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DOI:

[10.1016/j.midw.2018.02.006](https://doi.org/10.1016/j.midw.2018.02.006)

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*Document Version*

Peer reviewed version

*Citation for published version (Harvard):*

Goodwin, L, Taylor, R, Kokab, F & Kenyon, S 2018, 'Postnatal care in the context of decreasing length of stay in hospital after birth: The perspectives of community midwives', *Midwifery*, vol. 60, pp. 36-40.  
<https://doi.org/10.1016/j.midw.2018.02.006>

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# Postnatal care in the context of decreasing length of stay in hospital after birth: The perspectives of community midwives

The UK, along with many other Western countries, has seen a significant decrease in postnatal length of stay over the last four decades (Health and Social Care Information Centre, 2015). Whilst 45% of postnatal women in England remained in hospital for 7 days or more after birth in 1975, only 2% of women remained in hospital after birth for the same period of time between 2013 and 2014 (Health and Social Care Information Centre, 2015). Currently, in the UK, 20% of women go home the same day of birth ('day 0'), with a further 38% on day one and 23% on day two, making a total of 82% of women being discharged by day three after birth (NHS Digital, 2016).

Similar trends in the shortening of postnatal length of stay in hospital are seen in countries such as the United States (Fink, 2011), Sweden (Johansson et al., 2010; OECD, 2014), and the Netherlands (OECD, 2014). For example, in Sweden, the average hospital postnatal length of stay decreased from 6 days in the 1970s to 2 days in 2005 (Johansson et al., 2010).

Internationally, decreasing postnatal stay is driven by a number of factors, including financial pressures on maternity services, hospital bed availability and a movement toward 'de-medicalisation' of childbirth (Benahmed et al., 2017). In the UK, these factors are accompanied by a dramatic increase in birth rates and a concurrent rise in complex pregnancies (Schmied and Bick, 2014), further adding to the shortage of postnatal beds available. Alternatively, shorter duration of stay may also be requested by women who want to spend more time with their families in the comfort of their own homes (Brown et al., 2002).

Decreasing length of hospital postnatal stay inarguably increases demands on community postnatal services; the quantity and quality of which appears to vary globally. For example, in Iceland, women are offered eight home visits in the first 10 days postpartum, and report positively on their postnatal care (Askelsdottir et al., 2013). In Australia, however, women are meant to receive at least two weeks of postnatal support within their homes but continue to report low satisfaction with their postnatal care compared to antenatal and intrapartum services (Morrow et al., 2013).

In the UK context, community postnatal care is provided by midwives, and although the National Institute for Health and Clinical Excellence (NICE) previously recommended a minimum of three home contacts post-birth (NICE, 2006), many women are now asked to attend postnatal clinics instead, and there are no standards regarding the total number of postnatal contacts women should receive (NMPA project team, 2017). As such, wide variation is found in the number of postnatal contacts experienced by women in the UK; a recent report from the National Maternity and Perinatal Audit project team (NMPA project team, 2017) found that the number of planned postnatal contacts for healthy women and babies ranged from 2 to 6, with a median of 3. In an earlier survey by the Royal College of Midwives (RCM), 14% of women in the UK reported that they only received one visit and a small minority reported no visit whatsoever (Royal College of Midwives, 2014a).

There is mixed literature regarding the safety of reducing length of stay post birth for women and babies. A Cochrane Review (Brown et al., 2002), updated in 2008, reviewed ten randomised controlled trials which compared early discharge from hospital of healthy mothers and term infants with standard care (a total of 4489 women included). No statistically significant differences in infant or maternal readmissions were found in the eight trials reporting data on these outcomes (Brown et al., 2002). In line with this review, a recent systematic review of the literature on hospital discharge following vaginal delivery (Benahmed et al., 2017) reported no statistical difference in maternal and neonatal morbidity, maternal and neonatal readmission rates, infant mortality, newborn weight gain, neonatal hyperbilirubinemia, or breastfeeding rates when comparing groups under 'early discharge' care policies with control groups with 'standard' policies. However, in both reviews, authors cited a number of limitations to these findings; including a lack of statistical power (Brown et al., 2002), differing definitions of 'early discharge' across studies (Benahmed et al., 2017; Brown et al., 2002), poor methodology of the studies included (Benahmed et al., 2017; Brown et al., 2002), lack of compliance with the discharge protocol (Brown et al., 2002), and variation in the support package provided after discharge (Brown et al., 2002). As such, further research is required to establish the relationship between the safety of women and babies, and the duration of postnatal stay after a normal vaginal or caesarean birth (Jones et al., 2016).

## Postnatal Care: The views of women

Along with a lack of clarity regarding the safety of reduced postnatal stay, women in the UK consistently report lower satisfaction with the quality of their postnatal care, compared to that given during pregnancy and birth (Bhavnani and Newburn, 2010; Care Quality Commission, 2015; Redshaw and Henderson, 2015). Similar feelings of dissatisfaction from women are reported in reviews of postnatal care in Australia (Biro et al., 2012; Brown et al., 2005; Fenwick, et al., 2010).

In the UK, the recent National Maternity Review (National Maternity Review, 2016) reports on an extensive programme of engagement with the public, users of services, staff, and other stakeholders between 2015 and 2016. During this review, women reported a need for more postnatal support and shared a feeling that services are inadequately resourced for midwives to provide empathetic and comprehensive care (National Maternity Review, 2016). Indeed, while many women said that they received lots of care and support in the antenatal period, they suggested that this was not continued after birth (National Maternity Review, 2016). Breastfeeding support was also seen as lacking, with many women reporting that they had received conflicting information and as a result felt confused, and at times pressurised (National Maternity Review, 2016). This is in line with findings from the most recent NHS Digital 'Infant feeding survey' where 63% of 10,768 women surveyed reported that they had stopped breastfeeding before they wanted to (McAndrew et al., 2012), and suggested that more support and guidance from hospital staff, midwives and family could have facilitated them to breastfeed for longer (McAndrew et al., 2012). Similar findings were also reported by the 2010 National Childbirth Trust (NCT) Survey of 1260 first-time mothers (Bhavnani and Newburn, 2010), where less than half of first-time mothers felt they received all the help and support they needed with feeding their baby in the first month after birth, and 52% felt they had not received consistent information and advice in relation to feeding during this time frame. In a recent survey of women who gave birth in New South Wales, Australia (Bureau of Health Information,

2017), around one-third of women said that after giving birth, they received conflicting advice about feeding their baby (32%) or about caring for themselves or their baby (32%).

International research also suggests concerns from women regarding the physical health needs of both themselves and their babies during the postnatal period: in a UK NCT survey, one in five women said they received little or none of the physical care they needed, and around one in seven said they had received little or none of the information they needed about their baby's health (Bhavnani and Newburn, 2010). A similar survey of women's maternity experiences in the UK, published by the NPEU in 2015 (Redshaw and Henderson, 2015), found that some women did not always have confidence in the staff caring for them after discharge (27%) and a few (4%) did not have confidence in these staff at all. When asked about the number of postnatal home visits received, 23% of women found this lacking (Redshaw and Henderson, 2015). In an Australian focus group study, first-time mothers reported that a hospital stay of less than 24 hours was 'scary' (Forster et al., 2008, p. 5) and expressed the need for a longer stay in hospital to develop confidence in their ability to care for and feed their newborn (Forster et al., 2008).

Previous literature has also highlighted a need for additional emotional support in the postnatal period, with one UK survey suggesting that one third of women receive little or no emotional support in the first month after birth (Bhavnani and Newburn, 2010). In the recent UK National Maternity Review, women reported a similar need for more support and better access to counselling and therapy for those who have difficult or traumatic experiences, particularly those who have experienced stillbirth or neonatal death (National Maternity Review, 2016). In these instances, bereaved parents told of how communication between the hospital and community based services were poor, and many encountered health professionals who were not aware that their baby had died (National Maternity Review, 2016). Research conducted in Australia suggests similar frustrations regarding a lack of professional support, with women commenting that staff were often too busy or unavailable to provide the care that they expected (Forster et al., 2008).

## Postnatal Care: The midwife's perspective

In contrast to the wealth of literature on women's views of postnatal care, there is relatively little exploring the perceptions and experiences of the midwives providing this care. This is particularly evident when it comes to the context of community-based care; whilst there has been some international research with hospital midwives concerning postnatal care in ward settings (Bick et al., 2011; McLachlan et al., 2008; Rayner et al., 2008), there remains a lack of documented perspective from community midwives. This seems especially apparent in the UK context: after systematically reviewing the literature (search terms and database lists included in Figure 1), we could not find any peer-reviewed, qualitative research which directly explored the knowledge, beliefs and attitudes of UK community midwives on the early discharge and postnatal care of mothers and babies.

Despite the lack of representation from this particular workforce, there is evidence to suggest that midwives as a whole report concerns with postnatal care in both the UK and abroad (Bick et al., 2011; Morrow et al., 2013; Stewart-Moore et al., 2012), and highlight the challenges associated with increased workloads, busy work environments, and limited staff resources (McLachlan et al., 2008; Morrow et al., 2013; Schmied et al., 2008), as well as routine clinical cover and responsibilities towards safeguarding women in their care (Royal College of Midwives, 2014a). In fact, midwives

report that staff and resources are often directed from postnatal care to antenatal clinics or labour ward (Bowers & Cheyne, 2016), and a recent survey of UK midwives, conducted by the RCM, found that 65% of respondents reported that organisational pressures were the key determinant of postnatal care planning rather than individual care needs of mothers and babies (Royal College of Midwives, 2014a). Midwives in this survey also felt there was limited amount of time to provide women with all the information they needed about their postnatal recovery and care for their babies, and felt like they were stretching their resources and discharging women under pressure to meet time demands (Royal College of Midwives, 2014a).

These issues present themselves as hurdles and barriers to providing good quality care, where resources are spread thinly amongst community midwifery teams (Royal College of Midwives, 2014b). For instance, community midwives working in Northern Ireland and the Republic of Ireland report giving priority to certain groups of women during visits (Stewart-Moore et al., 2012); providing more visits to first-time mothers, women who were breastfeeding, women with jaundiced babies/infections, and those discharged within six-hours of birth (Stewart-Moore et al., 2012). This unofficial organisation of resources not only demonstrates the community midwives' need to allocate services on a needs based system, due to a lack of capacity, but also highlights their perception of short hospital postnatal stay as a factor which is likely to result in a need for additional postnatal support.

Having to compromise the level of care that women receive appears to be a stressful experience for midwives, who report feeling anxious and worried about women leaving their care (Stewart-Moore et al., 2012). The complexities and challenges of trying to provide postnatal care can result in job dissatisfaction and demotivation to continue working, especially if midwives are not able to spend more time listening to women and providing the support they felt women need (Morrow et al., 2013). Indeed, persistent issues surrounding working conditions and limited interactions with women have been reported to result in low morale and poor retention of midwives in their posts (Stewart-Moore et al., 2012). Furthermore, where efforts have been made to test alternative ways to provide postnatal care, midwives report continuing difficulties regarding the documentation and information that is available when women are discharged from hospitals to community care, or when alerting other healthcare professionals to an emergency or high risk situation (Hunter et al., 2015).

## Postnatal care in the UK: The Future

There is a widely held perception that postnatal care has long been a neglected aspect of maternity care (Royal College of midwives, 2014c; Wray, 2006), and in 2014 the RCM (Scotland) Professor of Midwifery, Helen Cheyne stated that postnatal care had been 'starved' of resources over recent years (Royal College of Midwives, 2014d). Indeed, a lack of funding in postnatal care is reflected in previous distribution of payments for services in NHS England (Bowers and Cheyne, 2016; Royal College of Midwives, 2014b), where maternity service funding has traditionally been focussed on antenatal and intrapartum services, and hospitals have received only around a quarter of the estimated costs for providing postnatal care (Bowers and Cheyne, 2016). This is worrying, given that the decreasing postnatal length of stay in hospital after birth means that more funding is needed for postnatal care in the community.

Whilst postnatal care has historically been viewed as the 'Cinderella service' in maternity care (Royal College of midwives, 2014c; Wray, 2006), the recent National Maternity Review (National Maternity Review, 2016) provides an opportunity to assess and revise postnatal care in England. The corresponding report, 'Better Births' states that "caring for the woman and baby after birth is equally as important as during pregnancy and birth" (National Maternity Review, 2016 pg. 61) and that there should be "better postnatal [care] and perinatal mental health care, to address the historic underfunding and provision in these two vital areas, which can have a significant impact on the life chances and wellbeing of the woman, baby and family" (National Maternity Review, 2016 pg. 10). As such, the report calls for "an upgrade to postnatal services" (National Maternity Review, 2016 pg. 62) which includes a consideration of women's individual needs.

However, there are issues surrounding the ability to provide seamless individualised care that transitions from hospital to community, as this requires regular, comprehensive communication between service providers at the hospital and community whilst taking into account each woman's views and experiences; something which has been identified as problematic in the literature (Hunter et al., 2015). This type of care would also require flexibility on the part of the infrastructure of the services, to present additional support (in terms of time and information) when requested, and not only for women with greater risk or increased clinical needs.

Local Maternity Systems are tasked with a number of steps to begin local implementation of the Better Births recommendations in England, which are outlined in the recently published document 'Implementing Better Births' (NHS England, 2017). For improvements to postnatal care, these steps include bringing together NHS maternity services, health visitors and GPs, identifying opportunities for and barriers to improving postnatal care, working with local service users to identify expectations for postnatal care, and improving transition between maternity services and the health visiting team (NHS England, 2017).

England is not the only place where increasing attention is being paid to postnatal services. In their recently published five-year forward plan for maternity and neonatal care, 'Best Start' (The Scottish Government, 2017) the Scottish government also cited "high quality postnatal care" as part of their key recommendations for improving maternity care, stating that "The provision of high quality routine postnatal care should be afforded a high priority, with staffing models being reviewed in conjunction with the introduction of the continuity of carer model" (The Scottish Government, 2017 pg. 65). Similarly, Northern Ireland's current strategy for maternity care (Department of Health, 2012) acknowledges the need to focus maternity resources on community postnatal care, due to decreasing length of hospital stay, and suggests that "the potential to improve health and well-being for both mother and baby during the postnatal period is significant" (Department of Health, 2012 pg. 66). In the most recent 'Strategic Vision for Maternity Services in Wales' (Welsh Government, 2011) postnatal care is not uniquely identified as an area of action, but rather incorporated in to plans to "provide a range of high quality choices of care as close to home as is safe and sustainable to do so...and place the needs of the mother and family at the centre" (Welsh Government, 2011, p. 3). A recent Welsh Government-funded survey of women's experiences of pregnancy and birth in Wales (Welsh Government, 2017) will be used to inform the next report, which is due for update in March 2018.

At a time where services are over-stretched and resources are scarce (Royal College of Midwives, 2014b), there is a need to explore what is realistic and feasible when planning services, so as to meet

the needs of both women and service providers. As discussed, research on postnatal care has so far neglected to explore the role and responsibilities of community midwives in a focused and meaningful way. Indeed, it appears that the only opportunity for community midwives to reflect on their experiences of delivering postnatal care during qualitative research has been whilst discussing other topics, such as breastfeeding, or maternity care as a series of interactions between various healthcare professionals as part of continuing support for women during their pregnancy, childbirth and postnatal period (Askelsdottir et al., 2013; Barimani and Hylander, 2008). We argue that this misses an important opportunity to explore practical issues as well as potential solutions, and could hold the key to improving service provision.

In addition to an exploration of the views of midwives, we suggest that co-production work with community/postnatal ward midwives, women, and maternity managers has the potential to provide credible ideas for improving postnatal care in the context of decreasing length of stay in the UK. This work is currently underway at the University of Birmingham as part of the Collaboration for Leadership in Applied Health Research and Care (CLAHRC) West Midlands Initiative. This research will have added value in its potential to influence and inform the delivery and implementation of current government policy on postnatal services.

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**Figure 1: Search terms and databases searched for literature review**

Search terms	Databases
<ul style="list-style-type: none"> <li>- Hospital stay</li> <li>- Postnatal</li> <li>- Postnatal care</li> <li>- Postpartum period</li> <li>- Postnatal stay</li> <li>- Length of stay</li> <li>- Early discharge</li> <li>- Patient discharge</li> <li>- Discharge</li> </ul>	<ul style="list-style-type: none"> <li>MEDLINE</li> <li>PubMed</li> <li>PsychInfo</li> <li>Embase</li> <li>CINAL</li> <li>ASSIA</li> <li>HMIC</li> </ul>
<ul style="list-style-type: none"> <li>- Midwi*</li> </ul>	
<ul style="list-style-type: none"> <li>- Experiences</li> <li>- Views</li> <li>- Attitudes</li> <li>- Perceptions</li> <li>- Knowledge</li> <li>- Belief</li> <li>- Feeling</li> <li>- Thought</li> <li>- Impact</li> <li>- Influence</li> <li>- Effect</li> </ul>	