healthwatch Camden

Birth Stories

Experiences of Maternity Services in Camden

November 2022

Contents

1. Introduction

There is no doubt that women's experiences during their pregnancy, giving birth, and after giving birth stay with them for a lifetime and can shape their (and their partners) views on healthcare services. NHS England stated in their National Maternity Review that their vision for England's maternity services:

> "Is for them to become safer, more personalized, kinder, professional and more family-friendly; where every woman has access to information to enable her to make decisions about her care."[1]

Studies have also shown that factors for positive pregnancy and birth experiences include continuity of care, communication, respectful care and a good relationship with healthcare staff[2]. Women who have a positive experience feel empowered as mothers and emotionally strong during the transition to motherhood, whereas those with negative experiences are at a higher risk of adverse mental and physical health outcomes[3].

Significant changes were placed on maternity services due to COVID-19. These included:

- **Suspensions or reduction of home births**
- **Restricted visiting in hospital wards and neonatal intensive care units**
- **More remote antenatal and postnatal appointments**
- **Cancelled appointments and reduced appointments**
- **Social distancing measures**

These restrictions placed obvious pressures on expectant families. One study showed 60% of expectant mothers were experiencing anxiety, 47% experienced depression and 40% experienced stress related to the psychological impact of COVID-19[4]. Moreover, in North Central London alone, Asian pregnant women are more than twice as likely to have diabetes in pregnancy, compared to White counterparts (21% vs. 9%). Therefore, a positive experience using Camden's maternity services is not just about the time on the maternity ward, but in ensuring the mother is listened to, respected, and that her health is put first.

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[1] NHS England. National Maternity Review: Improving Outcomes of Maternity Services in England. 2016

[2] Redshaw M, Martin CR, Savage-Mcglynn E, Harrison S. Women's experiences of maternity care in England: Preliminary development of a standard measure. BMC Pregnancy and Childbirth. 2019;19(1):167

[3] Henderson J, Redshaw M. Who Is Well After Childbirth? Factors Related to Positive Outcome. Birth (Berkeley, Calif). 2013;40(1):1-9.

[4] Filippetti ML, Clarke ADF, Rigato S. The mental health crisis of expectant women in the UK: effects of the COVID-19 pandemic on prenatal mental health, antenatal attachment and social support. BMC Pregnancy and Childbirth. 2022;22(1):68-.

1.1 Why did we do the project?

The Better Births strategy recommended that women should be offered a personalised care plan. The plan will give women the chance to record more about their choices and what is important to them. It will cover the time while women are pregnant, during the birth of their baby and for a short time after. Healthwatch Camden wanted to gather insight from local women and their experiences of using maternity services in Camden and giving birth at University College London Hospitals NHS Foundation Trust and Royal Free NHS Foundation Trust. We wanted to use this research as an addition to the Better Births strategy, and to identify gaps and put forward recommendations to support the well-being of women giving birth in Camden.

Currently, the number of women accessing perinatal mental health care in all boroughs is below the Long-Term Plan ambition and, except for Camden, also below the NCL 2020/21 ambition. Access to perinatal mental health services is a national priority and currently only half of pregnant women and people in NCL requiring support can access the care they need. Data shows that for some sites in NCL, the utilisation of their midwifery-led units was around 30% or under, whilst obstetric-led units were dealing with significant pressures. This means that currently, pregnant women and people giving birth in NCL are either not electing to give birth in midwifery-led settings in large numbers, or their level of complexity means this would not be recommended.

Healthwatch Camden held interviews with nine women who gave birth since 2020. This report explores the experiences of these women during their pregnancies, labour and giving birth, and after giving birth. We are grateful to everyone who shared their stories with us.

We consulted with North Central London Integrated Care Board throughout the project and initially contributed to their Start Well Guide. We were aware that the ICB were researching key areas of improvement in maternity services, including addressing inequalities in services, efficient neonatal care and improving the transition of care from children's services to adult services. Throughout our engagement phase Healthwatch Camden and NCL ICB supported one another's' research on maternity care which helped shape some of the questions asked to our participants.

We also sourced midwife staff directly through ICB colleagues who linked us up with the two trusts' maternity teams to explore their experience on the wards and paint an overall picture of life in a maternity ward. They provided some very useful insight and balance which helped us clarify and focus some of our recommendations.

1.2 Project Aims

- To explore experiences of women giving birth in Camden
- To explore experiences of midwives in Camden and how their role has changed since the pandemic.
- Understand how COVID-19 impacted maternity services
- Showcase positive and negative experiences of accessing maternity services
- Identify gaps in services and put forward recommendations using lived experiences
- To speak to women outside of the hospital environment in a safe space for them to speak freely and without prejudice.

2. Experiences in antenatal care

It is important to note that there is a variance in quality of maternity services across Camden and the wider North Central London area. This means that not all experiences will be similar, and not all out outcomes will follow a pattern[5].

2.1 Birth plans

Birth plans are a record of what you'd like to happen both during labour and after giving birth. Healthcare providers begin to plan this with the mother as soon as the pregnancy is medically confirmed. We found variance in whether the mothers had birth plans, and what choices they could make within them. We heard from several women that, unfortunately, weren't aware of a birth plan at all, and therefore weren't given the opportunity to discuss and make their own choices.

> "I did not have a birth plan, nor did anyone explain to me what a birth plan is. This is the first time I have heard of it"
> "No one gave me a choice about hospitals or birthing, I just assumed that this was normal"

One woman was a first-time mum giving birth to twins. Her birth plan was proposed for after she gave birth.

> "I did think it was a bit strange that they never spoke to me about birthing options, because I had twins… they never gave me the option to have a natural birth, c-section etc. They said maybe at 36 weeks they would talk about it, but I gave birth at 34 weeks."

[5] North Central London ICS. Start Well: Opportunities for improvement in maternity, neonatal, children and young people's services in North Central London. 2022.

Some were told that their medical conditions stood in the way of them having a say in their birth plan.

> "Because I had diabetes, they said 'we're going to have to do an induction'.... it was planned by them, but I didn't have a say"
> "I found out at the end of my pregnancy that they were not going to let me give birth naturally. They had this plan to induce me, and I didn't know about it until week 30. It was a bit of a surprise for me"

Some women were able to make choices for their birth plans and based this on experiences they had in previous pregnancies. Past experience of maternity services made it easier to know what they wanted and didn't want this time.

> "I wanted to do it naturally because my other two were born naturally"
> "My first baby came very quickly. Everything went very quickly. I wanted it to be the same way"

One of our interviewees detailed her experience with her midwife who only gave her the option to give birth at home:

> "I didn't have a written birth plan. The midwife asked me if I wanted to have my baby at home. They did not have a plan for me to go into hospital. I can't even remember them asking me about choices, they just told me. I was 5 months pregnant before I even got to see a GP".

2.2 Explaining women's choices by healthcare staff

Freedom to choose what happens in your own pregnancy is one of the greatest factors for having a positive pregnancy birth experience[6], as it allows patients to make an informed decision about their and their child's health. When we asked our interviewees whether they had a say in the choices made and if healthcare professionals explained these choices, we found that some healthcare staff took lots of time to explain everything for some people but not to others.

> "Yes, everything was explained to me. The midwife really wanted me to feel comfortable about everything. We were chatting a lot"
> "I didn't know I had choices and that there was a birth plan. They should take time to explain it so that pregnant women and their partners understand"
> "I think that inducing me was the only way they saw my pregnancy. I didn't get any other preference. I wanted to have it naturally"

[6] Jomeen J, Martin CR. The impact of choice of maternity care on psychological health outcomes for women during pregnancy and the postnatal period. Journal of evaluation in clinical practice. 2008;14(3):391-8.

2.3 Importance of communication between staff and patients

Through all our interviews, participants detailed the communication they received from healthcare staff and how this produced either a positive or negative experience.

> "I kept being late to appointments because I had two other children and my midwife was very understanding. She waited for me. Everything was explained"
> "It's difficult to get through to the ward or to the relevant doctor and sometimes you need them."
> "They did not explain anything because it was during COVID. No one phoned or kept in touch with me. I would have appreciated a phone call"

One of our participants was diabetic and had concerns because of her experience in previous pregnancies. She spoke to one of the lead midwives at UCLH who reassured her.

> "With my third pregnancy I had a tear, so my biggest fear was the same thing happening again, especially if I don't have a midwife that's going to be with me throughout the pregnancy. A midwife was dedicated to me throughout. She was fantastic"

2.4 The impact of COVID-19

As outlined in our introduction, COVID-19 placed enormous pressures on the NHS, no least in its maternity services, increasing the chance of a negative experience in care. One survey on expectant mothers in 2020 found that 85% of participants reported a negative impact on their mental health due to hospital restructures, as well as an increase in their child-birth-related anxieties[7].

Although the primary focus of this research was not COVID-19, as all our participants gave birth from 2020 onwards, we found that it impacted the care they received and their experiences. For example, whilst some were able to receive face to face appointments, others were given appointments online. They felt that the changes in hospital access made their experience more stressful for them, especially with childcare concerns.

> "One time I had a scan and… [a staff member] came and said you can't take your daughter with you because of the risk of COVID".

One woman felt that she did not receive enough support during her pregnancy compared to the care she had before the pandemic.

[7] Pregnant Then Screwed. Huge mental health toll that COVID restrictions have had on mothers to-be is laid bare in a landmark survey. 2020.

> "With the diabetes team most of the appointments were online. I don't think I had a nutrition team involved which was hard. They sent me a chart of what to eat, but at the same time I would have liked to have seen someone and talk through what I needed, even though I had a food diary. It was all over the phone".

Alongside mask-wearing and social distancing, there were limitations to those visiting/ accompanying people in hospitals, such as partners. Many found this restriction hard as they needed both physical and emotional support during the appointments, especially if there were complications.

> "I had to go to the appointment on my own, [and] scans as well… The staff told me that the baby was small, so it was a bit of pressure. When you have problems, you want to have someone with you".
> "The staff were excellent, but if my husband was allowed to be with me, it would have been better"

One interviewee went alone to her appointment and felt as though the consultant didn't listen to her. After this, she brought her partner with her to the following appointments to try to feel more listened to and have a better experience.

> "I think the first time I went alone, and it was not a nice experience. It was literally two minutes in and out. So, the second time I made sure that I brought him. He came to all the milestone scans"

2.5 Choosing your hospital

We asked our interviewees how they picked their hospital to better understand what factors are considered when making these decisions. Everyone highlighted how close the hospital was to them, showing us that proximity and convenience are key factors when making this decision. However, for those who had previous pregnancies, these experiences also factored into their decision.

Two interviewees didn't have a choice in the hospital they received their care at, and this was chosen by their GP.

> "I was referred to UCLH. The GP sent me there, they didn't give me a choice"
> "There was only one option at the time because we are refugees. We arrived here and we lived near the hospital. I was referred by the GP to the hospital so I went there"

3. Giving birth in the ward

3.1 The importance of partner presence and midwife support in their absence

The COVID-19 restrictions impacted all the interviewee's experiences. Those who couldn't have their partners with them due to COVID-19 restrictions highlighted to us how upsetting this was for them.

> "Yes, I didn't have a C-section, but my body has gone through quite a traumatic experience. It would have been nice to have my partner's support in there."
> "When I gave birth my partner couldn't come with me to help. I had to get an uber [to the hospital] by myself. I was contracting and literally had to stop every two minutes to gather myself"

Some partners were able to stay during the birth but had to leave immediately after.

> "It was actually very upsetting that he had to leave"

Several women, however, highlighted how their midwives supported them in the absence of their partners, and how important this was to them.

> "I still remember this midwife's name. She was the most cheerful and positive person I've ever met. She would try to cheer me up in every way and offer me anything I wanted, music, jokes etc. She made me really comfortable because she saw that I was anxious"
> "I was in active labour. The midwife was a lovely lady. I remember her name. She was helping me and said, 'I know your husband isn't here with you'. She was really there for me."
> "They gave me gas and air, and a bouncing ball. The midwives were really trying to help me. Whenever I said I can't do this anymore they were morally supporting me saying yes, you can do this, your body knows what it's doing. They were a really encouraging and positive team"

3.2 Communication between staff and patients

Effective communication during labour and birth can help women feel respected, in control, and feeds into their positive birth experience. Several of our interviewees expressed instances of effective communication, which fed into a good overall experience for them.

> "The staff on the ward were really good. They explained everything to me"
> "The midwife was communicating with me during the labour, kept telling me the options I have and was reminding me"

Whereas others had experiences of poor communication from staff on the ward.

> "We had no idea what was happening, honestly. They just went in and said oh you're in labour now. All I could think was that I want an epidural because it was really painful. I just know that they put me on an epidural, I waited, they let me push and then I had an emergency C-section"
> "My birth partner wasn't even allowed until the very last minute. The communication was very weak on the ward."

3.3 The notion of female pain tolerance

Research has shown that there is a gender bias in how healthcare staff interpret patients' pain, often to the detriment of women[8]. This is rooted in the notion that women are overly sensitive to pain and thus exaggerate it, causing healthcare staff to undertreat their pain. This was reflected in the experiences some of our interviewees had with staff on the ward, such as the following example of a consultant inserting a cook's balloon for her induction.

> "She was using this metal instrument which they put inside you to make it bigger. It was very painful. The consultant told me that I should take it, saying 'it's not a fun thing, it's going to be painful', so I should just take it. I was screaming… I couldn't stop crying. It was kind of violent. I'm not a very strong person. I'm lightweight. Honestly, from my heart, it took like two thirds of the energy I had for that day. I just couldn't stop crying"

Of the nine interviewees, three were told that because they didn't have a C-section, they should not be complaining about their pain.

> "I just gave birth and went into the ward. The midwife said to me 'you didn't have a C-section. You need to get up and change the baby'. I found it quite shocking and harsh"
> "I asked them to bring me something to help me. You feel so weak, you can't get up. If your baby's crying, you can't lift yourself up and you can't lift your baby. I called the midwife, and she asked me why do I feel so weak'

Additionally, some felt that their concerns were not being taken seriously. One woman told her midwife that her catheter had come out. The midwife dismissed her, but later, after feeling a lot of pain, the patient was correct - it had come out.

> "I called the midwife, and they didn't believe that my catheter came out. She said no it couldn't have come out"

[8] UCL. Analysis: Women's pain is routinely underestimated, and gender stereotypes are to blame. 2021.

4. Professionalism

The NHS states that it "aspires to the highest standards of excellence and professionalism"[9]. Some women we spoke to felt that the staff they interacted with lacked this core value.

> "She was very cold. It was strange, because you would expect someone who chose the profession of being a midwife to be a lot more compassionate than that"
> "I had this community midwife who was really friendly and easy to talk to. But because she was so friendly she would tell you extra things that you didn't need. My baby was small and she would tell me that women with small babies were at higher risk of having stillbirths. She would mention it every time I go to an appointment… She was doing it from her heart, but it wasn't professional"

One woman was undergoing a treatment where the consultant appeared to be learning on the job. The midwife then successfully completed the procedure, demonstrating better levels of professionalism.

> "The consultant was reading the instructions on how to do the procedure… It was like heaven and hell. Somehow the midwife did it within a couple of minutes… She was experienced… she was professional with what she was doing. She didn't need to read the instructions"

5. Understaffed and night staff

According to the Royal College of Midwives, maternity care services in England are currently facing a shortage of midwives – an issue before the pandemic but exacerbated since then[10]. These shortages were widely mentioned by the women we spoke to, with an emphasis on particular shortages of staff at night.

> "The consultant didn't seem surprised. I think they know that they're understaffed."
> "I didn't feel like the midwife had any empathy or understanding of what I needed, it wasn't nice. I just felt like she was rude because it was the night shift"
> "I felt like [the ward] was understaffed"

[9] NHS. The NHS Constitution for England. 2021.
[10] Royal College of Midwives. Government must fix maternity staffing crisis to ensure safety RCM tells TUC Women's Conference 2022 [Available from: https://www.rcm.org.uk/media-releases/2022/february/government-must-fix-maternity-staffing-crisis-to-ensure-safety-rcm-tells-tuc-women-s-conference/#:~:text=England%20is%20currently%20grappling%20with,the%20year%20to%20November%202021.

6. Experiences with postnatal care

Postnatal care plays a key role in ensuring that women can safely and successfully transition to parenthood. However, a survey from 2014 exhibited that the postnatal period is where women in England are least satisfied with the care they receive. The satisfaction rates for their pregnancy care were 88% versus 77% for their postnatal care[11].

6.1 Expectations on women to know what they're doing

We heard that healthcare staff in the postnatal ward often did not provide enough support to our interviewees on the grounds that they "should know what to do after giving birth".

> "I had an emergency C-section had two babies to feed and I couldn't even get out of bed. They told me to ring the bell when I needed help. Either someone wouldn't come or when they came, they said they can't help me".
> "They wouldn't help me with changing nappies or to feeding. I was a new mum, I knew nothing".
> "The midwife just wanted me to get on with it by myself. I can't remember what I needed help with, but I needed help".

6.2 Communication between staff and patient

After giving birth, our participants detailed both positive and negative experiences with the communication they had from the hospital.

> "I was informed about everything I needed to do like registering the birth etc. They gave me a booklet and papers explaining what to do. I would say the communication was good".
> "When you're inside the hospital everything is totally fine. But once you are outside, you have to be patient… The communication is too poor".

Many hospitals provide a birth reflections service, where you can go through what happened during the birth and why, as well as answer any questions a person may have. One of our interviewees found out about the birth reflections service through a friend, rather than from the hospital.

> "I didn't know this, but I heard that you could have an after session with a consultant and they'll go through everything that happened in your birth. I asked the midwife and requested that because I didn't know I could do it"

[11] Redshaw M, Henderson J, . Safely delivered: A national survey of women's experience of maternity care 2014. National Perinatal Epidemiology Unit, University of Oxford; 2015.

6.3 Communication between staff

Some of our interviewees expressed that there were also gaps in communication between different staff within the hospital.

> "I hadn't slept for days, the babies weren't even eating, they were losing weight. I asked everyday if they could be weighed. The midwife said no, the [Newborn Intensive Care Unit] has to come and weigh them. When the NICU came, they would tell me that the midwives have to weigh them."
> "The doctor was testing for a virus, the day nurse didn't know about the method of collecting urine with a bag, so we were struggling to collect urine with cotton wool balls. This is an outdated method. The evening midwife had the bag for the baby, which was extremely helpful".

6.4 Voicing medical concerns

Some parents felt reassured by staff voicing medical concerns about the baby, as it demonstrated to them the continuity of care for mother and child.

> "As long as they were looking at my baby and not just sending us home, I was happy that they kept me there to reassure me that the baby was okay".
> "We were happy to stay as long as my baby is getting what he needs to get".

However, when some of our interviewees voiced their medical concerns to staff, they felt as though their concerns were not listened to or brushed away.

> "There was no infection but the redness in his eyes was a concern for us. It was difficult to find someone to confirm there's no infection".
> "We felt like we had nowhere to go.".
> "I was shivering and had hives because of the epidural. I had to ask like 10 times for an antihistamine".
> "One of the babies had jaundice. I kept asking for somebody to look at him and none of the midwives would look at him".

7. Mental well-being

The experiences that women go through during pregnancy and afterbirth can impact their mental well-being, especially when they experience psychological trauma when giving birth and in the postnatal period; this can damage the early days of building the other-baby bond[12]. A few women spoke about their mental well-being after giving birth and the support that hospital staff provided.

[12] Reed R, Sharman R, Inglis C. Women's descriptions of childbirth trauma relating to care provider actions and interactions. BMC Pregnancy and Childbirth. 2017;17(1):21-.

"I had quite a bit of trauma from the birth. I had to go for primary care support with a specialist because it was so stressful for me, the experience triggered something".
"They let me know that there was help if I needed to speak to someone outside the family, which is great because sometimes you want to speak to someone who may understand what you're going through a bit more".
"The midwives told me that if I'm feeling depressed, I should always call them for advice".

7.1 Loneliness and social support

The COVID-19 New Mum Study has shown that a high proportion (59%) of women felt lonely after giving birth since the pandemic started[13]. This was reflected in the women we interviewed in Camden.

"In the beginning I was a bit down… No one can see us. But I did have support afterwards. I live with my in-laws and husband".
"The first six months I was isolated. I was alone and it was hard with two premature babies".

7.2 Midwife support

The support which midwives provide to women during pregnancy and after care, have a profound effect on positive or negative experience during pre-natal, birth and postnatal care.

"The midwives were helping me breastfeed the baby. This was very helpful".
"I was amazed. They were really helpful and very informative. I asked the midwife about tongue ties because I was unsure about this. This was the first midwife that explained to me that if the baby can't stick their tongue out then they have a tongue tie".
"There was an amazing midwife who came. She was lovely and made me feel happy. I was relieved to see her"

7.3 Continuity of care

Studies have shown that patients who receive continuity of care generally have better health outcomes and are more satisfied with their care, and vice versa[14]. A few of our interviewees expressed a break in their continuity of care, especially in staff changeovers.

"With every new person it's like you have to start explaining again".
"With UCLH they're always changing. Every few weeks you will see a different midwife".

[13] Dib S, Rougeaux E, Vázquez-Vázquez A, Wells JCK, Fewtrell M. Maternal mental health and coping during the COVID-19 lockdown in the UK: Data from the COVID-19 New Mum Study. 2020.
[14] NIHR. Improving health outcomes for women and babies at higher risk of complications during pregnancy and birth by changing how care is delivered. 2022.

"You feel like you don't haven't bonded together. It would be helpful to have one midwife from the beginning to the end".

8. Race and Ethnicity

Although our research did not directly focus on racial inequalities, most of our interviewees came from an ethnic minority background, reflecting the demographic in Camden. Across the UK, women from ethnic minority backgrounds face higher morbidity rates and mortality rates during pregnancy and childbirth. For example, Black women are four times more likely than white women to die during pregnancy or childbirth[15]. Women from minority communities also face poorer experiences across maternity care services compared to white women[16]. Some of our interviewees spoke of how they felt their ethnic/racial background impacted their care.

"Every time I was pregnant, I was like 'oh I'm going to go through the same thing again'".
"Maybe they don't speak the language and get treated in different ways".
"I think they feel like they can mistreat you because you're from a certain background".
"If there is something which gives women choices then it should be explained better to BAME women like us"

Just as there are disparities in perceptions on male/female pain tolerance, one woman saw the same along racial lines.

"At some point the nurse was like 'you should you this, you should be stronger because you're African. I was like, how am I supposed to know"?

** *To note, those who expressed that they had traumatic or negative experiences were offered by Healthwatch Camden to be signposted to relevant services.*

9. Midwives' Experiences

Healthwatch Camden is aware that many of the wards have lifted most Covid restrictions since these interviews were conducted, and we were eager to speak to staff to gather insights on what has changed since the pandemic, and what services are available to pregnant women. In October 2022 we held anonymised interviews with four midwives that worked at both hospitals to understand the experiences of people using maternity

[15] MMBRACE-UK. Saving lives, improving mothers' care. 2020 Report. 2020.
[16] Khan Z. Ethnic health inequalities in the UK's maternity services: a systematic literature review. British journal of midwifery. 2021;29(2)

services in the borough throughout the pandemic and their views and experiences of delivering maternity services in Camden.

9.1 Continuity of care - Experiences during COVID-19

The midwives shared their experiences of working through the pandemic and delivering maternity services at this difficult time. They described at times it was difficult to deliver consistent levels of care due to rapid changing in policies, which sometimes could be multiple changes in one day. This may have caused women coming in to feel on edge or have more fear of coming into a constantly changing environment thus affecting the level of efficiency they experienced.

> "I think for me, it was the rapid changing regarding what was happening in maternity care. Once COVID came in, we were getting daily updates from government websites from the trust and from NCL, so we were getting lots and lots and lots of information. So, it meant that we were literally changing policies daily."
> "We have three or four different [policies] coming in at the same time. And that was it. It was quite difficult for the staff as well, because what we decided to do in the morning sometimes would be different in the afternoon."

9.2 Continuity of care - Changes post COVID-19

During the pandemic a lot of face-to-face appointments became virtual appointments, and the midwives explained that this was well received as it allowed expecting mothers to speak to somebody without having to leave their home. They explained that although many Covid restrictions have been lifted, virtual appointments have continued.

> "Things like doctor's appointments are just on the telephone now. And I think that's a really good thing because it's more accessible for women and actually reduces some pressure on the service."
> "But there are still some appointments that are telephone appointments... I think they're not necessarily ones that would have needed to be face to face"

They described some of these changes were beneficial, and some appointments are still offered virtually as it has provided a more accessible service to women, their partners, and reduces some pressures on the service.

> "I also do a debrief clinic with women and we went to virtual over that. And we've continued to evolve, because very often when we will see they've got young babies, etc. So they quite liked the video appointments... as their partners can be there. They don't have to bring themselves all the way to the hospital... and not need childcare. So there are some [beneficial changes from the pandemic]. And there's been some good stuff that has come out of all the changes that we have."

As our interviews with the women demonstrated, the reception to virtual appointments was mixed, however generally presents as a positive move for accessibility, especially regarding childcare and transport provisions.

9.3 Support and Wellbeing – tackling 'compassion fatigue'

From our initial research we understood how difficult working through the pandemic was and wanted to understand the support that midwives received. From evidence we know that healthcare professionals can experience compassion fatigue and our interviews understood this and was generally sympathetic to the workforce. The midwives explained the difference in support and services that they receive and have access to.

UCLH:

The midwives working at UCLH explained how there are in-house psychologist services provided, but also stressed the significance of peer support.

> "There is an in-house psychologist, I think started a couple of months ago. I think she's going to run some like group sessions and if people have like a difficult case or something, they can reach out to her."
> "You know, generally people would reach support through their line managers, but I feel like there's a lot of like peer support. We've got like a midwife who's kind of a delegated staff wellbeing midwife. And she has managed to rope in some voluntary support from like massage people who come, and they offer free massages."

The UCLH midwives we spoke to thought that these massage sessions, for example, were useful in tackling fatigue – yet they explained that even though they had booked multiple slots they haven't been able to attend because of staffing issues.

Royal Free:

The Royal Free Hospital provide an external service called Care First Support Line and they receive emails to everyone that works in a Trust everyday advertising what support is available.

> "They're available 24/7 to all staff, and that's kind of promoted highly through our free net that's available to all staff and occupational health, and the managers always talk to their staff about it."S

Like UCLH, there is also in-house support provided to midwives and other support has been provided through formal and informal means. They now have a matron that goes on ward rounds and talks to the staff about what issues they are facing; they have weekly wellbeing rounds and a safe space for midwives to talk about their concerns.

> "There also have an occupational health and they have their own counsellors and stuff that are available... it's not 24 hours, it would be like, Monday to Friday, nine to five."
> "We've acknowledged that staff morale isn't going to be great, because we're so short staffed, but what can we do to improve that for our staff? That's something that we're working on, it seems to be going well, so far".

This provides a way for staff to suggest recommendations, and for management to put them into place.

> "We're working on staff morale, and for the staff we're doing weekly wellbeing rounds... [We speak with the midwives] about how they're feeling, how they're week is going and if they have any recommendations. We're then coming together and putting in place those recommendations."
> "We also have something a little bit more formal, it means that midwives or healthcare support workers have a safe space to talk about their concerns. It goes in a log, and they try to look at ways of improving. There's some improvement over the night stuff. I think there was issues about the coordination of changing staff after a night shift".

9.4 Birth Plans

From our interviews with expectant mothers, we found that a lot of them were unaware of birth plans. Or, if they were aware of them, some were unable to make full decisions because of their personal health or premature births. We wanted to ask midwives' views on how these are provided and if they are followed during birth. It was of the midwives' views that birth plans were often given out, discussed at 36 weeks. As births are always unpredictable, they are not always followed, however there are some parts of the plans that are stuck to.

> "I think most people come with an idea at the very least discuss it at their 36-week appointment. We have quite an affluent population and not everybody obviously, but because around sort of 78 to 80% of the women that come to us don't live in our catchment area, that just shows you how many women's select to come to [UCLH]"
> "They have a discussion with their community midwife for a rough plan to be made."
> "We don't lean towards very strict plans being made, because obviously, it's an unknown circumstance. So, we would just discuss what is available. And if they have any very strong preferences, they would be able to write those down."

9.5 Training on Race & Ethnicity

Although our research did not directly focus on racial inequalities, we know that more training needs to be provided on how to treat patients from a minority ethnic background. A lot of the patients that we interviewed were not fluent in English or wasn't their first

language, so they had to rely on family members to translate medical advice. The midwives we interviewed explained that there are interpretation services available on all wards and this helps to communicate medical advice and information.

> "Each floor [UCLH] has what we call an 'interpreter on wheels'. So, it's kind of like a tablet device, which you can select like the all the languages on and it can be a video face-to-face translation service or like a phone call but over the tablet."
> "At the Royal Free we do a three-way conversation in the clinics. Most of them have loudspeakers, the phones that we use have loudspeakers."

Although there wasn't an in-depth conversation on what types of training is provided, both hospitals mentioned that training on race and ethnicity is available.

> "We had some training offered to us from the 'FIVEXMORE' group, which is a group that focuses on the health and equalities that affect women from BAME backgrounds - but that was like optional, so only a few people I would say really have done that."

However, UCLH mentioned that these training modules are optional meaning that all staff weren't required to take extra training in treating BAME patients.

> "[There is] Optional online e-learning training is on personalised care, so it's not specifically focusing on that group, but it is on like personalised care planning. So being aware of ethnicity, considering it's a risk factor to take into account when making plans and considering risk. But I wouldn't say that we've had like any mandatory targeted training."

10. Conclusion

Our research demonstrates both positive and negative experiences of women using local maternity services, highlighting the importance of communication, social support, and choice. We heard that perceptions regarding women and pain, especially to BAME women, greatly negatively impacted the care they received.

Although the midwives we spoke to suggest the current system for birth plans in place is useful, our interviews with women suggested otherwise; there were common themes of decisions being made for the women, or little to no knowledge of what a birth plan was. Although births do not always go to plan, this disparity of understandings on birth plans is clear in this report and must be highlighted.

The pandemic, as discussed, provided huge pressures for the NHS and for the people using its services. It highlighted the health inequalities at play, and as suggested by

midwives, greater accessibility measures have been put in place since. Both staff and patients interviewed feel there are shortages in staff and funding, and the women we interviewed expressed large amounts of sympathy towards the staff facing these issues. However, there were common themes across these interviews that expressed a lack of communication – both between staff, and to the patient. While the NHS attempts to improve these shortages and their consequences, more attention needs to be paid to making sure women are kept up to date on the care provided to them.

Although this study was not targeted at women from ethnic minority backgrounds, we found that most of our interviewees were from a BAME background, in line with the demographic in Camden. Their experiences largely followed national trends. Language barriers were particularly linked towards poor experiences on maternity wards despite Camden speaking around 150 languages. Several of our women heard comments from healthcare staff insinuating, even gaslighting them that they should not be or are not in as much pain as they were claiming to be in. Studies in the UK and internationally have shown that ethnic minority patients are more likely to have their pain underestimated and therefore receive less effective pain management when compared to white patients. Although this report did not investigate experiences of racism on the maternity wards, our interviews highlighted examples where they felt side-lined due to their race. Camden is an extremely diverse borough, and this report can act as one start point towards addressing local needs in health inequalities.

As healthcare providers wield a lot of power, we rely on staff to look after us and our well-being. Healthcare providers should ensure that staff are trained and up to date so that these perceptions and biases do not impact the care that patients receive.

Healthwatch Camden is very grateful to the nine women who gave us the opportunity to hear their birth stories, and to the four midwives who shared their experiences. We will be sharing these findings of this report across Camden and North Central London to help work towards building better maternity care experiences.

11. Recommendations

We understand that the NHS works tirelessly to provide maternity care services, however feedback from the women we interviewed shows that there is still room for improvement. The following recommendations mirror those put forward by the North Central London Integrated Care System and other national initiatives, which focus on improving communication, equality and inclusion, and personalisation of care. These recommendations are from our interviewees directly, and we propose the following based on their experiences.

Continuity of care

- We echo the recommendation from the NHS CORE20PLUS5 initiative, where 75% of patients by 2024 should have one point of contact, such as one midwife, throughout the care cycle.

Appointments

- There should be a choice given to patients for face-to-face or virtual appointments to prevent access barriers such as childcare, transport, or language.
- Maternity wards, where possible, should communicate in advance to patients of changes in appointments and notice of who will be picking up appointments.

Birth plans

- Every woman should be given a birth plan during her pregnancy, and plans must be completed before average premature dates (32-34 weeks pregnant) to ensure that mothers have birth plans even when the births are premature.
- Staff should take time to explain what a birth plan is and their options, as some women are not aware of it and therefore denied their own informed choices.

Communication

- Staff within the hospital should work towards better communication between themselves on the decisions that are being made and their roles and responsibilities to avoid confusion and delays in patient care. This should also include managing expectations with expectant mothers around birth plans; birth can be uncertain which can make it difficult to follow a stringent plan, but this needs to be managed well and effectively communicated.
- Maternity care staff should work towards better communication with patients as many feel as though there is a gap in communication, e.g., the decisions being made for their care.

- Improved training is needed that focuses on addressing a patient's medical concerns. A system should be implemented that deals with complaints to ensure both peace of mind to patients and that nothing of concern is missed until later stages.

Race/ ethnicity

- Robust and mandatory training should be given on anti-racism and cultural safety for all staff. This should be run at least annually and develop clear standards on what constitutes racism and discrimination in the workplace and service provision.
- Pain narratives and expectations surrounding women, particularly BAME women, must be addressed as it can cause negative care experiences.
- In line with the national report by Birth Rights, we recommend the following:
    - Review the Maternity Incentive Scheme (CNST) to routinely capture ethnicity data at booking and address ethnic inequalities in maternity outcomes as core safety actions.
    - Revise the Birthrate Plus tool to include ethnic and social need data in calculations for staffing need e.g., to allow for potential extra time due to language barriers and cultural and social needs and put Black and Brown women and birthing people in control of their care and respect their dignity, choices and concerns.

Staff wellbeing

- Although peer support is important for staff morale, and safeguarding leads within staff proves useful, formal staff support should be outsourced to alleviate the need for midwives to have to organise their own care when their time is limited.

12. Appendix

12.1 Methodology and ethics

We sought to understand the experiences women had when pregnant, giving birth and after giving birth through 1-2-1 semi structured interviews. The interviews took place over the phone, lasting between 30-50 minutes.

Over June and July 2022, we independently sourced women through health workers based at the St Pancras and Somers Town Living Centre, advertisements on Voluntary Action Camden and other voluntary services and other social media campaigns for us to gain insights from those who had given birth in local hospitals. To those who were interested in telling us their stories, we explained the details of the research project and took verbal consent at this recruitment stage. We took verbal consent again at the beginning of each interview.

We made it clear to participants that it was not compulsory to answer questions they did not want to answer and that they were able to withdraw at any point. Guidelines for monitoring participants' well-being was observed throughout the interviews. We utilised one to one interview to provide a private environment allowing participants to comfortably share as much or as little as they liked about their experiences. The interviews were recorded, with consent, and transcribed in full verbatim. The recordings were encrypted so that they were only accessible by the research team and were deleted after the transcription and report were complete. Any personal details have been anonymized.

For this study, we used thematic analysis to analyse the data we collected. All members of the research team read and familiarized themselves with the interview data. An individual round of inductive coding was undertaken initially to prevent influencing each-other. An analysis session was then held to discuss what we all found. The research team then conducted a second round of coding together and produced the key themes that shaped our report's framework. Each interview was then analysed again using this framework.

12.2 Limitations

The research team consisted of women to allow participants to feel more comfortable sharing their experiences and build rapport. There are limitations to our research. As interviewees self-selected, there may be voluntary response bias. Those with more adverse experiences may have been more driven to participated and share their experiences. Additionally, our sample size is small however, upon conducting the interviews, we found that we reached data saturation at nine interviews and gained an in depth understanding of the experiences each of the women we spoke to.

Regarding the midwife interviews, Healthwatch Camden received participants who were selected by the management teams at the Royal Free and UCLH. Although, we have anonymised these interviews they may be identifiable by the management teams at both hospital, this may have limited them from sharing their full views and experiences. These midwives were also all Band 7, meaning they had some management duties themselves and did not always operate on the 'front line' on the delivery wards.

12.3 Demographics

This report is based on qualitative interviews and surveys with a relatively small sample size (9) of people and includes personal and sensitive data.
To maintain anonymity of participants, we have made the decision not to publish demographic data in the traditional method. Below showcases a combined description of who we interviewed.

- Age of participants ranged from 26 to 45
- Five of our participants were aged between 26-35 and four of our participants were aged between 36-45
- Two participants were from an Asian/Asian British-Bangladeshi background
- One participant was from an Asian-Indian background
- One participant was from a White background and one participant was from any other White background
- Three participants were from a Black/Black British African background
- One participant identified as other-Afghanistan
- Six of our participants gave birth at UCLH and three of our participants gave birth at Royal Free Hospital

12.4 About Healthwatch Camden

Healthwatch Camden is an independent organization with a remit to make sure that the views of local service users in Camden are heard, responded to, taken seriously, and help to bring about service improvements. Our duties (which are set out under the Health and Social Care Act 2012) are to support and promote people's involvement in the planning, running and monitoring of services; to gather views and experience and to make reports and recommendations for improvement based on those views; to offer information and advice on access to services and choices people can make in services; and to enable local people to monitor the quality of local services.

Our remit extends across all publicly funded health and social care in the borough. It includes statutory powers to enter and view any publicly funded health and social care service and to call for a formal response from the relevant bodies to any of the recommendations we make.

Healthwatch Camden has a seat on the Health and Wellbeing Board and contributes directly to strategies to reduce health inequalities across the borough.

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