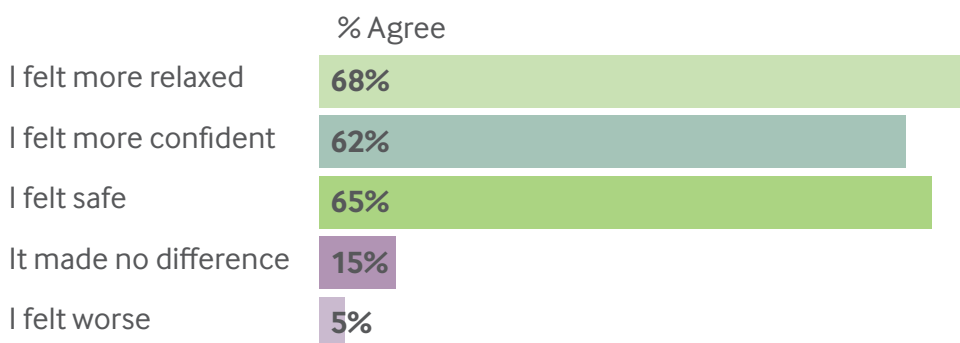
Women who received care from one to four midwives in the antenatal period were markedly more likely to report a greater satisfaction with their antenatal care than women who saw five or more midwives. Their care was more personalised, they were more likely to be treated with respect, they reported higher levels of confidence in the midwives they saw, and they were more likely to say that midwives were able to support them to lead a healthier lifestyle. This finding does not mean that *Better Births'* recommendation for teams of four to six midwives needs to be revised down, but highlights that team midwifery cannot rely on relational continuity alone. In order to work effectively, the team midwifery approach must embed a new culture that prioritises all three levels of continuity and in order for midwives to provide total continuity to women, resource constraints must be adequately alleviated.

We also found that, as *Better Births* suggests, continuity of carer is currently being delivered in a silo, often restricted to the antenatal period alone. When we asked women if they had met any of the midwives who looked after them during labour and birth before they went into labour, their answer made virtually no difference depending on whether they experienced continuity of carer antenatally or not.

The vast majority of women (88%) answered that they did not know their midwife before they went into labour or gave birth, which is the exact same result from our study four years ago. The results are not much better for women who laboured or gave birth where they originally intended to; only 15% of them had met their intrapartum midwife previously, up only 1% from our previous study.

Impact of knowing your midwife

We asked women about the impact of knowing or not knowing their midwife in order to gauge which aspects of continuity matter the most to them. Overwhelmingly, women report that knowing their midwife made a positive difference for them during labour:



'I felt that my wishes would be respected because my midwife understood why I had certain things on my birth plan and that they weren't just whims.'

'My husband had also met them...It made a huge difference.'

'I completely trusted my midwife as we had built up a good relationship. I saw her frequently during my pregnancy and she knew all of my birth preferences.'

Only 15% of women report that it made no difference and only 5% say that it made them feel worse.

Women who knew their midwife also report a much more positive experience of intrapartum care than the sample as whole. This shows that continuity of carer in the intrapartum, as well as the antenatal period, matters for women experientially as well as clinically. Midwives are better able to deliver on the policy goals enshrined in NICE Guidance when the preconditions for continuity of carer are in place.

Q: Thinking about your labour and birth experience, please indicate whether each of these statements is an accurate reflection of your experience:

| | Whole Sample | Women who knew their labour/birth midwife |
|------------------------------------------------------------------------------------------------------|--------------|-------------------------------------------|
| My maternity care took into account my personal needs and preferences | 68% | 85% |
| Staff took the time to keep me informed each step of the way | 69% | 84% |
| I was able to make decisions in partnership with midwives, other staff, my birth partner, and family | 69% | 82% |
| I was encouraged to eat or drink when I wanted to | 57% | 70% |
| I was given a choice about pain relief | 72% | 82% |
| If a loved one of mine were giving birth I would want them to receive the same level of care I got | 71% | 87% |

Impact of not knowing your midwife

For the 2,189 women who did not know their midwife before they went into labour, 52% of them say it made no difference to them, which is down considerably from our 2013 report (68%).

Women were most likely to say that not knowing their midwife made them feel frustrated as they had to keep repeating themselves to staff (22%), 12% of women said it made them feel alone and vulnerable, and 6% said it made them feel unsafe.

A number of women commented in the free-text area for this question, allowing us to better contextualise their responses. In particular these responses allow us to see why not knowing their midwife 'made no difference' for 52% of the respondents and assess whether it is that continuity in the intrapartum period mattered little for this group of women or if other forms of continuity were being provided for them in lieu of relational continuity.

A third of the women who commented said that not knowing their midwife made no difference to them because the professionalism and competence of the midwives more than made up for a lack of familiarity. Their experiences are testament to the fact that continuity can be delivered in many forms by midwives and other staff that work together coherently and, by using tools such as birth plans, are able to establish a rapport with the women they are caring for in a very short period of time.

'I don't feel like I developed a close relationship with the two midwives who cared for me in labour, but actually this mattered less than I had expected. What was important was that I trusted them and felt they were on my side.'

'My consultant midwife had shared my birth plan with the ward, there was a copy in my notes, and my [labour] midwife already had a copy and referred to it. I felt comfortable knowing that people knew about me.'

'I had an excellent midwife for birth. I wish I had known her before to build a stronger relationship; however she read my plan and took account of my birth preferences. I bonded with her.'

Sixteen per cent of women who commented said that although it made no difference to them, they would have preferred to know the midwife and 14% said it made no difference because it was what they were expecting.

What women said about continuity

Continuity was far and away the issue that women commented on the most when asked to share the best or worst practice of their maternity care. From their responses we can see that women's concerns about continuity, or lack thereof, touch on every aspect of their care, not just their care during labour.

“ *Most of all, I would have liked to have the same midwife through my pregnancy* ”
– First time mum who gave birth in 2016, London.

Antenatal care:

'I would have preferred to have consistency of seeing only one or two midwives during my pregnancy as at each appointment it took few minutes for the new midwife to read my notes. I would have thought then the care would have been more tailored to me and appointments perhaps shorter.'

'I never saw the same midwife more than once during antenatal appointments and they were based half an hour from my house, difficult in late pregnancy!'

Intrapartum care:

'Listening to expectant mothers has to become a priority. For this to happen we need continuity of care. When you're in labour you don't want to have to keep repeating things...'

'During labour I felt decisions were made for me and nobody took any notice of my birth plan or asked about it. I was left alone a lot especially in active labour and when the epidural wore off it took over an hour to find someone to top it up even though the pain was excruciating.'

Postnatally, women often described how a lack of continuity of carer and consistency in advice contributed to problems with breastfeeding:

'I saw a number of different midwives and health visitors when at home for my checks and all had different advice on feeding which just added to the stress when my baby was slow to gain weight.'

'I saw four different midwives at home once baby was born. They all had slightly different opinions on feeding. I would have liked to see just one midwife for consistency, ideally the one whom most of my antenatal appointments were with.'

'I wish I had fewer midwives, whilst they were fantastic individuals, I believe I would have benefited from less midwives as I would have formed a better, more trusting relationship with them. I wouldn't need to repeat myself. Same with establishing breastfeeding, I've never had so much different information. It was overwhelming.'

Positively, a number of women attributed their good birth experiences to solid delivery of the continuity promise:

'I was looked after by a community midwife team who worked on a caseload basis. My antenatal appointments were at home, I mostly saw the same, named midwife and could contact her whenever I had a problem or concern. The team ran informative and engaging antenatal classes. I had a homebirth and it was a fantastic experience. I cannot speak highly enough about the midwives and think every woman should have access to the kind of care I received.'

'I was lucky enough to be a part of a student's case-loading approach. This was an excellent experience. She attended every appointment, delivered my baby and saw me almost every day following the birth to help with feeding. I was able to contact her with any questions (even the trivial ones). This continuity of care made my first pregnancy very relaxed and I felt reassured and calm when I went into labour.'

'I was lucky enough to have a third year student caseload me, which meant she attended as many antenatal appointments as possible from approximately 30 weeks, the birth, and all postnatal visits. This was an absolutely wonderful experience and was far, far superior to my previous pregnancy where the antenatal and postnatal care were from different teams and different people every time.'

'I found consistency in midwife care vital. Having the same antenatal midwife throughout was extremely positive and should be encouraged.'

Summary

Midwife-led continuity of care leads to improved clinical outcomes for women and their babies and is the type of care that women prefer to receive and midwives find satisfying to deliver. *Better Births* calls on midwives to reorganise into a continuity model, where they care for women in small teams of four to six across the entire pathway. With a majority of women now requiring a more complex level of maternity care, providing continuity of care is more necessary than ever to help ensure positive clinical outcomes for women.

Our findings show that under current service models, 89% of women see between one and six midwives antenatally. However, they most likely see more in total along the entire care pathway since most women will not know the midwives that care for them during labour or birth. Our findings also indicate that the many benefits of relational continuity during the antenatal period flat line when women see five or more midwives and, furthermore, that antenatal continuity alone does not guarantee a more positive intrapartum experience. This means that for teams of four to six midwives to be effective in the way *Better Births* envisions they will need to provide a comprehensive level of continuity.

Women are clear that there are myriad benefits to knowing their midwife during labour and birth, with around two-thirds saying it made them feel more relaxed, confident, and safe. Women who knew their midwife during labour and birth also report a higher quality of intrapartum care and were more likely to receive the hallmarks of quality, safe care as recommended by NICE Guidance. For the vast majority of women who did not know their midwife during labour or birth, a third of them say that it made no difference to their care because the midwives they did see were able to provide other forms of continuity in lieu of relational continuity. Anecdotally, women commented on continuity more than they did on any other aspect of their care, humanising our above assertion that one of the biggest risks that maternity service providers can take is not prioritising midwife-led continuity of care models.

RECOMMENDATIONS

We call on maternity service providers to prioritise the development and implementation of midwife-led continuity of care models to ensure positive clinical outcomes for women and their babies and to personalise the level of care that women and their families receive at every stage.

1. We endorse *Better Births'* call for a continuity of carer model of midwifery staffing, with small teams of four to six midwives taking shared responsibility for a woman's care or caseload. We call on the early adopter sites to lead the way in developing models of this type of care-giving that can be adapted by other sites. However, we call for clarity on:
 - How midwifery staffing levels will be monitored and planned within this model?
 - What percentage of midwives will need to remain as core staff?
 - How will midwives be supported to transition to this type of working?
 - How will the provision of all types of continuity be assessed?
 - How will the experiences and views of women on continuity be incorporated into workforce planning?
2. We urge the Maternity Transformation Programme to commission research into levels of continuity of carer at every part of the pathway in order to determine a benchmarking rate to achieve *Better Births'* goal of increasing levels of continuity of carer by 20% year-on-year from 2018/2019.
3. We urge the Welsh Government to consider the emerging body of evidence regarding the clinical benefits of midwife-led continuity of care models and incorporate those findings into its maternity strategy.

3. Providing personalised care



Personalised care in context

It has now been over twenty years since *Changing Childbirth* laid out its strategic vision for a woman-centred maternity service and trusts, boards, midwives, and other providers have been striving to realise that vision in locally specific ways ever since.¹ ‘Woman-centred’ care is a culture of personalised care-giving that recognises the woman as an individual; it means care that rises up to meet all of her needs – be they social, cultural, physiological, psychological, or familial – and not just the needs of her pregnancy. Midwives and others that practise woman-centred care empower women with the necessary skills and knowledge to make informed choices about their own care and these practitioners must necessarily be operating within a system that guarantees, through appropriate infrastructure and supportive culture, those choices will be met.

‘Choice’ has emerged as a prerequisite for the delivery and experience of woman-centred care and enabling genuine choice has formed the bedrock of recent maternity policy. In 2007 *Maternity Matters* laid out a series of ‘national choice guarantees,’ promising that women in England would have a choice of how they accessed their maternity care, their type of antenatal care, choice of place of birth, and choice of place of postnatal care.² The *Strategic Vision for Maternity Services in Wales* also prioritises choice of place of birth and urges local health boards to provide women with a choice of homebirth, midwife-led unit, or obstetric unit.³

Choice is also linked very closely to service users having greater control over their own overall care experience as outlined in the broader NHS Choice framework⁴ and the Welsh Government’s Prudent Healthcare strategy.⁵ For maternity service users this means having control over decisions pertaining to their birth environment, such as lighting or birth position, choice of pain relief method, choice to use facilities such as birth pools, choice of birth companion, or choice of baby feeding methods, among others. To facilitate these choices, *Maternity Matters* recommended that every woman, in partnership with her midwife or obstetrician, draw up an individualised care plan.

Despite these stated commitments, what ‘choice’ in maternity practically means for women continues to prove elusive because some providers value certain choices more than others, especially for those who require more complex levels of care. Furthermore, ‘offering choice becomes increasingly difficult as women are expected to comply with the choices which are pre-defined by the service and which are already available.’⁶ This led Mavis Kirkham to conclude in what remains one of the most comprehensive analyses of the topic ‘that informed choice is unusual in maternity care and compliance is common.’⁷

Studies over the past decade have shown that a significant portion of women either get no choice of birth location or have severely limited choices.⁸ These studies have also demonstrated that for many women making a choice in no way guarantees that they will actually go on to achieve their choice, as a lack of staff, a lack of available facilities, or a lack of capacity often frustrates the ambitions of women and their caregivers. The availability of genuine alternatives to obstetric care is a particularly acute barrier to choice. For example, the National Audit Office reported that over one in five women did not live within a 30 minute drive of both an obstetric unit and a midwife-led unit, thus severely hampering their realistic birth place options.⁹

A lack of information and understanding is another key barrier preventing women from exercising choice. *Support Overdue* (2013) asked women if having choices, and knowing about them, impacted where they wanted to give birth. We found that, perhaps unsurprisingly, it did. When birthing facilities like alongside midwife-led units and freestanding midwife-led units are

“ I have been lucky enough to have three wonderful birth experiences. I think making my own choices and having those choices respected has been pivotal to their success ”

– First time mum who gave birth in 2014,
South West England.

presented to women as realistic options, women will choose to use them.¹⁰ Conversely, when women are unaware they have choices, their stated preferences will reflect that limited optionality.

Most significantly, *Support Overdue* (2013) found that although only 25% of women wanted to give birth in an obstetric unit, 87% of women did so. We also found that women with more options of birth settings are far less likely to want to give birth in an obstetric unit and that the realistic availability of homebirth services in particular significantly lowers the percentage of women who want to give birth in an obstetric unit. If the Welsh Government is to achieve the ambition set by its Chief Nursing Officer for 45% of women to give birth in midwife-led settings, homebirth services must be presented as a realistic option for women.¹¹

What does *Better Births* say?

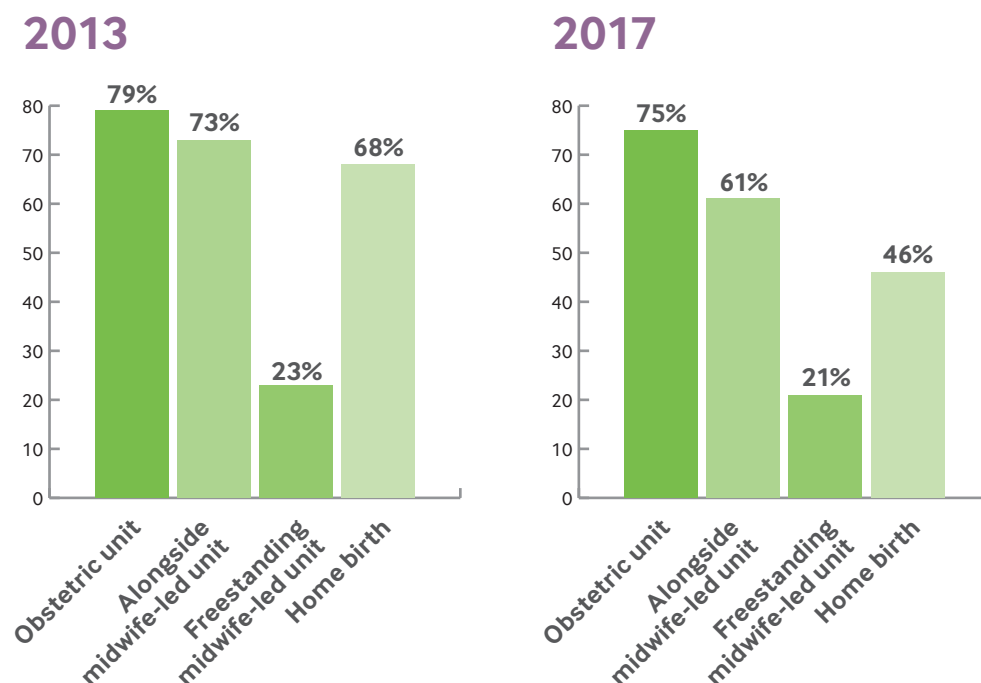
Recognising that safe care is personalised care, choice and personalisation remain central to *Better Births*' vision for care that 'wraps around' the whole woman and her family. It recommends that every woman have personalised care that is 'centred on the woman, her baby, her family, based around their needs and their decisions, where they have genuine choice, informed by unbiased information.' To achieve this, it recommends an ambitious personalisation strategy which will see all women develop their own personalised care plan and have access to their records through an interoperable digital tool. Eligible women will also be able to choose their provider through an NHS Personal Maternity Care Budget. These measures are all practical tools that, if implemented properly, will work in tandem to aid women in exercising genuine choice and forming meaningful relationships with their midwives and other caregivers. The Maternity Transformation Programme has finalised its list of the seven clusters of CCGs that will act as Maternity Choice and Personalisation Pioneers who, over the next two years, are going to explore the best models for delivering this type of personalised care.

Our findings

Our findings show many reasons for optimism. A majority of the time, midwives are delivering personalised, timely, and safe care for women and women are having their choices in labour and birth respected. Eighty-eight per cent of women say that while they were giving birth their birth partner and family were treated with respect by staff and 85% report that midwives and other carers gave them support and encouragement. There are, however, some troubling areas of persistent concern, especially with regards to birthplace choice, which suggest that women's ability to make informed decisions about their care has been eroded over the past four years.

We asked women to indicate the birth locations that, as far as they were aware, were realistic options for them to have their baby in their local area. Compared with our findings from 2013, the results show a significant decline in some midwifery led options for women, most dramatic being the fall in homebirth availability. This is despite NICE Guidance (December 2014) which recommends that low-risk, multiparous women be advised that homebirths and low-risk nulliparous women be advised that midwife-led care is 'particularly suitable' for them.¹² The cohort of women in this study all gave birth from 2014 onwards; meaning that this revised guidance was applicable to most of them.

Q: Please tick the birth locations that, as far as you were made aware, were realistic options for you to have your baby in your local area?



We can also see from this question how many birthplace options women are being presented with as realistic options for them. These findings also attest to a considerable decline in the amount of options compared to when we polled on this topic four years ago. Only 9% of women were offered four options of place of birth and a clear plurality (44%) were only offered one choice.

| Number of location options | 2013 | 2017 |
|----------------------------|------|------|
| 1 | 21% | 44% |
| 2 | 25% | 18% |
| 3 | 41% | 29% |
| 4 | 12% | 9% |

However, it is important that these findings about birthplace choice are digested within the context of our more nuanced understanding of what is an appropriate birth setting for women with different care needs. As researchers have pointed out, 'although no pregnancy can be considered entirely risk-free, by the same token, none are entirely "risky"' and each woman's individual care plan should be tailored according to where she falls on a spectrum, not a clearly demarked slab.¹³ A fall in the percentage of women saying they had a realistic option of a homebirth or a midwifery led unit may not be a cause for concern as it may be a reflection of the implementation of updated clinical guidance, as referenced above, which has provided more clarity on who those settings are actually most appropriate for. However, it may also point to instances where certain women who satisfy certain criteria are now unilaterally denied choices and presented with little to no genuine alternatives. As we did not ask women about the level of care they required this is merely conjecture, but it does make a compelling case for trusts and boards to think carefully about the case-mix level of their users for the purpose of assessing how they can best enable women's choices.



We also asked women if they made a decision about where they would give birth and whether or not their decision was realised. A slight majority (55%) indicate that they were presented with options, made a decision, and then had that decision achieved. This is a slight decline from 58% of women who achieved their birthplace choice four years ago¹. This means that for nearly half of women, something occurs at some time to prevent them from exercising or achieving their choice of birthplace.

Fourteen per cent of women say that they were not given any options and they were told where they had to have their baby despite their preferences. A quarter of women made a decision, but then did not have that decision realised.

Women who were able to exercise choice in birth location and who then also had that choice realised report an overall higher quality of care than women who did not have choice or did not have their choice realised. Our findings also show that having choice and then having that choice respected is just as crucial to women experiencing a high quality of care as continuity of carer during the antenatal period is.

Multiparous women were more likely to say that they had birthplace options and that their birthplace choice was realised than primiparous women, reflecting the importance of the woman knowing that she has agency to make decisions about the birth she wants. It also suggests that external factors, such as facilities, regional location, or a woman's individual circumstances are of less importance in determining her likelihood of having and achieving choice than previous experience of giving birth. This is especially true in light of NICE Guidance (2014) that specifically recommends some midwife-led options for multiparous women only.

| | Having choice (even if in the end it was not realised): | Not having choice: |
|-----------------------------------------------------------------------------------------------------|---------------------------------------------------------|--------------------|
| My preferences about where and from whom I received antenatal care were acknowledged and acted upon | 56% | 19% |
| I drew up a personalised birth plan with my midwife | 35% | 21% |
| I felt I was treated as an individual | 65% | 43% |
| I was always treated with dignity and respect | 73% | 50% |

¹This question was not repeated identically from *Support Overdue* (2013). *Support Overdue* (2013) asked: 'After a decision was made about where you would give birth, what actually happened?' whereas *Support Overdue* (2017) asked: 'Did you make a decision about where you would give birth' and included an answer option 'Yes, I was given options to choose from, I made a decision, and that is where I gave birth in the end.'

During the intrapartum period the benefits of having birthplace choice achieved are most evident:

| | Achieving choice | Not having nor achieving choice | Sample overall |
|----------------------------------------------------------------------------------------------------------|------------------|---------------------------------|----------------|
| My maternity care took into account my personal needs and preferences | 76% | 57% | 68% |
| I was able to make decisions in partnership with midwives, other staff, my birth partner, and family | 78% | 58% | 69% |
| I was encouraged to eat or drink when I wanted to | 63% | 48% | 57% |
| If a loved one of mine were giving birth, I would want them to receive the same level of care that I got | 80% | 60% | 71% |

The benefits of choice are also evident during women's experiences of postnatal care. We asked women if they saw a midwife as often as they needed to during the postnatal period. While the results to this question will be discussed in more detail in the following chapter, we can see that having birthplace choice, even if in the end it is not achieved, is a good indicator that women will also be able to see a midwife as often as they need to post birth.

| Having choice (even if it was not in the end achieved): | Not having choice: |
|------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|
| In the weeks following birth, did you see a midwife as much as you needed to? Yes: 83% No: 17% | In the weeks following birth, did you see a midwife as much as you needed to? Yes: 74% No: 26% |

Our findings also point to some other key areas of concern for personalisation during maternity care.

Care plans: *Better Births* recommends that women draw up personal birth plans with the coordinators of their care. Our findings show that only 33% of women are currently drawing up personal birth plans, so there is some way to go until that goal is achieved.

Choice in antenatal care: Only a slight majority (51%) of women say that their preferences about where and from whom they receive antenatal care were acknowledged and acted upon, which shows that nearly a decade after *Maternity Matters* half of all women are still not achieving that first choice guarantee.

Intrapartum continuity of carer and birthplace choice: *Better Births* makes the case that personalised care leads to safer care overall and some of our findings speak to that relationship. As we detailed in Chapter 2, most women did not know the midwife who attended to them during labour and birth and for a slight majority of those women not knowing their midwife made no difference to them. However, there is a noticeable difference in the impact of not knowing their midwife based on whether or not women had birthplace choice and if their choice is then realised.

“ *My point is that although I was told I had choice, I was made to feel like I didn't* ”

– First time mum who gave birth in 2015,
North West England.

For women who did not have a choice of birthplace or did not have their choice realised, the negative impact of not knowing the midwife who cared for them during the birth is far more pronounced. These women were considerably more likely to report that not knowing their midwife made them feel frustrated, alone and vulnerable, and unsafe during labour than women who achieved their birthplace choice.

What women said about personalised care

Fifteen per cent of women who chose to comment on aspects of their care did so about choice and personalisation. With regards to birthplace choice, overwhelmingly women told us that they either had no choice, restricted choice, or that in the end their choice was not realised.

A number of women wrote about feeling like ‘cattle’ or ‘a machine.’ They also discussed how their birth plan was not followed and how they felt that consent and control were taken from them:

‘I received a very “robotic” care. It wasn't very personal and I felt like just another person on the conveyor belt.’

‘I wasn't given an option to where I could give birth, I am aware that it is my right to choose however no options other than a hospital were discussed...’

‘I wasn't treated as a human. I was just a product on a conveyor belt. I was not respected and my birth has left me suffering PTSD.’

A number of women linked a lack of achieving their choices to a shortage of staff or facilities:

‘My chosen hospital ward and adjoining birth centre were extremely busy, or so I kept being told on the phone, which resulted in me having an unplanned homebirth.’

‘There was no room for me on the delivery ward. I ended up giving birth in the antenatal ward which meant I couldn't get either a water birth or an epidural. Disappointed not to have had the labour I wanted because of staffing issues.’

A number of women discussed how their choices were limited because of a poor understanding or explanation of ‘risk’ or an unwillingness to reconcile choice with women who required more complex care:

‘I had gestational diabetes and the option to birth anywhere other than the labour ward was literally laughed at despite the midwife led unit being on the same floor of the hospital.’

‘I really wanted to give birth in a midwife led unit, but because I once tested positive for being a carrier of ‘Strep B’ they refused to accept me and I was told I could either give birth in a hospital or have a home birth.’

A minority of women wrote in demonstrating how ‘risk’ can be managed to ensure choice, suggesting that where risk is effectively managed this can result in a positive experience:

‘I have a hip condition that may have made me unable to give birth in the centre, but the midwives liaised with my orthopaedic consultant on a regular basis and I was able to have my little boy in the birthing pool exactly how I wished.’

A number of women wrote in about how empowering it was to make an informed choice and discussed how informed choice went hand-in-hand with personalised care:

‘I didn't think I would have the option of a homebirth. At my first appointment I was given the ability to make this choice, closely monitored to ensure it was feasible, offered a course to support homebirths and the opportunity to meet with mothers who had similar experiences. Three midwives developed a personal relationship with me during my pregnancy. Overall an outstanding service...’

‘These experiences were so empowering. The midwives provided support whilst ensuring I was able to make my own informed decisions along the way.’

Summary

The case for personalised, woman-centred maternity care has been nearly a quarter of a century in the making, with bedrock policy documents and clinical guidance reiterating that care must take into account the whole woman, empower her to make informed decisions, and provide her with genuine acceptable alternatives should her individual circumstances require it. This philosophy of care-giving helps ensure, as *Better Births* emphasises, the delivery of safe care.

Yet, for too many women, informed, genuine choice in maternity is still an aspiration, rather than a reality. A lack of information, a dearth of facilities, staff shortages, and institutional biases all prevent women, especially those requiring complex care, from exercising and achieving their choices. Our findings today show that fewer women have the full range of birthplace choices than they did four years ago, with the fall in midwife-led options, especially homebirths, being the most dramatic. This is especially relevant in light of NICE Guidance which recommends care in midwife-led settings for a large cohort of women. Worryingly, we also found that 44% of women only have one birth option presented as realistic for them and nearly half of all women did not have their birthplace choice realised. These findings suggest that either choice is being severely undermined for women and their families or the new NICE Guidance is being applied in a way that restricts choice for women, whether the woman still feels like her care is personalised or not.

This matters because, according to our findings, exercising choice and having choice realised are just as necessary for women to experience a high quality of care as continuity of carer during the antenatal period. Furthermore, women who had their birthplace choice realised or were able to make decisions about their birthplace choice report a higher quality of care at every stage along the pathway. Women told us that when they were denied the ability to make choices it made them feel dehumanised, out of control, and unsafe. A number of women who required more complex care told us that their efforts to make decisions were often belittled or ignored. Conversely, the women who were supported to make decisions reported that their care was empowering.

RECOMMENDATIONS

Commissioners must prioritise woman-centred, personalised maternity care systems that provide the necessary infrastructure, workforce structures, and institutional culture that will ensure all service users, regardless of the kind of care they need, are able to exercise and understand choice and are provided with genuine alternatives should their individual circumstances require it.

1. We strongly endorse *Better Births'* recommendation that Clinical Commissioning Groups make available maternity services that offer the option of homebirth, midwife-led, or hospital.
2. We urge providers to investigate ways to increase the uptake and sustainability of their homebirth services. Trusts and boards should, as a minimum:
 - Commission an external evaluation of their homebirth services
 - Review homebirth models of care currently being deployed, such as at Birmingham Women's NHS Foundation Trust
 - Develop and pioneer homebirth continuity of carer models that safeguard midwives from burn-out

3. We urge providers to enable women to exercise genuine choice of birthplace by ensuring that adequate facilities, staff, and units are in place to accommodate their decision.
 - i. Providers need to agree a local menu of birthplace choices that are available to the different groups of women within their remit and these options and how women can access them must be clearly communicated to service users. Where trusts or boards fail to provide certain options, genuine alternatives must be put in place.
 - ii. We urge the Maternity Transformation Programme's 'Harnessing digital technology' work stream to include in the development of the digital maternity tool functionality that will allow women to fully understand their birthplace choice options in their local area.
4. Our findings show that over 40% of women do not understand 'risk' as associated with their own circumstances and women report that a poor institutional understanding of 'risk' has hindered their decision-making about their own care. We urge the Maternity Choice and Personalisation pioneers to develop a tool that can adequately explain to women the level of care that they require and remind the pioneers that workforce planning must take into account the time needed for midwives and others to explain this fully.
 - i. The Maternity Transformation Programme must clarify how the approximately 55% of women who annually require complex or intermediate levels of care will still benefit from *Better Births*' personalisation agenda. In particular, we would like clarity on how these women will benefit from the NHS Personal Maternity Care Budget.

4. Postnatal care



Postnatal care in context

Often referred to as the 'Cinderella service' of maternity care, the delivery of high quality postnatal care continues to prove challenging for commissioners and providers of maternity services. National surveys of women's experiences of their maternity care almost unanimously distinguish the postnatal period as the worst performing and most deprived segment of the maternity pathway.¹ Midwives too tell us that they are often unable to provide the quality of postnatal care that women and their families need, as they are too often forced to cut back on the time they spend with women to meet the organisational constraints of the service elsewhere.² This is unsurprising when we consider that on average in England only 8.5% of a woman's total maternity care budget is spent on her postnatal care,^{1,3} a percentage set to decline further still over the coming years.⁴

Women require postnatal care for a variety of often interconnected reasons, the most common being help with feeding their baby, bonding with their baby, caring for their baby, maintaining their own mental wellbeing, and taking the right action on their own physical morbidities or potentially life threatening conditions. These support needs are widespread as many women will experience a health problem in the immediate postnatal period (6-8 weeks), with some experiencing perinatal health issues for even longer. If these women do not get the support they need their physical and mental health can deteriorate. This point cannot be emphasised enough. Seventy-five per cent of maternal deathsⁱⁱ occur in the postnatal period, the majority of which occur in the days following the birth.⁵ If the NHS is to halt this unacceptable trend then postnatal care, in the community and delivery suite, must be prioritised over and above what is currently being provided.

NICE Guidance is prescriptive about the care women should receive from their midwife during the postnatal period: women should see a midwife as often as they require, their care should be personalised to their individual needs, they should develop and regularly review with their midwife a postnatal care plan that includes plans for feeding their baby, they should be asked about their emotional or mental wellbeing at each postnatal contact, and they should have a postnatal check about six weeks following the birth of their baby.^{6,7}

Studies consistently show that, like the rest of the pathway, a clear majority of women report satisfaction with their postnatal care. However, a sizable minority of women report that some or all aspects of their postnatal care have failed them. Contrary to clinical guidance, anywhere from one-fifth to one-quarter of women do not see a midwife as often as they need to postnatally. It is clear that pressures on the midwifery workforce are negatively impacting on postnatal care in hospital as well as in the home or community. When the RCM asked its members what the most significant factor was in determining how many postnatal visits an individual woman would receive, 65% of them answered 'organisational pressures.'² Only 23% of midwives said that 'women's needs' determined how many visits women received.

Even though women want continuity of carer postnatally just as much as they do antenatally, providers consistently undervalue continuity in the postnatal period and this is reflected in their workforce planning and women's experiences. The CQC recently reported that only 28% of women will see the same midwife in their postnatal appointments⁸ and the RCM reported that 50% of women will never have previously met the midwife caring for them in the postnatal period.² This lack of continuity fosters a situation where women can be on the receiving end of conflicting advice or information on things like feeding, caring for their baby, or caring for themselves. It also means that women with more complex social needs have to discuss their care with strangers who may be unaware of their history.

ⁱ For women that require standard care, as of 2014.

ⁱⁱ This definition refers to the death of a woman while pregnant or within 42 days of the end of pregnancy.

In particular, support for perinatal women with mental health problems continues to be a challenge for providers and commissioners. As of 2014, only 3% of CCGs had a perinatal mental health strategy in place and most NHS trusts do not provide any perinatal mental health service.⁹ There are no specialist mother and baby units in Wales, meaning that parents must travel to Birmingham, Bristol, or elsewhere to receive treatment, far from family networks, or seek treatment separated from their baby. Recognising this shortfall, the independent Mental Health Taskforce has recommended that NHS England ensure that by 2020/2021 at least 30,000 more women each year have access to specialist perinatal mental health services and NHS England has recently allocated funds specifically for the development of perinatal mental health community services.¹⁰ In March 2016, the Welsh Government pledged £1.5 million for community-based specialist mental health services for women with perinatal illnesses, their babies, and their families.¹¹

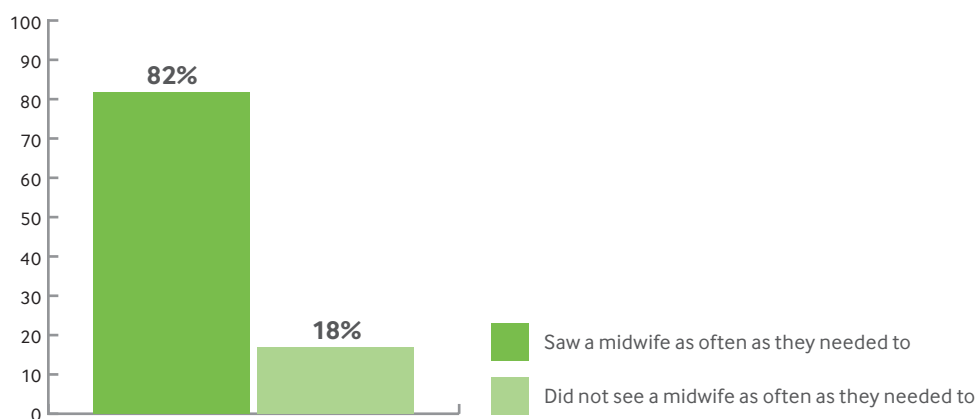
What does *Better Births* say?

Better Births places postnatal care front and centre, pledging 'better postnatal and perinatal mental health care to address the historic underfunding and provision in these two vital areas...' In particular, it endorses the recommendation from the Mental Health Taskforce for an increased investment in perinatal mental health services. *Better Births* also reiterates NICE Guidance which stipulates that women need to see a midwife as often as they require postnatally and calls for all postnatal visits to be extended by 10 minutes, which in practice can be distributed as midwives see fit. It does not comment on an acceptable average length of postnatal visits, which may make the call to extend their length by 10 minutes difficult to measure or benchmark. *Better Births'* recommendation for a continuity of care model of midwifery staffing (as outlined in Chapter 2) aims to increase continuity, consistency, and personalisation in the postnatal period as well.

Our findings

We asked women whether in the weeks following birth they saw a midwife as often as they required. We found virtually no change from when we asked this question four years ago: a clear majority of women (82%) saw a midwife as often as they needed to, while a sizable minority (18%) did not.

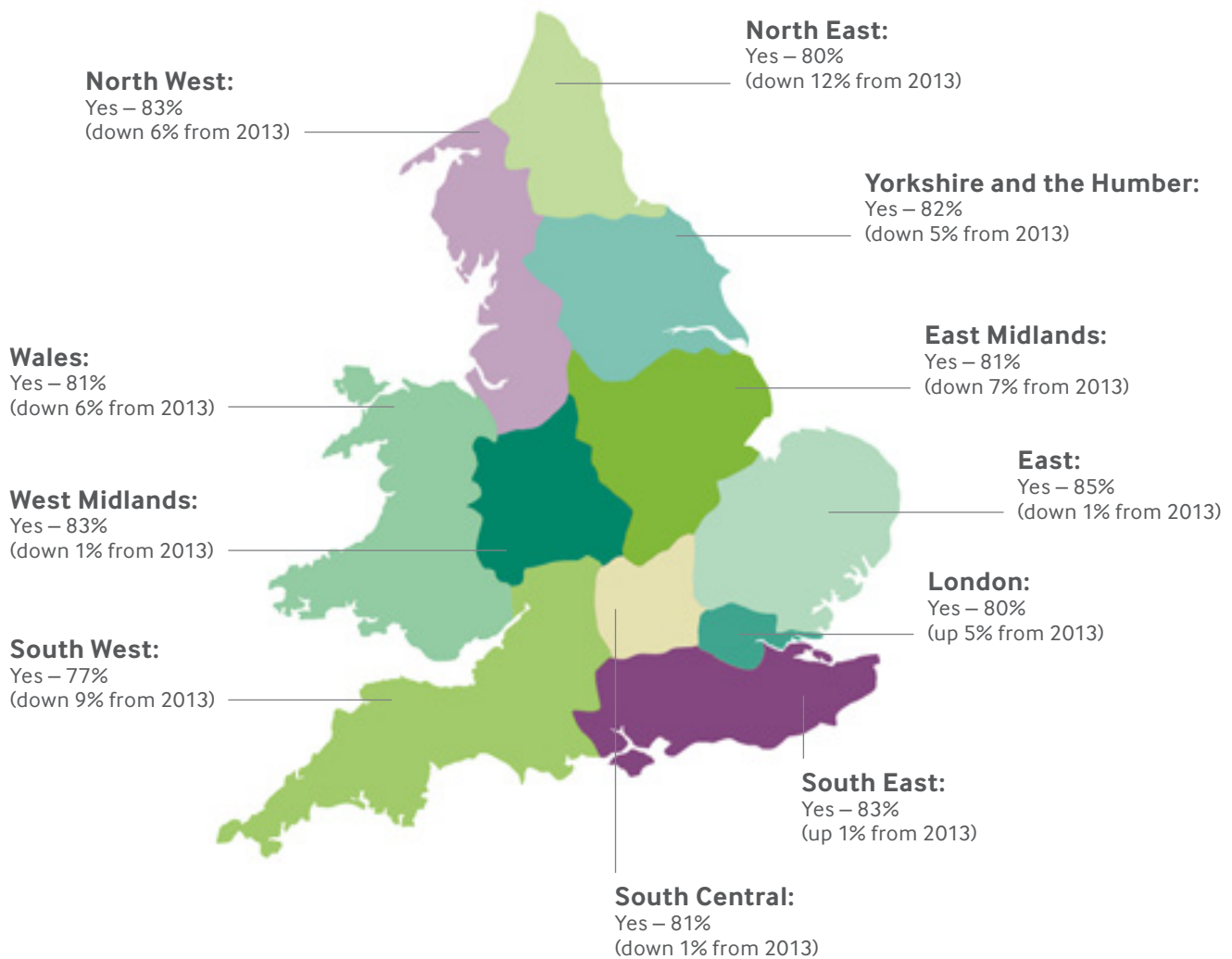
Q: In the weeks following birth, did you see a midwife as much as you needed to (either during home visits or going to a clinic yourself)?



Four years ago we found that there was a postcode lottery of postnatal care, where women in London reported a noticeably lower satisfaction with the provision of postnatal services than women elsewhere. Our findings this year, conversely, show that satisfaction in London has increased, while in almost every other region (with the exception of South East England) satisfaction has decreased. Of particular notice is the North East of England which went from being the top performing region to the second worst performing.

In line with other surveys, multiparous women were more likely to say that they saw a midwife as often as they required (84%) compared to primiparous women (80%), suggesting that there may be some merit to midwives taking this finding into account when they evaluate the respective postnatal care requirements of the women in their care.

Q: In the weeks following birth, did you see a midwife as much as you needed to (either during home visits or going to a clinic yourself)?

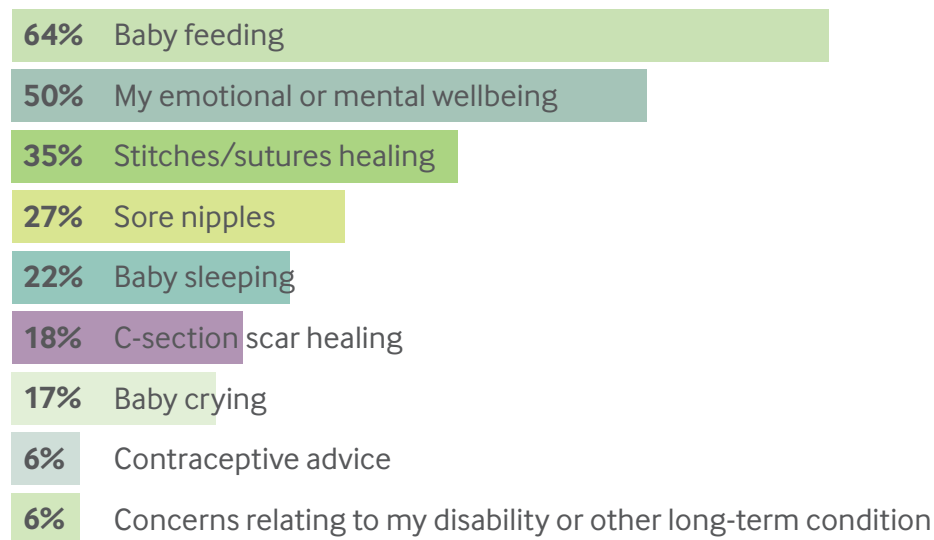


“ Home visits postnatally were undertaken by midwives I had never met before. It’s a very vulnerable time to let strangers into your home and talk intimately with them ”

– Second time mum who gave birth in 2015,
South West England

We also asked women what questions or concerns they wanted to raise that were missed by not being able to see a midwife as they required. The responses clearly show that women had a broad range of concerns that they wished to raise with their midwife, but were unable to, spanning the wellbeing of their baby and themselves. Nearly two-thirds had concerns about baby feeding, a finding that is particularly concerning given the low numbers of women in the UK that are still breastfeeding six to eight weeks following birth.¹²

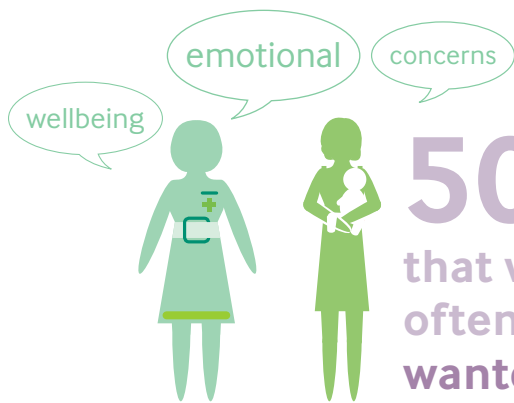
Q: What question or concern did you want to raise that was missed by not being able to see a midwife?



Baby feeding: The greatest area of unmet support for both primiparous and multiparous women was baby feeding; nearly three-quarters of first-time mums and half of those who had already had a baby indicated that they would have liked to raise this issue with their midwife, but were unable to. On face value, this difference in level of need is unsurprising; women who have already had a baby probably would have also received advice and support with feeding during their previous pregnancies. This finding demonstrates, however, that it would be wrong to assume that women do not require support with feeding with second and subsequent babies.

Mental and emotional wellbeing: The second most common concern that women needed more support with postnatally concerned their mental or emotional wellbeing, with 50% of the women who did not see a midwife as often as they required postnatally indicating that they needed more support for this reason. Eighty-five per cent of women that we polled overall said that, in accordance with NICE guidance, they were asked about their emotional or mental wellbeing during their postnatal appointments; 87% of these women saw a midwife as often as they required postnatally.

However, for the 15% of women (n=350) who say that they were not asked about their emotional or mental wellbeing during their postnatal appointments, 47% indicate that they did not see a midwife as often as they required postnatally. Of those, 64% say that they wanted to see a midwife due to concerns over their emotional wellbeing. This finding shows the vital role that the midwife plays during the postnatal period when she is able to ask the mums in her care about their feelings and ability to cope. This is also especially troubling in light of the finding that only 47% of midwives have the time to adequately discuss mental health issues with women in the postnatal period.²



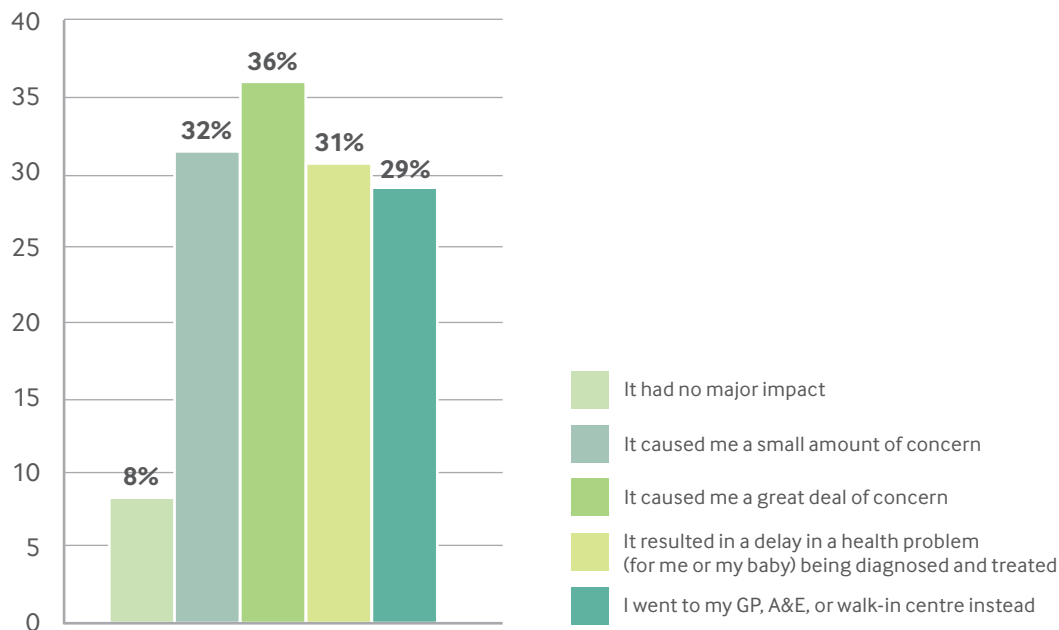
50% of women
 that were unable to see a midwife as
 often as they required postnatally
 wanted more support with their
 mental or emotional health

Midwives need to have the time to discuss this important topic with women adequately and we remain hopeful that *Better Births'* call for each postnatal appointment to be extended by 10 minutes will see improvements happen in this area. We caution, however, that with no national standard setting out the appropriate length of each postnatal contact, trusts and boards will need to first establish their own benchmarking rate from which they will then improve.

What is the impact of not seeing a midwife as you require?

We also asked women to consider the impact on themselves and their baby when they were not able to get the support that they needed on any of those above issues. For the overwhelming majority of women, not seeing a midwife was a cause of concern, with over a third saying it was a cause of 'great' concern. For a significant portion, not seeing a midwife resulted in a delay in a health problem for them or their baby being diagnosed and treated and 29% said they were forced to turn to other services in the NHS instead to get the help they needed.

Q: What was the impact of not getting the advice needed from a midwife?



Clearly, it is a false economy to prioritise other elements of maternity care at the expense of postnatal care. Lack of sustained investment over the years has meant that the burden of caring for women postnatally is being transferred from maternity staff onto other, often also overstretched, areas of the health service, where workers have little appreciation of their needs. This is only compounded by the fact that this service has in many respects already been displaced once before from the midwifery workforce onto maternity support workers due to budget constraints and staffing shortfalls. While maternity support workers play a valuable role in supporting midwives to deliver high quality care, they are not meant to be deployed as a substitute for time with a qualified midwife.

What women said about postnatal care

Postnatal care was the second most commonly criticised issue that women wrote about, only surpassed by lack of continuity of carer. However, if concerns about infant feeding are included in this category, then postnatal care is the number one issue that women wrote about when we asked them to comment on the quality of their care.

Women commented in large number on the poor quality of postnatal care in hospital, often linking it to staff shortages or problems of organisation. Some women spoke about how the postnatal care in hospital violated their dignity or compromised their safety:

'The aftercare in hospital was awful. I felt very alone and was in a lot of pain. It makes me feel very nervous about doing it again.'

'The poorest level of care was in the postnatal ward where they were short-staffed. Changing staff wouldn't know my history/situation, I was unsupported with breastfeeding and made to give my baby a bottle...'

'Postnatal care within the hospital was definitely where I felt the real problem lies. The staff are far too stretched to give you any level of care at all. I felt abandoned...'

'Postnatal care should be better staffed and midwives should not have to rush mothers and babies out of the hospital, this was when I was most disappointed with my care, but it is not the midwives' fault; they were clearly understaffed and pressured to move us on.'

'We didn't get any breastfeeding support at the hospital. I have struggled with PND since the birth. I don't blame the midwives! They were working so hard, there just wasn't enough of them to go round.'

Women commented in large number on the difficulties they had with feeding, often linking it to lack of continuity of carer or consistent advice:

'I saw four different midwives at home once baby was born. They all had slightly different opinions on feeding. I would have liked to see just one midwife for consistency, ideally the one whom most of my antenatal appointments were with.'

'I felt very saddened to realise that the midwife isn't allowed to have much contact or provide support in the postnatal appointments as that is done by the assistants... Early signs of postnatal depression were missed and I feel it was largely because the assistants didn't know me prior to giving birth so had no knowledge of who I was, my situation, or my mood.'

'I wish I had had fewer midwives....same with establishing breastfeeding. I've never had so much different information, it was overwhelming.'

Women commented on the challenges they faced with their mental or emotional health during the postnatal period:

'The only time my emotional health was asked about was at the check with the GP six weeks post birth. I was diagnosed with PND when my son was 14 months old.'

'It would be great to have had more at home postnatal care. This was my second category 1 emergency C-section and physically and emotionally I was extremely upset and in need of extra care. I have had postnatal depression and I do not feel there is enough support postnatally.'

Women commented on how their partners were treated:

'Post birth it was important for me to have my husband with me to support me in recovery & to help care for our baby. The wards were poorly suited to allow this & I gather that fathers are no longer allowed to stay on the ward. This is a shame.'

Women commented on the health of their baby or themselves:

'Better aftercare post-birth [is needed]. I had a retained placenta for four months that was not picked up.'

'My daughter suffered from tongue-tie which despite me and my husband asking to be checked for, we were told it did not form a part of the checks and therefore we could only be referred for a follow-up appointment. The appointment came through eight weeks later. In the mean-time we'd got the problem solved privately.'

'I was admitted to the postnatal ward for sepsis and severe mastitis at 10 days postpartum and the care was very poor....Due to severe shortages in midwifery staff my antibiotics were delayed each time.'

Women commented on how they either had no home-visits from their midwife, or how their appointments were difficult for them to attend:

'I received a phone call the day after I was discharged from hospital. I didn't want to cause a fuss but would have really appreciated a home visit. I suffered with PND. I kept thinking I would get better but I didn't and it took me a good few weeks to build the courage to visit the GP.'

'I had to travel to a midwife led unit a 10 minute drive away for each appointment which is hard when you've had a C-section so can't drive and have a toddler as well. I had to rely heavily on other people to help me get to almost daily appointments whether midwife, GP, or hospital due to post-birth complications.'

Summary

For too long postnatal care has been underfunded, undervalued, and underperforming for women and their families. Despite clear and prescriptive guidance outlining what makes high quality postnatal care provision, too many women are still not getting the support they need at this crucial time. This has consequences. We know that the clear majority of all maternal deaths that occur in the UK do so during the postnatal period, yet midwives tell us that because of workforce pressures it is the needs of the organisation, and not the needs of women, that determines how many postnatal visits women receive. This is not safe care.

Our findings show scant progress from four years ago, with almost 20% of women still reporting that, contrary to NICE Guidance, they were unable to see a midwife in the postnatal period as often as they needed to. These women required more support for a wide range of issues pertaining to their health and the health of their babies, most notably with baby feeding and for their emotional and mental wellbeing. We found that for these women the impact of not getting the help they needed from a midwife was significant, with most women saying it caused them some level of concern and a third saying that it resulted in a delay in a health problem (for them or their baby) being diagnosed and treated. Twenty-nine per cent of these women were forced to turn to another part of the NHS to get the postnatal care that they required.

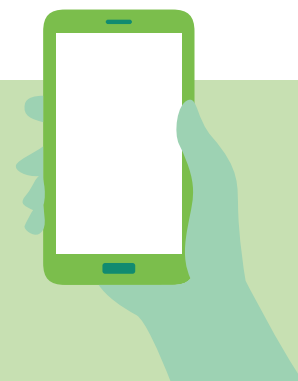
The recommendations outlined in *Better Births* for a continuity of carer model of staffing and for postnatal appointments to be 10 minutes longer are meant to ensure a greater level of consistency in the postnatal period and should facilitate midwives in the community to provide a more personalised level of care. We do caution, however, that as there is no nationally agreed standard for length of postnatal care contact, trusts and boards will need to establish their own benchmarking rates before they can move forward with this recommendation. Additionally, as reiterated elsewhere in this report, a continuity of carer model of staffing for the postnatal period will only work if midwife teams are staffed and organised appropriately and midwives are not pulled out of postnatal care and into intrapartum care as a matter of course. The commitments made by the Mental Health Taskforce and the Welsh Government regarding increased investment in perinatal mental health services are necessary, welcome measures and must be implemented as soon as possible.

RECOMMENDATIONS

Commissioners must ensure that the postnatal period is funded adequately, organised effectively, and staffed appropriately if the wide-ranging ambitions of the NHS to reduce maternal mortality, halve neonatal deaths and rates of stillbirth, and give every child the best start in life are to be realised.

1. We endorse *Better Births*' recommendation that, as per NICE Guidance, women should see a midwife as often as they require postnatally. To facilitate this:
 - i. We recommend that as a minimum standard all women should receive a postnatal home visit by their midwife at least twice. Any subsequent midwife-led postnatal appointments should be conducted at a time and place most convenient for the woman and her family. The location of each woman's postnatal visit should be discussed as part of her personalised care plan.
 - ii. Commissioners need to agree a locally specific acceptable average number of postnatal visits that is appropriate for their population, which should be monitored and updated annually. This average should be based on annually collected feedback from service users about the frequency and quality of their postnatal care contacts.
 - iii. Women should know or have previously met their postnatal midwife, which means that the midwife must be the woman's 'named' midwife or a member of the small team of midwives that is responsible for her.
 - iv. Providers must use an accredited workforce planning tool to make sure their staff complements are adequate for all parts of the pathway, including the postnatal period.
2. We endorse the Mental Health Taskforce's call to provide 30,000 more women with access to specialist perinatal mental health services annually by 2020/2021. In order to facilitate this, we urge commissioners to devise and publish a regional perinatal mental health strategy to ensure that referrals to these services are appropriate and timely.
3. We call on the Welsh Government to urgently review the provision of care for women requiring inpatient mental health care. This is likely to be best provided for with a mother and baby unit, but a more localised approach can be adopted if shown to optimise care. This solution should be in place within three years.
4. We call on NHS Improvement to investigate the full cost of postnatal care, both to maternity services and the wider NHS, and take appropriate steps to adapt the tariff to better reflect the resources required to deliver safe, efficient care at this crucial time.

5. Using digital technologies



“ *Urgent action is a moral imperative where paper is the currency of clinical practice* ”

– Tim Kelsey, Chair of the National Information Board in an address to NHS leaders at the NHS Innovation Expo Conference, September 2015

Digital technology has relevance for every chapter in this report; its appropriate and responsible use can complement continuity, facilitate choice, pre-empt red flag events, and save midwives valuable time on administration that is better spent providing care to women. By putting women in the driving seat of their own care planning, digital technology can facilitate a maternity service that proactively responds to the unique circumstances of every woman. Furthermore, by enabling midwives to work remotely more effectively, digital technology can foster a system that can adequately support the delivery of healthcare in the community.

Successive Governments have recognised this transformative potential, not just in midwifery, but across the NHS and social care sectors and have pledged time and again to harness the tools of the information age to cut costs, improve care, and empower patients. Most recently, the NHS 5YFV placed the digitisation of patient records at the heart of its vision for a sustainable, twenty-first century health service, promising an interoperable paperless patient record by 2020.¹ The National Information Board has been tasked with the delivery of the 5YFV’s digital ambitions and has recently published its framework for action, detailing a ‘new consensus’ that puts patient control and patient access to their own records at the centre of the NHS.² Following this, in February 2016, the Secretary of State for Health Jeremy Hunt committed £4.2 billion for the development of digital technologies for use by the NHS.³ The Welsh Government has also prioritised digital innovation as part of the new digital health and care strategy for the NHS and social care in Wales.⁴

Despite these repeated commitments from the Department of Health and its arms-length bodies, there is widespread consensus that healthcare lags consistently behind most other sectors when it comes to the use of digital technology. Practically this has meant that while technology has completely transformed the consumer experience more broadly, the health consumer experience remains stubbornly stuck in the past. Today only 2% of the UK population uses the internet to contact their GP and less than 4% of GP practices offer patients online access to their records.⁵ Top-down, national approaches to patient record digitisation in the NHS have infamously ended in failure, wasting billions of pounds and squandering good will. Localised approaches – characterised in the 5YFV as ‘letting a thousand flowers bloom’ – have subsequently failed to drive systemic change.¹

It is a vast understatement to describe this as a missed opportunity, particularly for the maternity service. Unlike the majority of NHS and social care users, maternity service users are mostly ‘digital natives’ who are already using technology to organise many aspects of their everyday lives and gather information, including about their healthcare needs. The National Perinatal Epidemiology Unit found that 76% of pregnant women in the UK currently use the internet to access information about their pregnancies⁶ while similarly an Australian study found that 75% of pregnant women are using specific pregnancy apps on their mobile phones or tablets.⁷

There are currently hundreds of pregnancy or baby-related apps available for women and their families to download, most of which are free or available at a very low cost. The majority of these apps are designed for the American user and in 2015 *The New York Times* reported that pregnancy apps were more popular than general fitness apps and four out of the top ten paid 'medical' apps available in the Apple iTunes store were baby related.⁸ These apps have been downloaded millions of times.

In the UK a number of third-sector organisations and entities, including NHS Trusts, have developed apps for women and their families to use in planning their care. Compared to other health apps, user uptake is high and continuing to climb. Feedback from women using these apps has been positive, with many indicating that the apps have made them feel more confident and knowledgeable.⁹ Encouragingly, these apps are also reaching socially disadvantaged women who often prove harder to reach via traditional health communication channels.

Despite UK organisations stepping in to fill the gap, it is very likely that women in the UK are using apps that were not designed with the UK user or midwife-led care in mind. The effects of this are potentially harmful, counterproductive, or confusing for women as many of these apps are designed for navigating private or insurance-based healthcare systems with different professional groups providing different types of care than in the UK. At this stage it is impossible to know where women in the UK are getting their digital information from. In the absence of a single NHS accredited digital tool women may be turning to inappropriate sources of information in high number. The RCM public health project found 'Women are telling us that they don't know which information is correct or safe when surfing the net.'¹⁰

Additionally, on the provider side, the potential for digital technology to enable midwives to provide a better standard of care and work more efficiently is great. A majority of midwives work in the community and we know that connectivity can be a challenge in this setting. In particular, digital technologies have the capacity to mitigate some of the challenges inherent in remote team-working. It is no coincidence that the Nuffield Trust, in its report on digital healthcare, singled out the example of midwifery when discussing the benefits that digital technology can bring, highlighting how remote access to clinical records at Imperial College Healthcare Trust saved five hours per midwife per week (the equivalent of £9,000 per midwife, per year) and saved £600 per year per midwife of travel costs.⁵

Despite these obvious benefits, *Support Overdue* (2013) found a maternity service overly reliant on paper, where record keeping was patchy and unstandardized. This made it difficult for trusts and boards to assess unit closures, staffing needs, and other care quality indicators. The very frequent mention of hand-held notes and ad-hoc paper records led us to endorse the recommendation by the Welsh Public Accounts Committee for a 'consistent and robust electronic data collection process for maternity services.'

What does *Better Births* say?

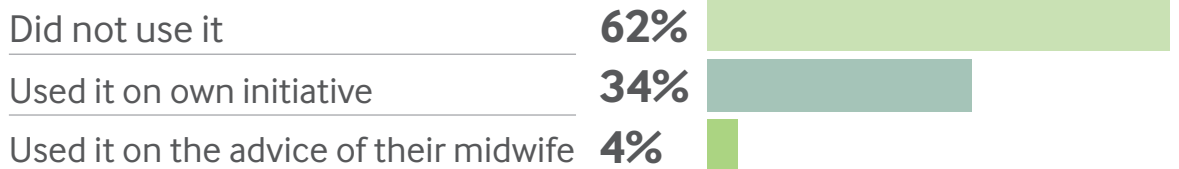
Digital technology forms a key part of how *Better Births* envisions the delivery and experience of maternity care. It recommends that every woman has her own digital maternity tool, which will enable them to access unbiased, evidence-based, and locally specific information about their own circumstances and the choices available to them (including their personal care plans and their Maternity Care Budget). Alongside, and in many ways complementary to, the digital maternity tool, *Better Births* also calls on NHS England and the National Information Board to prioritise the national roll out of interoperable maternity records for professional use by 2020. This interoperable record must provide an interface with the woman's digital maternity tool so that she can access her own records as well.

Our findings

We asked women if they used any specific digital technologies, such as an app for a mobile phone or tablet, when planning their care.

Use of technology

A majority (62%) say they did not. Of the 38% who say that they did, only 4% did so on the direct advice of their midwife, while the rest did so based on their own research or recommendations from others. This means that a substantial number of women are currently using digital technologies as provided or recommended by external parties, not their midwife, making it difficult to ensure that the information they are receiving is of high quality.



What are women using digital technology for?

Most of the women who used digital technology (65%) used it track milestones, such as when their baby kicked or when they had contractions. The next most common reason why women used digital technology was to connect to online forums to share and receive information with others (50%), followed by using it to access information about diet, alcohol, smoking, or other health issues (32%).

Much smaller minorities of women used digital technologies in the way that *Better Births* envisions: in an interoperable way where women can book appointments (5%), access their records (5%), communicate directly with their midwife (2%), or feedback on services they received (2%).

Q: What did you or your midwife use these digital technologies to do?

| | |
|--------------------------------------------------------------------------------------------|-----|
| To book my antenatal appointments | 5% |
| To access my maternity records or notes | 5% |
| To track milestones such as when my baby kicked or when I had contractions | 65% |
| To communicate directly with my midwife, other midwives, or other healthcare professionals | 2% |
| To make a complaint or provide feedback about services I received | 2% |
| To access information about diet, alcohol, smoking, or other health issues | 32% |
| To connect to online forums where I was able to share and receive information with others | 50% |

Using digital technology on your own initiative: In terms of impact, we found that the current digital tools women are using under their own initiative do not impact on the number of birthplace choice options that women said were realistic for them. Furthermore, these women were just as likely to have their birthplace choice realised as those that did not use any technology.

These women do report a slightly overall better antenatal experience than women who used no digital technology, with certain outliers that point to specific areas where it is apparent that digital technology is making a difference. For example, 39% of these women report that they drew up a personalised birth plan with their midwife, compared with only 30% of women who used no digital technology at all. However, other differences are much smaller, suggesting only a marginal correlation between using digital technology and satisfaction with antenatal care.

When compared to the cohort as whole, these women also report a very slight improvement in their experience of labour and birth.

The real difference in quality of care stems from whether or not midwives are using or are directing women to use digital technologies, as opposed to whether the woman is using them on her own or not using them at all.

We asked women if their midwife used any specific digital technologies and/or encouraged them to use any when planning their care. In keeping with the low uptake of digitisation, we found that only 7% of midwives used and/or encouraged women to use any. Following this small sample through the maternity pathway (n=167), we found that these women report a noticeable difference in the availability of birthplace choice. These women are more likely to report that they had a choice of an alongside midwife-led unit, freestanding midwife-led unit, and homebirth and less likely to report a choice of an obstetric unit only. These women are also 10% more likely to have made a choice of birthplace and then have that choice realised (65% compared to 55%) and they are 5% less likely to report that they had no choice at all.

There are also key differences in what these women and their midwives are using digital technology to do, when compared to the women who used it on their own initiative.

Midwife using and/or encouraging digital technology use:

Track milestones: 48%

Access information about diet: 35%

Connect with others: 34%

Access maternity records or notes: 16%

Book appointments: 14%

Communicate directly with midwife: 5%

Women using digital technology on their own initiative:

Track milestones: 64%

Access information about diet: 31%

Connect with others: 53%

Access maternity records or notes: 3%

Book appointments: 3%

Communicate directly with midwife: 1%

As seen in the chart above, women whose midwives used or encouraged them to use digital technology were much more likely to use the kinds of interoperable technology that the Nuffield Trust characterises as 'patient portals' compared to women who used digital technology without the advice of their midwife.

This may help explain why the former group of women report a very noticeable difference in the quality of their antenatal care compared to the cohort as whole:

| | Midwife using and/or encouraging digital technology use: | Entire sample: |
|--------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|----------------|
| My preferences about where and from whom I received antenatal care were acknowledged and acted upon | 62% | 51% |
| I drew up a personalised birth plan with my midwife | 43% | 33% |
| I felt I was treated as an individual | 77% | 62% |
| Midwives had the time to listen to my concerns and answer my questions | 74% | 60% |
| Even if I had not met them before, the midwives I saw had read my notes and knew my history | 51% | 39% |
| I understood any risks relating to my individual circumstances (such as a long-term health condition) and was able to discuss those openly | 68% | 58% |
| My midwife supported me to lead a healthier lifestyle in general | 42% | 26% |

It is clear that midwives who use or encourage women to use specific digital technologies are able to provide women with a more tailored, personalised level of care than midwives who do not. These women are considerably more likely to report that they achieved the 'choice guarantee' of place of antenatal care, that they drew up personalised birth plans with their midwife, and that they felt they were treated as an individual. They were substantially more likely to report that midwives had time to listen to their concerns, and that even if they had not met them before the midwives they saw had read their notes and knew their history.

Interestingly, women were 10% more likely to say that they understood the risks associated with their own circumstances if midwives used or encouraged them to use specific technologies. These women were also markedly more likely to say that their midwife supported them to lead a healthier lifestyle than the cohort as a whole. While only limited inference can be taken from this small sample, it does suggest that digital technology works particularly well in helping women to make healthier lifestyle choices.

These women also reported a more positive labour and birth experience than the sample as a whole, responding more positively to many of the questions we asked about being able to make decisions and whether or not their personal needs and preferences were accounted for.

Friends & family test

If a loved one of mine were giving birth, I would want them to receive the same level of care I got

Whole sample

71%

Midwives used and/or encouraged digital technology use

80%

Summary

Every day that NHS maternity services do not capitalise on the potential benefits that the smart use of digital technology can afford is another day wasted. Maternity service users are mostly digital natives, eager for digital content that is reliable and relevant to them and midwives in particular would benefit from technologies that allow professionals to work in the community more effectively. In the absence of an NHS accredited digital tool, women are turning to private providers in high numbers, which makes the information they are using difficult to vet. This is counterproductive and potentially unsafe.

Our findings show that 38% of women are using a specific digital technology, such as an app for their mobile phone or tablet, when planning their care. Only 4% of them, however, are using a specific technology as recommended by their midwife; the rest are using it based on their own research or recommendations from others. Sixty-two per cent of women are not using any digital technology at all.

Women that are using digital technology on their own initiative are using it primarily to track milestones, network with others, and learn about lifestyle factors. Only a very small percentage of these women are using technology as a portal to access their own records, communicate with their midwife, or book their appointments. The real noticeable difference in terms of quality of antenatal care, birthplace choice, and experiences of labour and birth comes when we follow the small group of women whose midwives used or encouraged them to use specific digital technologies compared to women whose midwives neither used nor encouraged them to use anything. Those belonging to the former group report a markedly better quality of antenatal care, a better quality of care during labour and birth, were more likely to have midwife-led birthplace options and were more likely to have their birthplace choice met.

These women, or their midwives, were much more likely to use digital technology in the interoperable ways envisioned in *Better Births*. This shows that there is a real need for a digital tool that incorporates interoperability capabilities, alongside devices which allow women to track milestones, access patient networks, and learn. Digital technology is also proving to have noticeable impact on women's understanding of the level of care they require (standard, intermediate, or high) and is also proving a successful aid in helping women make healthier lifestyle choices.

RECOMMENDATIONS

Safe, personalised, and efficient care cannot be delivered without the deployment of digital technology in ways that work for midwives and the women they care for. We endorse *Better Births*' recommendation that all women should have access to technology to help them be full partners in designing their care.

1. We urge the Maternity Transformation Programme's 'Harnessing digital technology' work stream to prioritise the development of a holistic digital tool that includes the types of functionality that is available via independent apps as well as NHS 'patient portal' features. The tool must be available in multiple languages and across multiple hosting platforms.
2. We endorse *Better Births*' recommendation that health professionals use electronic, interoperable maternity records that women can access and input data into and ensure that support is available to enable women to take advantage of these tools if they wish. We urge the Maternity Transformation Programme's 'Harnessing digital technology' work stream to formulate a national standard for interoperability in maternity records which can be adapted locally or regionally as providers see fit.
3. We urge Commissioners to invest in the development of IT systems for their providers which can be used for the electronic monitoring of unit and homebirth service closures/suspensions, staff levels, staff rotas, red flag events, and the availability of facilities.
 - i. A crucial component of this will be to invest in tools that allow midwives to work more efficiently in the community within the new continuity of care models recommended by *Better Births*. We, therefore, urge providers to develop an electronic training or support tool for midwives as they transition to this type of working and ensure that midwives have protected time to master the learning curve.

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