Better Births but worse postnatal care?
Designing a service fit for 2020 and beyond

A symposium bringing together 22 experts in various aspects of postnatal care was held in Westminster on 27 November 2019.

Those attending were invited to address the fragmented and under-resourced state of postnatal care in the UK and to help drive forward actions urgently needed to reverse this.

The attendance list included senior representatives from relevant Royal Colleges, the Institute of Health Visiting, academic institutions, service-user groups and charities.

The conveners were:

- Professor Debra Bick, Professor of Clinical Trials in Maternal Health, University of Warwick
- Elizabeth Duff, Senior Policy Adviser, NCT
- Dr Judy Shakespeare, retired GP

Better Births but worse postnatal care? Designing a service fit for 2020 and beyond'

A symposium bringing together 22 experts in various aspects of postnatal care was held in Westminster on 27 November 2019. Those attending were invited to address the fragmented and under-resourced state of postnatal care in the UK and to help drive forward actions urgently needed to reverse this. The attendance list included senior representatives from relevant Royal Colleges, the Institute of Health Visiting, academic institutions, service-user groups and charities. To help focus discussion, an editorial by the three symposium organisers had been circulated previously to all participants.[1]

The event was held in the period immediately prior to a general election, which prevented not only the attendance of NHS and government policy-makers (who had previously accepted the invitation) but also availability in the public domain of a number of new reports containing relevant data. The most significant of these was the MBRRACE-UK annual publication from the confidential enquiries into deaths of mothers, 'Saving Lives, Improving Mothers' Care 2019'[2]. As well as a wealth of useful detail about the causes and conditions underlying mortalities, the report gave the total numbers of deaths and when they happened, demonstrating that - as in every previous investigation – a substantial majority of maternal deaths take place in the postnatal period. It is abundantly clear that if the National Safety Ambition to halve maternal deaths by 2025 is to be reached then improvement of postnatal care is of extreme and crucial urgency.

Presentations from NCT, MBRRACE-UK and authors of the CMO report on women's health

After introductions and a welcome from the chair, Professor Rona McCandlish, there were brief presentations to inform and stimulate the discussion that was the principal aim of the day.

Elizabeth Duff, senior policy adviser at NCT (National Childbirth Trust), summarised 'What women want from postnatal care', starting with quotes from feedback to a postnatal survey[3] where among the telling words noted were: 'disappointed', 'unsupported', 'abandoned', 'alone and in pain'. Themes that emerged from this survey were the need for:

- A documented, individualised postnatal care plan developed with the woman
- High quality care on the postnatal ward
- Length of hospital stay appropriate for individual mother and/or baby
- Continuity between antenatal and postnatal care
- Consistent information from professionals especially around infant feeding
- Joined-up care between hospital and community
- Appropriate number and quality of home visits
- Appropriate specialist follow-up if needed
- Communication between midwife, HV and GP
- Consistent content and quality in the 6-week maternal postnatal check

Postnatal care must fulfil the widely accepted 'dimensions of quality care',[4] to be: safe **-** avoiding harm to patients; effective **-** providing services based on evidence and which produce a clear benefit; person-centred **-** establishing a partnership between practitioners and patients to ensure care respects patients' needs and preferences; timely; efficient; and equitable. Elizabeth suggested that the current model of fragmented care is not a service that fully meets any of these criteria. Most strikingly, with the risk of maternal deaths for black women at five times that for white women - and the majority of these postnatal - it would appear that equity is lacking: action on this is imperative.

[1] Bick D, Duff E, Shakespeare J. Better Births – But why not better postnatal care? Midwifery.2020; 80:102574. doi: 10.1016/j.midw.2019.102574
[2] Knight M, Bunch K, Tuffnell D, Shakespeare J, Kotnis R, Kenyon S, Kurinczuk JJ (Eds.) on behalf of MBRRACE-UK. Saving Lives, Improving Mothers' Care. NPEU, University of Oxford 2019.
[3] NCT & NFWI. Support Overdue: Women's experiences of maternity services. NCT, 2017.
[4] Quality improvement made simple: What everyone should know about health care quality improvement. The Health Foundation, 2013.

Higher rates of maternal mortality are also associated with women living in poverty and/or older maternal age. Awareness of these factors should influence priorities in postnatal care. The symposium was further urged not to forget the mothers without babies: for example, those who are: bereaved after a stillbirth or neonatal death; separated because of severe mental or physical illness; in prison; or whose baby is being looked after by social services. The absence of their baby in these women's' lives means they are already at heightened risk of poorer mental health; they may also neglect good care of themselves and thus delay physical recovery from the birth.

This presentation closed with the emphasis that, especially for first-time mothers, it is crucial that they are helped to know what are normal occurrences in the postnatal period and what are not normal and may be dangerous signs of adverse health in either mother or baby. Recommendations to caregivers were: Use regular review of the postnatal care plan to encourage questions from the mother; Ensure information given is consistent with that of multi-disciplinary colleagues; Signpost to reliable, evidence-based resources; Remember that postnatal care is often the only opportunity for inter-pregnancy care: advice on lifestyle choices now can improve experience in the next pregnancy.

Professor Marian Knight, of the NPEU (National Perinatal Epidemiology Unit) and MBRRACE-UK, then spoke of 'Postnatal care for women with multiple health, social and other challenges'. She showed a graph of trends in maternal mortality clearly demonstrating that, despite numbers reducing over earlier decades, in the past six years the trend has reversed and is now rising again. There is a 'changing maternity population' that includes older women, those with obesity and other adverse underlying health conditions, such as diabetes or high blood pressure, alongside more sedentary behaviour and other lifestyle choices that affect the chances of healthy childbirth. The inequalities apparent in mortality statistics include, as said above, black, mixed or Asian ethnic background; deprivation; and age of the mother – but not whether the mother was born in the UK.

Among late maternal deaths (6 weeks – 1 year), suicide continues to be a leading cause. Severe depression, post-traumatic stress disorder (PTSD) and other psychiatric conditions can impact on women after the end of 'traditional' postnatal care, even if women are offered a full physical and mental wellbeing check at 6-8 weeks. Sadly, this can lead to women harming themselves and taking their own lives. Marian highlighted a number of tragic case studies when women with multiple serious health conditions 'fell through the gaps' between various physical, mental and social care services, in spite of having seen health professionals a number of times: in over 80% of late maternal deaths the mother was experiencing at least four identified problems in addition to the condition which directly caused her death. It was stressed that 'The postnatal care plan for women with complex and multiple problems should include the timing of follow-up appointments, which should be arranged with the appropriate services before the women is discharged and not left to the GP to arrange'.

In addition, there was a heartfelt recommendation from the MBRRACE-UK report addressed directly to health professionals: 'Joined-up care, across services and systems, is essential. The more health and social factors a woman is dealing with, the more professionals are involved in her care, and therefore the greater the risk that care will fall apart for her. You have a responsibility to make sure her care is being co-ordinated and that needs are being addressed.'

Professor Debra Bick, Warwick Clinical Trials Unit, University of Warwick; and Dr Judy Shakespeare, retired GP were co-authors (along with others attending the symposium) of a chapter in the Chief Medical Officer's report 2014, which focused on 'Post-pregnancy care: missed opportunities in the reproductive years'. They spoke of how this area now remains, even more damagingly, a lost opportunity to: ensure women are well enough to care for their babies; follow up any clinical complications of pregnancy or birth; help the woman understand why these have occurred and whether her future health or subsequent pregnancies may be affected; provide information and support to amend their lifestyles if this will improve their health.

Debra referred to the conclusion of the chapter that postnatal care was not 'fit for purpose', as it failed to meet the needs of women giving birth in the 21st century. Evidence from successive large observational studies has shown that

women experience widespread and persistent physical and mental morbidity following birth, which current models of care fail to identify or manage. Furthermore, the health profile of pregnant women has changed significantly over the last decade. More women have a higher body mass index (BMI) at pregnancy booking; more are of older age at first pregnancy; and more are likely to have pre-existing medical problems such as hypertension and diabetes. This has contributed to an increase in labour and birth interventions such as induction and caesarean section,[5] yet the duration of inpatient stay following birth has declined. Women continue to report lack of support for breastfeeding, lack of attention to their health needs after birth, ongoing concerns about their mental health and well-being and poor communication about their needs between primary and secondary-care based clinicians. There is an urgent need for research into appropriate models of care for postnatal women, which includes planned care, tailored to individual need, with care planning commencing from pregnancy. Ideally a system of postnatal 'tri-age' of all women would ensure that women would receive the right level of follow-up, at the right time and with the right clinicians.

Judy asked whether GPs were still fit for purpose in postnatal care. Midwives generally withdraw from postnatal care at 10-12 days, so GPs and health visitors provide whatever care they can after that. Referring particularly to the situation in England, Judy warned that GPs lack training and experience in this area and Health Education England has no responsibility to provide any training for them after qualification as a GP. NHS England does not regard them as part of either the maternity or mental health workforces. GP services are under massive pressure because of increased consultations and difficulties with recruitment and retention. The GP contract no longer covers the 6-week maternal check; although negotiations are underway in an attempt to change this.[6] This is a 'perfect storm' where no-one is responsible for delivering safe care for women because of service boundaries and professional silo-working.

Discussion

In a session in three groups, participants were asked to think about: their ambitions for the postnatal care service; the obstacles and challenges that may prevent these being fulfilled; and what the present group and others can do in the short and longer term to implement the changes needed. After feedback from groups to the full symposium, further plenary discussion continued, with all participants contributing.

Emerging themes

In the *service* provided, a lack of:

- ***Accountability***: no one person or team is responsible for - or able to co-ordinate - care throughout the period, even up to six weeks. Many mothers will need planned, ongoing follow-up after this time, especially those with underlying conditions or who developed complications in pregnancy or at birth. Solutions have been previously proposed, e.g. 'a multi-disciplinary team-based approach, with a co-ordinating health professional who has the appropriate clinical skills to ensure that the mother receives the postnatal care she needs.'[7] The current fragmentation of care, sometimes with untimely handover from hospital to community to local authority and/or primary care, causes widespread problems for women, ultimately leaving some 'falling through gaps' with disastrous results, as reported by MBRRACE-UK. It was suggested that the best person to hold accountability is the GP.
- ***Clarity***: the term 'postnatal' is understood in different ways, which can cause unhelpful confusion. Either an evidence-based definition is needed, or a new term that is accepted across professional groups and perceived clearly by service users and the general public. ('New family wellbeing' or similar phrases were suggested but also argued against as this may revert to care being focused only on the baby).
- ***Planning & follow-up***: while guidance from NICE and others strongly recommends a tailored postnatal care plan for each mother, developed during the antenatal period and regularly reviewed, in practice this rarely seems to happen

[5] NHS Maternity Statistics, 2018-19 https://files.digital.nhs.uk/D0/C26F84/hosp-epis-stat-mat-summary-report-2018-19.pdf
[6] In February 2020 NHS England announced that from April 2020 funding for the 6-8 week check would be made available https://www.england.nhs.uk/publication/investment-and-evolution-update-to-the-gp-contract-agreement-20-21-23-24/
[7] National Service Framework for CYP & Maternity Services. DH/DES, 2004.

or caregivers are unaware of its content. Absence or ignorance of such plans means that services will lack knowledge of when levels of need change and increased resources may be required. This is a particular issue for women who require longer-term care, including advice for a subsequent pregnancy. In the USA, obstetricians proposed a 'redesign' of postnatal medical care, noting that 'Timely follow-up is particularly important for women with chronic medical conditions. Initial assessment should be followed up with care as needed, concluding with a comprehensive postpartum visit no later than 12 weeks after birth, [to] serve as a transition to ongoing well-woman care'.[8]

- ***Training:*** all health professionals involved in offering postnatal care need relevant, evidence-based and up-to-date skills. Some GPs acknowledge they are unskilled and highlight lack of funding to build on post-core training. In addition, both maternity support workers in the community and practice nurses in primary care may be required to provide postnatal care without the skills to identify developing issues in women's wellbeing.
- ***Evaluation***: currently, measurement, audit and evaluation of postnatal services are inconsistent and of poor quality. Data are sparse: the National Maternity & Perinatal Audit (in England, Scotland and Wales) records only the 'Proportion of women who have an unplanned, overnight readmission to hospital within 42 days of giving birth'. Meanwhile, the Care Quality Commission annual maternity survey, the Scottish Maternity Survey and other large-scale studies of women's experience demonstrate repeated feedback that postnatal care is overwhelmingly the least satisfactory phase of the maternity service.
- ***Evidence***: postnatal care was vividly described by one participant as an 'evidence-free zone'. Others acknowledged existing evidence of morbidity, poor breastfeeding and unplanned maternal readmission but noted the lack in terms of models that work. Although the upcoming review of NICE guidelines on postnatal care will identify relevant evidence to inform its recommendations, it may be beyond its remit to propose the radical changes that are necessary. More up-to-date research is urgently required, aiming to inform and grow an improved service from the roots of mothers' and families' needs.

In the *care* provided, a lack of:

- ***Consistency***: the postnatal period is a time when mothers most frequently report receiving 'conflicting advice'. This is predominantly about feeding or soothing their baby, but can also affect self-care, for example, what is 'normal' in terms of postnatal pain, loss of blood, bladder/bowel control, healing of stitches/surgical wounds and when to seek medical attention. Professional care should be both individualised and evidence-based, but – as noted above – evidence is widely lacking. Fragmentation of care among different professional groups also exacerbates the risk of advice and information being perceived as inconsistent and frustrating.
- ***Continuity***: there was a strong emphasis in discussion on the benefits of continuity of carer from antenatal to postnatal. Some suggested this is more important than a known carer in intrapartum care. The point was made that early identification of mental health disorder would be expedited if the woman saw a midwife who knew her and could detect unusual mood or behaviour. Knowledge of a woman's preferences and values about, e.g. infant feeding, as well as the influences from family and community, could also help a caregiver direct support in the most effective way.
- ***Equity***: there must be universal access to postnatal care for all women and families. The data from MBRRACE-UK show clearly that some mothers fall through gaps and receive insufficient or no care at all. The heightened risk of death among certain groups is unacceptable; and with knowledge that the majority of maternal deaths are postnatal it is clear that poor, more vulnerable and non-white mothers are not receiving optimal care after the birth of their babies. Reasons for this are multi-faceted: further work to inform our understanding is urgently needed.
- ***Kindness***: far too many women report a lack of kindness in the care they receive, particularly in the hospital postnatal ward. While it is known that these areas are commonly understaffed and under pressure, it is saddening to read of new mothers post-surgery or still immobilised by epidural anaesthesia being spoken to sharply and told to fetch their own glass of water or pick up their own babies to feed or change. It was suggested that the long history of postnatal care being perceived as least important, in comparison with antenatal and labour care, gives this area a

[8] ACOG Redesigns Postpartum Care https://www.acog.org/About-ACOG/News-Room/News-Releases/2018/ACOG-Redesigns-Postpartum-Care?IsMobileSet=false

low value, leading to reduced commitment to high-quality care. Changing a culture of behaviour is notably difficult but the impact of such comments from women in hospital should be used to help staff understand the effect of what is perceived as an indifferent attitude.

Ambitions

A solution is needed to the inter-related problems of: 1) the fragmentation of care among different professional groups; and 2) each of these groups being severely under-staffed and, in some cases, lacking relevant competency, e.g. to detect early postnatal disorders or provide appropriate follow-up to pregnancy and/or postnatal complications. This report does not aim to recommend specific roles for professionals, especially as systems vary somewhat in the different countries of the UK, but a number of principles arose:

- The **first 24-48 hours post-birth** were highlighted as an extremely important phase for new mothers: although most women remain in hospital at this time, individualised care may be lacking and women report little emotional support while they struggle with their own recovery and care for their newborn. There must be a focus on improving postnatal ward experience through co-design, based on women's views, and promoted through the MVP/MSLC. The presence both of women's partners and of trained volunteers can be beneficial but also controversial: agreements about how such supporters are included in a safe and sensitive way can be reached and should be a priority. Encouraging women in hospital to engage with and help each other can raise morale, form friendships and enable exchange of tips and hints about feeding and infant care.
- Poor experiences of **early baby feeding support** can set the tone and lead to a cascade of postnatal problems. Again, over-stretched staff may inadvertently make assumptions or use language about women's choices that upsets them at a vulnerable time. There is an appropriate role for maternity support workers (MSWs) or qualified peer supporters on postnatal wards to provide feeding support, so long as they have the required skills, are supervised by midwives and work in a way that is complementary. If properly trained, they can provide the time, space, listening skills and support that women need with feeding soon after birth, but which midwifery staff find hard to give.
- All staff working in postnatal care should have heightened **understanding of the experiences of parents** whose baby is premature, sick and/or those with diagnosed or undiagnosed disability. Anxiety about the baby can cause a mother to neglect self-care and delay her own recovery: emotional and practical support are essential for such women. When a baby has died around the time of birth, the National Bereavement Care Pathway (https://nbcpathway.org.uk) should be followed. In all situations when a mother is separated from her baby, including her involvement with social services or criminal justice system, extra attention is needed to ensure she receives the right care for herself.
- The **role of health visitors** should be better utilised as they have the relevant skills and adequate contact points for access in the early weeks. An antenatal contact point for health visiting was discussed, highlighting this as an important opportunity for relationship-building with expectant parents. The HV workforce needs enhanced support and recognition, as well as systems that facilitate prompt and effective communications between HVs and other staff working in PN care.
- There was considerable discussion about the **role of HCAs/MSWs in the community**. Over recent years this expansion has become widespread, with MSWs becoming able members of 'the midwifery team', and in some cases this has worked well. But there are questions about their training and competencies in the care of new mothers' mental and physical wellbeing. As part of the ongoing work to provide this professional group with improved clarity of role and relevant recognition, it is crucial that they are supported in being confident to assess maternal wellbeing and have the opportunity to refer women swiftly to specialist care when needed.
- The **location of postnatal care** was a major focus. It was mentioned that, in Sweden, postnatal care is run out of a central hub or family centre: ' …, including midwife, family nurse, social workers who work as a team'. The UK had a similar network of children's centres, but many have closed over the past 10 years. In England and Scotland, current maternity policy promotes the establishment of community hubs for maternity– antenatal, postnatal and in some cases intrapartum care. Where these exist, they could be an ideal venue, once the mother has had visits at home as often as she needs, and is physically and mentally confident to get out of the home with her baby. The key point is to ensure that *care for the woman* is provided and not marginalised by over-emphasis on the baby/ies.

- To **address the described 'evidence-free zone'** in postnatal care, it is essential that more research funding should be directed towards this area. Key topics suggested were: identifying ways to measure effectiveness of postnatal care in both short and long term; establishing why some women get insufficient care resulting in poorer outcomes (including those in remote/rural areas and those in cities who give birth 'out of area', as well as the groups cited above known to be at greater risk of postnatal death); follow-up of pregnancy complications that helps women to plan future pregnancies; and mental health support for new fathers. Two research projects at City University London were noted, which address questions relating to detecting PNMH issues and the best measures to use.[9]
- Managers and policy-makers should recognise the expertise available outside the usual specialisms, such as **breastfeeding counsellors, peer supporters** and others working in the voluntary sector. Physiotherapists are needed where mothers have a damaged pelvic floor, but other specialists in planned physical activity can help mothers get back to health through appropriate exercise, preferably with their baby and in social groups. All those working with new mothers should have access to evidence-based care and local knowledge for effective signposting.
- Overall**,** participants urged an emphasis on the importance of **timely action, referral and follow-up**: a crucial need to ensure that if a women discloses a problem, whoever in the health service she speaks to, that this is acted on promptly and she is directed to where she can get support. As above, accountability for care and the co-ordination of staff and services must be a priority: mothers who 'fall through the gaps' are those at greatest risk and MBRRACE-UK evidence shows that, too often, the result is tragedy.

Obstacles/challenges

- **Worsening health profile of women** and families. Growing complexity of the maternity population was highlighted, in terms of demographics (e.g. increasing age), obesity, smoking and drug use, and pre-existing medical conditions. The recognition of this trend in antenatal and intrapartum care has seen increased funding directed to these areas, but postnatal remains under-resourced, despite resources having to cover care both of a woman and her infant/s.
- **Fragmentation of care** is embedded in custom and practice. Recent changes in England have exacerbated the problem, in that hospital midwives, community teams, health visitors and GPs may all be: employed by different bodies; use and have access to different computer systems; never or rarely meet each other; never or rarely visit the same locations to provide care. The result can be communication breakdown with poor results for families.
- Women with **co-morbidities** - two or more conditions - often struggle to access services for either, or are deemed 'not to fit the criteria'. An example was women with both an additional physical need and postnatal mental health problems. As above, these women can easily fall through gaps and the need for overall accountability is paramount.
- **Range of professionals involved**: there are others beyond MWs, HVs and GPs, such as physiotherapists and practice nurses. It was warned that the 6-8 week postnatal check in primary care may be delegated to nurses or nursing assistants, who may not have had training in perinatal mental health problems or care of pelvic floor damage.
- As set out above, postnatal care has had many decades of **perception as the least valued phase** of care. Calls for improved maternity safety have resulted in greater surveillance and increased intervention in late pregnancy and birth care but not in postnatal, in spite of unarguable evidence that more deaths occur after the birth, in both early and late postnatal periods. This cultural attitude contributes to the obstacles in improving care and adds emphasis to the clear need for radical changes - not 'tweaking' of existing systems.

Debra Bick, Elizabeth Duff, Judy Shakespeare – with thanks to note-takers on the day

[9] https://fundingawards.nihr.ac.uk/award/17/105/16 and%20MATRix