The Patient Experience Library

Insight Report

Maternity Services

Compiled for: Bolton NHS Foundation Trust

February 2017

Contents

1. Introduction

1.1 About Insight Reports

There is no shortage of information on patient experience. Sources include CQC inspections, Healthwatch reports, Patient Opinion, Friends and Family Tests, NHS Choices star ratings and more. Making sense of it all can be very difficult – especially as the quality of some of it is questionable.

Our Insight Reports are based on in-depth trawls of the whole of the UK's evidence base on patient experience. Grading and analysis draws out high quality evidence to support commissioning decisions and service improvements. Our reports can take hard-pressed staff straight to the information they need, helping to save time and money.

For this report, we have worked on the assumption that the Trust has access to relevant background information from key documents and datasets such as Better Births (the Five Year Forward View for maternity care), the Report of the Morecambe Bay Investigation and the Care Quality Commission's Maternity Services Survey. In our search for evidence, therefore, we have drawn on reports that may not be so easily accessible to the Trust.

1.2 About the Patient Experience Library

The Patient Experience Library brings together the whole of the UK's collective intelligence on patient experience, plus patient and public involvement. We have catalogued and indexed over 35,000 reports, including:

- Patient experience reports from health and care charities and think tanks
- Guidance on matters such as patient-centred commissioning
- CQC inspection reports and patient survey results
- All the reports from the local Healthwatch network
- Quality Accounts from health service providers
- Valuable archive materials from bodies such as LINk and the NHS Institute

For more about our work, please visit ***www.patientlibrary.net***

2. Search results

2.1 Basic search

For our basic search, we trawled over 35,000 documents within the Patient Experience Library. Our searches yielded 278 results from sources including Healthwatch, the Care Quality Commission, government bodies such as the Dept of Health, NHS England, and NHS Improvement, plus national charities and think tanks.

We then applied relevance analysis and filtered out all reports with low relevance. That left us with 53 reports, which are listed alphabetically by title in the Appendix.

2.2 Graded search

We reviewed our 53 basic search results, to come up with a "top nine" reports list. We achieved this as follows:

Date: We filtered out any reports that were more than two years old.

Maximum relevance: Applying relevance analysis a second time enabled us to narrow down to reports where maternity services are a major focus, as opposed to a sub-topic, or a matter of passing interest.

Type: We concentrated on reports that could offer insights into patient experience of maternity services, looking for known topics of concern such as choice and continuity of care. We focussed much of our search on local rather than national studies, seeking learning points from experiences that, while coming from other parts of the country, might be equally applicable in Bolton.

Quality: It is generally acknowledged that the quality of patient experience reporting can be variable. Our top nine reports, in our opinion, demonstrate good quality, with work that is rigorous and credible, and with insights and solutions that could be replicable from one part of the country to another.

Our top nine reports on maternity services (listed alphabetically by title) are:

Antenatal & Postnatal Services in York
Healthwatch York, November 2016

Maternity Matters. What does a great service look like?
Healthwatch Cumbria, February 2016

Maternity service review
Healthwatch Blackpool, July 2015

Report on families' experiences of ante- and post- natal community services in Oxfordshire
Home Start, 2015

Supporting Mum. A Report of Patient Experience of the Maternity Pathway in Suffolk
Healthwatch Suffolk, 2016

Support Overdue: Women's experiences of maternity services
The National Federation of Women's Institutes (NFWI) and NCT, 2017

The experience of Reading women who have been diverted from giving birth at their place of choice
Healthwatch Reading, August 2015

The state of maternity services in England
Picker Institute Europe, July 2016

User feedback in maternity services
King's Fund, October 2016

3. Key findings

This section presents key learning points drawn from the top nine reports. Findings are mostly **presented in the form of direct extracts from the reports** within our top nine list. All sources are referenced in the end notes.

3.1 National overview – maternity services[1]

Despite the increasing complexity of cases, the quality and outcomes of maternity services have improved significantly over the last decade. Neonatal mortality in England fell by over 20% in the ten years from 2003 to 2013. Overall, maternal mortality in the UK has reduced from 14 deaths per 100,000 maternities in 2003/05 to 9 deaths per 100,000 maternities in 2011/13. The conception rate for women aged under 18 in England, a key indicator of the life chances of future generations, reduced by almost half, between 1998 and 2013.

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

3.2 National overview – women's experiences of maternity services [2]

Evidence suggests that, overall, women's experiences of maternity services are positive. The vast majority of women report excellent or very good care during labour and birth and, for the most part, in the pre and postnatal periods. In general, there has been an upward trend in results over the past few years; however, the 2015 maternity survey noted that some aspects of care during labour and birth required improvement, for example the number of women being left alone during labour.

The recent National Maternity Review also highlighted two significant exceptions to a generally favourable picture of women's experience of care. The first of these is in the area of care following birth, for both women and babies. Women reported poorer continuity of care in this period, with only 28 per cent of mothers seeing the same midwife for all check-ups, and more gaps in the information provided.

The second area highlighted by the National Maternity Review was choice. It has long been the expectation in the NHS that women are given full choice over where to give birth. However, although the 2015 maternity survey indicated that the proportion of women being offered a choice of birthing settings was higher than in 2014, the review highlighted that 16 per cent of respondents indicated that they had not been given a choice, suggesting that this is an area requiring improvement.

3.3 Top concerns

A report by Healthwatch Cumbria[3] concluded that the themes of interest to most recent users of maternity services were:

- The importance of continuity of care throughout the pregnancy, the birth and postnatal period
- Consistency and quality of information and communication
- Postnatal support for breastfeeding
- Support and information for women to make informed decisions and choices
- Accessible services and choice, thinking about some specific issues such as young mums, women with specific needs, travel, and place of birth

3.4 Antenatal support

Healthwatch York looked at the effect of moving ante-natal classes on-line. It said, "York Hospital Teaching Trust was the first NHS trust to replace face-to-face antenatal classes with 'virtual classes'. However, a number of areas have since introduced online antenatal classes, and there are at least nine areas in England, and one in Wales, where NHS antenatal classes have been cut or 'temporarily suspended'. The results of our survey suggest that the majority of respondents felt antenatal education could be improved. Further, 48% felt current provision did not meet their needs. The overall sense we got was that women want more face-to-face antenatal education on offer, particularly in the form of free classes." [4]

Responses to a survey by Healthwatch Suffolk found that "46% (n=26) of mums and 37% (n=22) of birthing partners stated 'no' they did not feel that antenatal classes equipped them for labour. 36% (n=20) of mums and 31% (n=18) of birthing partners said that antenatal classes... did not always cover the topics that they wanted. Antenatal classes run by the hospital should reflect the needs of the patients and partners attending. Importantly, antenatal classes should include education and support about breastfeeding tailored for expectant fathers/parents as tailored education has been shown to improve breastfeeding rates." [5]

3.5 Continuity of care

NICE guidelines[6] state that for continuity of care pregnant women should be assigned a named midwife. However, the Women's Institutes and NCT have said that "Compared to our findings four years ago, we can report scant progress in measures meant to ensure better clinical outcomes, such as continuity of carer." [7]

Healthwatch Blackpool reported that "90% felt that having a named midwife was important, yet only 44% reported seeing their named midwife consistently throughout their pregnancy." [8]

Home Start Oxfordshire said, "A key point coming from the feedback from this survey was around continuity of care. Parents reported seeing many different changes of professionals especially midwives delivering post-natal care. Seeing multiple professionals hinders parents' ability to build trusting relationships with professionals. We recommend that service

providers prioritise continuity of care when planning staffing to enable parents the opportunity to develop relationships." [9]

3.6 Choice

The Women's Institutes and NCT have said that "policy aspirations with regards to choice and personalisation are simply not being met." [10]

Healthwatch Blackpool found that "73% [of respondents to a survey] did not know they could have or were offered a choice of where their antenatal appointment could be held." [11]

Healthwatch Reading spoke to "eight women [who] shared in-depth experiences of not being able to giving birth in their chosen place. Seven out of the eight women felt strongly that women in the future should be routinely advised in advance that there was a possibility – no matter how small – that their birth place of choice may be changed due to capacity issues. This would allow women to emotionally and practically prepare for any last minute changes." [12]

Healthwatch Suffolk recommends that "During antenatal appointments all maternity professionals who are involved in birth plan preparation should be informing each patient that they do have a choice about where they could give birth. The midwife should provide enough information about the benefit and potential risk of each option for their patient to make an informed choice about where to give birth to their baby... 32% (n=22) of mums and 35% (n=26) of birthing partners stated that they did not get enough information from a midwife or doctor to help them decide where to have their baby and 26% (n=18) of mums and 19% (n=14) of birthing partners stated that they did not feel that the maternity staff involved them in the process of writing their birth plan." [13]

3.6 Overnight stays

Healthwatch Suffolk has noted "substantial evidence for the need for more flexibility regarding overnight stays at hospital for birthing partners. Over half of mums (52%, n=34) said they wanted their partner to stay overnight with them but they were not given the option for them to stay. Almost half of birthing partners (44%, n=31) stated that they would have liked to stay overnight but were not given the option to. A scheme called 'Partners Staying Overnight' was introduced at The Royal United Hospital in Bath, which provides a very good example of how a maternity unit can involve fathers and birthing partners in the period just after the birth of their baby. The published paper states that initially there were valid concerns from staff, such as that having the fathers and birthing partners on the ward for 12 hours a day might put additional stress on maternity ward staff. However, it was found that having fathers/birthing partners around eased the workload on midwives because mums had their partners to help them." [14]

3.7 Postnatal care

The Women's Institutes and NCT state that "The provision of postnatal care remains patchy, with no change in the percentage of women – roughly one in five- who were not able to see a midwife as often as they

required post-birth. Of the women who were unable to see a midwife as often as they needed to, a third reported that this resulted in a delay in a health problem for them or their baby being diagnosed and 29% said they were forced to seek help from their GP, walk-in centre, or A&E." [15]

Healthwatch Suffolk says "there may be a need to provide more information about potential expected emotional changes, particularly in the first few weeks after the birth of the baby. Nearly a quarter of mums (23%, n=15) and over 1/3 (36%, n=26) of birthing partners felt that they were not given advice on what to expect in the first few weeks after the birth." [16]

3.8 Neonatal care

Healthwatch Suffolk has observed that "Most respondents [patients of the neonatal unit at Ipswich Hospital] stated that they had to approach a member of staff and pro-actively ask for the health status of their baby. All respondents stated the midwife told them that their baby was well. New parents who have just been through the birth of their baby and who are dealing with worry of the removal of their baby into the neonatal unit may not be in a physically or psychologically fit state to 'chase' updates about their baby. Healthwatch Suffolk would encourage staff at Ipswich Hospital to endeavour to inform parents of the status of their baby as soon as possible and as often as possible. This is likely to positively impact the whole birth experience and the recovery period for both parents through reduced anxiety levels." [17]

3.9 Specialised support

We would recommend three further reports which offer useful insight into patient experience for specialised maternity services. These are:

- Beyond maternal death, improving the quality of maternal care through national studies of 'near-miss' maternal morbidity. National Institute for Health Research (NIHR) June 2016.
- Hidden Voices of Maternity. Parents With Learning Disabilities Speak Out. Change and PEN, August 2015
- Preparing for Home: a before-and-after study to investigate the effects of a neonatal discharge package aimed at increasing parental knowledge, understanding and confidence in caring for their preterm infant before and after discharge from hospital. National Institute for Health Research, March 2016

Appendix: Basic search list

The table shows results from our basic search, listed alphabetically by report title.

Title	Subtitle	Publisher
A Silent Problem – Perinatal Mental Health in Oxfordshire	Report by the Oxfordshire 1001 Critical Days Coalition.	Healthwatch Oxfordshire
Antenatal and Postnatal Services in York		Healthwatch York
Beyond maternal death, improving the quality of maternal care through national studies of 'near-miss' maternal morbidity		National Institute for Health Research (NIHR)
Bringing together physical and mental health		The King's Fund
Culture change in the NHS	Applying the lessons of the Francis Inquiries	Department of Health
Delivering high quality, effective, compassionate care	Developing the right people with the right skills and the right values	Department of Health
Delivering Our Potential	Our improvement plan for King George and Queen's hospitals	Barking, Havering and Redbridge University Hospitals NHS Trust
Each Baby Counts, key messages from 2015		Royal College of Obstetricians and Gynaecologists
Engagement about the Health and Social Care Needs and Experiences of Black, Asian and Minority Communities (BAME)	Final Report from the year 1st April 2015 to 31st March 2016	Healthwatch Worcestershire – Hereford and Worcestershire Age UK
Falling through the gaps	Perinatal mental health and general practice	Centre for Mental Health
Feedback for Maternity Review		Healthwatch Worcestershire
Female Genital Mutilation (FGM)	A Councillor's Guide	Local Government Association
Gypsy and Traveller Community experiences of healthcare in Oxfordshire	A Project Fund report	Healthwatch Oxfordshire – seAp
Hidden Voices of Maternity	Parents With Learning Disabilities Speak Out – Full Report	NHS England
Improving experiences of care	Our shared understanding and ambition	National Quality Board
Infant mortality and stillbirth in the UK		Parliamentary Office of Science and Technology (POST)
Maternity Focus Group		Healthwatch Brighton and Hove – Sussex Interpreting Services
Maternity Listening Project		Healthwatch West Sussex
Maternity Matters	What does a great service look like?	Healthwatch Cumbria
Maternity Review – Summary report of on-line responses and case studies		Healthwatch East Sussex
Maternity Service	Listening to Parents' Experiences	Healthwatch West Sussex
Maternity service review, July 2015		Healthwatch Blackpool
Maternity Services	Key findings from the Healthwatch network	Healthwatch England

Title	Subtitle	Publisher
Maternity Services in Norfolk	A snapshot of user experience Oct 2014 – April 2015	Healthwatch Norfolk
Maternity Services in North Somerset		Healthwatch North Somerset
Midwifery Service to Isles of Scilly		Healthwatch Isles of Scilly
Modelling of maternity services in England		National Audit Office
Pennine Acute Hospital Trust Services Report		Healthwatch Bury – Healthwatch Rochdale
Pregnancy in Barnet	A review of women's experiences in Barnet (updated version)	Healthwatch Barnet
Preparing for Home, a before-and-after study to investigate the effects of a neonatal discharge package aimed at increasing parental knowledge, understanding and confidence in caring for their preterm infant before and after discharge from hospital		National Institute for Health Research (NIHR)
Preventing avoidable harm in maternity care, Department of Health capital fund 2015-16		Department of Health
Priorities for mental health	Economic report for the NHS England Mental Health Taskforce	Centre for Mental Health
Privatisation and independent sector provision of NHS healthcare		British Medical Association (BMA)
Report of Survey Findings	Celebrating the Best of the Maternity Experience of Care with a focus on parents with learning disabilities	Patient Experience Network – NHS England
Report on families' experiences of ante- and post- natal community services in Oxfordshire		Home Start – Healthwatch Oxfordshire
Review of Maternity Services		The Pennine Acute Hospitals NHS Trust
Review of the Recommendations from the Maternity Report 2014		Healthwatch Isle of Wight
Right cot, right place, right time, improving the design and organisation of neonatal care networks – a computer simulation study		National Institute for Health Research
Saving Lives, Improving Mothers' Care	Surveillance of maternal deaths in the UK 2012-14 and lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009-14	MBRRACE-UK
Special measures, to special moments	An overview of maternity services provided by East Sussex	Healthwatch East Sussex
State of Maternity Services Report 2015		The Royal College of Midwives

Title	Subtitle	Publisher
Support Overdue, Women's experiences of maternity services		Women's Institute – National Childbirth Trust (NCT)
Supporting Mum	A Report of Patient Experience of the Maternity Pathway in Suffolk – Ipswich Hospital NHS Trust	Healthwatch Suffolk
The experience of Reading women who have been diverted from giving birth at their place of choice		Healthwatch Reading
The Report of the Morecambe Bay Investigation		Dr Bill Kirkup CBE
The state of maternity services in England		Picker Institute Europe
Turkish Speaking Carers Feedback on NHS (Antenatal, Intrapartum and Post Natal Care & Disability Services)	Addressing Health & Wellbeing Inequalities: Community Insight	Healthwatch Hackney
Turkish Speaking Women's Feedback on NHS Antenatal Services	Evaluating outcomes and impacts of culturally sensitive antenatal sessions	Healthwatch Hackney
User feedback in maternity services		The King's Fund
Using incentives to improve experience in maternity, children and young people's services	A report to consider how financial incentives could be used to improve the quality and effectiveness of maternity, children and young people's services	NHS
Why midwives leave – revisited		Royal College of Midwives
Young People and Parental Engagement Service Report		Healthwatch Worcestershire

References

1 The state of maternity services in England. Picker Institute Europe, July 2016

2 User feedback in maternity services. King's Fund, October 2016

3 Maternity Matters. What does a great service look like? Healthwatch Cumbria, February 2016

4 Antenatal & Postnatal Services in York. Healthwatch York, November 2016

5 Supporting Mum. A Report of Patient Experience of the Maternity Pathway in Suffolk - Healthwatch Suffolk, 2016

6 NICE Quality statement 2: Services – continuity of care

7 Support Overdue: Women's experiences of maternity services. The National Federation of Women's Institutes (NFWI) and NCT, 2017.

8 Maternity service review. Healthwatch Blackpool, July 2015

9 Report on families' experiences of ante- and post- natal community services in Oxfordshire. Home Start, 2015

10 Support Overdue: Women's experiences of maternity services. The National Federation of Women's Institutes (NFWI) and NCT, 2017.

11 Maternity service review. Healthwatch Blackpool, July 2015

12 The experience of Reading women who have been diverted from giving birth at their place of choice. Healthwatch Reading, August 2015.

13 Supporting Mum. A Report of Patient Experience of the Maternity Pathway in Suffolk - Healthwatch Suffolk, 2016

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