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Better Births – but why not better postnatal care?

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Editorial

National Health Service (NHS) organisations that provide maternity care in England are in the process of transforming local maternity systems (LMS) in response to the publication of *'Better Births: Improving outcomes of maternity services in England. A Five Year Forward View for maternity care'* (NHS England 2016). Since the report's publication, a series of initiatives have been launched across England to support local service providers to meet the ambition of 'Better Births', alongside similar initiatives for maternity care in Scotland and Wales. At the core of the policy map for NHS maternity care in England is a recommendation for *'continuity of carer to ensure safe care based on a relationship of mutual trust and respect in line with the woman's decisions'* (p9). Maternity service providers are expected to demonstrate how women will receive continuity from the person caring for them during pregnancy, birth and postnatally. Local maternity systems have been asked to put plans in place to meet these ambitions, with seven Early Adopter Local Maternity Systems taking forward the implementation.

That the UK maternity services are subject to major policy review is to be welcomed. Nevertheless, an important aspect remains neglected, namely postnatal care of women and their infants. From an organisational perspective, postnatal care is defined as the period of 6-8 weeks after birth, marking women's expected recovery from giving birth and the end of routine NHS maternity care (NICE 2006). Responsibility for postnatal care, which crosses secondary and primary healthcare sectors, traditionally includes obstetricians, midwives, health visitors and GPs (family doctors). Yet "Better Births" focusses only on postnatal care with respect to midwives who discharge most women from their care within 10-14 days of the birth.

For most women, the postnatal period and beyond are a continuum of their pregnancy and birth experiences, yet policy continues to address pregnancy rather than the crucial days, weeks and months which follow. This is despite successive Confidential Enquiries into maternal deaths in the UK and Ireland reporting that women are most likely to die following birth (Knight et al 2018). It also fails to take account of accumulating evidence of severe postnatal physical and psychological co-morbidity, complex social care needs and poor breastfeeding rates (Bick et al 2015). In 2015, the then Chief Medical Officer for England, Dame Sally Davies, published her report *'The Health of the 51%: Women'*. Chapter 8, entitled 'Post-pregnancy care: missed opportunities in the reproductive years', presented evidence which concluded that postnatal care was *'not fit for purpose, lacking any basis in either evidence or maternal need'* (p 97). This chapter, written by two authors of this editorial (DB and JS), focused on the lost opportunities for life-long reproductive and general health that occur uniquely in the time following birth (Bick et al 2015).

Despite 'Better Births' recognising the need for better postnatal and perinatal mental health care *'to address the historic underfunding and provision in these two vital areas, which can have a significant impact on the life chances and wellbeing of the woman, baby and family'* (p10), details of exactly what this meant or how it could be addressed were lacking. The recent reduction to the tariff for postnatal services offered by NHS England suggests that the 'historic underfunding' will not be reversed soon.

NHS England convened an expert reference group in 2017 to consider how postnatal care could be improved (ED and JS were members), but the report from this group will not be published.

The most glaring issue UK health administrations need to address is why, despite evidence of poor postnatal outcomes, policy consistently ignores postnatal care. For too many women, this is a deeply upsetting time, with fragmented care, and poor and/or conflicting advice on action to manage their own and their infant's health (NCT & Women's Institute 2017, Care Quality Commission 2019). The NHS Long-Term plan outlined several initiatives to reduce stillbirth and premature births and improve safety (NHS England 2019). Only three specific postnatal initiatives were included, namely provision of better perinatal mental health services for women with severe mental illness, baby-friendly accreditation of NHS maternity units and access to physiotherapists for women who experience incontinence or prolapse. There was no acknowledgement that women can experience a wide range of physical and psychological co-morbidities or how health problems in women will be identified and by whom.

Even if women do not appear to have had complex pregnancies, many cope with the burden of persistent incontinence, perineal pain and mild-moderate anxiety and depression. Little, if anything, has changed since we published our chapter (Bick et al 2015). A survey of 1,260 first-time mothers reported one in eight were highly critical of their postnatal care (Redshaw and Henderson 2015). An online survey of self-selected women found a third of 1,012 women who responded felt that their 6-8 week GP postnatal check did not meet their emotional needs, and a third that it was not thorough enough (NCT 2017). A more recent report from the NCT presented data from an online survey of women's experiences of the 6-8 week GP postnatal check. Over 1,000 women with children aged two years or younger responded to the survey, two-thirds of whom reported that the main focus of the contact was their infant. Around a third of the women reported that the contact included three minutes or less for their maternal check (NCT & NetMums 2019).

The health of UK women who become pregnant needs to be equally reflected in care planning before, during and following pregnancy. The most recent audit of clinical care provided in maternity units in England, Scotland and Wales reported that just over half of all women with a recorded Body Mass Index at pregnancy booking were overweight or obese (National Maternal and Perinatal Audit (NMPA) 2019), placing them at increased risk of poorer pregnancy outcome (van der Pligt et al 2013). Despite the NMPA covering all administrations in the UK, the small number of audit measures relevant to postnatal outcomes highlight a major limitation of how we record and measure care, with most measures only capturing the first few moments of postnatal care, for example the proportion of infants receiving skin to skin contact within one hour of birth. The wide variation in birth complications reported, including post-partum haemorrhage and severe perineal trauma (NMPA 2019) confirms that clinical skills and competencies are essential to prevent adverse maternal outcomes given the consequences for postnatal recovery and well-being.

It is difficult to collate data on exactly what postnatal contacts and care women receive, some NHS units offering phone calls and community clinic appointments, some offering a limited number of home visits from a midwife or Maternity Support Worker. Breastfeeding data are equally difficult to collate, with local authority areas in England responsible for the collation and return of quarterly data to Public Health England on breastfeeding rates at 6-8 weeks postpartum. Many local authorities fail to submit any data (144/698 in the last quarter reported, Public Health England 2019). There are anecdotal reports that postnatal readmissions are increasing as a consequence of maternal abdominal wound infections following a caesarean birth. A recent cross-sectional analysis of data on over one million infants readmitted to English hospitals within the first year of life between April 2008 and April 2014 for physiological jaundice, feeding difficulties and gastroenteritis, three conditions identified as

potentially preventable in the context of postnatal care provision, increased by 39% (39.55 to 55.33 per 1000 live births) relative to an overall increase of 6% (334.97 to 354.55 per 1000 live births) (Jones et al 2018). The biggest increase in admissions over the first year occurred in the first 0-6 days (RR 1.26, 95% CI 1.24 to 1.29) and 85% of this increase (12.36 to 18.23 per 1000 live births) was for these three potentially preventable conditions.

Readmission for potentially avoidable health problems is a clear indication that care following birth is not planned, prioritised or resourced appropriately. The current GP contract in England and Scotland for additional maternity services, requires GPs to provide care for the woman for the first 14 days and does not include the 6-8 week check. GPs may opt-out of providing maternity care altogether, despite being the 'gate-keepers' for women who need ongoing care, referral to other clinical services and pre-conception advice. That the health visiting service in England is now the responsibility of local authorities (rather than the NHS) places even greater barriers to provision of 'seamless' care following birth, unlike Scotland and Wales where the health visiting service remains part of NHS provision.

So why do UK policy reports continue to promote continuity of care for pregnant women as the main focus of recommendations? The Cochrane review on midwifery-led continuity of care models which presented data from 15 trials involving over 17,000 *low risk* pregnant women (Sandall et al 2016) is a main evidence source for current UK maternity policy. Only five included trials (one of which was a pilot trial) were from the UK and all were published between 1989 and 2003. No trials reported on longer-term outcomes such as incontinence, prolonged perineal pain or breastfeeding rates. Given recent evidence of higher levels of poorer health in women who become pregnant (NMPA 2019), increased interventions during labour and birth (NHS Digital 2019) and concerns about higher maternal mortality among Black and Asian women (Knight et al 2018), it is difficult to be optimistic that current policy drivers will improve outcomes if care following birth is not addressed.

Postnatal care in the UK is at a critical juncture. We have to consider long and hard what we want, given evidence that it is at least as important as antenatal care (if not more). If it is part of a woman's maternity journey we value, with the opportunity to support future maternal health, significant revisions are needed. These will have to be supported by evidence-informed policy, greater NHS investment, high quality data capture, appropriate clinical training and evidence of effective, safe models of care for *all* women. If we consider it is an historical artefact, with little added value, we continue to ignore and women will have to do the best they can. Current policy seems to adopt the latter view - the overwhelming evidence is that we need the former if we really are to achieve "Better births".

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