Department of Health

Making It Better: For Mother and Baby

Clinical case for change
Report by Sheila Shribman, National Clinical Director for Children, Young People and Maternity Services

NHS

DH INFORMATION READER BOX

Policy HR/Workforce Management Planning Clinical	Estates Performance IM & T Finance Partnership Working
Document Purpose	Policy
ROCR Ref:	**Gateway Ref:** 7796
Title	Making It Better: For Mother and Baby
Author	Sheila Shribman, National Clinical Director for Children, Young People and Maternity Services
Publication Date	06 Feb 2007
Target Audience	PCT CEs, NHS Trust CEs, SHA CEs, Care Trust CEs, Foundation Trust CEs, Medical Directors, Directors of PH, Directors of Nursing, Local Authority CEs, Directors of Adult SSs, PCT PEC Chairs, NHS Trust Board Chairs, Special HA CEs, Directors of HR, Directors of Finance, Allied Health Professionals, GPs, Communications Leads, Emergency Care Leads, Directors of Children's SSs
Circulation List	
Description	The National Clinical Director for Children, Young People and Maternity Services outlines how services are being reconfigured to meet the needs of mothers and babies.
Cross Ref	n/a
Superseded Docs	n/a
Action Required	n/a
Timing	n/a
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Making It Better: For Mother and Baby

Providing the best services is the major driving force behind service changes according to Sheila Shribman, National Clinical Director for Children, Young People and Maternity Services.

Introduction

In October last year a panel of independent experts decided the most appropriate way to provide safe, effective and accessible maternity services was to move consultant maternity services from Huddersfield Royal Infirmary to join with Calderdale Royal Hospital five miles down the road and to provide midwife-led services in Huddersfield.

The local campaign to stop the change was passionate and spirited. Campaigners were initially utterly convinced something good and beneficial was being taken away and that the changes were politically and financially motivated.

Amidst the din of protest there were accusations questioning the motivation and judgement of the Trusts that had proposed the change.

Some protestors said a patient-led NHS was a joke because they weren't listening to women. There were claims the extra travelling time would put the lives of mothers and babies at risk and others said reducing services was mad because demand was likely to grow.

In the face of these arguments, why would any review agree to the closure of the consultant service at one of the hospitals? What's so different about pregnancy and childbirth that we need to change?

Benefits of Maternity Service Redesign

- Safer care
- Improving access and outcomes
- More choice
- Promoting normality
- Local ante and post natal services closer to home
- Home-like birth environment

What's changed

In the early 1950s, mothers had a 1 in 1500 chance of dying in childbirth. Today, the chances are 1 in 20,000. In 1960, 30 out of every 1000 newborn babies were stillborn or died soon after delivery, whereas today it is fewer than five, a six-fold decline.

The major medical causes of maternal death or disability (haemorrhage, high blood pressure, infection, illegal abortion, cardiac disease and anaesthesia) have all substantially declined. Better recognition of risk factors and development of accessible care at all stages for mothers

and their babies have transformed care in this country. Medical and technical advances have improved our ability to look after babies in the womb and care for them after birth.

Our understanding of risk factors and complications of pregnancy has increased. Academic research and advances in medical knowledge have contributed to better management of complications to improve outcomes. Development of national clinical guidelines and standards of care have laid the foundations for excellence and equitable care.

Birth is safer than ever before, but there has been an increase in medical intervention and specifically caesarean section rates. There are many reasons contributing to this increase, but for many women, pregnancy and childbirth has been turned into a medical event, which now involves a complex range of professional support and technical equipment.

Fifty years ago, 36% of mothers gave birth at home and another 13% in nursing homes in the care of midwives or GPs. Many women and babies suffered because they gave birth or were born in the wrong environment, where the care available could not meet their needs. As a result, by the 1970s the proportion of women having babies in hospitals had increased to 66% and births at home had dropped to 12%. So, change in maternity services is nothing new.

This trend accelerated when the Maternity Care in Action report (Department of Health, 1984) said: *"as unforeseen complications can occur in any birth, every mother should be encouraged to have her baby in a maternity unit where emergency facilities are available"*. At the time, it was good advice but we now know that it is not necessary for every baby to be born in a hospital.

Today, on average, only about two to three per cent of women have their babies at home and four per cent in a community facility like a midwife-led birthing centre.

Maternity Network Model

Services should be redesigned so that pregnant women have easy access to and a choice of the following services:

- Consultant-led maternity units linked to neonatal units with obstetricians and obstetric anaesthetists available 24 hours-a-day.
- Midwife-led maternity units, either in hospitals or in community settings, offering a "home-like" environment and swift access to consultant-led services if needed.
- Home births overseen by experienced midwives where appropriate.
- Plans will be open to change at any point during pregnancy and any risks carefully assessed.

Behind this trend towards hospital births is another story. In 2004, less than half our women (48%) had a "normal" birth without the aid of instruments such as forceps or epidural anaesthesia. Also, caesarean section rates have risen from three per cent in the 1950s to 23% today.

The Calderdale perspective

Five years ago, well before the NHS's current financial problems, Martin de Bono, clinical director for Women's Services at the newly merged Calderdale and Huddersfield NHS Foundation Trust, knew his consultant-led maternity services were not operating safely.

Although the two services co-operated, the maths didn't add up. He needed to operate a 24 hour-a-day, seven days-a-week consultant service at both hospitals with four consultants in Huddersfield and four in Calderdale.

In practice, however, a pregnant woman arriving in difficulty during the night at either unit was far more likely to be treated by a junior doctor than a consultant who would have to be called out to attend emergencies.

The European Working Time Directive meant they could no longer efficiently or ethically plug the gaps with tired and inexperienced juniors. They estimated that to work within safety margins each unit needed at least eight consultants as well as anaesthetists available 24 hours-a-day and access to neonatal services. Even if these specialists had been available to recruit, there were insufficient births at each unit to keep them all fully occupied and up-to-date as specialists. Each unit catered for around 2500 births a year. On their own, neither was large enough to justify the increased expenditure in order to retain specialist skills.

The solution put to the board was to place all the Trust's obstetricians and trainee doctors at Calderdale, have a midwife-led service at Huddersfield and use any released resources to employ more community midwives to tackle the unequal provision of ante-natal and post-natal services in the community.

The storm of protest that followed did not surprise the Trust. They had the support of the majority of the clinical staff but it was difficult to overcome the perception that something beneficial was being lost locally.

The local clinical director explained, "How do you convince people it is better to travel 20 minutes to a unit where you know a consultant will provide the best possible care if you need it, than to travel five minutes to a unit where the necessary expertise may not be immediately available? It is impossible if local people continue under the impression their local hospital is always the best option."

The Independent Reconfiguration Panel was asked by the Secretary of State to review the proposals and consulted widely before making its recommendations. As well as improving access to safe, effective maternity services, the panel also identified that changes would free up accommodation, which would then enable a number of other clinical services to work in improved facilities. But they also stressed the need to improve community maternity services, especially in disadvantaged areas – a recommendation the local NHS readily accepted.

The vision

I have no desire to see the reduction of services. I desperately want to ensure we deliver the best possible services for all women and their babies. This is not about closure but it is about change which people find hard sometimes.

Our top priority must be to provide safe, high quality care for all new parents and their babies. Whilst for the majority of women birth is safer than it has ever been, there is still an unacceptably high level of risk for a minority of women.

As well as the higher standards and ever increasing technical and medical advances and the European Working Time Directive, there is a need for specialist obstetric anaesthetists, neo-natal services and obstetric services to meet new challenges with doctors' hours being reduced to 48 a week. Maternity services also have to take account of the government's pledge to give all women a choice over where and how they have their baby, and the type of pain relief they want, by 2009.

To meet this commitment, and the others I have already described, the NHS should offer women a range of settings to give birth in, appropriate to their needs and wishes, taking account of safety and any risks as a key priority.

All women should have a choice of the following services:

- a home birth supported by a midwife, or
- birth in a local facility under the care of a midwife such as a designated midwifery unit. The unit might be based in the community, or in a hospital; patterns of care will vary across the country to reflect different local needs. These units typically promote a philosophy of "normal" and natural births
- birth supported by a local maternity care team that includes a consultant obstetrician. For some women, this type of care may be the only safe option. These teams are nearly all hospital-based.

Any woman giving birth at home should have the assurance that if something goes wrong she can be transported to a consultant-led unit safely and quickly. Part of her decision about where to give birth will be dictated by her pain relief plan. Epidural anaesthesia during labour should be available to all women choosing to deliver in a unit with a 24-hour specialist anaesthetic service. Other forms of pain relief such as balls, birthing pools and gas and air should be available at all midwife-led services.

Care for newborn babies, including the most complicated cases, should be provided within the safety net of fully agreed networks to ensure they have access to the whole range of specialist services.

Postnatal care should be delivered in accordance with relevant guidelines. In the future, women should receive co-ordinated medical and social care working to an agreed pathway of care. This includes meeting the particular needs of women with babies in neonatal intensive care or those with post natal depression.

We know that the emotional wellbeing of new parents and the involvement of both mother and father can have an effect on a child's life chances including their health and educational attainment. Pregnancy and the first three years are vital to child development. If we are going to give children the best start in life services must meet the social and emotional needs of new parents and parents-to-be. Our vision of joined up services delivered in the local community will not only improve access and support a family's ability to choose but will allow for support for their health and social care needs from midwives, health visitors and the primary health care team.

Proposal not prescription

The provision of NHS maternity services has never been more important. Historically, maternity services have been planned around local geography, existing configurations and available NHS buildings and subsequent changes have been undertaken in a piecemeal fashion. Women and babies deserve better.

Using these and other ways of improving care as a guide, services can improve but what will be right for Whitechapel will not necessarily work in Whitehaven. There is no optimum number of births to make a unit sustainable. Small midwife and nurse-led units are providing a high level of care to mothers and their babies just as units with larger numbers are able to. More important is the way the local NHS chooses to organise their care to meet the needs of their local community and the investment it makes in the training and support of its staff. There is a balance between accessibility and the need for specialist care. Proposals for change must be developed in consultation with local people.

Reconfiguration that provides an opportunity to improve access to the full range of care and specialist services through networks is to be encouraged, as is normality. Approachable and supportive antenatal and postnatal services in convenient and accessible settings encourage and enable women to engage with maternity services early in their pregnancy and maintain contact throughout the pregnancy, the birth and the early post-birth period.

Some women, particularly those from more vulnerable and disadvantaged groups, may require more support and access to social or other services, eg housing, advice on benefits and, where appropriate, child maintenance and relationship support. By reorganising services, the NHS can ensure families have the best possible antenatal and postnatal care and other facilities such as Jobcentre Plus, close to home through community services including children's centres.

Every woman needs a midwife

In future, when they first believe they may be pregnant, women and their partners should be able to go directly to a midwife rather than having to approach their GP first. Enabling women and their partners to access midwifery services directly means that they should enter the maternity care system at an earlier stage of their pregnancy. Early contact with a midwife is very important since it gives more time for making informed choices in planning their care and ensures women can take advantage of all support and tests such as twelve week scanning and screening. Evidence suggests that this will improve clinical outcomes.

A guiding principle for maternity services in future is that *"all women will need a midwife but some need a doctor too"*. This means that in the future:

- midwives will be more widely recognised as the experts in normal pregnancy and birth, and have the skills to recognise and refer women or their babies for more specialist care if necessary
- all women and their partners, however complex the pregnancy, will know and trust the midwife who is responsible for providing their on-going care and advice during and after pregnancy and childbirth and co-ordinating between any specialist services that may be required
- midwives will ensure that women and their families are aware of the arrangements for on-going midwifery support during absences
- where a woman chooses to give birth outside her area, the midwives in each area are responsible for ensuring continuity of care and handover
- women will be individually supported throughout their birth

Midwives, in partnership with expectant women and their partners, will discuss all realistic options and draw up a personalised, individual and flexible plan for their care.

Midwives have the knowledge and experience to recognise abnormal signs and symptoms and will be able to directly refer a woman, without delay, to an appropriate consultant obstetrician or other specialist in the antenatal period, during birth or afterwards.

With the increased emphasis on care being provided in community based settings such as children's centres, midwives will have a more visible local presence and more flexible and accessible services for everyone.

Reaching out to the most vulnerable

One of the reasons I'm particularly passionate about reshaping maternity services is the opportunity it gives us to improve what we are doing for the health and wellbeing of the most vulnerable and excluded families in our society.

Why do they need more help? In England, in 2000-02 women from the poorest backgrounds were 20 times more likely to die of a pregnancy-related condition than a professional woman. Up to 30% of the worst off women did not get in touch with their maternity services until they were at least five months pregnant, if they got in touch at all. Women from minority ethnic groups were, on average, three times more likely to die. It is unacceptable in 2006 that some pregnant women in our advanced western society are more at risk than those in parts of the developing world.

One of the simplest solutions to helping these families is taking services to them and new services can do just that.

For example, Southampton PCT has reorganised its services so that midwives can take care of two very different vulnerable communities in its midst, disadvantaged local women and their large refugee community. The midwives work closely with community workers, Sure Start children's centres, interpreters, social services and GPs. They use peer groups to encourage women to breastfeed and they offer the kind of support that many other women in England have taken for granted and is envisaged in the National Service Framework for Children, Young People and Maternity Services.

Not surprisingly, the choices these two communities make are very different. Twenty per cent of disadvantaged women in Southampton now choose to have their babies at home but the majority of refugees opt for a hospital birth under a consultant at present.

As the Calderdale and Huddersfield experience, and many like it around the country have shown, reshaping maternity services is not going to be a quick and painless process. But I think Southampton shows we are committed to delivering maternity services in a way which is more personal and responsive to individual needs.

I know clinicians around the country back these reforms and I think the public will do too once they understand our intention is to provide better, safer services and that this is not about cutting costs. In some cases it will mean more investment not less.

We know better care is what women and their partners want. When we ask mothers and fathers their views on our services, "flexibility to meet our needs" is consistently the worst performing aspect of maternity care, along with dissatisfaction with services used while giving birth.

So, change is vital if we are to ensure the safety and well-being of all mothers and babies and that pregnancy and birth are as normal an experience as possible for the majority of women, whilst those with risks or complications also receive the best possible care wherever they live.

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279638 1p 1k Feb 07

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