

**SUPPORT OVERDUE:
WOMEN'S EXPERIENCES OF
MATERNITY SERVICES**

May 2013



theWI
INSPIRING WOMEN

THE NFWI AND NCT

THE 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, to learn together, widen their horizons, improve and develop the quality of their lives and those of their communities and together influence local, national and international affairs on issues that matter to members.

The NFWI is the largest women's organisation in the UK with some 212,000 members in 6,500 Women's 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

We're here for all new parents during their First 1,000 Days – from the start of pregnancy until their child's second birthday. Evidence shows that how parents cope during this time is absolutely critical to what kind of adult each child grows into.

Established in 1956, we help parents through our:

- supportive UK-wide network of 320 branches
- locally-delivered professional courses to 80,000 new parents each year

- popular and trusted website, which two million people visit each year
- national telephone helpline
- evidence-based research
- effective influencing activity.

Our achievements include campaigning to allow fathers into the delivery room; the labelling and then banning of Bisphenol A in baby bottles; reducing unnecessary interventions such as induction, episiotomies and enemas during childbirth; establishing the Healthy Start Scheme; influencing the Equality Act in Britain and the Breastfeeding etc. (Scotland) Act 2005 to protect women breastfeeding in public.

As a charity, we rely on our 5,000 volunteers and our 100,000 members – for their time, passion, and donations.

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THE NFWI 2013

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FOREWORD

“There are chronic shortages of midwives. The NFWI calls on the government to increase investment in the training, employment and retention of midwives in England and Wales to ensure services are adequately resourced and are able to deliver a high standard of care.”

Horwich WI Lancashire Federation, June 2012

At the 2012 AGM, WI members passed a resolution calling for the ‘employment of more midwives’. Brought to her WI by a midwife working in the North West of England, the resolution has highlighted an issue that touches so many women across the world. It is a call for action on a service that is often called the ‘shop-window’ of the NHS; a service that currently sees almost 2,000 women give birth each day and supports over 700,000 families annually.

The increasing pressure that maternity services have faced in recent years has been well documented. Barely a month goes by without a news story detailing the multifaceted challenges facing maternity services: the baby boom, the increase in more complex pregnancies and births from women with higher risk factors, and maternity units struggling with workforce numbers that have not kept pace with the rising birth rate.

Resources have been invested in this area, indeed, midwife numbers increased under both the current and the previous governments. But has the limited investment that we have seen to date been enough given the scale of the challenge?

As a mother of four, a grandmother and Chair of the UK’s largest women’s voluntary organisation, I have seen

first-hand how the unique challenges that our maternity system faces have translated into pressure on the maternity workforce and thus on maternity care.

In recent months the NHS has gone through an unprecedented period of change. Much has been said and written about the centrality of patient led-care to the reform programme and the commitment to ensuring that people have a positive experience of NHS care. The report we present here seeks to describe and analyse the experiences of women and families using NHS maternity services. It draws on the insight provided by members of the WI, the UK’s largest voluntary organisation for women, and NCT, the UK’s largest parenting charity. Alongside these voices it has made use of official data and information to provide a wider investigation into levels of care that women in different parts of the UK can expect to receive.

The majority of women have an outstanding experience of maternity care. This should be celebrated. Yet at the same time, for too many women the early days and weeks with a newborn baby are coloured by experience of a system that is less than satisfactory. Despite welcome progress, promising care pledges from government, and a robust

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framework of guidance, we are still not getting maternity care right, leaving too many women with a poor experience of care and too many midwives unable to deliver the excellent standard of care that they want to. The framework is in place and as the NHS moves through a period of major change it will remain important that maternity services continue to be a key priority. As we mark International Day of the Midwife 2013, I hope that the message that ‘the world needs midwives now more than ever’ is being heard by decision-makers.

Ruth Bond

Ruth Bond
NFWI Chair

EXECUTIVE SUMMARY

The birth of a child is a key and life changing moment for any family. It is the single biggest reason for admission to hospital with 700,000 women in England and Wales giving birth annually, most of them in hospital. Midwives play a vital role in setting families on the right path and have a major impact on new parents' experiences of pregnancy, birth and the first few weeks of family life.

Mothers in England and Wales enjoy some of the highest quality maternity care in the world based on a well-developed evidence base about what works and a robust set of guidance designed to steer service delivery within a choice-based framework.

Significant investment has been made in maternity services in the past year alone with the announcement of a package of measures aimed at improving care for women in pregnancy and the early stages of motherhood, as well a new tranche of money for improving and upgrading maternity facilities in England.

But almost 2,000 women will give birth today, and many will not be cared for in a way that is in keeping with the Department of Health and Welsh government's aspirations and vision for a patient-led National Health Service. Some will be denied the opportunity to make choices; some will be left out of decisions about their care; and others will find themselves without the emotional care, the physical support and the information and advice that they need during the first few weeks following birth.

This report examines the experiences of 5,500 women who gave birth in the past five years (three quarters of them in 2012) and the insights obtained

from official sources about levels of care, maternity services and the policy commitments made to women. Particular regard is paid to staffing and its impact, choice of location, the relationship between a woman and her midwife, and postnatal care. It is clear that the fact that too few midwives are in post is affecting all parts of the maternity system.

The report highlights a number of important issues for consideration by Welsh Health Boards, the Commissioning Board NHS England (as it establishes a national framework for quality and choice) and Clinical Commissioning Groups (CCGs) as responsibility for commissioning effective maternity care has shifted to them:

- **Choice remains an aspiration, not a reality, for many women**
Despite the commitment to delivering choice in NHS maternity, and the pledge offering four location options for women in their local area, too many women are still denied their choices on a daily basis.
- **Maternity care is fragmented**
Too many women experience fragmented maternity care with a clear disconnection between different elements of the pathway from pre-conception through to pregnancy and postnatal care.

Almost 2,000 women will give birth today and many will not be cared for in a way that is in keeping with aspirations for a patient led National Health Service.

- **Women face a postcode lottery of postnatal care**

Despite robust guidance from NICE, a 'postcode lottery' of postnatal care exists with unacceptably wide variations in the quality and standard of care across different areas of the country.

Key Findings And Recommendations

MISSING MIDWIVES – WORKFORCE CHALLENGES

- Despite experiencing an increase in births of at least 15% over the last decade, neither Wales, nor any of the regions of England meet the midwife to birth ratio of 1:28 per year as recommended by four Royal Colleges: the Royal College of Midwives, the Royal College of Obstetricians and Gynaecologists, the Royal College of Anaesthetists, and the Royal College of Paediatrics and Child Health.
- As of 1 May 2012, 71 trusts and boards have more midwives in employment than at 1 May 2011. This improvement has not been consistent across England and Wales and despite the ongoing baby boom, 50 trusts and boards employed fewer midwives at 1 May 2012 than at 1 May 2011.

Recommendations

- We urge maternity planners to take into account the wider health needs of women that extend the quantity and complexity of the care needed before, during and after birth for them and their babies, and to build this into future planning. Recognition of the role played by midwives in influencing positive lifestyle choices during the pivotal time of pregnancy and birth is

essential for improving public health and reducing health inequalities.

- We urge maternity planners to review maternity staffing with a view to fulfilling the standard set by the four Royal Colleges of a midwife to births ratio of 1:28 per year in hospital settings.
- We urge maternity providers to provide dedicated time across the NHS for Supervisors of Midwives to carry out their statutory duties, and to avoid using Supervisors of Midwives as a stop-gap measure to cover for chronic staff shortages.
- We urge Clinical Commissioning Groups and boards to place maternity care of women in their local area as a high priority and to view the work of midwives as such.
- More research on how Midwifery Support Workers can help women and the midwifery workforce is needed, and we urge trusts/boards to consider their appropriate use to give midwives more time to put their skills to use most effectively. We encourage trusts/boards and units to share best practice on innovative ways to provide the right care for women in the right place by the right people.

MY MIDWIFE AND ME – THE RELATIONSHIP BETWEEN WOMEN AND THEIR MIDWIVES

- 34% of women were not given the name and telephone number of a specific named midwife that they could contact with any concerns.
- 88% of women had not met any of the midwives who cared for them during labour and birth, before going into labour.
- For 68% of women, not meeting their midwife had no impact, however, 20% of women believed this had a negative impact on them or their baby.

Despite robust guidance from NICE, a 'postcode lottery' of postnatal care exists with unacceptably wide variations in the quality and standard of care across different areas of the country.

- Over 80% of women experienced 'one-to-one' care during established labour, yet 13% of women did not.
- Looking at the aspects of care women would have liked to have been better, around a third of mums want midwives to 'remain responsible for my care (not pass me to someone else)' and 'give me or my baby more attention'.

Recommendations

- We urge maternity providers to make it clear to women who they can call and the best phone number to reach them on. While most women have some way to contact 'a' midwife (be it her specifically assigned midwife or one of a team), this does not necessarily facilitate a relationship (though women may still receive the care and advice they need). We urge Clinical Commissioning Groups to monitor the use of 'assigned teams' by women during the antenatal period and the efficiency of this system if a 'named midwife' system is unworkable.
- We urge Clinical Commissioning Groups and boards to look at how providers can facilitate relationships between midwives and women during the antenatal period, and continue this into the intrapartum period, especially as many women give birth in locations which were chosen by them and known to providers months beforehand.
- We urge Clinical Commissioning Groups to look at how maternity providers manage staff changeovers in the best interests of maintaining support for labouring women. It has almost been ten years since both the Westminster and Welsh governments urged providers to

deliver one-to-one care.

- We commend trusts and boards who are attempting to measure the provision of one-to-one care and urge Clinical Commissioning Groups to continue this work. We urge maternity care providers to recognise the variation in one-to-one care experienced by women, and to begin measurement that will capture this variation. This will enable providers to improve the care given to women at this vulnerable time.

DECISIONS AND OBSTACLES – CHOOSING WHERE TO GIVE BIRTH

- Only 12% of women had four choices of where to give birth. Encouragingly given the clear evidence base on the benefits of offering women a range of choices, over a third of trusts and boards in our sample had recently completed building projects or had plans to expand location options by building new freestanding or co-located maternity units, or funding home birth services.
- The provision of additional facilities, such as birthing pools and partner accommodation were the most common reasons for wanting to give birth in a particular place. 21% of women chose a place of birth because of the facilities it offered. 19% of women selected a birth place because they would feel safe there.
- Twenty-four trusts reported 455 episodes when they temporarily closed to admissions or suspended maternity services during 2011 and 2012: 40% of these were primarily due to staff shortages and 40% due to capacity issues (for example bed space).

We urge Clinical Commissioning Groups and boards to look at how providers can facilitate relationships between midwives and women during the antenatal period, and continue this into the intrapartum period, especially as many women give birth in locations which were chosen by them and known to providers months beforehand.

- While just under 60% of women reported giving birth in their intended location, a minority of women (one in ten) did not get their choice for other reasons including a lack of staff and beds.
- Only 50% of women who would have liked a home birth were able to give birth at home.

Recommendations

- We urge maternity service providers to look closely at the decisions women make at the start of their pregnancy, the care pathway they take, and the resulting birth location. Our survey shows very few women change their minds on location once they have made a decision. While medical complications may arise, these are not always behind the restriction of women's choices.' FOI requests show there are a wide variety of events and policies – *within the control of trusts and boards* – that prevent women getting what they want.
- We urge maternity service providers to monitor suspensions and closures more closely to understand the impact of these and any patterns emerging as to when and why these happen. We urge planners to acknowledge that these incidents directly affect women's choice of where to give birth.
- We are especially concerned at the frequent mention of handheld notes and paper records as the form in which data on women's choices or their risk status is held by trusts/boards, which makes retrieval and analysis of this information very difficult. We endorse the recommendation made by Welsh Public Accounts Committee for the development of a 'consistent and robust

electronic data collection process for maternity services' in order to 'remove the need for inefficient manual data collection'.

CONTINUING CARE – POSTNATAL CARE

- One in five women report that they do not see a midwife as often as they would like to in the days and weeks following birth.
- There are clear differences in satisfaction with postnatal care by region: a quarter of women in London report they were unable to see a midwife as much as they wanted to following birth.
- Trusts and boards differed significantly in their approaches to postnatal care; highlighting perceived differences in understanding about the obligations, if any, on them to provide for a certain number of postnatal visits and varying information on actual visits.
- A quarter of women were unable to make postnatal appointments with midwives at times that were convenient for them.
- Almost 60% of women want more support with postnatal care.

Recommendations

- We urge maternity and health visitor providers to recognise that postnatal care services are not meeting the needs of significant numbers of women and review staffing in order to improve the quality and consistency of maternal care. The transition to parenthood is a critical period and further effort is needed to ensure that adequate services are available to support all women and their families in the early days and weeks of parenthood.

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- We urge NHS England to issue guidance to CCGs on the development of a framework to assess postnatal care in line with clinical guidance issued by NICE and the feedback from service-users. We urge the All Wales Maternity Services Implementation Group to do the same.
- We urge NHS England to issue guidance to CCGs on the development of a framework for planning the delivery of postnatal care in line with clinical guidance issued by NICE. Data collection should be improved to enable a clearer picture of the level of care women receive.

Almost 60% of women want more support with postnatal care.

INTRODUCTION

“Ensuring that every woman and her newborn have access to quality midwifery services demands that we take bold steps to build on what we have achieved so far across communities, countries, regions and the world... Our responsibility is clear: we must safeguard each woman and child so they may live to their full potential. The results will reverberate far beyond the lives of those directly affected, fostering a better world for all.”

Ban Ki-moon Secretary-General of the United Nations,
State of the World's Midwifery 2011

PROVIDING MATERNITY CARE IN A SHIFTING CONTEXT

Mothers in England and Wales enjoy some of the highest quality maternity care in the world. The UK as a whole ranks ninth on the global index of maternal mortality¹ and £2.5 billion is spent on maternity care in England alone.² Giving birth is safe for the overwhelming majority of women and babies, and maternal deaths directly attributable to problems in pregnancy or at birth have remained relatively stable at just over six per 100,000 maternities since the mid-1980s.³

The popularity of dramas such as *Call the Midwife* and documentaries including *One Born Every Minute* have led to a high profile for maternity in the media, bringing the experience of giving birth into primetime, and generating a surge of interest in midwifery as a profession.⁴ Giving birth is the single biggest reason for going to hospital⁵ and social media such as Patient Opinion and Mumsnet are now giving NHS users platforms to voice their experiences.

However, the challenges facing the maternity care system in both England and Wales are immense

and multifaceted. The NHS is going through an almost unprecedented spending squeeze, with efficiency savings of £15-20 billion earmarked for 2011-14 (known as the ‘Nicholson Challenge’).⁶ The reorganisation of clinical services and governance that is taking place across England and Wales, has led to media stories every week about public consultations and maternity unit closures. A decade-long baby boom is set to continue, and the number of women giving birth who need extra care continues to increase. Medical leaders have stressed more care needs to take place in the community, and hi-tech care should take place in fewer units.⁷ The role of a midwife is expanding⁸ as the importance of pre- and post-natal care for long-term health outcomes becomes clearer with more research. But midwives report being ‘burned-out’, most work part-time and the workforce as a whole is ageing.⁹

Maternity care is not like many other parts of the NHS. The independent Inquiry into Maternity Services in 2008³ noted that caring for at least two lives (mother and baby or babies) ‘simultaneously raises the stakes’ and although pregnancy and birth

The role of a midwife is expanding as the importance of pre- and post-natal care for long-term health outcomes becomes clearer with more research.

are normal physiological processes, ‘unexpected emergencies can develop rapidly’. Further, maternity care ‘is delivered over a long period, often in different settings and involving many professionals’, which can make simple things – consistent advice to patients, building trust between patient and carer – more difficult.

A suite of policy pledges and guidance, from clinicians to governments, have been designed to guide NHS trusts and boards, and more latterly, newly formed Clinical Commissioning Groups (CCGs), through these choppy waters. Women are ‘well served by an evidence base about what works and by standards that facilitate high quality’.⁵ The safety of birth in England and Wales and the satisfaction of most women with their care¹⁰ shows that improvements have been made; there is much to celebrate.

But 700,000 women will give birth next year, and as this research will show, many will not be cared for in a way that is in keeping with this guidance. Women will be denied the opportunity to make choices, taken out of decisions about their care, and give birth to their babies with the assistance of a workforce stretched to breaking point. Maternity is the NHS’ ‘shop front’, but for too long it has not had the investment to keep up with demand. The impact of this is significant, and cannot continue to be ignored. The quality of the birth experience can have lasting effects on mothers, babies and families,³ impacting on emotional and psychological wellbeing, as well as physical. It is time to do better.

NHS changes meant that the new CCGs in England, and reconfigured boards in Wales have an opportunity

to look again at maternity care provided in their local areas and understand why investment in midwifery and maternity is sorely needed and will reap benefits in the longer term. It’s clear that our current economic climate presents significant challenges, yet investment in the early years is the most effective kind of health spending.¹¹ The experience of families during the key transition points of pregnancy and postnatal care often have a long-term impact with implications for health and wellbeing throughout life.⁵

CONTINUITY, CHOICE AND CONTROL

The basic principles for organising maternity care for women can be expressed as continuity, choice and control;^{5,12} these have been principles for many years but recent changes in focus from policymakers have again brought these to the fore.

Choice is heralded as a way to place patients at the heart of the NHS, improving their experience and clinical outcomes. The Department of Health has developed the first NHS Choice Framework from its ‘No decision about me, without me’ consultation of 2012, which sets out a vision of healthcare whereby everyone has ‘more say over their care and treatment with more opportunity to make informed choices, as a means of securing better care and better outcomes’.¹³ Further, the Health and Social Care Act 2012 ‘makes clear the duties on... Clinical Commissioning Groups to promote the involvement of patients and carers in decisions about their care and treatment, and to enable patient choice’.¹³

The government in England has pledged to offer choice for women over

Women will be denied the opportunity to make choices, taken out of decisions about their care, and give birth to their babies with the assistance of a workforce stretched to breaking point.

how to access their maternity care, choice of place of birth, choice of type of antenatal care and choice of place of postnatal care for many years.¹⁴ In Wales, service planning should 'enable women to give birth at home, in a birth centre or midwife-led unit where that is their choice'.¹⁵

Continuity 'from antenatal care through to support at home', has been expressed in the NHS Operating Plan (and reiterated in advice to CCGs) as 'vital': 'Mothers and their families should feel supported and experience well-coordinated and integrated care'.^{5,16} Maternity care providers, to implement the policy of continuity into practice, are urged to promote early access to maternity care, adhere to NICE guidance, give women one-to-one care in labour and have an 'adequate staffing and a skill mix and deployment that ensures midwives are able to deliver continuity of antenatal and postnatal care'.⁵

The themes of this report mirror these two concepts – continuity and choice – and the experiences of women outlined also illustrate some aspects of the concept of control.

AIMS AND OBJECTIVES

The aim of this research was to add to the evidence base on the experiences of women giving birth in England and Wales and to consider what insights data from official sources can offer about levels of care, maternity services and the policy 'promises' made to women.

The objectives of the research were to explore: the experiences of women and their families through pregnancy and childbirth, and official data and information about levels of care in different parts of the UK.

Particular regard has been paid to: staffing and its impact, choice of location, the relationship between a woman and her midwife, and postnatal care.

It's clear that our current economic climate presents significant challenges, yet investment in the early years is the most effective kind of health spending.

RESEARCH METHODOLOGY

Ensuring that patients have the best possible care experience is central to effective and ethical clinical practice and it should be integral to efforts to improve safety and outcomes.

Angela Coulter Chair of the Patient Experience Excellence Framework editorial board

THE SURVEY

In August 2012, WI members were invited to take part in an online Survey Monkey survey about their own, or their relatives' maternity experiences in the last five years. Paper copies were also distributed to members on request and data was then entered into Survey Monkey manually.

Responses to this survey helped shape the next step, where in February 2013 NCT members were invited to share their experiences via an online-only, shortened survey covering the same themes. Women were asked various questions about the choices they made about their maternity care, the relationships they were able to build with their midwives, and the types of extra support they would have wanted, and when.

The survey questions were designed to follow on from previous work on birth experiences from the Healthcare Commission,¹ Care Quality Commission,² the NCT,³ and NPEU (the National Perinatal Epidemiology Unit)^{4,5} allowing trends over time to be observed and progress to be demonstrated. Other questions were designed to see whether the guidelines that set out how maternity care should be delivered (for instance, visions and policy from the Department of Health and Welsh government, and clinical guidance from the National Institute of Health and Clinical Excellence) were actually translated into the kinds

of care experienced by women.

The survey also comes at a time when patient experience is being emphasised as a key indicator of quality care in the NHS. The 'friends and family test' – which asks patients whether they'd like their loved ones to experience the same care as they received – is being rolled out to cover maternity services from October 2013.⁶ Patient experience is one of the three components of the new National Quality Board's 'quality care' definition,⁷ and women's experiences of maternity care is one of the ten indicators within the 'patient experience' theme that makes up the NHS Outcomes Framework for 2013-14.⁸ It has also been emphasised by Robert Francis QC in his recommendations following his investigation into poor quality care by Mid Staffordshire NHS Trust.⁹

Over five and a half thousand women started the survey and 91% of these completed the questions. We asked respondents to answer questions in relation to their most recent birth experiences. Questions were a mixture of multi-choice and free-text styles. Three-quarters of our respondents gave birth in 2012. 90% of our respondents were first time mums. Only 1.5% of our respondents are from Wales, and the English region with the most respondents is London (a third of our respondents). We collected only

Over five and a half thousand women started the survey, three-quarters of respondents gave birth in 2012.

a limited amount of demographic data from respondents in order to keep the survey as short as possible; we did not ask respondents about their age, ethnicity or income.

FREEDOM OF INFORMATION REQUESTS

Freedom of Information (FOI) requests were made to 147 NHS trusts and boards providing maternity care in England and Wales in October 2012: 128 trusts/boards responded with answers to at least some of the questions asked, 19 did not respond with any information or acknowledge the request by the end of January 2013.

The FOI requests were used to gather a variety of the data held by maternity care providers as well as their plans for improving their services and facilities in the future. Some of the questions asked mirror those asked in 2011 by the BBC's *Panorama*,¹⁰ programme, enabling us to compare data from snapshots 12 months apart. There was much variation across trusts/boards in what information they held, whether they held it at all, in what form, over what time periods. This means comparisons between them can only be tentatively made; trends and outliers, while apparent, need to be identified with caution. The fact the sample only represents those trusts/boards who were able to provide information – when almost 20 of their peers couldn't – means there is a risk of highlighting poor results from those who have at least practised good record keeping and complied with the provisions of the FOI Act 2000 in good faith.

Freedom of Information requests were made to 147 NHS trusts and boards providing maternity care in England and Wales in October 2012

MISSING MIDWIVES – WORKFORCE CHALLENGES

The shortage of midwives in England and Wales is well documented, and was the impetus for this piece of research. The ageing of the midwifery workforce, recent austerity measures and the increase in workload has made delivering quality midwifery care more complicated. It is up to new Clinical Commissioning Groups and boards to face this – the baby boom in England is predicted to continue, and Wales' midwifery workforce is shrinking.

This chapter will explore the current data about the midwifery workforce and some of the challenges it faces.

The shortage of midwives in England and Wales is well documented.

A MIDWIFE'S STORY

'I am a newly qualified midwife and have been working in an NHS hospital for six months, but I have had enough. To say we are short-staffed would be something of an understatement. **The gap between my vision of midwifery and the heartbreaking reality I experience at work couldn't be greater.** Allow me to explain.

I wanted to become a midwife to be there at the most pivotal time in any woman's life, to help them make the physical and emotional transition into motherhood. Coming into family life at such an important time puts midwives in an immensely privileged position: when enabled to do our jobs properly we can make a significant difference to the health and wellbeing of a woman and her family, benefiting not just the individuals, but also public health as a whole. However, with such privilege also comes a heavy burden of responsibility – make a mistake and you risk significant psychological and physical harm to both mother and baby, in the worst cases costing one or both of them their lives.

This burden has always been there for midwives to carry; it is part of our vocation, but in order to cope with this we need the support of management systems, to feel that our complaints and concerns are listened to, and most importantly that we have enough staff to carry out our jobs properly. Unfortunately this isn't happening. I became a midwife to care for women – what I am doing now is

managing them, and even then, some days I barely achieve that. Midwives all around me are leaving or reducing their hours. Women who have dedicated their lives to the profession have broken down in tears, unable to cope with the pressures piled upon them...

Aside from the impact of staffing levels on midwives and their ability to manage and minimise risk are the broader public health issues. In a high pressure environment it is the vulnerable women who are suffering the most. This means that there are women who are being beaten by their husbands, women with no safe home, women with histories of sexual abuse, women with depression, women who speak no English. They are left in a state of distress because not only do I not have time to ask them questions, I have neither the time nor the resources to act upon the answers I would get. I only just have time to try and keep these women physically safe, and some days it's a challenge even to achieve that.

I am letting women down every day at work, and it is slowly destroying me and my colleagues. This is not the job I signed up for, and I quite simply cannot do it any more. I would love nothing more than a long and fulfilling career as a midwife. It is a sad reality that I am instead applying for jobs as an office temp, a tour guide, a barmaid. I'm jumping ship. And believe you me, I am not alone.'

NHS midwife, daughter of a WI member, 2013

WELSH MUM AND WIMEMBER

'My midwife often went out of her way to make home visits, due to me not being able to drive during my pregnancy, rather than me travelling into the hospital regularly. She didn't have to, but did! She often did not stop for a drink, **and I remember her telling me that in a 12-hour shift they more often than not found it difficult to eat, and go to the bathroom, as they just don't have time, and don't want to leave the ladies in their care** – this feeling seemed to be shared from those I spoke to at the hospital...

I found that during aftercare (both in hospital), time was taken to answer any questions, but also a personal

side of what 'tips' had worked well from those midwives and nurses who were already mothers. The community midwives were fantastic. Unfortunately I had a problem with breastfeeding, so both the community midwife and a breastfeeding support woman came to visit us at home every day for three weeks – much longer than they needed to for the basic checks, but wanted to offer us the support. **It was clear how busy and short-staffed they actually were, but they made that extra effort to offer support where they could...**

WHY ENGLAND AND WALES NEED MORE MIDWIVES

The baby boom

In the decade from 2002 to 2011, almost seven million babies were born in England and Wales. While different areas of each country experienced different levels of the 'baby boom' for each of the years in that decade, more babies were born than in the previous year. In Wales, the number of births increased by almost 18%, and in England the increase was 21%.

While Wales and every region in England have experienced an increase in births, this has not been a uniform increase and not every trust or board within a region has experienced increases. For example, births in Yorkshire, Doncaster and Bassetlaw NHS trusts increased by over 80% over the last six years, while births in neighbouring Scarborough trusts dropped by 7% over the same period.¹

Fertility rates amongst women have been difficult to predict (the baby boom from 2002 followed a decade-long decline in fertility rates) and estimates over the last decade

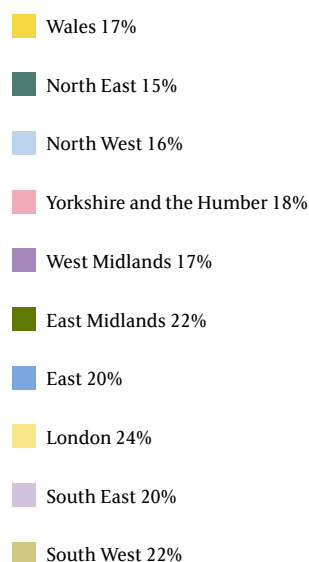
underestimated growth. Leaders have warned that workforce planning for the future cannot afford to make this mistake again and must take variation into account: if birth projections today are inaccurate as they have been over the last ten years then the number of future births could be anywhere between 10-15% higher than estimated.² Latest estimates predict that England's birth rate will continue to increase – with births expected to reach 740,300 by 2014 – while Wales' will plateau.³

Different mums, different needs, different midwives

Complexity of cases has been identified by the Care Quality Commission and the Welsh Government as a key theme in assessing maternity care provided across England and Wales.^{4,5} As in other areas of the NHS, obesity is the greatest challenge facing maternity services today.⁶ One in 15 maternities in Wales is to an obese mother⁶; at the start of pregnancy, 16% of women in England are obese;⁷ and there are clear impacts of obesity on women's reproductive health and the health

If birth projections today are inaccurate as they have been over the last ten years then the number of future births could be anywhere between 10-15% higher than estimated.

Increases in maternities (2002 - 2011)



Source: ONS, Vital Statistics: Population and Health Reference Tables (annual data), 26 Feb 2013 (and previous series 'Birth Statistics' and 'Births by Residence')

Figure 1 Percentage change in number of maternities 2002 to 2011 by regions of England and Wales

of their babies.⁶⁻⁹ Pregnancies in older mothers are more complicated than those who are younger¹⁰ and the number of births to women over 40 has almost trebled in the last two decades.³ The increased use of fertility treatment has also meant a higher rate of multiple births¹¹. Added to this, a 'significant proportion of women using maternity care are now recognised as having some level of complex physical and/or social needs' and more specialist care from midwives and doctors is required. These include women and families living in poverty, migrant women

who do not speak English as a first language, women with mental health problems, women who are misusing drugs and alcohol and women who have long-term conditions such as diabetes.¹¹

The 'Local Supervising Authority (LSA) Midwifery Officers' in every region of England and Wales used their latest reports to highlight the increasing complexity of care required by women. Obesity in particular is a challenge. In the East of England, for instance, some units report over 50% of their women have a BMI over 35.¹² The North East

A significant proportion of women accessing maternity care are now recognised as having complex physical or social needs.

LSA report speaks of the impact of substance abuse, and London's LSA of the impact of immigration.¹³

Maternity services face the resourcing challenge 'to reduce, minimise and manage the higher frequency of complications, and the greater demands on midwives, obstetricians and anaesthetists who manage the complications'.⁶ But this investment pays dividends. Deprivation and health inequality not only influences the needs of mothers and babies, but their health needs for the rest of their lives.¹⁴⁻¹⁶ 'Social and economic differences in health status reflect, and are caused by, social and economic inequalities in society' and these differences 'start before birth'. That's why giving every child the best start in life was the main policy objective from the Marmot Review's report into health inequality in 2010.¹⁵

Both Welsh and Westminster governments acknowledge pregnancy as a 'golden opportunity' to impact the health of not only individuals, but whole families and communities and, therefore, midwives' care for mothers before, during and after birth needs to expand to cover all conditions that impact maternal health.^{5,17} 'Pregnancy is a powerful motivator for change. It is a time when women and their partners, often for the first time, make positive lifestyle changes and choices in order to provide the optimal conditions to ensure the health and wellbeing of their unborn baby'.⁵ Midwives had been advised that they 'should help service users to improve their health, and all encounters, in whatever setting, should be used as opportunities for health promotion'.¹⁸ So as the demographics and needs of some of mothers have changed in recent years, so too the role of the

midwife has expanded and this has allowed some midwives to work in specialist roles. In the South West, for example, maternity units have employed specialist midwives for public health issues such as smoking, obesity, teen pregnancy and mental health.¹⁹ In Yorkshire, free training has been offered to midwives to learn about caring for refugees and asylum seekers.¹

Unfortunately, most midwifery workforce projections based on 'supply and demand' concentrate on birth rate only. 'They do not measure...increasing complexity of care, inequalities, policy drivers; and the subsequent impact of these on the increasing role expectations required of the midwife'.² This makes it very difficult for planners to quantify what's required for midwives' important public health role; budget cuts to maternity services are compromising this role too. A survey of Heads of Midwifery (HoMs) in 2011 found many were reducing specialist midwifery posts for public health issues like teenage pregnancy and substance misuse.²⁰ Only 6% of obstetric units in the UK in 2010 reported providing pre-conception care and advice to women with obesity.⁶ A recent survey of mums found 'during their first antenatal appointment, 61% of women said their midwife did not have enough time to discuss their concerns about weight management and nutrition'.⁷ In the North East, midwives are stretched as the number of case conferences regarding child safeguarding increases every year.²¹

We urge maternity planners to take into account the wider health needs of women that increase the quantity and complexity of the care needed

Maternity services face the resourcing challenge 'to reduce, minimise and manage the higher frequency of complications, and the greater demands on midwives, obstetricians and anaesthetists who manage the complications'.

before, during and after birth for them and their babies, and to build this into future planning. Recognition of the role played by midwives in influencing positive lifestyle choices during the pivotal time of pregnancy and birth is essential for improving public health and reducing health inequalities.

THE MIDWIFERY WORKFORCE

The challenges of a population with increasing needs, and a rising overall number of births, is further complicated by the entrenched problem of there simply not being enough midwives working in England and Wales. This report will outline not only what the lack of midwives means for women, but also what midwives are doing right now for women each and every day, and how these examples of exceptional care need to be celebrated and enabled. This means not only having more staff, but setting up working structures that utilise their talents and skills in the most effective way.

The make-up of the midwifery workforce

Planning for the midwifery workforce of the future clearly needs to not only take into account the birthrate and the broadening of care needs of women: it also needs to take account the aspects of the midwifery workforce itself that present particular challenges.

A quarter of the midwifery workforce is over 50.¹⁰ The average age midwives retire is only 58. Using this as a benchmark, by 2030 almost 83% of Welsh midwives currently working will have retired and 75% in England.² The policy challenge is how the NHS will replace the skills and experience

that it loses: with many senior midwives reaching retirement age, there is a concern that there will be a shortage of experienced midwives to take on management positions and leadership.²² It is also believed that midwives enter the profession at an older age than most other graduates.²¹

All LSA reports in 2011-12 mention the aging of the workforce as a challenge, and attempts are being made to soften the impact of retirements. But some places are in worse or more complex situations: in the North West, half the working establishment is over the age of 46.²³ In London, while only 17% of midwives are over 55, many of London's newly qualified younger midwives 'are unable to stay long-term in London due to the high cost of housing and living in the capital'.¹³

Research on nurses suggests older nurses exhibit different employment preferences and priorities than younger ones, such as preferring to reduce the hours they work, or avoid work that is too physically demanding.²⁴ It is certainly true that most midwives already do not work full-time, and stressful working conditions may be driving this.²⁵ In the context of an ageing workforce, two LSA regions have noted part-time work has helped them retain experienced midwives who may otherwise retire.^{26,27}

The number of midwives choosing to work part-time in Wales and England remained stable, at just under 60% between 2004 and 2009.² This figure is substantially higher than the overall average of part-time work in the UK (25%), but 80% of part-time workers are women²⁸ and the midwifery workforce is almost totally female.

A recent survey of mums found during their first antenatal appointment, 61% of women said their midwife did not have enough time to discuss their concerns about weight management and nutrition.

Data from LSA reports 2011-12 shows the trend towards part-time work is continuing, which suggests newly recruited midwives are working to previous patterns.^{1,12,29} Some evidence points the other way, however – London has had the greatest increase in midwifery numbers and less than 30% of its midwives work part-time.¹³ All this makes planning for the midwifery workforce in the future very challenging.

Local LSAs have noted that it is more difficult for part-time midwives to keep up to date with changing clinical practice or access professional development opportunities,^{19,27} as career structures remain organised around full-time employment. The impact of part-time work on the care midwives are able to give women has been of concern to policymakers – the Midwifery 2020 Programme called for an assessment of the impact of

part-time working on continuity of care and mentoring midwifery students,³⁰ but this has not been fully investigated as yet.¹⁰

THE MIDWIFE SHORTAGE IN CONTEXT

When the Prime Minister’s Commission on maternity services took submissions from the public, staff, and those who had used maternity services, one message stood out: ‘there were too few nurses and midwives and they did not have enough time to care’.¹⁸

While births increased by 21% in England and 18% in Wales, whole-time-equivalent (WTE) midwifery numbers only increased by 16% and 4% respectively, from 2002 to 2011 (see figure 3).

A quarter of the midwifery workforce is over 50. The average age midwives retire is only 58.

Age profile of midwives

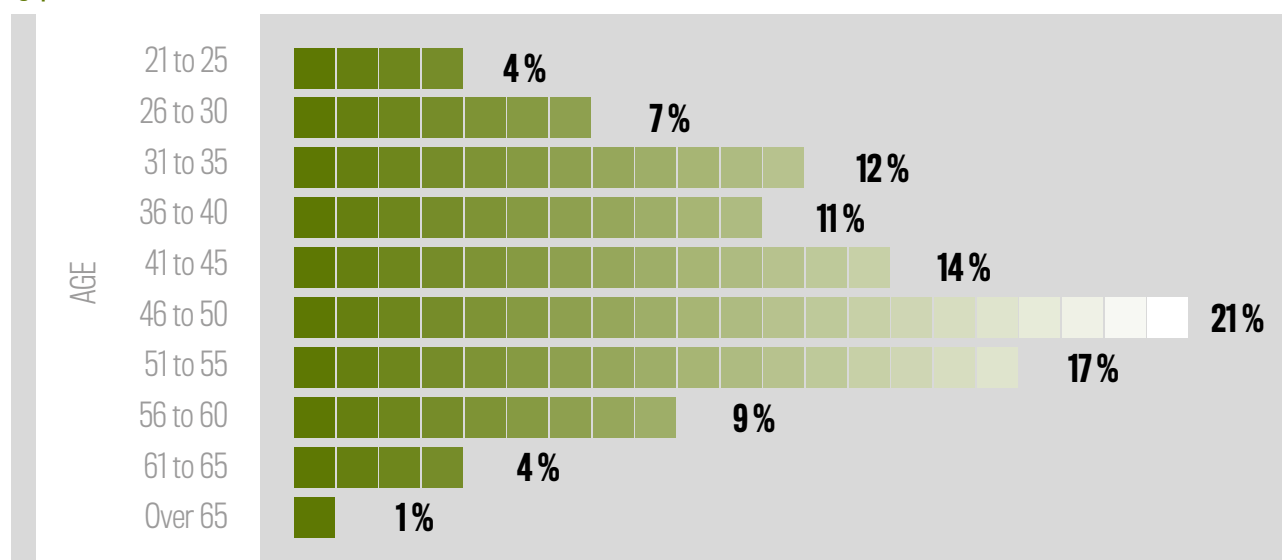
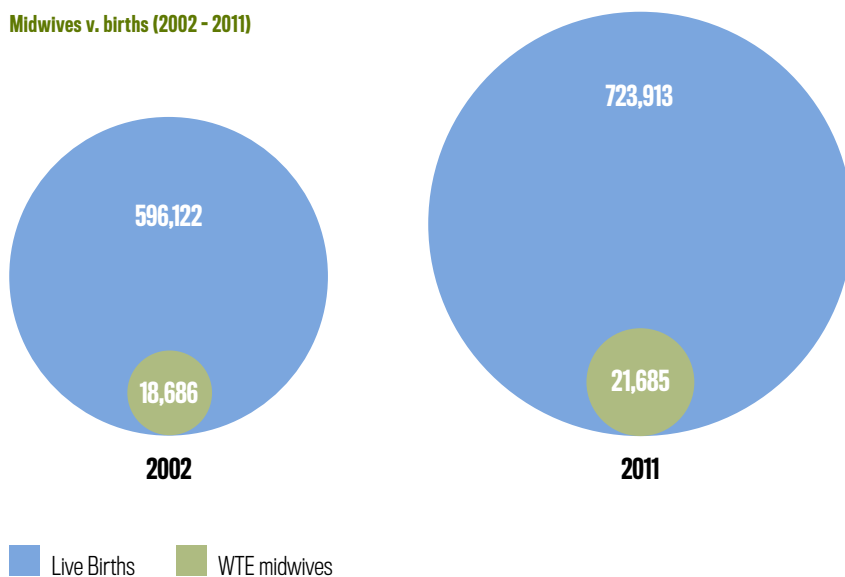


Figure 2 Age profile of midwives: Yorkshire, West Midlands, South Central, East and North East LSA reports 2011-12

Midwives v. births (2002 - 2011)



Source: England: Monthly NHS Hospital and Community Health Service (HCHS) Workforce Statistics in England – September 2012, Provisional Statistics December 18, 2012. Wales: StatsWales, Registered Midwives – WTE as at 30 Sept. Title: Hlth0411: Nursing, midwifery and HV staff; ONS, Characteristics of Birth 2, England and Wales, 2011, 2011 (final), 07 Feb 2013, table 1, Live births by sex, 1838-2011.

Figure 3 Midwives vs births 2002-11

The latest data from England is encouraging – 400 more midwives working in the NHS[†] in 2012 than 2011. ‘England is the star when it comes to training midwives with a record number of midwives-in-training currently.’³ The number of graduates from midwifery training in

England, Wales and Northern Ireland has increased from just over 1,000 in 2002-03 to over 1,500 in 2009-10.³¹ But there is much ground to make up. Using the Birthrate Plus (BRP) methodology,⁹ the RCM estimates there is still a shortage of thousands of midwives.

The trend of midwives working part-time is continuing, which suggests newly recruited midwives are working to previous patterns.

[†] 96% of midwives in the UK work in the NHS.

⁹ Birthrate Plus is a maternity workforce planning tool used across the NHS which takes into account the findings of the Safer Childbirth report²² in regards to midwifery staffing and skill mix.

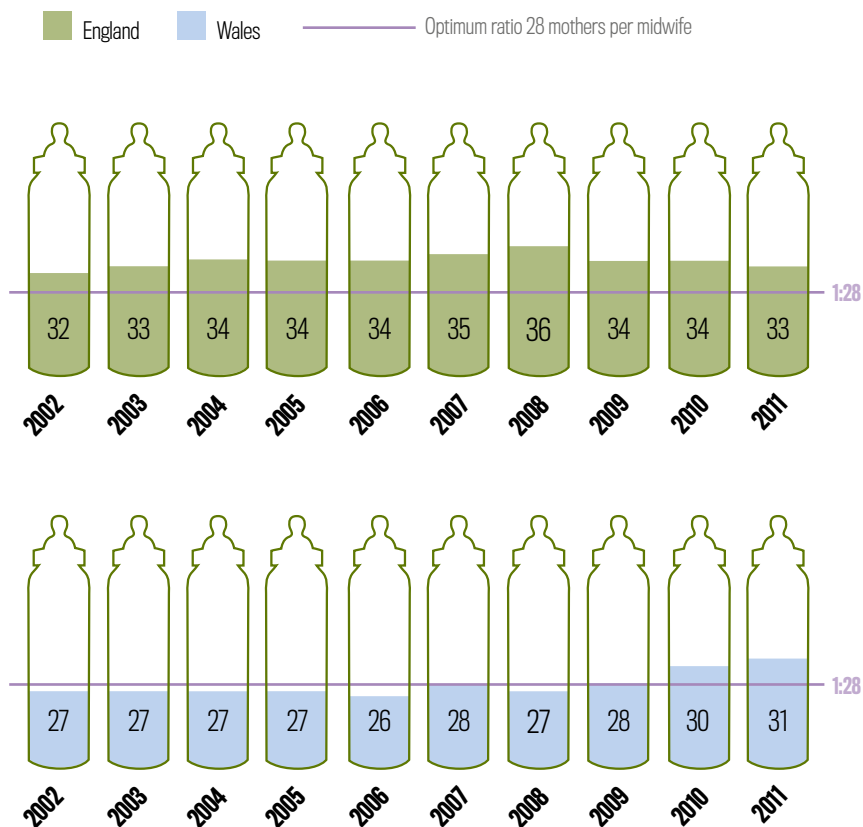


Figure 4 Ratio of midwives to births in England and Wales

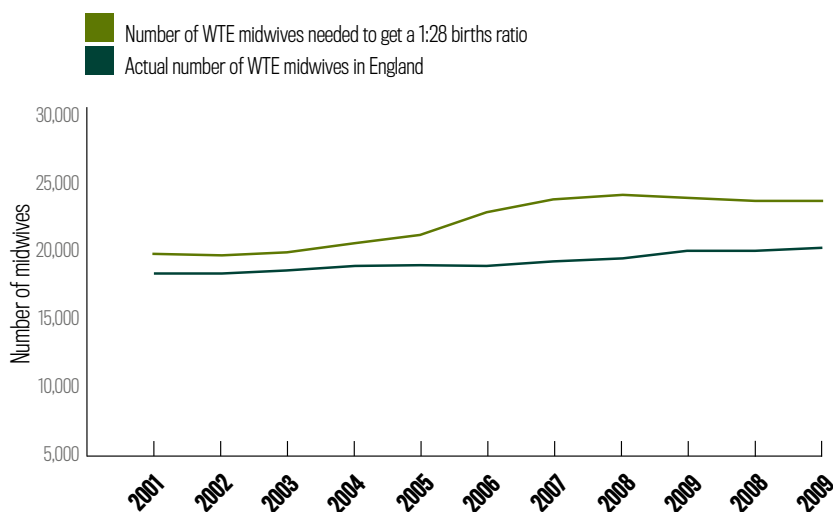
Source: England: Monthly NHS Hospital and Community Health Service (HCHS) Workforce Statistics in England - September 2012, Provisional Statistics December 18, 2012. ONS, Characteristics of Birth 2, England and Wales, 2011, 2011 (final), 07 Feb 2013, table 1, Live births by sex, 1838-2011.

Source: StatsWales, Registered Midwives - WTE as at 30 Sept. Title: Hlth0411: Nursing, midwifery and HV staff; ONS, Characteristics of Birth 2, England and Wales, 2011, 2011 (final), 07 Feb 2013, table 1, Live births by sex, 1838-2011.

Figure 4 above shows that the number of births to midwives (per year) ratio in England has improved in recent years, and London in particular has run a very successful recruitment programme.¹⁰ However, the ratio has never been lower than

1:32 over the last decade, when the ratio recommended for safe care in hospitals by four Royal Colleges is 1:28.²² The Royal College of Midwives (RCM) estimates England is still short of 5,000 midwives today.³

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Source: England: Monthly NHS Hospital and Community Health Service (HCHS) Workforce Statistics in England - September 2012, Provisional Statistics December 18, 2012. ONS, Characteristics of Birth 2, England and Wales, 2011, 2011 (final), 07 Feb 2013, table 1, Live births by sex, 1838-2011.

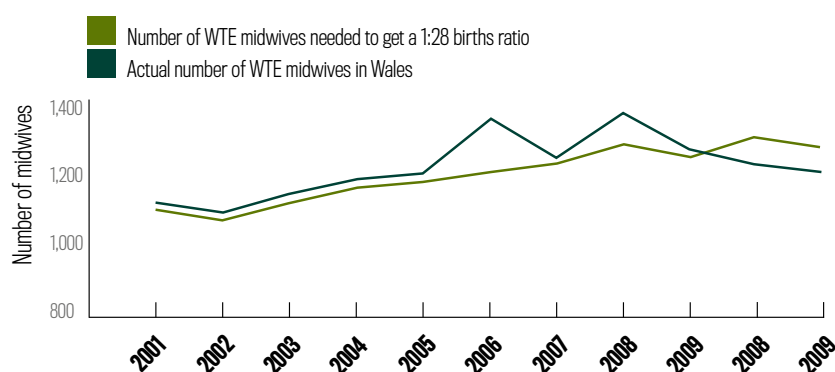
Figure 5 How many midwives does England need?

The number of midwives has decreased in Wales for the last three years running, and the Auditor General in January 2012 found four of the seven health boards in Wales were short of midwives to meet required standards.

The Care Quality Commission used its first 'market report' in 2012 to say maternity care was a growing problem for the NHS. Its investigations found one in seven hospital trusts providing maternity care in England didn't have the recommended standard of one midwife for every 28 births and almost one in 20 midwifery posts was vacant.⁴

In Wales, however, the story has been different. For most of the baby

boom, Wales' midwifery workforce was adequate, safely meeting the 1:28 ratio. Now, the situation has changed for the worse (see figure 6). The number of midwives has decreased in Wales for the last three years running,³ and the Auditor General in January 2012 found four of the seven health boards in Wales were short of midwives to meet required standards.³²



Source: StatsWales, Registered Midwives – WTE as at 30 Sept. Title: Hlth0411: Nursing, midwifery and HV staff; ONS, Characteristics of Birth 2, England and Wales, 2011, 2011 (final), 07 Feb 2013, table 1, Live births by sex, 1838-2011.

Figure 6 How many midwives does Wales need?

Following the reports by the Auditor General in Wales and more recently, the Welsh Assembly Public Accounts Committee, the Welsh Government and the Royal College of Midwives and have begun working to address the recommendations, and developments to hold Boards to account for outcomes – including staffing – are forthcoming.

Looking more closely at the ratios for individual regions in England provided by Parliamentary Question data, and in Wales from the ONS and StatsWales, we can see that it has been easier for some regions than others to manage their births-to-midwife ratio over the last decade.

Ratios have not increased in every region of England and Wales over the last decade, despite all regions having experienced an increase in births of at least 15% over the same period. Recruitment of midwives by trusts/boards has, therefore, been

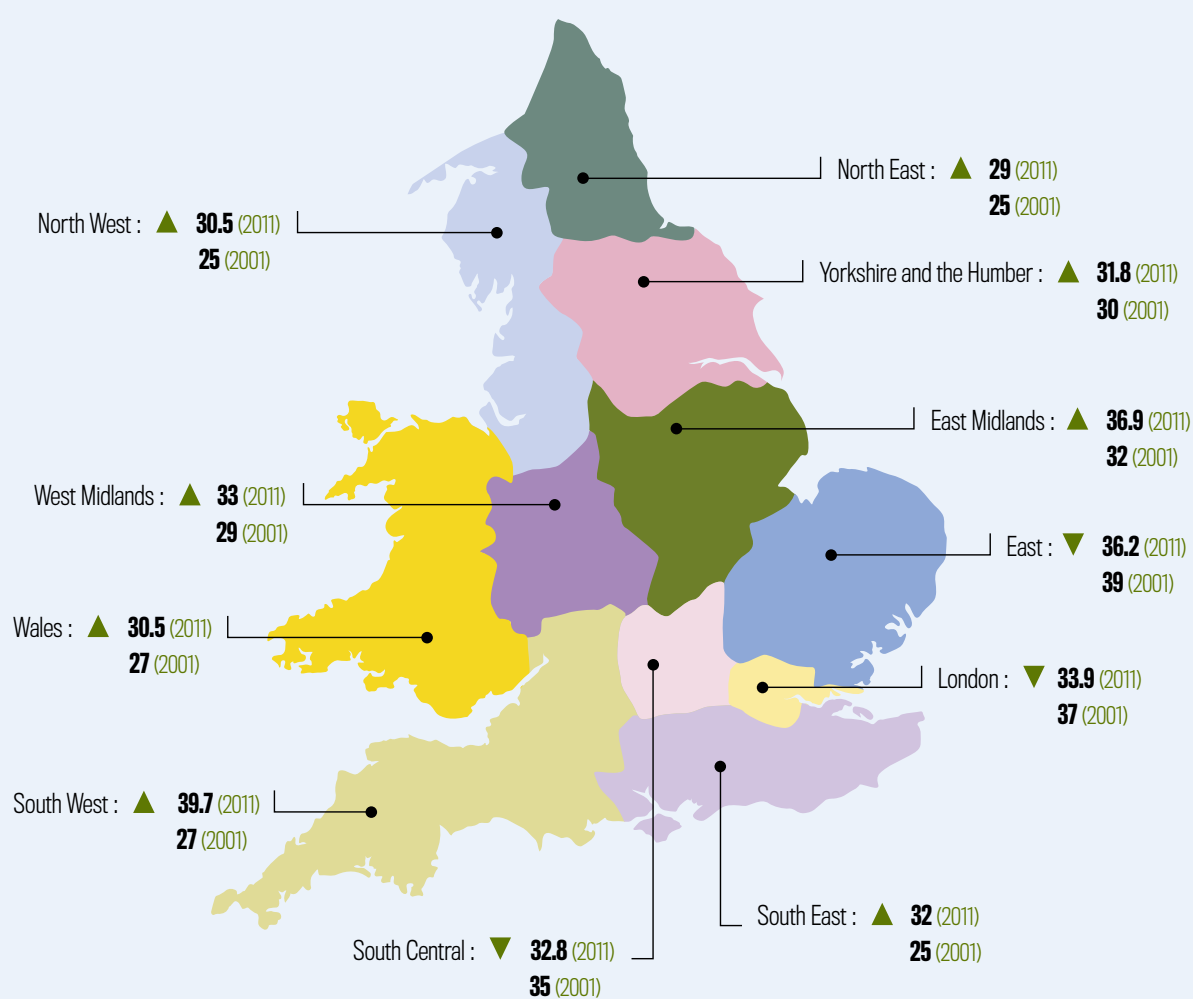
key to keeping a ratio in check and in 2007 the Department of Health noted the different approaches of trusts to staffing and the ‘marked geographical variation in vacancy rates...between employers operating in similar labour markets’.¹⁷ London in particular has been most successful at managing its birth increase – despite births increasing by 26%, it has lowered its overall midwife to births ratio over the decade (see figure 7).

MIDWIFE RECRUITMENT

The main cost in maternity care, like in all health care, is staff costs. Evidence suggests that the reduction in funding for the NHS has had an impact in the recruitment and retention of more midwives, but in fact, shortages of midwives were present before the Nicholson challenge. This was because of the increase in births, but also a shortage of new graduating midwives to replace those retiring.³⁴ The Healthcare Commission in 2008 reported many maternity services

Evidence suggests that the reduction in funding for the NHS has had an impact in the recruitment and retention of more midwives, but in fact, shortages of midwives were present before the current economic challenge.

The ideal ratio of births to midwife is **28:1**



Source: English Regions: HC Deb, 27 Nov 2012, column 231Q (WPQ 130090); HC Deb, 17 Oct 2011, column 763W (WPQ 73919); HC Deb, 4 April 2010, Column 680W (WPQ 50471); HC Deb, 13 September 2010, c780W (WPQ 13955); and HC Deb, 17 Dec 2008, column 913w (WPQ 243628). Wales: StatsWales, Registered Midwives - WTE as at 30 September. Title: Hlth0411: Nursing, midwifery and HV staff; and ONS, Characteristics of Birth 2, England and Wales, 2011, 2011 (final), 07 Feb 2013, table 1, Live births by sex, 1838-2011.

Figure 7 Births per 1 WTE midwife by region, 2001-11

were short of staff,³⁵ and the turnover rate for midwives reported in 2009 was 6.4%.³⁴ The situation isn't helped by findings that 20% of students drop out during their course and a further 5-10% drop out in the first 18 months of service.¹⁰

In February 2008, Health Secretary Alan Johnson announced a package of measures to recruit an extra 4,000 midwives to the NHS over the following three years. The Coalition government continued this work and pledged training places would hit record numbers in 2012-13, reaching 2,578. This resourcing into training new midwives has positively affected the predictions for the workforce supply in the future.

The Centre for Workforce Intelligence (CfWI) predicts the midwifery workforce in England will increase by 22% from 2010 to 2016, to 29,297 FTE midwives. The CfWI modelling forecasted the supply of registered midwives – based on a 1:28 ratio and taking into account attrition and training commissions – would meet demand by 2013.¹⁰ The Chief Nursing Officers of the four nations also agree that there will be enough students to cover retirements, though they note a caveat that 'this information...relies

on accurate birth projections and past projections have significantly underestimated birth trends over the last ten years'.²

Similarly, in Wales, the Chief Nursing Officers concluded that from 2012 to 2020 'Wales have a near matching of supply of students to cover retirements while maintaining the same level of midwives to birth ratio'.²

The key, therefore, to ensuring that the 1:28 ratio becomes a reality is the action taken by trusts and boards to employ the thousands of midwives trained to work in their services. Information from trusts and boards from previous research and our FOI requests does not present a clear picture of this happening (see below). The RCM's survey of Heads of Midwifery in 2010 found two thirds of HoMs said they did not have enough staff to cope with demand and 30% said they had been asked to reduce staffing levels.²⁰ The RCM is also concerned that the pay freeze in midwifery salaries – like many others working in the NHS – and the low starting salary for new graduates 'will create recruitment and retention problems in already understaffed maternity units'.²⁰

The key to ensuring that the 1:28 ratio becomes a reality is the action taken by trusts and boards to employ the thousand of midwives trained to work in their services.

Midwife to birth ratios

	Number of trusts/boards who provided their ratio to us	Average midwife: births ratio of those trusts/boards by region	2011 BBC data average ratio
East Midlands	3	1: 30	1: 31
East of England	9	1: 31	1: 34
London	12	1: 31	1: 33
North East	3	1: 27	1: 28
North West	8	1: 30	1: 32
South Central	6	1: 32	1: 34
South East Coast	6	1: 33	1: 36
South West	6	1: 32	1: 28
Wales	4	1: 29	1: 25
West Midlands	2	1: 33	1: 32
Yorkshire and the Humber	10	1: 31	1: 32
Total	69	1: 31	1: 31

Table 1 Midwife to births ratios supplied by trusts and boards

We asked trusts and boards about their current midwife to births ratio and if they had plans to improve it: 69 were able to tell us of their ratio, while 53 were able to supply further information about how their ratio was being set, monitored or implemented. Comparing this sample of trusts with what 117 trusts/boards reported to BBC *Panorama*³⁶ a year earlier (see table 1), there has been an overall improvement in the ratio. Only two regions have seen their ratio decrease: Wales, and the West Midlands. Wales's ratio is particularly notable as the number of midwives in Wales has decreased as the birth rate has plateaued.

Many trusts/boards disputed the premise that each maternity unit should aim for the ratio of 1:28, instead, for instance, relying on

guidance from their Strategic Health Authority. Similarly the King's Fund is sceptical about using the 1:28 ratio as a benchmark, and is calling for more research to fill the gap in evidence 'about whether its use contributes to improved safety'.³³ Trusts and boards provided a variety of responses to the question of how they are approaching the question of midwife to births ratios.

The RCM survey of HoMs found this too, with responses about the use of Birthplace Plus including [we are] using an adapted version of Birthrate Plus. Recommend all units in the region to be working towards a ratio of 1:30', and 'I feel that the Exec team (including the Director of Nursing) are of the view that Birthrate Plus is ... too idealistic'.²⁰

What plans do you have in place to improve your birth to midwives ratio?	Number of trusts/boards
Birtherate Plus run, current staffing is compliant	14
Review or Birtherate Plus run, more midwives coming soon	7
Asked for more midwives – business case rejected	1
Vague plan to improve over next three or more years	3
1:28 ratio only met with temporary staff or when no staff are sick	4
Planning more community midwives/Health visitors/maternity assistants to meet ratio	3
Have asked for more midwives, waiting on board decision	5
Going to run Birtherate Plus or staffing review soon	8
Recently hired more midwives (yet still short of ratio)	2
Trust says care is safe without meeting the ratio	3

Table 2 Trusts and boards responses to births to midwife ratio question

The Welsh Assembly too, found problems with boards' approach to staffing ratios despite them being advised to comply with Birtherate Plus guidance.³⁷ The Public Accounts Committee was concerned that 'the Welsh government is not necessarily receiving accurate or consistent data from health boards on the number of well-trained medical and nursing staff who are actually working in maternity services on a day-to-day basis', and further:

'We cannot be confident that health boards are necessarily meeting standards set by Birtherate Plus. Until methods of data collection are improved, health bodies could potentially continue to fall short of the recommended midwifery staffing levels set out by Birtherate Plus.'³⁷

A year later we followed up the question put to trusts and boards in *Panorama's* 2011 investigation about the number of midwives employed (see figure 9). Many have shown

improvement from the snapshot on 1 May 2011 to that on 1 May 2012, which is encouraging. But some have had a reduction in the number of midwives, while the number of women in their care has increased.

- 71 trusts/boards have more midwives now
- 50 trusts/boards have fewer

In Wales, each maternity service 'has now completed the Birtherate Plus assessment which led to some successful bids for an increase in midwife numbers'. But not all boards in Wales had 'reached the BRP standard' and the LSA notes 'funding pressures make this a constant struggle'.²⁷ In the South East, while Birtherate Plus modelling was undertaken by all trusts in 2009, only one trust had achieved the target workforce ratio by the time of the 2011-12 report.²⁶ Of the 15 trusts in the North East, only three had undertaken a Birtherate Plus assessment since 2010. Three trusts have plans to run the assessments in

Many trusts/boards have shown improvement from the snapshot on 1 May 2011 to that on 1 May 2012, which is encouraging.

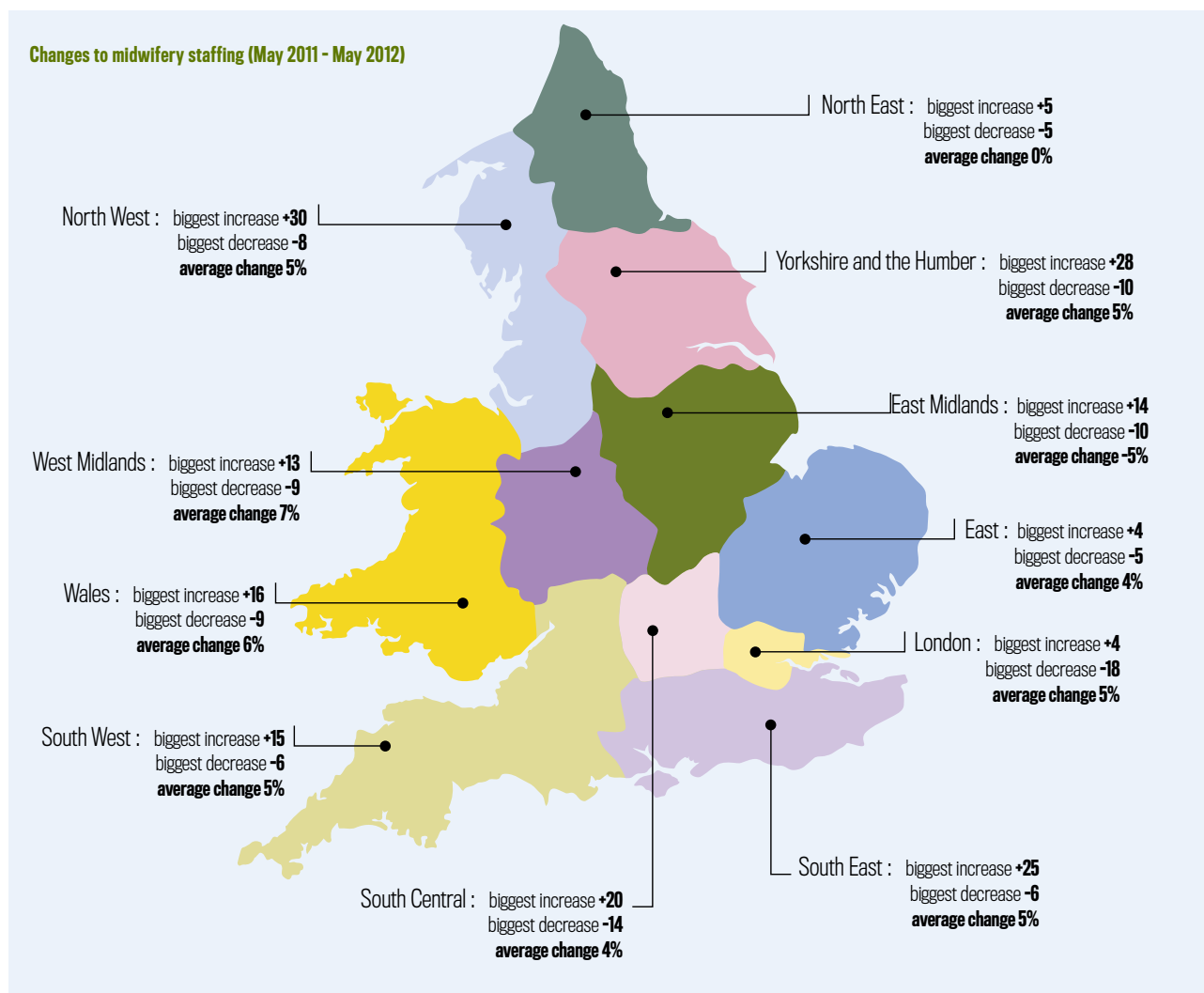


Figure 8 Percentage difference in midwifery WTE of trusts/boards, 1 May 2011 vs 1 May 2012

the near future, but others, including those who had last used the tool *seven years ago*, have no plans to do so.²¹

We urge maternity planners to review their maternity staffing with a view to fulfilling the standard set by the four Royal Colleges of a midwife to births ratio of 1:28 in hospital settings.

In Wales, not all boards have reached the Birthrate Plus standard and 'funding pressures make this a constant struggle'.

WHAT DOES IT MEAN FOR MIDWIVES WHEN THERE AREN'T ENOUGH OF THEM

Midwives are saying that they are coping with a workload that a few years ago would have been intolerable. When you don't have enough staff it has implications for safety. Problems affecting the mother or the baby can get missed, which could make it more difficult to arrange a fast response.

Jane Sandall, Professor of Social Science and Women's Health at King's College London

In 2012, the CQC concentrated its report of maternity performance on staffing of maternity units, as 'in line with our general findings across health and social care, staffing issues are the biggest area of concern when assessing the risk of poor quality care'.⁴

Staffing shortages affect women, care providers and midwives in many different ways. For women, it means rushed care, poorer support, less choice and a lack of continuity. It stops the care they should get – as set down for them and promised by successive governments – from happening. For trusts and boards, it means having to suspend or limit services. Further chapters in this report will explore in more detail these impacts.

For midwives, staff shortages mean burn out, frustration and disillusionment. The wider funding squeeze also affects midwives' training opportunities, their ability to mentor others and the chance to practice in the way they would like.

LOW PRIORITY FOR MATERNITY, LOW MORALE

The RCM notes that while midwifery has always been a challenging and fulfilling career, the pressures today are significant: 'understaffed units and an inability to progress ... the increasing complexity of cases, pressures to make efficiency savings in trusts/boards and verbal and physical abuse in the workplace'.²⁰ Some regions' midwives face unique challenges, like a reorganisation or refurbishment of units (which influences births-to-midwife ratios), lack of understanding of commissioning,²³ or particular birthing trends, such as 'free birth', which presents 'duty-of-care' challenges.¹

Alongside these challenges, changes to pensions and a pay-freeze have resulted in midwives 'working harder for less money'.²⁰ But NHS employers say the evidence from maternity providers is that an increase in pay-scales for midwives would not improve the recruitment, retention or motivation of staff; this requires 'wider solutions'.³⁸ Contributors to the *Safe Births* Inquiry in 2008 claimed that maternity services were of low priority for trust boards. Some claimed that this was due to the absence of centrally imposed targets, which are set for other areas of health care and command board attention.³⁹

The latest NHS staff survey finds morale among midwives was poor. Only 51% of midwives agreed or strongly agreed that they were able to deliver the care that they 'aspire to'. When asked about the extent to which their organisation values their work, only 31% were satisfied

The wider funding squeeze also affects midwives' training opportunities, their ability to mentor others and the chance to practice in the way they would like.

or very satisfied.⁴⁰ The previous year's survey found over 50% said they had thought seriously or very seriously about leaving their jobs, and over three-quarters cited workload and stress as the main reason why they want to leave. A further 76% said staff shortages were another reason why they considered leaving.⁴¹ In Wales, Supervisors of Midwives (SoMs) stepping down and taking extended leave of absence is 'of particular concern', and is being attributed to 'increasing pressures on midwives and midwifery services generally'.²⁷ Similarly, 'stress', leading to resignations and leave of absences is caused by the 'prevalent' practice of calling South East Coast SoMs into units at times of peak activity.²⁶ The South West notes its difficulty in attracting midwives to step up to become SoMs, partly because some midwives feel the extra responsibilities are simply added to their existing workload.¹⁹

Statutory supervisory and training is threatened by the lack of midwives. Most LSA regions noted clinical demands eat into the time when SoMs are supposed to be undertaking supervisory activity;^{12,13,23,42} in London, an audit found 84% of SoM teams 'are overwhelmed by their substantive posts and find the competing demands a challenge'.¹³ SoMs have reported carrying out their role 'in their own time because they are so passionate about the difference their support has on midwives practising'.^{19,43} The RCM survey of HoMs found 41% of their training budgets were being cut and some HoMs said midwives would have to complete online courses in their own time or would have to

fund their own delegate fees for courses. Time for training is cut 'as [midwives are] needed on the shifts for clinical safety'.²⁰

We urge maternity providers to provide dedicated time across the NHS for supervisors of midwives to carry out their statutory duties, and to avoid using Supervisors of Midwives as a stop-gap measure to cover for chronic staff shortages.

We urge Clinical Commissioning Groups and boards to place maternity care of women in their local area as a high priority and to view the work of midwives as such.

WHAT ELSE COULD HELP?

The role of the Maternity Support Worker (MSW)

There is a growing recognition that those working alongside midwives – their numbers and what they do – will be key to improving maternity services. The King's Fund study on staffing in maternity units found that the evidence linking outcomes with absolute staffing levels in maternity is mixed and 'the skill-mix of available staff and the way they are deployed was more important than absolute numbers'.³³

There is currently little detailed information about maternity support workers in England and Wales and what value they bring to maternity care.^{24,32,44} MSWs (also sometimes known as Healthcare Support Workers) work under the supervision of qualified midwives, in both hospital and community settings, and can perform a range of tasks such as preparing equipment, making observations, record taking or parent education.⁴⁵

The South West notes its difficulty in attracting midwives to step up to become SoMs, partly because some midwives feel the extra responsibilities are simply added to their existing workload.

The RCM supports the deployment of MSWs 'where they are appropriately trained, pay banded, managed by midwives and work as an integral part of the maternity care team ... [MSWs] must not be used as substitutes for midwives or to cover shortfalls in midwifery staffing numbers'. The RCM believes that the ratio of midwives to MSWs who are providing clinical care should be 90:10, based on Birthrate Plus calculations.⁴⁶ The West Midlands LSA reported on its use of MSWs – its ratio was 78:22.²⁹

The King's Fund review of England's maternity services⁴⁷ identified the impact of a shortage of midwives was compounded by their administrative overload. The 2008 inquiry into maternity services found midwives were sometimes diverted to tasks that could more appropriately be done by maternity support workers, theatre support staff, nurses or cleaners.³⁹ The Chief Nursing Officers of the nations argued 'maternity services should have appropriate support systems in place to avoid this misuse of a valuable and skilled [midwifery] resource'.³⁰ MSWs are thus viewed today as a critical part of the maternity service provided to women, and some trusts have begun to formalise MSWs' training and role, in order to deliver 'the skill mix element of the midwifery workforce growth'.¹²

The use of MSWs – and more generally, their skill mix – has been identified recently as being key to the maternity staffing problem. It is generally agreed that further research is required 'to firmly establish the implications of the use of support workers on safety and quality, paying particular attention to the level of training and supervision they require'³³, but this is especially necessary as 'skill mix'

grows in importance over 'absolute numbers':

'There is clearly a need for minimum levels of staffing in maternity services, but there is evidence to suggest that it is not just about absolute numbers of staff but also about effective deployment of existing staff. ... Although much of the evidence is mixed, and some needs to be treated with caution, there are examples that demonstrate the potential to bring about productivity gains while maintaining – and in some cases improving – safety and women's experience of birth. Midwife-led models of care, in particular, appear to offer positive outcomes and experience and a potential for cost-saving. There is potential for further task-shifting – e.g. to nurses and support workers – within maternity services and some of these models of staff deployment warrant further exploration.'³³

Other ways to optimise midwives' time

LSA reports from all over England and Wales show innovative approaches to making the best use of their midwives to care for women. For instance, trusts have introduced 'triage' systems to help give midwives in the labour ward the time and space to care for those women in the second stage of labour and beyond and mitigate the effects of a shortage of staff. Trusts in the South East Coast have developed a system where 'women are able to phone to receive support and can be seen for assessment to determine whether they are in established labour, at which point they are directed to the labour ward or the midwifery-led unit... The midwives on labour wards

The 2008 inquiry into maternity services found midwives were sometimes diverted to tasks that could more appropriately be done by maternity support workers, theatre support staff, nurses or cleaners.

are, therefore, free to care for women in established labour, facilitating the provision of one-to-one care'.²⁶ These changes have resulted in the percentage of midwife time spent on direct care increasing from 32 to 50% over seven months and a reduction in the number of complaints from women. Furthermore, 'no additional costs have been incurred'.³³

More research on how Midwifery Support Workers can help women and the midwifery workforce is needed, and we urge trusts/boards to consider their use to give midwives more time to put their skills to use most effectively. We encourage trusts/boards and units to share best practice on innovative ways to provide the right care for women in the right place by the right people.

The use of MSWs – and more generally, their skill mix – has been identified recently as being key to the maternity staffing problem.

MY MIDWIFE AND ME - THE RELATIONSHIP BETWEEN WOMEN AND THEIR MIDWIVES

“My Lords, women should expect to have one-to-one care from a midwife during labour, birth and immediately after birth, and to continue to have the support of their midwife after the birth.”

Earl Howe Parliamentary Under Secretary of State for Health¹

“It was very daunting being so vulnerable and being cared for by strangers.”

First-time mum WI member from London

“21% of midwives disagreed or strongly disagreed with the statement ‘I am satisfied with the quality of care I give to patients/service users.’

Results of 2012 NHS Staff survey

In recent years, the relationship between a woman and her midwife has grown in importance, as research began to show its impact not only on the birth experience for women, but on clinical outcomes for her and her baby. The relationship is critical during the whole of the care pathway.

During labour, one-to-one care has been shown to positively affect women's satisfaction with their birth experience, make labour shorter, and lower the need for expensive medical interventions like C-sections or forceps deliveries.²⁻¹¹

Further, studies have shown care during pregnancy by one midwife, or a small group of midwives, has improved women's confidence going into labour, their overall satisfaction with antenatal care, and positively impacts on outcomes during the intrapartum period.¹² Women's

perception of their safety and ‘risk’ is also affected by having a midwife with them. For some women, ‘unsafe’ care means being left alone, not knowing who was caring for them and not receiving the full attention of their midwives.^{9,13}

Links have been identified between normal birth rates and aspects of the woman-midwife relationship. ‘Normal birth’ in broad terms means birth without medical interventions. For some women, intervention is essential for the health and wellbeing of them and their babies. For others, interventions are an empowered choice. But for some women, interventions happen when other aspects of care have been deficient and this leads to worse outcomes for them and their babies.¹⁴ National policies have tried to advocate normal birth and decrease the amount of unnecessary interventions

During labour, one-to-one care has been shown to positively affect women's satisfaction with their birth experience, make labour shorter, and lower the need for expensive medical interventions like C-sections or forceps deliveries.

in both England and Wales. But 'inadequate midwife staffing levels are consistently cited as an impediment to achieving this goal'.¹⁵ Continuity and one-to-one care in labour are practices that are 'likely on past evidence to increase opportunities for normal birth without compromising safety'.⁵ These practices are dependent on having enough midwives.¹⁶

The importance of the relationship between a woman and her midwife is reflected throughout the guidance to midwives, commissioners and providers of maternity care in England and Wales. Advice to maternity commissioners suggests better access to community antenatal care could save millions of pounds, through enabling women to contact their midwives first, rather than going into hospital: 'Almost half of all spending on maternity care is unscheduled antenatal care – that is additional care beyond the routine and planned care women receive from their midwives and doctors... A large number of women also make contact with maternity services out of hours with queries about travel advice, swollen ankles, "large-for-dates"... In most cases these women have not sought any other advice before attending. If women with these low level medical conditions can be supported and cared for in primary care, this will ease the pressure on busy maternity units and save commissioners money'.¹⁷

Midwifery 2020's key principles for midwifery care included 'women should receive the majority of their midwifery care by the same midwife'; 'women should have 24-hour access to advice and support from a midwife when they think they are in labour' and 'women should have one-to-one

midwifery care when in established labour'.¹⁸ NICE stresses that pregnant women should be cared for by a named midwife throughout their pregnancy,¹⁹ and that women should be 'offered supportive one-to-one care' and shouldn't be on their own during labour unless they wish to be.²⁰ Commissioning Groups, who have just taken over commissioning maternity care in England, have been advised that 'continuity in all aspects of maternity care is vital, from antenatal care through to support at home. Mothers and their families should feel supported and experience well-coordinated and integrated care'.⁴ This means they will need to focus on one-to-one care in labour, as well as providing 'adequate staffing and a skill mix and deployment that ensures midwives are able to deliver continuity of antenatal and postnatal care'.⁴ RCM, RCOG and NCT guidance to commissioners has also stressed that one-to-one care in labour should 'be a top priority of maternity providers'.¹⁷

However, surveys of women experiencing maternity care consistently show that aspects of the relationship between women and their midwives do not always develop in line with the guidelines and policy.

A survey of 5,000 women in 2010 found the proportion of women who had previously met any of their midwives caring for them during labour and birth was 19%.⁶ A survey of 25,000 women the same year found this figure was 25%.²¹ Another study of 2,000 women found 42% of mums felt they knew their midwives 'not very well' or 'not well at all'.²²

More surveys in 2010 found one in five labouring women were left alone

NICE stresses that pregnant women should be cared for by a named midwife throughout their pregnancy, and that women should be 'offered supportive one-to-one care' and shouldn't be on their own during labour unless they wish to be.

at a time when it worried them⁶, half of them had three or more different midwives caring for them postnatally,⁶ and 42% of first-time mothers felt there were only ‘sometimes’ or ‘never’ enough midwives available to help them in hospital after the birth of their baby.²³

Our survey follows on from this previous work and asked a variety of questions relating to women’s relationship with their midwife. Our FOI requests asked how trusts and boards were facilitating various aspects of this relationship.

A NAMED MIDWIFE TO CONTACT

“We have listened to the concerns of women about their experiences of maternity care, which is why we are putting in place a ‘named midwife’ policy to ensure consistency of care.”

Andrew Lansley, (Former) Secretary of State for Health, 16 May 2012²⁴

We asked trusts and boards for the proportion of women who were assigned a particular midwife

by 12 weeks. Unfortunately, the question was interpreted in different ways across trusts/boards. Some supplied their ‘bookings by 12 weeks’ statistics, and did not refer to whether these women booked were also supplied with a named, specifically ‘assigned’ midwife. Others specified that women were assigned a ‘team’ of midwives. Others were unable to provide any information on women beginning their maternity care at 12 weeks, nor the allocation of a midwife or team.

Only four trusts/boards said specifically that they had a policy of assigning women to a ‘team’ of midwives. It may be that many of the 46 who could supply data on women ‘booking by 12 weeks’ also have team allocation rather than ‘named midwife’ but this was not stated in their responses. Certainly ‘team’ allocation is what many women in our survey report – when asked whether they had a name and number of a dedicated midwife, they chose ‘other’ and explained they had a team. We have reclassified these to ‘no’, as the Westminster government pledge (above) is to be allocated *one* midwife, not a team.

More surveys in 2010 found one in five labouring women were left alone at a time when it worried them, half of them had three or more different midwives caring for them postnatally, and 42% of first-time mothers felt there were only ‘sometimes’ or ‘never’ enough midwives available to help them in hospital after the birth of their baby.

‘What was the proportion of women who were provided with a name and contact details of an ‘assigned’ midwife for her care by the 13th week of their pregnancy?’	Number of Trusts/boards
Provided % of women with named midwife by 13 weeks	7
Provided ‘% booked by 13 weeks’ data; no mention of midwife allocation	46
No booking data provided; stated policy that every women gets a named midwife	18
No booking data provided but data collection starting soon; stated policy that every women gets a named midwife	1
No booking data provided but data collection starting soon; stated team allocation policy	2
No booking data provided and stated team allocation policy	2
Nothing recorded or not recorded electronically for ease of retrieval	15
Total	91

Table 1 Responses by trusts and boards to allocated midwife

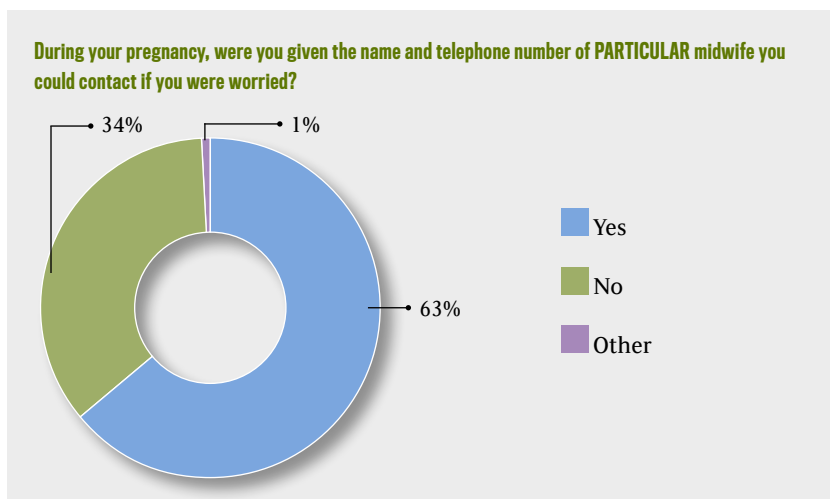


Figure 1 Responses to survey question on 'allocated midwife' (n=5579)

There is also a marked difference between women from different regions reporting being allocated

one midwife; London's rate of only 40% is markedly less than other regions.

There is also a marked difference between women from different regions reporting being allocated one midwife; London's rate of only 40% is markedly less than other regions, for example, Yorkshire, where 89% of women can be expected to be allocated one midwife.

Proportion of women having name and telephone number of dedicated midwife

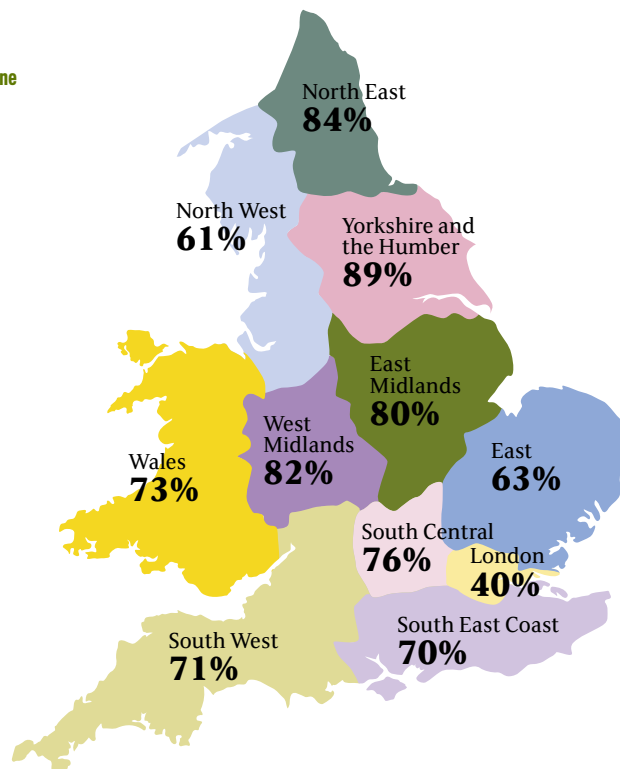


Figure 2 Allocated midwife by region (n=5540)

While 1,915 women were not given the name and number of a particular midwife, we know from free text answers that 22% of these women were instead assigned to a team, and given a phone number to reach any of that team (for instance, the number for the birthing unit, or 'team of midwives answerphone'). Other women said they had their obstetrician's/GP's/independent midwife's name and number.

We asked WI members about their use of the named midwife service: whether they called their midwife and what was useful about talking with her. Of 140 women with a number to call, only 66% actually did so. We

asked remaining 47 women who didn't call about their reasoning for this: 91% didn't feel they needed to and the others felt uncomfortable, suggesting that this service is not necessarily essential for all women (though as this sample is small, firm conclusions are not appropriate).

However, of the 92 women who called their midwife, 53% on at least one occasion were not able to speak with her. Only six women were able to call somewhere else (the birthing unit, for instance). The remaining 46% who did speak with their midwife wrote what was useful about calling. The answers show the variety of mothers' needs during the antenatal period:

We asked WI members about their use of the named midwife service: whether they called their midwife and what was useful about talking with her. Of 140 women with a number to call, only 66% actually did so.

'Good to have someone to run by all your worries, and as a woman who's never been through this experience before you have LOTS of worries!'

'I had an independent midwife whom I saw at least very two weeks during my pregnancy and yes it made all the difference in the world for both my pregnancy and birth'

'Yes, she helped with concerns regarding blood sugars.'

'Of course yes. My little boy got chickenpox when I was pregnant. I had never had it so had to discuss with my midwife the risks to me and my unborn baby.'

'Yes. She was very reassuring – much needed having previously lost five babies in pregnancy.'

'Yes, put my mind at rest in-between appointments. It wasn't anything urgent so just talking to someone helped.'

Not all found it useful:

'Not really – I felt she was under time pressures and it is difficult to communicate properly with someone and feel reassured when it is over the phone.'

'On reflection, I feel disappointed with the midwife care whilst pregnant. I saw lots of different people, no one knew me, too many patients – not enough midwives.'

'When I phoned the midwives in the community office they were never there and was put through to the antenatal ward. They were rude, aggressive and dismissive, so no – I can't say that's very helpful.'

'When I phoned the midwives in the community office they were never there and was put through to the antenatal ward. They were rude, aggressive and dismissive, so no – I can't say that's very helpful.'

We urge maternity providers to make it clear to women who they can call and the best phone number to reach them on. While most women have some way to contact 'a' midwife (be it her specifically assigned midwife or one of a team), this does not necessarily facilitate a relationship (though women may still receive the care and advice they need). We urge CCGs to monitor the use of 'assigned teams' by women during the antenatal period and the efficiency of this system if a 'named midwife' system is unworkable.

KNOWING YOUR MIDWIFE BEFORE BIRTH

"I didn't really see the point of the 'point of contact' midwife as when it came to the labour they were nowhere to be seen or even after, which would have been so useful. I saw little point in building the relationship over nine months then not to see them when it really counted." *First-time mum, NCT member, South Central England*

In order to begin to gauge continuity of care, and the relationship between midwives and mothers, we asked women whether they knew the midwife who was caring for them

during labour and birth before this time. We found the vast majority of women did not, and this was most

pronounced for women giving birth in hospitals, either in obstetric units or alongside midwifery units.

We found the vast majority of women did not know the midwife who was caring for them during labour and birth before this time, and this was most pronounced for women giving birth in hospitals, either in obstetric units or AMUs.

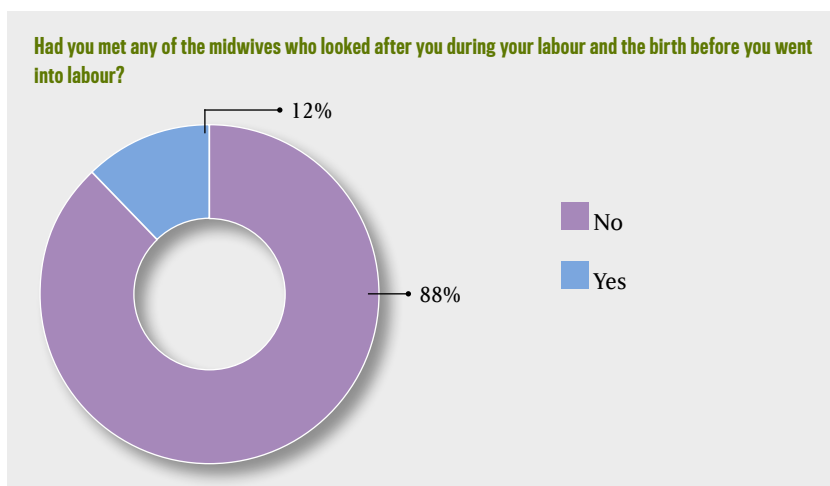


Figure 3 Knowing your midwife (n=5512)

Had you met any of the midwives who looked after you during your labour and the birth *before* you went into labour?

Birth location	No	Yes
At home	51%	49%
Freestanding midwifery unit	76%	24%
Alongside midwifery unit	90%	10%
Obstetric unit	90%	10%
Other (please specify)	71%	29%
Total	87%	13%

Table 2 Knowing your midwife, by location (n=5139)

Further, even of the women who made a choice about their birth location and gave birth there (i.e. were never transferred), the proportion who knew their birthing midwife prior to labour is still only 14%.

Women were asked about the impact of knowing, or not knowing, their midwife in labour. Overwhelmingly,

those who knew their midwife reported positive impacts. 80% of women said it made them feel more confident or more relaxed, and only 20% of women said it made no difference to them or had a negative impact. The comments from women show the extent to which a relationship with a midwife is crucial to many women's birth experiences:

Women were asked about the impact of knowing, or not knowing, their midwife in labour.



Other women mentioned how 'lucky' they felt that knew their midwives, knowing that this is a rare occurrence:

*'I was **VERY lucky** that the midwife I had seen for antenatal checks was on home birth duty Easter weekend and, therefore, was in the hospital when I went in. She took over from the midwife who was going to be with me.'*

*'I was **very lucky** as I had a lovely midwife with me throughout my entire labour, but this wasn't planned and I did worry in the last few weeks of pregnancy that I would have lots of unknown staff wandering in and out of my delivery room.'*

*'It was **by chance** we had a familiar student midwife. I was just glad to see a familiar face.'*

*The fact it was a midwife I knew was **purely coincidental**.'*

Only 19 women reporting difficulties from knowing their midwife previously, through a 'clash of personalities', for example.

Also, 119 women mentioned that 'knowing' their midwife made no

difference, sometimes because previous meetings had been so fleeting, a 'familiar face' was barely familiar. Others reported negative experiences when they had their 'known' midwife for a while, but then 'lost her':

'I had briefly met the midwife who assessed me, but none of the others. I wanted her to be in the actual labour but she was already allocated to someone else.'

Had met a couple of them, but didn't know them enough to draw any confidence from their presence.'

'The one I had met left before delivery, disappointed.'

We also asked the 4,810 women who didn't know their midwives, what impact this had on them. Options were provided for women to choose but many chose to write their own impacts. These have been classified and combined with the original options to see more clearly the pattern of impacts women reported.

In total, 3,285 women said there was no impact from not knowing their midwife, and yet over 1,000 specified a particular negative impact. Hundreds of others wrote things that are between these two poles and show the nuances of women's expectations and fears of the birth experience.

What were the impacts from not knowing your midwife? (re-categorised)	% of respondents
No impact	68%
It had a negative impact on me/my baby	21%
No impact, because I expected I would not know them	1%
No impact, but it would have been nice	4%
Negative impact from a personality clash (not from lack of familiarity)	4%
Unknown and other	2%

Table 3 Impact of not knowing your midwife (n=4,810)

What becomes clear is that the expectations of some for a 'known midwife at birth' have been lowered through the maternity care experienced to date. Further, other women stressed that the professionalism and skills of midwives and other staff were more important to them than familiarity. This mirrors findings from a 2007 study where 'the consistent theme' of women's perceptions of 'safety' of birth 'was the importance they placed on the skills and professionalism of the individuals caring for them'.⁹ These comments are a credit to midwives who have had no opportunity to build a relationship with their patients.

Other women were deeply upset and hurt by being cared for by 'strangers'. For some, this left them disempowered and unable to get the kind of birth experience they wanted. The comments also show how shift change/handover is a key point at which vulnerability increases. In conjunction with the positive comments from women who knew their midwife, and the clinical literature that demonstrates the positive impact of continuity of care, we can clearly see relationships between midwives and mothers are worth fostering.

'Not knowing my midwife had no impact on me'

'I'm truly grateful to the midwife who attended me because her expertise and quick actions saved mine and my baby lives.'

'Felt a little anxious that they didn't know me and the birth I wanted, but overall [I] trusted they knew their job and they quickly put me at ease.'

'The two midwives that looked after me were lovely and listened to our wishes – they also introduced themselves and did a proper handover.'

'I'm truly grateful to the midwife who attended me because her expertise and quick actions saved mine and my baby lives.'

'Hadn't met the midwife but she was excellent and I felt safe – this is more important than whether I'd met her before.'

'I was happy to be treated by any of these professional caring women.'

'I would have preferred someone I knew but by that point I just wanted to get some pain relief; I didn't care who gave it to me!'

'Positive impact'

'I felt happy because I hadn't become 'friends' with my midwife who delivered, so it was easier to be naked and screaming in front of a stranger!'

'No impact but I didn't even expect to know them'

'I was used to having no continuity. I saw a different midwife throughout my pregnancy.'

'I didn't mind – it was what I'd been told to expect and they were lovely.'

'It was not ideal but not unexpected.'

'I knew in advance that I would not know the midwife, but they were so professional and attentive I felt confident that I was getting good care.'

'No impact, but it would have been nice'

'I had built up a good relationship with my nominated midwife, Jenny, but I went into labour on a Sunday morning and it wasn't her turn on call. I was disappointed, because I knew she really wanted to be there for my home birth, but actually it made no difference as Gemma was great too.'

'I'd had such unremarkable antenatal care, I didn't expect to know my birth midwife though I would have preferred to.'

'It would have been nice to know them, but I hadn't seen the same midwife twice throughout my pregnancy so was used to it.'

'The midwives were lovely but every time I had an appointment I saw a different person and it would have been reassuring if I could have gone into labour knowing that I was familiar with the midwife who would deliver my baby.'

'It would have been good to have had a relationship established with them but I wouldn't say it was frustrating or made me feel vulnerable, just that it was a shame.'

'In an ideal world I would have loved to have my community midwife during my labour but she only attended home births and even if I did have a home birth there was no guarantee she would have been able to attend. Due to the length of my labour in hospital, I had three separate midwives but they were all very supportive.'

'I was sad, but it was fine.'

'Yes, not knowing her had a negative impact on me/my baby'

'I kept having to start again with new midwives – trying to build rapport and get the natural birth we wanted.'

'I found it frustrating that the doctors and midwives in surgery **didn't know my name.**'

'It added to the **apprehensions** prior to labour and I saw a number of different people in the six hour space before I was induced, none of whom attended the delivery. **I felt a bit like a specimen rather than a birthing mother during this time.**'

'Made for a more **stressful** experience as had to update each midwife on pregnancy problems etc., each time the staff had to familiarise with my history etc.'

'I just felt as if we were on a conveyor belt, **because the unit is so busy, it was so impersonal at a very emotional and vulnerable time.**'

'Had no relationship with her established [before I was] frightened or in pain. So she didn't know what behaviour was normal for me or how to best relate to me. It was much more difficult to trust her quickly. **Strange to be experiencing the most frightening and disorientating experience of my life with a stranger.**'

'It was disconcerting and not what I imagined my experience to be... At least one friendly 'seen before' face during the experience would have been nice/comforting.'

'It felt impersonal and **you were not able to build up a relationship with someone who was going to take part in the most life-changing experience I was ever going to go through...** Let alone the most vulnerable.'

'I felt at the mercy of fate/ shift patterns for getting one I felt comfortable with.'

'I would have preferred to have the midwife that I had seen during pregnancy as I would have trusted her more and she would have known me better. The midwife did not read my birth plan.'

'**Because resources were stretched, the midwives at the birth centre had been pulled onto the labour ward, so I got a replacement midwife called in from the community team who wasn't familiar with the facility.**'

Other women took steps to mitigate the effects of not knowing their midwife – they expected this to be the case and, therefore, hired more carers themselves:

'I had a doula for this exact reason, which really helped.'

'I hired my own doula to ensure continuity of care. The first midwife attending was great, but the second one had a very matronly approach, so it was great to have my doula throughout.'

Our survey shows the vast majority of women report positive effects from knowing their birthing midwife before birth and having developed a relationship with her; many women do not get the opportunity to build this kind of relationship and while they on the whole seem unperturbed, many have resigned themselves to the fact they are not likely to get to know one midwife in particular. We do not think that their low expectations should continue to set the benchmark for 'good' care.

We urge CCGs and boards to look at how providers can facilitate relationships between midwives and women during the antenatal period, and continue this into the intrapartum period, especially as many women give birth in locations which were chosen by them and known to providers months beforehand.

ONE-TO-ONE CARE IN LABOUR

"Women receive one-to-one care (one woman receiving the dedicated time of a midwife) once labour is established."²⁵ *Welsh Assembly Government, 2005*

"Maternity services develop the capacity for every woman to have a designated midwife to provide care for them when in established labour for 100% of the time."²⁶ *Department of Health, 2004*

We asked women about whether the care they were given during established labour and birth was one-to-one.²⁷ The answers show that the definition of one-to-one is not easily understood by women, and further, their expectations for it are low.

In total, 80% of women said they had experienced one-to-one care, 4.5% either did not experience established labour or were not cared for in the usual way (for instance, those undergoing caesarean sections or who birthed alone by accident) and 13% said their care was not one-to-one. The remainder could not remember or didn't know.

Our survey shows the vast majority of women report positive effects from knowing their birthing midwife before birth and having developed a relationship with her; yet many women do not get the opportunity to build this kind of relationship.

²⁷The question explained how one-to-one might work on a practical basis, taking into account long labours which might cross shift patterns: 'In England, the Department of Health has pledged to give women one-to-one care during established labour and birth. This may be delivered by more than one midwife - shift patterns and length of labour mean it is difficult to allocate a woman just one midwife during birth - but the idea is for each woman to be continuously supported. Do you feel that care given during established labour and birth was 'one-to-one'?'

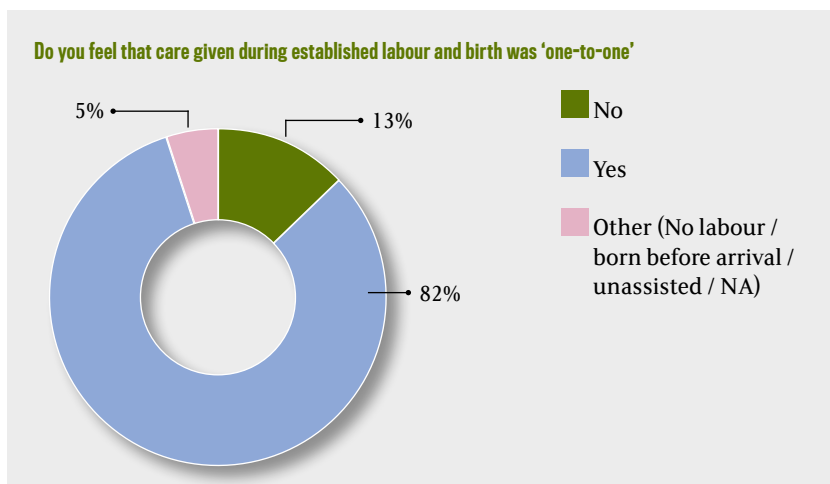


Figure 4 Do you feel care given during established labour and birth was 'one-to-one'? (n=5556)

We asked women about whether the care they were given during established labour and birth was one-to-one. One-to-one is not easily understood by women, and further, their expectations for it are low.

One-to-one care?	Yes	No	Other (No labour / born before arrival / unassisted / NA)
Birth location			
At home	86%	9%	5%
Freestanding midwifery unit	91%	7%	2%
Alongside midwifery unit	88%	10%	2%
Obstetric unit	80%	15%	5%

Table 4 One-to-one care by location (n= 5504)

Over 80% of our respondents said they experienced one-to-one care; however, this rate varies across birth locations. Of those birthing in the four main locations, mums in obstetric units are most likely to report not receiving one-to-one care in labour – 15% – compared to only 7% of mothers birthing in freestanding units. There was little geographical variation in

the delivery of one-to-one care (from 79% to 85%), but there has been an improvement across time (82% of those giving birth in 2011 onwards report one-to-one care, compared to 74% of 2007-2010 births).

Many respondents highlighted the quality of support given by midwives and other staff during labour. Others

mentioned the positive impact of midwives who stayed on or went the extra mile to keep continuity of care. What is also clear is the expectation among some women that one-to-one care *would not be possible*. Some women took the extra step of hiring other supporters, such as doulas, to compensate for what they thought would be a lack of care. Others thought that correct assumptions of what care they would receive tempered any

effect of being left alone. Comments also show how one-to-one care is patchy – women say they had one-to-one care and then write of situations when this clearly wasn't the case; one-to-one changes with every shift change, every handover, and it is at these moments that women feel especially vulnerable.

One-to-one care changes with every shift change, every handover

'Yes, I had one-to-one care'

'Pretty much one-to-one but additional midwife joined at end and very good that previous midwife stayed beyond her shift end to "see it through!"'

'I had the most competent, professional and empathetic midwife.'

'The independent midwives work in pairs so I actually had 'two-to-one' throughout – brilliant!'

'I had a team of dedicated professionals looking after me. It was about 12 to one. I feel very lucky that I had access to the NHS.'

'I had one-to-one care at different times, in different ways'

'Partly – one midwife provided 'one-to-one' care then there was a shift change and the same level of care was not provided.'

'During delivery yes, during established labour no.'

'Yes, for first 24 hours was amazing, but the last four were not. Hardly saw my midwife and she did not communicate.'

'Yes, however, over the course of my induction we saw five shift changes, this meant that some of the care was inconsistent. They would not break my waters due to the fact they were understaffed...'

'Yes, but had to wait six hours for a midwife to be available.'

'It was one-to-one until a shift change.'

'I had two midwives that kept changing every two hours.'

'In hospital, it did not feel like one-to-one care. The midwife always seemed busy – in and out of the room and filling in paperwork after paperwork.'

'Almost. But they were way too busy and not there all the time until the very end.'

'No, I did not receive one-to-one care'



We urge CCGs to look at how maternity providers manage these changeovers in the best interests of maintaining support for labouring women. It has almost been ten years since both the Westminster and Welsh governments urged providers to deliver one-to-one care.

of women felt they had one-to-one care in labour when they wanted it', but its own audit two months later in August 2012 put the delivery of one-to-one care at only 67% of women.

DELIVERING ONE-TO-ONE CARE

We asked trusts/boards for their data on providing one-to-one care. 18 replied by saying one-to-one care was a policy, or saying 'all women' received this care, but did not provide any data or detail on how this was measured. 55 trusts/boards replied with data from their own measurement. Trusts/boards varied in the ways they measured the delivery of one-to-one care in labour: some monitor this daily, others do monthly audits, or seven-day snapshots three times a year. Others use patient surveys; discrepancies can exist between what women report and what trusts and boards measure. For instance, a trust in the South West found, 'a survey of women in June 2012 showed that 92%

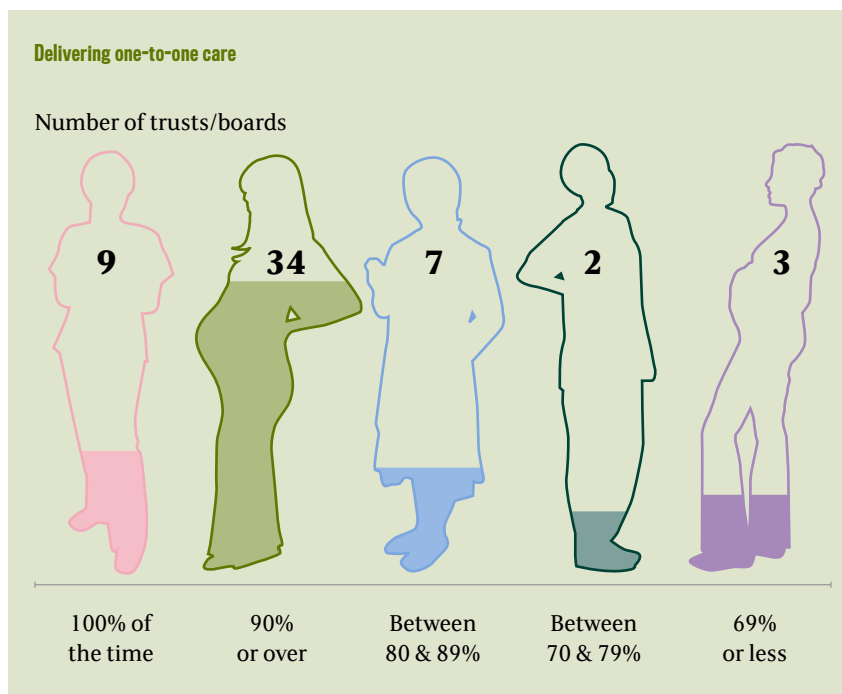


Figure 5 Delivering one-to-one care - trusts/boards who measure

Some trusts/boards also acknowledge the difference between their maternity sites. A trust in Yorkshire found their

one-to-one care was much better at midwifery-led unit sites than obstetric sites:

Women receiving one-to-one care in different sites in a Yorkshire trust			
Location	2010	2011	2012
Midwifery-led units	Mean 94.5%	Mean 85%	Mean 94%
Obstetric unit	Mean 74%	Mean 63%	Mean 65%

Table 5 One-to-one care in different sites in a Yorkshire trust

In the South East, one trust noted that while, 'all home and midwifery unit births would definitely have one-to-one care in labour ... with regard to [obstetric unit] we are actively working to have a monitoring tool in place within the next three months'.

IMPROVING ONE-TO-ONE CARE?

Whether trusts/boards are measuring one-to-one care, or what their one-to-one care is currently assumed to be, does not necessarily determine their plans, if any, to improve the provision of one-to-one care. Nineteen specified in their FOI responses that the recruitment of more midwives was key to improving their one-to-one care provision (six of these trusts/boards were not measuring how one-to-one was being delivered at the time).

Reports from Local Supervisory authorities (LSAs) make clear that one-to-one care in labour is a challenge that staff numbers directly contribute to. The impression from 2011-12 LSA reports is that while one-to-one is the ideal, and 'a goal for supervisors of midwives,²⁷ the capacity to guarantee this level of care for every women is highly dependent on staff numbers: 'The percentage of women who receive one-to-one care in labour can

be seen to decrease as capacity and midwifery resources are stretched'²⁸; and conversely, 'One of the impacts of this rise in workforce has been that in March 2012 98% of women stated they received one-to-one care in labour' (compared to 85% in August 2009).²⁹ Most maternity units in London 'reported an improvement in being able to provide one-to-one care for all women in established labour' in 2011-12,³⁰ which may be a reflection of their ability to get more staff. In 2011, London was commended by the Royal College of Midwives for facilitating a 45% rise in midwifery numbers since 2002, equivalent to almost half of the net rise in midwifery numbers in England overall, despite only 20% of births taking place in the capital.³⁰ However, London NHS trusts had previously expressed doubts about meeting the one-to-one requirement, seeing it as placing 'competing pressures on relatively scarce midwife time'.⁸

Seven trusts/boards spoke of changing their skill mix, or the way they were organised, to improve one-to-one care. Again, some of these trusts/boards currently measure one-to-one, others don't. Others have changed their systems to help give midwives in the

Nineteen trusts/boards specified that the recruitment of more midwives was key to improving their one-to-one care provision.

labour ward the time and space to care for those women in the second stage of labour and beyond. This kind of change is advocated in advice to CCGs too ('Keeping labour wards free for only labouring women is a good way of ensuring that midwives spend their time with those women'.)¹⁷ Trusts in the South East Coast have developed a system where 'women are able to phone to receive support and can be seen for assessment to determine whether they are in established labour, at which point they are directed to the labour ward or the midwifery-led unit. ... The midwives on labour wards are, therefore, free to care for women in established labour, facilitating the provision of one-to-one care.'²⁸

'We are in the process of increasing the number of maternity support workers who will take on non-midwifery duties releasing midwifery time to work on the labour ward.' *South East trust, not currently measuring one-to-one*

'Plans in progress to reduce the number of women not in established labour on the labour ward to enable intrapartum midwives to be with labouring women; increase the number of midwives on birth centre by restructuring community model; embed maternity triage; implementing of an induction of labour bay.' *London trust, currently measuring one-to-one*

Five trusts/boards said calling in community midwives was a way to improve one-to-one care.

'There is an agreed escalation policy in place to call in staff when necessary to provide one-to-one care to women in labour.' *South Central trust*

This short-term solution is worrying as these trusts/boards are all making the effort to measure one-to-one, and all said their current provision was less than 95% (one trust was only 80.1%). It also poses practical problems for mums: one respondent said she received one-to-one care but 'it was contract staff so unfamiliar with hospital, e.g. couldn't find me a pillow'.

While one-to-one care is important, prioritising women in labour over other times of maternity care is not a way to solve a staffing shortage; simply moving staff around only compromises care elsewhere and regulators in both England and Wales have stressed this point. The Care Quality Commission noted in 2012 that staff working in antenatal and postnatal care were often pulled into the labour wards, leaving those areas understaffed and unable to deliver the care that women need.³¹ Similarly, in Wales, the Auditor General reported:

'... midwife staffing resources were diverted from other activities to ensure that clinical safety was not compromised, especially during labour, where the aim must be to provide one-to-one care. However, the impact of this practice is that midwife resources are being diverted away from other important activities such as staff training and development, and from some aspects of antenatal and postnatal care'.³²

Other trusts/boards said the opening of new birthing unit or promoting normal birth would help one-to-one care be provided. Three said their plans to improve are starting with measuring how they are delivering one-to-one. Most of those who said they had no plans to improve their one-to-one care were currently

Five trusts/boards said calling in community midwives to the labour wards was a way to improve one-to-one care.

measuring it, and all were at over 90%:

‘Out of the 2,683 deliveries ... only 106 women did not receive one-to-one care ... There are no action plans or proposed measures in place as the trust is currently 96% compliant (the standard is 70%).’

West Midlands Trust

However, many trusts/boards were unable to provide any answers about their one-to-one care provision and thus did not address the question about plans to improve.

We commend trusts and boards who are attempting to measure the provision of one-to-one care and urge Clinical Commissioning Groups to continue this work. We urge maternity care providers to recognise the variation in one-to-one care experienced by women, and to begin measurement that will capture this variation. This will enable providers to improve the care given to women at this vulnerable time.

GETTING ATTENTION

As previous surveys showed a sizable proportion of women being left alone in labour or not receiving one-to-one care, we asked women about what happened if they (or someone with them) had called for a midwife’s attention.

While one-to-one care is important, prioritising women in labour at the expense of other times of maternity care is not a sustainable way to solve the staffing shortage.

Can you recall a time in labour when you (or someone with you, like your partner) called for a midwife’s attention but they weren’t able to attend to you?

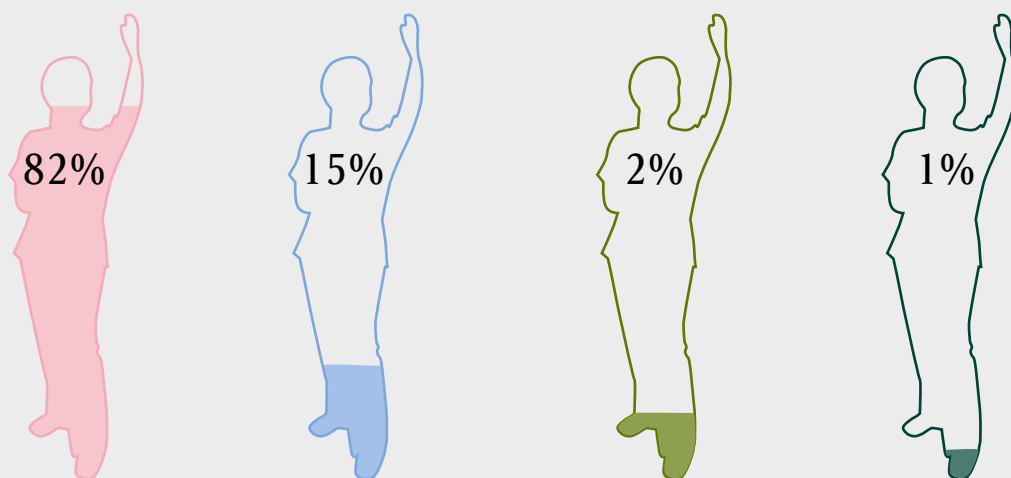
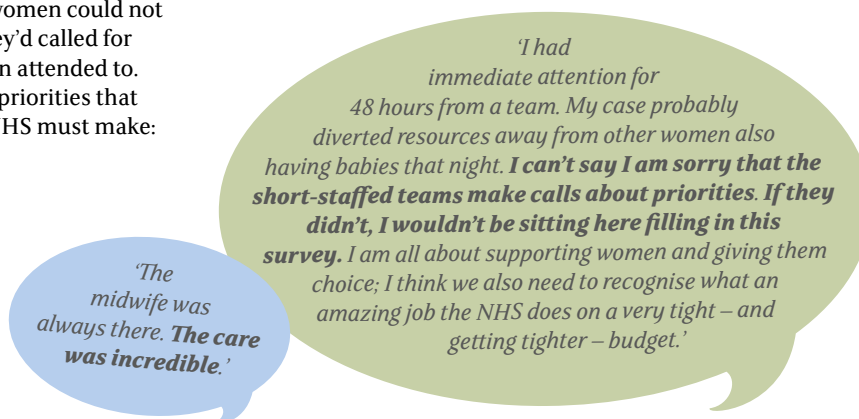


Figure 6 Calling for attention (n=5387)

The vast majority of women could not recall a time when they'd called for attention and not been attended to. Some mentioned the priorities that they recognised the NHS must make:



However, almost 15% of women reported this happening at least once. Interestingly again, many of these women explained the times this had happened by answering 'other' to this question (rather than

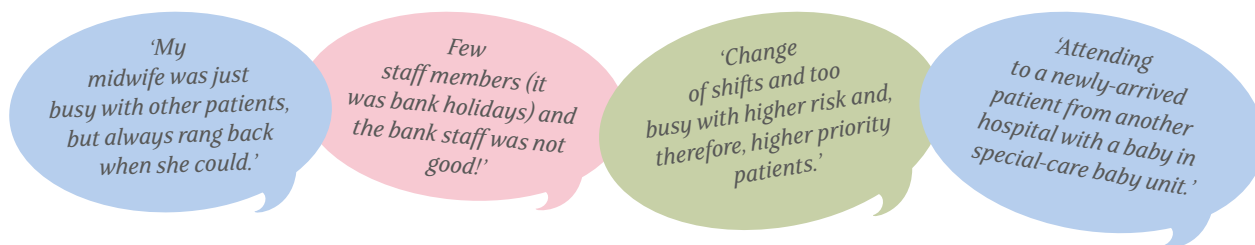
'yes'), suggesting a desire to express the variability of care they received over time. Getting attention when first arriving at a hospital/midwife unit was a common theme among comments:

'It was the weekend and they were short-staffed.'



Others linked being unattended to staff shortages:





The first survey of WI members asked for reasons given to women about why staff had not come when called: 35 women answered this. Only one respondent mentioned paperwork or other non-clinical tasks taking midwives away. One mentioned delays in other maternity staff's work: 'Waiting on other hospital staff (doctors, pharmacists etc.) to do something.'

But almost all mentioned the combination of too many other patients (13 respondents) and not enough staff (nine respondents).

Breaking down these results by birth location, women were least

likely to report 'calling for attention and being ignored' if they gave birth in freestanding midwifery units, and most likely at alongside midwifery units.

OTHER ASPECTS OF THE RELATIONSHIP

The final question of our survey looked at what aspects of care women would like to have been better, during any stage of their maternity care (antenatal, intrapartum, postnatal). Women were presented with a number of statements relating to care taken from NICE guidance. They were asked to choose any that they would have liked to be improved.

Can you recall a time in labour when you (or someone with you, like your partner) called for a midwife's attention but they weren't able to attend to you?

Birth location	Yes once or more than once	No, I don't think that happened	I can't remember	Other (please specify)
At home	16%	83%	1%	0%
Freestanding midwifery unit	6%	92%	1%	1%
Alongside midwifery unit	17%	79%	3%	2%
Obstetric unit	15%	82%	2%	1%

Table 6 Calling for attention, by location (n=5387)

Of the 4,505 women who answered this question, 19% of them said they didn't want for anything. Figure 5 below shows which options were chosen by the remaining 79% (3,638 women) in our sample.

Of the options to choose, 'remaining responsible for my care' was chosen by 34% of women, closely followed by 'give me or my baby more attention' on 31%.

From earlier survey questions, we can see the relationship between women and their midwives is not always

living up to the guidelines for different aspects of care. What the responses to this question show, however, is that while many women report receiving one-to-one care and feel little or no negative impact from not knowing their midwife previously or being able to get attention when asking for it, it is precisely these aspects of their care expressed in different ways – 'give me more attention' and 'stay responsible for me' – that the greatest number of respondents identified as needing improvement. Women want someone in charge to take care of them, even if they have only just met that person.

Women want someone in charge to take care of them, even if they have only just met that person.

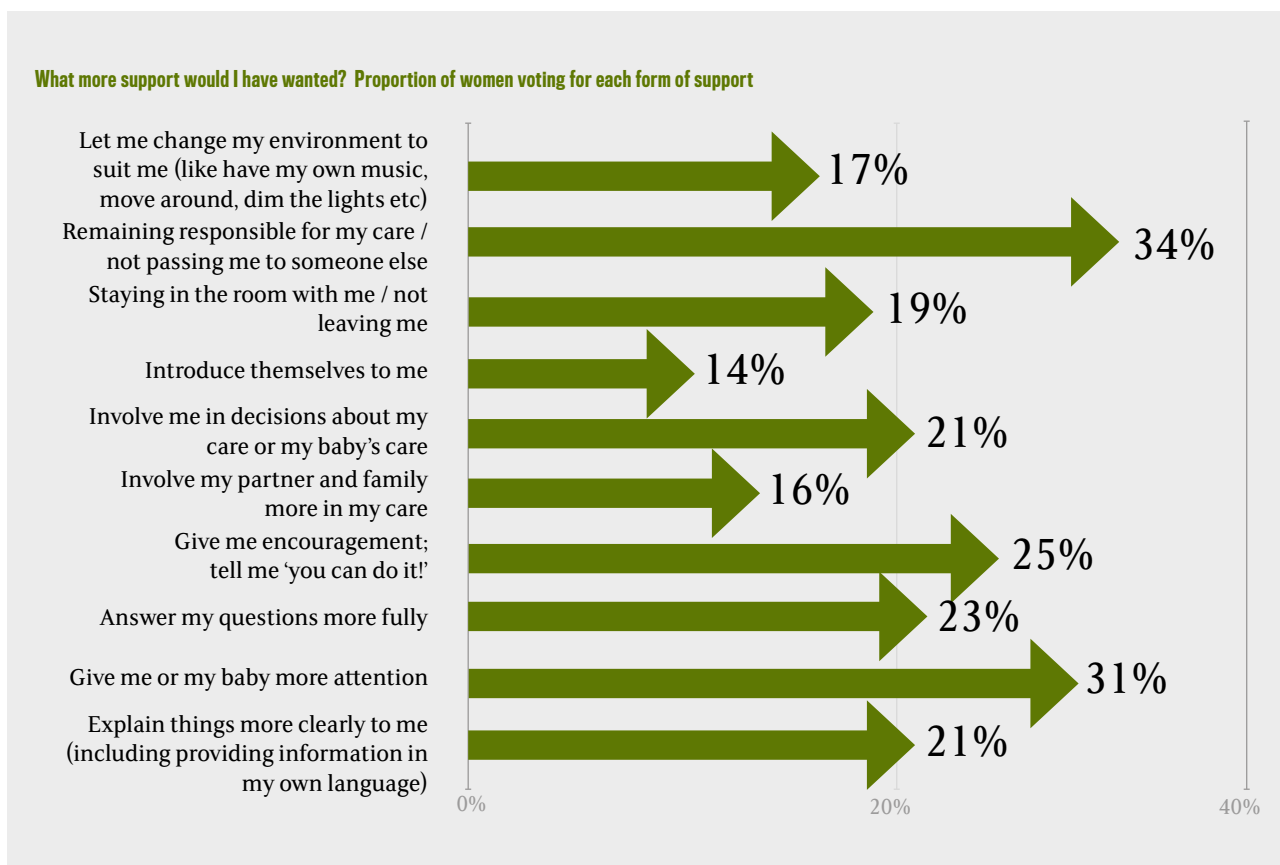


Figure 7 Proportion of women voting for forms of support (n=3638)

The location of where respondents gave birth had little bearing on the support options they chose: mothers who birthed at home, in obstetric units or in AMUs, all gave 'remaining responsible' the most votes. Only for women birthing in FMUs was this pattern not kept: attention and encouragement received the most votes from those women. There were also similarities between the wants of primiparous and multiparous women.

The forms of support that got the least number of votes – around 500-600 votes each – were 'involving my partner', introducing themselves, and changing their environment. There are two ways to interpret this. These aspects of care may have happened more often than others, so women did not see the need to 'want' more support in this form as it was already happening. Or, these aspects of care could be not as important to as many women as other aspects, regardless of whether they were being delivered or not. These are also forms of support which are about further empowerment of women – bringing *their* people into decisions, facilitating *their desires* for the room layout to change, asking staff to be respectful through introduction. They are not necessarily the things frightened or disempowered women would choose. A greater number of women want to have more explanation (or find this aspect of care more important) than those who want more involvement in decisions.

DECISIONS AND OBSTACLES - CHOOSING WHERE TO GIVE BIRTH

To be honest, my community midwife, as lovely as she is, didn't present me with the options for my area. It was just assumed that as it was my first child I would go to hospital and assumed I knew what options were available. The information on the NHS website wasn't easy; I couldn't determine if there was a birthing centre locally. There was no conversation, discussion or options presented!

East Midlands WI member

Over the past century there has been a revolution in the locations where women give birth. From being overwhelmingly based in the home, birth from the middle of the century onwards moved into institutional settings, and today, only around 3% of births take place in women's homes. By 2007, of births taking place outside of the home, 95% were in obstetric units, though midwives were still the lead healthcare professional for two-thirds of those births.¹

The concentration of women into high-tech obstetric units has continued while 'choice of birth location' has become the cornerstone of maternity care in England and Wales. The benefits of different locations and of exercising choice has led to 'choice' being reiterated in different policy statements from governments, NGOs and clinicians over the last decade:

National Childbirth Trust, 2009: 'Having the choice of where to give birth empowers women, increases numbers of straightforward births and improves parents' satisfaction with their birth experience.'²

Department of Health, 2007, 'National Choice Guarantee':

'Depending on their circumstances, women and their partners will be able to choose between three different options. These are: a home birth; birth in a local facility, including a hospital, under the care of a midwife; birth in a hospital supported by a local maternity care team including midwives, anaesthetists and consultant obstetricians. For some women this will be the safest option.'³

Welsh Government, 2011: 'The Welsh Government expects the NHS to take action to deliver maternity services which ... provide a range of high quality choices of care as close to home as is safe and sustainable to do so, from midwife to consultant-led services.'⁴

Chief Nursing Officers of England, Northern Ireland, Scotland and Wales, 2010: 'Midwifery services will be planned around offering choice of place of birth.'⁵

WHY LOCATION MATTERS

For many women, a normal birth is either impossible or undesired. Tens of thousands of women and their babies every year need to be cared for in high-tech units by medical professionals – their lives depend on being in obstetric units. Other women

The concentration of women into high-tech obstetric units has continued while 'choice of birth location' has become the cornerstone of maternity care in England and Wales.

choose interventions as is their right. However, evidence shows some women are undergoing unnecessary *and* unwanted interventions while giving birth.⁶ If things were different, they *could* give birth normally, and normality has benefits:

‘The substantially lower incidence of major interventions, including caesarean section, in all three non-obstetric unit settings has potential future benefits to both the woman and the NHS. There is a need to address the higher frequency of major interventions and the relatively low proportion of ‘normal’ births for low-risk women in obstetric units.’⁷

‘Avoiding unnecessary interventions in pregnancy and childbirth has been shown to lead to better outcomes for women, quicker recovery, improved satisfaction and saves the NHS money ... Women experiencing a normal birth are more likely to breastfeed and will require less postnatal care and are less likely to visit their GP with postnatal complications.’⁸

The links between normal birth and low-tech birth locations has been documented by various studies,^{6,9-13} and LSA reports from the West Midlands, Wales, East of England and the South East Coast provide examples of how trusts/boards are linking the opening of new AMUs and FMUs in their communities to their goals of increasing normal birth.¹⁴⁻¹⁷

Results from the Birthplace study in 2011 have given further weight to the safety arguments for expanding the choices of where to give birth. Birthplace was funded by the Department of Health ‘to

fill important gaps in the evidence relating to the availability, safety, organisation and costs of maternity services provided for women in labour in four birth settings: in hospital obstetric units, in AMUs, in FMUs, and at home’.¹⁸ Researchers found after studying 64,000 births in 2008-10, that planned births in freestanding midwifery units (FMUs) and alongside midwifery unit (AMUs) had no significant difference in adverse perinatal outcomes compared with planned birth in obstetric units (OUs). In regards to women having a second or subsequent babies, home births ‘appear to be safe for the baby and offer benefits for the mother’; however, for women having a first baby, a planned home birth increases the risk for the baby.¹³ ‘The results support a policy of offering healthy women with low risk pregnancies a choice of birth settings’,¹⁹ and CCGs have been advised that ‘with many units now delivering more babies than they were designed for, the recent Birthplace study offers the opportunity to rethink birth location and increase midwifery-led birth environments.’²⁰

Expanding location choice could also save the NHS money: on average, births to low risk women in AMUs, FMUs or at home are between £200 and £600 cheaper than births in obstetric units.¹⁹ Further, occupancy rates for freestanding midwifery units (30%) were under half that of obstetric units (65%) and much lower than alongside units (57%). ‘Should occupancy rates rise in FMUs they would become an increasingly cost-effective source of provision of maternity care’.⁷ The King’s Fund argues that ‘midwife-led models of care should be deployed across the service for low- and medium-risk women’ in order to provide ‘a more

Avoiding unnecessary interventions in pregnancy and childbirth has been shown to lead to better outcomes for women, quicker recover and saves the NHS money.

cost-effective service that releases obstetricians to focus on women with more complex needs'.²¹ However, while births in obstetric units are more expensive, there are some costs associated with hospitals, which remain relatively constant regardless of numbers – there are minimum standards of high-tech equipment and professional staffing in obstetric units that must be maintained. Therefore, any change of provision based on where women want to go has a limited effect on overall costs of maintaining services.

Trusts, boards, and CCGs have a long way to go if they are to offer women a full range of places to give birth. In 2009, NCT research found only 4.2% of women in England had realistic access to a full range of choices – that is, obstetric unit (OU), alongside midwifery unit (AMU), freestanding midwifery unit (FMU), or home, and over 40% of women were living in areas where they were still not able to make a choice between having their baby in a midwife-led unit or an obstetric unit.² The Birthplace study found that in 2010 only 8.8% of trusts in England had an AMU, FMU and obstetric unit for women giving birth; almost half of trusts only provided an obstetric unit.¹⁹ The Department of Health wants NHS England to work with partner organisations to ensure that the NHS offers women the greatest possible choice of providers.²²

Payment by results and normality

Maternity policy in England²³ and Wales²⁴ has explicit promotion of normal birth and reducing interventions where they are unnecessary. The Department of Health is hoping a new payment system for maternity in England will further bolster these efforts. The

Payment by Results (PbR) system – in short, how maternity care providers are remunerated for the care they give women – has been redesigned in the hope of taking out 'perverse incentives' for interventional care and encouraging 'the right services' for women.²⁵ There is no more money in this new system but the way that the £2.5 billion (in England) is spent on maternity is allocated is changing. Instead of payments based on 'episodes' of care, payments will be for a women's whole 'care pathway' whether her pregnancy is low, medium, or high-risk:

'PbR (Payment by Results) was first introduced in 2003 for some elements of elective care. However, the system has not worked well for maternity care. ... The episodic payment system provide[d] payment for each inpatient spell, scan or hospital visit. In short, the more clinical interventions, the more a hospital is paid. Hospitals providing more proactive, community-based maternity care would in fact be worse off financially ... The new pathway payment system – in conjunction with choice and local contracts that focus on outcomes, quality and women's experiences – will remove these perverse incentives and free providers to develop the right services for their women without the prospect of losing income. This new system removes the financial reward for undertaking all interventions in a hospital setting, and delivers freedom to providers to deliver their services how they and their women deem best.'²⁵

Commissioners have also been advised that the new PbR system does not mean costs trump everything else,

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and they should also judge providers on 'their outcomes, quality and patient experience' and 'implement penalties and incentives' to reflect these outcomes too.^{25,26}

The Birthplace study concluded that women giving birth in high-tech locations experience more interventions,⁷ and from next financial year, these kinds of interventions – if these women were on the standard-resource pathway – will now not be financially rewarded. Importantly, the Department of Health has set the payment system on the basis of its estimate that 65% of women could be placed on the standard resource pathway,²⁵ and it intends that 'it will prove a false economy to organisations to prevent required care or choice from being delivered'.²⁶ Critics of this new PbR system, while welcoming the change away from financially rewarding 'interventions' in birth, do worry that continuity along the care pathway for each woman is not rewarded; giving care to a woman during her pregnancy, birth *and* postnatally does not have a financial incentive over those only caring during one or two of those stages. However, the Department of Health has given messages about financial incentives for other 'quality of care' measures, and continuity may be able to be rewarded in this way.

With choice being a fundamental aspect of providing quality maternity care, we asked women about what choices were presented to them about where they would like to have their baby. We also asked trusts/boards to provide us with the information they held about what kinds of locations they offered and where women were choosing to go.

WHAT LOCATIONS ARE BEING OFFERED TO YOU?

We asked women about the location options 'that, as far as you were made aware, were realistic options for you to have your baby in your local area'.* One fifth of women reported there being only one. Only 12% said there were all four options.

Number of location options presented to women	Proportion of respondents
1	21%
2	25%
3	41%
4	12%

Table 1 Number of location options presented to women (n=5577)

Similar proportions of women reported there being an obstetric unit and an AMU available for them (79% and 73% respectively). Only 68% said there was a home birth service, and only 23% reported an FMU. This suggests limited progress has been made in the last three years – the Birthplace study in 2010 also found that only 24% of trusts had an FMU.¹⁹

We asked women about the location options 'that, as far as you were made aware, were realistic options for you to have your baby in your local area'. One fifth of women reported there being only one. Only 12% said there were all four options.

*Other studies have looked at women's available choices on a geographical basis – for instance NCT's Location, Location, Location used mileage and journey times, but our survey examined options from the women's point of view.

There are marked geographical differences in the birth locations presented to women (see figure 1).

Only 11% of women in the North West reported an FMU as being a realistic option for them, compared to 39% of mothers in the South East.

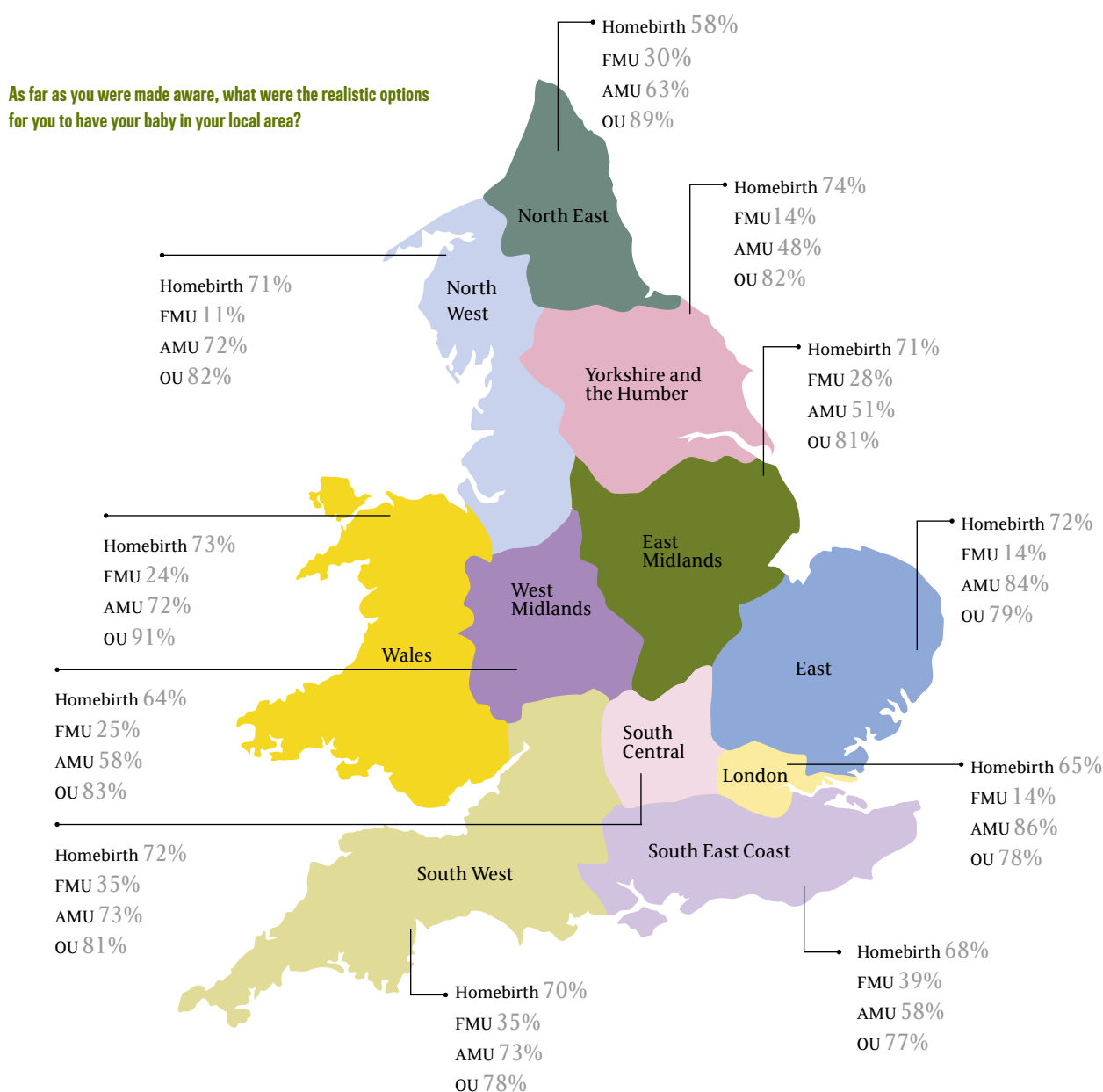


Figure 1 Options of where to give birth (n=5,576)

FMU – Freestanding Midwifery Unit
 AMU – Alongside Midwifery Unit
 OU – Obstetric Unit

WHERE DID YOU WANT TO GIVE BIRTH?

Almost half of women surveyed wanted to give birth in an AMU – a midwife-led unit inside a hospital (see Figure 2). Only 25% wanted to give birth in an obstetric unit, in stark contrast to the number of women who end up there (see below).

Of our sample, 10% expressed no preference for where they wanted to give birth, and over half of these women said this was because ‘they had no choice anyway’. Only 1.3% women said they did not feel informed enough to make a choice, which is a significant improvement from the 40% that the Healthcare

Commission found in their sample of women in 2008.²⁷

In all regions apart from the East Midlands, AMUs were the most popular choice. North East mothers were the least likely to want to birth at home (however, this proportion, at 5% of respondents, is still higher than the national average of actual home births). Only 3% of London mothers wanted to give birth in an FMU. Yorkshire mothers had the most diversity in their choices – mothers in this region were the most likely to want a home birth, and most likely to choose a obstetric unit.

There are also preference differences for primiparous and multiparous

Almost half of women surveyed wanted to give birth in an AMU – a midwife-led unit inside a hospital.

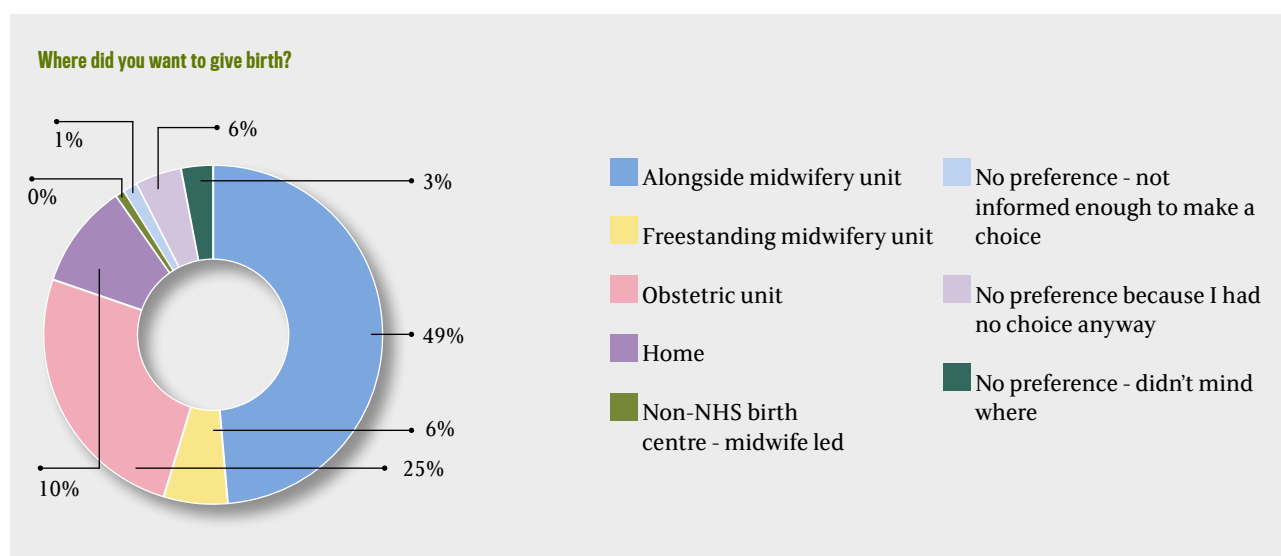


Figure 2 Birth location preference (n=5636)

Birth order	Location preference - proportion of respondents			
	Home	Free-standing midwifery unit	Alongside midwifery unit	Obstetric unit
The first time I ever gave birth	9%	7%	56%	28%
The second time I have given birth	26%	3%	37%	34%
The third time I have given birth	52%	7%	18%	23%
The fourth time I have given birth	50%	15%	4%	31%

Table 2 Choice of location by primi or multipara status (n=4885)

women (see table 2).

The results show women begin wanting the ‘best of both worlds’ (midwife-led care with obstetricians ‘down the corridor’) and then their preferences diverge into higher- and lower-tech sites with subsequent births. A quarter of second-time mothers said they wanted a home birth compared to only 9% of first-timers. Over half of women having their third baby wanted to birth at home, but as only 97 women make up this sample, strong conclusions cannot be made.

DOES HAVING CHOICES EFFECT WHAT YOU CHOOSE?

Evidence from LSA reports shows that some regions have seen a decrease in the number of home births, which they contend is a consequence of opening midwifery-led units.^{14,15} In London, ‘Eight of the ten trusts that have seen a decrease in home births have excellent birth centre facilities now on offer to women.’²⁸ For CCGs who are being urged to increase the low-tech options for women giving birth, this is something to consider.

Our survey explores the relationship between women who say a location is available to them, and where they wanted to go. Women with more options of places to give birth are far less likely to want to give birth in obstetric units. Wanting to give birth in an AMU remains quite similar regardless of how many other places are offered to women.

A quarter of second-time mothers said they wanted a home birth compared to only 9% of first-timers.

Number of locations you could give birth	Birth location preference - proportion of respondents			
	Home	Free-standing midwifery unit	Alongside midwifery unit	Obstetric unit
1	5%	4%	53%	38%
2	13%	5%	49%	33%
3	12%	5%	60%	23%
4	10%	18%	51%	21%

Table 3 Choice of location by options in your area (n=4985)

With many regions of England and Wales without an FMU for women to birth in,¹⁹ the full impact of building these units to increase choice needs to be considered. Tables 4 and 5 look at how women's choices change when home birth and FMUs are available to them, and when they are not. Understandably, few women want to give birth in a location which wasn't available to them; rates of wanting to give birth in a freestanding unit,

or your own home, are markedly different if those options are actually possible. This means planning maternity services – like whether to increase the number of midwives working in the community for home births, or building an FMU – should not simply take into account the preferences that women in the area currently hold. Our survey shows women's location preferences change as the locations change around them.

Understandably, few women want to give birth in a location which wasn't available to them.

FMU as a choice for you in your local area?	I wanted to give birth in an AMU	I wanted to give birth in an FMU	I wanted to give birth in an OU	I wanted to give birth at home
Yes	41%	21%	28%	10%
No	58%	2%	29%	11%

Table 4 Wanting to give birth in an FMU (n=5039)

Home birth as a choice for you in your local area?	I wanted to give birth in an AMU	I wanted to give birth in an FMU	I wanted to give birth in an OU	I wanted to give birth at home
Yes	54%	7%	25%	15%
No	54%	6%	37%	3%

Table 5 Wanting to give birth at home (n=5039)

When an FMU is available or not available, the proportion of women choosing a home birth and an obstetric birth remain similar. What does change is the number of women who want to go to an FMU and an AMU. Commissioners should also bear this in mind when considering the opening of FMU: it won't necessarily discourage women from choosing high-tech locations, but nor does

it necessarily replace home births as a preference, as some LSAs have reported.^{14,15}

The proportion of women wanting to give birth in an AMU or FMU are similar whether the area has a home birth service or not. What does change, however, is the number of women wanting to give birth at home, and those who want to birth in obstetric

units – the latter is much higher when there is no home birth service.

WHY DO WOMEN WANT TO GIVE BIRTH IN DIFFERENT PLACES?

Surprisingly, considering that choice is a core part of maternity care planning, there has been little research into the reasons why women choose different

places to give birth. WI members were asked to explain in their own words why they wanted to give birth in the place they preferred. These answers were grouped into categories which then became multi-choice options for the NCT survey. Women were able to choose four attributes that explained why they wanted to give birth in a particular location (see table 6).

There has been little research into the reasons why women choose different places to give birth.

Why did you want to give birth there?	Proportion of women choosing
It had facilities I wanted, like birth pools or partner accommodation	67%
I would feel safe there	58%
There would be less medical intervention there, it would be a more natural birth	47%
It had the medical staff and technology I required	45%
It was practical i.e. it was close to where I live	39%
I knew they gave great care there	26%
It was a friendly, supportive place or a place with staff that I knew already	17%
I didn't feel comfortable about going anywhere else, this was the 'least bad' option	7%
Other	7%

Table 6 Location attributes (n=4471)

Facilities and safety were the most common reasons given for choosing a birth location, appealing to 67% and 58% of women respectively. Investment in upgrading facilities – like the £25 million offered to trusts by the Department of Health in late 2012 – makes sense from these results. Of the attributes, having friendly or

known staff was the least common reason – which may be a consequence of women not expecting to know who their midwife/midwives would be ‘on the day’. The results show that different locations are appealing to women for different reasons, but importantly, many attributes are universal to all four main location options.

Facilities and safety were the most common reasons given for choosing a birth location.

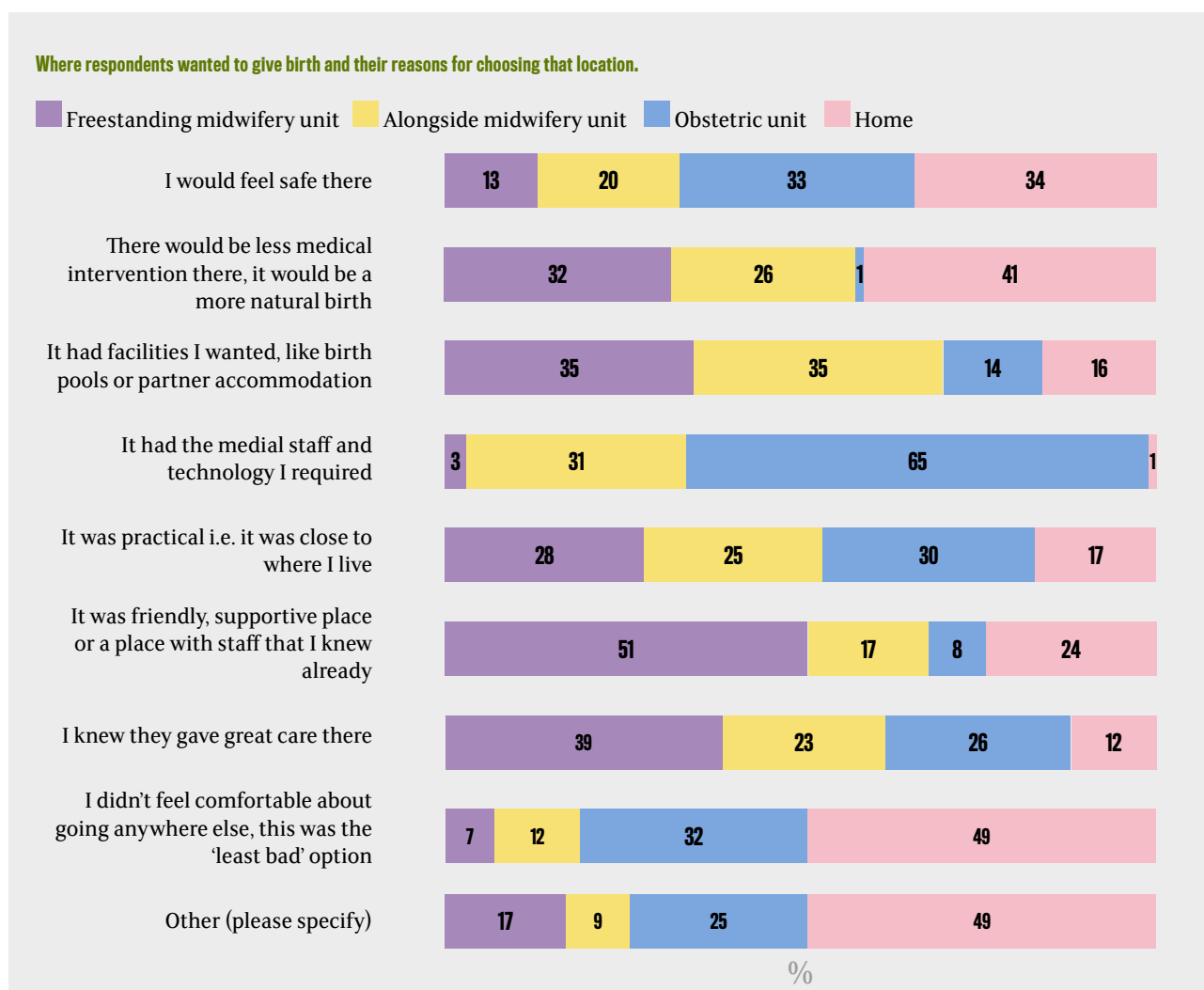


Figure 3 Different locations – what appeals to women? (n=4866)

71% of women choosing a home birth listed safety as one of their reasons for choosing this. This is a higher proportion of mothers than those who were choosing to give birth in obstetric units. Choosing a location on the basis of it being the 'least bad' option was rare, but more often it was factored into the decision to birth at home than anywhere else.

More women wanting to give birth in obstetric units listed 'practical' as a reason than women choosing elsewhere; but had fewer women listing facilities as a reason. FMUs appealed on the basis of being friendly or known much more than other locations (but appealed much less on the basis of safety).

'I liked the idea of the brand new, midwife-led centre as it had birth pool etc, and the fact that I was in hospital so help was on hand if I needed it or if there were complications.'

WI member from the South West wanting to birth in an AMU

'I wanted to give birth in a midwife-led unit outside of hospital because there was a double bed for my husband and it was more relaxed.' **WI member from the West Midlands wanting to birth in an FMU**

Privacy, security, one-to-one care and respect for myself and my child as individuals.' **WI member from the South East Coast, wanting a home birth**

I wanted to be located in a hospital as, because this was my first child, I didn't know what level of pain relief I wanted and I wanted to keep it possible to have everything if needed.' **WI member from the South West wanting to birth in a obstetric unit**

PAYING FOR CHOICE AND COMPLEXITY

Understanding and planning birth locations presents a challenge to commissioners. 'Choice' is determined by a multitude of factors: individual preference, clinical need, locality, familiarity and facilities. It is only women with low risk pregnancies, who, theoretically, should be able to choose to give birth in any of the four locations available. This makes commissioning maternity services – using resources most efficiently and effectively to provide not only 'the best experience' of care but high *quality* care for a diverse

population – a particular challenge. This challenge is not made any easier by the lack of data trusts/boards hold about the women in their care.

As explained earlier, the way providers of maternity care in England are paid for their work (Payment by Results) is changing, and the key to the new system of payment is classifying women into levels of 'risk'.*

'Payment is based on the commissioner receiving information about the woman's health and social care assessment

71% of women choosing a home birth listed safety as one of their reasons for choosing to give birth there.

*For details about the kinds of conditions that place women into these categories, see¹⁰

recorded from the booking appointment ... The level of payment is dependent on the pathway assigned – standard resource, intermediate resource, or intensive resource – based on the woman’s health and social care complexities identified at the booking appointment.’²⁶

Trusts were advised to start collecting data about the women under their care in 2012 in order to start to implement the new PbR system for the 2013-14 financial year, enabling them to begin to understand the financial implications of the new system, and ‘to understand their casemix and activity information, against which 2013-14 contracts can be developed with commissioners’.²⁵

We asked trusts and boards a variety of questions relating to patient choice. We asked about the number of low risk women in their care, and where these women wanted to give birth. We then asked where these women did eventually give birth. We also asked about their plans, if any, to increase the birth location choices in their local areas.

Disappointingly, in light of the upcoming changes to how they are going to be paid, few trusts were able to tell us about low risk women in their care and fewer still could provide the location preferences of low risk women. In 2011 the Audit Commission warned the government that the NHS needed to improve the quality of its data if Payment by Results was to work effectively.²⁹

Forty-three trusts or boards were able to provide some data on the number of low risk women they cared for, whether this be measured, estimated, or inferred (at different times during their care):

‘The total ... are the women assessed at booking [by the midwife] to be low risk in pregnancy.’

London trust

‘The following numbers of women were booked for midwife-led care which would indicate that they were considered “low risk”.’

London trust

““Low risk” women as assessed at the onset of labour.”

South Central trust

“We do not have specific numbers; however, approximately 30% of women should be low risk at booking. Their status can change at any stage during the course of the pregnancy and this information is not recorded centrally as it is only detailed in the individual handheld records.” *Welsh board*

Trusts and boards around England and Wales have very different populations, and the variety of responses (shown in table 7 below) illustrates the difficulties commissioners have in providing choice and also providing for clinical need. Even within trusts, changes in reporting systems see the numbers change drastically. With the PbR tariffs set by assuming 65% of women will begin on the standard low risk pathway, the financial implications for the many trusts deviating from this are not clear:

Disappointingly, in light of the upcoming changes to how they are going to be paid, few trusts were able to tell us about low risk women in their care and fewer still could provide the location preferences of low risk women.

Proportion of low risk women in trusts'/boards' care, measured or estimated

Region of each trust or board	2007	2008	2009	2010	2011	2012	Average
London	82%	80%	80%	78%	78%	73%	78%
Wales						70%	70%
North West					69%	68%	69%
Yorkshire					71%	65%	68%
South West		68%	65%	65%	66%	66%	66%
North West					64%		64%
West Midlands				61%	61%	61%	61%
South East Coast		60%	62%	64%	58%	56%	60%
North East						60%	60%
West Midlands	60%	60%	60%	60%	60%	60%	60%
London				60%	60%	60%	60%
Yorkshire				47%	64%	68%	60%
South West				64%	56%	53%	58%
East Midlands		58%	57%	56%	55%	59%	57%
London	64%	59%	56%	53%	53%	55%	57%
North East					57%		57%
East						56%	56%
South West			63%	56%	52%	48%	55%
North West			45%	56%	52%	48%	50%
East	49%	49%	49%	49%	49%	49%	49%
West Midlands	57%	51%	44%	44%	45%	43%	47%
West Midlands			45%	46%	45%	48%	46%
East	48%	48%	46%	46%	45%	43%	46%
South West		54%	40%	49%	36%		45%
London				41%	45%	47%	44%
North West					41%	42%	42%
North East	37%	37%	42%	41%	41%	43%	40%
North West						38%	38%
Yorkshire					36%	38%	37%
Wales		19%	43%	42%	41%		36%
Wales				37%	38%	33%	36%
Wales						36%	36%
North West	9%	5%	34%	56%	58%	53%	36%
South East Coast	33%	36%	36%	35%	38%	35%	36%
London				35%	33%		34%
West Midlands			31%	31%	38%	36%	34%
Yorkshire			25%	30%	33%	38%	31%
Wales	30%	30%	30%	30%	30%	30%	30%
West Midlands				32%	26%	27%	28%
West Midlands	20%	22%	19%	17%	21%	24%	21%
South East Coast			13%	14%	16%	28%	18%

Table 7 Proportion of low risk women in trusts'/boards' care

Of the trusts and boards, 46 did not hold any data about low risk women or did not address the question, and 22 trusts refused to answer on the basis of cost or privacy. A few trusts mentioned that due to the changes coming to PbR they would be holding this kind of information soon.

‘We cannot provide this information as we do not keep a record of this categorisation.’

North West trust

‘The trust does not hold this information, but is looking into the possibility of collating information from our system which identifies patients under one of the following categories: Intensive, Intermediate and Standard.’ *Yorkshire trust*

‘We consider the only accurate way to answer your question would be to review the recording of a woman’s antenatal visits from the handheld records to see where these visits had taken place...’ *North West trust*

‘Information is not held centrally to determine “low risk”. The information you have requested would be recorded in individual patient medical records. Patient records constitute Personal Information and can only be accessed on a strict “need to know basis”.’ *East Midlands trust*

We hoped to discover whether women at low risk of complications were able to choose to birth in any of the four main location options, or whether their choices were restricted by their local areas not providing services. In terms of location choices, only 35 trusts/boards were able to supply where low risk women in their care planned to give birth. These data

are very different from the survey data regarding choices, for a variety of reasons. Firstly, we asked for ‘planned’ to birth location, in the hope of capturing the data trusts/boards held for their own planning purposes. Secondly, our survey captures women of all risk levels, not just low. Thirdly, 13 of the 35 trusts/boards only have a home birth service and an obstetric unit, therefore there would be no ‘recorded choices’ for birthing in an AMU or FMU as it would be impossible; women’s wishes for services not provided would not be recorded. For example:

‘[We] operate an obstetric service; there is no designated alongside midwifery unit. Although midwifery-led care is provided, the service does not keep data reflecting choice.’ *Yorkshire trust*

Three trusts only recorded home birth choices and lumped ‘everything else’ together. Very roughly, from the data supplied from these 35 trusts and boards, from 2007 to 2012 (which totals over 80,000 ‘low risk’ births), the proportion of women recorded as planning a birth in an obstetric unit is 66%, and home only 4%. Only 25% of births were recorded as ‘planned’ to happen in AMUs or FMUs.

These proportions are very similar to where, from our survey data, we know women of all risk levels ended up. They *are not* a reflection of choice exercised at the start of a care pathway as our survey shows. While it is useful that for the trusts who record ‘planned’ place of birth, their numbers will roughly reflect what happens nine months later, we remain concerned that women’s choices are not reflected in the trusts/boards’ ‘choice’ data

We hoped to discover whether women at low risk of complications were able to choose to birth in any of the four main location options, or whether their choices were restricted by their local areas not providing services.

(especially the thousands of choices for low risk locations) and, therefore, the women who are prevented from giving birth where they want to for non-medical reasons (over 9% of our sample, see below) remain hidden.

We are especially concerned at the frequent mention of handheld notes and paper records as the form in which data on women's choices or their risk status is held by trusts/boards, which makes retrieval and analysis of this information very difficult. We endorse the recommendation made by Welsh Public Accounts Committee for the development of a 'consistent and robust electronic data collection process for maternity services' in order to 'remove the need for inefficient manual data collection'.³⁰

AFTER YOU MAKE A CHOICE, WHAT HAPPENS?

We asked women who had expressed a location choice about whether they gave birth in the place they intended, or if something happened that meant they gave birth elsewhere: 58% of women birthed where they intended to, though this was much more likely to happen if women were choosing a obstetric unit birth.

Table 8 shows the variety of outcomes after women make a choice. Most moved because the kind of medical care they or their baby required changed. But over 400 women (9.5%) did not get their choice for other reasons. Worryingly,

over 100 women were denied their location choice because of a lack of staff or beds. Several were denied by policies that they weren't aware of at the time, others moved because their priorities changed, or the service stopped being available in their local area. In light of the commitment to provide choice, commissioners should be aware of the everyday occurrences – mostly out of women's hands and down to trusts/boards – that stop women getting what they want.

Worryingly, over 100 women were denied their location choice because of a lack of staff or beds.

'After I made my choice...'	Percentage of women
That's where I gave birth	58%
I ended up giving birth somewhere else because my or my baby's medical condition changed	33%
I ended up giving birth somewhere else because the location couldn't accommodate me or my baby	1.7%
I ended up giving birth somewhere else because I changed my mind later on	1.7%
I ended up giving birth somewhere else because the location didn't have enough staff	0.9%
Unclear / other	1.5%
Baby born before arriving at intended location (BBA)	0.6%
Choice not available in local area	0.4%
Transfer / risk policy	0.4%
Facilities broken	0.1%
Practicalities	0.1%
Choice changed to fit family's wishes	0.1%
Total	100%

Table 8 What happens after you make a choice (n=5031)

In all, 97% of women who intended a obstetric-led birth got what they chose (see table 9). For women choosing a home birth, this figure is 47%, and for

AMUs, 42%. Only a third of women choosing an FMU actually birthed there.

Number of women choosing each location		% women getting their choice	% women whose location changed because of medical reasons	% women whose location changed for other reasons
Home	560	47%	41%	12%
Freestanding midwifery unit	326	34%	48%	18%
Alongside midwifery unit	2,721	42%	46%	12%
Obstetric unit	1,424	97%	0.3%	3%

Table 9 What happens to women's location choices (n=5031)

A SELECTION OF RESPONSES: 'WHY WOMEN DON'T GIVE BIRTH WHERE THEY WANT TO'

The location couldn't accommodate me or my baby



In all, 97% of women who intended a obstetric-led birth got what they chose.

The location didn't have enough staff

The midwives wouldn't come out to house – short-staffed (apparently). West Midlands mum who wanted to give birth at home, ended up in AMU

Choice changed to fit family's wishes

'My partner was too worried to have a home birth.' West Midlands mum who wanted to give birth at home, ended up in consultant unit

Choice not available in local area

'There is no [stand-alone] midwife-led unit in my areas.' South West mum, who wanted to give birth at an FMU, ended up in AMU

'Home birth on my street was only available through a hospital ten miles away that I couldn't get to by public transport for maternity appointments. Home birth midwives from the nearest hospital (two miles away) were not allowed to practice there as we live the other side of the borough boundary by one street.' London mum who wanted to give birth at her home, ended up at AMU

'The birthing centre was closed on my due date!' South Central mum who wanted to give birth at an FMU, ended up in consultant unit

Transfer/risk policy

'There was a pressure from the hospital because of my age.' **London mum who wanted to give birth at an AMU, ended up in consultant unit**

'Birthing criteria changed and I was no longer suitable to birth there.' **South East mum who wanted to give birth at an AMU, ended up in consultant unit**

'I was told I was too high risk to give birth there (but ended up having baby there anyway as consultant led unit too busy!).' **East mum who wanted an AMU**

Our survey shows very few women change their minds on location once they have made a decision, and the wide variety of events and policies that prevent them getting what they want, notwithstanding the medical complications that can arise.

Practicalities

'It was the Olympics and we [later] chose the closest location because we were worried about traffic if there was a problem.' **London mum who wanted to give birth at an AMU, ended up in consultant unit**

'I gave birth at the hospital midwife-led unit because of the bad snow. Home births were withdrawn as staff were needed to be focused on those women who didn't live [as] near the hospital.' **North East mum who wanted to give birth at home, ended up in AMU**

'Facilities broken

'No-one answered the doorbell so I went to the labour ward' **East mum who wanted to give birth at an AMU, ended up in consultant unit**

'The birthing pool was leaking, so I went to a different hospital.' **South East mum who wanted to give birth at a consultant unit, and went to another one instead**

We would urge commissioners to look closely at the decisions women make at the start of their pregnancy, the care pathway they take, and the resulting birth location. Our survey shows very few women change their minds on location once they have made a decision, and the wide variety of events and policies that prevent them getting what they want, notwithstanding the medical complications that can arise.

There is little difference across England and Wales when it comes to the number of women giving birth in the four main locations.

Where women gave birth, regionally

At home
 At an alongside midwifery unit

 At a freestanding midwifery unit
 At an obstetric unit

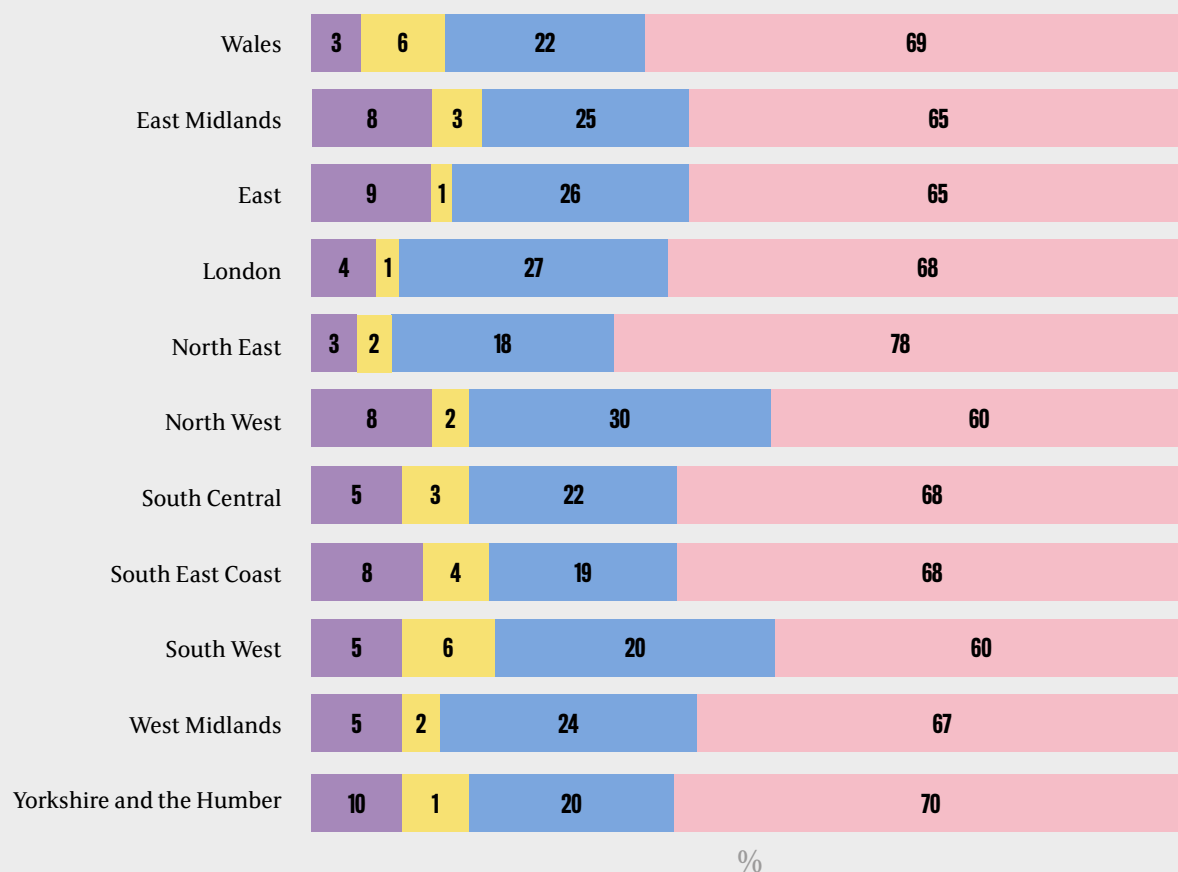


Figure 4 Where births take place, by region (n=5206)

CLOSURES AND SUSPENSIONS AND THEIR IMPACT ON CHOICE

Since April 2012, incidents when units temporarily close or suspend their service must be recorded as a Serious Incident. It may be that since this recommendation has been in place, the data collection of these incidents by trusts/boards has been prioritised and improved, meaning closures may not be more frequent, but just better reported. The RCM's survey of Heads of Midwifery in 2010 found 37% said their unit had to close in the last 12 months.³¹

The reports from the LSAs document these incidents. The difficulties of 'measuring' closures/suspensions and what they *mean* is acute: 'there is still no national clarification of the definition of "diverts" "suspensions" and "closures", so consistency of reporting cannot be assumed'. Further,

'It is not necessarily the number of escalations but the impact of diverts, suspensions and closures on women which needs to be captured in the data, as frequently, a divert, suspension or closure has not directly affected any women. This is challenging to collect and it is impossible to collect the impact that not escalating would have had.'³²

But while data is scarce, suspensions or closures are stressful for birthing women and are a denial of their right to make location choices, negatively affecting their experience and satisfaction.^{15,28,33} Staff shortages lead to closures and this prevents women getting their choice. The Care Quality Commission noted while reporting on Castle Hill Hospital,

'On two occasions, people had to be transferred to Hull Royal Infirmary when there were not enough staff at the centre to ensure meeting their needs. When we spoke to the staff on the ward, they told us about the times when the birthing centre would have to be closed for a period of time. This had the potential to cause great distress and did not promote patient choice; women had made a positive choice to have their baby at the centre, but staffing levels had prevented this.'³⁴

There are examples which show constant closures can be destructive for the units themselves. The Jubilee Birth Centre in Yorkshire shut after the Care Quality Commission found women had 'no confidence in where their baby would be born, due to the high level of service suspensions'.³² Research from the NCT in 2009 found 'staff shortages mean that birth centres are often subject to temporary closure and economic pressures put them at risk of permanent closure' and thus 'monitoring the capacity and utilisation of units should form part of any concerted effort to monitor choice'.³⁵

We asked trusts about if they closed/suspended their services, when, and the number of women affected. Of the 78 trusts that responded to this question, 30 had never experienced a closure or suspension of services in any year (2007-10 as reported by BBC *Panorama* from their requests, and 2011 and 2012 as asked by us). Unfortunately, data from 2007 and 2008 is patchy and was not easily retrievable by trusts.

There are examples which show constant closures can be destructive to maternity units themselves.

Data from trusts show almost all that were effected by closures from 2009-10 have shown improvement in 2011 and 2012, experiencing fewer incidents, or none at all. However, of the 46 trusts that did close or suspend maternity services during 2009-10, 20 of them had at least two incidents of further closures/suspensions in 2011 or 2012.

LSA reports and this FOI information seems to suggest ongoing problems of closure affect a small number of trusts/boards. For instance, of the 85 closures in the East of England in 2011-12, 50 were from just three units.¹⁷ But poor data means direct inferences are difficult to make. The South East Coast LSA notes that as pressures increase on capacity and staffing 'there appears to have been an increase in diverts and closures of services; however, historical reporting has been poor'.¹⁵ Other trusts have seen dramatic improvements in closures. In the North West, the number of closures/suspensions has fallen rapidly from 2009,³⁶ credited to a reconfiguration of units rather than a reduction in workload. Other regions' units, like the North East, 'rarely, if ever' close.³⁷

Looking at the reasons why trusts closed to admissions (or provided a 'reduced service', or stopped providing a home birth service) during 2011 and 2012, of the 455 closure episodes that 24 trusts were able to give details on, 186 of those were primarily due to staff shortages, and 182 to capacity ('no beds'). These reasons mirror *Panorama's* findings a year earlier. Unfortunately, when asked for details about the impact of these closures, most trusts were unable to give details on when these closures were occurring (i.e.

particular shift patterns) and some did not record how many women were 'moved' from their original planned location.

The reports from the LSAs make clear that lack of staff to cope with workload and a lack of beds leads to suspensions and closures.^{15-17,28,32,33}

Some LSAs report SoMs being 'called out of hours to provide a pair of hands to keep maternity units open or to support home births'.³³ In the East of England, 'some units remain challenged to maintain the home birth service at times of increased clinical activity in the delivery suite'.¹⁷ In Yorkshire, 'a link between midwife to birth ratios and service suspensions has been identified' (and the number of incidents increased by 31% last year)³² and similarly in the capital, the increased demand on maternity services is 'evidenced by the number of times a Maternity Service has suspended its services'.²⁸ Capacity problems are probably best exemplified by Poole hospital: 'The rising birth rate has also resulted in many more closures of services due to the original architecture of the building as seen by Poole Hospital NHS Foundation Trust built for 3,000 births but now delivering 4,773 women....'.³³

The information from trusts/boards shows closures can happen for all manner of other reasons – snow interrupted home birth services in 2011, a lack of neonatal beds and an electrical power failure also shut units down. There are several trusts where regulatory authorities enforce birth limits on units as a safety measure (for instance Barking, Havering and Redbridge trust in 2011-12).

LSA reports and FOI information seems to suggest ongoing problems of closure affect a small number of trusts/boards.

The comments made by women highlight the impact that closures, service suspensions and reductions in facilities can have:

'My daughter-in-law was due to have her baby at ... Infirmery and when they rang there, ready to go, they were told they were full and couldn't admit her, even if they went! They suggested that she ring our other hospital, which they did only to be told they were full so couldn't help also! They then contacted their community midwife who suggested she had a warm bath which would either speed up or slow down her labour. Bear in mind, she was already two weeks overdue ... Eventually she was admitted and the care was wonderful ... but she was so exhausted and worried...'

Glynis, WI member

Because of the NHS cuts, the centre my daughter-in-law was due to give birth in was not allowed enough money to employ another midwife to replace the one who was retiring ... with the consequence that they were no longer covered 24/7 ... Fortunately she managed to give birth before it closed for the evening, so there was time for a little rest then she had to go home ... This in itself caused problems, as, because of the closure, all the tests that are normally done while the mother is in the postnatal stage in hospital had to be done in other places. This involved an appointment at [her] local health centre 8.30am the day after giving birth, and then the following day a drive of an hour to another centre for another test. It was doubly sad as due to the upheaval and stress, and because there was no ongoing breastfeeding care, she lost her milk.'

Anonymous WI member

We urge commissioners to monitor suspensions and closures more closely to understand the impact of them and any patterns emerging as

to when and why it happens. We urge them to acknowledge these incidents directly affect women's choice of where to give birth.

INCREASING THE PLACES WHERE YOU CAN GIVE BIRTH

In all, 98 NHS trusts answered our initial question on whether they had 'any plans to increase birth location choices for women'. Fewer trusts answered the follow-up question about the encouragement (if any) given to women to utilise the options provided for them, and fewer still outlined how plans would be resourced.

In our sample of 98 trusts and boards, 36 from England and Wales have recently completed projects, or have plans to expand the location options for women in their local areas by building new freestanding or co-located Maternity Units, or funding home birth services. These range from the imminent openings of new units in 2013, to trusts just beginning public consultation or beginning to write a business case. Considering the financial situation of the NHS, this is very encouraging, and shows an acknowledgment of the evidence to support offering more low risk options for women. Seven trusts specified that they were part of region-wide reviews into maternity or healthcare provision more widely, which in some places could involve closures of existing units in the future, or the creation of new ones.

Of the 49 trusts and boards with no plans to create new maternity units or home birth services, almost half are making efforts to improve choice uptake of their existing maternity locations. Trusts have made low risk locations the default choice for low risk women, implemented new booking systems or refurbished existing units. Many too have committed to providing better information in user-friendly ways –

tours, DVDs, focus groups and social media. Our survey of women's reasons for choosing locations could help trusts/boards tailor their advertising to match locations' strengths.

INCREASING THE NUMBER OF HOME BIRTHS

Home birth has been promoted as a safe birth location option for certain women³⁸ and trusts are showing a variety of ways to encourage women to choose it. The Birthplace study found for multiparous women, babies born at home were at no increased risk compared to other locations,¹³ and other studies have found women's homes are empowering, with women requiring less pain relief³⁹ and reporting higher levels of satisfaction with the birth experience.⁶ However, Birthplace also found variations across trusts in England in the support given to out-of hospital births, including training for safety and teamwork across the maternity workforce.⁷ Our survey also shows around half of women who wanted a home birth didn't get one. Several trusts and LSAs report mention their attempts at increasing home birth and the barriers – including staff numbers and working structure – to achieving this:

'When recruited to fill establishment we will be able to promote home births with more emphasis.' *East of England trust*

'Due to the lack of resources, any ideas and plans have to be developed within budget and the new Head of Midwifery is hoping to start a dedicated home birth team by using midwife hours that will be released from staff working in different ways.' *Yorkshire trust*

36 trusts/boards report having recently completed projects, or have plans to expand the location options for women in their local areas by building new freestanding or colocated Maternity Units, or funding home birth services.

‘... We will concentrate on increasing our home birth numbers and we are currently in the process of reviewing the community midwifery work patterns to accommodate this. We have a very successful caseloading team who have a high percentage of home births for their women.’ *London trust*

‘Some units remain challenged to maintain the home birth service at times of increased clinical activity in the delivery suite.’ *East of England LSA report*

However, increasing the number of home births runs into the challenge of women's perceptions. Our survey found only one in ten women wanted to give birth at home (though this rate was much higher among multiparous mothers). Trusts also face this barrier:

‘Patient choice is stopping the numbers of home births increasing as well as the risk factors associated with the patients.’ *West Midlands trust*

‘Action Plan to increase Home Births includes engaging with woman via a Focus Group/Feedback from women and plan to reinstate Home Birth Group to raise awareness.’ *North West trust*

With studies showing that different locations can have a profound impact on women's experiences and clinical outcomes, women should be able to make informed choices to choose a location right for them.

CONTINUING CARE - POSTNATAL CARE

A new arrival in the family is a joyous time but can present challenges for mums and families, particularly new families. I want to help women and their partners as much as possible.

Dr Dan Poulter, Health Minister, November 2012

Once I've given birth I don't stop needing care.

WI member and first-time mum, from the East of England

For new parents the postnatal period marks a key transition point in adjusting to the physical and emotional demands of parenting. From a clinical perspective, this period is critical in terms of the health and wellbeing of women and their families.

Midwifery 2020 sets out a vision in which midwives will embrace a greater public health role and deliver continuity of care across the maternity pathway in recognition of the fact that development in early childhood has a 'profound influence on subsequent life chances and health through skills development, education and occupational opportunities. Early childhood experiences also directly impact on the subsequent risks of obesity, malnutrition, mental health problems, heart disease and criminality. So investment in early years provision and support offers the potential to reduce health inequalities within a generation.'¹

Clinical guidance from NICE stresses that care should be 'flexible and tailored' to meet women and their babies' needs. It states that every woman should have: an individual postnatal care plan; a named healthcare coordinator; opportunities to talk about their birth experience

and ask questions about the care that they received during labour; opportunities to discuss their own health and that of their baby; and opportunities to discuss emotional wellbeing, as well as any changes in mood, emotional state and behaviour that fall outside the woman's normal pattern.²

Yet the care on offer following the birth of a child is often referred to as the 'Cinderella service' of the maternity pathway.³ In 2010, the Care Quality Commission's survey of the experiences of 25,000 new mothers found that there was room for improvement in the 'information and support given to women, particularly about emotional changes that women may experience after the birth'.⁴ It recommended 'Greater coverage is needed in terms of providing information about contraception, and the availability of help and advice about feeding in the six weeks after the birth'. Postnatal care was rated least positively in comparison to other areas of maternity services.⁴

Research from the NCT examined the postnatal care experiences of 1,260 first-time mothers to assess the extent to which recommendations about the delivery of postnatal

Postnatal care is often referred to as the 'Cinderella service' of maternity care.

care had been implemented, following the publication of NICE recommendations, issued in 2006⁵. The charity found just over 40% of first-time mothers received all the 'emotional support' they felt they needed after giving birth, a third of women felt they received little or no emotional support in the first month after the birth, and 42% of women who had given birth in a hospital felt that at times there were not enough midwives to provide them with the level of support that they needed; those who gave birth at home or in a midwife-led centre were less likely to describe shortages.⁵

Most women will face a wide range of emotions after giving birth. For the majority, the birth of a child will be a joyful experience; others may well experience 'baby blues' and feel tearful, anxious and emotional

for a short period. While these feelings commonly disappear within a few days after giving birth, an estimated 70,000 women a year will experience deeper and longer term depressive illness. Postnatal depression impacts on women's ability to function and parent effectively; if untreated it can have long term consequences for children and family stability, impacting on the mother's relationships with her baby and partner.⁶ Puerperal psychosis, affecting one in 1,000 women, is the most severe type of mental illness that can occur after childbirth.

HELP AND SUPPORT IN THE POSTNATAL PERIOD – WOMEN'S EXPERIENCES

In order to gauge satisfaction with postnatal care in the weeks following birth, we asked women if they saw a midwife as much as they wanted,

Most women will face a wide range of emotions after giving birth. For the majority, the birth of a child will be a joyful experience; others may well experience 'baby blues' and feel tearful, anxious and emotional for a short period.

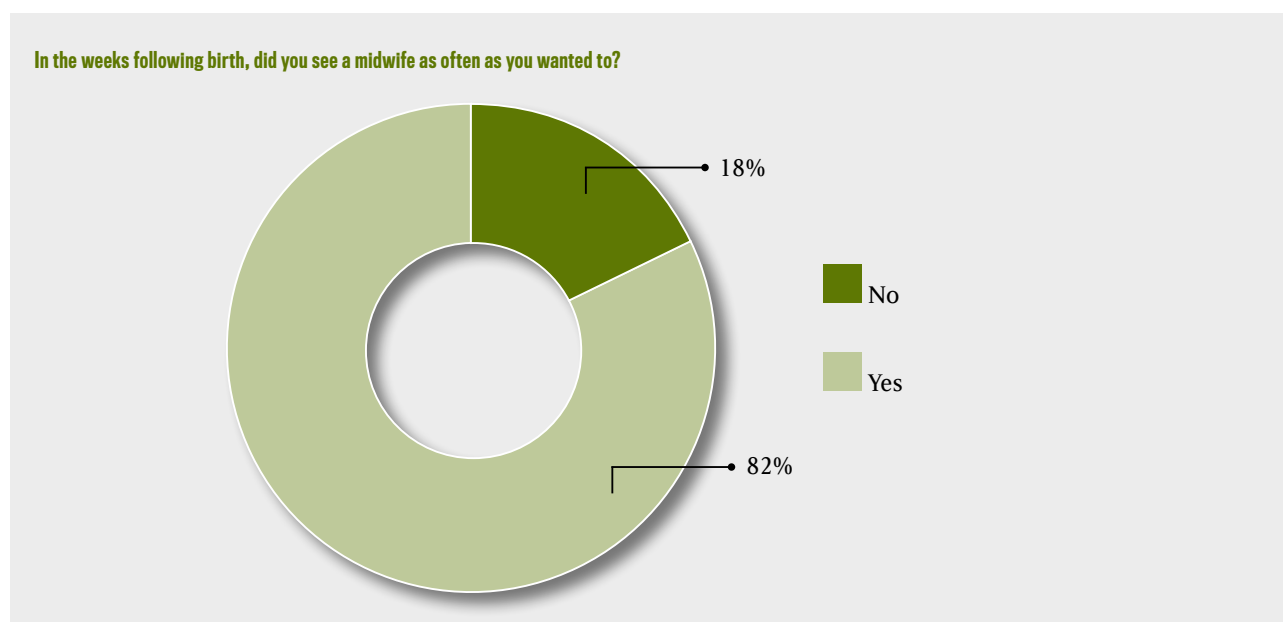


Figure 1 Seeing a midwife as much as you wanted to (n=5518)

either during home visits or by visiting clinics.

The majority of women (81%) felt that they had enough contact with midwives after they gave birth.

Furthermore, many women detailed how useful their postnatal contact had been during the early days and weeks in assisting the transition into parenthood:

'I had problems establishing breastfeeding and my baby was losing weight. Postnatal visits gave me some of the support I needed.'

'[I was given help with] Everything! Breastfeeding, feeling low, tired, looking after my baby! The visits were essential.'

'My son never did breastfeed but I expressed milk for nine months, and I probably would have given up long before that without the support, help and care I had from these midwives, and I've come out of it knowing that I haven't failed, but I and they did the very best that they could.'

'[The postnatal care was] Very valuable. I had hundreds of questions and having a home visit was essential for us. We didn't have family nearby and no previous experience with babies, so being able to ask all the early questions while being at home was very useful.'

'My baby had lost weight and was on the verge of us having to be admitted to hospital, which would have been particularly disappointing after a great home birth, and she gave us a tiny feeding cup and a schedule to feed and express to give him supplemental feeds from the cup; she created a chart to record everything including his nappies. It was just what we had needed as no one else had given us this quite basic help, but it gave us a lifeline to not go into hospital. It was gruelling but in the end it is what built up our baby's strength to then be able to feed properly without any intervention. For this we were truly grateful.'

'It was good to see a familiar face and ask questions in my own home. I didn't feel too well physically for a while after and my midwife kept me on her books for a week longer than she should have done, just to make sure I was ok, which I really appreciated.'

However, 18% of women expressed dissatisfaction with their overall contact with postnatal carers following birth. These women's concerns frequently centred on

the amount of time they were able to spend with the midwife, or the information, help and advice that they received:

'There was just one appointment. No issues with me or my baby, just a general check-up. No further appointments were offered.'

'I didn't think they were particularly comprehensive and more interested in just fulfilling the visit criteria.'

Others felt that the appointments were rushed; concern about staffing shortages and the pressure the

midwives appeared to be working under was a strong theme:

'I felt that I was signed off by the midwife quite quickly (although this was at the ten-day point) and that the process was quite rushed.'

'I felt they were rushed and didn't really listen to me.'

'It generally felt like they were always busy and I didn't want to bother them.'

'My midwife always gave me the impression that she couldn't wait to get out of the door.'

This sense of being rushed led some women to feel that their own health was of less concern than the baby's:

'Not much other than a fixation on the weight of my baby and questions about feeding, but little support.'

'It seemed like midwives had a long check list and this is often what they focused on, missing out my health needs.'

'They weighed my baby and said she looked fine. End of.'

'I felt too much focus was placed on breastfeeding rather than overall care ... I was suffering from an infection which was brushed over/ignored by three midwives on home visits while they pushed breastfeeding and I ended up seeking help from the GP who was great.'

A number of women reflected on their emotional needs and the importance of the midwife in helping them to

cope with the emotional changes and complex feelings that they were experiencing following birth:

'More focus on postnatal care [is needed] – surely this is the foundation to starting an amazing relationship between mother and child, giving the mother confidence to cope and thrive at a time when normally confident women like me can feel very vulnerable and lost in this massive life change.'

'I think I should have been more honest about feelings etc, rather than trying to pretend everything was ok.'

'They felt rushed, their resources are clearly stretched, they're under pressure, and again I saw different ones most times, it was impersonal, especially at an emotional time.'

'I believe that better care in the postnatal stage would benefit mothers physically and mentally. I believe if my care had been better I wouldn't have become depressed so easily or secretly; I believe I would have settled into being a mother/feeding and so on more easily. I also believe that better care physically would save a lot of pain and discomfort; I know that my case was pushed forward in a way that is not open to most mothers and I dread to think how much longer I would have suffered if this hadn't been the case.'

'[I would have liked the midwife to] Give an extra ten minutes to talk to me, not just zip in and out to check the baby and rush off to the next appointment – it made me feel like a burden.'

Broken down geographically, there is a clear difference in satisfaction by region. Only 75% of women based in London reported that they were able to see their midwife as often as

they would have liked to. Women in other areas, including those in the North East and the North West reported higher satisfaction with their postnatal contact.

In the weeks following birth, did you see a midwife as often as you wanted to?

Region	No	Yes	Women
Wales	13%	87%	85
East Midlands	12%	88%	263
East of England	14%	86%	548
London	25%	75%	1,786
North East England	8%	92%	84
North West England	11%	89%	280
South Central England	18%	82%	765
South East Coast England	18%	82%	623
South West England	14%	86%	470
West Midlands	16%	84%	330
Yorkshire and the Humber	13%	87%	248
Total	18%	82%	5,518

Table 1 Seeing a midwife as much as you wanted to, by region (n=5518)

We asked women if they were able to see the midwife at a time that was convenient to them.

Were the visits able to be made at a time most convenient for you?

Yes	65%
No	25%
Other (please specify)	10%

Table 2 Seeing a midwife at a convenient time (n=5514)

The majority of women (65%) told us that they were able to see the midwife at a convenient time:

'The midwife was busy, but tried to accommodate my preferred times.'

"The midwives decided on the timings of the visits, but as I wasn't going anywhere it wasn't a problem!"

'The visits were made at no specific time of the day but frankly, since in the days after giving birth having a shower was a challenge, I wasn't planning on leaving the house and thus missing any visits from my midwife!'

'We fitted our day around when the midwife could see us as I saw this as the priority and not other commitments.'

Yet 25% of women found that appointments were not flexible or available to suit their needs, and a further 10% of women selected 'other'. Free text comments from these women frequently highlighted that many had low expectations

about being able to see the midwife at a convenient time. Comments also suggest that better scheduling and planning of postnatal care visits would have a significant impact in improving many women's experiences of postnatal care:

'A couple of times I waited in all day because I was told a midwife was coming but nobody turned up. It was frustrating because on both occasions I made sure I was up, washed and dressed by 9am (as we weren't given a time), when really I could have done with catching up on some sleep as the baby didn't sleep much during the night at that stage.'

'I had to phone to ask why a midwife had not been to see us.'

'I was visited once (very briefly) at home, then told to go to the 'local' clinic for weigh-ins etc. Which was really difficult as the clinic was only open for two hours in the morning twice a week, and getting a newborn and a 17-month-old ready for 9am was really tough.'

'My midwife never contacted me.'

'Specific timing of visits wasn't given, so I spent the whole day waiting in which was frustrating.'

'Had to travel for later midwife appointments, but I couldn't drive due to the C-section.'

'No time is convenient with a newborn!'

Despite most women seeming to be satisfied by the overall contact level with their midwives after they had given birth, when asked at what point they felt that they needed more

support from midwives, postnatal care stood out as a weak point in the system: 57% of women said they would have welcomed more support in the postnatal period.

57% of women wanted more support in the postnatal period.

Proportion of women

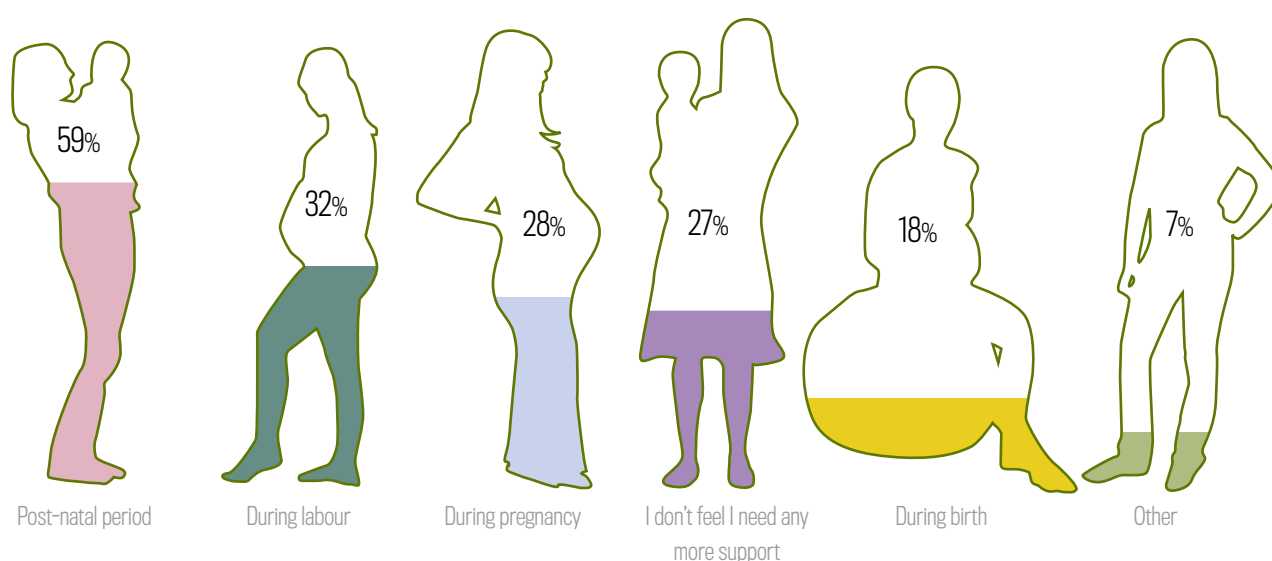


Figure 2 When women want more support (n=4636)

The comments made by women highlight a lack of support with feeding in particular, both in hospital and at home:

'In the postnatal period when we stayed in hospital for several days ... I felt a bit neglected. I had problems with feeding and didn't really get much support. My baby turned out to have tongue-tie and no one noticed. My baby had to have antibiotics and no one really explained why.'

'After birth is where I felt my care could have been improved. Busy wards meant little support. I wish I had more help with breastfeeding and more help with helping me to "know what to expect re: wet and dirty nappies, feed frequency, skin-to-skin, etc".'

'I just felt as if we were on a conveyor belt, because the unit is so busy, it was so impersonal at a very emotional and vulnerable time.'

'[I wanted] More information on first few hours – when to breastfeed, wake up baby etc. All was well with the labour despite the rush to hospital and I dispatched myself after three hours but felt at home I could have used more info for first few hours.'

'Care in labour was good, postnatal care in hospital wasn't. The staff were over-stretched.'

Further, continuity of care was frequently identified as a problem,

both in hospital postnatal care, and at home:

'Just to have a consistent midwife during and after the birth would have been nice, also more consistent breastfeeding help.'

'After leaving hospital every midwife visit turned out to be a different person!'

[I wanted] More consistency. Every midwife advised differently which was very confusing in a postnatal, vulnerable state.'

'I never saw the same midwife in the community and they missed a serious infection I developed following an episiotomy. I am now having to have surgery to repair the damage.'

'My nearest hospital was in a different county from my home so the community midwives worked for a different NHS trust, which didn't help.'

'As the shifts changed I got differing advice in respect of breastfeeding which was confusing, but also upsetting as I was exhausted and anxious to do the best for my new baby.'

PLANNING POSTNATAL CARE

Trusts and boards differed significantly in their responses to questions about postnatal care, highlighting perceived differences in understanding about the obligations, if any, on them to provide for a certain number of postnatal visits, and varying information on how many women received the prescribed number of visits, or the number of visits women received overall.

All trusts/boards mentioned the individual needs of women when determining the appropriate amount of postnatal care. But how many visits the average women would receive under a trust or board's care is not recorded by each of them, thus hampering planning for the provision of postnatal community midwifery.

There were 51 trusts/boards which said they had no 'target' for the number of postnatal visits they

provided to women. Some said this was in accordance with NICE guidance:

'The trust does not have a target for the number of postnatal contacts, this will depend on the patient's individual need.' *North West trust*

'The trust does not have targets, but follows guidelines set by the National Institute for Health and Clinical Excellence (NICE) on postnatal care.' *North East trust*

Thirty trusts/boards said they did have a target, though this would be superseded in line with individual need. Three said that their targets were in accordance with NICE guidance.

Only 12 trusts/boards were able to provide data on the number of postnatal visits each woman under their care received after their baby was born.

‘We run our services in line with the recommendations set by the National Institute for Health and Clinical Excellence – Postnatal Guidelines (2008). The target is four visits.’ *Welsh board*

‘The NICE antenatal guidelines are adopted within the unit; women are offered a minimum of three visits postnatally but will often have additional visits if support is needed.’ *West Midlands trust*

‘The target minimum is one, but this would depend upon the circumstances and condition of the mother and baby.’ *London trust*

Only 12 trusts/boards were able to provide data on the number of postnatal visits each woman under their care received after their baby was born. The detail in this data is variable:

For the period January to September 2012, there were, on average, four postnatal attendances per patient.’ *London trust*

‘We aim to give all postnatal women three visits. We maintain handwritten statistics only and these demonstrate over 95% compliance with this goal.’ *London trust*

‘A minimum target of three postnatal visits dependent on clinical needs. The proportion of women whose number of postnatal visits reaches or exceeds this target: 2007 – 45%; 2008 – 43%; 2009 – 43%; 2010 – 53%; 2011 – 60%; 2012 – 70% (Jan-Oct).’ *East of England trust*

The experiences of the women who participated in our research suggest

standards of postnatal care continue to vary tremendously, echoing concerns raised in previous research about the extent to which postnatal care has improved in recent years.⁵

The picture our research paints of postnatal care remains a mixed one. While the NICE guideline appears to provide a robust framework in terms of the type of support and information women told us that they wanted, it is clear that guidance is not applied systematically across all areas. Those women who have a positive experience of postnatal care clearly indicate the tremendous difference it makes in providing the practical support, expert advice and information that empowers and enables them to make a smooth transition to parenthood. The skills and experience of midwives are vital in this period; poor postnatal care and on-going and unresolved physical problems can have long term clinical impacts on not only the quality of women’s lives, but also the relationships of women with their newborn children. The women in our research talked about tongue-tie and problems with breast-feeding, as well as infections being missed, all issues that have potential to escalate into much more serious problems and result in hospital readmission.

Thousands of women identify this period as the specific time at which they need more support, yet women are seemingly routinely being let down with care that does not meet their needs. Some women aren’t offered the physical and emotional support they need, others object to being asked to wait around all day for a visit and many other women want consistency and to be able to bring someone that they’re able to feel they know and

Thousands of women identify this period as the specific time at which they need more support, yet women are seemingly routinely being let down with care that does not meet their needs.

trust into their homes, rather than a different health professional at every visit.

RECOMMENDATIONS

- **We urge maternity and health visitor providers to recognise that postnatal care services are not meeting the needs of significant numbers of women and review staffing in order to improve the quality and consistency of maternal care. The transition to parenthood is a critical period and further effort is needed to ensure that adequate services are available to support all women and their families in the early days and weeks of parenthood.**
- **We urge NHS England to issue guidance to CCGs on the development of a framework to assess postnatal care in line with clinical guidance issued by NICE and the feedback from service-users. We urge the All Wales Maternity Services Implementation Group to do the same.**
- **We urge NHS England to issue guidance to CCGs on the development of a framework for planning the delivery of postnatal care in line with clinical guidance issued by NICE. Data collection should be improved to enable a clearer picture of the level of care women receive.**

The transition to parenthood is a critical period and further effort is needed to ensure that adequate services are available to support all women and their families in the early days and weeks of parenthood.

CONCLUSION

Through analysis of the responses of 5,500 women and official information from NHS trusts and boards, this report has shown that while maternity care in England and Wales is well-served by policies, guidance and directives, too often women and their families are not getting the high quality care that they deserve. The fact that too few midwives are in post affects all parts of the maternity system and has created considerable variation in NHS maternity services:

- **Choice remains an aspiration, not a reality, for many women**

Despite the commitment to delivering choice in NHS maternity, and the pledging to offer four location options for women in their local area, too many women are still denied their choices on a daily basis.

- **Maternity care is fragmented**

Too many women experience fragmented maternity care with a clear disconnection between different elements of the pathway from pre-conception through to pregnancy and postnatal care.

- **Women face a postcode lottery of postnatal care**

Despite robust guidance from NICE, a 'postcode lottery' of postnatal care exists with unacceptably wide variations in the quality and standard of care across different areas of the country.

To conclude, we asked women to tell us about special moments during their maternity care, and messages they wanted to send to the Secretary of State for Health. Below are statements that show the dedication and professionalism of midwives, and how great care, whether it be kind words, clinical excellence or the best technology, profoundly shapes the path to parenthood and experiences of a service that touches the lives of many women and their families.

Great care, whether it be kind words, clinical excellence or the best technology, profoundly shapes the path to parenthood.

BEST MOMENT OF MY MATERNITY CARE

Sally, my midwife was the first person I saw when I walked into the hospital in labour...All day she helped me, with breathing, rubbing my back, advising me on what medicine I might want or not. I felt **totally secure** in her care. She advised my partner of ways to help me. When it came to stage two, she kept my spirits high, and encouraged me even when I wanted to give up. She was, I truly believe, the reason I had such a smooth labour.

When I was kept on an antenatal ward all night on my own in labour with fetal heart monitor on... waiting for a space on a delivery suite for induction. The midwife came and **sat with me and chatted with me** and kept ringing the labour suite to try and get me onto it, she was kind and caring.

Being brought tea and toast after giving birth! Such a **kind, homely touch**, and my goodness I needed that cup of tea!

In the very last moments the calmness of the midwives when my baby had his chord round his neck and the **swiftness with which they acted** to make sure nothing went wrong.

I was on a ward for 3 days waiting to be induced on the delivery ward but due to a lack of staff myself and 4 other women had to wait. One of the midwives argued to get us all seen in the early hours of the morning. I was really relieved as... I was a gestational diabetic...the midwife concerned took this into consideration when **fighting my corner**.

During the labour and birth the team were outstanding, I had a traumatic birth that was over 21 hours and we had **someone with us** all the time. We felt like they understood my fears, the situation and were in control.

My midwife taking control when I couldn't, she made me push when I thought I couldn't. The baby was in danger so we had to be quick **and she made me make it happen**.

When my son was in the special care baby unit the midwife took time to explain why he was there and what they were doing to him and for him. It was very **reassuring** to have someone with experience of his problems to care for him.

I had an emergency C-section, she helped my husband weigh our little girl and **helped him settle her** whilst I was still in surgery. Just writing this makes me cry with joy for meeting such a fantastic person.

The lady who was there first my early stages of labour **came to see me** when she came back on shift after my baby was born to see us both.

MESSAGES TO THE SECRETARY OF STATE FOR HEALTH

EVERYONE should have a positive birth experience - and midwives are crucial to this.

We need more midwives! There is no consistency and the joyful process of having your first child is hugely tainted by this issue.

More midwives are needed to be able to provide women with more personalised care. This will allow mothers to build positive relationships with their midwives and feel empowered to make decisions about their experiences.

Midwives are worth investing in. The birth of a child is the most important time for not just the baby being born but also for the mother, father and rest of the family concerned. You can't put a price on that.

Please, please don't scrimp on maternity care.

Just because women survive and endure labour doesn't mean they have received adequate care - many women accept pretty poor treatment and just get on with it because they have to!

Some wonderful staff stretched too far. Things need to change.

The midwives I met were amazing, hardworking people but all stretched to full capacity.

It is a very scary time for a woman, confusing and you are at your most vulnerable. Because of this you need to feel listened to and supported the whole way along by trained professionals.

Please prioritise funding for more midwives. My midwife saved my baby's life and I will be eternally grateful. There just aren't enough midwives to go around.

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GLOSSARY

Alongside midwifery unit or AMU: 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 diagnostic and treatment medical services, including obstetric, neonatal and anaesthetic care are available, should they be needed, in the same building, or in a separate building on the same site. Transfer will normally be by trolley, bed or wheelchair.

Clinical Commissioning Groups or CCGs: GP-led organisations in England who as of 1 April 2013 are responsible for commissioning services from trusts.

Freestanding midwifery unit or FMU: 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. Geographically separate from an obstetric unit, but could be within a hospital that doesn't have an obstetric unit. 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 - transfer will normally involve car or ambulance.

Health Boards: In Wales, NHS health care is provided through local Health Boards. Unlike the English NHS system which has a commissioner/provider split, Health Boards are responsible for delivering all NHS services.

Home birth: A woman who chooses to have a home birth will be looked after by community midwives attached to a local maternity unit.

Local Supervising Authority or LSA: LSAs are responsible for ensuring that statutory supervision of all midwives is exercised to a satisfactory standard within its geographical boundary. Local Supervising Authority arrangements differ across the United Kingdom. In England the LSAs are the Strategic Health Authorities, in Wales the Health Inspectorate. Each LSA has an appointed LSA Midwifery Officer (LSAMO) to carry out the LSA function. Each LSAMO compiles an annual report

for the Nursing and Midwifery Council, which outlines supervisory activities over the past year, key issues, audit outcomes and emerging trends affecting maternity services.

Multiparous: A woman who has given birth two or more times or is pregnant a second time.

NHS England: Originally named the NHS Commissioning Board, NHS England an independent body, at arm's length to the Government which as of April 2013 has taken on many of the functions of the former primary care trusts (PCTs) with regard to the commissioning of primary care health services, as well as some nationally-based functions previously undertaken by the Department of Health.

NICE: Formerly the National Institute for Health and Clinical Excellence, now known as the National Centre for Health and Care Excellence. It develops evidence-based guidance for health practitioners in the form of quality standards or outcome indicators. Accountable to the Department of Health but is operationally independent of government.

Normal birth: A term for a vaginal birth without induction, without the use of instruments, not by caesarean section and without general, spinal or epidural anaesthetic before or during delivery.

Obstetric unit or OU: a clinical location in which care is provided by a team, with obstetricians taking primary professional responsibility for women at high risk of complications during labour and birth. Midwives offer care to all women, 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, 24 hours a day.

PbR or Payment by Results: Funding mechanism employed in the UK NHS where payment is linked to activity.

Primary Care Trust (PCT, or 'trust'): In England, trusts were responsible for commissioning primary, community and secondary health services from providers. Primary Care Trusts were abolished on 31 March 2013 and replaced by Clinical Commissioning Groups (CCGs).

Primiparous: A woman who has given birth to only one child or who is pregnant for the first time.

Supervisors of Midwives: The Supervisors of Midwives (SoMs) in the UK are statutorily bound to supervise the midwifery workforce (both NHS and independent midwives). Their main duties include an annual review of each registered midwife by their named SoM.