ROYAL
COLLEGE
OF MIDWIVES

ISSN: 2633-8408 June 2021 Vol.19 No.2

EVIDENCE BASED MIDWIFERY

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The digital midwife

Keywords: digital midwife, technology, role of the midwife and evidence based midwifery

What does the phrase 'digital midwife' mean? I searched for it on Wikipedia on 13 March 2021 and *it does not exist*; the option to create it was there but I declined. The meaning of the term was not clear to me and I continued my search.

In my earlier work, a digital midwife was a virtual midwife in touch electronically with women who needed the knowledge and skills of the midwife but could not meet face-to-face, and this was prior to COVID-19. We used this term interchangeably with the 'virtual midwife' or the 'e-midwife' for research purposes but now it seems the digital midwife is a distinct and specific role, and one of great importance.

In my Google search for digital midwife I found several job advertisements for posts in England and, in one instance, the salary was Grade 8a (West Hertfordshire Hospitals NHS Trust 2021), indicative of the high level of importance and expectations of the post holder. The job specification included being the lead midwife for information technology (IT), coordinator and collator of maternity data in the service and liaising with internal and external agencies on digital matters. It became clear to me that this role was significant and of strategic impact.

Further searching revealed that the origins of the role were rooted in the creation of NHS Digital (2017), and it seemed to me that the voices of midwives had indeed been heard at government level when they were planning a major overhaul of the NHS IT systems in England. The potential for a more accessible electronic patient record (EPR) system with standardised operating systems, streamlined data input, easier data transfer and data access from any patient administration system in the NHS was, and is, of enormous value to clinical midwives and to research midwives. The history of the origination of the digital midwife role and its prominence was beginning to emerge.

Further exploration led to finding a well-established plan of action for the development of the role by the Royal College of Midwives (RCM). The terminology 'digital midwife' was described by the RCM in their March 2021 position statement. The professional impact was evident from the high visibility of the role, which was prominent on the RCM newsfeed and website. The RCM has appointed Hermione Jackson as the specialist advisor on all matters digital. In addition, the RCM is calling for every maternity service to have a new digital midwife appointed within the next 12 months to lead the 'digital transformation' (Anon 2021).

I thought about the RCM statement and the 12-month plan and wanted to gain a deeper insight into the expectations of those taking up these new roles. I began to search jobs related to digital midwife. The jobs I found described the uniqueness of the role and the similarities across services. In essence, the role requires a midwife who would retain professional status and yet have a key role in developing the EPR. There appeared to be a recognition of the value of having knowledge of the clinical administration systems that interface with the EPR (NHS Jobs 2021). However, I could not see any reference to research and hope this may eventually be included as a part of the job specification. Research using electronic data requires specific skills but these can be taught.

My next step in this exploration was more like a leap into the ether. The role of the digital midwife had by now taken on a new focus for me; the exploratory work had compelled me to use the researcher lens to imagine how the role could be developed to facilitate midwifery research. First, my midwifery research bias must be acknowledged and I need to declare that my primary goal in the next few sentences is to inspire some of you who read this to take action. I hope you will be eager to develop a digital midwifery research network, or a digital midwifery research data bank, in collaboration with the RCM, that will contain critically appraised and evidence-supported research questions/topics of importance to midwives. Examples are national data on birth type

and place, infant feeding patterns, medications taken during pregnancy, chronic conditions, mental health, birth anomalies, and encapsulating this data within a more user-friendly and interactive system. Hopefully, multiple data sets will be more easily linked, such as prescribing databases, anomaly registers and child health systems.

Midwives are creative with technology so it is great to see news about midwives making technology work for them, and for mothers, during COVID-19. An excellent example was recently reported by the RCM in relation to the Birmingham symptom-specific obstetric triage system (BSOTS). I accessed the Birmingham website and could see it was launched last year as an e-system, built on using specific algorithms to triage women in terms of obstetrical level of need for immediate care. It was refreshing to see the midwifery expertise highlighted and the training led by Professor Sara Kenyon, who is currently working at the Institute of Applied Research in Birmingham and is a registered midwife with an established research profile (Birmingham University 2020).

The programme consists of an online educational component followed by a one-hour clinical element. Reports indicate the BSOTS system is easy to use and has been evaluated positively, with over 15 units currently operating it and more in the preparatory stages (Birmingham University 2020). The most important point to note is the rollout of the training across all four countries of the United Kingdom (UK) and this signals a hallmark of quality and a seal of approval (Jackson 2021).

The light touch search to enlighten myself about the digital midwife led me to ask the next question: *What is a digital doctor?* The Wikipedia search mirror-imaged the findings for 'digital midwife' (does not exist but I could create a definition). My Google search produced an interesting perspective — the digital doctor search produced over 250,000 hits, with the first couple of pages clearly linking this title with a face-to-face doctor providing online services. My follow-on search of the Royal College of Obstetricians and Gynaecologists' webpage for 'digital doctor' produced interesting results about digital exams but nothing specific to the creation of a new role or a visionary position statement like the recent one by the RCM (2021).

In conclusion, it looks very much as if the COVID-19 pandemic has brought some major benefits to the digital agenda and the technological role of the midwife. I have been researching in this area for over 25 years and, at last, it looks as if the IT systems will talk to each other and accessing data from multiple sources will no longer be a frustrating experience.

The catalyst of the pandemic has to be used for good, where possible, and it is truly inspiring to see the leadership of the RCM paving the way to the digital future. Midwives have a major opportunity to make the EPR fit for research purposes. I hope some keen, early career researchers will already be working on the data linkage and extraction process.

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Evidence Based Midwifery

Women's opinions about their birth partners staying overnight on the postnatal wards

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Date submitted: 26 October 2020 **Date accepted:** 17 February 2021 **Date published:** 1 June 2021.

ABSTRACT

Background: Prior to the COVID-19 pandemic, several NHS trusts facilitated birth partners staying overnight on postnatal wards. However, a literature search found that there is a lack of published literature evaluating women's opinions of this service.

Aim: To identify women's opinions on birth partners staying overnight on postnatal wards in a trust which did not facilitate overnight stays.

Ethical approval: Ethical approval was granted by Ethics and Research Governance Online at the University of Southampton in 2018, ID 40747.

Methods: The design was exploratory, using a convenience sample approach on three wards in the local maternity unit which cared for postnatal women but did not facilitate birth partners staying overnight.

Postnatal women staying across the four-week data collection period were recruited by ward staff who distributed a paper-based questionnaire to the bedside. Additionally, posters displayed information about the study so women could ask staff to participate. The questionnaire contained categorical, demographic and narrative questions to ascertain women's opinions about birth partners staying overnight. Women aged under 18, those who were bereaved, or with neonates in the neonatal unit were excluded.

Data analysis involved descriptive statistics and manually collating narrative responses which were checked with a colleague for consistent interpretation.

Results: Fifty-nine questionnaires were returned completed. Of the 54 who answered the primary question, 80 per cent (n=43, 95% CI 0.67-0.88) wanted their partner to stay overnight, and the majority (n=36, 61%) felt comfortable about having other women's birth partners staying. The most common reasons for wanting partners to stay were: emotional and practical support (n=29); so partners could bond with and help care for the baby (n=8); reference to immobility due to a caesarean (n=8) and to reduce the midwives' workload (n=7).

Those who did not want partners to stay most commonly said they would feel uncomfortable (n=6), would experience a lack of privacy (n=5), and felt it would negatively impact on their choice to breastfeed (n=2).

Conclusion: In this small study the majority of women want their birth partner to stay overnight — but some women feel negatively about this which could potentially impact on their feeding method. If overnight visiting is enabled, women who would feel uncomfortable with partners staying overnight should have the option to stay in a room without partners. Research needs to explore women's opinions further, as well as midwives and partners' views, particularly following the COVID-19 pandemic as their views may have changed.

Keywords: overnight visiting, postnatal, birth partner, women's opinions, Evidence Based Midwifery

Introduction

A fundamental objective driving excellence in maternity care is to ensure that it is women-centred, as championed in the *Better births* report (National Maternity Review 2016) and the National Health Service (NHS) long term plan (NHS 2019). This encompasses considering women holistically, and caring for them, their neonates and their wider family, including their partners. Following this principle, one assumption is that women will benefit from having their partners stay overnight on the postnatal ward to support them with childcare.

The ability for birth partners to stay overnight on postnatal wards is common and facilitated in several trusts. A literature search was undertaken using PubMed, the National Institute for Health and Care Excellence (NICE) evidence search tool and the Cochrane Database of Systematic Reviews to identify if anything had been published on women's perspectives of this service.

A study from Sweden was identified which directly looked at women's opinions and found that both women and men reported higher satisfaction levels with postnatal care when fathers were enabled to stay overnight (Tingstig et al 2012). A study based in England exploring pregnant women's preferences for birth setting found that the ability for birth partners to stay overnight positively influenced their choice of birthplace (Fletcher et al 2019). Other identified papers explored the impact of partners' mental health and bonding with the neonate and identified improved breastfeeding rates with good partner support.

A further general web-based search identified some relevant guidelines, published reports and opinion pieces from the media. However, there is a gap in the literature exploring women's perspectives on having birth partners stay overnight.

The Care Quality Commission (CQC) survey of women's experiences of maternity care (2019) found that 71 per cent of women in 2018 were allowed their partner or someone else close to them to stay, an increase from 63 per cent in 2015. Women who said they were restricted by visiting times decreased from 30 per cent in 2015 to 22 per cent in 2018.

NICE's postnatal guideline states that the needs of partners have not been properly evaluated and therefore this area is under-explored (NICE 2015). In the evidence presented by NICE to inform this guideline, a questionnaire given to partners by the National Childbirth Trust (NCT) was referenced. This found that 20 per cent of men felt that they were unable to be as involved as they wanted to be because they could not stay at the hospital (NCT 2000). Though this study is dated, the opinions expressed are echoed in the fathers' testimonies presented in *Better births*, indicating that some fathers still feel excluded from the process today (National Maternity Review 2016).

Opinion pieces from individual authors in the media suggest that women may feel uncomfortable having unknown men around on the wards: concerned about their babies' safety and experiencing a lack of privacy at such a vulnerable time (Perrins 2013, Dickinson 2015). Conversely, one article suggests that women do want their partners to stay and that implementing overnight visiting will reduce the midwifery workload and instil greater confidence in women prior to discharge home (Gafson 2015). Though not peer-reviewed, nor necessarily reliable sources of evidence, these articles demonstrate varying reactions from women in trusts which currently offer this service.

In 2011, the Royal College of Midwives (RCM) proposed involving partners to address the fact that they often feel excluded or undervalued (RCM 2011). The recommendation is a shift towards supporting both parents, as opposed to concentrating solely on the mother, to offer family-centred support. The report (RCM 2011) cited a pilot study from a trust in south-west England as being the first to trial partners staying overnight, thought to improve family attachment and reduce the strain on midwives as the partners help the women. However, there is nothing published to support this.

Fathers report wanting to stay overnight postnatally to support their partners due to their sense of responsibility towards their family (Johansson et al 2013). If partners do not bond with their neonates, there can be long-term social and psychological consequences (Burgess 2014). Paternal mental health issues are becoming more widely acknowledged and this can impact on bonding and the cohesiveness of the family unit (Cockshaw et al 2014). Research conducted over 10 years ago indicated the benefits of including fathers in caring for neonates; men who feel supported to care for their neonates have fewer mental health problems, and subsequently are better able to support their partners and children (Deave & Johnson 2008). Asking women's partners to leave overnight may be accelerating the development of these issues, particularly if they perceive the birth to be traumatic and are then separated from their partner soon afterwards.

Postnatal support from fathers was shown to improve breastfeeding rates at six weeks by 6.4 per cent in a small Australian study (Maycock et al 2013). Having partners stay overnight on the ward to provide support may ensure women get the best start with breastfeeding. Other research suggests skin-to-skin by fathers has similar positive effects on the neonate, such as temperature control, as well as promoting bonding and reducing paternal stress (Shorey et al 2016). If partners stay overnight then skin-to-skin could be shared between the parents, potentially resulting in a calm neonate and rested mother.

However, other studies have shown that women's decisions around infant feeding are influenced by their partner's opinions and those whose partners felt negatively about breastfeeding found this impacted on their confidence (Mannion et al 2013). If partners are negative their constant presence on the ward may prevent women from confidently breastfeeding.

While the evidence suggests partners are undervalued in maternity, with more needed to include them in decisions and care following the principles of *Better births* (National Maternity Review 2016), maternity care should be women-centred. It is crucial to remember that some women from particular ethnic groups, those who do not have partners, have female partners, or other personal circumstances, may have different perspectives about other women's partners staying overnight. It is therefore important to gain an understanding of women's opinions on this topic as this is an under-researched area. This study aims to provide initial results to fill the gap in the evidence-base by identifying women's opinions on birth partners staying overnight on the postnatal wards in a trust which did not facilitate overnight stays.

Method

The evaluation was a prospective survey utilising a questionnaire with qualitative and quantitative type questions.

Setting

This clinical evaluation was conducted in partnership with the local trust to develop current practice and enhance women's experiences with the possibility of enabling birth partners to stay overnight, depending on the findings. Three wards in the local hospital were involved: A, a high-risk postnatal ward; B, a low-risk birth centre with postnatal beds and C, a high-risk antenatal ward which accommodates postnatal women as overflow. None of these areas was equipped to have birth partners stay at the bedside overnight and enforced visiting hours were 9am–9pm.

Sample

The participants were all postnatal women who met the eligibility criteria (see Table 1) and who were staying on one of the three wards.

Those excluded from the study included those who were bereaved, or with neonates on the neonatal unit, as it was important not to cause increased stress to these women. Women under the age of 18 were not included, for ethical reasons. Due to no funding being available for translation services, only women who could read and write English were able to take part.

This was an empirical master's project with a timeframe of only four weeks for data collection. The aim was to gather as many completed questionnaires as possible during this period. This timeframe was discussed with a university statistician and the trust and deemed to be sufficient to provide useful data.

Recruitment

A convenience sampling approach was taken. Questionnaires were distributed by midwives, student midwives and maternity support workers at women's bedsides and participation was voluntary. The inclusion and exclusion criteria were displayed in the midwives' office and staff therefore knew which women were eligible to participate. Staff reminded women about the questionnaire when they introduced themselves on the ward, or when they discharged them. Posters were displayed in each ward area to encourage women to ask for questionnaires from staff. Once completed, questionnaires were collected by the staff when they cleaned the bed spaces following discharging women, or by women returning the questionnaires which were then placed in a collection box stored in the ward office. Ward B has a family room and some questionnaires were left on the table there for women to find.

Data collection

Data were collected using a semi-structured questionnaire (available from the corresponding author on request) which was developed in partnership with midwives, the consultant midwife, and in consultation with service users at the local trust to ensure it was fit for purpose and suitable for the local population of women.

The first 10 collected questionnaires were reviewed with the project supervisor at the university to ensure that women were interpreting questions as intended prior to further distribution. The questionnaire included categorical questions, such as yes or no, as well as Likert scale questions and descriptive questions inviting women to supply narrative responses and offer their opinions to support their categorical answers. The primary question was 'Do you want your birth partner to stay overnight on the postnatal wards?'. The data collected was completely anonymous but included demographic questions of ethnicity, age, parity and employment status.

Ethics

Ethical approval was gained from the Ethics and Research Governance Online, the local university's ethical review board, and approval was gained from

Table 1. Inclusion and exclusion criteria.

Inclusion criteria	Exclusion criteria
Postnatal women staying on wards A, B or C who opted to fill in the questionnaire	Women who were bereaved and staying in an appropriate side room on ward C
Women able to read and write English	Women under the age of 18
	Women with neonates on the neonatal unit

the trust governance process, including user-group feedback. To ensure confidentiality, all documentation given to women was produced using a General Data Protection Regulation-compliant template.

All data collected were anonymous and consent was given by women if they chose to fill in the questionnaire which was distributed in a non-coercive manner and was completely voluntary. Data collection in the hospital was overseen by a Nursing and Midwifery Council-registered midwife to ensure the safety of the women undertaking the project. The participant information sheet referred women to the local birth debriefing service if they felt they needed it. Data were transcribed on to a secure password-protected computer and the hard copies stored in a locked office at the university to ensure ongoing anonymity and rigour of the project.

Data analysis

The data were transcribed on to an Excel spreadsheet during the data collection period and then input into SPSS statistical software to enable analysis. A random sample of the completed questionnaires were checked against the spreadsheet for transcribing errors by a colleague to ensure reliability.

Statistical analysis deemed to be appropriate following discussion with the statistician were descriptive statistics to compare the categorical responses using means and distributions. Using a technique referenced in Creswell & Plano Clark (2011) to analyse qualitative data by converting it to quantitative data, narrative questions were analysed by collating responses through manually identifying key words and counting up their frequency. The identified phrases were checked with the project supervisor for consistent interpretation.

Results

Across the four-week data collection period, from August to September 2018, 59 completed questionnaires were collected. The majority of questionnaires (64%, n=38) were collected from the postnatal ward, 15 (25%) were collected from the birth centre, and six (10%) from the antenatal ward. Demographic data for the women who filled in a questionnaire (see Table 2) show the overview of responses to each question. In several questionnaires, not all questions were answered (shown in the table by 'Not answered'). Only seven women (12%) answered all 17 questions, including providing narrative responses.

Categorical questions

In the 59 completed questionnaires, 54 women answered the primary question: 'Do you want your birth partner to stay overnight on the postnatal wards?' Of the 54 women who answered, 43 answered 'yes', giving an overall finding of 79.6% (95% CI 0.67-0.88).

Table 2. Overview of the baseline characteristics of participants.

Baseline characteristics	Number	Percentage
Age		
18–24	5	8
25–34	37	62
35–44	14	24
Not answered	3	5
Parity		
1	31	53
2	14	24
3+	11	19
Not answered	3	5
Ethnicity		
White	49	83
Black/ Black British	1	2
Mixed	2	3
Asian/Asian British	4	7
Not answered	3	5
Employment status		
Employed	47	80
Self-employed	2	3
Not employed	7	12
Not answered	3	5
Days since birth		
0 or 1	32	54
2	12	20
3+	15	25
Number of babies this pregnancy		
One	57	97
Twins or more	1	2
Not answered	1	2
Shared or side room		
Shared room	46	78
Side room	10	17
Ticked both	3	5
Birth type		
Normal vaginal delivery	35	59
Instrumental vaginal delivery (forceps or ventouse)	12	20
Elective caesarean	3	5
Emergency caesarean	8	14
Not answered	1	2
Method of feeding		
Breastfeeding	36	61
Bottle feeding	13	22
Mixed feeding	9	15
Not answered	1	2

Please note: percentage values have been rounded to nearest integer.

Table 3 shows the responses to the primary and secondary outcomes. A small number who did not answer particular questions are represented in 'Not answered' data.

A key aim was to ascertain how comfortable women felt about having other women's partners stay overnight by using a Likert Scale with 1, extremely

Table 3. Women's views on their partners and other women's partners staying overnight.

	Question	Response	Number	Percentage
Primary outcomes	Do you want your birth partner to stay overnight?	Yes	43	73
		No	11	19
		Not answered	5	8
	How comfortable are you about other women's birth partners staying? (1= extremely uncomfortable to 5= extremely comfortable)	Comfortable (4+5)	36	61
		3	10	17
		Uncomfortable (1+2)	11	19
		Not answered	2	3
	Would having your birth partner stay enhance your overall experience?	Yes	40	68
		No	14	24
		Not answered	5	8
Secondary outcomes	Would having your birth partner overnight impact on your chosen feeding method?	Yes	12	20
		No	45	76
		Not answered	2	3
	Would other women's birth partners staying impact on your method of feeding?	Yes	4	7
		No	54	92
		Not answered	1	2
	Partners would be unable to shower or have food. Does this change your answer?	Yes	1	2
		No	53	90
		Not answered	5	8

Please note: percentage values have been rounded to nearest integer.

uncomfortable, to 5, extremely comfortable, choices. An answer of 3 was taken as women not having a strong view on the subject. Responses 1 and 2 were combined to become 'uncomfortable' and 4 and 5 combined to form 'comfortable' for data analysis. The majority of women felt comfortable or extremely comfortable about having other birth partners around the ward (n=36, 61%).

Secondary outcomes were to explore whether women felt that their own, or other women's, birth partners being present overnight would impact on their feeding method, and whether their decision to have their partner stay would be impacted by the lack of services available for partners (Table 3).

The majority of women felt their method of feeding would not be impacted on by having their partner or other partners present on the wards. Though a few women stated it would impact on their ability or wish to breastfeed, eight of those who said it would impact on them reported feeling more likely to be supported to succeed with breastfeeding. Of these women, seven were breastfeeding and one was mixed feeding.

Other factors explored were whether parity, employment status, ethnicity or age made a difference to whether women said they wanted their birth partners to stay overnight. The open question 'How many children do you now have?' led to answers ranging from 1–4 so these were grouped into 1, 2 and 3 or more children to increase the statistical power in each group. Age categories remained the same but there is no data for women over 45 years old. However, the small sample size prevented more in-depth statistical analysis so it was not possible to suggest which groups of women were more or less likely to want their partners to stay.

Descriptive questions

Ninety-five per cent (n=56) of respondents gave one or more narrative answers to support their other answers. The most commonly used words or phrases given by women who did want their birth partners to stay overnight were 'support' or 'help', either in reference to emotional or practical aspects (n=29), reference to partners 'bonding' with the baby (n=8), wanting them to 'care for baby' (n=8), reference to immobility due to a caesarean section (n=9) and reference to the midwives being busy or that it would reduce their workload (n=7). Nine women reported they wanted their partner to stay due to feeling 'alone', 'lonely', or 'vulnerable'.

Responses from women who did not express strong opinions either way on the subject of birth partners staying stated that it was due to this being a subsequent child (n=3) or they would only want it to happen if they were placed into a side room (n=5).

Women who supplied negative responses most commonly reported they would be uncomfortable (n=6), experience a lack of privacy (n=5), would not be happy to breastfeed if there were other men around (n=2), and referenced the additional noise (n=1).

Further findings of note were the use by two respondents of the word 'we' when supplying narrative answers, and though partner opinion was not sought in this questionnaire, there was one

comment received from a partner which was 'partners need a rest too', supporting their negative view of having birth partners to stay overnight.

Discussion

This study demonstrated that the majority of women asked support the idea of having birth partners stay overnight and do not feel that having other partners around will negatively affect them. The findings support Tingstig et al (2012) who found that both women and their partners reported higher satisfaction levels if they were enabled to stay overnight and, furthermore, support the practice existing in several units prior to the COVID-19 pandemic of inviting partners to stay. A UK-based study exploring pregnant women's decision making around choice of birthplace found that the ability for partners to stay overnight positively influenced their decision, but the reasoning for this was not evaluated within this study (Fletcher et al 2019). The original literature search was repeated following data analysis but no new papers were identified on this topic.

Though the final sample size was small the study was challenging to conduct in such a tight timeframe. The women were postnatal and already challenged with caring for their neonate, establishing breastfeeding, if applicable, and may have been sleep deprived or recovering from their birth which made recruiting them difficult as filling in the questionnaire required time and attention. In addition, women who birth normally and where all is well go home soon after birth (6–12 hours), so these women from the birth centre may not have had time or seen the need to complete the questionnaire, as it would not apply to them. This was indicated by the low number of questionnaires returned from this area. Furthermore, the postnatal wards are very busy as the unit is a tertiary unit with over 6000 deliveries a year and this made gaining support from staff to distribute the questionnaires to women, in addition to their heavy workload, challenging. Negative reactions were received from staff about the project and the perception was that they did not want partners staying overnight due to fear of them being in the way, which further reduced the ability to effectively data collect.

The reactions have highlighted that midwives also have strong views which need investigating. All but a few comments received from midwives about the project were negative. This may be due to a fear of change and challenging the status quo so a further project may be required to gain midwifery support before any change can be implemented. Implementation science has indicated that, without support, new ways of working are unlikely to succeed (May 2013).

It is impossible to state categorically what midwives are against until research is conducted, but some comments related to the personal safety of the staff overnight, how it might impact on their clinical tasks and issues with safeguarding vulnerable women. Midwives have safeguarding responsibilities to protect women and their infants from harm, and this extends to providing women safe spaces to disclose domestic abuse and violence (Williams et al 2013). As such partners are often controlling, they are likely to stay overnight, and therefore opportunities may be lost for women to gain support from staff when left alone. Additionally, for some women from certain cultures or religions, it will not be appropriate to stay in a postnatal bay with other men overnight. Midwives must be sensitive to their needs so they do not receive inappropriate care (Pollock 2005). Some women may need care in a bay without men, or in a side room, ensuring their privacy and dignity is maintained, which will involve additional resourcing demands.

Interestingly, some women who responded felt that, because the midwives were busy, their partners staying would help the midwives by reducing their workload. This may encourage greater partnership between women and midwives following *Better births* principles (National Maternity Review 2016). Personal discussions with staff from two other trusts where overnight stays have been introduced support its effectiveness and revealed that women appreciate and utilise the opportunity. However, another trust began offering overnight stays and stopped due to staff finding it negative: staff consultation is therefore vital prior to implementation.

For the primary outcome it was anticipated that most women would want their own partner to stay but would feel uncomfortable with other partners staying, therefore the results were surprising. Two responses to the primary question, 'How comfortable are you about other women's birth partners staying?', were directly contradictory to each other in the narrative and categorical responses. The written answers were taken as stated and used in the analysis following good clinical practice data integrity principles (National Institute for Health Research 2016) as it was not ethical to adjust them and infer meaning, but potentially women misinterpreted the use of the Likert scale. Had the answers been changed from 1 to 5, as indicated from the narrative response, the percentage of women who felt comfortable with other partners staying would be 64 per cent as opposed to 61per cent (95% CI 0.52-0.75). Of those women who gave narrative answers as to why they wanted their birth partner to stay overnight, the majority wanted support or help, both emotional and practical, as well as identifying that partners need to bond with the baby. One woman referenced the baby as being a 'shared responsibility' and this shows that women want their partners to be more involved with care, which is not supported by the current system. This concept of teamwork was identified in a study exploring women's perceptions of positive postnatal support from their partners (Kirova & Snell 2019)

and echoes the views of partners in some literature (NCT 2000, RCM 2011). Other research suggests a lack of partner bonding can cause long-term social and psychological consequences and disruption of the family unit (Burgess 2014).

A key principle of *Better births* (National Maternity Review 2016) is to improve postnatal care. Nine women (15%) who responded used emotive words in their responses to support their view that their partner should stay: 'lonely', 'alone' and 'vulnerable'. With strained maternity services, postnatal staff are stretched thin and have the care of several women, anecdotally meaning that they cannot provide the immediate in-depth support they would like to. However, this is not a reason to leave women feeling this way and if something can be done to make them feel better supported once postnatal, then it must be considered.

The secondary outcome exploring the impact of partners staying on women's feeding method found that most women stated that they did not feel it would have any impact on them and, of those who did, the minority felt it would negatively impact them. Comments from women supporting their views were that their partner staying overnight could help them as they establish breastfeeding to provide emotional support. This is something supported by literature which suggests that partner support improves breastfeeding rates (Maycock et al 2013). All of these supposed benefits should be researched to ensure that they are benefits and that partners staying does not result in less professional care and have negative consequences on maternal or neonatal wellbeing.

Strengths and limitations

A strength of this clinical evaluation was that it is a service development suggestion to inform local practice and as such may lead to potential changes in woman-centred midwifery care. Some trusts have instigated overnight staying but it was not possible to identify any published evaluation data.

A limitation is the small sample size of 59 women and the lack of statistical power in a trust where the birth rate is 6000+ per annum. The study did not stratify according to ethnicity and this would also be required for future research.

A further limitation is that all data were collected using a questionnaire. This is a useful way of collecting data because it has a high response rate and minimises interview bias (Oppenheim 1998) and was felt to be an appropriate way of gathering feedback from a large sample of women under the time constraints. However, unlike an in-depth interview, it was not possible to probe further and explore women's answers. Additionally, it cannot be determined whether women filled in the questionnaires themselves, or filled in multiple questionnaires.

Implications for practice

Though a small sample, the results do support partners staying overnight. From these results, the recommendations are for further research to be conducted with a power-based sample stratified to include ethnicity and social status.

Since this study was conducted, visiting times have changed due to the coronavirus pandemic. Trusts have reduced postnatal visitors to just women's partners or prevented overnight visiting where it was previously allowed. Some have stopped birth partners visiting the postnatal ward altogether. Clearly, in these unprecedented times it is unadvisable to introduce overnight visiting for birth partners until it can be facilitated safely, so this topic would need to be revisited once the crisis is over or new measures are introduced. Anecdotally, women without their partners on the postnatal wards are engaging more with each other. Further research will be needed after the pandemic to establish if this situation has altered their opinions on the subject.

Research

This study has highlighted the importance of gathering narrative feedback from women to support their views, so qualitative methods would be required to give more in-depth analysis. Potential methods would be to send an i-survey to all postnatal women to reach a larger proportion, or to approach them antenatally, though their views may be different once they have experienced the postnatal wards. A retrospective approach to contact all women who have delivered in the last year may be an appropriate method, perhaps as a supplement to the postnatal friend and family survey.

Additionally, due to the experience of the author during data collection, research should also be conducted with midwives to discover their views on the subject and how they feel it may impact on their work. As policy suggests care should be family-centred (National Maternity Review 2016), birth partners' views should also be evaluated. Despite not requesting it, one partner offered their opinion in the questionnaire, so their views are also needed to ensure that the services being offered to women and their families are appropriate and fit for purpose.

Conclusion

In conclusion, the majority of women in this small study wanted their birth partners to stay overnight and therefore the recommendation is for trusts to explore the feasibility of this at ward level.

Implementing overnight visiting will require consideration of several factors, including accommodations for women who would be uncomfortable sharing a room with other partners, safeguarding policies, and practical aspects, such as facilities provided for partners. Research is needed

into this unexplored area to ensure the service is responding to the needs of women and their partners, and this may have changed following the COVID-19 pandemic. Partners staying could potentially support midwives working in an already overstretched service so research from midwives is also required to explore their concerns and enable successful implementation.

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Acknowledgements

We would like to thank the women who took part in the study. Thank you to Dr Sean Ewings from the University of Southampton for his support with statistical analysis and consultant midwife Dr Kylie Watson for her feedback on the publication. We would also like to thank Princess Anne Hospital, University Hospital Southampton NHS Foundation Trust for supporting this research.

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How to cite this paper:

Barber C, Cluett E (2021). Women's opinions about their birth partners staying overnight on the postnatal wards. *Evidence Based Midwifery* 19(2):5-12.

Spiby H, Stewart J, Watts K, Hughes A, Slade P (2021). Antenatal education class provision across maternity services in England: information provided from national surveys of heads of midwifery and facilitators of antenatal education. *Evidence Based Midwifery* 19(2): 13-20

Antenatal education class provision across maternity services in England: information provided from national surveys of heads of midwifery and facilitators of antenatal education

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Date submitted: 10 February 2021 **Date accepted:** 17 March 2021 **Date published:** 1 June 2021.

ABSTRACT

Background: Historically, antenatal education classes have been available to support new parents as they make the transition to parenthood. While national guidelines specify that new parents should be offered antenatal education, individual trusts decide how to implement this. A resource pack, *Preparation for birth and beyond* (PBB) (Department of Health (DH) 2011a), offered guidance on this issue. It highlighted the needs of different groups, including fathers, women from minority ethnic groups and young women and how these could be addressed.

Purpose: To investigate the range, frequency, duration, and groups offered antenatal education classes in National Health Service (NHS) trusts and to determine the extent to which the PBB resource had been utilised.

Study design: Two linked cross-sectional surveys.

Ethical approval: The survey was service evaluation, thus NHS ethics and organisational approvals were not required.

Methods: Two national surveys were undertaken across all NHS trusts providing maternity services in England. The first sought perspectives of Heads of Midwifery (HoMs), as service leads; the second was sent to facilitators of antenatal education classes, who are closer to service delivery. Questions to HoMs included service configuration and the priority accorded antenatal classes. Facilitators' questions addressed current provision and availability for different groups. Both were asked about experiences of using the PBB resource.

Results: Information was returned by 136 of the 137 trusts, an overall response rate of 99.3 per cent. While all trusts offered some provision there was considerable variation, including the number of sessions. Courses most frequently had three (n=33, 28%) or four (n=35, 30%) sessions, while 14 per cent (n=16) offered one or two sessions. Provision for specific groups varied; few trusts offered men-only sessions (n=9, 8%); almost half (n=57, 48%) enabled separate discussion for men and women during the sessions. Eighty (68%) trusts provided specific classes for young parents. Specific sessions for women from minority ethnic groups were available in 25 trusts (21%).

The PBB resource had been used in fewer than half the trusts (n=51, 43%); a third were unaware of the pack (n=21, 33%). Of the 51 that had used it, 37 (73%) reported that the resource was helpful.

Conclusion: Antenatal classes varied considerably with potential for some groups to receive limited or no meaningful provision, including those whose needs were previously identified as under-served. We identified challenges to antenatal education provision and only partial use of a new resource, reflecting the need for additional approaches to dissemination.

Keywords: maternity services, antenatal education, antenatal education classes, Preparation for birth and beyond, survey, Evidence Based Midwifery

Background

New parenthood is a unique time when women and partners are 'information hungry' (DH 2011a). Professionals in the NHS, health and social care have an important role in helping parents negotiate this transition successfully and most new parents expect such support (DH 2011b). Antenatal education is one potential route, delivered via group sessions, often referred to as 'classes', historically provided free of charge in the UK NHS. *The National Service Framework for children, young people and maternity services* (DH 2004) stated that good antenatal care should include access to parent education and preparation for birth through classes or other means. However, overall, only 60 per cent of women were invited; this was more likely for first time parents (86%) (Healthcare Commission 2007). Fewer Asian (56%) and Black (47%) women than white women (65%) were offered classes (Redshaw & Heikkila 2010).

Systematic reviews have reflected uncertainties about the effectiveness of small group antenatal education for obstetric and psycho-social outcomes (Gagnon & Sandall 2007, Brixval et al 2015). However, it remains popular in Western birth settings and components support women's knowledge acquisition (Hillier & Slade 1989), increase new parents' social networks (Fabian et al 2005), and reduce anxiety about labour and birth (Stoll et al 2018). The Healthcare Commission identified a need to improve antenatal classes (Healthcare Commission 2008).

The DH commissioned work to address questions raised about the focus of antenatal education and its adequacy in supporting parents. *Birth and beyond*, a systematic review of evidence about antenatal education (Schrader McMillan et al 2009), highlighted factors that influence provision, including skills and styles of facilitators. It synthesised evidence about the cost and effectiveness of antenatal education and included stakeholders' perspectives; these confirmed the contribution of antenatal classes in preparing women and their partners for birth and early parenthood (Schrader McMillan et al 2009). Further research was recommended to identify the specific needs of young women, those from minority ethnic communities, asylum-seeking women and fathers (Barlow et al 2009).

To support review, a resource pack, *Preparation for birth and beyond* (PBB) (DH 2011a) addressed the organisation, content, skilful facilitation, and format of antenatal education. Part 1 provided an overview of evidence and highlighted the understanding practitioners need to successfully deliver cost-effective antenatal education. Part 2 included the theories and concepts that underpin the methods and content of the PBB resource with practical examples and tips for translation of principles into practice. It provided guidance on the information available to understand the local context in which antenatal classes are provided and the importance of informing commissioners why resource allocation to antenatal classes is important.

The PBB resource has six themes covering core aspects of pregnancy, birth, early child development and the transition to parenthood:

- Our developing baby
- Changes for me and us
- Giving birth and meeting our baby
- Caring for our baby
- Our health and wellbeing
- People who are there for us.

This paper reports findings from surveys that were part of a suite of mixed-method, multi-site studies. They mapped antenatal education provision, including availability for groups with unmet needs: young women under the age of 20 years, women from minority ethnic groups and fathers. We also aimed to explore the extent to which service providers had utilised PBB recommendations.

Objectives

There were two objectives:

A. to identify the range and frequency of different approaches to antenatal classes, organisation, content, including provision for young women, asylum-seeking women and those from minority ethnic communities and fathers.

B. to determine the extent to which the DH PBB resource pack had been utilised, its impact and associated barriers and facilitators.

Methods

The survey was service evaluation, thus NHS ethics and organisational approvals were not required. The anonymity of sites and individuals completing surveys was maintained.

Both objectives were addressed using two national linked questionnaire surveys in each trust providing midwifery services. These targeted the Head of Midwifery (HoM) to capture strategic perspectives, and facilitators of antenatal education (subsequently referred to as facilitators) to obtain operational perspectives.

Questionnaire development and content

The questionnaires were informed by existing literature, including policy and guidance. Both were piloted in two stages and finalised, following minor revisions. The HoMs survey included service configuration, the priority accorded to antenatal education and inclusion in service-level agreements (SLAs). The facilitators' survey addressed current provision and content and services provided to the

groups that were the focus of this research, namely women from the general population, young women, women from minority ethnic communities and fathers. Factors that limited provision were also explored. We asked both HoMs and facilitators about the use of PBB.

Establishing the sampling frame

NHS trusts providing maternity care in England and their HoM were identified using contemporary sources, including Local Supervising Authority databases[1,2]. HoMs provided contact details for the facilitators of antenatal education within their trust who were contacted directly by the research team.

Data collection

The research team sent an initial invite by email that included an embedded link to the SurveyMonkey online platform (www.surveymonkey.co.uk). Non-response to email was followed by a range of strategies including postal version, telephone contact or email. Data collection took place between September 2013 and March 2014.

Analysis

Questionnaire responses were entered into SPSS v22 and analysed using summary statistics. Free text responses to open questions were subjected to a simple categorical analysis. Labels were allocated to free text responses following agreement by two members of the research team.

Results

Information was returned by 136 of the 137 trusts contacted for the survey, a response rate of 99.3 per cent. We received a response from 131/137 HoMs or their designee (response rate 96%): electronically (53), by post (37) and by telephone (41).

Some trusts had more than one facilitator and findings are reported with the NHS trust as the unit of analysis; 148 facilitator questionnaires (electronic 130; postal 18) were returned by providing information from 118 trusts (response rate 86%). Facilitators described their roles as midwifery manager (n=37, 31%), antenatal education specialist midwife (n=34, 29%), midwifery matron (n=25, 21%) and other/unstated (n=22, 17%).

Most were involved in class organisation and management (n=104, 88%), around two-thirds in course design (n=78, 66%), course evaluation (n=75, 64%) and just over half delivered classes (n=67, 57%).

Objective A: To identify the range and frequency of different approaches to antenatal classes, organisation, content, including provision for young women, asylum-seeking women and those from minority ethnic communities and fathers.

To what extent was antenatal education a priority?

Seventy-four HoMs (57%) reported inclusion in their commissioning agreement. The prioritisation of antenatal education within each trust was reported as: a key priority (n=33, 25%), behind a few other priorities (n=45, 34%), behind several other priorities (n=41, 31%) and not a priority (n=7, 5%).

Aims, theories and feedback process

Facilitators were asked whether there was a set of aims/objectives for antenatal classes in their trust; fewer than half of the trusts (n=54, 46%) were reported to have these. Facilitators were asked to list aims as free text; these were coded using simple categorical analysis. Aims related to: keeping healthy during pregnancy; care for the newborn, infant feeding and health education related to baby; providing information about hospital processes and available options. Information about labour commonly included: recognition of labour onset; stages/process of labour; methods of coping — pharmacological and non-pharmacological. The promotion of normality in labour and birth was also identified as an objective. In relation to infant feeding, breastfeeding was most frequently mentioned and then safe bottle feeding.

Antenatal education was reported to be informed by a range of principles and theoretical approaches: midwifery research (n=92, 78%); evidence from studies of antenatal care/classes (n=88, 75%); audit/service evaluation (n=88, 75%), adult learning (n=81, 69%), psychology (n=56, 48%) and physiotherapy research (n=43, 36%).

Feedback was captured most frequently on a class-specific basis (n=97, 82%); included in trust satisfaction surveys (n=43, 36%) and informal feedback provided by the Maternity Services Liaison Committee (n=64, 54%). In 10 (8%) trusts none of the pre-specified feedback mechanisms was utilised.

Visit to the planned place of birth

Historically, pregnant women and their companions have had the opportunity to visit their planned place of birth, either as a separate activity or included in the antenatal course; virtual provision was a relatively recent addition. An actual visit to the planned place of birth within classes was offered by 57 (48%) of trusts and as a stand-alone activity in 73 trusts (62%). A virtual visit was offered within classes by 40 (34%) and by 62 (53%) as a stand-alone activity. In five trusts, the opportunity to visit the maternity unit was unavailable.

The 'usual' course

Using an open question, we asked facilitators the

number of weeks gestation when the trust *aimed* for women to start classes and when they were able to do so. There was considerable variation from prior to 26 weeks to after 34 weeks pregnancy. While the majority reported the aim and actual start were the same (n=66, 56%), some reported starting 2–4 weeks earlier than the aimed number of weeks gestation (n=12, 10%), 20 (17%) reported classes starting 2–6 weeks later than they aimed, for a further 20 (17%) the data were missing or unclear.

Considerable variation also occurred in the number of sessions and total number of hours offered in a course. Courses most frequently comprised three (n=33, 28%) or four sessions (n=35, 30%); sixteen trusts had one and two sessions (14%), 12 had five (n=4, 3%) or six sessions (n=8, 7%). Six (5%) did not provide a response. Sessions ranged from 1–1.5 hours in 15 (13%) of trusts, 1.5–2 hours in 74 (63%) trusts and were of an unspecified duration in 19 (16%). Twenty-five (21%) trusts offered antenatal classes over either one or two days at the weekend.

We defined types of classes as 'standard' antenatal classes (defined as content frequently covered in antenatal classes, for example, staying healthy in pregnancy, labour, pain relief, different types of birth, breastfeeding, baby care and postnatal health), active labour and aquanatal sessions. Table 1 demonstrates those groups offered each type of provision.

Questions about the content of classes were guided by the PBB resource (theme 3) and with response options of *always, sometimes, never, not, not stated*. The frequency with which labour topics were 'always' included was generally high. *Knowing what to expect when going into labour* and when and who to contact when in labour was always covered in 111 trusts (94%). *Understanding the physical processes of labour, the options for pain relief, having a set of coping strategies to use for labour* and *skin to skin contact with their baby* was 'always' covered by 109 trusts (92%).

Topics also reported as 'always' covered were *understanding the benefits of breastfeeding* (n=106, 90%), *preparation of birth partners for their role* (n=101, 86%) *understanding the emotional aspects of labour* (n=95, 81%). Least likely to 'always' be included was *understanding procedures that may be used during labour/birth*' (n=94, 80%).

Antenatal education for specific groups of parents

We asked about provision for groups whose needs were previously identified as under-served. Nine trusts (8%) provided a 'men only' class; almost half provided an opportunity for separate discussion for men and women during sessions attended by both (n=57, 48%).

Over two-thirds of trusts included provision specifically for young parents (n=80, 68%), available variously in hospital and/or health centres, daytime and evening, between one and six sessions that included both bespoke (n=68, 85%) and standard (n=6, 8%) provision.

Twenty-five (21%) trusts provide specific classes for women from minority communities and five (4%) reported classes for asylum-seeking women. These classes were available in various locations: hospital (n=5, 20%); at health centres (n=7, 28%) and in both hospitals and health centres by 10 (40%) trusts. Provision varied: most occurred during the daytime Monday–Friday (n=19, 76%); between 1–6 sessions, with bespoke (n=17, 68%) and standard (n=6, 24%) provision. Across all trusts, for women and their companions whose first language is not English, classes were provided in women's native language by 10 trusts (9%); held in English with language support available throughout in 51 trusts (43%) and held in English without language support in 54 (46%) trusts.

Factors limiting provision of antenatal education

We asked both HoMs and facilitators about factors limiting the provision of antenatal classes. Following categorical analysis of 82 free-text responses from HoMs, the most frequently reported related to midwifery staffing, time, or workload (n=57, 70%); followed by space, other facilities, or equipment

Table 1. Type of classes available and for whom (n=118).

Classes currently provided	'Standard' antenatal classes	Active labour	Aquanatal
All women + companion	81 (68.6%)	60 (50.8%)	6 (5.1%)
Primigravid + companion	16 (13.6%)	11 (9.3%)	0
All women	5 (4.2%)	4 (3.4%)	22 (18.6%)
We don't provide these	7 (5.9%)	25 (21.2%)	71 (60.2%)
Not stated	9 (7.7%)	18 (15.3%)	19 (16.1%)
Total	**118**	**118**	**118**

(n=49, 60%). Women considered as not engaging with provision or language barriers were reported by 22 (27%); funding or financial issues (n=21, 26%); midwives' skills, training, or culture (n=12, 15%) and demand outstripping availability (n=10, 12%).

With the facilitators, we explored seven pre-specified factors for the extent to which they limit provision. Responses for *significant* and *some* limitation were combined (vs *no limitation or not stated*). Factors reported most frequently: *staffing levels* (n=86, 73%) and *staff 'do not like doing it'* (n=82, 70%). Further free text information related to 12 trusts included a lack of priority accorded to antenatal classes, and financial restrictions on administrative and interpreter support.

Objective B: To determine the extent to which the DH *Birth and beyond* resource pack was utilised, its impact and associated barriers and facilitators.

Heads of Midwifery were asked about pre-specified activities to disseminate the PBB resource in their trust; information cascaded to staff (n=65, 50%); discussed at midwives' meetings (n=42, 32%); discussed with commissioners (n=22, 17%); delegated to midwife with particular responsibility (n=51, 39%); ensured classes were reviewed (n=52, 40%) and discussed at Maternity Services Liaison Committee (n=45, 34%). At least one activity was reported by 106/131 HoMs (89%), over half (n=76, 58%) identified three, a further 40 HoMs (31%) recorded four activities. Fifteen (12%) did not select any, and four (3%) were unaware of the resource. Other HoMS were not in post at the time the PBB resource was published, had involved external trainers, or discussed with external agencies and services (n=7, 5%).

Use of the PBB resource

Facilitators provided information about use of the resource. Sixty-three trusts (53%) had not used the PBB resource. Reasons for non-use included not being aware of the resource (n=21, 33%); one-fifth were planning use (n=12, 19%) and 12 (19%) felt their current provision was in line with the resource.

The PBB resource had been used to plan and run antenatal classes in fewer than half of trusts (n=51, 43%). Using an open question, facilitators were asked to identify three features that supported midwives' use of the resource pack: responses were subjected to thematic analysis. The following represent those most commonly reported: materials organised into specific themes; usability of the pack; research-based; impact on organisational and midwifery change; increased the scope of antenatal materials to use in classes; supported change and improved services for women; production by the DH signified importance and potential for use by multiple agencies. Challenges encountered in using the resource included: service constraints; staff training; size of the resource and insufficient time to engage with it.

Facilitators' views on usefulness of PBB resource to plan and facilitate antenatal classes

The majority who had used specific aspects of the PBB resource to plan and facilitate their classes found it helpful, details can be seen in Table 2. Fewer had used the section on 'reaching groups previously less likely to attend classes' and they did not find it as helpful as other sections. Table 3 presents use of the PBB resource by PBB theme.

Changes or impacts from using the PBB resource

Facilitators were asked to provide free text responses to the three most significant changes or impacts from use of the resource. These included improvements in quality (n=22, 43%); shift of focus (n=16, 31%) or style of information (n=16, 31%), increased access to hard-to-reach groups (n=5, 10%), while two (4%) reported no change.

Discussion

We found considerable variation in antenatal education provision in NHS maternity services.

Table 2. Perceived usefulness of specific aspects of the PBB resource to plan and facilitate antenatal classes (n=51).

Specific aspect	Used – helpful n (%)*	Used – not helpful n (%)	Not used, not required or some other reason n (%)	Missing n (%)
Ability to change your plans about content/format of the class to meet the needs of the parents	44 (86)	1 (2)	2 (4)	4 (8)
Plan the content of each class (topics to be covered)	41 (80)	0	6 (12)	4 (8)
Plan different activities to help parents learn (how you get the topic information over to parents)	39 (76)	2 (4)	4 (8)	6 (12)
Develop group dynamics	37 (73)	2 (4)	8 (16)	4 (8)
Facilitate exchange of information and ideas amongst parents in small discussion groups	37 (73)	2 (4)	7 (14)	5 (10)
Give parents the opportunity to establish relationships with other parents	37 (73)	1 (2)	9 (18)	4 (8)
Reach groups previously less likely to attend classes	20 (39)	9 (18)	18 (35)	4 (8)

* n (%)= number followed by percentage

Table 3. Use of PBB resource for specific content of classes (n=51).

Theme	Used Number, (%)	Not used, not required or some other reason Number, %	Missing Number, %
Our developing baby	35 (69)	9 (18)	7 (14)
Changes for me and us	37 (72)	6 (12)	8 (16)
Giving birth and meeting our baby	41 (80)	6 (12)	4 (8)
Caring for our baby	39 (77)	6 (12)	6 (12)
Our health and wellbeing	40 (78)	6 (12)	5 (10)
People who are there for us	36 (71)	8 (12)	7 (14)

The priority accorded to classes varied, as did the extent to which trusts reported pre-set objectives, utilised underpinning theory, and routine feedback. While NICE (2019) states that women should be offered opportunities to attend participant-led antenatal classes, provision rests with trusts (Care Quality Commission 2020).

Both HoMs and facilitators reported demand for classes outstripped what was provided, an issue of concern that women highlighted in national surveys (Healthcare Commission 2007, Redshaw & Heikkila 2010). Under-provision could be a consequence of the priority accorded antenatal education by the trust.

HoMs identified language barriers as a limiting factor in some settings; financial constraints impacted on administrative and language support, availability of suitably trained midwives, interpreters, or resources. Midwifery factors, referred to by HoMs, appeared to contribute to limitations in provision and almost 70 per cent of facilitators indicated that midwifery staff did not like being involved.

A significant proportion of HoMs indicated that some women did not take up the offer, also reflected in a recent national survey where 29 per cent of women were not offered NHS antenatal classes, 30 per cent were offered and attended, and 41 per cent were offered but chose not to attend (Care Quality Commission 2020). The structure, location and timing of traditional classes are all known to deter some women from attending (Nolan 1997, Healthcare Commission 2007, Tomintz et al 2013).

Fewer than half of trusts had explicit aims/objectives, yet these are required to enable staff to be clear on what it is they are trying to achieve in antenatal classes (Nolan 2020). Aims were largely those relating to labour and birth, but antenatal classes as a means of women forming ongoing relationships with their peers, and supporting parents' emotional well-being, were mentioned infrequently.

The use and type of theory that informed antenatal classes varied. While preparation for childbirth includes a psychological component, like Escott et al (2009) we found that psychological theory was not used universally. Previous evidence indicates that women value the opportunity antenatal classes offer to form new relationships and learn with their peers (Fabian et al 2005 Nolan 2009, DH 2011a); but meeting this need was not a stated objective.

There was variation in the 'usual' courses, when women could start them, number of sessions and total number of hours. Information on the NHS Choices website suggests that current provision overall seems similar to our findings:

'Classes are normally held once a week, either during the day or in the evening, for around 2 hours. Some classes are for pregnant women only. Others welcome partners or friends to some or all the sessions'. (NHS 2021:online).

The variation in provision for particular groups is also evident:

'In some areas, there are classes for single mothers, teenagers or women whose first language is not English' (NHS 2021:online).

Clearly, changes to mode of delivery have been required recently due to the COVID-19 pandemic (Grussu et al 2020). In our survey, class content seemed less varied than availability, with facilitators reporting various labour topics always being covered; however, we cannot comment on the level of detail provided.

Provision for specific groups of parents, that is, fathers, young women and women from minority ethnic groups was variable. The PBB resource (DH 2011a) highlighted how antenatal classes for new fathers need to be responsive to their needs, concerns and interests and recommended offering one or two 'men only' sessions; only seven trusts reported offering this option. In addition, as fewer than half the trusts offered fathers an opportunity to discuss issues in a 'men only' forum it is unlikely the needs of first-time fathers are being fully addressed (Deave & Johnson 2008). Young parents may engage best if antenatal classes are specifically designed for them (DH 2011a) and many trusts reported specific tailored sessions for young women. The PBB resource highlights that parents value culturally and linguistically appropriate courses (DH 2011a); however just under half of trusts did not provide language support for women whose first language was not English.

Not all trusts offered a visit to the planned place of birth, those that did offered variably actual or virtual visits. In the current century, some trusts changed their provision, despite evidence that planned hospital visits are an important way to help new parents, especially fathers, plan for the birth (DH 2011b).

Implementation science recognises that successful implementation of evidence into practice is a function of quality and type of evidence, the characteristics of the setting or context and the way in which the evidence is introduced (Harvey & Kitson 2016). The PBB resource was only available online and that may have reduced utilisation. It would seem unlikely that a resource that is only available online will achieve the level of change required. For change to occur, innovations require local champions and opportunities to enable discussion amongst those responsible for, and affected by, change (Sustainable Improvement Team 2018).

Our surveys were carried out approximately two years after the launch of the PBB resource. The resource was discussed within trusts, less with Maternity Service Liaison Committees. Least frequently reported was discussion with commissioners; this suggests that potential opportunities that would also raise the profile of antenatal education were not utilised. Features that supported use of the resource overall were identified, although use of different components varied. One aim of the pack was to support reaching groups less likely to attend; this component was reported as helpful least frequently.

Strengths and limitations

We conducted a rapid literature review to identify ways to encourage participation (Chizawsky et al 2011, VanGeest & Johnson 2011) and achieved a very high response rate. We surveyed acute trusts as they host maternity services, the largest provider of antenatal education. The inclusion of community trusts could have identified additional provision led by health visitors. It is some time since data were collected. However, contemporary provision, as described on the NHS Choices website, appears very similar to our findings in terms of topics covered:

'Some classes cover all these topics. Others focus on certain aspects, such as exercises and relaxation, or caring for your baby' (NHS 2021:online).

Since our surveys were carried out the importance of personalisation of care and priority accorded to perinatal mental health have increased (National Maternity Review 2016); antenatal education can make an important contribution to enabling all childbearing families to access information about the options available to them.

Conclusion

Contemporary policy drivers for maternity include increasing personalisation of care (National Maternity Review 2016); antenatal classes offer women a route to knowledge that can inform decision making and choice. However, variable provision between trusts has potential for inequitable services across different groups of women and childbearing families; achieving a universal service for antenatal education requires attention.

Notes

[1.] The Local Supervising Authorities (LSAs) carried out audits of the statutory function of supervision of midwifery to ensure that the requirements of the Nursing and Midwifery Council (NMC) were met. LSAs generally operated at regional level, covering several NHS trusts that provided midwifery services for their population. A database for each LSA facilitated the audit function. In 2017 the LSAs were disestablished. The previous databases are archived and held by NHS England.

[2.] https://wilmingtonhealthcare.com/what-we-do/data-marketing-and-marketing-insight/contacts-databases/

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Acknowledgements

The research was funded by the Bupa Foundation The Medical Research Charity.

The authors thank all midwives who responded to the surveys.

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How to cite this paper:

Spiby H, Stewart J, Watts K, Hughes A, Slade P (2021). Antenatal education class provision across maternity services in England: information provided from national surveys of heads of midwifery and facilitators of antenatal education. *Evidence Based Midwifery* 19(2):13-20.

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