

The state of maternity services in England

Policy briefing

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Author: Giuseppe Paparella, Policy Officer

Picker Institute Europe

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Picker Institute Europe

Buxton Court

3 West Way

Oxford, OX2 0JB

England

Tel: 01865 208100

Fax: 01865 208101

Email: Info@PickerEurope.ac.uk

Website: www.pickereurope.org

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Introduction

Maternity services in England attract a high level of public and political interest. This is understandable: having a baby is the single most common reason for hospital admission in England (NHS England, 2014).

Pregnancy, the birth and the early weeks of a child's life is a crucial period for the future of the family and of the child (Michael Marmot, 2010). This period has a major influence on physical, social, emotional and language development (Department for Education & Wave Trust (Charity), 2013; Michael Marmot, 2010). For mothers and the wider family, pregnancy may be the first time they have sustained contact with health services and so presents the ideal opportunity to influence their life style and to maximize their life chances. As noted in the 2016 National Maternity Review, it is therefore vital that families are supported by high quality maternity services which cater for their needs and support them to begin their new lives together (National Maternity Review, 2016).

In 2014 there were 664,543 births in England, compared to 566,735 in 2001 (National Maternity Review, 2016). According to statistical forecasts, by 2020 the number of births will increase overall by 3% to 691,038 (Office for National Statistics, 2015b). Following successful campaigns to encourage mothers to give birth in hospital in the 1950s and 1960s, the vast majority of births take place in hospital: more than 97% as of 2014. The demographics of first time mothers have changed in the past decades: there has been a steady increase in average age from 27.2 years in 1982 to 30.2 years in 2014. The proportion of women who have conditions such as diabetes in pregnancy has increased. In line with these trends, a higher proportion of births involve more complex care, which requires risks to be managed and more interventions to be delivered (National Audit Office, 2013).

In England, maternity services are provided by 136 NHS trusts plus 15 mother and baby units provided by mental health trusts. There are four broad types of settings for care in labour and birth: at home, freestanding midwifery units (FMU), midwifery units (AMU) and hospital obstetric units (OU). In 2012, 87% of births took place in NHS obstetric units. Although 96% of NHS trusts offered home births, only 2.4% of births were at home (National Audit Office, 2013).

Medical Personnel in maternity services comprises approximately 1,970 consultants and 1,630 trainees working in the Obstetrics and Gynaecology specialty in England (National Maternity Review, 2016). Data from the Health and Social Care Information Centre (HSCIC) shows that in 2014 there were a total of 21,517 full time equivalent midwives working in maternity services based on a head count of 26,139 (National Maternity Review, 2016). Nevertheless, the Royal College of Midwifery estimate that this represents a shortfall of around 2,600 from the number required to guarantee good quality care (The Royal College of Midwives, 2015).

Despite the increasing complexity of cases, the quality and outcomes of maternity services have improved significantly over the last decade. Neonatal mortality in England fell by over 20% in the ten years from 2003 to 2013 (National Maternity Review, 2016). Overall, maternal

mortality in the UK has reduced from 14 deaths per 100,000 maternities in 2003/05 to 9 deaths per 100,000 maternities in 2011/13 (Knight et al., 2014). The conception rate for women aged under 18 in England, a key indicator of the life chances of future generations, reduced by almost half, between 1998 and 2013 (Office for National Statistics, 2015a).

However, there is evidence of a need for improvement in several aspects of maternity services. For instance, during the period December 2013 to May 2015 almost half of safety assessments in inspections by Care Quality Commission were either “inadequate” (7%) or “requiring improvement” (41%) (NHS England, 2015). As reported by the most recent NHS Maternity Survey these trends persist to some extent: according to recent findings, only 57% of women said their midwife definitely asked them how they were feeling emotionally during antenatal visits. Similarly, just 54% of women giving birth for the first time felt they were definitely given enough information about emotional changes which may be experienced after the birth (Care Quality Commission, 2016a).

In the following sections, we will focus on the meaning of maternity care and will analyse the main characteristics of maternity services. In addition, we will outline the broader implications of changing quality in maternity care settings. Finally, further actions and policy measures to improve quality of care in English maternity services will be suggested.

Limitations of the analysis

The focus of this briefing is limited to live births. It is not intended to cover abortive outcomes – including miscarriages, stillbirths, baby loss, terminations, and so on – in detail for a number of reasons. Whilst these are common and important aspects of maternity experiences, our focus on healthy babies reflects the availability of data and evidence which inform this briefing. For example, and as highlighted in the key findings of a 2014 review by NHS Improving Quality on the support available for loss in early and late pregnancy, accurate numbers of early miscarriages are unknown as many women are treated in a primary care setting. Comprehensive data can be difficult to find, which impacts on service planning. Crucially, sensitivity around miscarriage and stillbirth makes it hard to capture data in surveys, leaving the parents’ voices unheard by the service (NHS Improving Quality, 2014).

Given the current limitations of the evidence available on abortive outcomes, we highlight the need for more research to explore women’s and families’ experiences of miscarriage, abortion, stillbirth, and baby loss. We urge the NHS to review ways of engaging with bereaved parents to seek more comprehensive and systematic feedback on their experience of care across the care pathways.

What is meant by ‘maternity care’?

Maternity services cover care for women from when they become pregnant through to sign off by their midwife: this is usually around 10 days after the birth but can be up to 6 weeks postnatally. The components of maternity services are typically divided into the three stages of pregnancy, namely antenatal, intrapartum (birth) and postnatal care. In addition, neonatal care can be seen as an extension of maternity care as the baby has not yet been discharged home (Baxter, 2016).

Individuals’ pathways through maternity can vary considerably, with the potential for different levels and types of treatment at each stage. Figure 1, below, provides an outline illustration of this, highlighting different routes into and through pregnancy as well as different outcomes. This serves to demonstrate the range of personal journeys that exist within the broad category of ‘maternity care’: for simplicity, this briefing focuses on the broad stages of care.

MATERNITY JOURNEY

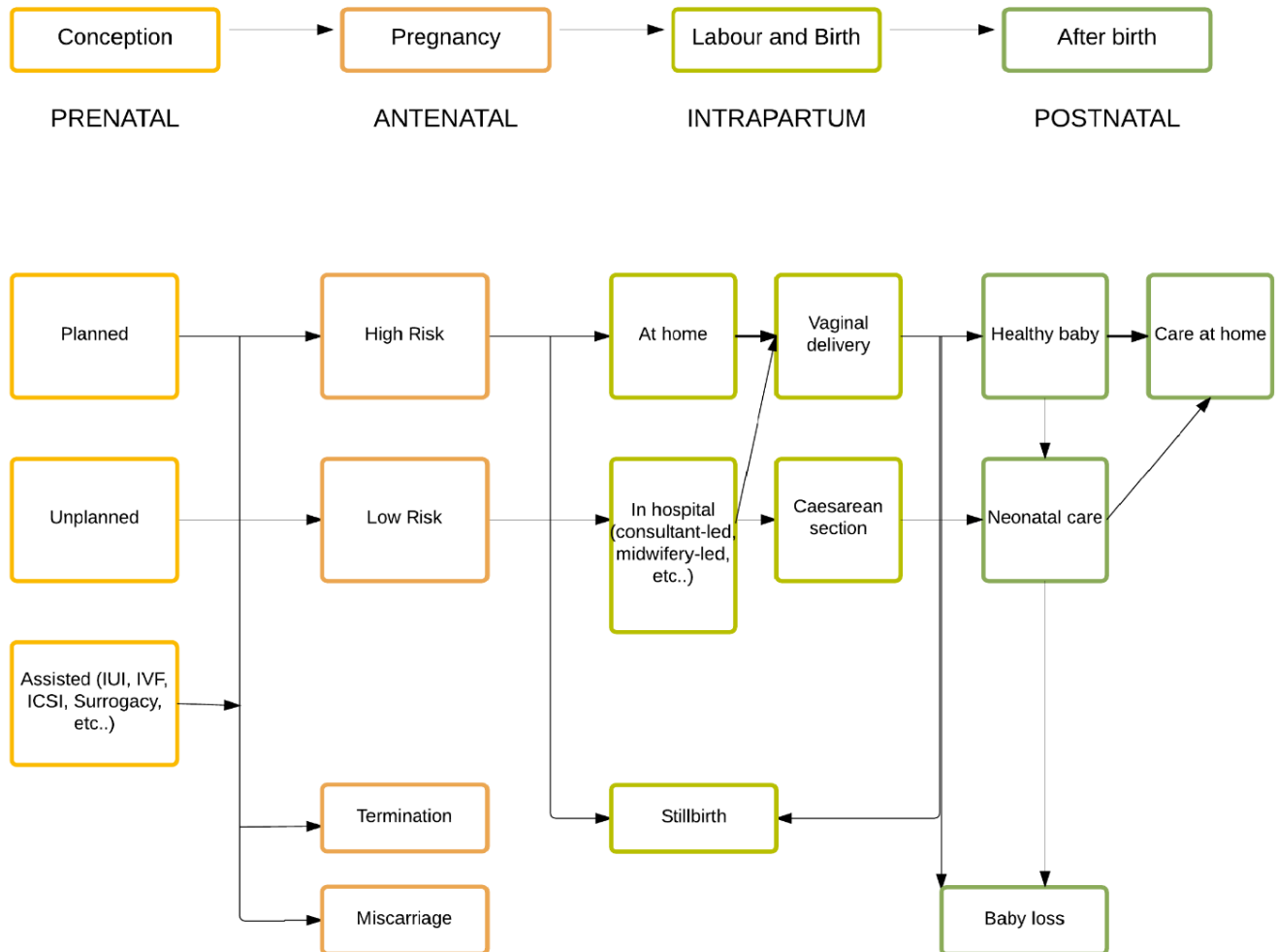


Figure 1: The maternity journey

Antenatal Care

Antenatal care generally commences between 9-12 weeks into pregnancy and the purpose is to support women and their partners during pregnancy and identify potential problems with mother and baby early through detailed history taking and risk assessment. Good antenatal care is essential in providing choice for women. It is important that women and their partners are given the information to enable them to make an informed choice over all aspects of their pregnancy.

Women can be referred to antenatal services by their GP or alternatively they can access antenatal care directly by contacting their midwife when they think they are pregnant.

Antenatal screening and scanning is hospital based and it is crucial that it occurs at defined stages of pregnancy. For women who are assessed to be "low risk", care is typically provided by midwives working from community health facilities, GP surgeries and increasingly from Children's Centres. At Children's Centres, midwives work in partnership with other agencies in areas of social deprivation to try and influence improved health outcomes for mothers, babies and families. If a woman has a higher risk pregnancy or complications then she will typically be placed under the care of a named hospital consultant. Her antenatal care will be provided within an acute trust setting whilst ongoing links with the community midwifery team will usually be maintained. Some hospitals have established Early Pregnancy Units (EPUs) which are midwife/nurse/consultant led clinics that provide assessment and care for women who have problems in early pregnancy.

Intrapartum care

Intrapartum care covers the onset of labour through to immediate care after birth (first, second and third stages of labour). Depending on the needs of a woman and the services available in her local area, a woman will give birth in one of the following settings:

Home birth services

When specific health and safety criteria are met, women can choose to give birth at home. A 'named midwife' who will provide care for the women and their family throughout the pregnancy, labour and postnatal period will be assigned. The named midwife will help the women to develop a tailored and comprehensive birth plan, and be available to provide additional advice and support whenever needed. The named midwife, and usually a second midwife met during pregnancy, will be on hand to attend the homebirth.

Obstetric unit/Team based care

A unit in which care is provided by a team, with consultant obstetricians taking primary professional responsibility for women, particularly including those at high risk of complications during labour and birth. Midwives offer care to all women in these units, whether or not they are considered at high or low risk, and take primary responsibility for women with straightforward pregnancies during labour and birth. Diagnostic and treatment medical services, including obstetric, neonatal and anaesthetic care are available on site.

Alongside midwifery unit

A unit offering care to women with straightforward pregnancies during labour and birth in which midwives take primary professional responsibility for care. During labour and birth the full range of diagnostic and treatment medical services (including obstetric, neonatal and

anaesthetic care) are available in the same building, or in a separate building on the same site should they be needed. Transfer will normally be by trolley, bed or wheelchair.

Freestanding midwifery unit

A unit offering care to women with straightforward pregnancies during labour and birth in which midwives take primary professional responsibility for care. General Practitioners may also be involved in care. During labour and birth, diagnostic and treatment services (including obstetric, neonatal and anaesthetic care) are not immediately available but are located on a separate site should they be needed. Transfer will normally involve car or ambulance.

Depending on the number of units involved, different care pathways during the intrapartum phase may be considered: <http://pathways.nice.org.uk/pathways/intrapartum-care/care-throughout-labour>. NICE has also developed a useful guidance that offers evidence-based advice on the care of women and their babies during labour and immediately after the birth: <https://www.nice.org.uk/guidance/cg190>.

Postnatal care

Most women leave hospital within one or two days of the birth of their baby. Community midwives visit at home generally until the tenth day postnatally (depending on the women's needs). They formally hand over care to health visitors at 10-28 days depending on local arrangements. Women who have had complications may be transferred to a postnatal ward. Care provided should respond to the physical, psychological, emotional and social needs of women and their family in a structured and systematic way. NICE has produced and recently reviewed a guideline about postnatal care up to 8 weeks after birth. The document aims to identify the essential core (routine) care that every woman and her baby should receive in the first 6–8 weeks after birth, based on the best evidence available. According to the guideline, a documented, individualised postnatal care plan should be developed with the woman ideally in the antenatal period or as soon as possible after birth. This should include:

- Relevant factors from the antenatal, intrapartum and immediate postnatal period.
- Details of the healthcare professionals involved in her care and that of her baby, including roles and contact details.
- Plans for the postnatal period.

The plan should be reviewed at each postnatal contact. Planning and regularly reviewing the content and timing of care for individual women and their babies, and communicating this (to the woman, her family and other relevant postnatal care team members) through a documented care plan can improve continuity of care. Women and their babies should receive the number of postnatal contacts appropriate to their care needs (NICE, 2015).

Neonatal Care

Neonatal care is provided for babies who are born prematurely and/or who are experiencing complications. Neonatal care networks have been established since 2004/05 and are the recommended vehicle for providing a more structured and integrated approach to care. Agreed referral pathways should exist across a network to ensure effective arrangements for managing the prompt transfer and treatment of women and babies experiencing problems. They should be designed to ensure that mothers and babies receive care within their local network, in a unit that is at the level appropriate for their needs, as near to home as possible.

Within a neonatal network, different neonatal units will provide different levels of care. Level 1 units provide special care only. Level 2 units provide high dependency and limited intensive care. Level 3 units provide the full range of intensive care and some will also provide neonatal surgery and other specialized services, for example, cardiac. Issues of capacity, transfers and staffing shortages within the neonatal system can result in mothers and their babies being transferred long distances in order to access the right level of care.

Maternity Networks

Networks link groups of health professionals and organisations (from primary, secondary and tertiary care, and social services) with the aim of ensuring equitable and cost-effective provision of high quality, clinically effective care. Managed networks in maternity are relatively less established than neonatal networks but include arrangements for managing the prompt transfer and treatment of women and babies experiencing problems or complications, by ensuring there are agreed referral pathways across the network.

Each stage of care in maternity settings is important: women and families will interact with a broad and varied range of professionals, and all of this together comprises the maternity experience. Communication issues are particularly important in maternity services where there may be multiple handovers depending on the duration of labour; transfers between home settings and hospital, often in an emergency; and referrals between midwives and obstetricians. Failure to communicate information clearly and to ensure that it has been received and understood has been highlighted as a cause of unsafe care (Thomas & Dixon, 2012).

It is essential therefore that there is clear communication and the sharing of information between healthcare professionals to ensure that care provided at different stages is woman focused, family-centred and safe.

Women's experiences of maternity services in England

The latest available evidence on women's experience of maternity services has been provided by the 2015 NHS Maternity Services Survey, the results of which were published in January 2016. The national NHS Maternity Services Survey provides the biggest and most systematic insight into the experiences of women in maternity services in England. The 2015 survey was completed by 20,631 people and found variation in the quality of communication, involvement and information provision for mothers using maternity services (Care Quality Commission, 2016b)

Antenatal care

In 2015, results show that a higher percentage of women saw a midwife as the first point of contact when they realised that they were pregnant than in 2013. The percentage of women seeing a GP in the first instance is steadily decreasing over time. Overall, 74% of women stated that if they contacted a midwife they were always given the help they needed. A further 20% said that they received the help sometimes – leaving 6% who either didn't get the help they needed or were not able to contact a midwife.

As for choice about where to give birth, the results of the 2015 maternity survey show that a considerably greater proportion of women in 2015 were offered a choice of a midwife-led unit or birth centre (41% in 2015 compared with 35% in 2013). Similarly, a larger proportion of women were offered the option of giving birth in a consultant-led unit (18% in 2015 compared with 16% in 2013). Compared to 2013, a higher percentage of women in 2015 felt that they received enough information from their midwives and doctors to help them decide where to have their baby (58% in 2015, 55% in 2013) (Care Quality Commission, 2015).

However, continuity of care in antenatal maternity settings needs to improve significantly. According to survey results, only 36% of women saw the same midwife every time for their antenatal care. Although this is an increase from 2013 (34%), nearly two thirds of women (63%) do not see the same midwife for each appointment. Whilst there may be valid reasons for this, changes in practitioner can be a barrier to effective continuity of care, and ideally women should normally be able to see the same midwife at each appointment if they want to. Continuity of care in antenatal settings is crucial for a smooth experience: the majority of women (73%) who saw the same midwife every time said their midwife was always aware of their medical history during their antenatal check-ups, compared with 21% of those who did not see the same midwife but who wanted to (Care Quality Commission, 2015).

A significant improvement recorded since 2013 was about communication with staff: in 2015, 89% of women said they were spoken to in a way that they could understand. This

is a very slight but significant increase since 2013 (by 1% point). Of those who saw the same midwife at every antenatal check-up, 89% said the midwife always listened to them. Again, a lower percentage (63%) of women who did not have the same midwife all the time but who wanted to reported that they were always listened to. A similar divide is also being seen for women having the opportunity to ask questions: more women who saw the same midwife reported that they always had enough time to ask questions (85%). However, the figure was much lower for those who did not see the same midwife but who wanted to (57%)(Care Quality Commission, 2015).

Intrapartum care (care during labour and the birth)

During labour and birth, 64% of women said they were always able to get a member of staff to help them within a reasonable timeframe if they needed attention. When asked if they, or their partner/companion, were left alone during labour and birth, 75% of women said they were never left alone at any time when they were worried. There was a slight increase from 13% to 14% between 2013 and 2015 in women saying that they were left alone at a time when they were worried during early labour, and a very slight (but statistically significant) decrease in the percentage of women who were left during the later stages of labour (9%) (Care Quality Commission, 2015).

Communication during labour and birth improved significantly in 2015, with a greater proportion of women reporting positive examples than in 2013:

- 87% of women said they received appropriate advice and support when contacting a midwife, which is a 2% point increase since 2013.
- 84% of women said that all staff introduced themselves, which is a statistically significant one percentage point increase since 2013;
- 89% of women reported that during labour and birth they were always spoken to in a way that they could understand (2% point increase since 2013);

A similar upwards trend has been seen also in women's involvement during labour and birth. Since 2007, the percentage of women answering positively to this question has increased year on year, reflecting a slow but steady improvement. According to 2015 data, 82% of women felt that their concerns were taken seriously. Additionally, 75% of women felt that they were always involved in decisions about their care during labour and birth (Care Quality Commission, 2015).

Postnatal care

Survey results from the 2015 NHS Maternity Services Survey reflect a generally improving service in crucial aspects of antenatal and intrapartum maternity care: despite continuing challenges around staffing levels and demand, the majority of women are reporting positive maternity experiences. However, effective user involvement, as a central tenet of person

centred care, is not always being achieved – particularly in terms of postnatal care. Overall, patient experience data – also collected by the National Perinatal Epidemiology Unit in its 2014 National Maternity Survey – suggests that this part of the maternity pathway shows significant scope for improvement. Once mothers returned home, they reported poorer continuity of care and there were some gaps in information and support. In 2015 (Care Quality Commission, 2016b):

- Only 51% of women giving birth for the first time were definitely given enough information about their own physical recovery after the birth;
- Only 28% of mothers saw the same midwife for each of their postnatal appointments and check-ups, despite the majority (78%) seeing a midwife no more than four times after returning home;
- Only 24% of women who saw a midwife at home after birth wanted to see the same midwife on all visits but did not. In terms of continuity of care, this figure has important implications: when looking at the results for being listened to alongside whether women had seen the same midwife for each postnatal appointment, there were more positive responses from women who saw the same midwife for each postnatal appointment (88% said that they always felt listened to). Of the women who did not see the same midwife but would have preferred to, only 56% said they felt the midwives listened to them. This shows a similar pattern to the antenatal findings, again showing how good communication is an important part of continuity of care.

Similarly, NPEU's 2014 survey found that only 77% of women had the name and telephone number of a 'named midwife' or health visitor they could contact. Room for improvement is also needed about emotional support in postnatal care settings (Care Quality Commission, 2016b):

- Although almost all mothers (97%) were asked how they were feeling emotionally, only 57% were given information about potential postnatal emotional changes.
- Less than two in three women said that they "definitely" got enough help and advice about feeding their baby in the six weeks after the birth – although this did represent an improvement from 2013 (65% vs 63%).
- Just 54% of women giving birth for the first time felt they were definitely given enough information about emotional changes which may be experienced after the birth.

Finally, the Neonatal Survey 2014, led by Picker Institute Europe in collaboration with Bliss (the charity "for babies born too soon, too small, too sick"), shows that while parents are having high quality experiences for many aspects of neonatal care, communication is varied. The survey involved 88 hospital neonatal units from 72 NHS trusts in England (including special care baby units, local neonatal units and neonatal intensive care units), in addition to the neonatal services at Jersey General Hospital. Participating units fell into 13 different neonatal networks across England, and responses were received from 6000 parents – a response rate of 38%. According to its main findings (Sarah-Ann Burger, 2015):

- One in three (33%) parents noted that only some of the staff introduced themselves. Further, a large proportion of them – 55% - stated they were not fully able to talk to a doctor as much as they wanted.
- However, the survey revealed a high level of parent trust and confidence in the care teams caring for their babies, with 87% of respondents stating that they “always or nearly always” had confidence and trust in the staff caring for their baby.
- Only 79% of parents stated that they were “always” able to talk to staff if they had worries and concerns, and only 79% “always” received information about their baby’s treatment in a way they could understand.

According to results from available surveys and relevant national reviews on maternity services, most women received good levels of care and support in the antenatal period which is not always continued after birth. For some women, additional support – sometimes simply someone to talk to – could help to prevent the onset of postnatal depression and other mental health conditions, particularly in relation to the days spent in hospital which can often be a low point for women (National Maternity Review, 2016):

Furthermore, recent qualitative research into individual stories of women’s experiences of hospital-based postnatal care across the UK has generated a range of useful evidence. According to a report from Patient Opinion released in March 2016, essential elements to a good service include adequate communication, maintaining patient dignity and respect for and treating people as individuals. From a thematic analysis of stories of women’s experiences on the postnatal ward, it is revealed that variation in information provision and explanation, as well as lack of emotional support, are a common cause of concern and anxiety across important areas considered in the report, such as: breastfeeding support, continuity of care, and approach to care (Joanna Fawcett, 2016).

Feelings of isolation and loneliness were expressed by a number of mothers who did not receive breast feeding support. In addition to that, there were inconsistencies in the breastfeeding guidance given to women (Joanna Fawcett, 2016). Several interviewees described variation in the information given by different staff members even within the same hospital, echoing the findings of the 2015 NHS Maternity Survey where only 55% of all women surveyed said they were always given consistent advice on feeding their baby (Care Quality Commission, 2016b).

Continuity of care achieved through knowledge of medical history is another crucial aspect of good maternity care. According to the 2015 NHS Maternity Survey, only 55% women reported that their midwife knew their medical history (Care Quality Commission, 2016b). This lack of consistency is reflected on the findings of the Patient Opinion study. Here, it is highlighted the importance of having the same midwife as it means women do not have to give repeated explanations to every new midwife who is involved in their care: *“The crux of the issue is communication, there was no continuity with the midwives and we had to explain everything that had happened multiple times during the day.”*(Joanna Fawcett, 2016)

The report also stressed the correlation between the keyword ‘care’ with a number of other keywords used in stories of positive maternity experience, such as: ‘support’, ‘reassurance’, ‘professionalism’, ‘encouragement’, ‘compassionate’, ‘dedicated’, ‘passionate’ (Joanna

Fawcett, 2016). However, lack of medical explanations at the postnatal stage sometimes left women feeling scared and not in control. In the 2015 Maternity Survey only 62% of women reported that they were always given the information they needed in hospital after the birth (Care Quality Commission, 2016b). This is confirmed by some of the comments collected by Patient Opinion, for example: *“No one from the obstetric team came to see me the following morning and explain what had happened and why and be there to answer any of my questions.”*(Joanna Fawcett, 2016).

Discussion

As shown by the most recent findings into women’s experiences of maternity services in England, more attention needs to be paid on good information provision, support around physical and emotional wellbeing, and involvement in decision making, as well as practical issues such as feeding.

The surveys show evidence of particular challenges around postnatal care. For instance, with regards to antenatal appointments, 15% of women said that midwives were not aware of their medical history, compared with 22% at the postnatal stage. (Care Quality Commission, 2015).

The survey also showed that women who saw the same midwife for each appointment tended to report better experiences of care. This demonstrates the value of having an ongoing relationship with a single practitioner as a means of ensuring continuity of care. Whilst there will be occasions where people need to see different midwives due to changes in staffing, personal circumstances, or preferences, it is important for as many women as possible to be given the opportunity to see the same midwife throughout their maternity care if they want to.

Improving maternity services

The National Maternity Review

In March 2015, Simon Stevens, Chief Executive of NHS England announced a major review of maternity services as part of the NHS Five Year Forward View. Baroness Julia Cumberlege was asked to lead the independent review working with a panel of experts and representative bodies.

The scope of the review was to assess current maternity care provision and consider how services should be developed to meet the changing needs of women and babies. Drawing on wide-ranging evidence, and in consultation with women and their families, as well as a wide range of stakeholders including NHS staff, the review published its findings in February 2016.

The National Maternity Review set out wide-ranging proposals designed to make care safer and give women greater control and more choices. Among its findings, the review acknowledges that despite the increases in the number of births and the increasing complexity of cases, the quality and outcomes of maternity services have improved significantly over the last decade. However, the review also found meaningful differences across the country, and further opportunities to improve the safety of care and reduce the incidence of stillbirths. For instance, prevention and public health have an important role to play, as smoking is still the single biggest identifiable risk factor for poor birth outcomes. Obesity among women of reproductive age is increasingly linked to risk of complications during pregnancy and health problems in the child (NHS England, 2016).

This landmark report highlights seven key priorities to drive improvement and ensure women and babies receive excellent care wherever they live. Specifically, the review sets out a list of recommendations for action, of which two are particularly relevant to person-centred care and user experience: personalised care and continuity of care.

Recommendations on personalised care and continuity of care

Since every woman, every pregnancy, every baby and every family are different, quality services – safe, effective and providing good experience – must be personalised, argues the review. Therefore, personalised care during antenatal, intrapartum and postnatal stages should be centred on the woman, her baby and her family; based around their needs and their decisions, offering them choice and unbiased information (National Maternity Review, 2016). This is consistent with the first principle of person-centred care set out in the Picker Principles – that care should show respect for patients' values, preferences, and expressed needs (Picker Institute Europe, 2016). In the review, the concept of personalisation of care develops around four principal items:

- **Personalised care plan:** this plan sets out women's decisions about care, and so it should reflect their wider health needs and is kept up to date as the pregnancy

progresses. The plan should be developed by women with their midwife and other health professionals;

- **Information provision:** the report recommends that unbiased information should be made available to all women to help them make their decisions and develop their care plan. This should be through their own digital maternity tool, which enables them to access their own health records and information that is appropriate to them, including the latest evidence and what services are available locally;
- **Choice:** women should be able to choose the provider of their antenatal, intrapartum and postnatal care and be in control of exercising those choices through their own NHS Personal Maternity Care Budget. Women who choose to use the NHS Personal Maternity Care Budget could use it to select their chosen provider which is accredited and incorporated within the local governance arrangements;
- **Involvement in care:** women should be able to make decisions about the support they need during birth and where they would prefer to give birth, whether this is at home, in a midwifery unit or in an obstetric unit, after full discussion of the benefits and risks associated with each option.

As we have described above, continuity of care is seen as necessary to build a relationship of mutual trust and respect between women and healthcare professionals, which in turn ensures safe care. The review places this as a fundamental part of a good experience of care in maternity settings and recognises the need for improvement, recommending that (National Maternity Review, 2016):

- every woman should have a midwife, who is part of a small team of 4 to 6 midwives, based in the community who knows the women and family, and can provide continuity throughout the pregnancy, birth and postnatally;
- each team of midwives should have an identified obstetrician who can get to know and understand their service and can advise on issues as appropriate;
- the woman's midwife should liaise closely with obstetric, neonatal and other services ensuring that she gets the care she needs and that it is joined up with the care she is receiving in the community.

Perinatal care

As defined by the World Health Organisation, the perinatal period commences at 22 completed weeks (154 days) of gestation and ends seven completed days after birth. Perinatal and maternal health are closely linked ('WHO | Maternal and perinatal health'). The National Maternity Review clearly addresses the need for better perinatal mental health care: this is described as an area of "vital" importance in maternity care given its impact on the life chances and wellbeing of the woman, baby, and family (National Maternity Review, 2016).

According to the review, depression and anxiety affect 15-20% of women in the first year after childbirth, but about half of all cases of perinatal depression and anxiety are undetected. As

shown by the 2014 national survey of women's experience of maternity conducted by the National Perinatal Epidemiology Unit (NPEU), 18% of women were not asked about their current emotional and mental health around the time of booking in pregnancy, and 16% of women were not asked about past mental health problems and family history (Maggie Redshaw & Jane Henderson, 2015). Alongside this, the review estimates that about 40% of women in England lack access to specialist perinatal mental health services (National Maternity Review, 2016).

By acknowledging the need for training and sharing best practice to reduce variation and the standardisation of service provision across the country, as well as the lack of improvement initiatives at the current time, the review outlines a series of recommendations for this area, by urging:

- significant investment in perinatal mental health services in the community and in specialist care, as recommended by NHS England's independent Mental Health Taskforce;
- a better transition between midwife, obstetric and neonatal care, and ongoing care in the community from women's GP and health visitor.

Postnatal care

The 2016 National Maternity Review recommends a series of improvement measures relating to postnatal care. According to the report, current postnatal services are unfit for purpose, and commissioners and providers must attach sufficient importance to securing high quality neonatal and postnatal care, which can have a significant impact on the life chances and wellbeing of the woman, baby and family (National Maternity Review, 2016).

Specifically, the review calls for an increase in investment in postnatal settings, in order to guarantee women access to their midwife and to receive empathetic and comprehensive care. This recommendation couples with a strong emphasis on continuity of care in maternity services, with the report aiming at smoother transition between midwife, obstetric and neonatal care, as well as ongoing care in the community from their GP and health visitor (National Maternity Review, 2016).

Implementing measures to improve communication and better information provision to patients would be crucial:

- To ensure women do not receive conflicting information on matters such as breastfeeding, with the result that they feel confused and at times pressurised. According to research conducted in 2005, 90% mothers who gave up breastfeeding within six months would have preferred to breastfeed for longer, this level declining as breastfeeding duration increased. Even among those who breastfed for at least six months, 40% would have liked to continue longer (Keith Bolling, Catherine Grant, Becky Hamlyn, & Alex Thornton, 2005).
- To prevent the onset of postnatal depression and other mental health conditions, particularly in relation to days spent in hospital, which can often be a low point for women

(Leahy-Warren, McCarthy, & Corcoran, 2012) (Watkins, Meltzer-Brody, Zolnoun, & Stuebe, 2011).

As of now, the next step should be to improve the aforementioned aspects of patients' experience by making a better use of the patient experience information currently available. Adoption of an effective improvement methodology can support this aim.

Using patient experience information for service improvement

At present, there are a number of initiatives underway with the specific aim of using people's feedback about their experiences to improve maternity services. Below, we highlight several examples: including three projects backed by the national maternity challenge fund, the #matexp campaign, and the Institute for Health Improvement and Picker Institute Always Events™ initiative.

Maternity Experience Challenge Fund

In order to promote the aims of the 2016 National Maternity Review and the broader NHS England's strategic agenda, the Department of Health launched in March a new initiative with the aim of improving maternity services through patient feedback. The Fund aims to explore innovative ways to make better use of patient insight to deliver improved services. The initiative was not about further collection of data but about finding new ways to use the feedback that trusts are already collecting to generate change and add value for patients (NHS England, 2016b).

So far, the two winning trusts will develop original projects by using patient feedback for improvements in maternity services:

- University Hospitals of Morecambe Bay – Improving the Culture of Communication of the Maternity Multidisciplinary Team through Experience Based Co-design, Communication Training Toolkit: the project will develop a more intense, innovative and radical approach to addressing negative patient experience and develop a cultural change in communication across maternity teams. Using patient feedback and involvement of families, real stories and experiences, this project aims to develop a training video describing how communication impacts upon service users.
- Kingston Hospital NHS Foundation Trust – “Nobody’s patient”, seriously ill women and babies falling through the gaps: the project will design and develop *Whose Shoes?*® scenarios that will enable service users and health care providers to discuss local successes and challenges, leading to collaborative improvement work. According to its creators, *Whose Shoes?*® tools “help explore many of the concerns, challenges and opportunities facing the different groups affected by the transformation of health and social care.” (<http://nutshellcomms.co.uk/>). Therefore, a new toolkit will be developed to explore collection and use of feedback from seldom heard groups: families with babies in neo-natal units (NNU); severely ill women faced with an unexpectedly serious illness in

pregnancy or the immediate postnatal period and women who miscarry in the second trimester.

Such innovative projects will build on existing work done on maternity experience, with insights from a range of sources – patient surveys, the Friends and Family Test, patient letters, complaints and discussion on social media – helping to identify issues, find solutions and share good practice.

#MatExp

#MatExp is a grassroots social campaign, founded by Gill Phillips and Florence Wilcock in September 2014. Since its inception, #MatExp has existed as a growing and now very influential social movement, run by a team of volunteers whose main task is to identify and share best practice in maternity services all over the country so every woman gets the care that is right for her needs, every time (#MatExp Website, 2015).

The #MatExp community, comprised of women and families, midwives and doctors, promotes its work by using the *Whose Shoes?*[®] approach, which has triggered interesting discussions on the aspects of maternity experience that need improvement (Laura James, 2016). Several improvement initiatives and workshops have been inspired and carried out by #MatExp:

- A leadership and facilitation toolkit was produced in partnership with the London Strategic Clinical Networks to support the *Whose Shoes?*[®] workshops. Sessions have now been held at 18 hospitals across the country, with more planned (Source: <http://www.londonscn.nhs.uk/publication/maternity-experience-workshop-a-guide-based-on-the-learning-from-the-london-pilot-workshops>). According to an official evaluation report of the five original pilot workshops produced by London SCN, 235 members of staff were involved, in addition to women and families using services. The report highlights that “93% of attendees said that the workshop changed the way that they think about maternity services and have spoken about seeing situations from new perspectives, thinking differently and reframing their actions.” (Source: <http://matexp.org.uk/wp-content/uploads/2016/06/Whose-Shoes-report-Maternity-SCN.pdf>).
- The *Whose Shoes?*[®] board game was included in all the listening events held by the National Maternity Review team.
- A booklet of case studies of best practice arising from the early workshops was produced by the London Strategic Clinical Networks in December 2015 (Source: <http://www.londonscn.nhs.uk/publication/involving-service-users-for-quality-improvements-in-maternity/>).
- As a follow up, several hospitals have created ad hoc monthly newsletters reporting on actions arising from pledges made at the workshops, such as the Guy’s and St Thomas’s NHS Foundation trust, and the Leeds Teaching Hospitals NHS Trust.
- As part of the next NHS Change Day held in October 2015, #MatExp launched a social campaign called NHS Change Day Maternity Experience which aimed to: “1) *Encourage*

and empower users of maternity services to join conversations about their experiences of maternity care, and to share what really makes a difference to that experience; 2) Get health care professionals (in and beyond the NHS) and local communities to listen and work in partnership with women and families to improve maternity experiences; 3) Enable anyone to take action to improve maternity experience, whether a user, partner, community group or NHS staff” (‘Fab Change Day #MatExp’, 2015).

Interested people can get involved in various ways, such as: joining the Twitter conversation, using the #MatExp hashtag (as of now, #MatExp has recorded 437 million Twitter impressions, with roughly 1 million Twitter impressions every day since its launch); watching a #MatExp video on Youtube to see what ideas the campaign has been promoting so far; giving feedback on the eight #MatExp actions being promoted in order to improve crucial aspects of maternity experience like general wellbeing of mother and baby during and after birth, communication with medical staff, postnatal care, and information provision (Martin Turner, 2015).

More information on current campaigns and activities of #MatExp can be retrieved from their official website: www.matexp.org.uk.

Always Events

A further example of improvement strategy – now being trialled in England – is Always Events. Always Events are an organising principle defined as “*those aspects of the patient and family experience that should always occur when patients interact with healthcare professionals and the delivery system*”. As such, an [Always Event™](#) is a clear, action-oriented, and pervasive practice or set of behaviours that provides the following (Picker Institute Europe, 2014):

- A foundation for partnering with patients and their families;
- Actions that will ensure optimal patient experience and improved outcomes; and
- A unifying force for all that demonstrates an ongoing commitment to person and family centred care.

Always Events are aspects of the patient experience that are so important to patients and families that health care providers must perform them consistently for every patient, every time. In November 2014, NHS England introduced their Always Events improvement initiative in collaboration with Picker Institute Europe and Institute for Healthcare Improvement. The key concept is co-design – patients, carers and staff engaging in true communication to establish the care that’s both wanted and needed. As part of the Always Events pilot programme undertaken by Picker Institute Europe with NHS England, three major NHS foundation trusts are currently involved with specific projects focused on maternity services and postnatal care:

- Taunton and Somerset NHS Foundation Trust: the trust is focusing their Always Events pilot on patient information, with the expectation that midwives must always direct women to up-to-date, evidence based information that is easily accessible so that “*women always have the right information, at the right time, at their fingertips*”.
- University Hospitals of Morecambe Bay: during April 2016 the trust tested allowing partners to stay overnight up to 24 hours after the birth of the baby on the postnatal ward

at Furness General Hospital. The trust predicted that allowing partners to stay overnight was of most benefit for mothers of those babies born out of visiting hours (9pm-9am).

- Mid Yorkshire NHS Foundation Trust: Picker Institute Europe have been working with Mid Yorkshire NHSFT to provide a foundation for an ongoing co-designed quality improvement work.

Maternity Services Liaison Committees (MSLCs)

The Maternity Services Liaison Committees (MSLCs) are an independent, multi-disciplinary advisory and action groups with service user involvement at the centre. They are a forum in which commissioners, providers and service users (women and families) work together to explore what is known about particular groups of pregnant women and families, service users' experiences, services and the profile of service users locally, what needs to be researched further locally, and what needs to change. The MSLC uses participatory processes to establish priorities and co-design an annual work plan. This approach combines the expertise of professionals in partnership with the perspectives of women, who are experts by experience.

As locally-based groups of all those involved in planning, providing and receiving maternity care, MSLCs are well placed to advise on developments in local maternity services and monitor progress towards agreed standards. In addition to that, main objectives of the Maternity Services Liaison Committees are:

- To carry out a programme of work to explore the experiences and needs of recent service users and improvement activities;
- To monitor the range and quality of services available against the delivery plan, clinical guidance recommendations and developing best practice, and send reports to the Trust's board level champion;
- To monitor acceptability and equity of access to services available for women locally;
- To provide advice and feedback on maternity commissioning and service delivery; and
- To feed into development initiatives at local (e.g. Joint Strategic Needs Assessment) and regional levels (e.g. Clinical Networks), including feeding into the wider community strategy and joint working with local authorities and early years provision including health visiting and children's centre services.

Conclusion

Maternity services are an important area for person centred care. As has been noted, childbirth is the most common reason for hospital admission in England. It is also an area where – comparatively speaking – people are more likely to want to exercise choice and select services that will deliver not just the right care but the right experiences. Childbirth is one hospital experience that every user hopes will be unforgettable.

Evidence from national surveys is encouraging. The majority of new mothers in England report positive maternity experiences in NHS facilities. However, effective involvement, a pillar of person centred care, is not always being achieved – particularly in postnatal care – and there remains significant room for improvement in some key components of maternal experience.

To pursue improvements in maternity services – as outlined in the 2016 National Maternity Review – maternity care should become safer, more personalised, and more family friendly. This means that women and families ought to have access to information to enable them to make decisions about care, and that they can access support that is centred on their individual needs and circumstances. It also means that healthcare staff need to be supported to deliver person centred care. To enable this, they should have the opportunity to work in high performing teams and organisations which are well led and in cultures which promote innovation, continuous learning, and break down organisational and professional boundaries (National Maternity Review, 2016).

Improving people's experiences of maternity care therefore requires providers to hear and respond to user feedback, and to ensure that staff feel supported to provide the best quality care. Results from the national maternity survey and the NHS staff survey should be powerful tools to help services in this task, but they should be complemented by other evidence – including the feedback volunteered by families through compliments and complaints, as well as through targeted efforts to understand and explore people's experiences. This is particularly important for those kinds of maternity experiences less well served by national datasets at present, and the challenge for services and researchers alike is to ensure the broadest possible range of voices are heard. If this can be achieved, then there is a good chance of addressing the areas – such as involvement – where improvement is most needed.

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Picker Institute Europe
Buxton Court
3 West Way
Oxford OX2 0JB

Tel: + 44 (0) 1865 208100
Fax: + 44 (0) 1865 208101

info@pickereurope.ac.uk
www.pickereurope.org

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