Postnatal care is a subject close to my heart and an area I have researched for over 20 years. My master’s thesis study showed, for the first time, that common postnatal health problems were severe and impacted on women’s lives. My PhD thesis focused on implementation of a new model of midwifery-led postnatal care that was associated with better mental health outcomes and use of NHS resources.

But long before me was the pioneering Zepherina Veitch who, along with others, campaigned for the statutory training and registration of UK midwives in the early 20th century. Born in 1836, she was the daughter of a cleric and witnessed first-hand the impact of birth on the health of poorer women in her father’s parish. Her midwifery training was completed at the British Lying-In Hospital in Endell Street, London, at a time when hospital maternal mortality rates were extremely high, mainly as a result of puerperal sepsis.

Several early attempts to introduce a ‘Midwives Act’ had failed and in 1892 Zepherina gave evidence to a Parliamentary Select Committee where she referred to the inability of poor families to pay for doctors, who would not even ‘wash babies as beneath their dignity as educated gentlemen’ (Halliday and Halliday, 2007). Sadly, Zepherina died in 1894 before the first Midwives Act received royal assent in 1902. Maternal deaths had halved by 1917 and continued to decline over the next decades, reflecting better public health, access to emergency obstetric care and introduction of antibiotics, as well as universal midwifery care.

Such was the fear of puerperal sepsis that midwifery postnatal care in the early 20th century was highly prescriptive. Midwifery texts of the time included recommendations about how often a woman’s perineum should be swabbed postnatally to prevent genital tract infection (Marchant, 2009) and the need for postnatal women of different social classes to be managed appropriately to promote adequate rest, a particular concern for women from lower social classes (Marchant, 2009).

Postnatal care in the NHS
In 1948, the NHS was launched, which formalised the GPs’ role in maternity care and provided universal health care ‘from the cradle to the grave’. In the last revision to the Midwives rules, from the current NMC, a minimum contact of 10 days post-birth is still promoted, although midwives can maintain contact with women ‘for such longer period as the midwife considers necessary’ (NMC, 2012), introducing a much broader scope of practice. It is worth noting, however, that there is no evidence base to support the definitions of ‘postnatal’ that we currently use.

From 1948, changes to maternity care included transfer of place of birth from home to hospital, increased medicalisation and high inpatient turnover. Policy to inform service revision was often based on assumption rather than evidence until the Winterton report (House of Commons Health Committee, 1992), which recommended that maternity services should be focused on choice, control and continuity with women at the centre of the service.

In 2007, the Department of Health (DH) in England published Maternity matters (DH, 2007), which recommended maternity networks and a national choice ‘guarantee’ that women could choose where they gave birth. In 2006, the NICE guideline for
Achieving an effective continuum of midwifery care is fraught with difficulty. Giving birth is the most common reason women are admitted to hospital, yet birth cannot be demand-managed or controlled through referrals. Maternity is a core NHS service, delivered by acute service providers but mainly in primary care settings, with wide unexplained variation in outcomes between NHS trusts (National Audit Office, 2013). We lack effective measures of postnatal care, and reductions in service provision have raised concerns about an overall decline in women-centred quality standards (Bhavani and Newburn, 2010). The RCM Pressure Points campaign found that only a quarter of women were offered information about severe postnatal morbidity in line with NICE guidance (RCM, 2014). Many NHS trusts are in financial deficit and new maternity pathway tariffs could impede service development due to poor quality data and lack of strategic planning. More midwives are needed (National Audit Office, 2013), although resources could be better utilised through revision to current postnatal systems and processes (Bick et al, 2012).

NHS reforms in England could mean the end of the NHS as we know it, or we could meet challenges by engaging and reforming postnatal services. Evidence has shown that midwives can make a difference to the health of women, their infants and families (MacArthur et al, 2003), but current NHS service provision and funding mitigates effective universal postnatal care.

Maternity pathways need to reflect planned, tailored postnatal care based on an individual woman’s needs, with midwifery staffing projections reflecting policy ambition for life-long health, rather than a predicted number of births. We need objective measures that reflect the priorities of women and their families. Engagement with local clinical commissioning groups is essential to ensure universal postnatal care is promoted to enhance priority health outcomes.

Postnatal care should no longer be viewed as the poor relation of maternity services.

During labour and birth are continuing to rise (Health & Social Care Information Centre, 2013). Evidence from the 1990s onwards shows high rates of maternal morbidity including incontinence, perineal pain and depression. Despite evidence of morbidity, the content and duration of postnatal care have not been revised.

Inpatient care generates more complaints than other aspects of maternity services, with evidence that women feel unable to ask for help and are unfamiliar with hospital routines (Beake et al, 2010). The incidence of severe maternal morbidity is increasing, with evidence of the impact of maternal obesity on infant outcomes (Denison et al, 2014) and inequalities in maternal health outcomes (Knight et al, 2009). Genital tract sepsis was the leading direct cause of maternal death during 2006 to 2008 (Lewis, 2011). It begs the question: can 21st century health needs be met within a 20th century postnatal framework?

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For references, visit the RCM website.