Midwives' perspectives on personalised maternity care in the UK

Abstract

Background/Aims **Personalised care is associated with high-quality, safe maternity care. Limited evidence exists on midwives' perception of personalised care and potential barriers and facilitators associated with implementing it in practice. The aim of this study was to explore midwives' perspectives of personalised care.**
Methods **An online mixed-methods survey was conducted exploring the perspectives of 46 NHS midwives. Data were analysed using descriptive statistics and thematic analysis.**
Results **Assessing individual needs was perceived as a key facilitator and time restrictions were considered a significant barrier to providing personalised care in practice.**
Conclusions **Providing personalised care is associated with increased job satisfaction for midwives, and key barriers include inflexible healthcare systems and limited resources.**
Implications for practice **The findings contribute to an understanding of the factors that influence the provision of personalised care and have the potential to inform improvements in maternity services.**

Keywords

Burnout | Job satisfaction | Midwives | Personalised care

Jayne Wagstaff
Department of Allied Health Professions, Sport and Exercise, School of Human and Health Sciences, University of Huddersfield; St James's University Hospital, Leeds Teaching Hospitals NHS Trust
jayne.wagstaff@nhs.net

Nicola Draper-Jennings
Department of Allied Health Professions, Sport and Exercise, School of Human and Health Sciences, University of Huddersfield

Zoë Darwin
Department of Allied Health Professions, Sport and Exercise, School of Human and Health Sciences, University of Huddersfield

Tomasina Stacey
Florence Nightingale Faculty of Nursing, Midwifery and Palliative Care, King's College London

Women and birthing people have welcomed the vision set out by the UK government to increase personalisation in maternity services, where they can expect to be treated as an equal partner throughout their maternity journey and receive care based on 'what matters' to them (NHS, 2019a, b). Personalised care is outlined in the National Maternity Review (2016) report, 'Better Births', as providing care based on the individual needs of women and birthing people. It is associated with improved experiences and safer care, particularly for women and birthing people from minority ethnic communities and those living in deprived areas (National Maternity Review, 2016; Birthrights, 2022; Felker and Knight, 2024). There remains uncertainty around the specifics of what personalised maternity care involves, and a range of concepts appear linked to the aim of achieving personalised care in maternity services. These include informed choice (Winfield and Booker, 2021; Royal College of Midwives, 2022), relational care (Sandall et al, 2016), continuity of carer (Sandall et al, 2024), woman-centred care (Leap, 2009) and person-centred care (Nursing and Midwifery Council, 2023).

Insights have emerged since the publication of Better Births (National Maternity Review, 2016) into the implementation of personalisation in UK maternity services. For example, over 1000 people took part in a national maternity survey in 2021, almost half of whom (45%) reported that they did not feel they were seen as a key decision maker in their care (Birthrights, 2021). Recent investigations into UK maternity services have reported an association between a lack of personalised care and poor pregnancy outcomes (Kirkup, 2022; Ockenden, 2022; The All-Party Parliamentary Group on Birth Trauma, 2024).

To deliver the vision for personalised maternity care outlined in the Better Births report, there is a need to transform how healthcare staff provide personalised care (Winfield and Booker, 2021). Midwives play a key role in tailoring care around individual circumstances (Nursing and Midwifery Council, 2023). Although some evidence

© 2024 MA Healthcare Ltd

exists around their experiences of supporting women to make personal decisions about their care (Ahmed et al, 2013; Feeley et al, 2022), little is known about how the concept of personalised care is regarded by midwives, and limited practical guidance exists in the literature around how to implement personalised care in practice. Given midwives are at the frontline of maternity services, they are well placed to report on the factors that create opportunities or barriers to facilitate personalised care and increasing knowledge in this area has the potential to inform future improvements in care.

A survey was undertaken to understand how NHS midwives describe the concept of personalised maternity care, and to explore their views on factors that may facilitate or act as barriers to providing personalised maternity care in practice.

Methods

Midwives were invited to complete an anonymous online survey, which remained open for 4 weeks in February 2023. The survey was hosted securely by Qualtrics XMTM survey platform, and the checklist for reporting results of internet e-surveys was used to inform reporting of the survey methods and results (Eysenbach, 2004). The survey was publicised via JW's personal and professional networks, including social media, where an online link in the message led to information about the study (including details of the research aims and data storage), and a subsequent link for those agreeing to participate to start the survey. The study invitation and questionnaire link were sharable, to enable participants to forward the survey to colleagues without access to professional social media platforms.

Sample

A convenience sample was obtained of midwives employed in a midwifery role in the NHS within the previous 3 years. Potential participants were initially directed to study information, then asked to confirm whether they had worked as a midwife in the NHS in the past 3 years. Only those who answered 'yes' were able to consider taking part. Respondents who answered 'no' were not eligible to complete the survey and were directed to a page explaining this and thanked for their time.

Data collection

Data were collected using opinion scales and open-ended questions. The survey was developed by the lead author during a final year MSc project, with guidance from the rest of the team. It was piloted by two clinical colleagues and refined to produce the final version.

The survey consisted of 22 questions exploring midwife demographics, professional experience and perspectives on what does and does not work well when providing personalised care. For scale-based questions, participants were asked to answer using a scale of 1 to 100, with 1 indicating 'strongly disagree' and 100 indicating 'strongly agree'.

Data analysis

Demographic information and participant responses to closed questions were analysed using descriptive statistics (frequency and distribution). Analysis of data obtained via the open-ended questions was undertaken using thematic analysis (Braun and Clarke, 2006). All comments were coded independently by the lead author, then grouped under categories and organised into themes using an iterative process, refined in discussion with the rest of the team. The quantitative data were used to provide further context to the qualitative findings.

Ethical considerations

Heath Research Authority approval was not required as midwives were not invited to participate via communication in the NHS. No incentives were offered to participants. Those agreeing to participate confirmed their consent prior to the survey becoming available online. Data were collected anonymously.

Results

A total of 46 midwives participated in at least one aspect of the survey. *Table 1* outlines participants' characteristics and *Table 2* shows their professional background. Half (50.0%) of the participants were 36–45 years old, and the majority were White (84.4%), female (96.9%), heterosexual (84.4%), did not have any disabilities (96.9%) and defined their place of birth as either the UK (37.5%) or England (46.9%). The largest group of participants worked in a hospital in antenatal, intrapartum or postnatal care (37.0%) and were Band 6 (43.5%). Half (50.0%) had worked as a midwife for 6–10 years and the majority worked more than 30 hours per week (71.7%).

Participants' responses to scale-based questions are shown in *Table 3*. Only 33 of the participants completed this section. The analysis of responses to open questions identified four key themes: the benefits of personalised care, influences of the system, influences of relationships and preparing to make decisions.

The benefits of personalised care

Most participants referred to personalised care in terms of the benefits it may offer, and agreed that care provided in this way may lead to significant improvements.

> ***'Personalised care is an incredible tool for improving women's outcomes [and] experiences … women and families don't fit into boxes and care, whilst benefiting from some standardisation, needs to be flexible around the needs and wishes of the individual'. P1***

© 2024 MA Healthcare Ltd

Table 1. Participants' characteristics

Characteristic		Frequency, *n*=46 (%)
Age (years)	≤25	2 (4.3)
	26–35	12 (26.1)
	36–45	23 (50.0)
	46–55	7 (15.2)
	>55	2 (4.3)
Ethnic group (*n*=32)	White	27 (84.4)
	Irish	2 (6.3)
	Any other White background	1 (3.1)
	Asian or Asian British	0 (0.0)
	Black, Black British, Caribbean or African mixed or multiple	0 (0.0)
	Any other mixed or multiple	1 (3.1)
	Other	1 (3.1)
Gender (*n*=32)	Female (including trans woman)	31 (96.9)
	Male (including trans man)	1 (3.1)
	Prefer not to say	0 (0.0)
Sexuality (*n*=32)	Heterosexual or straight	27 (84.4)
	Bisexual or pansexual	2 (6.3)
	Prefer not to say	3 (9.4)
Disabilities (*n*=32)	Yes	0 (0.0)
	No	31 (96.9)
	Prefer not to say	1 (3.1)
Country of birth (self-defined) (*n*=32)	UK	12 (37.5)
	England	15 (46.9)
	Scotland	2 (6.3)
	Northern Ireland	1 (3.1)
	Ireland	1 (3.1)
	Prefer not to say	1 (3.1)

Although many participants regarded personalised care as an approach to providing high-quality, individualised care, some believed it may be perceived in other ways.

> ***'For some people, personalised care will mean that they want to do everything their way …for some people, personalised care will mean that they want to be told what to do'. P15***

Most participants reported midwives were in a key position to provide personalised care, and played a vital role in understanding individual needs, balanced alongside facilitating appropriate care.

> ***'[Providing personalised care is] a huge role, we are the glue between expectations and reality [and] can provide calm compassionate care where women feel informed throughout'. P3***

Around two-thirds of the 33 participants who answered scale-based questions (63.6%) strongly agreed and one-third agreed (30.3%) that providing personalised care increased job satisfaction for midwives (*Table 3*).

> ***'It's the thing that drives me most when supporting women and birthing people. It gives me huge job satisfaction when people feel heard, respected and enabled'. P23***

Barriers to providing personalised care: influences of the 'system'

The majority (81.8%) of participants strongly agreed that the way maternity services are designed was an important factor in whether or not the provision of personalised care was possible (*Table 3*).

> ***'Unfortunately, the current system does not easily support truly personalised care'. P18***

While the survey questions asked about maternity services generally, and did not mention 'the system', some participants described 'the system' explicitly as a key barrier to providing personalised care in responses to open questions. The authors inferred that participants used 'the system' as a reference to the structure and management of NHS maternity services.

When asked whether personalised maternity care is usually achieved in practice, less than one-fifth (15.2%) of participants who answered this question strongly agreed, and over one-third (30.3%) disagreed (*Table 3*). Some participants felt that being unable to provide personalised care potentially had a detrimental effect on midwives, both individually and as a workforce.

> ***'We have many challenges to overcome if we are to truly provide women-centred, holistic, safe care for all. I hope that it can be achieved, but I fear for the future of midwifery'. P20***

Over three quarters (81.8%) of participants strongly agreed that time constraints had a significant impact on the provision of personalised maternity care and that assessing the preferences of each woman and birthing person was key to providing personalised care (*Table 3*). Many participants described the importance of

© 2024 MA Healthcare Ltd

having sufficient time to assess individual needs during interactions with women and birthing people in order to provide personalised care.

'Time is the biggest barrier [to personalised care], as midwives are often pushed to complete visits within a very short time frame, which doesn't leave any room for discussion regarding choices. The 36-week visit ends up being a tick-box exercise and not a full discussion regarding choices'. P1

Some participants suggested differences may exist between providing 'personalised' and 'basic' care, and associated having insufficient time to assess individual needs with being unable to provide personalised care.

'There is not enough time … The bare minimum care is standard now'. P4

Many participants also reported inadequate staffing levels as a barrier to providing personalised care.

'Poor staffing both in community and in the acute setting – leading to a conveyor belt experience for women'. P30

Some participants reported a lack of understanding around the needs of people from diverse socioeconomic and ethnic communities along with discrimination as barriers to personalised care.

'The changing demographics of people that access maternity services [and] not truly understanding our ever-changing society on how they communicate'. P20

'Racism is a factor that is often overlooked as a barrier to individualised care'. P28

In contrast, one participant reported the consideration of an individual's cultural needs as an essential aspect of providing personalised care.

'Personalised care [is] tailored to their individual needs, desires and choices including care that is culturally safe'. P24

When asked whether it may be challenging to provide personalised care to women and birthing people where English was not their first language, 24.2% of participants strongly disagreed and 30.3% strongly agreed.

'Language barriers can make things challenging, though translation services are usually very good'. P15

Table 2. Participants' professional background

Characteristic		Frequency, *n*=46 (%)
Current place of work	Hospital (antenatal, intrapartum, postnatal care)	17 (37.0)
	Hospital delivery unit	5 (10.9)
	Community (antenatal, postnatal care)	11 (23.9)
	Clinical research delivery	8 (17.4)
	Other	5 (10.9)
Current NHS Agenda for Change band	5	7 (15.2)
	6	20 (43.5)
	7	12 (26.1)
	8 a/b/c	7 (15.2)
Midwifery experience (years)	<2	6 (13.0)
	2–5	10 (21.7)
	6–10	23 (50.0)
	>10	7 (15.2)
Hours worked per week	<20	2 (4.3)
	20–30	9 (19.6)
	>30	33 (71.7)
	Prefer not to say	2 (4.3)

Some participants perceived working within clinical guidelines in maternity services as a further barrier to providing personalised care, where challenges could exist when striving to shape care around individual needs.

'The policy-based practice of current maternity care … the risk-based approach and fear of litigation'. P19

Participants also reported a need for improved guidance for midwives to enable them to support women and birthing people requesting care outside of clinical guidelines.

'Better support for midwives to support women who make choices which don't fit standard policy [facilitates personalised care]'. P8

The influences of relationships on personalised care

Many participants described relationships based on trust between midwives and women/birthing people as an important element of providing personalised care. Continuity models of care (also referred to as 'case loading', where a midwife or team of midwives

© 2024 MA Healthcare Ltd

Table 3. Perceptions of personalised care

Response	Frequency, *n*=33 (%)				
	Strongly disagree (1–20)	Disagree (21–40)	Neither agree nor disagree (41–60)	Agree (61–80)	Strongly agree (81–100)
The way maternity services are designed is an important factor in the provision of personalised care	2 (6.1)	0 (0.0)	0 (0.0)	4 (12.1)	27 (81.8)
Active listening is an essential skill required to provide personalised maternity care	0 (0.0)	0 (0.0)	1 (3.0)	4 (12.1)	28 (84.8)
Assessing the preferences of each woman/birthing person is key to providing personalised care	1 (3.0)	0 (0.0)	1 (3.0)	4 (12.1)	27 (81.8)
Generally, it may be challenging to provide personalised care to women/birthing people where English is not their first language	8 (24.2)	2 (6.1)	4 (12.1)	9 (27.3)	10 (30.3)
It is usually possible to provide personalised care when meeting a woman/birthing person for the first time	4 (12.1)	6 (18.2)	8 (24.2)	7 (21.2)	8 (24.2)
All women/birthing people usually have the opportunity to make genuine choices about their care	4 (12.1)	12 (36.4)	6 (18.2)	8 (24.2)	3 (9.1)
Personalised maternity care is usually achieved in practice	7 (21.2)	10 (30.3)	6 (18.2)	5 (15.2)	5 (15.2)
Time constraints have a significant impact on the provision of personalised maternity care	0 (0.0)	3 (9.1)	0 (0.0)	3 (9.1)	27 (81.8)
Providing personalised care increases job satisfaction for midwives	0 (0.0)	0 (0.0)	2 (6)	10 (30.3)	21 (63.6)

provide care to a woman or birthing person on multiple occasions) were seen as a positive approach to building relationships and providing personalised care, and the lack of it created a challenge.

> ***'In my previous post, there was no antenatal continuity, which was a massive barrier [to personalised care] as [women and birthing people] would feel like they were having to explain everything multiple times and conversations were not documented'. P5***

One participant described the continuity of carer model as potentially negatively influencing both the provision of personalised care, and midwives' working conditions.

> ***'Too far has the pendulum swung towards continuity of carer, which has destroyed morale and personalised care by making it target driven, rather than based on a caring relationship with women in your care'. P2***

Some participants reported relationships among staff as associated with the quality of care received by women and birthing people. An unbalanced power dynamic among staff was seen as a barrier to providing personalised care.

> ***'Equality between obstetricians and midwives [is required] so that there can be true partnership working … the medical model of care provided by most hospitals [and] hierarchical and misogynistic power structures [is a barrier]'. P29***

Some participants shared ways to improve relationships among staff, and potentially improve provision.

> ***'Everyone having the same desire to provide personalised care across the multidisciplinary team … good teamwork to ensure continuation of agreed plans of care where possible'. P6***

Preparing to make decisions

Most participants considered enabling women and birthing people to make decisions about their care as an important aspect of personalised care. However, when participants were asked whether women and birthing people are usually given the opportunity to make

© 2024 MA Healthcare Ltd

genuine choices about their care, 24.2% agreed and 36.4% disagreed. An overlap was noted in the data in relation to team working and decision making and the impact on providing personalised care. Some participants reported the challenges of facilitating personalised care when there were differences of opinions in the multidisciplinary team.

> ***'Change of staff can sometimes be challenging when previously agreed plans are then discouraged due to difference of opinions of new staff'. P16***

The importance of preparing women and birthing people in advance for making decisions in situations that may change was also noted.

> ***'People can feel empowered when given the information to make informed decisions about their care ahead of time. As well as giving them tools to make decisions in changing situations'. P22***

Discussion

This study identified UK midwives' perceptions of personalised care and the factors that enable or create barriers to providing this in practice. Personalised care was highly regarded, considered 'an incredible tool' for improving outcomes and experiences for women and birthing people. Time constraints were a key barrier, echoing existing literature linking time-limited interactions between midwives and women and birthing people with a negative impact on building personalised, caring relationships (Cull et al, 2020). The present study also identified a link between providing personalised care and increased job satisfaction for midwives, aligning with existing literature (Warmelink et al, 2015; Harvie et al, 2019; Cull et al, 2020).

Conversely, the participants associated situations where midwives were unable to provide personalised care with an increased risk of experiencing burnout. Burnout is defined as 'a prolonged response to chronic emotional and interpersonal stressors on the job' (Maslach et al, 2001). The risk of burnout among midwives is well recognised in the literature (Cramer and Hunter, 2019; Ismaila et al, 2021), and it is also known that healthcare staff experiencing burnout is associated with a negative impact on patient safety (Hall et al, 2016) and with midwives leaving the profession (Tabib et al, 2024), contributing to staff shortages (Feeley, 2023). It is possible that being unable to deliver personalised care may contribute to burnout (Hunter et al, 2019; Moran et al, 2023), which, in turn, may impact the ability to provide suitable standards of care (Garcia et al, 2019).

To inform future improvements in maternity services, it may be useful to consider whether the system itself may intrinsically contribute to factors that increase the risk of burnout for midwives, and consequently lead to reduced provision of personalised care. For example, staffing pressures may lead to increasing time constraints and interactions may become more prescriptive. Further research into identifying how time is used in maternity services and personalised care provision may be an important step towards understanding more effective ways to provide personalised care to all women and birthing people throughout their entire maternity journey.

Another barrier to providing personalised care reported in the present study was the 'policy-based' approach in maternity services. This echoes existing evidence that 'protocolising' can exist in place of personalised care when tensions exist between offering choices to women and birthing people and providing safe care (Feeley et al, 2022; Norman et al, 2022). In maternity service provision, there may be the perception that prescriptive approaches to care increase safety, although this contradicts the findings from national investigations where personalising care was associated with improved pregnancy outcomes (Kirkup, 2022; Ockenden, 2022).

Having a limited understanding of the needs of people from minority communities was reported as a barrier to facilitating personalised care, and one participant reported racism as an associated factor. This is consistent with recent evidence highlighting poor maternity care experiences of some women from ethnic minority communities, including discrimination and cultural insensitivity (Birthrights, 2022). The perspectives of midwives caring for women and birthing people from ethnic minority groups were explored in a literature review by Crowe (2022). Although the midwives included aimed to provide care shaped around individual needs, they reported that the challenges in achieving this included language barriers and time restrictions to explore individual needs. Further research exploring the experiences of women and birthing people from ethnic minority groups, along with the perspectives of midwives caring for them, is required to enable equity in the provision of personalised maternity care.

The findings from the present study suggest that it may be possible to mitigate barriers to providing personalised care, for example by improving relationships between midwives and obstetricians and providing relational care using continuity of carer. Participants reported continuity models of care as having a positive impact on relationships between midwives and women and birthing people. This view aligns with a review by Sandall et al (2024) that demonstrated the significant benefits of relational continuity of care, including improving midwives' ability to determine individual needs (Rayment-Jones, 2020).

It is important to acknowledge the views of one participant who suggested the continuity of carer approach was 'target driven'. This perspective may not

© 2024 MA Healthcare Ltd

Key points

- Midwives associated providing personalised care with high-quality, safe care and increased job satisfaction.
- Being able to assess individual needs was perceived as a key element of providing personalised care.
- The structure and management of NHS maternity services were perceived as considerable barriers to providing personalised care.
- Midwives associated reduced opportunities to provide personalised care with an increased risk of burnout.

be representative of all midwives, but it highlights a potential challenge when the essence of a concept (such as the relational element of care in the continuity model) is not adhered to during the implementation process, especially when scaled up in different contexts. The Ockenden (2022) report suggested providing care in this way may add further pressure to maternity services and should only be rolled out in trusts that have adequate and sustainable staffing. It is important to consider how such an approach can maintain fidelity when scaled up.

Implications for practice

The findings imply that providing personalised care may have a positive impact on midwives as well as women and birthing people, given the potential to reduce risk of burnout and increase job satisfaction. Strategies to improve personalised care may therefore also positively influence the personal experiences and wellbeing and retention of midwives, supporting long-term improvements to UK maternity care.

Strengths and limitations

The first author's experience as a midwife may have impacted interpretation of the survey responses. However, a conscious awareness of this was maintained throughout the study, enabling increased transparency (Olmos-Vega et al, 2022). Limitations of the survey method are also acknowledged, particularly being unable to ask further questions to clarify responses. Additionally, it was not possible to determine the survey's response rate, as it is unknown how many midwives saw the survey and subsequently participated or not. However, consistency was noted across the survey responses, suggesting the findings are likely to represent the views of UK midwives.

Although the survey approach was a convenient, effective, low resource strategy in the project's scope, as a result of the small sample size, the authors acknowledge that the views presented here are not representative of all NHS midwives and self-selection bias may be relevant as the study was shared using social media. Around a quarter of participants did not provide their demographic information concerning protected characteristics and most participants were from a White British background and identified as female and heterosexual. Hearing from midwives from minoritised groups would be beneficial and may identify additional aspects relating to provision of personalised care in midwifery. Researchers can play an important role in achieving this by actively seeking the perspectives of people from minority backgrounds (including both women/birthing people and practitioners), potentially contributing towards reducing disparities in maternity care (Lovell et al, 2023).

Conclusions

Midwives perceived the provision of personalised care as a vital component of high-quality, safe care, and strived to achieve this. Facilitating personalised care was associated with increased job satisfaction, and having sufficient time to assess individual needs was seen as key to providing personalised care. Barriers to providing personalised included inflexibility in the NHS system, a lack of continuity of carer and a lack of understanding of the cultural needs of women and birthing people. Future research, co-designed in partnership with clinical midwives and women and birthing people, may identify practical solutions to using time more effectively in maternity services, better enabling personalised care without contributing to the risk of burnout among midwives. BJM

Acknowledgements: *The authors would like to sincerely thank all midwives who participated in this study, and the following organisations for their support with sharing the study invitation: The Royal College of Midwives, All for Maternity and The Society for Reproductive and Infant Psychology.*

Funding: *No funding has been received for this work.*

Data sharing: *Data are available from the authors on reasonable request.*

Author contributions: *JW conceptualised and designed this study and was responsble for data collection and analysis in an MSc program. JW wrote the initial manuscript draft, and all authors commented on and revised all drafts and approved the final version of the manuscript.*

Declaration of interests: *The authors declare that there are no conflicts of interest.*
Peer review: *This article was subject to double-blind peer review and accepted for publication on 13 August 2024.*

Ahmed S, Bryant LD, Cole P. Midwives' perceptions of their role as facilitators of informed choice in antenatal screening. Midwifery. 2013;29(7):745–750

Birthrights. Birthrights submission to the Expert Panel to the Health and Social Care Committee – May 2021. 2021. https://

© 2024 MA Healthcare Ltd

tinyurl.com/2s499xjt (accessed 23 March 2024)
Birthrights. Systemic racism, not broken bodies: an inquiry into racial injustice and human rights in UK maternity care. 2022. https://tinyurl.com/4a2we9br (accessed 10 April 2024)
Braun V, Clarke V. Using thematic analysis in psychology. Qual Res Psychol. 2006;3(2):77–101
Cramer E, Hunter B. Relationships between working conditions and emotional wellbeing in midwives. Women Birth. 2019;32(6):521–532. https://doi.org/10.1016/j.wombi.2018.11.010
Crowe R. Factors contributing to maternal health inequalities for women who are not white British in the UK. Br J Midwifery. 2022;30(3):160–171. https://doi.org/10.12968/bjom.2022.30.3.160
Cull J, Hunter B, Henley J, Fenwick J, Sidebotham M. "Overwhelmed and out of my depth": responses from early career midwives in the United Kingdom to the Work, Health and Emotional Lives of Midwives study. Women Birth. 2020;33(6):e549–e557. https://doi.org/10.1016/j.wombi.2020.01.003
Eysenbach G. Improving the quality of web surveys: the checklist for reporting results of internet e-surveys (CHERRIES). J Med Internet Res. 2004;6(3):e34
Feeley C. Supporting physiological birth choices in midwifery practice: the role of workplace culture, politics and ethics. London: Routledge; 2023
Feeley C, Downe S, Thomson G. 'Stories of distress versus fulfilment': a narrative inquiry of midwives' experiences supporting alternative birth choices in the UK National Health Service. Women Birth. 2022;35(5):e446–e455. https://doi.org/10.1016/j.wombi.2021.11.003
Felker A, Knight M. MBRRACE-UK update: key messages from the UK and Ireland confidential enquiries into maternal death and morbidity 2023. Obstet Gynaecol. 2024;26(1):27–31. https://doi.org/10.1111/tog.12902
Garcia C, Abreu L, Ramos J et al. Influence of burnout on patient safety: systematic review and meta-analysis. Medicina (Kaunas). 2019;55(9):553. https://doi.org/10.3390/medicina55090553
Hall LH, Johnson J, Watt I, Tsipa A, O'Connor DB. Healthcare staff wellbeing, burnout, and patient safety: a systematic review. PLoS One. 2016;11(7):e0159015
Harvie K, Sidebotham M, Fenwick J. Australian midwives' intentions to leave the profession and the reasons why. Women Birth. 2019;32(6):e584–e593. https://doi.org/10.1016/j.wombi.2019.01.001
Hunter B, Fenwick J, Sidebotham M, Henley J. Midwives in the United Kingdom: levels of burnout, depression, anxiety and stress and associated predictors. Midwifery. 2019;79:102526. https://doi.org/10.1016/j.midw.2019.08.008
Ismaila Y, Bayes S, Geraghty S. Barriers to quality midwifery care: a systematic review and meta-synthesis of qualitative data. Int J Childbirth. 2021;11(3):84–100. https://doi.org/10.1891/IJCBIRTH-D-20-00037
Kirkup B. Reading the signals: maternity and neonatal services in East Kent - the report of the independent investigation. 2022. https://tinyurl.com/mry3cua6 (accessed 23 March 2024)
Leap N. Woman-centred or women-centred care: does it matter? Br J Midwifery. 2009;17(1):12–16
Lovell H, Silverio SA, Story L, Skelton E, Matthew J. Factors which influence ethnic minority women's participation in maternity research: a systematic review of quantitative and qualitative studies. PLoS One. 2023;18(2):e0282088. https://doi.org/10.1371/journal.pone.0282088
Maslach C, Schaufeli WB, Leiter MP. Job burnout. Annu Rev Psychol. 2001;52(1):397–422
Moran L, Foster K, Bayes S. What is known about midwives' well-being and resilience? An integrative review of the international literature. Birth. 2023;50(4):672–688. https://doi.org/10.1111/birt.12756
National Maternity Review. Better births improving outcomes of maternity services in England: a five year forward view for maternity care. 2016. https://tinyurl.com/mr2e3y67 (accessed 23 March 2024)
NHS. The NHS long term plan. 2019a. https://tinyurl.com/b9rc4wyk (accessed 10 April 2024)
NHS England. Universal personalised care: implementing the comprehensive model. 2019b. https://tinyurl.com/2twkvczh (accessed 14 October 2024)
Norman JE, Stock SJ, Harmer C. After the Ockenden review: a chance to reset maternal and perinatal care in the UK? Lancet. 2022;399(10344):2331–2333. https://doi.org/10.1016/S0140-6736(22)00823-6
Nursing and Midwifery Council. Practicing as a midwife in the UK. 2023. https://tinyurl.com/ze9k4ucv (accessed 23 March 2024)
Ockenden D. Ockenden report - final. 2022. https://tinyurl.com/3vtxxtvc (accessed 23 March 2024).
Olmos-Vega FM, Stalmeijer RE, Varpio L, Kahlke R. A practical guide to reflexivity in qualitative research: AMEE guide no. 149. Med Teach. 2023;45(3):241–251. https://doi.org/10.1080/0142159X.2022.2057287
Rayment-Jones H, Silverio SA, Harris J, Harden A, Sandall J. Project 20: midwives' insight into continuity of care models for women with social risk factors: what works, for whom, in what circumstances, and how. Midwifery. 2020;84:102654. https://doi.org/10.1016/j.midw.2020.102654
Royal College of Midwives. Informed decision making. 2022. https://tinyurl.com/3da8f9tp (accessed 10 April 2024)
Sandall J, Coxon K, Mackintosh NJ et al. Relationships: the pathway to safe, high-quality maternity care. 2016. https://tinyurl.com/mup8z3tp (accessed 7 October 2024)
Sandall J, Fernandez Turienzo C, Devane D et al. Midwife continuity of care models versus other models of care for childbearing women. Cochrane Database Syst Rev. 2024;4(4):CD004667
Tabib M, Humphrey T, Forbes-McKay K. 'Doing' is never enough, if 'being' is neglected: exploring midwives' perspectives on the influence of an emotional intelligence education programme, a qualitative study. Women Birth. 2024;37(3):101587. https://doi.org/10.1016/j.wombi.2024.02.003
The All-Party Parliamentary Group on Birth Trauma. Listen to mums: ending the postcode lottery on perinatal care. 2024. https://tinyurl.com/497f4fp8 (accessed 15 October 2024)
Warmelink JC, Hoijtink K, Noppers M et al. An explorative study of factors contributing to the job satisfaction of primary care midwives. Midwifery. 2015;31(4):482–488. https://doi.org/10.1016/j.midw.2014.12.003
Winfield S, Booker M. Personalised care in maternity. Br J Midwifery. 2021;29(8):472–474. https://doi.org/10.12968/bjom.2021.29.8.472

CPD reflective questions

- Can you think of any specific circumstances where you find personalised care easier/harder to achieve and why may this be?
- Why might midwives feel at risk of burnout if they are unable to provide personalised care and what may help to mitigate this?
- How can personalised care contribute to reducing inequalities and enabling all women and birthing people to receive safe, high-quality care?
- How might you ensure that all women and birthing people are supported to provide feedback on their experiences to inform service improvements?

© 2024 MA Healthcare Ltd