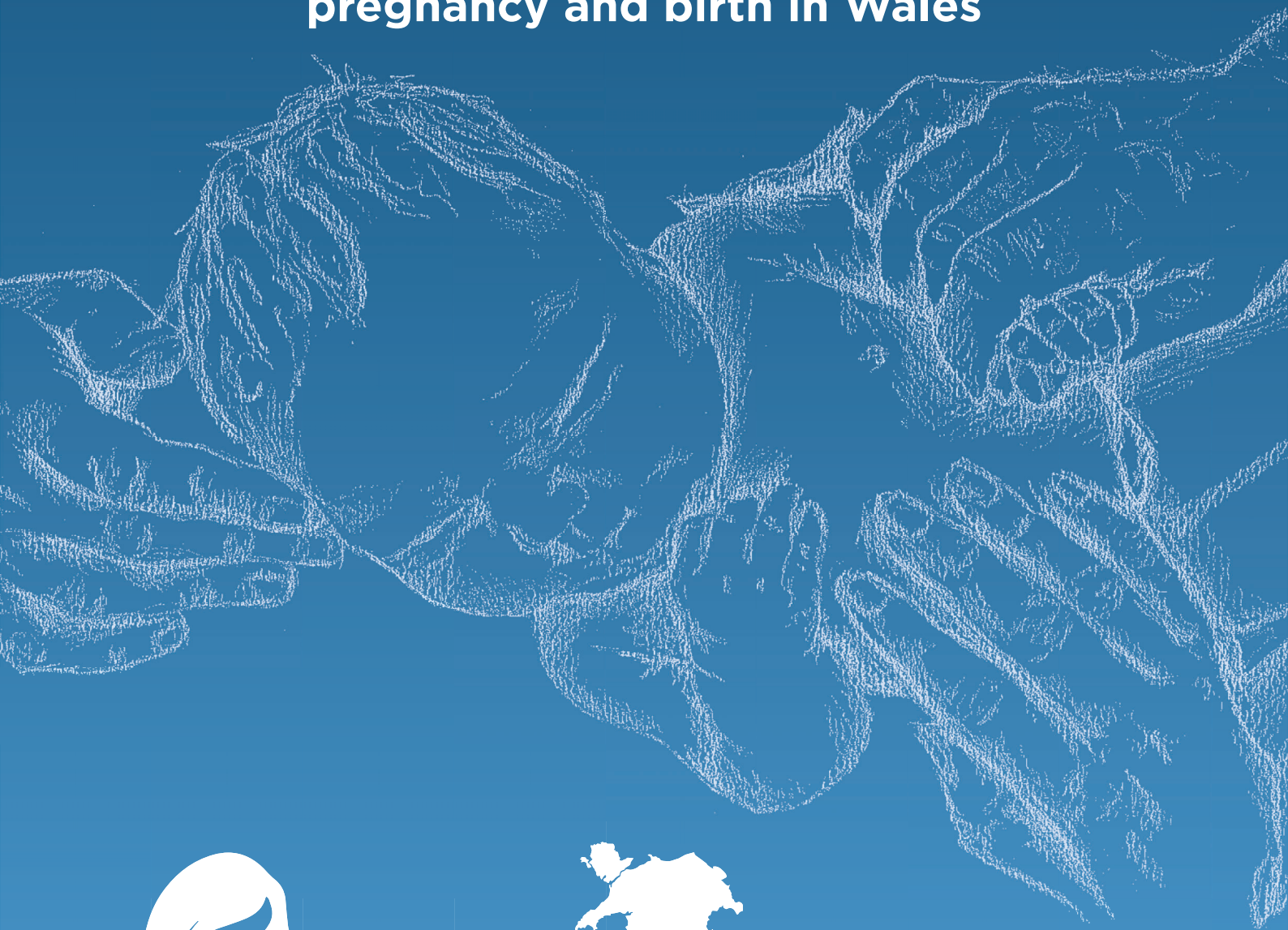


# Your Birth – We Care

**A Survey exploring women's experience of pregnancy and birth in Wales**



Consultant Midwives Cymru

**Heads of Midwifery Advisory Group  
H.O.M.A.G.**



Llywodraeth Cymru  
Welsh Government

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pregnancy and birth in Wales**



## Project Lead

Louise Taylor, Consultant Midwife, Aneurin Bevan University Health Board

## Research Associate

Emma Mills, Clinical Research Midwife, Aneurin Bevan University Health Board

## Project Team

Judith Cutter, Consultant Midwife, Cardiff and Vale University Health Board

Maggie Davies, Consultant Midwife, Abertawe Bro Morgannwg University Health Board

Polly Ferguson, Consultant Midwife, Betsi Cadwaladr University Health Board

Sarah Fox, Consultant Midwife, Abertawe Bro Morgannwg University Health Board

Abigail Holmes, Consultant Midwife, Cardiff and Vale University Health Board

Julia Sanders, Consultant Midwife, Cardiff and Vale University Health Board

## Stakeholder Group

Emily Brace, Midwife and Royal College of Midwives representative

Claire Brown, Service User

Dawn Davies, Senior Midwife, Cwm Taf University Health Board

Samantha Davies, Service User

Karen Jewell, Welsh Government Nursing Officer for Maternity and Early Years

Sharn Jones, Senior Midwife, Betsi Cadwaladr University Health Board

Shelly Jones, Senior Midwife, Powys Teaching Health Board

Ebba Lewis, Midwife, Hywel Dda University Health Board

Eleanor Lyle Thomas, Service User

Eryl O'Neill, Midwife, Cwm Taf University Health Board

Victoria Owens, Midwife, Abertawe Bro Morgannwg University Health Board

Kerry Phillips, Senior Midwife, Aneurin Bevan University Health Board

Rebecca Westbury, Midwife, Aneurin Bevan University Health Board

Lucy Williams, Service User



Consultant Midwives Cymru

**Author**



Llywodraeth Cymru  
Welsh Government

**Funded by**



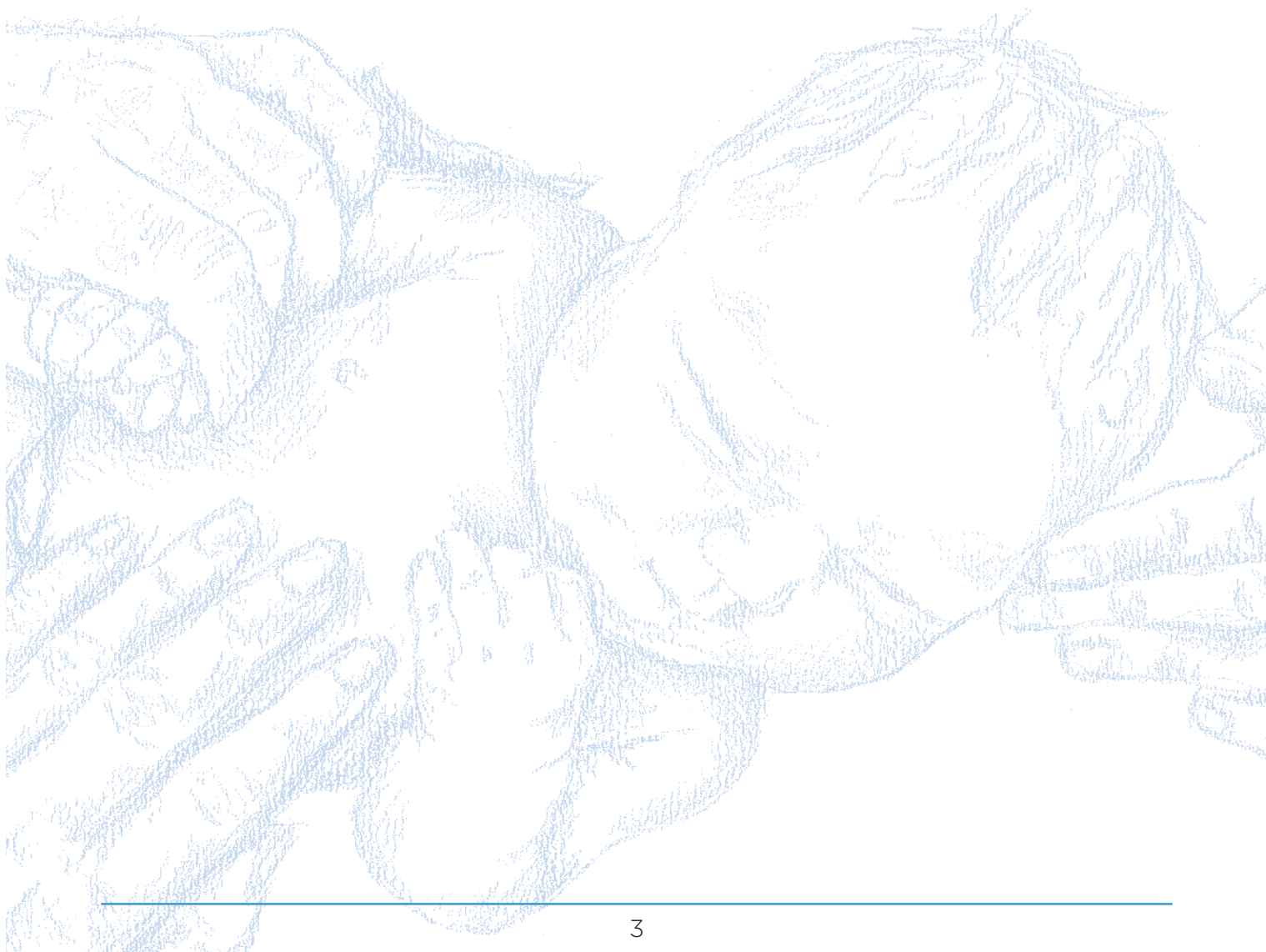
## Acknowledgements

We are immensely grateful to the women and their families who took the time to complete this survey. The response from women across Wales highlights a shared passion and enthusiasm for developing maternity services together.

Alongside the core project team, we would like to acknowledge the contribution from the wider stakeholder group and the service users whose down to earth approach supported us with the survey design and assisted in promotion of the survey in all areas of Wales.

This survey should be noted for the equal contribution provided by all seven Health Boards in Wales. It is a demonstration of our joint determination to improve and standardise maternity services for women in Wales, wherever they live.

The cover features Libby Dawn Preston, born in Wales on 3rd September 2017, kindly illustrated by Isabelle Taylor.



## Foreword

Childbirth is an important and momentous event in every family's life, which retains lifelong memories and begins the journey into parenthood. It is essential that we collectively ensure that maternity care provides positive experiences that meet the needs of women and families in Wales. Welsh Government commissioned this survey of all women who had birthed in Wales over the last year, as a gauge of where current services fit with expectations and what we can do better. The voice of service users is central to ensuring that maternity services are the best that they can be, in conjunction with a performance management framework that includes annual maternity performance data from each health board as an assurance to Welsh Government of quality and outcomes.

This survey provides valuable recommendations which will be utilised as part of a wider review of maternity services in Wales, which will culminate in a new 'prudent' vision for maternity care in Wales in spring 2018. The messages the survey provides in relation to quality of information, the importance of a named midwife and choices in care provision are key to future services. I would like to congratulate the team of Consultant Midwives in Wales and other stakeholders in the production of this excellent overview of women's views of maternity services in Wales.

Welsh Government is committed to the provision of world leading maternity services in Wales and proud of the current exemplars of best practice that are already shared across the world which originated in Wales. This document provides the foundation stone for the next phase in advancing services in Wales and ensuring that provision is planned together with families and listening to how services should be provided in the future.



**Professor Jean White CBE**  
**Chief Nursing Officer for Wales**

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## Definitions

The following definitions are based on the Birth Place National Cohort Study<sup>1</sup> (2011)

**Obstetric led units (OLUs)** are units based in hospitals that provide 24 hour services including medical, obstetric, neonatal and anaesthetic care. For women with perceived risk factors, obstetricians take responsibility for care during labour; however care is also supported and provided by midwives.

**Alongside midwifery led units (AMUs)** are based within hospitals but are separate from obstetric units. Midwives take responsibility for care during labour and support normal birth.

**Freestanding midwifery led units (FMUs)** are birth centres on a separate site from the nearest main hospital. Midwives take responsibility for care during labour and support normal birth.

**Home birth** refers to planned birth at home with care provided by midwives during labour and birth.

**Table 1** Glossary of terms

Alongside Midwifery Led Unit	AMU
Body Mass Index	BMI
Caesarean Section	C/S
Freestanding Midwifery Led Unit	FMU
Glucose Tolerance Test	GTT
Midwifery Led Care	MLC
Midwifery Led Unit	MLU
Maternity Services Liaison Committee	MSLC
National Childbirth Trust	NCT
National Health Service	NHS
National Institute for Clinical Excellence	NICE
National Perinatal Epidemiology Unit	NPEU
Obstetric Led Care	OLC
Obstetric Led Unit	OLU
Office of National Statistics	ONS
Vaginal Birth after Caesarean	VBAC



**Table 2****Place of residence by Health Board**

<b>Wrexham</b>	<b>Betsi Cadwaladr University Health Board</b>
<b>Gwynedd</b>	
<b>Flintshire</b>	
<b>Denbighshire</b>	
<b>Conwy</b>	
<b>Isle of Anglesey</b>	
<b>Powys</b>	<b>Powys Teaching Health Board</b>
<b>Carmarthenshire</b>	<b>Hywel Dda University Health Board</b>
<b>Ceredigion</b>	
<b>Pembrokeshire</b>	
<b>Neath Port Talbot</b>	<b>Abertawe Bro Morgannwg University Health Board</b>
<b>Swansea</b>	
<b>Bridgend</b>	
<b>Merthyr Tydfil</b>	<b>Cwm Taf University Health Board</b>
<b>Rhondda Cynon Taff</b>	
<b>Cardiff</b>	<b>Cardiff and Vale University Health Board</b>
<b>Vale of Glamorgan</b>	
<b>Blaenau Gwent</b>	<b>Aneurin Bevan University Health Board</b>
<b>Caerphilly</b>	
<b>Newport</b>	
<b>Torfaen</b>	
<b>Monmouthshire</b>	

## 1 Executive Summary

In 2015 Welsh Government wrote to all Health Boards requesting that they invest in services to prepare and implement plans that are in line with the findings of the National Maternity Review, as well as the NICE Guidelines on Intrapartum Care<sup>1</sup>. In particular, Health Boards were asked to note the evidence that suggests up to 45% of women could safely commence labour care in a midwife led setting<sup>2</sup>.

There are many factors that influence whether women plan to give birth in midwife led settings. One area that has not been recently explored in Wales is how women feel about planning birth at home or in a Midwifery Led Unit (MLU). As part of a plan to refresh the Strategic Vision for Maternity Services in Wales<sup>3</sup>, a two-day seminar was held in Spring 2016. Developed and planned in collaboration with Welsh Government and the Royal College of Midwives, the seminar brought together Heads of Midwifery, Consultant Midwives, Heads of Midwifery Education and Supervisors of Midwives from across Wales.

One area of discussion was how to offer women greater choice and control over the planning and organisation of their maternity care. The need for evaluation and improvement was identified. One of the recommendations from the seminar was that an all Wales survey of women's views should be carried out to ask women how they feel that they can be best supported to plan birth outside of an obstetric unit. Welsh Government agreed to fund a survey, and Consultant Midwives Cymru were requested to lead the project. The survey aim was to evaluate how well current antenatal services prepare women for labour, birth and parenting and to answer the question 'how can maternity services support women to feel confident for birth outside of an obstetric unit?' The intention was to develop a shared vision for the future of midwifery led services and how these can best meet the needs of its users. An online survey was developed which included thirty five questions presented in a variety of styles. To be eligible to participate women needed to have given birth in Wales within the previous 12 months. The survey was available to participants between February 13th 2017 and April 28th 2017. All quantitative data were analysed and described within parity subgroups. Thematic analysis was performed on open text data.

A total of 4,583 women responded to the survey of whom 3968 (86.6%) met the eligibility criteria and progressed to complete the full survey. Respondents represented all geographical areas of Wales. Women who had given birth to their first baby and those who had experienced previous births were equally represented. Women from all age groups completed the survey; the largest number of respondents ranging between 25 - 34 years of age.

This report presents a picture of women's experiences of planning for birth, as well as their experiences during labour. The survey results enhance understanding of what women value in maternity care, and service changes required to deliver the prudent maternity care agenda in Wales.

## Key Messages

### Models of Care

1. The majority of respondents knew whether they had received Midwifery Led Care or Obstetric Led Care.
2. Many women reported support from professionals for their birth place choices.
3. Some women reported a lack of information about birth choices or receiving biased information.
4. Understanding who was the professional responsible for their care was important to women.
5. The Birth Place Decisions leaflet has the potential to facilitate a positive discussion.
6. Many respondents reported being anxious about what would happen if an emergency situation occurred in an MLU.
7. Women urged midwives to create a supportive positive environment in all birth environments.
8. There is a lack of choice for women.
9. Some respondents believed that MLC is the best option for low risk women.
10. Some respondents reported a lack of standardization across Health Boards in relation to available facilities.



11. Less than half of the respondents were aware of all four options for place of birth.
12. The majority of women had planned birth outside of an OLU.
13. More women birthed in an OLU than planned to.

### **Antenatal information giving**

1. It was recognised that antenatal clinic appointments were an opportunity for midwives to discuss place of birth options with women.
2. Over half the respondents were informed about NHS antenatal classes by their midwife.
3. When antenatal clinic appointments felt rushed, the respondents perceived this to be due to staff shortages.
4. Women stated that rushed appointments affected their ability to build relationships with their midwife.
5. A high proportion of women did have the options for place of birth discussed during antenatal appointments but many commented that it was presented in a way that suggested the decision had already been made for them.
6. The majority of respondents choosing to attend NHS classes were primiparous.
7. Over half of the respondents found the NHS antenatal classes helpful and useful.
8. There was an underlying theme of sharing experiences with other mothers and mothers to be in the antenatal classes, and the positive benefit of this.
9. Respondents felt it was important that antenatal classes empower women and increase their confidence in their ability to have a natural birth.
10. The availability and accessibility of NHS antenatal classes varied across geographical areas.
11. Many women thought information about birth was insufficient in NHS antenatal classes and described various private classes as being useful and helpful.
12. Respondents found online research and also the NHS book 'Bump, Birth and Beyond' helpful, although they would like to see more information leaflets and to be directed to local maternity services websites.

13. Women stated that the person who they felt had the most influence on their decision making in relation to place of birth was their partner.
14. The person who provided the most valued information to help with decision making was the named midwife.
15. The highest percentage of respondents considered their named midwife as knowledgeable regarding pregnancy and birth.

### **Continuity of Carer**

1. The majority of respondents had a named midwife, although some mentioned them going on sick leave, changing jobs or being 'rotated' from community into a hospital role.
2. Most respondents saw their named midwife either for all or most of their antenatal appointments.
3. Respondents directly linked continuity of carer with good quality care.
4. Good continuity was perceived to generate more meaningful discussion.
5. The characteristics women rated most highly in their named midwife was being well informed and providing continuity, and seeing the same midwife.
6. Listening to women, being compassionate and avoiding unsupportive language were characteristics respondents valued highly in their midwife.
7. Kindness and trust were seen positively whilst 'keeping things formal' was of little importance.
8. Women considered that having what they perceived as a 'good' or 'bad' midwife had a direct impact on decision making and choice.
9. Empathetic midwives allayed fears and were perceived to reduce pain.
10. Respondents generally found their antenatal appointments positive and reassuring, enjoyable and/or the right length of time, however some women felt the appointments were rushed and of little value.

## Enabling Choice

1. Respondents wanted to understand why transfer out of a MLU in labour may be recommended, so that they could make an informed choice.
2. Respondents who were pre-warned that this could happen seemed to be more accepting of reasons for transfer to an OLU.
3. Women wanted to be informed whether transfer back to a MLU may be possible.
4. On occasions, due to a shortage of midwives, women who plan to birth in a MLU or at home have this option withdrawn once they are in labour.
5. Women recognised that transfer to an OLU was sometimes due to staffing levels, or internal systems, rather than clinical need.
6. Women described maternity services being busy with women planning a home or MLU birth being frequently directed to an OLU.
7. Many recognised that there were challenges within the maternity services, and valued efforts to support their birth choices when services are busy.
8. The uncertainty with getting ones first choice for birth place, increased the fear levels and anxiety for women.
9. Some respondents believed that the OLU was the default option for birth place.
10. Many respondents felt strongly about broadening the criteria for having the choice of birthing in a MLU so that more options were available to more women.
11. Women valued the opportunity for a birth discussion and believed that this could contribute to reducing unnecessary intervention.
12. Respecting women's choices and support throughout pregnancy and birth was viewed as essential for a positive birth experience.



## 2. Background

### 2.1 Strategic Vision

In 2011 the Strategic Vision for Maternity Services in Wales<sup>3</sup> was published, with the aim of endorsing a maternity service that

*'promotes pregnancy and childbirth as an event of social and emotional significance where women and their families are treated with dignity and respect. For every mother wherever they live and whatever their circumstances, pregnancy and childbirth will be a safe and positive experience so that she, her partner and family can begin parenting feeling confident, capable and well supported in giving their child a secure start in life.'*

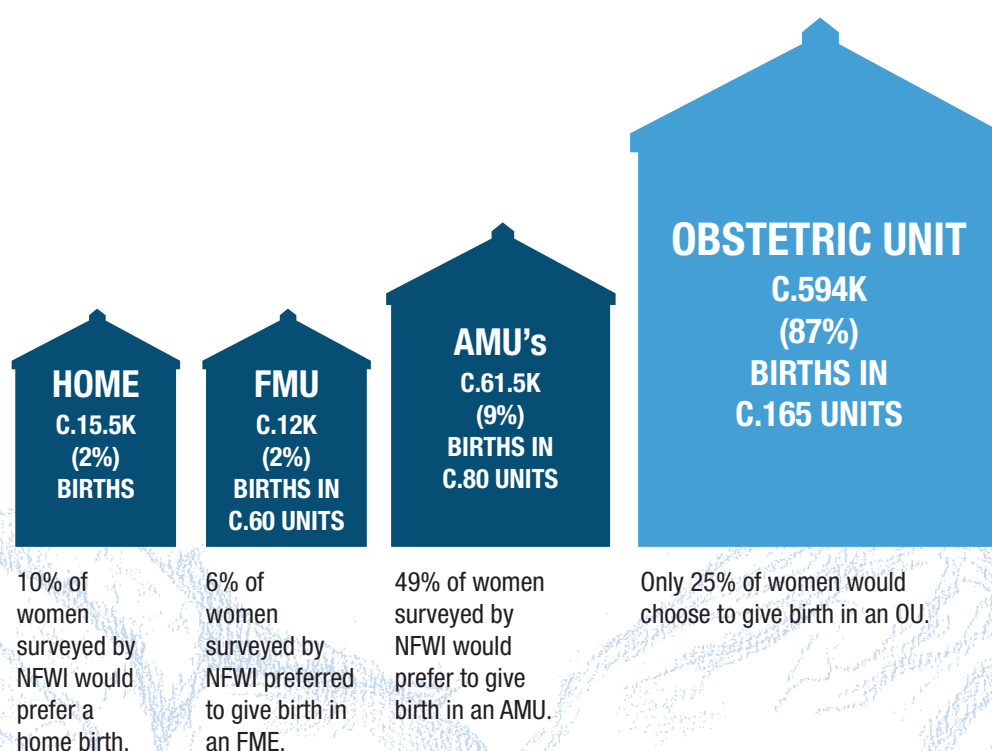
Providing a range of options for place of birth, in order that women can choose the most appropriate place for them, is a fundamental principle of women centred care. Much of the emphasis on implementing this vision has, to date, been on promoting healthy lifestyles and on ensuring that midwife led care and planning birth in a midwife led setting is available to all women who have a straightforward pregnancy.

Evidence to support decision making in relation to planned place of birth was published in the same year - 2011. The Birthplace National Cohort Study<sup>4</sup> provided high quality evidence about outcomes and cost associated with different planned settings for birth.

In terms of planning birth outside of an OLU, overall the study found that MLUs were as safe for the baby, with the proportion of babies with adverse outcomes similar to births planned in OLUs. However for women expecting their first baby, planning birth at home was found to be associated with an increase in adverse neonatal outcomes. MLUs were also found to be safe for the mother, and women who planned their birth in a MLU were significantly more likely to have a normal birth. Additionally for women having second or subsequent babies, planning birthing at home was found to be as safe as in OLUs for both mothers and babies.

## 2.2 Current care provision

A survey of over 5000 women in England and Wales by the National Maternity Review<sup>5</sup> found that women were not giving birth in their preferred place. It was found that 65% of women would choose to give birth at home or in a MLU. However, 87% of women gave birth in an OLU.



National Maternity Review 2016 NHS Five year forward view for maternity care (Page 20).

At present the proportion of women who commence labour outside an OLU, in the seven Health Boards in Wales is much lower than the 65% of women in England that stated this as their preference.

In 2015 Welsh Government wrote to all Health Boards requesting that they invest in services to prepare and implement plans that are in line with the findings of the National Maternity Review, as well as the NICE Guidelines on Intrapartum Care<sup>1</sup>.

In particular, Health Boards were asked to note the evidence that suggests up to 45% of women could safely commence labour care in a midwife led setting<sup>2</sup>.

There are many factors that influence whether women plan to give birth in midwife led settings. These include the availability of local services, general health of pregnant women, midwives' attitudes and skills and the availability of unbiased evidence based information and support for women and their families. However, one area that has not been recently explored in Wales is how women feel about planning birth at home or in a MLU.

## 2.3 What do women want?

In 2009, the Wales Audit Office published a national report entitled *Maternity Services in Wales* that included a survey of women's views of their maternity care. No national survey of maternity care has been repeated in Wales since that time.

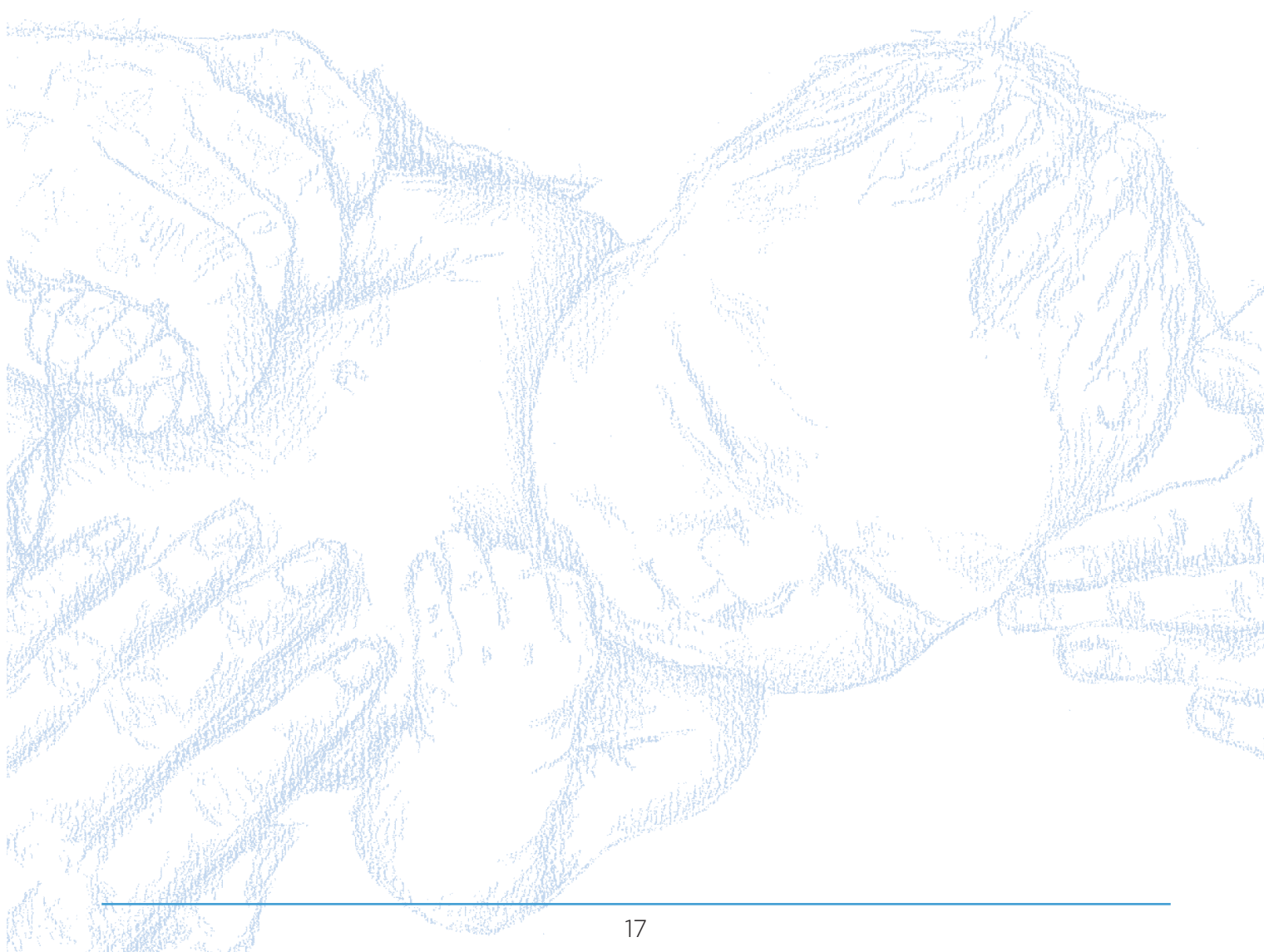
As part of a plan to refresh the Strategic Vision for Maternity Services in Wales, a two-day seminar was held in spring 2016. Developed and planned in collaboration with Welsh Government and the Royal College of Midwives, the seminar brought together Heads of Midwifery, Consultant Midwives, Heads of Midwifery Education and Supervisors of Midwives from across Wales. All Wales principles for prudent maternity care were developed. These included *'Healthcare which is conceived, managed and delivered in a cautious and wise way characterised by forethought, vigilance and careful budgeting which achieves tangible benefits and quality outcomes for patients'*.

One area of discussion was how to offer women greater choice and control over the planning and organisation of their maternity care. Although maternity services in Wales have a strong history of involving women, the need for evaluation and improvement was identified.

One of the recommendations from the seminar was that an all Wales survey of women's views should be carried out to ask women how they feel that they can be best supported to plan birth outside of an obstetric unit.



Welsh Government agreed to fund a survey, and Consultant Midwives Cymru were requested to lead the project. The survey aim was to evaluate women's views of antenatal services and how well current service provisions prepare women for labour, birth and parenting and to answer the question 'how can community midwifery services support women to feel confident for birth outside of an obstetric unit?' The intention was to develop a shared vision for the future of midwifery led services and how these can best meet the needs of its users.



### 3. Methods

#### 3.1 The survey

A working group with a core of the seven consultant midwives employed in Wales was established. All Health Boards were requested to nominate representatives from senior midwifery management, midwives and service users to join the stakeholder group, and the Royal College of Midwives, Maternity Services Liaison Committee, student midwives and midwifery education were also represented.

In order to reach a large population of mothers with young babies, an easily accessible tool was required for data collection. For this reason an online survey was selected as the survey tool. The survey was supported by a Facebook page that encouraged group discussion around some preliminary findings of the survey.

Survey monkey was selected as the host for the survey being confidential, easy to use, good value for money, and with excellent data collection and analysis tools. The survey involved thirty five questions presented in a variety of styles including multiple choice, free text, sliding scales and rankings. Although structured question formats were mainly used, the free text option gave women the opportunity to clarify points and express their views if desired. Prior to use service users and representatives from the Maternity Services Liaison Committee (MSLC) checked the survey for readability and appropriateness of questions.

Translators recommended by Public Health Wales were used to translate the survey and all the promotional material into Welsh, so that women completing the survey had the choice to do so in either English or Welsh.

Questions relating to participant's demographic characteristics were used including geographical area of residence, age and parity. This was both to be able to describe respondents, but also to be able to identify if any social groups were under-represented in order that they could be specifically targeted and encouraged to complete the survey. The geographical areas covered Wales and respondents were given the option of adding their postcode.

An introduction to the survey provided information on who was conducting the survey and how results would be used. Midwifery terms were explained in lay language and it was confirmed that the survey was confidential. Women were informed that participation in the survey was optional and no identifiable information was to be recorded.

The survey was available for use on a desktop or laptop computer and also for use on a tablet, phone or other handheld device. A contact email was included for the project lead in case respondents wanted to complete the survey in any other languages via language-line. As the survey was a service evaluation under the NHS Research and Development Governance Framework, NHS research ethical approval was not required. Approval for the service evaluation was obtained via Aneurin Bevan University Health Board.

### **3.2 The sample**

To be eligible to participate women needed to have given birth in Wales within the previous 12 months. The first question confirmed the woman met the eligibility criteria and, if not, the survey directed the respondent to the end of the survey and thanked them for their time. There were 30,675 births in Wales in 2015-16<sup>6</sup> and it was considered that a 10% sample, 3,000 respondents, would be sufficient to meet the survey objectives.

### **3.3 Data Collection**

The survey was available to participants between the 13th of February 2017 and the 28th of April 2017. It is acknowledged that women with certain social demographic characteristics, for example teenage mothers, may be under-represented in the survey responses. The survey was initially to run for one month, but was kept open for longer to give further opportunity for promotion and participation amongst less represented groups.

### **3.4 Data Analysis**

All quantitative data were analysed and described within parity subgroups. Thematic analysis was performed on the open text qualitative data.



## 4. Results

### 4.1 Participants

A total of 4,583 women responded to the survey of whom 75.0% (N=3726) responded in the first month, including 3437 who responded in the first week. Amongst the respondents, 3968 women (86.6%) met the eligibility criteria and progressed to the full survey.

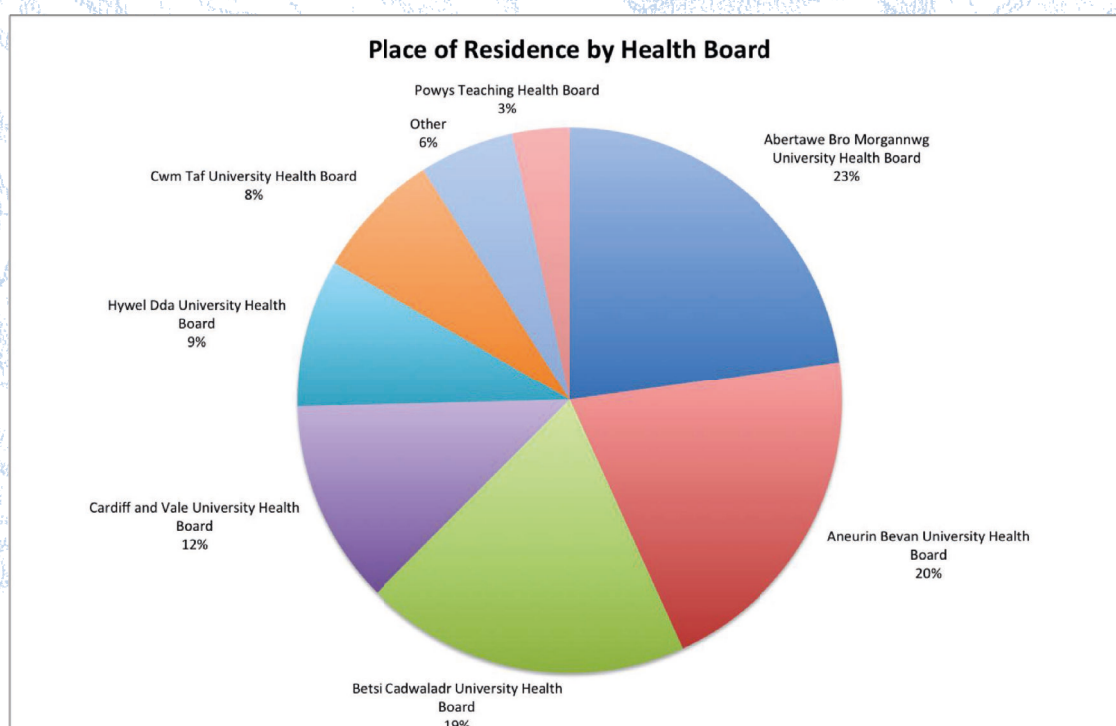
### 4.2 Parity

Amongst respondents 51.2% (N=1914) were primiparous, 33.3% (N=1247) had two children, 10.9% (N=406) three, 3.0% (N=112) four and 1.7% (N=63) five or more.

### 4.3 Geographical demographics

Respondents represented all geographical areas of Wales. 98.4% of respondents completed the survey in English language, whereas 67 women completed the survey in Welsh language which accounted for 1.6% of overall respondents. The majority of women completing the survey in the Welsh language were from North and West Wales. Women were asked which county they lived in rather than which Health Board they gave birth in. However, in order to support Health Boards to interpret the survey responses locally the geographical data is presented in Health Boards.

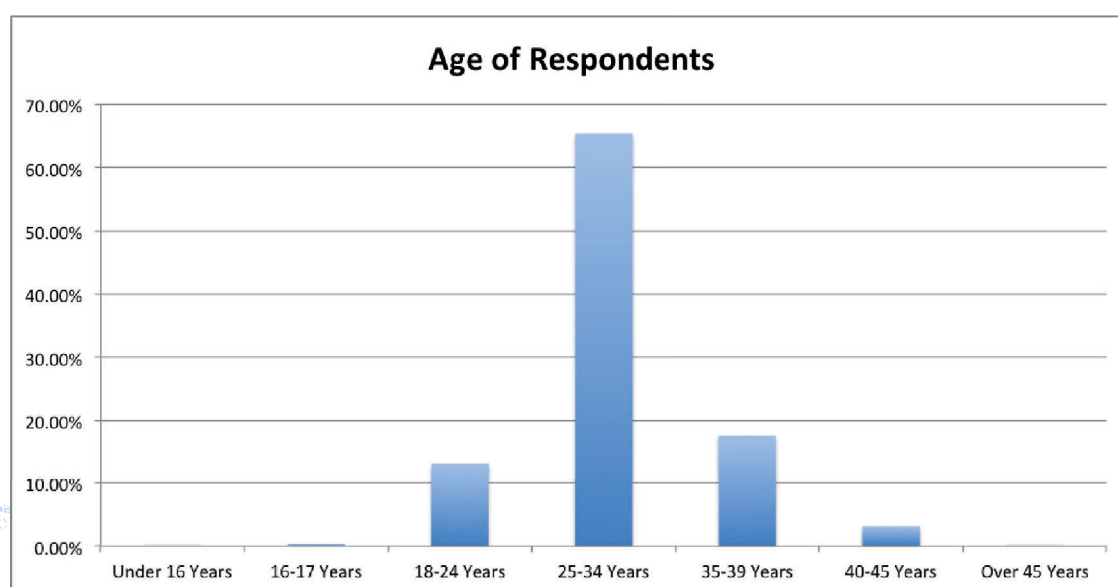
**Figure 1**



## 4.4 Age

Age categories were classified according to the Office of National Statistics' recommendations. Of respondents 0.2% (N=6) were under 16, 0.3% (N=10) were aged 16-17, 13.2% (N=491) aged 18-24, 65.5% (N=2441) aged 25-34, 17.7% (N=658) aged 35-39, 3.1% (N=117) aged 40-45 and 0.2% (N=6) were over 45. The percentages in the sample were considered to reflect the age of childbearing women in the UK, with the current average age being 34 years.

**Figure 2**



## 4.5 Models of Care

Respondents were asked if, to their knowledge, they received MLC or OLC for their pregnancy and birth. 33.4% (N=1287) responded that they received MLC, whilst 31.8% (N=1189) received OLC. A further 21.3% (N=796) began with MLC but were then transferred to OLC, whilst 6.4% (N=239) of women began as OLC and were transferred to MLC.

A similar proportion of primiparous and multiparous reported receiving MLC or OLC, however fewer multiparous women began as MLC and then became OLC, and in contrast a higher percentage of multiparous women began under OLC and transferred to MLC. This was further explored in the qualitative data analysis where reasons such as assertiveness and a greater understanding of the birth process are considered.

Some women were unsure of their care pathway, 2.8% (N=106), and 3.2% (N=120) of respondents replied with 'other'. Further analysis revealed that the majority of such respondents would fit into the category of either 'I began as MLC and transferred to OLC' or the reverse, 'I began as OLC and transferred to MLC'.

Some reasons given by respondents for being unable to give a definite response included

*'I was midwifery led care until I had premature rupture of membranes', 'I was midwifery led care until 38 weeks but was found to have reduced waters so I was transferred to consultant care' and 'I was midwifery led care until I was admitted for induction due to being two weeks overdue'.*

Some respondents described being transferred several times between MLC and OLC and one respondent who was having her second baby replied

*'I was initially midwife led, then had a sub-chorionic haematoma so became obstetric led, but transferred by the consultant back to midwifery led care at 35 weeks'.*

This woman had her choice of a home birth at term, a positive impact of being transferred back to MLC.

Respondents were asked if, at the beginning of their pregnancy, they were considered to meet the criteria for MLC. Of women who responded to this question 58.8% (N=2191) stated they met the criteria for MLC. Of the 31.2% (N=1161) of respondents who were advised that they were not suitable for MLC, the reasons given included waiting for results

*'I could be Midwifery Led care if my platelet count is okay', 'I can be midwifery care if my GTT is normal'*

and history of medical or obstetric complications including a family history of deep vein thrombosis, previous caesarean, cardiac problems, previous recurrent urinary tract infections or mental health problems.



One woman said that

*'I was told I could choose'*

but did not elaborate on her obstetric or medical history. Her responses to other questions show that she chose to give birth in an OLU and felt happy with her antenatal care.

Women were informed in the survey that midwives in Wales are committed to providing choice in regards to place of birth, and it is hoped that women will share this vision. Respondents were asked to comment on their experience of choice in relation to planned place of birth and 23.3% (N=926) of women answered this question.

Some women commented positively

*'...they supported my decision to opt for elective c-section due to prior emergency section with first baby'. 'I felt very supported choosing a home birth for my first pregnancy and would do so again' as well as another saying 'I was given a lot of information and all my questions were answered...'*

A high proportion of women's responses related to a lack of information about choice or biased unhelpful information.

*'Present women with options and let them choose. Don't just inform them that as they are high/low risk they will be delivering in one particular area' and 'I was given no info, so anything would've been nice, at least this time round I have a better idea of my options and if able I will be going to the birth centre again'.*

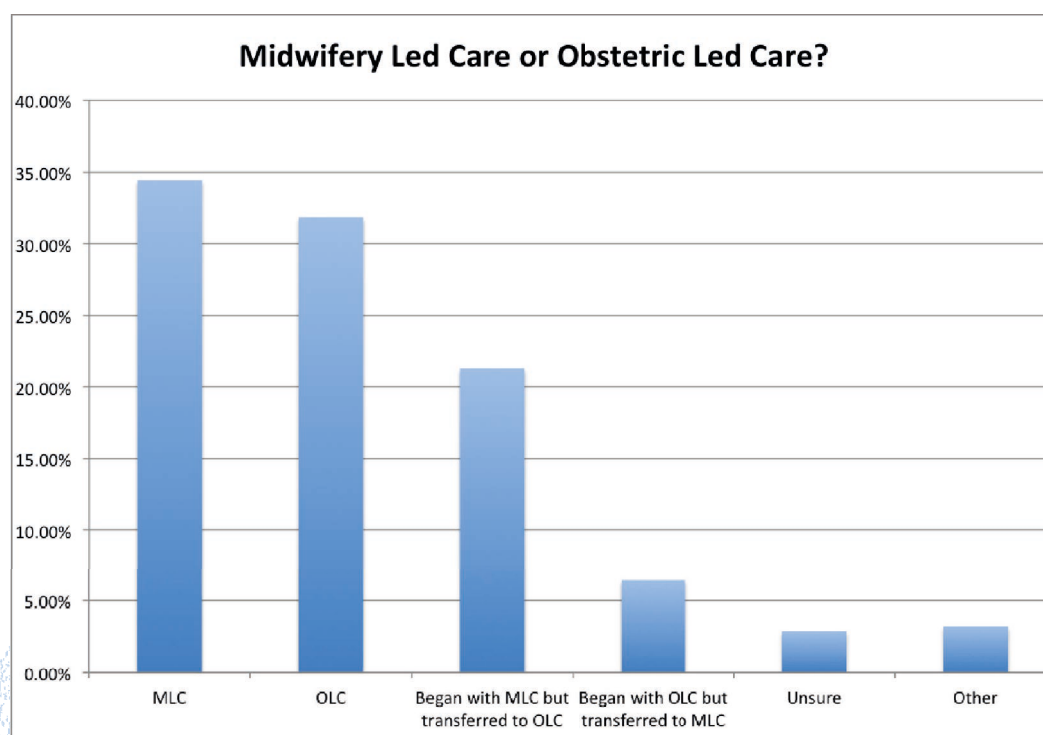
Many women responded that home birth was not discussed enough and felt that this needs to be addressed

*'encourage more home births. I feel it was quicker and more relaxing in my own home. I also feel I've recovered quicker from it than other women in the ward'.*

Further education in birth choices was a recurring theme throughout not only data analysis in regards to supporting choice around place of birth, but also in relation to comparative questions.

*'I personally would never opt for a home birth however I feel that maybe a more in depth seminar or workshop solely on home birth may help encourage more mothers to consider home birthing'.*

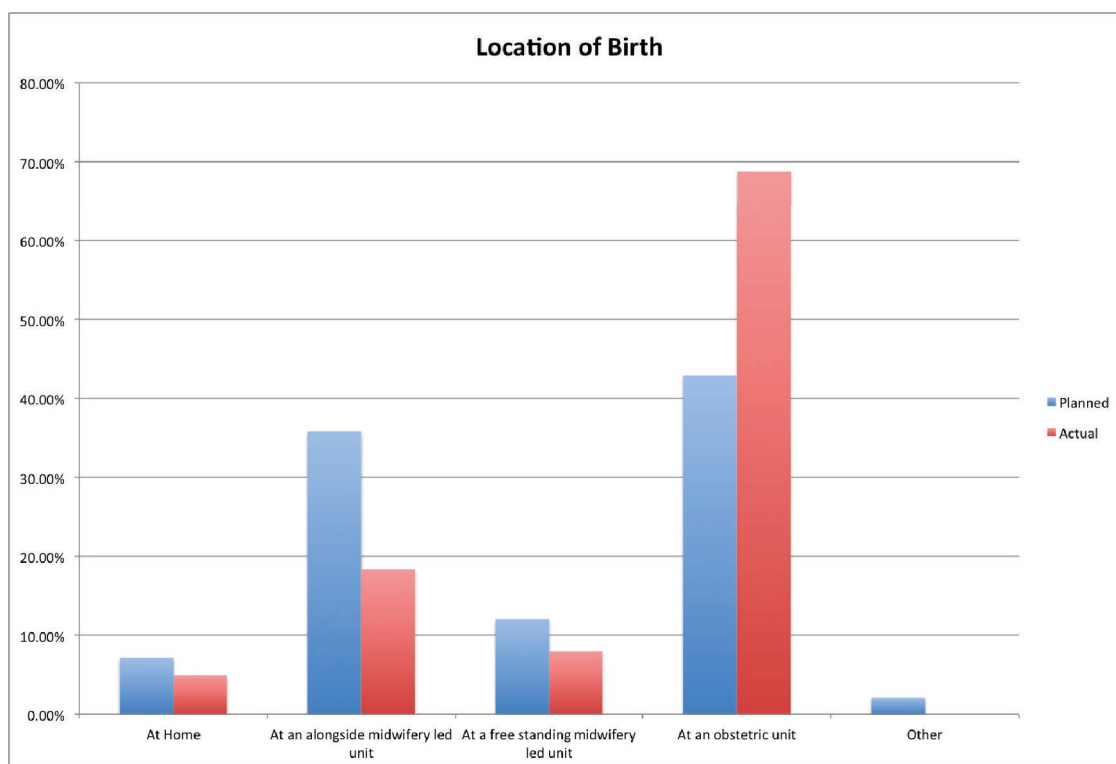
**Figure 3**



### 1.1 Planned and actual place of birth

Women were asked where they planned to give birth and also where they actually gave birth. The majority of women, 55% (N=2049), planned to give birth in a midwifery led setting. Of the women who planned birth in Midwifery led settings 56% (N=1160) did so, and 44% (N=889) gave birth in an obstetric unit. Women were not asked specifically when they were transferred to obstetric care, for some women this would have been in the antenatal period and for other women, during labour.

The following figure and table show the proportion of all respondents who planned and gave birth in each individual birth setting. In Table 3 the planned and actual places of birth are described separately for primiparous and multiparous women.

**Figure 4****Table 3****Planned and actual place of birth by parity**

	Primiparous*		Multiparous*	
	Planned N (%)	Actual N (%)	Planned N (%)	Actual N (%)
Home	87 (4.6)	54 (2.8)	187 (10.4)	128 (7.1)
FMU	267 (14.2)	128 (6.7)	182 (10.2)	168 (9.3)
AMU	820 (43.8)	340 (17.8)	514 (28.8)	342 (18.9)
OU	697 (37.2)	1381 (72.6)	901 (50.5)	1174 (64.8)
Total*	<b>1871</b>	<b>1903</b>	<b>1784</b>	<b>1812</b>

\*Numbers differ slightly due to missing data



### 4.5.1 Home

Overall 7.5% (N=274) of respondents planned to give birth at home and 4.9% (N=182) gave birth at home. Of the respondents planning to give birth at home, 31.7% were primiparous and 67.3% were multiparous.

Amongst women who planned birth at home, the proportions who gave birth at home, for primiparous and multiparous women were 62.1% (N=54) and 68.4% (N=128) respectively.

### 4.5.2 Freestanding Midwifery Led Unit

Overall 12.3% (N=449) of respondents planned to give birth in a FMU and 8% (N=182) gave birth at a FMU. Of the respondents planning to give birth in a FMU 59.4% were primiparous women and 40.5% were multiparous. Amongst women who planned birth in a FMU, the proportions who gave birth in a FMU, for primiparous and multiparous women were 47.9% (N=128) and 92.3% (N=168) respectively.

### 4.5.3 Alongside Midwifery Led Unit

Overall 36.5% (N=1334) of respondents planned to give birth in an AMU and 18.4% (N=682) gave birth in an AMU. Of the respondents planning to birth in an AMU, 61.5% (N=820) were primiparous and 38.5% (N=514) were multiparous. Amongst women who planned birth in an AMU, the proportions who gave birth in an AMU, for primiparous and multiparous women were 41.5% (N=340) and 66.5% (N=342) respectively.

### 4.5.4 Obstetric Led Unit

Reflecting transfers to obstetric led care or settings during the antenatal and intrapartum periods, 42.9% (N=1598) of respondents planned to give birth in an OLU and 68.8% (N=2555) gave birth in an OLU. Some respondents (N=176) provided additional text to explain further where they had actually given birth. The majority of responders described having had a planned caesarean section, induction of labour or conditions such as obstetric cholestasis. One woman stated that reasons may be complex

*'I was told I would have to be obstetric led and give birth in hospital. During my pregnancy I was given reasons for this by different doctors (high BMI/ taking antidepressants/asthma) but nobody was specific'.*

The quality of information giving and informed choice was further explored in the survey.

#### 4.5.5 Promoting normal birth in a midwifery led setting

Women were asked how promoting the option of a midwifery led setting for birth could be improved. 19.9% (N=790) of women answered this optional question- 19.9% (N=157) responses were excluded as not relating to the question, and 80.1% (N=633) responses were included in the thematic analysis.

There was evidence in the responses that MLC in labour is already perceived as the best option by many women.

*'I think it's a tricky one as in my experience the midwife led units are heralded as the best option and most other births are seen as "lesser"' 'To be fair I think the team at my midwifery led unit have nailed it. So it's a bit tough to write anything on how they could do better'. 'Make the midwife unit the default place for women with no complications'.*

Some of the responses suggested that there is a need to ensure that midwives and obstetricians have a positive attitude to all options for birth, and that attention is given to creating a pleasant and reassuring environment in all areas.

*'Important to make sure that in all the promotion of the MLU, the labour Ward doesn't seem like a scary "bad" option, which is what I think it became in my head until I went to see the labour ward and met the midwives there'. 'I'd like to see more done to bring elements of midwifery care to obstetric settings. I don't like the fact that anyone who doesn't qualify for the MLU is condemned to the bright lights and high beds. All the rooms should be welcoming and calm with equipment added as necessary'.*

A number of respondents stated that all Health Boards should offer up to date facilities in order to provide a suitable environment for birth. This includes increasing the number of MLUs and availability of birth pools.

*'Greater availability of birth pools is so important. I was very lucky but I know so many people who have missed out on the opportunity and the natural pain relief it offers'. 'I had to get out of the pool in the final stages of labour as the pool had begun to leak and there wasn't enough water for a safe delivery.....The midwife assigned to me was wonderful, so calm and reassuring. Sadly the equipment let her down and I didn't get the water birth I had hoped for'. 'More availability to units that are midwife led'.*

Fear was a common thread running through many responses. These responses and themes mirrored analysis of earlier parts of the survey with many women believing that reassurance should be given about planning birth in a MLU and that midwives needed to provide clear information about what would happen if the labour did not progress as anticipated.

*'I think people tend to be scared to come away from the labour ward in case anything goes wrong whilst giving birth. I personally didn't want to as I had heard so many horror stories about what could go wrong. I wanted to be in the safest place for me and my baby even though it wasn't the most relaxing restful place'.*

Some women were unconvinced that midwifery led settings provided a safe option:

*'Birth is an inherently dangerous process and it should always take place in a hospital under the supervision of obstetricians'.*

Other respondents felt women should be informed of the risk of additional interventions associated with planning birth in an obstetric unit

*'Emphasising that giving birth in a maternity led unit means a lower risk of intervention and explain the risks of those interventions'.*



AMUs were viewed by a number of respondents as a more reassuring option than a FMU. Access to emergency care and the need to transfer by ambulance to another unit during labour was a concern voiced in responses.

*'I think if the unit is attached to the hospital then it would be more reassuring to those afraid of things going wrong'. 'More MLUs in alongside units as these provide a far safer option for both mother and baby. The freestanding MLU in my area is a 30 minute drive from an obstetric unit which I feel is far too risky should there be a complication during labour'. 'I would have loved a MLU birth but the lack of an obstetrician on site totally put me off this option. I needed intervention with my first child and the thought of having to be transferred frightened me'.*

It is recognised that over the last 5 years there have been various adverse media campaigns across the UK regarding birth in FMLUs which may add to women's concern regarding safety.

#### 4.5.6 Communication

Women were asked how they felt promotion of birth in a midwifery led setting could be enhanced, with responses around the theme of improved communication. It was suggested that midwives should take the time and opportunity to promote the MLUs earlier in the pregnancy, particularly during antenatal classes.

*'Be very open with women from the start of their pregnancy that they have choices.....I thought birthing units didn't exist and that you had to give birth in a hospital for your first baby. I found out this was untrue half way through my pregnancy' 'I feel a mindset change early on in pregnancy would be more beneficial. If mums were made aware of the benefits of a calm and rational birth scenario and bought into this concept, they would seek an environment to support it'. 'Discussing this earlier on- I asked when we would talk about planning the birth and was told it wasn't until week 36'.*

*'Consistent information about my birth choices I would have liked to have felt more able to discuss options with the obstetricians rather than just got an 'any questions' at the end of an appointment and for the midwife present to have facilitated this on my behalf. I felt like the onus was on me to research and question medical advice and found that stressful. Just being told that option 1 is clinically indicated based on best practice guidelines but these options are available but not recommended and here's why. Even being directed to information would have been nice and better than Dr Google.'*

A number of responses related to using the preconception period to prepare women physically and mentally for pregnancy so decreasing the chances of pregnancy complications

*'Promotion of pre pregnancy health to reduce risk and open this option to more mothers'.*

Some women described confusion around who was responsible for their care and talked about both their obstetrician and midwife assuming each other was seeing her regularly. One woman (reflected by others) said

*'I didn't really see anyone it was like my midwife thought I was seeing an obstetric team and the obstetrics team thought I was seeing a midwife but I wasn't seeing anyone except the lady who was giving me growth scans every month'.*

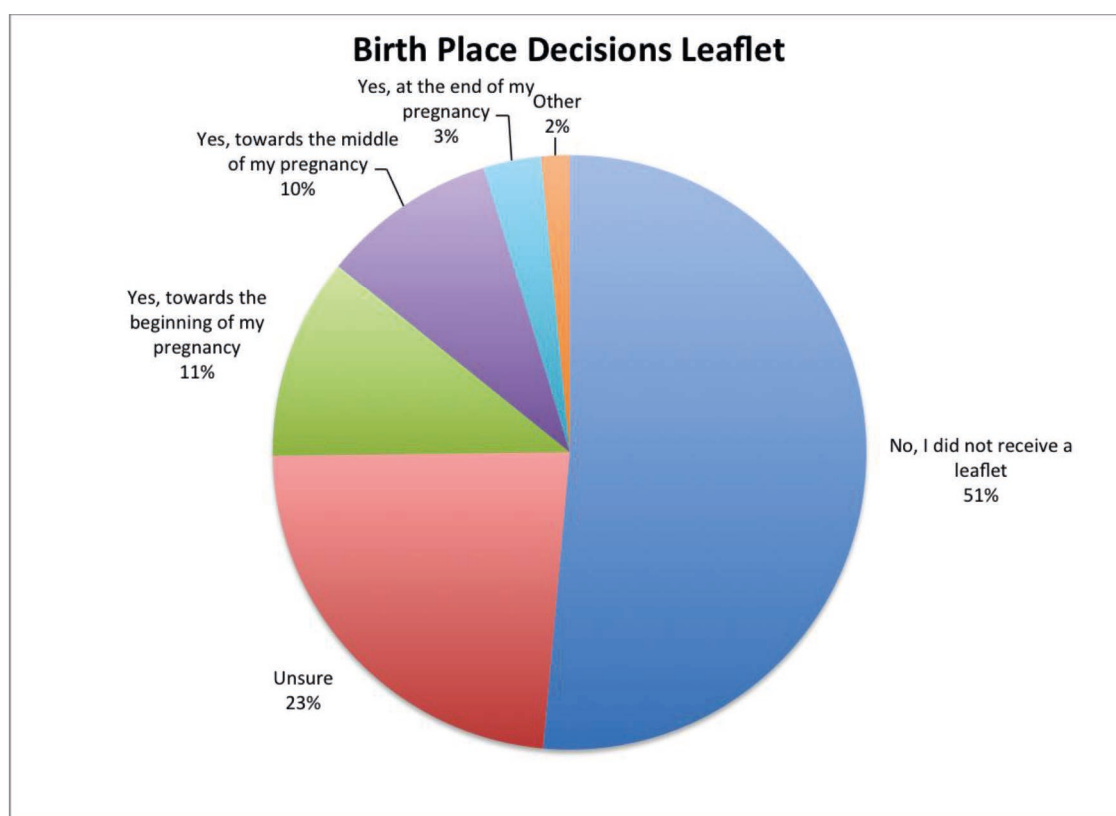
Women also expressed enhanced fear and anxiety;

*'I was told every time how high risk I was making me more anxious as they only focussed how dangerous the pregnancy was'.*

#### 4.5.7 The Birth Place Decisions Leaflet

The *Birth Place Decisions leaflet*<sup>7</sup> was adopted by Heads of Midwifery in 2016 for use across Wales to inform all women of their options for place of birth. Although every pregnant woman in Wales should have access to the leaflet, it is recognised that in 2016 distribution varied between Health Boards due to printing, informing staff and other factors. However, the *Consultant Midwife Cymru* group were interested to know how many women had access to the leaflet when making decisions.

There was difference in parity in relation to women receiving the *Birth Place Decisions Leaflet*. Of the 23.7% (N=657) of respondents who were aware of receiving a leaflet, 58.6% (N=385) were primiparous. 51.4% (N=1429) of respondents did not receive a leaflet and 23.4% (N=649) were unsure.

**Figure 5**

To compare responses as to whether a *Birth Place Decisions Leaflet* was received and potentially how that could have impacted on decision making, respondents were asked what options of place of birth they were aware of.

It is likely that women's choices in relation to their stated options of place for birth were influenced by their locality and the facilities available in their area. The large majority of women knew about OLU and home as options for birth (92.3% (N=2560) and 79.8% (N=2212) respectively). The percentages however dropped in relation to awareness of both FMUs and AMUs, with 52.2% (N=1446) of women aware of both or either options. The responses varied by parity. In rural geographical areas (e.g. Powys) women were more aware of a FMU as an available option (89.3% (N=83) of women) but fewer than 50.0% (N=42) were aware of the option of an AMU.

It is also recognised that the Birth Place Decisions leaflet was not the only way women were able to find out about birth place options as each Health Board also had individual ways of sharing this information including other leaflets and discussions.



#### 4.5.8 The ability to make a choice

Respondents were asked whether they had felt able to make a choice about their place for birth. Around half of the respondents (49.4%, N=1367) were aware of all of the available options and able to make a choice. A further 33.0% (N=913) were aware of all of the available options but felt their choice was restricted due to medical or obstetric complications, and therefore, perceived their birth place options to be limited.

Only 5.1% (N=142) of women said they were not aware of options for place of birth, and 4.2% (N=116) felt unsupported when they made a choice. There was no difference in parity; however, the majority of women responding to this question were primiparous.

*'Give pregnant women more information.....give suggested reading lists/links to decent websites for those who want them'. 'More information and literature for birthing centres so people can visually see the difference in the environment compared to a hospital ward. If the benefits of a midwifery led setting were laid out clearly in a leaflet then mothers could make a more informed decision and may be more likely to consider a birthing centre. Access to a website giving reviews and personal experiences would also help mothers to consider birth centres'.*

#### 4.5.9 Models of Care Key Points

1. The majority of respondents knew whether they had received MLC or OLC.
2. Many women reported support from professionals for their birth place choices.
3. Some women reported a lack of information about birth choices or biased information.
4. Understanding who was the professional responsible for their care was important to women.
5. The Birth Place Decisions leaflet has the potential to facilitate a positive discussion.
6. Many respondents reported being anxious about what would happen if an emergency situation occurred in an MLU.

7. Women urged midwives to create a supportive positive environment in all birth environments.
8. There is a lack of choice for women.
9. Some respondents believed that MLC is the best option for low risk women.
10. Some respondents reported a lack of standardization across Health Boards in relation to available facilities.
11. Less than half responders were aware of all four options for place of birth.
12. The majority of women had planned birth outside of an OLU.
13. More women birthed in an OLU than planned to.

#### **4.5.10 Models of care Discussion**

A higher proportion of multiparous women planned birth in an OLU, probably reflecting complexity of obstetric history. Assertiveness and experience may contribute to women achieving their planned place of birth and is a characteristic more commonly associated with multiparous women. Many women felt supported by professionals in their birth place choices, whilst others reported lack of information about choices or biased information impacting on decision making.

The majority of women planned birth under MLC. This suggests strong support and confidence in the service. There are many factors that lead to a woman not giving birth where she had planned. Many of these factors would have occurred prior to the onset of labour, so the reduction in the proportions of women giving birth in MLC settings does not reflect an intrapartum transfer rate. The challenge for the maternity services is to increase the proportion of women planning birth under MLC, but also to reduce the proportion of women requiring transfer to obstetric care during the antenatal and intrapartum periods.

The survey figure for homebirths was above the Welsh rate of 2.3%<sup>6</sup> suggesting that women who birthed at home were more likely to participate in the survey.

Greater numbers of respondents planned to birth in an AMU than a FMU reflecting their geographical locations in areas of highest population density.

A greater proportion of primiparous women did not give birth where they had planned, this would be expected due to higher proportions requiring induction due to 'post dates' and higher intrapartum transfer rates amongst women starting labour in an AMU.

Survey responses suggest that poor environments, in obstetric units impact women's comfort, relaxation and belief in their ability to birth naturally without intervention. It remains a challenge to provide women with appropriate birth environments in all maternity settings.

Many respondents reported being anxious about what would happen if an emergency situation occurred in a MLU where there were no doctors. This was particularly relevant to women who had concerns about ambulance transfer times from a FMU to the nearest OLU, indicating a need for clear and consistent information for women on all birth settings.

Communication of the available options and benefits of MLU early in pregnancy and the promotion of healthy lifestyles was identified by a number of respondents as useful in supporting women to be confident in their ability to have a natural birth in an MLU.

Women considered it important and reassuring to know which professional was responsible for their care, but this was not always women's experience. Women who felt unable to develop a relationship with their main care giver reported experiencing higher anxiety levels, conflicting information and less compassion and understanding around birth choices.

A lack of awareness of all four options for place of birth may reflect the limited options available in some areas of Wales. Additionally midwives and obstetricians may assume that when the criterion for MLC is not met, women are content to accept OLC as the only option.

When women outside of conventional criteria desire to plan birth in a MLU setting they should be referred to a consultant midwife who can provide relevant individualised information and support the woman in her choice.



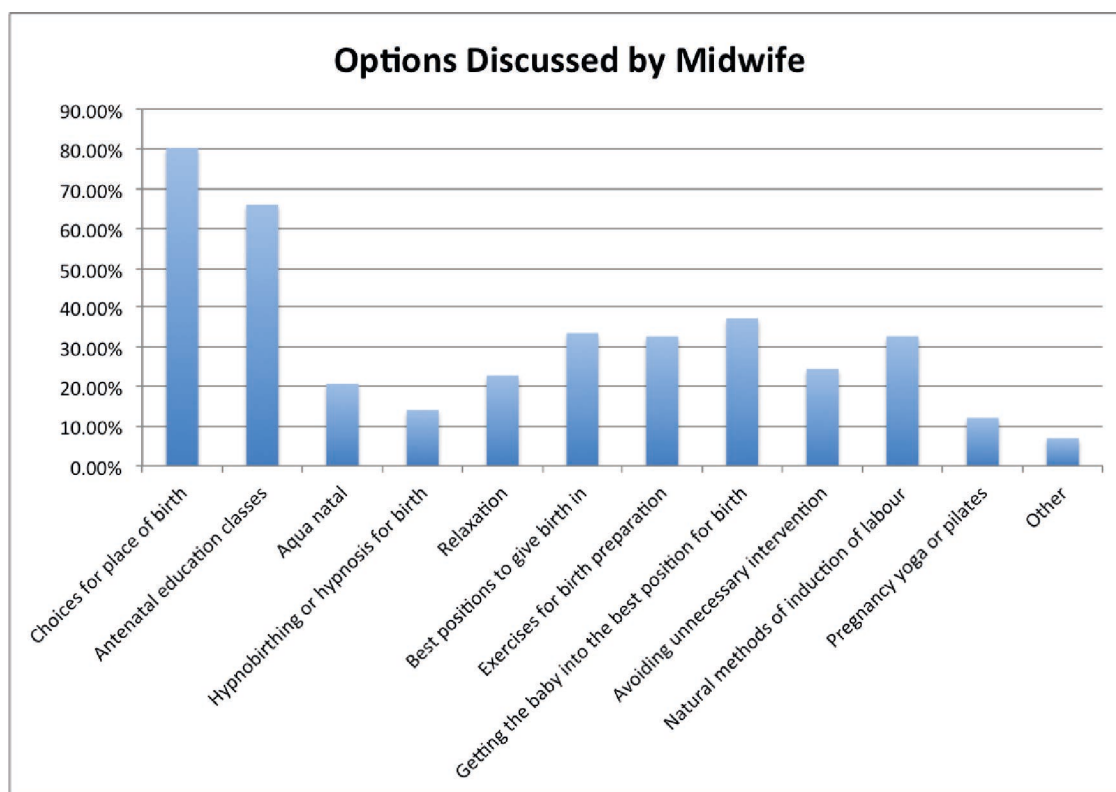
#### 4.5.11 Models of Care Recommendations

1. All women should have access to the 'Birth Place Decisions' leaflet around the time of the booking visit. This information needs to be revisited on at least two further occasions during the pregnancy. All women in Wales should be aware of the option to choose one of four settings to birth.
2. Midwifery Led Care for women with uncomplicated pregnancies needs to be actively marketed.
3. Investment is required to ensure that the birthing environment for all women is safe, private, fit for purpose and supports the principles of promoting normality.
4. Each Health Board should aim to provide women with access to a pool in labour.

#### 4.6 Antenatal Information Giving

The Royal College of Midwives<sup>2</sup> recognise that preparing both physically and psychologically for birth can have a positive impact on birth experiences and birth outcomes. The type of information that women were given and the opportunities they had to discuss this were considered in both quantitative and qualitative aspects of the survey.

Women were presented with a list of options that may have been discussed by their midwife in the antenatal period. 66.1% (N=1834) of women said they were informed about NHS antenatal classes.

**Figure 6**

Women were asked what options they considered to prepare for birth. Over 56.3% (N=1259) of overall respondents had considered attending NHS antenatal classes, including 73.9% (N=893) of primiparous women. Exercises for birth, methods for a natural induction and best positions for labour and birth were considered by 33.6% of respondents, regardless of parity.

The responses to options that women considered for birth preparedness reflected the information that midwives gave, suggesting a strong influence from the midwife and the benefit of information giving.

Women were asked about their antenatal appointments and their perception of them in relation to length of appointments and helpfulness. 8.96% (N=218) of women provided free text answers in response to exploring how they would best describe their antenatal appointments with midwives. The majority of women would have liked to *tick more than one box* and described *long waiting times for visits* that were then *rushed or frequently interrupted by the midwife taking phone calls (from other women or from the hospital)*. The majority of women appreciated midwives were busy and understaffed, and generally described their midwives positively but repeatedly felt

they were let down with the quality and duration of visits due to the other factors. One woman wrote

*'not the fault of the midwife just understaffed'.*

Another woman wrote

*'the midwives although lovely are spread far too thin, no chance to build relationships or any continuity of care'*

The survey specifically explored whether women felt they had enough time to discuss options for place of birth with their midwife during antenatal appointments. 2452 women responded and 70.2% (N=1721) of women felt they had enough time to discuss birth options. However, of the 427 women who said they did not have enough time, over 50.1% (N=214) also responded with additional text suggesting that they felt strongly about this. The comments reflected women feeling rushed, being offered limited choice and being told that they did not have options due to medical or obstetric history. Representative comments included

*'didn't discuss options, it appeared it was decided for me. But I did want a hospital birth anyway'*

and

*'I wasn't able to make a choice. I was told I was giving birth on an obstetric unit'.*

The women who had stated that they felt they were given enough time to discuss options did not go on to comment further suggesting that they were happy with this aspect of their care.

The positive comments related mostly to the attitudes of midwives, once again reflecting an observation or understanding of high acuity levels.

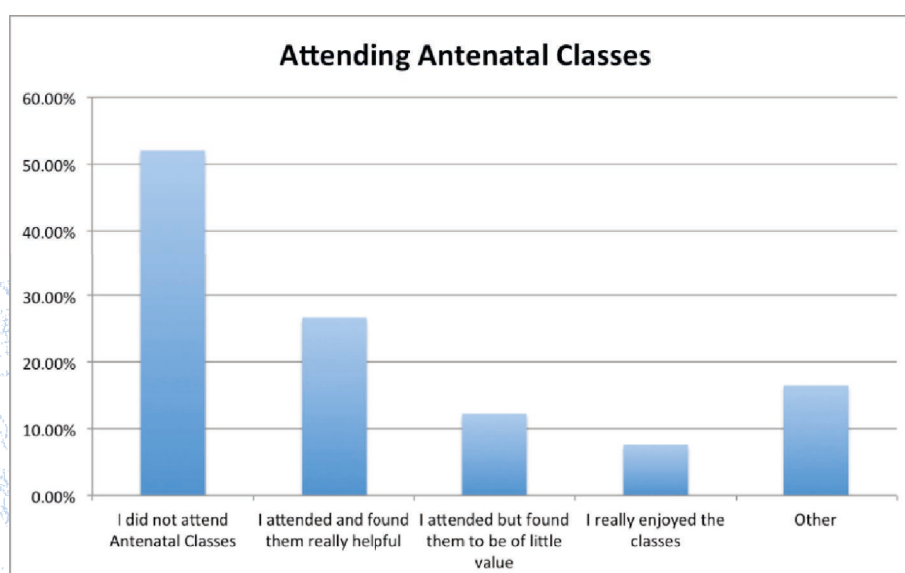
*'The calm and reassuring manner of the staff on the ward was great, despite them being horrendously understaffed'. 'The midwives that supported me were lovely, very reassuring, down to earth, trustworthy, caring and very well informed. They really made me feel reassured during my pregnancy as everything was new to me and nothing was too much trouble.'*



### 4.6.1 Attending NHS Antenatal Classes

More primiparous women 79.2% (N=855) felt they were able to access NHS antenatal education classes compared to 60.5% (N=482) of multiparous women. Not all of these women however, chose to attend. When asked what prevented women attending NHS antenatal classes, 26.8% (N=628) indicated not knowing that classes were available, 26.3% (N=616) feeling that the choices were limited in their area, and 18.1% (N=425) chose not to attend. Many women commented on classes being unavailable outside working hours (predominantly the primiparous women) and difficulties with childcare (the multiparous women). Over 2344 women answered the questions about antenatal classes fully, which suggested it was an aspect women felt strongly about.

**Figure 7**



### 4.6.2 Usefulness of antenatal classes

Of 1537 women who attended NHS antenatal classes, 54.4% (N=836) said that they found the classes really helpful and really enjoyed them. 12.3% (N=299) found them of little value and 16.5% (N=402) replied with a free text response with comments including enjoying meeting other parents-to-be, choosing to attend NCT classes rather than NHS or the classes not being offered in their area.

Respondents rated the usefulness of their NHS antenatal classes and 1230 women responded to this (significantly less than the 1537 women who responded to previous questions about antenatal classes). On a scale of 0-100, women were asked to rate the usefulness with 0 being very poor and 100 being very good. The average score (mean) was 60, the median 70 and range (0-100).

There was an underlying theme of the importance of sharing experiences with other mums and mums to be in the classes, which was noted as helpful in the preparation for birth as well as attendance to both private and NHS run classes. This included many positive responses:

*'Meeting other mums to be at the antenatal classes who had the same fears.'*  
*'Talking to other mums during antenatal classes, aqua natal classes etc and making new mum friends.'* *'Definitely the antenatal classes. There was a lot of information that me and my husband did not know. Put me more at ease'*  
*'The Hypnobirthing classes and pregnancy yoga (private and paid for) were a huge help to me achieving the natural birth that I wanted. The antenatal classes were also practical and useful'.*

High importance was placed by respondents on antenatal classes that empower women and increase their confidence in their ability to have a natural birth;

*'Antenatal classes helped me to have a normal birth with relaxation techniques and information about the process'. 'Try to dispel fears face to face. I know friends who could have been more informed.....the classes reassured my partner that I didn't need to be in a medical setting to have a safe labour'. 'I was sent on hypnobirthing classes to help with anxiety. The woman who ran the class opened my eyes to a natural birth and I cannot thank her enough for that. I managed to breathe my baby out and just had gas and air and no intervention'.*

Many respondents indicated that classes were difficult to access or in short supply with requests to

*'make antenatal classes available'*

and comments such as

*'antenatal classes were informative and run by knowledgeable midwives, unfortunately I believe they have changed the way they are run so they are more difficult to access, and especially if you work'.*

A further theme within this category was around visiting the maternity units prior to birth, and it was clear that where such tours were included in an antenatal education programme, it was perceived as being helpful in the preparation for birth;

*'Found it v useful to have a tour of hospital so it was familiar when I went for labour. Two recent mothers with different labour stories came to answer questions and share experiences which was very useful'. 'Allowing me to visit the birth centre was very useful and reassuring. I loved my experience there and hope to use it again in the future.'*

A strong emerging theme in the survey was women requesting more information about birth generally. Many of the women who responded rated the information that they received through 'Hypnobirthing' and 'Daisy-Birthing' classes to be useful and helpful.

*'Perhaps have the midwives run through various scenarios and provide more info as I wasn't sure what questions I should be asking.' 'More information about options for giving birth'. 'Offer more information about alternative birthing methods (hypnobirthing etc)'. 'I never received info on birthing positions or breathing .... The most helpful things during labour. Antenatal classes could benefit from this as I was bombarded with pain relief info but not natural birthing techniques'. 'I obtained all my support and guidance about birthing choices from a private class I attended'. More information and the support from the community midwife would have been helpful'.*

Women were asked if they were able to access alternative birth preparation classes, for example hypnosis, aqua-natal, yoga or pilates. Although over 71.2% (N=1337) of women were able to access antenatal education classes, a number of respondents stated that they were not made aware of any of the alternative options, and resorted to doing their own online searches and finding that often the choices were privately provided, or difficult to access when working. A word cloud highlighted commonly used words in the qualitative data.



Natal Classes Section Daisy Birthing Start Access  
 Second Child Not Available Support Given Ask  
 Midwife Sessions Attend Midwives  
 Offered Options  
 Antenatal Classes Problems Aware  
 Own Research Privately Mums NCT Classes  
 Limited Pregnancy Yoga

Many comments were made in relation to the importance of sharing positive birth experiences with other women and visiting the MLU to experience the environment;

*'Perhaps a mentor scheme could be looked at to assist midwives where women who have given birth naturally could also help support those who were unsure or want a realistic down to earth view'. 'I think a more structured programme of antenatal classes would help to reassure and influence women to consider home or local birth centres, especially if women who had had positive birth experiences were invited in to talk about their birth stories and mums to be were given space to discuss the options'.*

This was reinforced with free text data from questions relating to information giving, with women saying that hearing about other women's experiences and testimonials felt like an invaluable tool in helping to make choices.

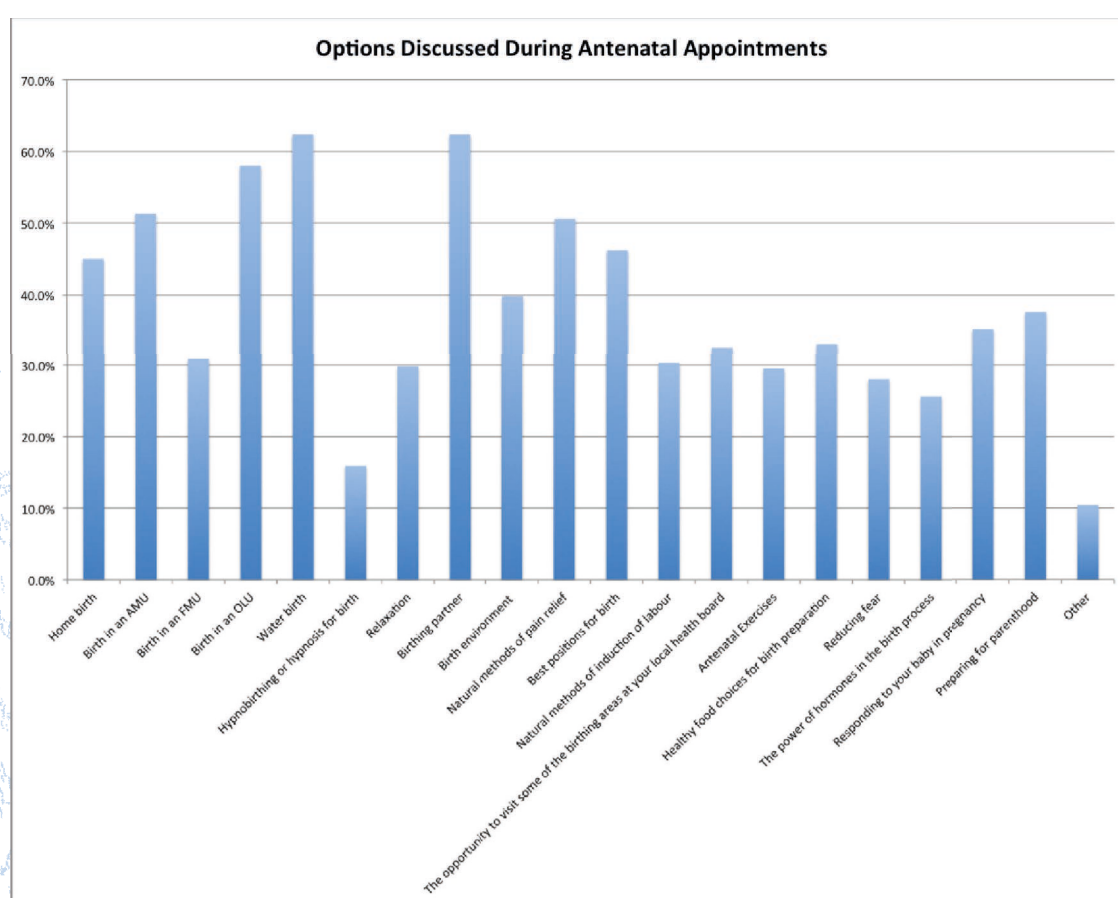
*'Maybe talking to other mothers who had a birth in the local midwifery led unit would reassure mothers. I tell everyone how brilliant it was to encourage them to do the same'.*

### 4.6.3 Making choices based on information given in NHS antenatal classes

Discussion around birth place decisions and choice in NHS antenatal classes was explored, and of the 1911 women who answered this question 57.0% (N=1090) were primiparous.

The respondents were asked about the information given and discussions within the group. The most commonly discussed points were the importance of your birth partner (62.4%, N=1193) and water birth (62.4%, N=1193). The discussion point with the lowest percentage was hypnobirthing or hypnosis for birth (15.9%, N=304).

**Figure 8**



Birthing in an OLU was discussed as a choice during classes with 58.0% (N=1108) of women whilst 30.9% (N=591) were informed about birthing in a freestanding MLU. The information about birth choices in NHS antenatal classes varied geographically reflecting locally available options. 51.3% (N=980) of women were informed of choices in relation to birthing in an alongside MLU. Homebirth was discussed in NHS antenatal classes with 859 women (45.0%). No differences were found in the options presented to primiparous and multiparous women.

Women were asked on a scale of 1-100 how they would rate the usefulness of information provided by a midwife during the antenatal period, including classes, general information giving and birth preparation support. 2437 women answered this question. 52.2% (N=1271) of the respondents were primiparous, with an even spread across geographic areas and an even proportion of age groups in line with Office of National Statistics data. The average score was 66 (range 0-100 with 100 being very useful and 0 being not at all useful).

#### 4.6.4 Online information and literature

The use of social media and the internet was perceived by some to be the best way to provide links to information and useful websites. Some suggested more modern tools for women to share their experiences of the different birth options with each other. This included accessing online information at home such as online search engines, pregnancy forums, apps, Facebook pages as well as books, CDs and DVDs. A common reoccurrence was that of hypnobirthing literature.

*'I did a lot of online research and bought home hypnobirthing book/CD because I was unable to book onto a class'. 'Online research, joining a Facebook group and reading positive birth stories, hypnobirthing exercises & relaxation, hypnobirthing book - felt confident going into birth'.*

Online research appeared common among multiparous women with a respondent stating that she was too embarrassed to ask her midwife for information.

*'I felt that as this was my 3rd baby it was assumed I knew everything and so nothing was really offered and most things were glossed over or spoken about at super speed I guess so as not to bore me as I already know it. But to be honest I'd have happily listened to it all again but I felt too embarrassed to ask for information or to slow down as it made me feel like I should know all this stuff still. I ended up just looking on the internet for most things'.*



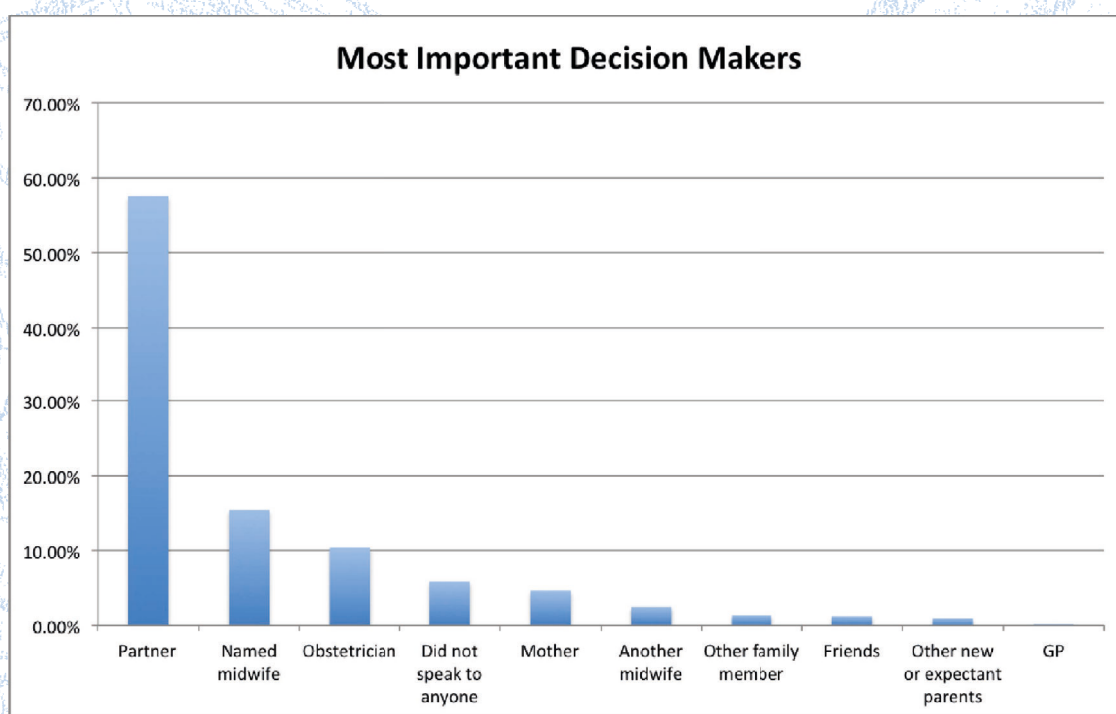
A number of respondents requested information leaflets with up to date information. NHS Patient information and literature was also highlighted with a frequent mention of the Bump, birth and beyond book and NHS choices website as being a helpful tool for preparing women for birth.

*'NHS book "bump, baby and beyond" – it gave me a lot of information that I found very useful in fact essential'.*

#### 4.6.5 Exploring characteristics

The people who had the most influence on decision making were explored as well as this person's characteristics, knowledge and quality of information giving. Participants were given the opportunity to rank the individuals or groups who had the most influence on their decision making and clear trends emerged. Both the respondents' partner and their named midwife ranked highly. 57.6% (N=1626) of respondents ranked their partner as having had the greatest influence.

**Figure 9**



GPs were ranked as having the least influence reflecting their minimal input into maternity care. The named midwife scored more highly than 'other midwife' although the obstetrician was also important.

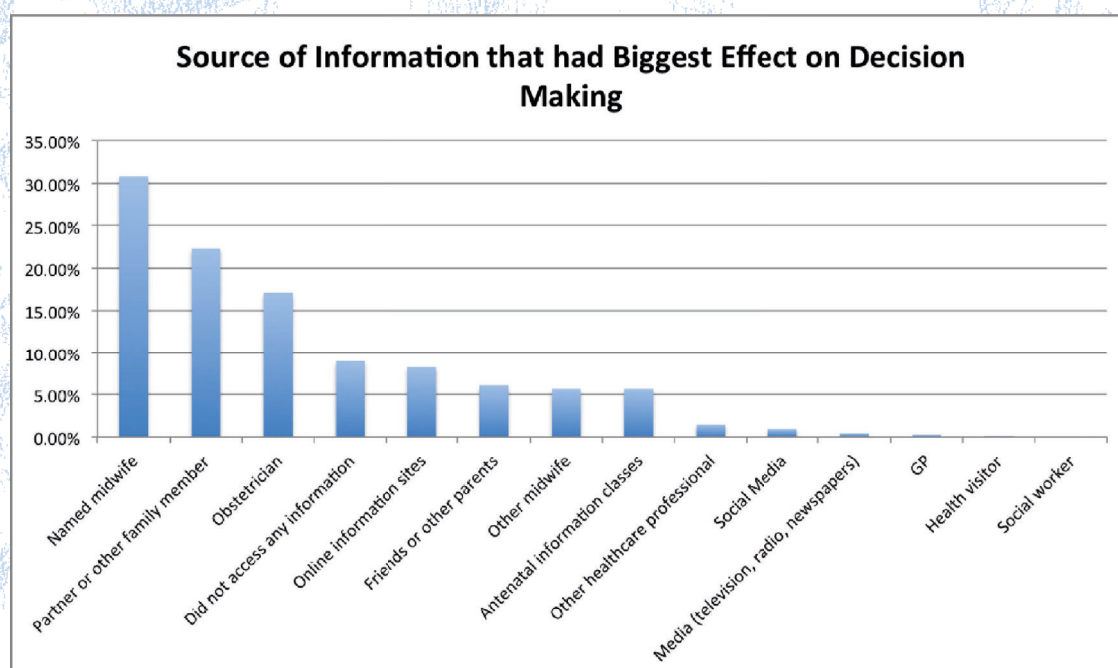
Interestingly, friends and other expectant parents did not score highly and this will be explored further.

A complimentary question asking 'where did you get the information that had the most effect on your decision making' saw a different ranking with the named midwife ranked most highly and the respondent's partner as the second highest ranked information giver. This was followed by the obstetrician; with other expectant parents ranked higher than 'other midwife'. Perhaps surprisingly, media ranked low on the scale.

This data could be interpreted in a number of ways. It could be that respondents felt they were given too many options; only 63.5% (N=2900) of respondents answered these questions. It could also be that the responses were diluted due to the options (for example if named midwife and other midwife were combined the results would appear very differently and the midwife per se would be seen as both the biggest influence and also giving the most influential information).

For women who were booked under OLC the obstetrician was named as the most influential and who gave the most influential information, followed by the midwife, then partners.

**Figure 10**



Respondents were asked what personal qualities and characteristics they value most about the person or people who helped them with their decision making. 2799 people answered this ranking question, a similar number to the respondents who had mainly described their partner and their named midwife as the people who helped them with making choices, as above.

Of twelve possible options, 60.0% (N=784) of women put 'he/she is knowledgeable regarding pregnancy and birth' as their main reason for valuing the opinion of their influential person, closely followed by 50.7% (N=706) of respondents who put 'I trust him/her' as their first choice. 75.2% (N=560) of respondents put 'I know him/ her well' in their top three choices supporting qualitative analysis later in the survey demonstrating women wanting continuity of carer. The trends suggest that having no alternative options and assertiveness were not characteristics valued highly by women in the context of their main influential people.

This data provides evidence that women obtain most of their information from their midwife as well as sharing experiences with peers; the midwife is the resource for signposting to hypnobirthing and antenatal classes where women have found these to be beneficial to the preparation for birth. However, there are examples to show an increasing trend towards obtaining information online.

#### **4.6.6 Antenatal information giving key points**

1. It was recognised that antenatal clinic appointments were an opportunity for midwives to discuss place of birth options with women.
2. Over half the respondents were informed of NHS antenatal classes by their midwife.
3. When antenatal clinic appointments felt rushed, the respondents perceived this to be due to staff shortages.
4. Women stated that rushed appointments affected their ability to build relationships with their midwife.
5. A high proportion of women did have the options for place of birth discussed during antenatal appointments but many commented that it was presented in a way that suggested the decision had already been made for them.



6. The majority of respondents choosing to attend NHS classes were primiparous.
7. Over half of the respondents found the NHS antenatal classes helpful and useful.
8. There was an underlying theme of sharing experiences with other mothers and mothers to be in the antenatal classes, and the positive benefit of this.
9. Respondents felt it was important that antenatal classes empower women and increase their confidence in their ability to have a natural birth.
10. The availability and accessibility of NHS antenatal classes varied across geographical areas.
11. Many women thought information about birth was insufficient in NHS antenatal classes and described various private classes as being useful and helpful.
12. Respondents found online research and also the NHS book 'Bump, Birth and Beyond' helpful, although they would like to see more information leaflets and to be directed to local maternity services websites.
13. Women stated that the person who they felt had the most influence on their decision making in relation to place of birth was their partner.
14. The person who provided the most valued information to help with decision making was the named midwife.
15. The highest percentage of respondents considered their named midwife as knowledgeable regarding pregnancy and birth.

#### **4.6.7 Antenatal Information Giving Discussion**

It was recognised that routine antenatal clinic appointments were points of contact for midwives to provide information on place of birth choices and birth preparation, and the opportunity for women to have a meaningful discussion with their midwife. However; some respondents felt that these appointments were rushed and it affected their ability to build a relationship with their midwife. With the increasing public health agenda, the numerous pieces of information and the clinical assessments that are

advised within an antenatal appointment, it could be argued that there is not enough time in a routine antenatal appointment for a meaningful and fully informed discussion.

Furthermore, where women reported discussing options for place of birth in antenatal classes, they frequently commented that it was presented in a way that suggested the decision had already been made for them. This could be influenced by individual midwives' personal experiences or interpretation of the woman's clinical need. However, all women should have the opportunity to discuss their options in a balanced way.

Over half the respondents were informed of NHS antenatal classes during their antenatal appointments with their named midwife; however the majority of women who chose to attend were primiparous. It may be that the majority of multiparous women had attended during their first pregnancy, as some commented that they assumed the classes were for first time parents.

It was clear that the respondents valued the contact with other mothers and mothers to be; therefore it may be beneficial for more multiparous women to attend classes alongside primiparous women. Unfortunately some respondents reported difficulties accessing the classes due to work or geographical area. Others described the classes as insufficient and subsequently attended alternative private antenatal classes to gain further information and birth preparation. The focus, class sizes and accessibility may vary between NHS and private classes, and this could account for why some women chose to attend private classes. Flexibility in timing, availability and location of private classes may have further contributed to this.

Women stated that the key person they felt helped them make decisions around birth preparation and birth place choices was their partner. This would be expected as for the majority of women it is assumed their partner is the person they feel closest to, it is usually a shared process and often an exciting time for families. It is recognised that some women do not have the support of a partner, are in challenging or even abusive relationships, where having the partner as the main influence on choices may not be viewed positively.

In contrast, the person who respondents considered provided the most valuable information in relation to birth preparation and birth place decisions was the named midwife. A positive, empathetic midwife delivering the information in a non biased way seemed to be valued by respondents, whereas rushed antenatal visits or insufficient

antenatal classes had a negative impact on women's perception of their ability to make an informed choice. This in turn could impact on women making decisions around their place of birth but also in the confidence to achieve a positive birth experience. Quantitative and qualitative aspects of the characteristics and qualities of the named midwife are explored further in 3.7 'Continuity of carer'.

#### 4.6.8 Antenatal Information Giving Recommendations

1. The workload of the community midwife needs to be reviewed to ensure all community contacts with women facilitate a meaningful discussion in which information is given.
2. Each Health Board needs to clearly communicate to women what NHS parenting education is available in their area.
3. Local reviews should be undertaken to review content of classes and to ensure they are delivered by skilled and motivated clinicians.

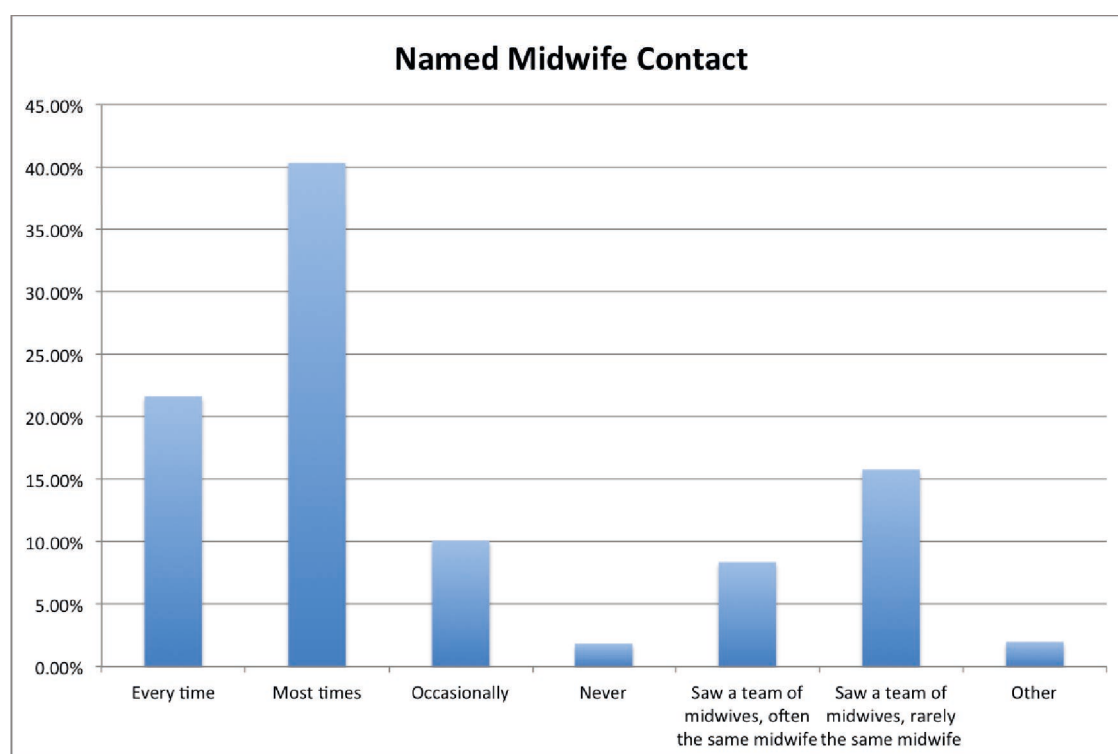
#### 4.7 Continuity of Carer

Respondents were asked if they had a named midwife. Of the 2947 women who responded 87.3% (N=2574) said they had a named midwife, 7.5% (N=221) did not, 1.8% (N=54) were unsure and 3.3% (N=98) responded with other. Parity had little influence on women's responses. Women were asked to elaborate with free text comments and 87.3% (N=98) of the comments mentioned named midwives going off on sick leave, changing jobs or being on rotation.

Respondents were also asked how regularly they saw their named midwife and of the 2944 women who answered this question, 62.0% (N=1825) saw their named midwife either all of the time or most of the time. 10.1% (N=297) saw their named midwife occasionally. The qualitative data analysis from this question reflected the answers to the previous question 'did you have a named midwife' with some comments around sickness and change of jobs as well as

*'I saw a really small team of midwives due to sickness within the team- all fantastic!!'*



**Figure 11**

A ranking question asked respondents to consider the characteristics that were important to them in relation to their named midwife or main care giver. 2883 women responded to this question and 51.5% (N=1485) of women who responded were primiparous.

33.5% (N=650) of women stated that the most important characteristic to them was that their main care giver was 'well informed', and 87.6% (N=1700) of respondents rated 'being well informed' in their top five priorities. This was supported with the characteristic ranked second as most important as 'someone who knows what they are doing'. 81.2% (N=1433) of women rated 'seeing the same midwife' in their top five, and in contrast 'seeing lots of different midwives was ranked in the lower five for over 90.0% of women with over 40.0% (N=170) choosing it as their least valued characteristic.

Responses highlighted the importance of listening to women and being compassionate; avoiding the use of unsupportive language.

*'Listen to pregnant mums whether first pregnancy or not. Sometimes mums just know when something's wrong. I was treated like a silly girl who couldn't cope with pain on my first baby'. 'I did not want an epidural and felt totally bullied when I was really vulnerable and so were my birth partners'. 'Being told they "have" to do something or they aren't "allowed" and not informed of actual choices. Being frightened into doing as they are told for fear of harming their baby'.*

'Kindness', 'compassion' and 'trust' were also all ranked highly whereas 'integrity' and 'keeping things formal' were ranked with little importance. 'Good communication skills' and 'enthusiasm' were ranked midway along the scale, but it could be challenged that women may assume that these are skills imbedded in midwifery culture and not chosen characteristics. It could be further challenged that communication skills are only apparent to the general population if the skills are very good or very bad.

#### 4.7.1 Personal and Professional Support

There were frequent statements highlighting the supportive role of the midwife and midwifery teams when preparing women for birth.

*'The midwife team were very accessible and always had time for any questions, very supportive'.*

This was reinforced by another respondent saying

*'Knowing that I could ask my midwife anything and that she was really supportive'.*

Continuity of carer from the midwife also presented regularly in the text; one respondent stated

*'Continuity of care from my named midwife who was very pro-choice and supportive of my decisions, gave me thorough information to help base my decisions upon.'*

In contrast to this, further respondents discuss the importance of support from peers and family members.

*'Support from family was better than my midwife due to lack of consistency (seeing someone different every time)'.*

In addition, there were numerous statements in relation to peer support in birth preparation.

*'Talking to other mothers and hearing their stories'. 'Speaking to other expectant mothers and sharing worries and experiences'.*

Further support was identified from partners, family members as well as doulas in the preparation for birth.

#### **4.7.2 The relationship between a woman and her midwife**

The survey responses included lengthy narratives in the free text options, with women expressing they wanted clear, easy to understand information on what is available. Numerous respondents described what they felt they needed was a trusting and compassionate relationship with one midwife. The interpersonal skills of kindness, being non-judgemental, knowledgeable, and compassionate were frequently mentioned in both positive and negative contexts.

*'My midwife for the birth was superb, reassuring, kind and I trusted her...one lady in particular was absolutely fantastic and a real asset to the NHS. She encouraged me and helped me'.*

In comparison another woman wrote

*'Be kind, the pain they are feeling is individual to them. You all seem very put out, blasé and not bothered'.*



Continuity of carer to enable a trusting relationship to develop was seen as important to good quality care and was reflected by many women with statements like

*'...seeing the same midwife to build up a relationship and knowing your care', 'the midwives I saw were lovely but I saw a different one every time. I would prefer consistency', 'a good relationship with my community team and the knowledge that a member of this team would be present at my delivery would make me more likely to consider delivery away from an obstetric unit'.*

Empathetic midwives were cited as allaying fears, especially in relation to managing pain.

*'I had an experienced midwife who made me feel very relaxed and didn't tell me my baby was back to back which could have made me anxious and as a result I ended up with a natural birth and no interventions. She believed in me I suppose'. 'Sometimes you just need someone to understand you are scared and calm you down'.*

The perceived quality and usefulness of midwife and mother interactions was explored and women were asked about their overall feelings in relation to antenatal contact with a midwife. 2433 women answered this question, with an even spread of responses across geographical areas, age groups and groups of parity. Women were given the opportunity to give one answer that best described their experience which despite giving more weight to their actual answer did mean they were restricted from combining thoughts and feelings (for example- I found the contact reassuring, enjoyable and the right length of time). There were three assumed positive options (enjoyable, reassuring and about the right length of time) and six assumed negative responses (rushed, too long, too short, unsatisfying, over whelming and underwhelming), however there was also an opportunity for free text.

Of the respondents, 40.2% (N=979) described the contact as reassuring, and there was a combined percentage of 67.7% (N=1647) describing the contact positively, either enjoyable, reassuring or the right length of time. In comparison, the highest scoring perceived negative response group was 11.0% (N=269) of women feeling that antenatal visits were rushed and 23.4% (N=568) of respondents giving a perceived negative response.

Of the 133 women who responded negatively on the length of antenatal visits, 86.5% (N=115) felt the visits were too short, compared to 13.5% (N=18) who felt they were too long. This was further supported by 11.0% (N=269) of women feeling that antenatal visits were rushed.

For the respondents who commented positively, this was mainly in relation to individual midwives who provided good continuity. In such circumstances the quality of the antenatal visit was described as much more

*'meaningful'.*

Individual midwives were described as

*'excellent, I honestly couldn't fault the care provided'.*

It was also recognised that

*'majority of them were brilliant but it did depend on which midwife'.*

Others further confirmed the need for continuity

*'with my main midwife- reassuring. With other midwife whilst usual midwife was on holiday- scary and overwhelming'.*

Positive comments and praise described midwives as

*'committed and passionate'.*

One woman said

*'my experience of midwife led care has been overwhelmingly positive for both my births. I have always been treated with warmth and respect and have felt safe in their care. This influenced my decision to have two home births.'*

Any negative comments, although in the minority, also related to attitude with comments including

*'I felt they didn't care where you had the baby and was just a tick box question'.  
'I feel my midwife appointments were a waste of time. As she only ever recorded my blood pressure. Because of this, I opted for an elective C/S as I felt apprehensive about having a natural birth with midwives.'*

Further comments on how women feel things could be improved in the future confirmed being able to build a trusting relationship with the midwife and having enough time to talk during appointments as important for building women's confidence.

#### **4.7.3 Continuity of Carer Key Points**

1. The majority of respondents had a named midwife, although some mentioned them going on sick leave, changing jobs or being on rotation.
2. Most respondents saw their named midwife either all or for most of their antenatal appointments.
3. Respondents directly linked continuity of carer with good quality care.
4. Good continuity was perceived to generate more meaningful discussion.
5. The characteristics women rated most highly in their named midwife were being well informed, and 'seeing the same midwife.
6. Listening to women, being compassionate and avoiding unsupportive language were characteristics respondents valued highly in their midwife.
7. Kindness and trust were seen positively whilst 'keeping things formal' was of little importance.
8. Women considered that having what they perceived as a 'good' or 'bad' midwife had a direct impact on decision making and choice.



9. Empathetic midwives allayed fears and were perceived to reduce pain.
10. Respondents generally found their antenatal appointments positive and reassuring, enjoyable and/or the right length of time, however some women felt the appointments were rushed and of little value.

#### **4.7.4 Continuity of Carer Discussion**

Although the majority of respondents had a named midwife, some mentioned named midwives going on annual leave, sick leave or being on rotation. Respondents' acceptability of this seemed to vary and reflected the way they viewed their named midwife. For respondents who commented positively about the relationship with their named midwife, they seemed to accept that they could not always see their named midwife, but valued good communication within teams of midwives. However, some respondents viewed this very negatively.

Although most women saw their named midwives either all of the time or most of the time for antenatal appointments, the perceived value of these visits varied in direct correlation with the way women viewed their midwives. As expected, the women who described their midwives as kind, compassionate and well informed, also felt they had sufficient time in clinic appointments to ask questions and discuss options. However, the respondents who did not describe their named midwives characteristics positively, or who saw a number of midwives, felt the visits were rushed and of little value. Being deprived of the opportunity to discuss options is likely to impact on women's confidence during birth and increase fear and anxiety in relation to birth.

When respondents felt they were able to build a positive relationship with their midwife, had the opportunity to talk and to be listened to and had the support of their named midwife to make choices, their pregnancy and birth experiences were perceived to be positive. However, when asked whether good communication skills were important for the named midwife, women ranked them as neither positive nor negative. It could be assumed that women believe these skills to be embedded in midwifery culture, a pre-requisite of being a midwife, and not a chosen characteristic. Equally it could be further challenged that communication skills are only apparent to the general public if they are either very good or very bad.

Women recognised that empathetic midwives were able to allay their fears and therefore, were seen to reduce pain in labour. This is likely to be linked with reducing adrenaline by helping women feel safe and calm with good communication and encouraging positive relaxation techniques, and also encouraging oxytocin release by using the same methods<sup>8</sup>. In 'Undisturbed Birth' Buckley<sup>8</sup> discussed the impact of fear on the hormones associated with birth and describes a calm birth environment and a supportive care giver as crucial to promoting and protecting the normal birth process. This was further supported by women commenting that continuity of carer seemed to ensure good quality care, and is reflected with women saying that good continuity created more meaningful discussions.

It is recognised that there are limitations to asking a self nominated group of women about their experiences. Some women are very keen to share their positive experiences, whereas others may be motivated to talk about things that went wrong, or hope that by sharing their stories it will improve future care for other women.

#### **4.7.5 Continuity of Carer Recommendations**

1. Women should expect to see a maximum of two different midwives and obstetricians during routine antenatal and postnatal care.
2. Mandatory training for midwives in communication skills should be ongoing, and the value of kind, compassionate, empathetic and respectful care should be widely recognised.
3. All Health Boards as a minimum should be birth rate plus compliant.
4. Online tours need to be available for all NHS intrapartum facilities, and the link to these shared with women.
5. Midwifery leadership needs to be strengthened to include a consultant midwife with a remit for Midwifery Led Care in all Health Boards.

## 4.8 Enabling Choice

### 4.8.1 When choice is restricted

It was recognised that on occasions women plan to birth in a MLU or at home, but due to shortage of midwives this choice cannot be supported. Women were asked to respond and share their thoughts and feelings if this had happened to them and 113 women responded, suggesting this occurrence is not uncommon.

There were many comments in the survey relating to criteria for midwifery led intrapartum care. Women who responded were very aware of admission criteria and many accepted that when their pregnancy moved out of the normal spectrum their planned place of birth choice would need to be amended accordingly

*'I would have felt confident giving birth in the midwife led unit but due to being induced I had to birth in an obstetric unit' and also 'I planned a home birth but needed to be transferred as the baby had a poo inside me.'*

To ensure they can make an informed choice relating to what is right for them, women and their families wanted to understand why transfer from Midwifery Led Care in pregnancy or labour may be recommended. Women also needed to be aware if transfer back might be possible. Responses suggested this is not always the case and could lead to confusion or a feeling of lack of control

*'I gave birth in (a freestanding MLU) but got transferred to (CLU) for surgery for a tear and was told that I could go back to (FMLU) for after care. This was untrue I was very upset by the wrong info given.'*

Many women reported being transferred to an OLU, but no respondents reported being transferred back to a MLU or home during labour.

*'When in labour I was notified I was ok to go to MLU however, ended up remaining on Obstetric Unit due to baby needing to be monitored' and 'I wanted to give birth in a midwifery led unit but had meconium in my waters so had to go to labour ward and I ended up having a forceps delivery'.*

When considering this woman's individual responses to other questions, she suggested that going to the consultant unit was the reason she had an instrumental delivery and this actual place of birth does not reflect her birth choices made in the antenatal period.



### 4.8.2 Facilitating birth choices when acuity levels are high

Women commented on their experiences, their understanding of challenges within the maternity services and efforts to support their birth choices when services are busy. In reference to a MLU birth potentially not being able to be facilitated, one woman commented

*'this did not happen as support was put in place by the birthing centre to assist in ensuring my needs and birthing plan were met'.*

Reflected by many others with similar experiences

*'...this almost happened with my first labour but the midwifery team went out of their way to ensure I had a home birth, they called a midwife from a different area'.*

The descriptions of positive experiences were minimal in comparison to the negative responses that described choices being influenced by challenges in service provision. Responses suggest that during periods of high acuity, a frequent response of maternity services is to redirect women to the OLU

*'this happened on my first child. Again she was planned at home but there was no one on call. I'm fairly laid back and as long as my daughter was born healthy I wasn't at all bothered about going into hospital. I was well looked after and had a great team of midwives looking after us and I had the perfect "homebirth" just in hospital'.*

Although for some women this transfer reflected an experience they considered to be positive, many suggested an impact on choice and actual place of birth.

*'I was pre-warned about this being a possibility and it happened to me. The midwife was called into the hospital to work so I had to attend. The alongside birth centre also had staffing issues so I ended up on labour ward.'*

Women appreciated the pressure the maternity services can experience but comments reflected how this can influence choice available to women:

*'Planned to attend alongside midwife led unit but due to staff shortage gave birth on obstetric unit. Excellent experience but unfortunate that there aren't the staff despite having the facilities available.' 'I was told that all the community midwives on call in the area had already been called in and I laboured in the assessment area of (OLU) until someone came on for the morning.'*

Some women reported being transferred to an OLU during labour due to staffing issues rather than clinical need;

*'I was in a midwifery led unit during my contractions during the day, when the night shift started a member of staff on the midwifery unit phoned in sick and they were a member of staff down, as there was only one member of staff on the midwifery unit they had to close the unit for the member of staff to help on the other ward, which meant I had to go to the labour ward to give birth.'*

It was recognised by respondents that women sometimes need to revise their plans due to units being unable to staff their MLU, it was apparent that some women felt better prepared for this than others.

*'I planned to give birth in an alongside midwifery led unit with obstetrics nearby in case I needed more help. On the night I went into labour I was told the hospital was full and can I go to a midwifery led unit which was further away and that I had never been to. I had problems delivering and had to be transferred back to the original hospital I had wanted to give birth in.'*

*'This did not happen to me but I was made aware that if the labour ward was full I may need to go elsewhere. I had been provided this info in advance and knew it was a possibility. 'I was pre-warned that this may happen and in fact during my labour my midwife received phone calls saying that she was needed elsewhere.'*

Some of the responses suggested a lack of emotion, presented in a very matter-of-fact format, which could be interpreted as women accepting that this is reasonable and appropriate action by maternity services.

Women mentioned being frightened and let down. One woman described her feelings when labour began

*'I rang my local midwife unit and unfortunately was told they were short staffed and couldn't send anyone out, but if I could come in and be examined in an hour if I wanted. My brother took the initiative to phone an ambulance and baby was here within 30 minutes.....I did feel let down that in my moment of panic I was left on my own by the midwife unit.'*

Other respondents showed an understanding of high acuity levels and challenges on the midwifery service provision, whilst others believed they only got their choice through luck or tenacity. A number of respondents described needing to be assertive and needing to insist on their original choice.

*'Said there were no midwives available to come to my home, said I wasn't coming in, they managed to find me two, might have ruined a birth experience had I not known my rights'*

#### 4.8.3 Avoiding a default option

A number of respondents suggested that maternity systems 'default position' are an OLU. If labour is advanced, they often just go straight to an OLU without questioning it. Some women described arriving at the hospital in advanced labour and it being assumed that they would birth in the OLU.

*'I requested in my plan for alongside midwifery but on arrival just got taken to labour ward. Was in too much pain to ask for anything different'*

likewise another respondent said

*'I got to hospital...and was 9cm dilated so mid contraction my mind wasn't fully aware of what my options were (originally planning a midwifery led birth). When I got into the assessment unit I was taken straight through to a delivery room on the labour ward.'*



#### 4.8.4 Broadening criteria and supporting choice

Many comments related to the need to broaden the criteria for accessing the MLU including

*'Be trained to give antibiotics so that women with strep B can deliver in the midwifery led setting'. 'Over 40 but otherwise healthy should be allowed midwife led as long as it's alongside an obstetric unit'. 'Just because someone has a high BMI doesn't mean they're unhealthy and can't deliver a baby without intervention'. 'Is it really necessary that an induction means a hospital birth?' 'There are some pregnancies and births that are so high risk or complicated that they obviously require a hospital type approach. But there are plenty, like mine, which are in that grey area between low risk and high risk. When you're in this grey area it feels like you end up shunted closer to the high risk hospital approach'. 'Tell women they hold all the cards and their body belongs to themselves - let them choose what happens to it , even if it holds risks, let them choose'.*

It was recognised that unnecessary intervention can limit women's choices and women suggested that this should be reviewed in the future.

*'I ended up on a medical ward, on a monitor and in bed. As a result I ended up having an epidural (which I previously didn't want) as I was stuck in bed unable to move about to ease the pain of contractions.....I do wonder if I would have progressed further if I was not stuck in bed'. 'When a labour is progressing well they should take a step back rather than interfering all the time. Far too much intervention by midwives in my opinion ruins the chances of a normal birth'.*

An opportunity to discuss birth options was valued particularly when women had pregnancy complications but still wished to access the MLU for birth. Respondents felt that a birth discussions option could reduce the risks of unnecessary intervention.

*'More individualised care planning for people with complicated pregnancies that would allow them more choice over place of birth and less 'blanket' decision making'. 'Birth choices clinic for women who would like to birth on MLU but deemed higher risk... opportunity to attend a clinic for full discussion and talk about risks etc'.*

Respect for women's choices and support throughout pregnancy and birth was viewed as essential for a positive birth experience, and respondents felt this could be improved.

*'I hated being made to feel like I was some sort of enormous risk because I wanted a VBAC, being told what I was and wasn't 'allowed' and being made to feel like I wasn't capable of making my own decisions'. 'Listen and respect women's choices and the reasons for those choices even if they aren't routine'.*

#### 4.8.5 Enabling Choice Key Points

1. Respondents wanted to understand why transfer out of a MLU in labour may be recommended, so that they could make an informed choice.
2. Respondents who were pre-warned that this could happen seemed to be more accepting of reasons for transfer to an OLU.
3. Women wanted to be informed whether transfer back to a MLU may be possible.
4. On occasions women plan to birth in a MLU or at home but due to shortage of midwives this choice is not supported.
5. Women recognised that transfer to an OLU was sometimes due to staffing levels and not clinical need.
6. There were negative responses in relation to maternity services being busy with women planning a home or MLU birth being frequently directed to an OLU.
7. Many recognised that there were challenges within the maternity services, and valued efforts to support their birth choices when services are busy.
8. The uncertainty with getting ones first choice for birth place, increased the fear levels and anxiety for women.
9. Some respondents believed that the OLU was the default option for birth place.

10. Many respondents felt strongly about broadening the criteria for having the choice of birthing in a MLU so that more options were available to more women.
11. Women valued the opportunity for a birth discussion and believed that this could contribute to reducing unnecessary intervention.
12. Respecting women's choices and support throughout pregnancy and birth was viewed as essential for a positive birth experience.

#### **4.8.6 Enabling Choice Discussion**

On occasions women plan to birth outside of an OLU, but due to shortage of midwives this choice cannot be supported. This practice varies across Health Boards but suggests some regard this as acceptable. Some respondents recognised this may happen and appeared to accept the possibility. When communicated effectively with women, the chance of transfer to an OLU seemed less distressing for the woman, although it is clear that it is not what women want and should represent a response to exceptional acuity rather than a frequent occurrence. Women recognised that transfer may be necessary for clinical reasons, this being viewed more positively.

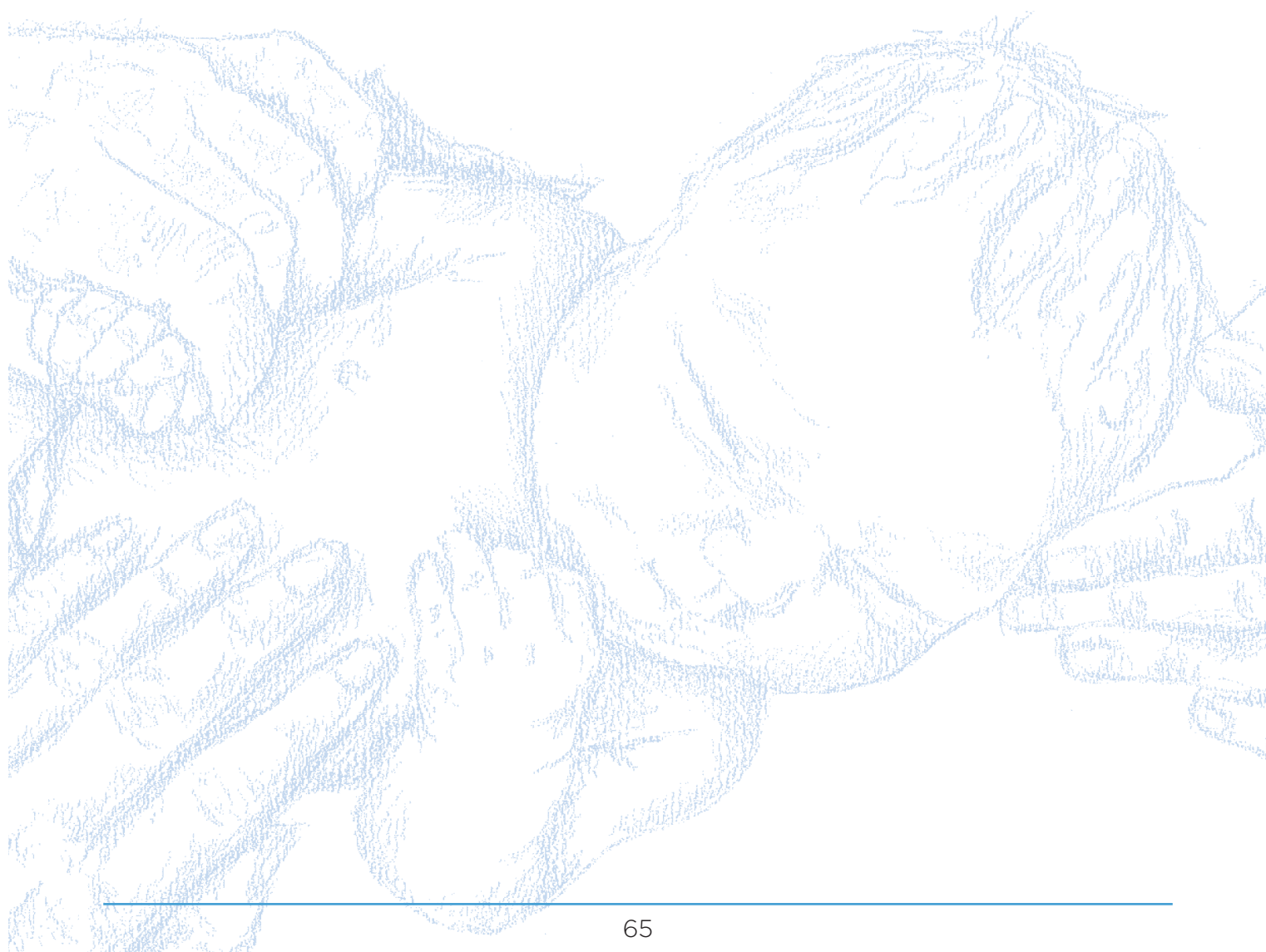
It was apparent that respondents were aware of high acuity levels. Wherever women choose to birth (albeit at home or in a quiet private room within an OLU) it could be argued that midwives should be making every effort to protect women from the anxiety of a busy and potentially frantic environment. The portrayal of high activity within the unit could have a negative impact on their birth experience.

A number of respondents described the OLU as the default position, describing scenarios where they had presented at the OLU in advanced labour, or been advised to attend the OLU without someone first discussing their medical and obstetric history as well as birth place preference. For these women, their first choice for place of birth was in a midwifery led setting. Some respondents suggested making the MLU the 'default position' for all uncomplicated births, however it should be recognised that creating predetermined places for women to give birth removes the essential element of choice. Women should make an informed choice about place of birth during the antenatal period and maternity services need systems in place to support these choices when women present in labour. Respondents mentioned broadening the criteria for MLC, including, for example, challenging BMI boundaries for otherwise low risk women.



#### 4.8.7 Enabling Choice Recommendations

1. Women are sometimes being denied their chosen place of birth due to service acuity. This needs to be monitored through audit of red flag events<sup>13</sup> and managed through a risk assessment process such as DATIX.
2. Systems need to be reviewed to ensure every effort is made to support women's choices for MLC care and environments during times of high acuity.
3. Maternity services need to ensure clear care pathways that support women's chosen place of birth.
4. An all Wales review of MLC intrapartum criteria (including BMI, GBS and other perceived risks) to be undertaken by key stakeholders.



## 5 Conclusion

This report presents data collected in a survey conducted to inform the prudent maternity care agenda in Wales. A central component to this agenda is the targeting of maternity services to achieve 45% of women receiving midwifery led intrapartum care. The survey was designed to ask women, who had given birth in Wales during 2016/2017, what they valued in maternity care and what would need to change in Wales if this target is to be achieved.

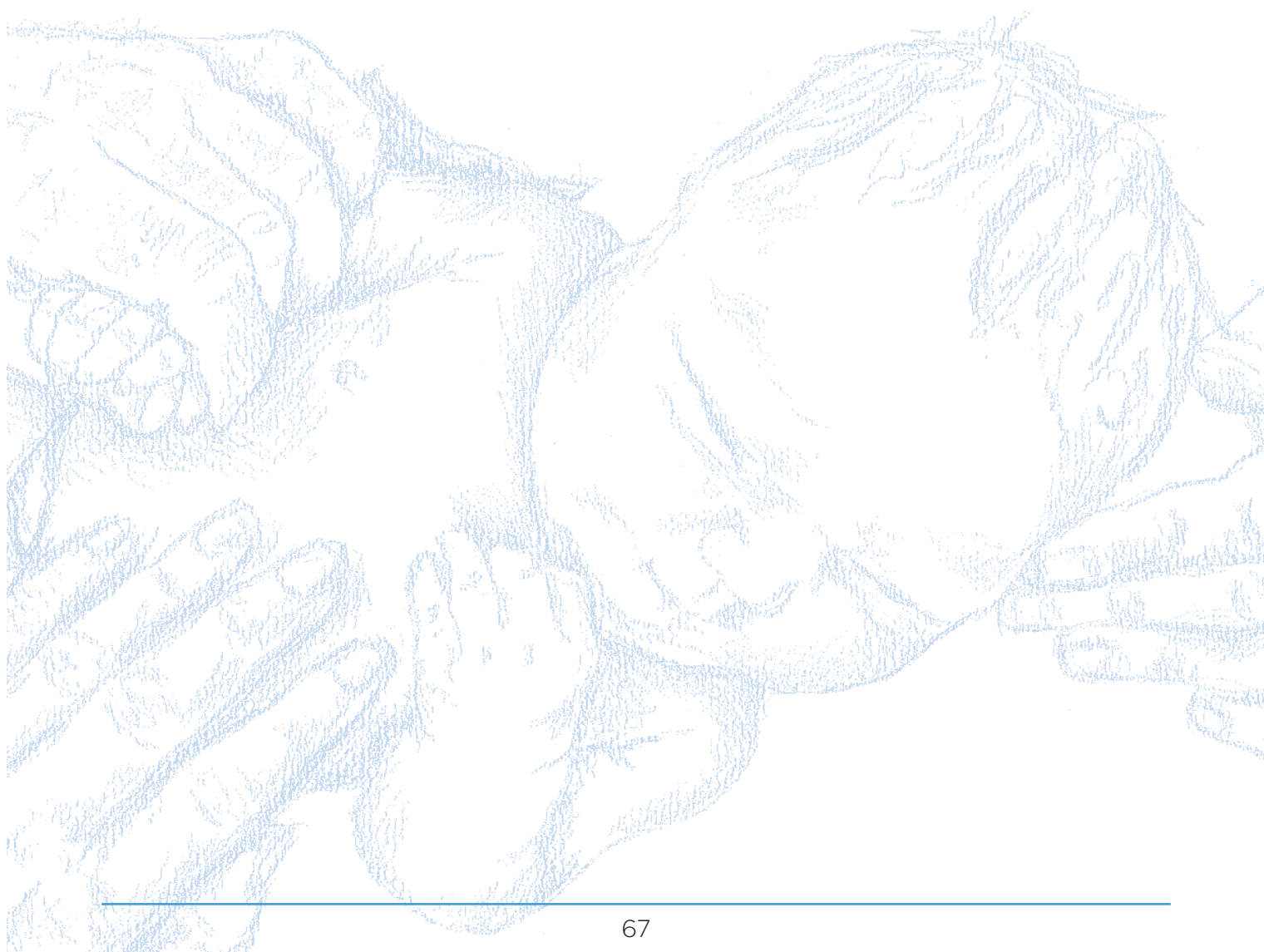
Over 4,000 women from across Wales, and from different socio-demographic groups, completed the survey. Whilst the findings represent the views of many users of the maternity services, it represents around 10% of women who gave birth during the eligibility period, and this may limit generalisability to the whole population.

The findings present a picture of women's experiences of planning for birth, as well as their experiences during labour. Most data are presented by parity, as this was regarded as an important determinate of a woman's maternity care experience. Overall, the majority of women planned to give birth in a setting of midwifery care, either at home or in a freestanding or alongside Midwifery Led Unit. This finding demonstrates that many women desire to give birth under the care of midwives and have confidence in this model of intrapartum care. It was also found that many women who plan birth under midwifery care are transferred to obstetric care either during the antenatal or intrapartum periods. For some women, this was in response to clinical need, but disappointingly some women reported that having planned during pregnancy to give birth in a midwifery led setting, this option was withdrawn after their labour started either due to over stretched maternity services or systems that did not support their choice. This finding challenges maternity services to further increase the proportions of women planning birth under midwifery care through thoughtful review of existing criteria, but also to ensure that, for women who plan birth under midwifery care, this choice is supported.

Women who made the choice to give birth in an obstetric unit, or who required such care for clinical need, highlighted the need to ensure that all birth settings provide comfortable private surroundings for women in labour, including access to birth pools. Listening to women who use the maternity services and understanding their viewpoint is important, and women described clearly what they value in maternity care. This survey supported many previous surveys, confirming that women desire kind, respectful maternity care from knowledgeable professionals, with whom they get an opportunity to develop trusting meaningful relationships. Many women were very positive about their experiences of maternity care and valued the trusting relationship they had developed with midwives who were respected. Others expressed

disappointment and frustration either by a lack of continuity or time during antenatal care to discuss individual needs, or availability of accessible birth preparation.

Women of Wales have given generously of their time to share their experiences. It now remains for Welsh Government and Health Boards to respond to support all women in their birth choices.

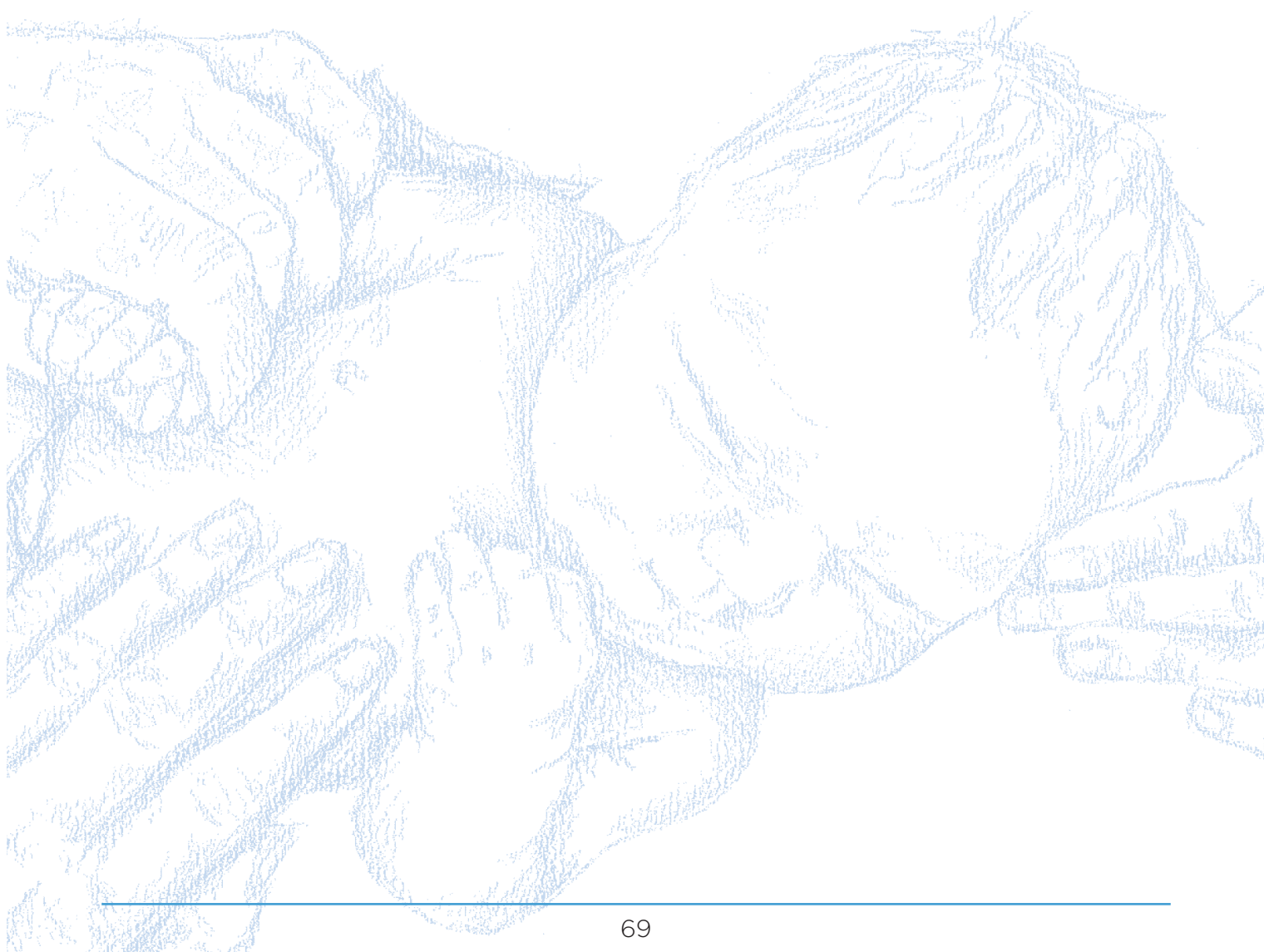




## 6 Summary of Recommendations

1. All women should have access to the '*Birth Place Decisions Leaflet*'<sup>7</sup> around the time of the booking visit. This information needs to be revisited on at least two further occasions during the pregnancy. All women in Wales should be aware of the four different place of birth options.
2. Midwifery Led Care for women with uncomplicated pregnancies needs to be actively marketed.
3. Investment is required to ensure that the birthing environment for all women is safe, private, fit for purpose and supports the principles of promoting normality.
4. Each Health Board should aim to provide women with access to a pool in labour.
5. The workload of the community midwife needs to be reviewed to ensure all community contacts with women facilitate a meaningful discussion in which information is given.
6. Each Health Board needs to clearly communicate to women what NHS parenting education is available in their area.
7. Local reviews should be undertaken to review content of classes and to ensure they are delivered by skilled and motivated clinicians.
8. Women should expect to see a maximum of two midwives and two obstetricians during routine antenatal and postnatal care.
9. Mandatory training for midwives in communication skills should be ongoing, and the value of kind, compassionate, empathetic and respectful care should be widely recognized.
10. All Health Boards as a minimum should be Birthrate Plus<sup>®</sup> compliant<sup>9</sup>.
11. Online tours need to be available for all NHS intrapartum facilities, and the link to these shared with women.

12. Midwifery leadership needs to be strengthened to include a consultant midwife with a remit for Midwifery Led Care in all Health Boards.
13. Women are sometimes being denied their chosen place of birth due to service acuity. This needs to be monitored through audit of red flag events<sup>9</sup> and managed through a risk assessment process such as DATIX.
14. Systems need to be reviewed to ensure every effort is made to support women choices for MLC care and environments during times of high acuity.
15. Maternity services need to ensure clear care pathways that support women's chosen place of birth.
16. An all Wales review of MLC intrapartum criteria (including BMI, GBS and other perceived risks) to be undertaken by key stakeholders.



## 7 References

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