Maternity Services Evaluation

September 2012
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1. Executive Summary

1.1. Introduction & Evaluation approach

In November 2011 we commenced a review of Wirral maternity services that aimed to evaluate both main providers of maternity services in Wirral and establish comparable evidence of the maternity outcomes and service user experience of both services.

The approach taken included a review of the underpinning literature, case studies of good practice in maternity care, analysis of performance data, an externally commissioned evaluation and ‘patient learning’ and anecdotal evidence from service users.

1.2. Good practice in maternity services

Two examples of good practice in maternity services were considered and case studies generated for South Hampshire Maternity Services (via desk top research) and Sandwell PCT & Sandwell and West Birmingham Hospitals NHS Trust Maternity services (from a visit to the service). The key aspects noted of the services include:

There are a number of common themes in the models assessed from South Hampshire and Sandwell.

- Both services provide choice of:
  - An obstetric led unit
  - A midwifery led unit alongside the obstetric unit
  - A stand alone birthing centre
  - Home birth

- Both aim to provide a ‘home from home’ environment for women who cannot give birth at home or choose not to. This addresses a perceived need for women to have a relaxed, comfortable setting during their pregnancy and birth to promote self confidence and a sense of security.

- Relaxation and comfort are facilitated through design of the environment with the conviction that this can often promote a more straightforward birth.

- There is a focus in both services on the normalisation and de-medicalisation of maternity care. In Sandwell this is structured as the default option for ‘low risk’ women being the midwifery led unit unless they opt out.

- The midwifery led services are managed separately to obstetric services in both areas. Obstetric services exist only to support ‘high risk’ women and deal with any unexpected complications during pregnancy and birth.

The success of the model of care in Sandwell was felt to be not only the birth centre environment but also the clear leadership and a coherent ethos amongst staff that supports the vision and philosophy and emphasises kindness alongside midwifery
expertise. The model also supports the caseload or ‘domino model’ where there is continuity of antenatal, birth and postnatal care.

1.3. Programme Evidence
1.3.1. Performance and Effectiveness
Each maternity service completes a monthly ‘performance’ dashboard recording activity in relation to referrals, bookings, births and maternal health. Data for the period January to May 2012 demonstrated that:

- Between January and May 2012, there were 1839 referrals in total (1566 to WUTH and 273 to One to One). The number of referrals was consistent across the months during the period considered.

- There were 1650 births in total recorded for the period January to May 2012, with 1528 recorded by WUTH (93% of total births for the period) and 122 for One to One (7% of total births for the period). The number of births month by month was consistent during the period considered.

- CEMACH guidelines advocate that at least 80% of users should be offered booking within 2 weeks if they were greater than 12+6 weeks gestation at point of referral. Both providers achieved 100% of users being offered booking in this circumstance.

- The target for normal vaginal deliveries is that at least 70% of women would not require additional clinical intervention. A total of 72% (88) births to women registered with One to One during the period were normal vaginal deliveries, compared with 66% (1001) of the births at WUTH. The One to One deliveries included those delivered by WUTH who received their antenatal care from One to One.

- The target for instrumental vaginal delivery rate is between 10 and 15% of all births. Both providers achieved this target during the period, with One to One reporting an instrumental vaginal delivery rate of 9.5% and WUTH reporting 12%

- The target for total caesarean section rate (planned and unplanned) is less than 22%. Both providers achieved this target with caesarean rate at 21.7% for WUTH and 18.4% for One to One.

- The planned home birth rate was higher for One to One (13.5%) during the period January to May 2012, than WUTH (1.1%). The achieved home birth rate for the period was 32.5% for One to One and 0.7% for WUTH.

- Smoking targets for pregnant women relate to reducing the number smoking at delivery who were smoking at booking. Both providers were within these targets during the period considered.

- The target for breastfeeding initiation rates is at least 70% of mothers, in line with national average rates. Breastfeeding initiation rates for WUTH were consistently below target at between 51% and 59%. One to One were also below target for
breastfeeding initiation for 3 of the months during the period, with rates of between 53% to 75% across the period.

1.3.2. Stakeholder consultation & Service User Experience
As part of the overall review of maternity services, NHS Wirral commissioned an independent research agency, Mott MacDonald, to examine user perceptions and experiences of maternity services on Wirral and to gather stakeholder views.

- The methodology used included a short survey emailed to maternity staff and stakeholders, a survey posted to current and recent users of the services and focus groups and interviews with service users from both providers.

- 117 responses were received from the stakeholder and service provider consultation, including GPs, midwives, Children’s Centre staff and health visitors.

- 72% of stakeholders considered a midwifery led unit (MLU) based alongside an obstetric care provider to be the best model for good quality maternity care. It was felt that this approach acknowledges that the majority of births proceed normally but obstetric support is available nearby for those that do not. Midwives were the group of stakeholders least likely to express this view.

- 18% of stakeholders favoured a stand alone midwifery led unit, which would refer to an obstetric care provider where necessary. Over half of the stakeholders expressing this preference were midwives.

- Common themes in the stakeholder survey included promoting the normality of pregnancy and birth, a move away from an overly medical model of maternity services, continuity of care and increased communication between professionals and services including GPs.

- The most important components of good quality care for stakeholders were clinical competence of midwives and obstetricians. More patient-centred priorities such as place and time of care and continuity of relationship with midwife were considered the most important components by service users.

- Of the 1200 surveys (WUTH - 867 & O2O - 333) sent out, Mott MacDonald received 246 responses, which gives an overall response of 20.5%. Response rate from WUTH service users (n=179) and One to One service users (n=69) was very similar.

- For the vast majority of service users, a GP was their first point of contact upon discovering that they were pregnant. Reasons for this included thinking this was where they should go, not being aware of alternatives, convenience of locality of the service and familiarity with GP surgeries. Comments indicated that once aware that they could go directly to a midwife about their pregnancy, some may do so in future.

- There was evidence of lack of awareness of choice of maternity provider and lack of awareness and understanding about the specific aspects of services offered in
Wirral. Service users would prefer more information about appointments and birth choices as well as locations of services.

- Continuity of care was the top influencer of choice for service users. Building relationships with the midwives (including flexible communication throughout antenatal care) and a midwife you saw through your antenatal care being at the delivery were also in the top 5.

- Service users felt that convenience of location and time for seeing your midwife were highly important. Home visits were appreciated and felt to be a component of good quality care. Most survey respondents were happy with the locations where they saw their midwife but some WUTH users desired more flexibility, not being rushed and the option of home visits.

- There were mixed experiences of birth and immediate postnatal care in hospital and some key recommendations have arisen from users comments. Themes of confidence in care, clarity of communication and respect were shared by many service users in both services but continuity of care was experienced by few of those registered with WUTH.

- General postnatal care was seen as good and the availability of home visits was appreciated. More consistency in timings of appointments and communication may improve this component of service as detailed in the recommendations.

- The performance data show that breastfeeding rates in Wirral are well below national and regional averages, and in the service user survey only 61.8 % of women had breast fed their most recent baby. More information about the reality of breastfeeding and approaches to overcome some of the difficulties experienced (instead of the sole emphasis on its benefits) was requested by users. There was little evidence that available breastfeeding support services were being promoted.

- There is evidence of some underlying tensions between service providers that is impacting upon patient care and service user experience. This included discontinuity of service but also staff attitude toward women requiring care from both providers.

1.3.3. Other evaluation data
Evaluation data routinely collected by the service providers was provided for the evaluation, including satisfaction surveys, complaints and compliments.

- Results from the WUTH Learning with Patients Questionnaire show high levels of satisfaction with the maternity ward at Arrowe Park Hospital. There was also improvement in satisfaction with some areas since the previous quarter.

- Positive comments from WUTH registered women related to helpful staff, good breastfeeding support, good level of cleanliness and hygiene, good level of privacy and continuity of care.
• Negative comments included to lack of support from staff, issues with staffing levels, bad staff attitude/manner, lack of respect and care, low level of care and an experience that was traumatic and stressful.

• One to One satisfaction survey results show that all respondents were extremely positive about their experience and satisfied with their care and 100% of participants said they would recommend One to One to a friend.

• There were a number of complaints made to both providers during the period of analysis. For WUTH, nine complaints during the period of evaluation related to communication, staff attitude, delays as a result of over-stretched staff (in discharge, requested medication and meals) and issues with the delivery suite (admission, phone advice and latent phase of labour)

• Five complaints made to One to One (over a 15 month period) related to pain not being sufficiently acted upon by midwife, lack of continuity of care, delay in transfer of care to WUTH, not connecting with midwife on a personal level and named midwife not being available at birth

• Specific issues around communication when giving difficult news and hostilities between providers were raised in this section and details of a compliment from a One to One service user.

1.4. Recommendations

A number of recommendations arise from analysis of the data collected. A summary of the rationale for each of these recommendations is given in the main body of the report (Section 6.2).

Recommendation 1:
Explore the further development of midwifery led care for Wirral

Recommendation 2:
Explore the use of caseload midwifery model

Recommendation 3:
Improve promotion of patient choice

Recommendation 4:
Information to facilitate patient choice needs to be more systematically given

Recommendation 5:
Improve continuity of care

Recommendation 6:
Increase the flexibility of appointments and opportunity for home visits

Recommendation 7:
Increase the availability of unscheduled communication with midwives
Recommendation 8:
Improve listening to women’s preferences and responding to incidents

Recommendation 9:
Review midwife to women ratios in view of best practice guidelines

Recommendation 10:
Increase involvement of family members

Recommendation 11:
Improve support around breastfeeding practice

Recommendation 12:
Improve systems to ensure collaboration between providers
2. Introduction

2.1. Maternity Services in Wirral

On average, Wirral has approximately 3500 births per year. There are two main providers of maternity services on the Wirral:

- Wirral University Teaching Hospital (WUTH) NHS Foundation Trust
- One to One (NORTH WEST) Ltd

Wirral University Teaching Hospital (WUTH) offer antenatal, postnatal and birthing services to women in Wirral. WUTH have recently undergone major changes to the hospital inpatient services with a newly refurbished centre at Arrowe Park.

One to One (NORTH WEST) Ltd offer antenatal, postnatal and, more recently, birthing services to women in Wirral. The One to One service was originally commissioned as a pilot project for a 12 month period to work with a targeted group of approximately 150 mothers in the most deprived areas of Wirral. In October 2011 they were commissioned to provide antenatal, birthing and postnatal services to women across Wirral.

2.2. Background to the Evaluation

In 2009, NHS Wirral commissioned an external agency to carry out a survey with users of Wirral University Teaching Hospital (WUTH) maternity services with the purpose of engaging with the service users, gauging satisfaction with the service at both the antenatal and postnatal stages, as well as while giving birth, and identify whether improvements made to the service in January 2009 had been effective and resulted in an improved service. The agency was also commissioned to carry out qualitative research with users of the WUTH maternity service in early 2010, to explore their experiences of the service further.

2.3. Aims & Objectives

In November 2011 a further review of maternity services commenced. This aimed to build on the evaluation work carried out in 2009 and 2010, and recognise the changing landscape of maternity services in Wirral, following the expansion of the One to One service Wirral-wide. The overall aim of the review was to evaluate both maternity services in Wirral and establish comparable evidence of the value of both services, on maternity outcomes and service user experience.

The review specifically aimed to:

- Review maternity service provision and practice in the context of evidence in the literature and against examples of good practice elsewhere;
- Investigate and compare service performance through data analysis;
- Investigate ongoing service user perceptions of maternity services in Wirral;
- Explore the appropriateness and effectiveness of service provision in Wirral;
- Explore any barriers to access to maternity services.
2.4. Evaluation approach

Various sources of evidence have been considered for this evaluation. Evidence within the literature has been reviewed, along with examples of good practice in maternity care and a case study undertaken. Specific programme evidence has been analysed including performance data, an externally commissioned evaluation which included work with service users and stakeholders, and additional ‘patient learning’ and anecdotal evidence from service users.
3. Underpinning Evidence

3.1 Background

Department of Health guidance ‘Maternity Matters: choice, access and continuity of care in a safe service’ (2007) provides recommendations for commissioners, service providers and other organisations involved in the provision of maternity services (Department of Health (DH) 2007b). It highlights the Government commitment to developing a high quality, safe and accessible maternity service through the introduction of a new national choice guarantee for women which will ensure that all women have choice around the type of care that they receive, together with improved access to services and continuity of midwifery care and support. This has been followed up in 2010 with the document Maternity and Early Years (Department of Health, 2010).

In addition National Institute of Health and Clinical Excellence (NICE) guidance sets the standards for high quality healthcare and encourages healthy living. For maternity services, guidance is available on a range of related areas including:

- Antenatal and postnatal mental health;
- Antenatal care;
- Pregnancy and complex social factors;
- Maternal and child nutrition;
- Quitting smoking in pregnancy and following childbirth
- Weight management before, during and after pregnancy
- Pregnancy (rhesus negative women) routine anti-D
- Diabetes in pregnancy
- Hypertension in pregnancy
- Multiple pregnancy
- Induction of labour
- Intrapartum care
- Caesarean section
- Postnatal care

In the Healthcare Commission Review of Maternity Services 2007, Wirral was found to score fairly low (level 2) in terms of the how much choice women have in how their antenatal care is provided. However, fairly high scores (level 4) were attributed to how much choice women have for tests and scans and how much choice women have in the delivery of their babies. The Trust also received an acceptable score (level 3) for how readily women can access maternity care and information. Each indicator is scored on a scale of 1 to 5, with 1 representing poor performance, 5 representing high performance and 3 representing an acceptable level of performance.

A further survey was carried out in 2010 with the Care Quality Commission Survey of Women’s experiences of maternity services 2010. Wirral achieved high scores in the majority of questions, particularly on those relating to the staff during labour and birth. In relation to choice, Wirral scored highly on whether women were given the choice of having their baby at home. However, in relation to access to information and the provision of antenatal care, low scores were given for explanation of the dating (12 week) scan and the 20 week scan. Continuity of care is not specifically mentioned in the results for these surveys.
A survey of 252 mothers carried out by Mott MacDonald in 2009, found that very few mothers were offered a choice of midwife (6.8%) but more choice was offered regarding where to see their midwife and a large proportion were given a choice of venue (62.5%). Very few mothers (10.8%) saw the same midwife throughout their pregnancy and mothers, on average, saw 4 different midwives. A qualitative report by Mott MacDonald (2010) also highlighted lack of continuity of care.

In a service user insight focus group carried out by NHS Wirral (April 2011), participants notably valued the person centred approach and tailored care they received from One to One Midwifery Service and the positive impacts associated with this. This insight work also raised questions of integration with other services where pathways crossed from one service to another and concluded that this should be explored in a future evaluation.

3.2 Midwifes role in public health and addressing health inequalities

The Marmot Review states that "Giving every child the best start in life is crucial to reducing health inequalities across the life course. The foundations for virtually every aspect of human development – physical, intellectual and emotional – are laid in early childhood. What happens during these early years (starting in the womb) has lifelong effects on many aspects of health and wellbeing – from obesity, heart disease and mental health, to educational achievement and economic status." (Marmot, 2010). A child's experiences before birth and during its early years affect its health throughout life. The availability and quality of the advice, support and care provided from the early stages of pregnancy to birth and the early years of a baby's life is important for all. High quality antenatal and postnatal care are crucial in ensuring parents feel adequately supported and equipped with the skills and knowledge to give their child the best possible start in life.

Children under five years living in deprived areas are 8 per cent more likely to be obese; 9 per cent more likely to be of a low birth weight; and 12 per cent more likely to have an accident than those living in the rest of England (Audit Commission, 2010). Tackling the inequalities at this early age can only seek to improve life chances as children develop into adults.

Midwives have a vital role to play in improving health and social well-being for all women and reducing health inequalities. Disadvantage starts before birth and accumulates throughout life and so action to reduce inequalities must start before birth and be followed through the life of a child. Midwives are well placed to help every child make the best possible start in life (Midwifery 2020 Programme 2010a). The programme goes on to recommend that midwives should use their advocacy role for influencing and improving the health and wellbeing of women, children and families. This will include making the economic case for committing resources so that the midwife can deliver public health messages in the antenatal and postnatal periods, and ensuring that there is a midwifery contribution at policy, strategic, political and international level. Finally it suggests that seamless maternity services which work effectively between community and hospital settings should continue to be developed. These will support families to achieve improvements in early childcare and development and will facilitate access to parenting programmes and good quality early years’ education.
3.3 Inequalities in Antenatal Care

In addition to general health inequalities there are also inequalities in antenatal care. A recent study by Thomson et al. (2012) concludes that inequalities in antenatal care persist with service users from vulnerable population groups continuing to express that these services do not meet their needs. Analysis from a public health perspective has suggested four key areas of inequality: antenatal attendance, frequency of antenatal appointments, location of antenatal care and the provision of risk information. Participants in the study expressed frustration at a ‘one size fits all’ approach which fails to adequately consider psychosocial and educational needs and the study identified that this failure prompted non-compliant behaviour. The report however concluded that concerns were somewhat compensated for by community-based antenatal services (Thomson et al., 2012).

Maternity services in the Wirral have a particular challenge. The Wirral is made up of some of the most deprived and some of the most affluent areas in England. The needs of women from the contrasting areas in the Wirral, and the choices they wish to make, are likely to be significantly different. Therefore, to serve its local population effectively, Wirral must commission services that are flexible enough to accommodate both groups. Person centred care appears to be a theme running through national policy and local feedback received and is further evidenced through a range of literature available. For example in a systematic review of pain and women’s satisfaction with the experience of childbirth four factors were identified as being important to experience: personal expectations; the amount of support from caregivers; the quality of caregiver-patient relationship; and involvement in decision making. These appear so important that they override the influences of age, socioeconomic status, ethnicity, childbirth preparation, the physical birth environment, pain, immobility, medical interventions and continuity of care (Hodnett ED 2002).

3.4 Models of maternity care

The well-being and needs of a mother and her child are paramount and should be the primary focus (Nursing and Midwifery Council (NMC) 2004) when considering or reviewing models of maternity care. In terms of continuity of midwifery care the guiding principle is that every pregnant woman requires care from a midwife and some will need a doctor too. (Department of Health (DH) 2007a). It is therefore fundamentally important that this is the focus of any recommendation on future models of care. Midwives are the experts in normal pregnancy and birth and have the skills to refer to and coordinate between any specialist services that may be required. A report by the midwifery 2020 Programme in 2010 recommends the following key principles are incorporated into any future models of care:

- Women should have a seamless maternity service supported by an integrated model of midwifery care;
- The majority of maternity care is based in the community setting, therefore when planning models of midwifery care there should be equal value given to acute and community based provision;
- Women should have easy access to a midwife as first point of professional contact when pregnant;
- 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;
• Women should have one-to-one care by a midwife when in established labour;
• The role of the midwife extends to the postnatal period, the duration of which is determined by the professional judgment of the midwife;
• The needs of women and their families should determine the models and location of care;
• To effectively care for women, midwives should be able to directly refer to other professionals/agencies and receive referrals back;
• Women’s care should be embedded in a multi-agency and multi-professional arena.

In many parts of the world midwives are the primary providers of care for childbearing women. However, there are considerable variations in the education and role of the midwife and the organisation and delivery of maternity services (World Health Organisation, 2006). For example, in New Zealand and the Netherlands care is offered by midwives, obstetricians and family doctors, whilst in North America obstetrician care is the norm.

The priority for modern maternity services throughout the UK is to provide choice within a range of safe, high-quality models of care. However, the reality is that the care and choices women receive during their pregnancy and labour can vary greatly according to the place or model of care available, whether through choice or necessity (NCT 2009).

Midwife-led services can be based in hospital settings, standalone birth centres or in community settings. Evidence regarding the relationship between the location of care delivery and birth outcomes is mixed (Hatem et al, 2009). The current Cochrane review of home-like settings indicates that low risk women randomised to birth centres that are geographically close to hospital settings have less intervention than those randomised to the hospital, but any impact on perinatal mortality is unclear (Hodnett et al 2002). Observational studies from around the world tend to support these findings. In all cases intervention is reduced, but some non-randomised studies suggest reduced perinatal mortality, whilst in others it is increased. There are no randomized trials of outcomes for women and babies in standalone birth centres or at home. Non-randomised studies tend to show similar results as those for the alongside birth centres (Walsh & Downe 2004).

The overall percentage of women who are offered the opportunity to give birth at home, and who take this option up, remains low, at around 2.7% in UK in 2007. However, in seven specific local authorities in England and Wales in 2009, this has risen to 10% (NCT 2009). This suggests that there is a greater interest in this option than the national data would suggest, and that women may not be being routinely offered this choice. For a healthy woman with a straightforward, low risk pregnancy, there is no evidence that a home birth is less safe than a hospital birth, provided the midwife is experienced and has the backup of a modern hospital system (Cresswell and Stephens 2007). A Joint Statement of support for homebirths for women with uncomplicated pregnancy from the Royal College of Obstetricians and Royal College of Midwives was published in 2007.
The recent ‘Birthplace in England’ review (NHS Confederation Research Digest, 2012) highlights new evidence from recently published research on maternity services across England. It provides authoritative findings from the Birthplace Research Programme, commissioned in 2007 to address key gaps in the evidence, including a national prospective cohort study of low-risk women giving birth in different settings. The review concludes that:

- Evidence supports the policy of offering low risk women a choice of birth setting.
- There is considerable variation within and between regions on what services are provided and evidence of inequalities in provision. Options for place of birth have improved since 2007, but almost half of all women do not have a full range of choice. At present, less than 10 per cent of women give birth outside an obstetric unit.
- Babies delivered through planned births in midwifery units have the same outcomes as those in obstetric units, with fewer interventions and around half the rate of caesarean sections for low-risk women.
- For women having a first baby, a planned home birth increases the risk for the baby and there is a fairly high probability of transfer to hospital during or immediately after labour.
- For women having a subsequent baby, a planned home birth does not increase risk for the baby, and reduces the risk of interventions for the mother.
- A third to almost a half of first-time mothers transfer from home and midwifery units to obstetric units.
- Intrapartum care costs are higher in obstetric units, even given substantially lower occupancy rates and higher staff ratios in midwifery units. Should occupancy rates rise in freestanding midwifery units, the cost-effectiveness differential could be even more marked. However, the main cost drivers are unit overheads and staffing, which would make simple cost shifting difficult.
- The shortage of midwifery staff is another challenge – given higher staff ratios in settings outside obstetric units, any expansion of home and midwifery units (although potentially cost-saving) is likely to require more midwives. Those reviewing services need to consider the impact across the whole system, taking into account costs, benefits and staffing capacity.
- There is substantial variability in costs, occupancy rates and staffing levels between units of similar types.
- Increased provision of midwifery units (freestanding and alongside units) and home births is potentially cost saving, particularly for women having their second or subsequent children, but the study did not assess the potential financial impact on trusts of changing the configuration of services.
- Variations exist at trust level in support to out-of-hospital births, including deployment of community midwifery and teamwork across the maternity workforce. Hub and spoke models, with an obstetric unit linked to a number of freestanding midwifery units, may offer benefits, including rotation of midwifery staff to different settings.

The midwifery 2020 programme report (Midwifery 2020 Programme 2010b) identifies a variety of models of midwifery care that include:

- **Community Midwifery/Home Birth** - Community midwifery care is provided for the majority of women during the antenatal and the postnatal periods.
- **Midwifery-led Care** - Options for midwifery-led models of care include those situated as stand-alone models in the local community or alongside the acute hospital setting. A Cochrane review (2009) involving 12,276 women where midwife-led were compared with other models of care and examined aspects of continuity, normality and safety. Overall, the review demonstrated that midwife-managed care for a healthy woman is safe and confers added benefits for women. Specific findings supported the research hypothesis, in that midwife-managed care resulted in similar or reduced rates of intervention; similar clinical outcomes and complication rates; enhanced satisfaction with care; improved continuity of carer; and was cost effective throughout antenatal, intrapartum and postnatal care (Sandall et al, 2009).

- **Team Midwifery and Caseload Midwifery** - These models of midwifery care are currently practiced throughout the United Kingdom. In some cases, small teams of six or more community-based midwives aim to provide antenatal, intrapartum and postnatal care for women, supported by core staff on the maternity ward, delivery suite and antenatal clinics. This model is based on evidence from trials showing clear advantages for women who receive care from a team of midwives. However, although team and caseload models have demonstrated many benefits to women, many midwives feel that the aims of such models are unachievable in midwifery practice (Andrews 2006).

- **Obstetric-led care** - For those women who are classified as being in high risk groups, a consultant-led model is the safest option and therefore must be provided in a modern maternity system to promote safety for both mother and child in high risk groups. Although the lead professional is the obstetrician, throughout the woman’s pregnancy, coordination and continuity of care is provided by midwives and a range of other professionals which may include anaesthetists and paediatricians.

- **General Practitioner (GP)-led care** - Internationally, the involvement of General Practitioners (GPs) in maternity care is variable. In Canada, the USA and, to a lesser extent, Australia and New Zealand, GPs still providing intrapartum care are GP-obstetricians rather than maternity care providers. They provide low-risk as well as high-risk obstetric care, especially in rural areas with few specialist obstetricians. In Europe, GPs do not provide high-risk obstetrical care, emphasising their function as generalists and competing with midwives for a central role in maternity care for women with an uncomplicated pregnancy (Wiegers 2003). A literature survey revealed that GPs in United Kingdom had high levels of involvement in some aspects of maternity care: confirmation of pregnancy (90%), postnatal visiting (76%), the six week postnatal check (95%). There were low levels of involvement in intrapartum care (7% had attended a birth in the last year); and extremely variable levels of involvement in routine antenatal care (0 to 15+ visits). The future promotion of this model of maternity care would require greater partnership and collaboration with midwives, preferably in shared care programs, however, the advice from NICE (2008) emphasises that GPs should refer all pregnant women to maternity services as soon as possible.

- **Non-NHS midwifery care** - For women choosing to have maternity care outside what is provided by the NHS, a range of care should be made available. Independent midwives are registered midwives who have chosen to work alongside the NHS in a self-employed capacity. Independent midwives fully support the principles of the NHS and are currently working to ensure that all
women have access to the full range of services available. On the Wirral one of the NHS maternity service providers is an Independent Midwife Organisation commissioned to provide NHS care.

- **Multidisciplinary care** - A number of multi-professional team approaches to the management of complex pregnancy are emerging in the maternity care literature. There has also been an increase in the number of maternity units with midwives with a special interest in supporting women with complex pregnancy.

Other key reports have been published more recently that provide insights into the needs of the population with regards to their maternity journey. An example of this is the report commissioned by the Department of Health where three pieces of qualitative research about the experiences of expectant and new parents were evaluated. The three projects explored how parents feel about the pregnancy and parenthood journeys, their expectations of the health service and whether they feel those expectations are met (Department of Health, 2011).

### 3.5 References


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4. Good practice in maternity services

This section considers two examples of good practice in maternity services. The first is a desk based case study demonstrating the provision of choice in maternity services for women in South Hampshire. The second is a case study based on a visit to Sandwell maternity services at City Hospital Birmingham and Halcyon birth centre and interview with Kathryn Gutteridge Consultant Midwife on 5th July 2012.

4.1. South Hampshire Maternity services (Desk based case study)

Case study: South Hampshire Maternity Services

South Hampshire Maternity services are based at the Princess Anne Hospital, Southampton, with an additional birth centre in the New Forest. They are a centre of excellence for maternity care, providing a comprehensive service and a choice of birth options, including home birth, for about 5,000 women each year from around Southampton. They are also a regional centre for foetal and maternal medicine, providing specialist care for women with medical problems during pregnancy, and for those whose baby needs extra care before or around birth. The hospital is a leading teaching centre for nursing, midwifery and medical students, and is home to the regional centre for neonatal intensive care.

Women in South Hampshire and the surrounding area have the choice of a number of different places to have their baby. These include:
- The Obstetrician-led unit (Labour Ward at Princess Anne Hospital)
- The Broadlands Birth Centre at the Princess Anne Hospital
- The New Forest Birth Centre in the New Forest
- Home birth

It is recognised that when the time comes for women to have their baby, they will want to be in a place where they feel relaxed, comfortable, confident and secure, and for everything to go smoothly. It is also recognised that choosing where to have their baby will be a choice that is individual and will be based on a number of different priorities and factors.

For some women, particularly those who have had problems in previous pregnancies, or who have medical conditions that may affect them or their baby during labour, it may be preferable and advisable to give birth in the obstetrician-led labour ward. This is because of the additional facilities available there. Conditions might include heart problems, a BMI of over 35 at the start of your pregnancy, multiparous pregnancy or a previous problem giving birth.

Other mothers-to-be who have straightforward pregnancies can opt for the Broadlands Birth Centre or the New Forest Birth Centre.

The Broadlands Birth Centre is based in the Princess Anne Hospital. It is on a different floor to the obstetrician-led unit and is suitable for women wishing to have a natural birth in a home-like, atmosphere. It is a midwife-led unit and is suitable for women with no complications in pregnancy or labour. If a problem developed in labour, or if an epidural...
was needed, the woman would need to transfer to the nearby obstetrician-led unit. The unit is designed to provide a relaxed environment for women and their partners and birthing pools are available that can be used during labour and/or birth. In 2009, 60% of women who went to the Broadlands birth centre to labour and birth went on to have a normal birth there.

The New Forest Birth Centre is run by experienced midwives and support staff and offers a safe, friendly environment for mothers and babies. It is located at Ashurst on the edge of the New Forest and is suitable for women having a healthy pregnancy and those expecting to have a straightforward birth, even if it is their first baby. The birth centre offers a ‘home away from home’ environment as an alternative to the traditional labour ward or home. Figures available for 2009 show that over 76% of women who came to New Forest Birth Centre to labour and birth, had a normal birth there as planned. The birth centre also provides antenatal support in preparation for parenthood, postnatal transfer facilities and private spaces and ongoing support including breastfeeding support groups.

Home birth is also offered to women in South Hampshire. Home birth and birth centre care are similar in terms of resources available, for example basic resuscitation equipment. Midwives are trained to quickly detect the onset of problems and, in the rare event that a woman or baby need emergency treatment, midwives are able to provide first level emergency care, for example oxygen and suction. If further aid is needed they are transferred in an ambulance to the obstetrician-led unit for specialist care.

The emphasis of the provision in South Hampshire is very much based around patient choice with choices that reflect the diverse nature of women’s preferences, experiences, pregnancies and births. There is an option for all different scenarios, from those requiring the facilities available in the obstetrician led unit to those who would rather have midwifery led care with the availability of obstetric facilities should they need it, to those who would rather give birth in a home setting or a ‘home from home’ setting in the New Forest with little or no medical or obstetric intervention at all. Providing this level of choice allows for a truly personalised service that can be adapted to the wishes and needs of individual women.
## 4.2. Sandwell Primary Care Trust & Sandwell and West Birmingham Hospitals NHS Trust Maternity services (Observation and Interview based case study)

<table>
<thead>
<tr>
<th>Case study: Sandwell Primary Care Trust &amp; Sandwell and West Birmingham Hospitals NHS Trust Maternity services</th>
</tr>
</thead>
</table>

### Introduction

Sandwell and West Birmingham Hospitals NHS Trust have undergone a complete overhaul of maternity services over the past 5 years. Maternity and neonatal services transferred from Sandwell Hospital to City Hospital in January 2010, the Serenity Birth Centre midwifery led unit opened in May 2010, followed by the Halcyon stand alone birth centre, which opened in Smethwick in October 2011. Serenity is co-located within City Hospital and the Halcyon freestanding birth centre is in Smethwick, Sandwell, 3 miles away. Both centres are for low risk women and work alongside the obstetric unit at City Hospital, which offers specialist clinics for high risk women.

### Background

When Consultant midwife Kathryn Gutteridge started at Birmingham City Hospital 5 years ago, she was met, in her view, with a maternity service that was in crisis. She reported that there was poor practice, poor leadership, bullying, issues around maternal death, high turnover of staff, no medical leadership and apparently no desire to change. The Trust Executive team commissioned an external company to carry out a staffing review and there was also a RCOG review of the current service specification for both Sandwell and City Hospital maternity services. There was found to be both replication and varying practices between the two sites. This was followed by an audit of clinical outcomes, which included scrutiny of induction rates, caesarean section rates and admissions to neonatal. It was found that rates were higher than national averages, inductions appeared to be ‘random’ and carried out with no reference to guidance or audit on outcomes.

For Ms Gutteridge, there was perceived to be an absence of respect in the service. It was felt to be dysfunctional, divisive and, as a result, providing a poor standard of care to women. It was felt that there needed to be a complete overhaul of leadership. Ms Gutteridge was Acting Head of Midwifery at the time and brought an obstetrician from Leicester Hospital on board. They repeated the audit by looking at 66 random sets of notes and the results showed again that outcomes were poor for women using Sandwell and City Hospital maternity services.

### A new model of maternity care

Ms Gutteridge recounted that the attempt to ‘turn it around’ began with adopting an approach of zero tolerance to unprofessional behaviour and leading from the front. The Sandwell site was closed and a very defined service specification was developed for the Midwifery Led Unit at the City Hospital. For the model of care adopted, the allocation of care was to be such that Ms Gutteridge, as Acting Head of Midwifery would be responsible for the low risk women and the high risk women would be the responsibility of the Obstetric-led unit.
The midwifery led unit was to be an opt out, rather than opt in unit, which would be the default place for women to deliver unless there were any risks that may prevent this. If a woman is deemed low risk and subsequently the risks change they would be assessed and offered specialist clinic consultation. The whole premise was to be built around the idea that the norm is the midwifery led unit and if intervention is needed women are referred to the specialist clinic.

However, it was felt that there also needed to be an appropriate facility available to women needing a higher degree of clinical input. Rather than a delivery suite in an obstetric department, there was a determination that such a facility should be a separate, midwifery led unit. There was a vacant building in City Hospital and funding was secured to turn it into the Serenity suite. Ms Gutteridge led the project from start to finish. When designing it she advised those working on it to go and visit a hospice as that was the type of relaxed homely environment she wanted for the women.

‘End of life care is streets ahead of start of life care.’

The Serenity Birth Centre

The Serenity Birthing Centre opened 2 years ago in April 2010. There was a non traditional approach to staff recruitment. There was a recruitment day where candidates were asked more about their beliefs and philosophy rather than their training and qualifications. The fact that the midwives had been trained and were suitably qualified was considered a given, it was their philosophy of what it meant to be a midwife that was important to Ms Gutteridge, who was looking for potential to develop and kindness.

“In terms of midwifery skills it is the bit that is beyond basic training that is important here…they have passed their qualifications but they need kindness.”

‘Leadership and kindness are essential’

Ms Gutteridge attributes the success of the unit to leading from the front, setting examples, being clear about what message you want and all being on the same message. The staff have a review of cases each morning with midwives and doctors and levels of communication are high. The unit was also set up around much local consultation. The community were involved as it was their resource and they felt it was important to involve dads too so they held a ‘dads’ evening and survey.

“Opening here has changed the whole culture of maternity services.”

“Good kind care gives us the best outcomes.”

Serenity is located near to the obstetric suite at City Hospital, although is not part of it. All women are assessed by midwives and if deemed low risk they will automatically be booked to give birth at either Serenity or Halcyon birth centres. Women may opt out at any time and give birth in the obstetric suite on the labour ward instead.

The birth centre is staffed and run by experienced midwives, without medical input, not offering epidural anaesthesia. They aim to offer a comfortable and homely environment where birth is treated as a “normal” process rather than a medical one. Midwives are
trained to offer different ways to cope in labour such as using alternative positions, relaxations, water for labour and aromatherapy. The environment is purposely designed not to look like a hospital, women are encouraged to eat and drink light food and move around and most are able to go home within a few hours after giving birth.

Ms Gutteridge’s ethos was that the centre was built around family and home. ‘Your birth in our home’ is their strap line. 67% of their local population are from non English speaking families and so they bore that in mind. They were aware that take up of home birth was low due to size of property, cultural reasons, multi generational family homes or lack of privacy and so ensured that the unit was child friendly, so they are set up for families to be ‘home from home’.

“If you can't have it at home, have it at our home”.

A tour of Serenity demonstrated this ethos: floor to ceiling murals; 5 ensuite rooms, all with birth pools available; beanbags and pull down double beds; a garden; a kitchen and a treatment room for reflexology and aromatherapy. The emphasis is on the women, their needs, their families and as little medicalisation as possible.

The Halcyon Stand Alone Birth Centre

After the first year of operation of Serenity there was political pressure to open a new unit for the women of Sandwell and funding was sought to do it. As a result the Halcyon Stand alone unit was opened 3 miles away from City Hospital. The same midwifery team, based on the same model of care, operates across both centres. If women are high risk, they are booked into the specialist clinic at Birmingham City Hospital.

Like Serenity, Halcyon was designed to be a relaxed, comfortable home from home environment. ‘Halcyon’, chosen by a father during the consultation exercise, means peace and tranquillity and this theme is reflected in the purpose built design of the three rooms, arranged around a sensory courtyard garden so that women can have access to an outside space and have a pleasant outlook through a large wall of tall windows. All the rooms have fixed birthing pools, TVs, ipod docking station and ensuite facilities. There is a drop down double bed and sensory lighting. The centre has a kitchen and dining area for the use of women and their families and treatment room where they can access aromatherapy or reflexology. It is located next to a main dual carriageway, giving easy access to the hospital 3 miles away should a transfer be necessary. The main reception looks like a hotel reception, complete with guest book and the rooms look akin to an upmarket Spa.

“It is about experience rather than medical procedure.”

The recently opened centre has a target of 350 births over a 3 year period to fulfil the lease agreement, with a target of 100 in the first year and since opening in October 2011 there have already been 80 births at the centre. There is a 14% transfer rate of women who need assistance in delivery, which is lower that the initially set transfer rate of 25%.

The model of midwifery care in both birthing centres is supported by a caseload or domino model of midwifery where there aims to be continuity of care ante nataly, during birth and then post nataly. As the Serenity and Halcyon are birth centres, not inpatient facilities, women can stay for up to 6 hrs after delivery and if they want to stay longer
they can do so in hospital. Their philosophy is that the midwife who has cared for a woman during birth will then ‘follow her home’ afterwards and resume care postnatally at home.

Ms Gutteridge noted that this type of facility is particularly beneficial for the women of Sandwell as there are large areas of deprivation nearby and many women locally do not expect to receive this kind of service, in this kind of environment. However, Ms Gutteridge linked it to outcomes further forward, believing that if parents and children feel valued from birth, with the positive experience at Serenity or Halcyon, their whole lives are starting positively and it is hoped that these positive outcomes will continue forward through their lives.

4.3. Summary of good practice evidence

There are a number of common themes in the models assessed from South Hampshire and Sandwell.

- Both services provide choice of:
  - An obstetric led unit
  - A midwifery led unit alongside an obstetric unit
  - A stand alone birthing centre
  - Home birth

- Both aim to provide a ‘home from home’ environment for women who cannot give birth at home. This addresses a perceived need for women to have a relaxed, comfortable setting during their pregnancy and birth to promote confidence and a sense of security.

- Relaxation and comfort are facilitated through design of the environment with the conviction that this can often promote a more straightforward birth.

- There is a focus in both services on the normalisation and de-medicalisation of pregnancy and birth. In Sandwell, this is structured in, with the default option for women being the midwifery led unit unless there is a reason for more intervention or they opt out.

- Midwifery led services are managed separately to obstetric services in both areas. Obstetric services exist only to support high risk women and deal with any unexpected complications during pregnancy and birth.

The success of the model of care in Sandwell was felt to be not only the birth centre environment but also the clear leadership and a coherent ethos amongst staff that supports the vision and philosophy and shows kindness alongside midwifery expertise. This model also supports the caseload or domino model where there is continuity of care antenatally, during birth and postnatally.
5. Programme Evidence

5.1. Performance and Effectiveness

5.1.1 Introduction
Each maternity service is required to complete a monthly performance dashboard recording activity in relation to referrals, bookings, births and maternal health. The maternity services dashboard was recently updated and reissued to providers in January 2012 for accumulation of data from January 2012 onwards. At the time of evaluation, the new dashboard was in use by the One to One service, but not yet in use by WUTH. Therefore, the means by which some of the data have been collected from the providers is not directly comparable. In addition, given the analytical window used, antenatal performance recorded will not always refer to the same group of women for whom postnatal data have been collected.

Where possible, comparison between the previous (in use by WUTH) and existing (in use by One to One) dashboards has been analysed. Furthermore, the dashboard requires additional supporting data for verification purposes, which WUTH were unable to provide for the period January to May 2012. Therefore, interpretation of the data analysis that follows must be treated with some caution.

Finally, the women asked about their service experience (section 5.2) were drawn from a pool of users who had received a service between January and December 2011, whereas, the performance data considered for the purposes of this report covers the period January 2012 to May 2012 inclusive. Ideally data would have been gathered and analysed from the corresponding period. However, due to the introduction of the new dashboard and the lack of comparable data from 2011, this was not possible. The use of a common dashboard for both services will allow the future (more representative) analysis of a cohort of women though the whole process of antenatal, birthing and postnatal care.

5.1.2 Referrals & Bookings
Between January and May 2012, there were 1839 referrals in total. 1566 women were referred to WUTH (85% of total referrals for the period) and 273 to One to One (15% of total referrals for the period). The number of referrals was consistent across the months during the period considered (Figure 1).

Between 15% and 30% of referrals to One to One during the period were transfers in from a different provider. The percentage of women booked on or before 12+6 weeks gestation was 100% for One to One and between 80 and 85% for WUTH over the period (target set at ≥80%). All users of both providers were offered booking within 2 weeks if they were greater than 12+6 weeks gestation at referral, according to CEMACH guidelines.
5.1.3 Births
There were 1650 births in total recorded for the period January to May 2012, with 1528 recorded by WUTH (93% of total births for the period) and 122 for One to One (7% of total births for the period). The number of births was consistent across the months during the period considered, with no particular peaks or troughs of activity (Figure 2).

Figure 2: Number of births (Jan – May 2012)

One to One users may give birth at home or at WUTH, Liverpool Women’s Hospital or the Countess of Chester. The One to One data is broken down by type of birth but not location of birth. A large proportion of One to One service users give birth at WUTH and a proportion of One to One recorded births will therefore also be recorded in the WUTH
dataset as WUTH births. The only births recorded by One to One that we can be certain do not fall into the WUTH dataset are the recorded home births from One to One.

There is currently no differentiation in the WUTH data between the births of women booked with their service and those booked with the One to One service. If One to One were to differentiate between which hospital (if applicable) their users give birth in and WUTH were to differentiate deliveries for women booked with themselves and those booked with One to One, it would then be possible to accurately assess the birth outcomes for both sets of service users. Meantime, where conclusions drawn here may be misleading because of this data uncertainty, this is noted in the analysis.

The target for normal vaginal deliveries is that at least 70% of women would not require additional clinical intervention. A total of 72% (88) births to women registered with One to One during the period were normal vaginal deliveries, compared with 66% (1001) of the births at WUTH (Figure 3). Between January and April 2012, One to One achieved this target or higher each month, but only 66% of births in May 2012 were normal vaginal deliveries (monthly data not shown). WUTH were consistently below target for normal vaginal deliveries during the period, fluctuating month by month between 64 and 66% (monthly data not shown). Around half of the 88 normal vaginal deliveries recorded by One to One were not home births and would have taken place at WUTH, Liverpool Women’s Hospital or Countess of Chester.

**Figure 3: Type of birth by provider (Jan – May 2012)**

![Figure 3: Type of birth by provider (Jan – May 2012)](image_url)

The target for instrumental vaginal delivery rate is between 10 and 15% of all births. Both providers achieved this target during the period, with One to One reporting an instrumental vaginal delivery rate of 9.5% and WUTH reporting 12%.

The target for total caesarean section rate (planned and unplanned) is less than 22%. Both providers achieved this target with caesarean rate at 21.7% for WUTH and 18.4% for One to One. Despite overall performance, planned caesareans for users of WUTH reached red flag level (i.e. >10%) in March 2012 (10.7% rate of planned caesarean) and for users of One to One in April 2012 (13%). Unplanned caesareans also reached red flag level (i.e. >15%) for users of WUTH in May 2012 (17.4%) and for users of One to
One in January 2012 (22%). As mentioned earlier, the One to One recorded caesarean sections will have taken place at either WUTH, Liverpool Women’s Hospital or Countess of Chester and so may be incorporated into the WUTH recorded data.

The planned home birth rate was higher for One to One (13.5%) during the period January to May 2012, than WUTH (1.1%). This reflects the principles upon which One to One Midwifery is based, specifically encouraging and facilitating home birth as an option for women. However, the achieved home birth rate over the same period (i.e. amongst a different cohort of women) was higher than planned for One to One (32.5%) and lower than planned for WUTH (0.7%).

Further data relating to birth and delivery at WUTH (Figure 4 - not collected for One to One) demonstrate:

- An increasing trend (March to May) in the number of babies ‘born before arrival’ (at WUTH) albeit still within target. These are babies born before arriving at hospital or arrival of the midwife for a home birth.
- 7 intensive care unit admissions made in obstetrics during May 2012, which represents a very significant breach of the red flag target (>2). This was accompanied by 7 serious incidents recorded for this month, with one scored as red.
- The incidence of hypoxic encephalopathy (grade 2 and 3) was also high for the period, with 2 in both January and February, 3 in March and 1 case in each of April and May 2012. Again the target is zero so these signify amber and red flag alerts.

**Figure 4: Additional birth data (WUTH only)**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Goal</th>
<th>Alert</th>
<th>Red Flag</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of babies born before arrival (BBA's)</td>
<td>&lt;=4</td>
<td>&gt;4</td>
<td>&lt;8</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Number of intensive care unit admissions obstetrics</td>
<td>0</td>
<td>&gt;0 &lt;=2</td>
<td>&gt;2</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td>Number of eclampsia’s</td>
<td>0</td>
<td>&gt;0 &lt;=2</td>
<td>&gt;2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Number of post partum hysterectomies</td>
<td>0</td>
<td>&gt;0 &lt;=2</td>
<td>&gt;2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Number of blood transfusions &gt;3000mls (10 units)</td>
<td>0</td>
<td>&gt;0 &lt;=2</td>
<td>&gt;2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Number of meconium aspirations</td>
<td>0</td>
<td>&gt;0 &lt;=2</td>
<td>&gt;2</td>
<td>0</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Number of hypoxic encephalopathy (grade 2 and 3)</td>
<td>0</td>
<td>&gt;0 &lt;=2</td>
<td>&gt;2</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Number of SI’s scored as orange</td>
<td>&lt;=5</td>
<td>&gt;5 &lt;8</td>
<td>&gt;=8</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>Number of SI’s scored as red</td>
<td>&lt;=2</td>
<td>&gt;2 &lt;4</td>
<td>&gt;=4</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Failed instrumental delivery rate</td>
<td>&lt;=1%</td>
<td>&gt;1% &lt;3%</td>
<td>&gt;3%</td>
<td>0.3%</td>
<td>0.0%</td>
<td>0.7%</td>
<td>0.6%</td>
<td>0.6%</td>
</tr>
<tr>
<td>Number of massive PPH &gt;2 litres</td>
<td>&lt;=10</td>
<td>&gt;10 &lt;15</td>
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<td>2</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>Number of shoulder dystocia</td>
<td>&lt;=6</td>
<td>&gt;6 &lt;10</td>
<td>&gt;=10</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>3rd and 4th degree tear rate</td>
<td>&lt;=4%</td>
<td>&gt;4% &lt;7%</td>
<td>&gt;=7%</td>
<td>3.2%</td>
<td>1.4%</td>
<td>3.8%</td>
<td>2.6%</td>
<td>2.3%</td>
</tr>
</tbody>
</table>

**5.1.4 Complaints and Thanks**

WUTH received 12 formal complaints during the period January to May 2012 of which 5 were responded to, lower than the target response rate of 80%. One to One did not receive any formal complaints during the period.
As part of the maternity dashboard, each provider also records the number of thank you letters they have received per month. WUTH record this as a number and One to One as a generalised statement such as ‘More than 10’. In the dashboard figures for January to May 2012, WUTH recorded receiving an average of 29 thank you letters per month (146 in total for the 5 month period) and One to One recorded receiving more than 10 each month.

5.1.5 Maternal health
All smoking data suggests that both providers are within target for reducing the number of users smoking during pregnancy.

Figure 5: Smoking data (both providers) Jan – May 2012

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Goal</th>
<th>Alert</th>
<th>Red Flag</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
</tr>
</thead>
<tbody>
<tr>
<td>% smoking at booking</td>
<td>&lt;=25%&gt;25%&lt;30%&gt;30%</td>
<td>WUTH</td>
<td>O2O</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% smoking at delivery</td>
<td>&lt;=20%&gt;20%&lt;25%&gt;25%</td>
<td>WUTH</td>
<td>O2O</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number referred to specialist smoking cessation services (One to One only)</td>
<td>OW</td>
<td>OW</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

One to One also provided additional data on maternal health issues which are detailed below in figure 6. We do not have comparable data for WUTH.

Figure 6: Additional maternal health data (One to One only)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of women identified as having alcohol/substance misuse problem</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>% of these already in service with Wirral Drugs/Alcohol Services</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Number of women identified with mental health problems</td>
<td>3</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>% of these women whose care follows the perinatal mental health pathway</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>% of these that are new identifications of mental health problems</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>% with BMI over 30 at booking</td>
<td>7%</td>
<td>2.40%</td>
<td>3%</td>
<td>0%</td>
<td>0.00%</td>
</tr>
<tr>
<td>% with BMI over 35 at booking</td>
<td>5.00%</td>
<td>4.80%</td>
<td>9%</td>
<td>8%</td>
<td>11.00%</td>
</tr>
<tr>
<td>% of women advised and provided with contraception of choice at discharge</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>% of women aged 15-24 tested for chlamydia during care episode</td>
<td>2%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of families with Children in Need plan in place</td>
<td>0</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>2</td>
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<tr>
<td>Number of families with a Child Protection Plan in place</td>
<td>0</td>
<td>3</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Number of families with CAF/TAC plan in place</td>
<td>0</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>% of these where the midwife is the lead professional</td>
<td>0%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Number of families with identified domestic abuse issues</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Number of MARAC meetings attended</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
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<tr>
<td>Number of CIN/TAC meetings attended</td>
<td>0</td>
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5.1.6. Breastfeeding
The target for breastfeeding initiation rates is currently at least 70% of mothers, in line with national average rates. Breastfeeding initiation rates for WUTH were consistently below target at between 51% and 59%. One to One were also below target for breastfeeding initiation for 3 of the months during the period, with rates of between 53% to 75% across the period (Figure 7). There was only one referral made to breastfeeding peer support services during the period and this was for a user of One to One.

Figure 7: Breastfeeding Initiation rates (both providers) Jan – May 2012

5.1.7. Training & Staffing
As a measure for midwife caseload, the target (minimum) ratio is one midwife for every 30 births. Monthly ratios for One to One fell well within this target at between 1:17 and 1:20. The midwife to birth ratio for WUTH was lower (between 1:25 to 1:32) and below target in three of the five months.

The target (minimum) ratio for supervisor to midwife is one supervisor for every 15 midwives. This target was not met by WUTH in any month (ratio between 1:18 and 1:26) with 4 of the 5 months representing a red flag alert. The supervisor to midwife ratio for One to One was consistently 1:11 across the period.

Additional WUTH data shows that for the first 3 months of the period, between January and March 2012, there were 40 hours per week of consultant cover on labour ward, which is below the target of 60 hours per week. The remaining 2 months of the period were on target at 60 hours.

One to One reported 100% attendance at education and training programmes, however, WUTH did not provide comparable data.
5.2. Stakeholder consultation & Service User Experience (Mott MacDonald evaluation)

5.2.1 Introduction & Methodology
As part of the overall review of maternity services, NHS Wirral commissioned independent research agency, Mott MacDonald, to conduct an evaluation project to examine user perceptions and experiences of maternity services on Wirral and gather stakeholder views. The main themes arising from this piece of work are discussed here and the full report from Mott MacDonald can be found in Appendix A.

The methodology used included a short survey emailed to maternity staff and stakeholders, a postal survey with current and recent users of the services and focus groups and interviews with service users from both providers.

The email survey was sent to staff and key stakeholders with an interest in maternity services via a cascade method whereby heads of service, managers and members of the Maternity Service Liaison Committee were sent the email link and asked to cascade it to their staff and teams accordingly.

The service user survey was carried out with service users from both providers, which sought to assess perceptions of, levels of satisfaction with, and experiences of the service. The survey was sent to a sample of 1200 service users (867 WUTH and 333 One to One) who had booked with a Wirral maternity service between January and December 2011. Prior to the survey being sent out, a letter was sent to a sample of 1500 users to give the opportunity for users to opt out. The samples were also cross matched to remove any users who had suffered a miscarriage, stillbirth or termination.

The service user qualitative work was also carried out with users of both providers in the form of 2 focus groups and 8 interviews to provide an in depth and focused review of experiences and perceptions of the two services provided. The recruitment for the qualitative component was achieved through the inclusion of a question in the survey that identified a 'pool' of interested people to recruit from.

5.2.2 Stakeholders and Service Provider Consultation
Due to the cascade nature of dissemination we do not know exactly how many people were sent the survey proforma. We received 117 responses. Similar proportions of responses were received from midwives (27%), GPs (26%) and Children’s Centre workers (20%) and 9% were from health visitors. Participants were not asked to identify which maternity provider they worked for.

Service model
Respondents were asked about different models of maternity care and asked which they felt was the best model to facilitate good quality maternity care. The majority advocated a midwifery led unit (MLU) based alongside an obstetric care provider to be the best model (72%).

When considered by type of respondent, the data show that this overall favoured model of a MLU alongside an obstetric provider was felt to be the best model by 39% of midwives, 91% of children’s centre workers, 82% of health visitors and 77% of GPs. Reasons for supporting an MLU alongside an obstetric provider related to a preference
for an ‘integrated’ service which fostered a close working relationship and good communication between obstetrics and midwifery care so that all eventualities from low risk to high risk would be catered for. It was felt that this approach acknowledges that the majority of births proceed normally but obstetric support is available nearby for those that do not.

A stand alone midwifery led unit, which would refer to an obstetric care provider where necessary, was favoured by 18% of respondents. This included around half (55%) of the midwives who responded. Reasons for supporting this model included reference to promoting the normality of pregnancy and birth and a move away from an overly medical model of maternity services.

Similar comments relating to the skills of the midwife, allowing for the ‘de-medicalisation’ of birth, with the midwife being the main contact point and at the forefront of care, were given in support of both a MLU alongside obstetric model and a stand alone model. This is interesting as it seems that a wholly midwife run unit, in general, where midwives have autonomy, is the common priority for all. However, it is access to obstetric care should it be needed, that leads the majority to advocate for the MLU alongside the obstetric unit model rather than a stand alone unit.

The remaining midwives (6%) opted for caseload midwifery which was an ‘other’ option suggested by the respondents themselves. Caseload midwifery refers to a model which includes a named midwife, continuity of care throughout pregnancy, continued throughout birth and after birth. It is based on midwives (or two ‘buddy’ midwives) having cases and working with that case throughout for best outcomes. This is the model that has been promoted by One to One Midwifery and appears to be popular with service users who have experienced this type of care. Reasons given for favouring caseload midwifery mainly related to continuity of care provided by specific midwives throughout the duration of pregnancy.

**Components of good quality care**

Stakeholders were asked to consider which the most important components of good quality maternity care are and what the greatest impacts of good quality care would be. Respondents were asked to rank their views in order of most to least important.

The most important components from a stakeholder perspective related to quality of clinical care (clinical competence of midwives and secondly, of obstetricians). The third and fourth most important ranked components were meeting the individual needs of women and personalized service/continuity of care. The fifth and sixth most important components related to the short and long term outcomes for women and children. The least important component for stakeholders was the convenience/venue for the delivery of services.

These priorities differ from the opinions expressed by service users (see below). More patient-centred priorities such as place and time of care and continuity of relationship with midwife were considered the most important components. It should perhaps be acknowledged in planning services that ‘meeting the individual needs of women’ should include consideration of these service user perspectives.

There were some comments from GPs in the stakeholder survey which related to process of maternity care, including good communication between services to keep GPs
informed, greater involvement of GPs in the maternity process and continuity of care. Also, on the whole, the GPs in the survey seemed to support midwifery care as the main model of care for women and championed continuity of care.

It is interesting that some GPs felt that they have become distanced from the maternity process despite the majority of service users contacting their GP as their first port of call upon discovering they were pregnant. This seemed to relate to ongoing communication between medical professionals through the pregnancy and birth. A recommendation could be that GPs are regularly updated on a patient’s pregnancy, so they are fully informed about issues affecting their patient.

The main impacts of good quality care for the stakeholders were felt to be improved health, wellbeing and development outcomes for baby and for women and reduced rates of maternal and infant mortality/morbidity.

The stakeholder survey also asked for suggestions for the future. In response, there were comments that reiterated the earlier desire for continuity of care for women, a shift towards caseload midwifery and having a specific named midwife. Also mentioned were the need for better integration of services and communication between services. Continuity of care was a recurring theme throughout the stakeholder survey and this is echoed in the service user findings below. The components of caseload midwifery championed by some of the stakeholders, namely continuity of care with the same midwife throughout are also advocated by service users below.

5.2.3 Service User Consultation

Of the 1200 surveys (WUTH - 867 & O2O - 333) sent out, Mott MacDonald received 246 responses, which gives an overall response of 20.5%. Response rate from WUTH service users (n=179) and One to One service users (n=69) was very similar.

Seeking advice

For the vast majority of service users who responded to the survey, and this was echoed in the qualitative work, their GP was their first point of contact upon discovering that they were pregnant (89%). Only 8% had spoken to their midwife first and this was more commonly the case for One to One users (16%, 11/67) than for WUTH (5%, 9/179). Reasons for going to the GP first included thinking this was where they should go, not being aware of alternatives, convenience of locality of the service and familiarity with GP surgeries. Wanting to access a service locally was a common theme for service users.

Service user comments indicated that once aware that they could go directly to a midwife about their pregnancy, some may do so in future. This suggests that raising awareness of where women can seek advice would be beneficial and acted upon. Those respondents who had gone directly to their midwife may have either already had a baby with the particular service or had seen service provider promotional material containing information about the referral process.

Choice of maternity service

Over half (58%) of respondents were not aware that they had a choice of maternity provider. This is surprising when such a large proportion of respondents had initially sought advice from their GP. Women are potentially accessing their GP as a local and familiar healthcare provider and making an assumption that they will be provided with information and advice about maternity services. It should be the case that all those who
sought advice from their GP were also aware that they had a choice of midwifery provider.

This initial consultation is an ideal opportunity for GPs to be involved in the future care planning of their patients and provide key information about their choices in pregnancy. The lack of awareness suggests that there is a lack of standard process at this initial GP visit and patients are not being provided with the information about their choice of maternity provider. It is important that women are offered choice as detailed in Maternity Matters (Department of Health 2007). This guidance from the Department of Health highlights the Government commitment to developing a high quality, safe and accessible maternity service through the introduction of a new national choice guarantee for women, which should ensure that all women have choice around the type of care that they receive, together with improved access to services and continuity of midwifery care and support.

As well as not being provided with a choice of maternity provider there is also a lack of service user understanding of what exactly is on offer in Wirral and the nature of the services. There is a quote from a service user which raises questions over how the One to One service works, whether it is a private service and how it links to private medical insurance. Again, it would be expected that the dual provider system in Wirral is explained to women by their GP and any misinformation about private providers clarified at this first point of contact. This lack of understanding about the scope and nature of maternity provision in Wirral needs to be addressed by GPs and service providers themselves by raising awareness.

Factors influencing choice

Service users were asked what would influence their choice of maternity provider. The top five influencers identified were:

- Continuity of care
- Convenience of location for seeing your midwife
- Convenience of time for seeing your midwife
- Building personal relationships with your midwife
- A midwife you saw through your antenatal care being at the delivery

These aspects were also highlighted by a number of GPs in the stakeholder survey and highlighted as components of good quality maternity care by a number of midwives and other professionals, but not with the same priority attached as for service users. The focus amongst stakeholders on clinical competence does not feature for service users, perhaps suggesting that this is a given for women engaging with maternity care. Having said that, safety of medical care in hospital was the next most important factor after these five, alluding to the understanding amongst women that midwife-led care still requires the back up of high quality and accessible obstetrics if needed.

These three key aspects of maternity care – continuity and convenience of location and timing for appointments - were also discussed in the qualitative component of the evaluation by service users. These aspects were particularly commended by users of the One to One service, who have built their service model around this notion of continuity and personalised care. There are comments throughout the evaluation from One to One service users who are highly satisfied with these components of care and
they are highly valued by users of both services. Due to the level with which service users rate these influencers and value these components it is recommended that WUTH focus on improvements to these areas of service.

Home visits were also raised as a less important but key influencer and this was reinforced in the qualitative work. This aspect was identified as a particular reason that some service users had used One to One and it was felt to be a positive component of care. Home visit appointments were felt to be convenient and enabled women to have appointments in a comfortable and familiar setting and allowed family members to have an active and engaged role in the pregnancy. This aspect of family involvement was felt to be very positive by service users and a beneficial aspect of maternity care. Home visits were only experienced by one to one users. There was some confusion over whether WUTH offered home visits and this needs to be clarified. Further to the recommendation above relating to improvements to the WUTH service to encompass continuity and convenience of location and timing for appointments, home visits could also be incorporated into the WUTH service offer.

Antenatal care during pregnancy

Venue and timings
Overall, 96.3% of survey respondents were happy with the locations where they saw their midwife during their pregnancy. As mentioned, for One to One users many of these visits were home visits which was a concept well received. For WUTH users, ante natal appointments were in a variety of venues such as Children’s Centres and the hospital and the majority were happy with the venues offered. There was an issue raised in relation to information about the range of venues where WUTH offers ante natal appointments, with a participant not being informed that she could have had her appointments closer to home. Users may benefit therefore from better communication and information about what and where services are on offer so they can plan which would be most convenient for them to access.

There were mixed views from WUTH users regarding the acceptability of available appointment times. There were comments about lack of flexibility in appointment times, being rushed and not being able to get an appointment due to the midwife being ‘booked up’. In some cases, this resulted in key appointments being missed. One service user described not being able to get an appointment as ‘stressful’. Conversely, the One to One users interviewed experienced flexible timings and evening appointments, which they found favourable and convenient to fit around work and family commitments. It is recommended that WUTH consider increasing the flexibility of their appointments and include the option of evening appointments.

Continuity of care
A very high percentage of One to One service user survey respondents (93.8%) were happy with the number of midwives they saw during their pregnancy and just over three quarters of WUTH service users (78.4%) were happy with the number of midwives they saw during their pregnancy. In the qualitative phase, One to One users generally saw fewer midwives throughout their pregnancies than WUTH users and most saw the same midwife throughout or a ‘buddy’ midwife. Some WUTH service users reported seeing one midwife throughout their pregnancy and some saw a number of midwives. Whilst service users in the qualitative phase tended to agree that continuity of care by one or a
small number of midwives was preferable they were generally happy with the number they saw.

Similar findings were identified regarding the number of times participants saw their midwives, with high proportions happy with this. It was noted in the qualitative phase that it was felt to be positive if the frequency of visits is explained to women and One to One users also appreciated the fact that they were assured they could contact a One to One midwife at any time between appointments.

The respondents were provided with a list of comments about antenatal care and asked how often they applied. The number of respondents (out of 246 survey respondents) who reported that the comments ‘always’ or ‘often’ applied, is given below in descending order:

- I was/am treated and listened to with respect (233 respondents)
- I have/had trust and confidence in the care I received/am receiving (225 respondents)
- I was/am listened to carefully (223 respondents)
- I was/am given sufficient time to discuss my problems (220 respondents)
- I received/am receiving clear explanations about any treatments or actions (220 respondents)
- I was/am given info/advice that I need (218 respondents)
- My questions were/are answered clearly (217 respondents)
- The midwifery services were/are well informed about my pregnancy (205 respondents)
- I was/am able to contact my midwife when I need (ed) (203 respondents)
- I was/am provided with appointment times that were/are convenient for me (197 respondents)

Overall these results are positive, with high numbers reporting that they were treated with respect and had trust and confidence in their care, amongst other positive attributes. When these findings were compared by the two user groups, larger proportions of One to One users said that the statements ‘Always’ applied, compared to WUTH users. However, the proportions of WUTH and One to One users who stated that they ‘Always’ or ‘Often’ applied were similar for the majority of statements. Slight variations were seen in relation to the following statements, where slightly more One to One users than WUTH users said that they ‘always’ or ‘often’ applied:

- The midwifery services were/are well informed about my pregnancy (205 respondents)
- I was/am able to contact my midwife when I need (ed) (203 respondents)
- I was/am provided with appointment times that were/are convenient for me (197 respondents)

Indeed in the qualitative phase, positive comments from both WUTH and One to One users centred around continuity of care, seeing a small number of midwives and having good relationships with their midwives. Even though it was more common for One to One users to have seen the same midwife and have continuity of care, this was the case for a small number of WUTH users too. This was very positively received and this is
perhaps something that WUTH could build upon to improve user experience as this is a valued component of care for service users.

**Access to midwives**

Another valued component of care was communication throughout antenatal care. Users greatly appreciated being able to contact a midwife in between appointments should they need him/her and some did so throughout their pregnancy, particularly One to One users. There was general satisfaction that midwives could be contacted between appointments, however, some WUTH users in the qualitative phase reported difficulty in trying to contact WUTH midwives. As this issue of communication is important to service users, it is recommended that WUTH review their practice and improve the availability of service contact between appointments.

**Overall satisfaction**

There were high levels of satisfaction with the antenatal care provided by each provider. Key satisfaction influencers, as mentioned, were communication with their midwife between appointments and seeing the same midwife. These are aspects that are mentioned by the vast majority of One to One users and a high proportion of WUTH users. Other aspects which One to One users mentioned more often and seemed to feature in their care plans more was involving the family, home visits, going ‘above and beyond’, providing lots of information, flexibility and not being rushed at appointments. These are all good practice components of care which should be provided by both maternity services in Wirral.

**Birth**

Overall there were high levels of satisfaction from users of both providers about the midwifery care they received when giving birth.

There was similar high satisfaction with the explanations respondents were given about the choices they had of where to give birth (88.3%). However, the qualitative insight demonstrates that whereas the One to One users were given information about different birth choices, such as water birth, WUTH users were given information about locations only, in terms of the three local hospitals. There was also an emphasis for the WUTH users of having to find out information rather than being given information about birth choices. It is recommended that there is clearer information provided about all locations and options for birth and distributed to all women and discussed at antenatal appointments, including water birth and home birth options.

A high proportion (83.3%) of all respondents had chosen to have their baby at Arrowe Park hospital. However, over half of One to One respondents had chosen to have their baby at home or at Liverpool Women’s hospital. During the qualitative phase factors such as the location of Arrowe Park, its recent refurbishment and previous experience, were key in their decision to have their baby there. Home births were not identified as a common choice for WUTH users. Indeed the performance data shows an achieved home birth rate of 32.5% for One to One compared to 0.7% for WUTH. Reasons for home birth given by service users in the qualitative phase were linked to advice and information from midwives, and previous experience of a hospital birth.

The majority of survey respondents and qualitative participants were able to have their baby in the place they wanted to. For those that had not, reasons generally related to
unforeseen complications and circumstances. However, one WUTH user in the qualitative component recounted her experience of being discouraged from going to the hospital so much so that it resulted in her baby being born at home which she found very stressful and negative.

Survey respondents who had given birth (204) were asked about their satisfaction with the care they received at birth. They were given comments and asked how often ‘always’ or ‘often’ applied:

- I was treated and listened to with respect (179 respondents)
- My partner was treated and listened to with respect (175 respondents)
- I had trust and confidence in the care I received (175 respondents)
- My questions were answered clearly (172 respondents)
- I was listened to carefully (171 respondents)
- I received clear explanations of any treatments or action (170 respondents)
- I was given sufficient time to discuss any problems (165 respondents)
- They were well informed about my pregnancy (162 respondents)
- The midwives who looked after me during my pregnancy also looked after me during labour (39 respondents)

In general, the level of personal care from the perspective of service users is welcome. High numbers were treated with respect and had trust in the care they received during the birth. However, only half (19) One to One users and 13% (20) WUTH users (who answered the question) said it was always or often the case that the midwives who looked after them during their pregnancy also looked after them during labour. Given that continuity of care and having access to the same midwife are important themes throughout the evaluation, and especially for service users, this is a significant finding needing to be addressed. It is recommended that continuity of care, not only throughout antenatal care, but also through the birth process is a practice that is considered by both providers.

There were mixed experiences of birth which is to be expected, as every woman’s birth experience is individual. There were some positive comments from One to One users about the service they received at Arrowe Park. However, there was also a negative experience relayed by a woman who had suffered a traumatic caesarean section. Other common themes recounted about the birth process related to information (too much and lack of), communication and being listened to. There are mixed opinions of how much information women want and require during the birth process but it is good practice to provide information to patients if procedures are going to be carried out or changed. Being listened to however, was an aspect of care greatly valued by users and this should be borne in mind by the service providers as lack of listening can have a negative impact on user experience.

**Postnatal care**

**Survey respondents**

Amongst the 200 service users who had recently given birth to a baby, the survey showed high levels of satisfaction with postnatal care received, with 86% of WUTH users and 90% of One-to-One users rating themselves as being fairly or very satisfied. All agreed that their postnatal care was provided in a location convenient to them and this
was generally at home. In terms of the care itself, a high number said they were treated and listened to with respect (184 respondents) and their questions were answered clearly (181 respondents). Many also said they were given information and advice they needed (179) and information about how to stay healthy (176).

However, 10 respondents (3 One to One users and 7 WUTH users) stated that they were never given information about other services and support available after giving birth, and 7 (1 One to One user and 6 WUTH users) said that midwifery services were never well informed about their pregnancy or that they were never given information about how to stay healthy (7 WUTH users). Furthermore, 7 respondents (1 One to One user and 6 WUTH users) also said that they were never provided with appointment times that were convenient to them. Despite the fact that these are in themselves small numbers it is still important to note that these women stated that they had ‘never’ received these aspects of care. Being given information about services and staying healthy, midwives being well informed and particularly appointment times, are aspects of care that are important to service users and have been mentioned throughout the evaluation. It is recommended that these aspects of care are considered by service providers and their procedures checked to ensure that women are given consistent and high quality advice, information and support.

**Qualitative phase**

Furthermore, a small number of negative experiences recounted during the qualitative phase about postnatal care should be noted and acted upon, as examples of unacceptable patient experience. The Mott MacDonald report details comments from WUTH service users describing ‘dreadful’ care in hospital after delivery and ‘rude’, ‘unhelpful’ ‘horrible’ midwives. There were also instances discussed where infection was not identified, sufficient advice about breastfeeding was not given and women were discharged without appropriate medication. These experiences have had a profound effect on the users, with distress evident in their quotes and reports of them getting very upset as they recounted them. In one case, a perception that staff were ‘horrible’ led to a mother being afraid to bother them and giving her baby milk that was old. This is unacceptable practice and it should not be the case that users experience such negative care at a time when they are vulnerable. It is recommended that these aspects of care mentioned are reviewed immediately by service providers and if necessary staff receive further training on attitude relating to patients and understanding their needs during this crucial postnatal maternity phase.

Other issues commented upon during the qualitative phase related to location and timing of postnatal care, home visits, continuity of care and communication. Home visits were seen as very important by participants and reported to be suitably provided by both service providers. However, not knowing when to expect the midwife, having to ‘wait in all day’ and an incident where a midwife did not attend her postnatal appointment was raised by some WUTH users. These were felt to be problematic and a negative aspect of postnatal care. It is therefore recommended that WUTH review their procedure for allocating and attending postnatal appointments and ensure that visits are made and investigate if there is some way of informing women about timings, perhaps through a telephone update system on the morning of the visit, if firm times cannot be set.

In addition to the issues mentioned above, one WUTH user felt that there was some level of exclusion of her partner and family at postnatal visits. Indeed the inclusion of family members at appointments was a component which One to One users had praised.
and felt was of value. It is recommended that this aspect of visits be considered by WUTH and where possible partners and family members are included in the process wherever possible and appropriate.

**Breastfeeding**

In the survey, levels of satisfaction with information about breastfeeding and its benefits (via discussion and written materials) were generally high for users of both providers. The qualitative phase also revealed that breastfeeding information was provided antenatally and postnataally and users were generally happy with the level of information they received. There was a positive comment where a WUTH user noted being given lots of information and advice from a midwife about breastfeeding as well as a DVD and literature.

However, some comments related to an over-emphasis on the positive benefits of breastfeeding at the expense of the message that it can be hard and how to overcome difficulties. Indeed, when asked why they did not breastfeed their baby, a number of user comments related to baby not latching on (15 respondents), not producing enough milk (14), painful/uncomfortable (12). These are all aspects that could be discussed more with women to prepare them for the issues with breastfeeding and how to overcome them and there was similar suggestion from users that midwives should be more realistic with women about what to expect and how to deal with certain issues.

The performance data for Wirral maternity services shows that breastfeeding initiation rates are consistently lower than North West and National rates. The local breastfeeding target is currently set at at least 70% of mothers, with initiation rates for WUTH between 51% and 59% and between 53% to 75% for One to One. In the survey, only 61.8% of women had breast fed their most recent baby.

It is also relevant to note the earlier comments from users about their postnatal care in hospital and lack of support with breastfeeding. There are comments from users which demonstrate inconsistent levels of support postnatally, with some receiving detailed advice and others not. It is recommended that service providers continue their discussions and efforts to provide information and advice to women about breastfeeding antenatally but should also review their practice in relation to care postnatally around breastfeeding and support for the unexpected negative aspects that can occur when breastfeeding, including advice about milk supply. It is also recommended that better use is made of breastfeeding support services.

**Service improvement ideas**

The majority of respondents said they would recommend their service provider. Reasons given for this from One to One users included reference to information, communication, continuity of care, building relationships with their midwife. These are all aspects which have been raised throughout the evaluation as aspects of importance for service users. In their recommendations for future improvements 27 WUTH service users would like more continuity of care, 10 would like better post natal care and 9 mentioned wanting more frequent and longer appointments. It is recommended that these components of care are all reviewed and implemented at WUTH.
Provider relationships
Throughout the commissioned evaluation there is evidence of underlying tension between service providers that is impacting upon patient care and service user experience. This is described in more detail in the following sections.

In the stakeholder survey there were comments from respondents around the need for better leadership and management within Wirral Maternity services and better (more professional) collaboration required between service providers. In the suggestions for the future part of the stakeholder survey, there were comments about the introduction of AQP/private service providers. There was evidence of disharmony about the commissioning of One to One as an additional choice of maternity service for women. There was a quote about destabilising the existing service and a question about the safety and effectiveness of providers. There is evidence of what is referred to as ‘unrest’ in the evaluation between providers and about the dual provider situation. This needs to be addressed as any unrest or issue with the situation will only impact upon the patient ultimately.

Indeed, it was mentioned in the qualitative phase by some One to One users that they sometimes encountered problems within other medical settings, such as when attending the hospital for scans or for the birth, because they were with an alternative maternity service provider. There were issues with notes and lack of communication and the attitude of staff towards One to One users. One participant relayed feeling that

"the people that I dealt with in Arrowe Park didn’t want anything to do with the One to One service whatsoever."

This was seen as very negative by service users and is something that should be acted upon by both providers. If lack of communication and collaboration between providers is leading to a negative patient experience and potential safety issues this needs to be addressed as it compromises safety and wellbeing.

Also, in the service user consultation, One to One user participants felt there should be improvements relating to One to One midwives being able to provide maternity care during labour in Arrowe Park and improved communication between One to One midwives and the hospitals.

Overall, the relationship between WUTH and One to One needs to improve collaborative working arrangements in the interests of women. There are services and resources that could benefit from being shared between services e.g. antenatal or parent-craft sessions. Users would certainly benefit from a more harmonious interchange between providers at crucial times such as the labour and birth process. If One to One users feel that they will be treated negatively when accessing the hospital they will be more vulnerable and less likely to achieve positive outcomes.

It is recommended that the relationship between providers is improved and that they work together in the interest of the women. There are many services in Wirral and other areas that are provided by a number of different providers and the positive impact upon service experience and outcomes as result of collaborative working is evident.
5.3. **Other evaluation data**

Evaluation data collected by the service providers themselves were provided for the evaluation. This includes WUTH ‘Learning with Patients’ data, complaints information and action plans and One to One Client Satisfaction and complaints information. Also included in this section is evidence from a service user complaint directed to the commissioner via PALS and a service user compliment sent directly to the commissioner.

5.3.1. **Learning with Patients**

*Quantitative results*

Results from the WUTH Learning with Patients Questionnaire (contained in Appendix B) show that for the first quarter of 2012/2013, there were high levels of satisfaction with the maternity ward at Arrowe Park Hospital. The results also show that between quarter 4 of 2011/2012 and quarter 1 2012/2013 there was also improvement in some areas.

The number of patients who were satisfied that they were involved as much as they wanted to be in their care or treatment rose (from 77% to 81%), as did the number of patients not experiencing delays (from 73% to 82%), whether the ward appeared to be effectively managed (from 84% to 89%) and whether they could find someone to talk to about their worries (from 76% to 84%). These aspects of care were all addressed in an action plan following Quarter 4 2011/2012 figures (contained in Appendix C), which stated measures taken to improve in these areas.

However, the number who said they were told about medication side effects fell from 70% in quarter 4 to 62% in quarter 1, as did the number who said the staff introduced themselves (from 84% to 82%). These aspects were also included in the action plan (contained in Appendix C).

*Comments*

WUTH also provided details of comments made by 27 patients upon discharge (contained in Appendix D), about the care they experienced whilst on the maternity ward in quarter 1 of 2012/2013 (April 2012 to June 2013).

Nine of the comments specifically praised the staff who had cared for them during their stay in maternity:

“Night staff were particularly lovely.”

“…with the help from all the wonderful staff…”

“All staff made me feel totally individual and that my care was highly important.”

Other positive comments included reference to good breastfeeding support by 3 patients and good level of cleanliness and hygiene. Good levels of privacy and continuity of care were mentioned by others.
However, lack of support from staff was mentioned by 2 women, issues with staffing levels by 3 women, bad staff attitude/manner, lack of respect and care, low level of care and an experience that was traumatic and stressful were mentioned by others.

Other issues mentioned included:
- Lack of recognition of dietary requirements
- Lack of sick bowls
- Lack of pain relief
- Lack of availability of drinks on ward
- Dusty
- Poor quality food
- Insufficient linen/linen not changed
- Having own room was isolating
- Lack of advice and information
- Delay with medication
- Lack of support with breastfeeding
- Lack of suitable facilitates for partners to stay over

Within these comments there were two particular causes for concern. One woman detailed how she experienced poor staff attitude and poor bedside manner from a midwife who she felt ‘belittled my concerns’. She also said she felt “quite bullied and pressured”. She highlighted that her birth plan was ignored and the member of staff was insensitive, blunt and cross with her. Kindness, building a relationship with midwives and feeling listened to, were all important aspects of care advocated by women in the commissioned evaluation and they certainly seem to be a priority for this woman. It is recommended that WUTH continue to review staff attitude and ensure that this component of care is improved alongside listening to staff and personalised care.

Another comment detailed how the patient felt ‘ignored’, that ‘some of the midwives were quite rude’ and that despite a doctor requesting regular observations she was left without observation for 15 hours. A recurring theme of staff attitude is present here and throughout this section and it is recommended that WUTH continue to work on this crucial aspect of care.

5.3.2. Client Satisfaction

In order to learn from their patients, One to One provide patients with the opportunity to complete an online satisfaction survey. This has been available from April 2012 and so the results are for the first quarter of 2012/2013 from April 2012 to June 2012 (See Appendix E). The results show that all survey respondents were extremely positive about their experience and satisfied with their care and 100% of participants said they would recommend One to One to a friend.

Participants were asked about such aspects as the quality of information and advice given, time to discuss problems, whether they were listened to, convenient appointment times, explanations, staff manner and standard of care. Respondents reported 100% satisfaction with all of these components of care. 100% of respondents were also happy with the information, advice and support around breastfeeding.

The One to One client satisfaction and complaints report also provides comments from service users about their care:
“My midwife went above and beyond with every aspect of care for me during and after my pregnancy. I cannot stress enough how her support and guidance has helped me and my family”

“I cannot rate One to One highly enough…”

“I've had an amazing experience with one2one, I hope this gets made available countrywide. I felt extremely supported throughout and it’s made an important and scary time of my life feel safe, special and amazing, thank you”

5.3.3. Complaints
In 2011/2012 there were 26 formal complaints made to WUTH regarding maternity and 12 complaints received via the Patient Advice and Liaison Service (PALS). In the first quarter of 2012/2013 (April 2012 – June 2012) there was 1 formal complaint and 8 PALS complaints. There were common themes reported relating to:
- Communication issues
- Staff attitude
- Delays/discharge/medication/meals
- Delivery suite/admission/telephone advice/latent phase of labour

Action planning and measures to facilitate improvements have since been put in place at WUTH including:
- Work with Sundown (Downs Syndrome organisation) to improve communication and care for women who give birth to babies with Downs Syndrome
- Daily ward sister face to face rounds
- Weekly matron rounds
- Daily visit from PALS to maternity ward
- Encouraging patient feedback
- Team briefings
- Monitoring of staff attitude and
- Work to encourage staff attitude and promote communication and teamwork.

During the same period (2011/2012 and quarter 1 of 2012/2013) One to One received five complaints (See Appendix E), relating to:
- Pain not acted upon by midwife
- Lack of continuity of care and not booked at the appropriate time
- Delay in transfer of care for booking appointment from One to One to WUTH
- Not connecting with midwife on a personal level
- Named midwife not available and alternative midwife rude and unhelpful

Each complaint was reviewed by One to One and appropriate action taken to remedy the situation, including liaison with a patient’s GP, re allocation of midwife and ‘reflection on practice’.

5.3.4. Specific Issues

Communication
There have been complaints to WUTH relating to communication issues around breaking difficult news to women who have given birth to a baby with Downs Syndrome. WUTH
have since met with a representative from Sundown and put an action plan in place. They have improved the information packs on the maternity ward and arranged further meetings with the organisation and ward sister to make improvements and improve information for staff and identified a link on the maternity ward.

**Hostilities between Service Providers**

A complaint from a pregnant woman who was booked with the One to One service indicates a level of alienation felt by women booked with One to One when dealing with midwives from another service. Not satisfied with the information and advice she received from One to One when she had cause for concern, the woman went to WUTH midwives for assistance, because she was booked to give birth at WUTH. The same advice was reiterated by WUTH midwives, however, the issue for the patient was the fact that after the initial advice, the WUTH midwives simply referred her back to One to One with no further support. They simply said that she had to contact One to One and that One to One had their own protocols, which differed from WUTH. The patient was left feeling that the midwife was not interested in her and had used bureaucracy to deflect her concern.

The complainant described her perception of tensions and animosity between service providers.

“…as a service user, the tensions between these services is clear to see and it is plain from the comments from midwives representing both services that the way in which these services are commissioned is not joined up.”

She describes a parenting class in Birkenhead where the animosity between the providers was clearly expressed and remarked that her dissatisfaction with the clinical advice she had been given was actually secondary to the feeling ‘caught in the middle’ of the two services. The woman described feeling ‘disempowered’ by the experience and maintained that ongoing issues between the providers are ‘stressful and unpleasant for service users’.

“I don’t care about the differing philosophies concerning maternity care between Arrowe Park and One to One: I want to deliver my baby safely and without incident.”

This experience echoes similar issues described by service users and stakeholders in the commissioned evaluation (section 5.2) and highlights the recommended need for providers to work together so as not to compromise patient care.

**5.3.5. Compliments**

A service user who had used the One to One service wrote to the commissioner of maternity services to commend the service she received. She commented upon the level of care she received from her midwives at One to One and described her experience in detail. She emphasises that her pregnancy and birth were the ‘best experiences of her life’ and attributes this to the ‘excellent care’ she received.

She highlights the extensive and up-to-date information she was given, the ‘kind and reassuring’ midwife with a ‘positive attitude’ and ‘quiet friendly manner’ that filled her with confidence. She praised the practice of appointments in the home and involvement and
patience with her family members and the support provided with the difficulties of breastfeeding. The service user recounted that the care One to One provide is:

‘..safe, supportive, reassuring and most importantly empowering for women like me’.

These aspects echo those that are identified by stakeholders and service users throughout the evaluation as aspects of high importance to women. The aspects of continuity of care, building relationships with their midwives, home appointments, provision of information, family involvement, positive attitude and manner, ‘nothing being too much trouble’ and support with breastfeeding are all held in high regard for service users and stakeholders as a means to facilitate positive patient experience and good quality maternity care. The One to One model appears to encompass these components and there are also some of these aspects of care evidenced within practice at WUTH. It is recommended that service providers work together to maximise the opportunities for all women in Wirral to experience such a positive pregnancy and birth scenario.
6. Conclusions & Recommendations

6.1. Conclusions

There are themes running through the stakeholder survey around models of care that put the midwife at the forefront of care, whilst maintaining the safety of being alongside an obstetric unit should risks escalate. All stakeholders tended to prioritise medical expertise over convenience for women but the majority agreed and voiced comments about the benefits of continuity of care and personalised midwife led care. The emphasis on midwifery led care was in line with the two examples of good practice discussed in chapter 4. These models also focus on the midwife as central to the good quality care of women.

Themes in the service user consultation were similar in that many valued the midwife focused care, continuity and building relationships with their midwife. However, for service users convenience of timing and location and availability of flexible and home visits were paramount. These were not considered of high importance for stakeholders who prioritised medical expertise and outcomes for women and baby.

Overall levels of service user satisfaction of the services were high both in the commissioned evaluation and evaluation evidence provided by the service providers (5.3) and there were many positive experiences noted of both service providers. However, there were some negative experiences and complaints discussed which indicate that care has fallen below an acceptable standard in some instances and these should be embraced as learning points by service providers.

6.2. Recommendations

6.2.1 Explore the further development of midwifery led care for Wirral

There was high support for a midwifery led unit alongside an obstetric unit in the stakeholder survey and the benefits of midwifery led care were valued by service users. This is a model of care that could be promoted and facilitated in Wirral as there is existing infrastructure at WUTH that would support this model. This coupled with the existing strong community midwifery service provided by One to One would begin to mirror the model used in the two case studies covered in chapter 4. The current provision is a maternity unit alongside obstetrics but it is not a midwifery led unit (MLU) run wholly by midwives. Implementation of such a unit or a move towards more wholly midwifery led care should be explored in Wirral.

6.2.2 Explore the use of caseload midwifery model

Aspects of this type of model such as continuity of care, building relationships with midwives and having the same midwife antenatally, at the birth and postnatally, were aspects highly valued by service users throughout the evaluation. Stakeholders advocated the importance of continuity of care and having a named midwife and service users highly valued these components, as well as flexible and home visits. These aspects were particularly commended by users of the One to One service, who have built their service model around this notion of continuity and personalised care.

The use of caseload midwifery could be explored alongside this model whereby the two models work in tandem together. The community services provided by One to One and
WUTH could link together and be stitched into a midwifery led unit at the hospital so that if women did not want to give birth at home they could also have the option of the MLU, with the ease of access to obstetric care should risks escalate.

6.2.3 Improve promotion of patient Choice
Choice of maternity service was an important theme for service users. For the vast majority of service users who responded to the survey, their GP was their first point of contact upon discovering that they were pregnant. Reasons for going to the GP first included thinking this was where they should go and not being aware of alternatives. Women are not aware of that they can refer themselves directly to a provider.

All those who seek advice from their GP should be made aware that they have a choice of midwifery provider. Ensuring that women have enough information to make an informed choice of maternity health provider is the responsibility of commissioners, service providers and GPs as detailed in maternity matters (DH, 2007). It is recommended that the service providers raise awareness of their services for women and the fact that they can refer direct, by enhancing their internet-based information or through other publicity.

6.2.4 Information to facilitate patient choice needs to be more systematically given.
There is evidence that informed choice is currently hampered by a lack of standard process in terms of patient choice offered and inconsistent information given about the available providers, available arrangements for appointments (e.g. home visits) and available options for birth (e.g. water or home birth). The dual provider system in Wirral and the options involved (in terms of accessibility) should be explained to all women by their GP and at other appropriate points in the antenatal pathway. In particular, any misinformation about providers should be identified and clarified at this first point of contact. A standard process with perhaps an information pack offered to women would provide opportunity to give balanced advice about services for women to make an informed choice. This should also include information given postnatally around health and wellbeing services available for new parents.

6.2.5 Improve continuity of care
This was of priority for both service users and stakeholders and service providers must ensure that service users are offered a named midwife/ves and have some level of continuity of care and are able to build relationships with service users. This aspect of care was mentioned throughout the evaluation and is valued highly by service users. Continuity if care was also a common theme throughout the stakeholder survey, mentioned by midwives in relation to a caseload model, advocated by doctors and other stakeholders in the survey and felt to be positive by service users in the survey.

Only a small number of service users said it was always or often the case that the midwives who looked after them during their pregnancy also looked after them during labour. Continuity of care, throughout antenatal and through birth to postnatal is an aspect of value to service users and one that is in line with the caseload midwifery model. It is therefore recommended that continuity of care, not only throughout antenatal care, but also through the birth process is a practice that is considered by both providers.

6.2.6 Increase the flexibility of appointments and opportunity for home visits
Convenience of timing and venues for service appointments were differentially ranked in importance by stakeholders and users. The degree of flexibility within both providers also seemed to differ. Users of One to One found them to be flexible and to offer evening and home visits, which were valued and a key motivator for women to choose this provider. There was some confusion over whether WUTH offered home visits and this needs to be clarified. Some WUTH users reported a lack of flexibility in appointment times and not being able to get an appointment due to the midwife being booked up. Confusion over when to expect visits postnatally was also specifically reported.

It is recommended that both services regularly review their approach to offering appointments to ensure it meets the needs of service users and incorporates as much flexibility as possible. It is recommended specifically that WUTH consider offering antenatal home visits or, if this is already the case, clarify the choices available. Clarity of communication around postnatal appointments also needs review.

### 6.2.7 Increase the availability of unscheduled communication with midwives

Another valued component of care was the opportunity for ongoing communication throughout antenatal care. Users greatly appreciated being able to contact a midwife in between appointments should they need him/her. There was general satisfaction that midwives could be contacted between appointments, however, some WUTH users in the qualitative phase relayed issues in trying to contact WUTH midwives. It is recommended that WUTH review their practice on this issue and ensure they are contactable as it seems to be an important aspect of care for users.

### 6.2.8 Improve listening to women’s preferences and responding to incidents

Service users raised the issue of being listened to about and during the birth process. This was an aspect of care greatly valued by users and their perceived lack of voice can have a negative impact on user experience and result in a de-personalized service. Although there was high satisfaction with both service providers, the evaluation identified experiences of very poor patient experience around birth and postnatal care, alongside unacceptable levels of intensive care unit admissions and a number of formal complaints. Services should urgently review their ability to capture negative user experience and effectively act on issues of care that emerge. A systematic process for learning from incidents should be put in place and maintained. Consideration of staff training related to patient engagement may be appropriate.

### 6.2.9 Review midwife to women ratios in view of best practice guidelines

Reference to staffing levels was alluded to in the stakeholder survey results with a provider making a suggestion for the future that there are more midwives and another advocating that there are ‘...enough midwives and clinicians to support choice.’ This was also mentioned in the patient learning data and the service user survey and evidence in the performance data suggests that there could be better ratios of midwives to patients. It is recommended that service providers review their staffing levels and ensure they meet guidelines for the safety of women and adhere to good practice.

### 6.2.10 Increase involvement of family members

Home visits were generally advocated by service users as a useful component of maternity care. Reasons given for this by some users include that home visits enabled involvement of the family and made them feel part of the proceedings. One written compliment specifically praises the One to One service for the way in which it sought to involve other members of the family. However, a WUTH user reported feeling that there
was some level of exclusion of her partner and family at postnatal visits. It is recommended that this aspect of visits be considered by WUTH and where possible partners and family members are included in the process wherever possible.

6.2.11 Improve support around breastfeeding practice
The breastfeeding initiation rates were consistently below target for WUTH-registered mothers and below target for several of the months reviewed for One to One registered mothers. Some mothers reported a lack of support with breastfeeding and no advice given whilst in hospital after birth; others reported receiving detailed advice. The nature of information given was at times felt to be impractical (focused on benefits rather than some of the barriers experienced) and there was almost no evidence of breastfeeding support services being used. It is recommended that service providers review breastfeeding support strategy, ensure consistency of input from maternity services staff, explore innovative ways to promote breastfeeding and increase the use of support services such as peer support.

6.2.12 Improve systems to ensure collaboration between providers
It was mentioned in the qualitative phase by some One to One users that they sometimes encountered problems within other medical settings, such as when attending the hospital for scans or for the birth, because they were with an alternative maternity service provider. There were issues with notes and lack of communication and the attitude of staff towards One to One users. This was seen as very negative by service users and prompted one complaint where a service user felt strongly that hostilities between service providers had affected her care and her experience. It is recommended that the relationship between providers is improved and that they work together in the interest of the women. There are many services in Wirral and other areas that are provided by a number of different organisations and the positive impact upon service experience and outcomes as result of collaborative working is evident.
7. Appendices

Appendix A: NHS Wirral Maternity Evaluation 2012 by Mott MacDonald
## Patient Experience Report 2012/13

### WUTH

#### National CQUIN Indicators

<table>
<thead>
<tr>
<th>Question</th>
<th>Qrt 4 (2011/12)</th>
<th>Qrt 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>% Trust</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>Were you involved as much as you wanted to be in</td>
<td>76</td>
<td>2078</td>
</tr>
<tr>
<td>Did you find someone to talk to about your worries and</td>
<td>73</td>
<td>1492</td>
</tr>
<tr>
<td>Were you given enough privacy when discussing your</td>
<td>93</td>
<td>2037</td>
</tr>
<tr>
<td>Were you told about medication side effects to watch</td>
<td>69</td>
<td>1440</td>
</tr>
<tr>
<td>Were you told who to contact if you were worried after</td>
<td>93</td>
<td>1702</td>
</tr>
</tbody>
</table>

#### Local CQUIN Indicators

<table>
<thead>
<tr>
<th>Question</th>
<th>% Trust</th>
<th>n</th>
<th>% Trust</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>I got enough help from staff to eat my meals</td>
<td>91</td>
<td>260</td>
<td>85</td>
<td>246</td>
</tr>
<tr>
<td>I received assistance with drinking</td>
<td>89</td>
<td>189</td>
<td>87</td>
<td>179</td>
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#### Core Themes

<table>
<thead>
<tr>
<th>Question</th>
<th>% Trust</th>
<th>n</th>
<th>% Trust</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>My privacy and dignity was maintained when being</td>
<td>99</td>
<td>2035</td>
<td>98</td>
<td>1899</td>
</tr>
<tr>
<td>I was treated with courtesy and respect</td>
<td>96</td>
<td>2071</td>
<td>95</td>
<td>1945</td>
</tr>
<tr>
<td>I was cared for in a clean environment</td>
<td>97</td>
<td>2050</td>
<td>97</td>
<td>1912</td>
</tr>
<tr>
<td>I would recommend this hospital to my family and</td>
<td>97</td>
<td>1966</td>
<td>96</td>
<td>1858</td>
</tr>
</tbody>
</table>

#### Advancing Quality

<table>
<thead>
<tr>
<th>Question</th>
<th>% Trust</th>
<th>n</th>
<th>% Trust</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>I received the care that mattered to me</td>
<td>98</td>
<td>189</td>
<td>97</td>
<td>1843</td>
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</table>

#### Learning with Patients (Additional measures)

<table>
<thead>
<tr>
<th>Question</th>
<th>% Trust</th>
<th>n</th>
<th>% Trust</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Someone showed me the location of the nearest toilets</td>
<td>89</td>
<td>1969</td>
<td>89</td>
<td>1836</td>
</tr>
<tr>
<td>The toilets on the ward / unit were clean</td>
<td>96</td>
<td>1971</td>
<td>96</td>
<td>1850</td>
</tr>
<tr>
<td>I was provided with information that helped me</td>
<td>86</td>
<td>2059</td>
<td>86</td>
<td>1915</td>
</tr>
<tr>
<td>I felt able to ask questions</td>
<td>92</td>
<td>2081</td>
<td>92</td>
<td>1943</td>
</tr>
<tr>
<td>The staff introduced themselves</td>
<td>88</td>
<td>2000</td>
<td>83</td>
<td>1957</td>
</tr>
<tr>
<td>Staff treated any concerns I raised seriously</td>
<td>93</td>
<td>1895</td>
<td>91</td>
<td>1765</td>
</tr>
<tr>
<td>Patients not experiencing delays</td>
<td>65</td>
<td>1750</td>
<td>61</td>
<td>1670</td>
</tr>
<tr>
<td>I was provided with a reason for the delay / kept</td>
<td>64</td>
<td>578</td>
<td>68</td>
<td>551</td>
</tr>
<tr>
<td>I had confidence in the staff</td>
<td>92</td>
<td>2045</td>
<td>91</td>
<td>1916</td>
</tr>
<tr>
<td>The ward / unit appeared to be efficiently managed</td>
<td>92</td>
<td>1993</td>
<td>90</td>
<td>1848</td>
</tr>
<tr>
<td>I observed staff wash or gel their hands between</td>
<td>87</td>
<td>1761</td>
<td>86</td>
<td>1671</td>
</tr>
<tr>
<td>My pain was effectively managed</td>
<td>91</td>
<td>1401</td>
<td>90</td>
<td>1283</td>
</tr>
<tr>
<td>I received a copy of the patient discharge sheet</td>
<td>94</td>
<td>1931</td>
<td>94</td>
<td>1835</td>
</tr>
<tr>
<td>I found the information useful</td>
<td>98</td>
<td>1702</td>
<td>97</td>
<td>1613</td>
</tr>
<tr>
<td>I was provided with a level of assistance to meet my</td>
<td>93</td>
<td>1086</td>
<td>93</td>
<td>999</td>
</tr>
</tbody>
</table>
**Appendix C: WUTH Patient Experience Maternity Ward Action Plan Quarter 4 2011/2012**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1.</strong> Were you told re medication side effects to watch out for when you went home? 70%</td>
<td>1. Laminates placed in boxes on each nurse base. All staff informed of the importance of giving this information to women at the ward meetings. Staff to document in patients notes that side effects have been discussed. Ward sister to hold daily discussions (mini meetings) with the staff on duty to remind them of this. To be discussed on daily sister ward rounds.</td>
</tr>
<tr>
<td><strong>2.</strong> The staff introduced themselves 84%</td>
<td>2. Staff to be informed of the results at the staff meetings and daily discussion sessions. Notice boards in pace in all rooms with staff names on to be completed daily by CSW’S on a daily round at the start of the shift.</td>
</tr>
<tr>
<td><strong>3.</strong> Patients not Experiencing Delays 73%</td>
<td>3. To be discussed at staff meetings and daily discussion sessions. Staff to discuss any delay in patient care with the patient and to document in the patient notes e.g. delay in transfer to delivery suite, delay in medical review. Ensure that TTH’S are ordered ASAP and all staff to use the tracker on PCIS.</td>
</tr>
<tr>
<td><strong>4.</strong> The ward / unit appeared to be effectively managed 84%</td>
<td>4. Ward Sister /Deputy to perform daily ward rounds to discuss any concerns with the patients. Drop in sessions with ward sister to be arranged. Weekly ward rounds by the Matron to see all inpatients. Discuss with all staff about not discussing staffing levels/ sickness etc with the patients.</td>
</tr>
<tr>
<td></td>
<td>5. Inform all staff of results via staff briefs. Ensure full discussions are documented</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>5. Were you involved as much as you wanted to be in decisions about your care and treatment? <strong>77%</strong></td>
<td>regarding treatment plans and discussions. Midwives to be reminded about the importance of discussing birth plans with all women including high risk and planned induction of labour.</td>
</tr>
<tr>
<td>6. Did you find someone to talk to about your worries and fears? <strong>76%</strong></td>
<td>6. Ensure midwives are accessible to woman and are visible to allow women to talk to them. Ward sister to be visible on the ward to allow discussions to take place. Midwife to go on all medical ward rounds and ward sister if possible.</td>
</tr>
</tbody>
</table>
### Appendix D: WUTH Learning with Patients Questionnaire Comments

#### Maternity Ward Quarter 1

<table>
<thead>
<tr>
<th>WARD</th>
<th>REF CODE</th>
<th>NORIAKI CODE</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternity</td>
<td>60</td>
<td>IND E+D BF II</td>
<td>As a Jehovahs witness patient with specific needs in regard to blood management, I felt the staff were professional and respectful of my decisions. In general, Midwives and Doctors have been extremely helpful and attentive. Excellent support provided for breast feeding.</td>
</tr>
<tr>
<td>Maternity</td>
<td>328</td>
<td></td>
<td>The people on both wards were very helpful apart from the first person on labour ward who kept telling me I wasn't in labour and sent home my partner and mum.</td>
</tr>
<tr>
<td>Maternity</td>
<td>551</td>
<td>NB</td>
<td>I feel that all members of staff gave me excellent support throughout my stay in Hospital. Also my aftercare at home from the Midwives has also been excellent. I had complications during my labour and required a c-section, all members of staff involved were both caring and professional.</td>
</tr>
<tr>
<td>Maternity</td>
<td>559/360</td>
<td>Cause for Concern</td>
<td></td>
</tr>
<tr>
<td>S3</td>
<td>614</td>
<td>SB</td>
<td>Gluten free food / vegetarian very difficult whilst in hospital. I found this suprising as Arrowe Park was a Gastroenterology Unit where this requirement must come up frequently. I had complications following surgery (c-section) but when I came to the room at 12.30am I was just left with the baby until the following morning. I think more support would be good and certainly appreciated.</td>
</tr>
<tr>
<td>S3 + 54</td>
<td>630/626</td>
<td>Cause for Concern</td>
<td></td>
</tr>
<tr>
<td>S3</td>
<td>1015</td>
<td>PM MM WN SS</td>
<td>Overall my care was more than satisfactory. My only problem was I had asked for painkillers and waited quite some time to receive them. I understand at times its very busy on a ward and appreciate there will be delays but 3 hours is a long time to wait especially after having had a c-section the day before! I did feel that the night staff were stretched which made me reluctant to ask for help when I needed it, mostly to pass me my baby to feed him as I was unable to reach him.</td>
</tr>
<tr>
<td>S3</td>
<td>1033</td>
<td>NB SI IND</td>
<td>The care I received on both Labour ward and Maternity was fantastic and my emphasis really was on care. Despite being incredibly busy I was always given time and made to feel important by all the staff. Me and my baby girl can't thank you all enough!</td>
</tr>
<tr>
<td>S3</td>
<td>1086</td>
<td>NB</td>
<td>The care was fantastic. The new layout of the ward/own room lovely. Overall very impressed, staff lovely and visiting hours brilliant.</td>
</tr>
<tr>
<td>S3</td>
<td>1181</td>
<td>SS BF</td>
<td>I found the staff on the ward were over stretched. I needed help with feeding my baby and we had to wait quite a long time for the baby to be fed. We felt helpless and frustrated at times when the baby was crying and kept waiting for a considerable time. We wish that the staffing level can be improved in the future.</td>
</tr>
<tr>
<td>Maternity</td>
<td>719</td>
<td>BF SA</td>
<td>Majority of staff on the Maternity ward and Delivery Suite were excellent. Unfortunately a few let the team down with an abrupt manner towards patients. Night staff were particularly lovely from Health Care assistants to Midwives. Breast feeding assistant was also very understanding, none patronising and supportive.</td>
</tr>
<tr>
<td>Maternity</td>
<td>746</td>
<td>NB</td>
<td>The care I received was excellent. I was treated with dignity and respect throughout my entire stay in the Hospital. Any concerns that I raised were dealt with in a timely, efficient manner, no matter what time of day or night. I cannot praise the treatment I received highly enough.</td>
</tr>
<tr>
<td>Maternity</td>
<td>940</td>
<td>EI BF</td>
<td>The only comment would be availability of drinks. As I was breast feeding I felt I needed lots of fluid and the water/drinks containers were for small cuppils only.</td>
</tr>
<tr>
<td>Maternity</td>
<td>979</td>
<td>FM IC</td>
<td>Only comment was regards to the ceiling tiles within the rooms and that there was a present of dust. Other than that the level of hygiene and cleanliness was of good standard. The individual rooms are an excellent addition to the Maternity unit.</td>
</tr>
</tbody>
</table>
One to One (North West) Ltd (One to One) provide high quality evidenced based maternity care that is underpinned by core values of: Excellence; Safety, Integrity; Women Centred and Professionalism. A service that is flexible, that is built around the needs of women and their families. A service where the woman and her partner are empowered to be part of their birthing process to take control and to work in partnership with their named midwife ensuring a happy birth memory.

As part of our commitment to quality and excellence One to One commenced on-line client satisfaction surveys from April 2012. We see this survey as an important tool in involving the woman and her partner in developing care and improving the quality of the overall experience with One to One. All women receiving services from One to One can report their experience, either good or bad, through different mediums: Through our website; facebook and experience surveys, in addition women who wish to report a problem or complaint may do so to her named midwife, a senior manager or through the independent LINk/Health Watch advisor.

The on-line client satisfaction survey is available to all women on the day of their discharge from our service. The named midwife has a copy of the survey on her ipad, which she gives to the woman to complete, this is done in total confidence, on completion of the survey the woman will press the send button ensuring the survey is instantly emailed directly back to our office, the named midwife does not see the completed survey, ensuring women are open and honest about their care. Since the introduction of the on-line survey we have had forty women discharged from our service with 100% compliance on return

The survey aims to capture the woman’s experience with One to One in the areas of:

- Information and advice
- Midwife attitude
- Overall care
- Birthing experience

The survey will be a rolling evaluation of women’s experiences with One to One and will inform the company of our strengths, challenges and areas that need to be improved, enhanced or re-designed. The satisfaction report will be produced on a bi-annual basis starting with the current report.
Summary

All participants receiving One to One midwifery service where extremely positive about their experience and satisfied with their care. In addition, 100% of participants said they would recommend One to One to their friend.

Participants were asked to rate the quality of information and advice given and the spirit in which the midwife delivered care:

Information, Advice, Attitude:

<table>
<thead>
<tr>
<th>Did your Midwife:</th>
<th>Always</th>
<th>Often</th>
<th>Sometimes</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>Listen to you?</td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Give you enough time to discuss problems</td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Give good advice and information</td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Answer your questions or concerns when you needed them</td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Where you provided with appointment times convenient to you and your partner.</td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Take enough time at appointments</td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Explain in a way you understood</td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Carry out care in a friendly helpful way</td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Make herself available to you when you contacted her</td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gave an excellent standard of care</td>
<td>94%</td>
<td>6%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gave excellent information on USS and One to One community clinics</td>
<td>96%</td>
<td>4%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Breast Feeding:
One to One actively promotes breast-feeding in all women receiving OTO midwifery services. Participants were asked if they were given information, advice and BF support:

<table>
<thead>
<tr>
<th>During your pregnancy did your midwife</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discuss breast-feeding with you?</td>
<td>100%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Give you written materials or information on breast feeding?</td>
<td>100%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did your midwife discuss the benefits of breast-feeding with you?</td>
<td>100%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did you receive breast-feeding support from your midwife?</td>
<td>98%</td>
<td>2%</td>
<td></td>
</tr>
</tbody>
</table>
Overall Care:
Participants were asked to rate their overall care experience with the One to One service:

![Overall Satisfaction Rate Diagram]

Women were invited to add comments to the survey in the free text box provided. Below is an example of typical comments made:

- “My midwife went above and beyond with every aspect of care for me during and after my pregnancy. I cannot stress enough how her support and guidance has helped me and my family”
- “We would both like to thank Cheryl and Lauren for the excellent care and support we received before, during and after our birth. Their support enabled us...
to have the perfect home birth that we had hoped for. We can't recommend One to One enough”

- “I can say Emma is an excellent professional, and I would recommend her all the time. And the experience with one to one has been great. I definitely happy of my choice”

- “I cannot rate one to one highly enough especially the care and support received from Karla and also Katie. I would not hesitate to recommend one to one to my friends and family. Karla met all our questions with informative answers and made us feel completely at ease at all time”

- “I've had an amazing experience with one2one, I hope this gets made available countrywide, I felt extremely supported throughout and it's made an important and scary time of my life feel safe, special and amazing, thank you”

- “I've recommend one to one to many people already. It is a great service - it would be great if Liverpool provided it (officially!) too as it is more joined up. Thank you”

- “Lauren has been absolutely amazing from our first meeting to our post natal six week check. She has been so supportive, understanding and wonderful. During my pregnancy I had a few complications and Lauren was always there if I ever needed her and helped me to understand everything. We decided to have a home water birth and it was absolutely everything I wanted, it was a fantastic birth experience and I couldn't be happier with one to one midwives. Lauren is a real gem, you are very lucky to have her on your team. I will 100% recommend one to one. Thank you so much for this service”.

- “Karla has been a fantastic support to me during my pregnancy and after the birth of my son. It is midwives like her that make One to One the service it was set up to be. Thank you so much”

**Birth Stories**

One to One clients often send in their birth stories for publication on our website: [www.onetoonemidwives.org](http://www.onetoonemidwives.org) Below is a small selection of the many stories posted:

“It's hard to know where to start when I'm talking about my time with One to One as it's very hard to put into words the gratitude I feel towards this service but in particular my midwife Katie.

As soon as I was put into contact with her she arranged to meet me at only two weeks pregnant. From then on every opportunity was made available to me to discuss any worries or concerns but at the same time giving professional and common sense advice at appropriate times. I was spoken to like an intelligent woman who had a choice and could make her own decisions about her care, the care of her baby and what was ultimately going to happen at the birth. Katie was always there for me and never made me feel like I was being stupid or being a nuisance.
This was my second pregnancy so I knew what to expect second time round and felt much more confident about the pregnancy and the welfare of my baby but as my son was born five weeks premature I was convinced it would happen again so was very much focused on premature labour and all the complications that brings. I was still feeling very sad about the start in life my Son had and the labour and birth experience I didn't have and was determined that I wouldn't let that happen to me or my baby again. Katie really worked with me on this aspect of my pregnancy and helped me to be positive and start focusing on having a normal labour/birth experience.

When my waters broke around midnight I rang Katie to let her know as she had asked me to do this. By about 2.30 a.m. I was ready to make my way over to the Liverpool Women's Hospital. I had expressed a wish for Katie to be there if it was possible and she was available. From the moment my waters broke I knew she was there. She rang ahead to the Women's for me and made all of the arrangements, by the time we got there everything was ready for me, they knew who I was and what I wanted to do. Katie met us there and shortly after we went through to the pool room were my daughter was born after the most peaceful and calm labour. It was everything I had hoped for and I truly believe it wouldn't of happened that way if I wasn't with One to One but in particular Katie. She was absolutely amazing. She just got me from day one, and understood what it was I wanted and why it was so important to me. I can't thank her or the service enough and feel very privileged to have been able to be looked after by them. Having the same midwife all the way through really makes a difference. Katie went above and beyond her call of duty to be the best support to me and to provide the best care. I can't recommend them highly enough”.

“I found out I was pregnant and I was passed on to the One to One midwives, where I was introduced to Katie, I was finding it hard to get my head around and was upset at first as this was my first pregnancy and I was scared. Katie was very Helpful and was always there if I needed someone to talk to. Katie would come out to my house whenever needed even on weekends and I found my pregnancy easier knowing she was there. She got me involved in antenatal classes which were very interesting. I became friends with Katie and even when my son was born i would always phone her for advice?

I would always recommend One to One midwives xx

“I was recommended by a friend that I should explore the possibility of choosing One to One Midwives to support me through my pregnancy and postnatal period. Previously, my experience of childbirth had been a difficult one and had left me extremely anxious regarding the impending delivery. After meeting with Kayleigh a One to One midwife I was immediately reassured that the care and attention I would receive would help ease my anxieties and fears. I was not disappointed. Kayleigh visited me in my home
regularly; always spent time with me and never made me feel that she was in a rush. I was supported in the choices I wanted to make for the labour and Kayleigh facilitated my wishes completely ensuring that I was in control which in turn allayed any impending fears. When the day arrived as anxious as I was initially the gentle support and encouragement I was given by Kim and Kayleigh as I laboured was invaluable. Throughout I was in control and calm and this was definitely helped by the care and support I received by the One to One Midwives. They helped to make the birth of our son a happy and memorable occasion”.

“121 Midwives were key in helping me achieve the most empowering and important moment of my life--bringing my daughter into this world naturally. I was determined to give her the gift of life free from a drug-induced haze, free from an anatomically hindering position, free from artificial lights and needless intervention. Fully supported by the expertise and endless kindness of the 121 Midwives, I gave birth at home, in a pool loaned to me by them. It was a peaceful, beautiful labour, done by candlelight, soothing music, and using Hypnobirth techniques. The moment I stepped into the pool, I knew I was not getting out! The instant freedom and suspension provided by the water would convince almost any woman that no pillow or mattress can stand up to the comfort and relief of such a ‘liquid hug.’ Being in the pool meant I was able to get into a perfect squatting position easily and naturally, and stay there until my daughter arrived. The water relieved and prevented any potential stress on my back, my joints, my neck, and my legs.

Water birth--and indeed, home birth--is a right that should be afforded all women. 121 Midwives believes in the innate nature and wisdom of a woman’s body, and that belief washes into the pregnant woman, helping her build faith and confidence that she, too, can do as her mammalian sisters do, and birth using her own will and exquisitely designed body. Birthing by water is a natural extension of that nature and wisdom.

What a world it would be if we recognized women’s bodies as capable, perfect vessels of deliverance, as opposed to medical tragedies begging for needless interference. Woman should feel ecstatic at the opportunity to give birth, not scared. It’s precisely that shift that hallmarks the incredible work that 121 Midwives are providing in the community.”

Complaints:
All staff at One to One (North West) Ltd consistently strive for excellence, to that aim we actively encourage all women to feedback regarding their birthing experiences with us. It is really important to the company that women receive a high standard of care and as such take client complaints or concerns very seriously. Immediately there is a complaint an initial review is undertaken by the senior team usually within forty-eight hours.

The initial review will include:
• What happened and where
• Who or what is responsible
• Contributing factors
• Communication with complainant usually within twenty four hours
• Support for both midwife and client
• A plan of action that is taken forward by appropriate manager.

The focus is on responding to a complaint in a timely manner keeping an emphasis on communication within the organisation, with clients or outside agencies as applicable. The process will culminate in identification of service successes or deficiencies with a plan of action in place for communicating lessons learned, the need for training or policy update. In addition, areas of good practice are fed back to managers and midwives. All relevant agencies will be informed of the outcome of any review in a timely manner.

Since August 2010 One to One have offered over 960 women midwifery services. Within that time the company have received five complaints.

<table>
<thead>
<tr>
<th>Date</th>
<th>Complaint</th>
<th>Review</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>18/08/11</td>
<td>Woman complained of severe back/pelvic pain. Not acted upon by OTO midwife</td>
<td>Throughout the pregnancy client received: Osteopathy, Reiki, physiotherapy, massage and acupuncture. Analgesia: Paracetamol, Co-Codamol, Morphine Patches. Referred for obstetric input by OTO midwife within appropriate timeline of 32/40 for possible IOL or CS</td>
<td>No clinical recommendations – One to One midwife acted in accordance with best practice and within Midwives Rules (NMC 2006). This lady had received appropriate care from Primary Care Team. Results sent to PCT/PALS/WUTH/GP</td>
</tr>
<tr>
<td>18/08/11</td>
<td>GP complaint that his patient booked with OTO had:</td>
<td>Woman seen two midwives as one went off sick. A copy of the blood results from the Royal Liverpool Hospital Laboratory received. A transcript that one of the midwives kept of the care she gave to Kathleen - Confirmed booking appointment and the booking USS from SMI the</td>
<td>None required. GP informed of review findings and was happy with result.</td>
</tr>
<tr>
<td>Date</td>
<td>Event</td>
<td>Details</td>
<td>Action</td>
</tr>
<tr>
<td>----------</td>
<td>----------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------</td>
<td>---------------------------------------------</td>
</tr>
<tr>
<td>04/09/11</td>
<td>Delay in transfer of care for booking appointment from OTO to WUTH</td>
<td>Woman had an early USS (9+5 weeks) with OTO but was never booked with the company. The midwife sent a request to GP on woman’s behalf in a timely manner that was not acted upon by the GP until the woman was 13 weeks pregnant.</td>
<td>None required from OTO. Review results sent to PCT/WUTH/GP</td>
</tr>
<tr>
<td>27/01/12</td>
<td>Unhappy with her midwife not connecting on a personnel level.</td>
<td>Recognised that not all women and their allocated midwife will get on</td>
<td>Called by the CGL to discuss concerns. New MW allocated with 24 hrs.</td>
</tr>
<tr>
<td>23/06/12</td>
<td>Although had an excellent antenatal and postnatal experience with her named midwife client complained about her birthing day, her named midwife was off-duty and she described the midwife on call as rude and unhelpful</td>
<td>Team Leader and named midwife have discussed and reflected on the care this woman received with the midwife in question, who deeply regrets her actions.</td>
<td>Reflection on practice</td>
</tr>
</tbody>
</table>

**Conclusion:**
One to One believe in women, in their ability to birth, in their strength and in their resilience. It is this belief that we promote in women who trust in us to ensure their birthing journey is a positive fulfilling memory that will last a lifetime.

Below is a poem sent to a One to One midwife from a teenage mother:

---

**To Belinda**

“I really appreciate you,
Your helping giving ways,
And how your generous heart,
Your unselfish displays.

I thank you for your kindness
I will not soon forget;
Your one of the nicest people
I have ever met.”
Thank you so much,
You believed in me,
So I believed in me".