AIMS For a better birth...

Maternal Medicine Networks

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By Natalie Whyte

Maternal Medicine Networks were commissioned by NHS England in 2021 following MBRRACE reports showing that progress to reduce the rate of maternal death nationally has stalled. In 2016-18, 'indirect' causes of maternal death – such as cardiac and neurological disease, and sepsis – continued to outweigh 'direct' causes. More than two thirds of women who died had pre-existing physical or mental health problems. In 2016-18, 23% of deaths were attributed to cardiac disease alone, and 13% occurred in women with epilepsy.

Many of these deaths could potentially be avoided by early referral to a multidisciplinary team of physicians, obstetricians, midwives, nurses, psychiatrists and other specialists with specific training and experience in the care of medical diseases in pregnancy. The Maternal Medicine Network service specification also emphasises that midwifery is a key component, and that the network will also need to engage with all those who might provide part of the care pathway such as health visitors, social workers, ambulance trusts, mental health teams, and the voluntary sector.

The aims of the service are:

- To provide advice and planned care for women with pre-existing medical conditions, before, during and after pregnancy – ensuring equitable access, excellent experience and optimal outcomes for all communities served by the service.
- To provide advice and planned intrapartum and postpartum care for women with medical conditions that arise during pregnancy.
- To provide local clinical leadership on the identification, referral and management of women with medical conditions, including reviewing training, clinical guidelines and referral pathways for all staff in contact with pregnant women across the footprint.
- To reduce inequities in pregnancy outcomes relating to medical complexity across all demographics.

There is much to be welcomed in the service specification, however a lack of ringfenced funding and other challenges have led to variation in the implementation and development of the service across NHS regions.

This article offers a reflective account of my role as a service user within the Maternal Medicine Network and draws on my personal experience as a woman who has experienced long term health conditions, adverse pregnancy outcomes and participated in research as a patient voice representative.

My engagement within the *West Midlands Maternal Medicine Network* maternity and neonatal services is driven by a deep-seated commitment to improving outcomes, equity, and experiences for all who use perinatal care. As an educator by profession and a perinatal health advocate, my work is more than a career, it is deeply rooted in my mission for service improvement, true co-production, and advocacy.

Between pregnancies I was dealing with fibroids and a cancer diagnosis, and during pregnancy I developed high blood pressure, pre-eclampsia, HELLP syndrome and anxiety after my pregnancy loss. At 34 weeks I went into premature labour after being discharged from hospital after a short stay due to pre-eclampsia. At that time my care was not joined up; there was no continuity of care. After receiving conflicting advice I was discharged and a few days later my baby was stillborn.

My lived experience has informed my understanding of the need for inclusive, culturally competent, and trauma-informed approaches within Maternal Medicine Networks, and I have developed a profound understanding of the emotional, clinical, and systemic challenges, behavioural relationships and inequalities faced by women navigating complex pregnancies. For women from the global majority these challenges are often even greater due to cultural barriers and cultural stigmas. As a bereaved parent, I am particularly committed to ensuring that provisions for those who experience pregnancy or baby loss

are embedded throughout maternity care. Bereavement support must extend beyond immediate care to include emotional, psychological and practical individualised support for both parents and siblings. Through advocacy, education, and collaboration with service providers, I aim to contribute to systems where compassionate care is a consistent standard, not a matter of circumstance.

Women with multiple long-term conditions face difficult and often complex challenges during pregnancy, birth, and the postnatal period. This includes uncertainties carried on beyond pregnancy, as sometimes conditions get worse after the stress on the body. Their care requires coordinated, multidisciplinary approaches that address physical, psychological, and social needs. Even with the acknowledgement of the importance and benefit of personalised care, many women with MLTCs have a lack of joined up care. It is essential to have a well-integrated Maternal Medicine Network where the patient voice has helped to shape the pathway and is embedded within the core framework.

The loss of my baby prompted me to become involved with the Leicester Maternity and Neonatal Voices Partnership (MNVP) and I chaired this group for two years. I then became the regional service user voice representative for maternity for the Midlands and so became involved with the Maternal Medicine Network. These positions have afforded me the opportunity to gain valuable experience in gathering and triangulating parent feedback to present to NHS trust leadership, ensuring that service user experience directly informs the development, implementation and evaluation of perinatal services.

The inclusion of patient and public perspectives helps to contextualise data and the impact of change. I am particularly proud of some engagement work we did on perinatal mental health pathways, where I collaborated with multidisciplinary teams to identify gaps in care delivery and was able to advocate for holistic approaches that prioritise continuity, psychological safety, and early intervention. This work reinforces the importance of embedding service user engagement as a vital element for the future of Maternal Medicine Networks across the UK.

As an educator by background, I decided to utilise my skillset by teaching sessions for student midwives on the importance of the patient voice. This consistently highlights that these sessions deepen their understanding of the human impact of care decisions and foster empathy within clinical encounters. Embedding lived experience in midwifery education bridges the gap between theory and practice, reinforcing the importance of respectful, individualised care for women with long-term conditions.

My personal experience as a service user voice representative on the *West Midlands Maternal Medicine Network* has been both deeply rewarding and profoundly educational. This role provided me with a unique opportunity to collaborate as part of the multidisciplinary team, gaining insight into the complexities of women with long term conditions or arising conditions in pregnancy, and the commitments involved in delivering safe, high-quality maternal care.

The frustrating issue was the travel aspect where patients would have to travel far for their care and sometimes cross local government and hospital trust boundaries. With the current financial climate, it is clear to see that this could negatively impact upon the care of those that live in deprivation. At the time when I was working closely with the *West Midlands Maternal Medicine Network* there was no financial

support given for the increased hospital attendance. In the current economic climate this could really pose a high risk for women accessing the services of the Maternal Medicine Network.

As part of my involvement, I conducted the 15 Steps Challenge, an activity that enabled me to observe the Maternal Medicine Network clinics from a service user's perspective and offer constructive feedback aimed at improving the patient experience journey. I was also invited to test software designed to support the management of the Maternal Medicine Network, contributing patient insights to help ensure that the system is accessible, efficient, and fit for purpose. As an active member of the West Midlands board, I was able to establish regional meetings to raise awareness of the Maternal Medicine Network among service users and the West Midlands Regional Team. These meetings aimed to foster dialogue, share best practices, and promote collaborative engagement across the region. It has been a privilege to help shape a system that listens to and acts upon the voices of those it serves. It would be great for Maternal Medicine Networks to implement the *Patient Voice Framework* that I created. **See Figure 1.1**

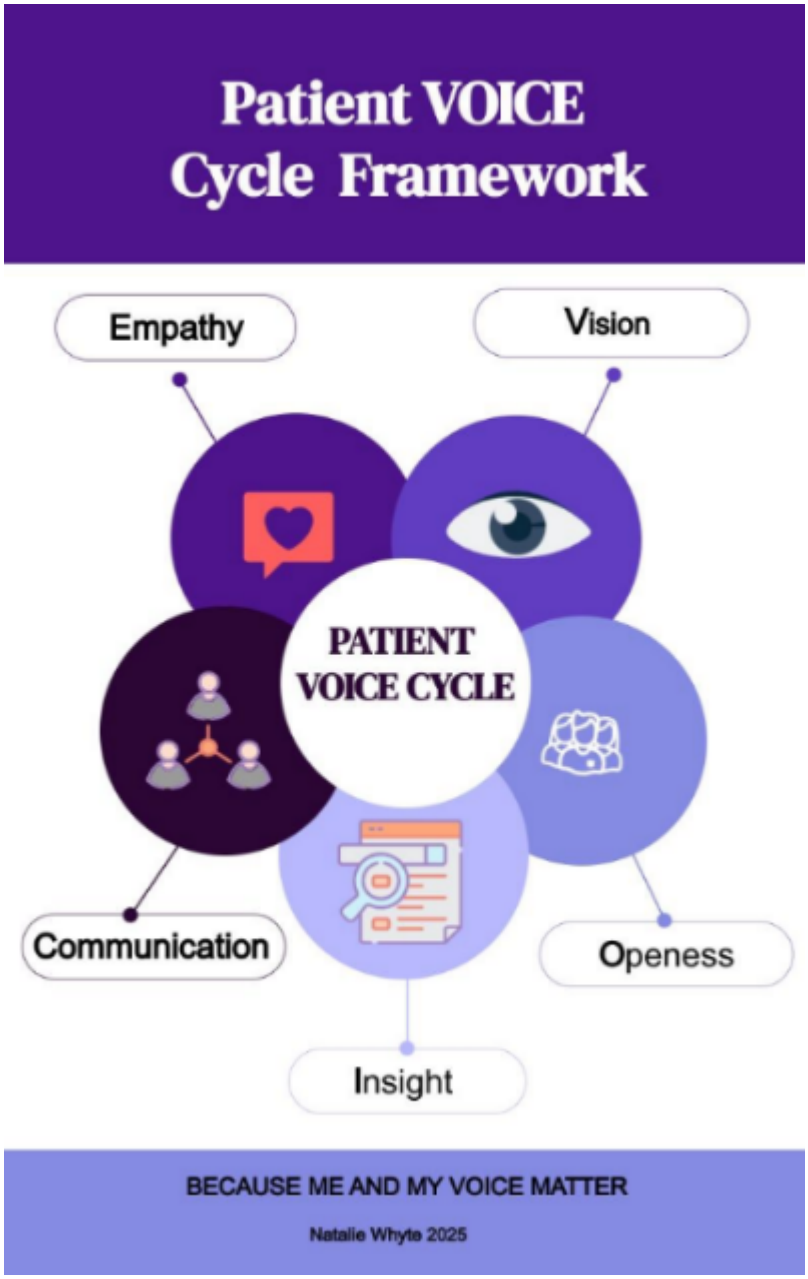

Figure 1.1

The implementation of this *Patient Voice Framework* in all Maternal Medicine Networks across the United Kingdom would allow for us to have a standardised model that will be beneficial to all that use the service and provide the medical interventions.

I was also given the opportunity to attend a service user voice event in Leeds in 2023, where I heard about the MuM-PreDiCT project and was invited to join the parent and public involvement group. This has been a life-changing experience where I have had the chance to be a part of life-changing research. The group has highlighted the need for consistent communication between clinicians and personalised care along with compassionate emotional support for women throughout their maternity journey.

I understand that work is ongoing to evaluate the rollout of Maternal Medicine Networks across the country and I am looking forward to reading more about progress on this.

Questions/actions for Maternity Voices Partnership (MVP) leads and birth activists to consider

1. Find the website for your local Maternal Medicine Network (MMN), contact the project manager or Maternal Medicine lead midwife.
2. Consider setting up information sessions for the MMN lead midwife and obstetrician to talk to local families and health professionals.
3. Look into including MMN clinics in your regular feedback collection visits and conducting a 15 Steps audit of the clinics – will your MNVP fund time for this?
4. Ask about financial and/or transport support for women attending MMN clinics.
5. Ask women using the MMN about their experience of moving from maternity care to standard care after the birth.
6. If you are invited to join the MMN or regional board as a service user representative, check arrangements for paying you for your time, travel expenses and childcare.

Author Bio: Natalie Whyte is a mother, bereaved parent, former MNVP lead and Service User regional representative for the Midlands, a member of the MuM-PreDiCT Parent Advisory Group. Natalie is extremely passionate about amplifying the voices of those who use maternity services including work force and student midwives. NHS service and overall maternity improvements across the community and cross sectors remain integral to the ongoing work of Natalie.
