



House of Commons  
Health Committee

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# Provision of Maternity Services

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Fourth Report of Session 2002–03

*Volume I*





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Fourth Report of Session 2002–03  
Volume I

*Report, together with formal minutes*

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## The Health Committee

The Health Committee is appointed by the House of Commons to examine the expenditure, administration, and policy of the Department of Health and its associated bodies.

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### Committee staff

The current staff of the Committee are Dr J S Benger (Clerk), Jenny McCullough (Second Clerk), Laura Hilder (Committee Specialist), Frank McShane (Committee Assistant) and Anne Browning (Secretary).

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### Footnotes

In the footnotes of this Report, references to oral evidence are indicated by 'Q' followed by the question number. References to written evidence are indicated on the form 'Ev' followed by the page number.

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## Summary

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Although fewer mothers in England die in childbirth than ever before, some women still go without the kind of advice and support that they need, throughout and after their pregnancies, to secure the best possible health outcomes for themselves and for their babies. This report looks at the services available to women in England today, at the variation in these services across the country, and at four issues of particular concern: the collection of data from maternity units, caesarean section rates, the staffing structure of maternity care teams, and the provision of training for health professionals who advise pregnant women and new mothers.

In order to gain a 'snapshot' of the provision of maternity services, and to hear from those most closely involved, we took evidence from health professionals and user representatives from maternity units in each of the eight NHS regions. Our intention was not to attempt an all-encompassing survey of maternity services or to appraise the services provided by individual maternity units but rather to hear a range of views on issues of particular concern and also to engage in a wider debate on the provision of maternity services. We have sought to represent these views in our report.

The maintenance of a comprehensive and accurate statistical evidence base for maternity care is a vital component of work to improve services at national and local level but our report concludes that data collection at all levels is seriously impaired, not only by inadequate or nonexistent data systems and by inconsistent use of terminology, but also by a lack of IT and analytical support for maternity units.

We remain concerned that in undergoing caesarean section some women are exposed unnecessarily to the risks of surgery. In making decisions about caesarean section women must have access to appropriate information, advice and reassurance both from midwives and from experienced doctors, throughout pregnancy and during labour. The most important factor in a positive experience of birth for all women and in any setting is continuity of care and carer, where a woman is supported at all times.

In a great many maternity units, midwifery and medical staffing levels are not sufficient to provide this level of support. In some delivery suites midwives have to care for several women at a time, and levels of on-site consultant cover are low. As the number of hours doctors can spend in training is limited, less experienced doctors may be more likely to intervene in labour. Rising rates of intervention in labour and staffing shortages create gaps in the skills mix of maternity care teams. The provision of training for maternity staff to develop the appropriate skills is crucial to the quality of care that women receive.

The experiences of maternity care staff and of pregnant women and mothers, as we heard them during this inquiry, will inform our future inquiries into Inequalities in Access to Maternity Services and into Choice in Maternity Services.



# 1 Introduction

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1. At the beginning of its Second Report of Session 1991–92, which examined maternity services, the then Health Committee stated:

The Committee was stimulated into conducting this inquiry by its awareness of the fact that it is now over a decade since the last major inquiry into these matters ... and by hearing many voices saying that all is not well with the maternity services and that women have needs which are not being met.<sup>1</sup>

The Report affirmed the conviction that it was possible for the outcome of a pregnancy “to be a healthy mother with a healthy, normal baby and yet for there to have been other things unsatisfactory in the delivery of the maternity care.”<sup>2</sup>

2. After that inquiry, the Government set up an Expert Maternity Group, chaired by Baroness Cumberlege (then Joint Parliamentary Under-Secretary of State, Department of Health), to review NHS maternity care. Implementation of the Group’s recommendations, as set out in *Changing Childbirth*,<sup>3</sup> was to ensure that maternity services would offer women choice, control and continuity with regard to the care that they received during pregnancy, childbirth and the days and weeks after delivery.

3. In the House of Lords on 15 January 2003 Baroness Cumberlege again called attention to the quality of provision for maternity services. She registered her concern that:

With the closure of so many maternity units, with the crisis in recruitment and retention of midwives, not only is choice a luxury, but the very basic standards are not being met.<sup>4</sup>

4. We shared Baroness Cumberlege’s concern that a decade after our predecessor Committee’s inquiry and after *Changing Childbirth*, a great many women might still go without not only the kind of maternity care that they wanted, but also in some cases even without the advice and support that they needed throughout and after pregnancy. Maternity service planners and researchers, providers and users told us of their concerns over such issues as rising caesarean rates, maternity staff shortages and training requirements, a huge variation in services across the country and the lack of pertinent and accurate data for a secure evidence base.

5. In March 2002 we asked the Department of Health (the Department) to update us on the current situation in respect of maternity services in the context of our predecessor Committee’s Report. We received this in June 2002 and list the main policy developments in maternity services as an Appendix to this report. The Department told us that it was safer than ever before to have a baby in England.<sup>5</sup> We do not doubt that this is so and we recognise the continued efforts of health professionals and policy makers in working to

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<sup>1</sup> Health Committee, Second Report of Session 1991–92, *Maternity Services*, HC 29, para 2

<sup>2</sup> *Ibid*, para 3

<sup>3</sup> Department of Health, *Changing Childbirth: the report of the Expert Maternity Group*, 1993

<sup>4</sup> HL Deb, 15 January 2003, col 268

<sup>5</sup> See Appendix

improve the standard of maternity care. In particular, we welcome the guidelines on maternity services which have been developed by the National Institute for Clinical Excellence (NICE) and we look forward to the publication of the Maternity Services Module of the Children's National Service Framework.

6. However, we were keen to establish for ourselves a picture of maternity services as they are provided across the country, to gain an insight into the inequities and inequalities which might prevent access to appropriate services, and to develop an understanding of measures which might improve women's experience of pregnancy, childbirth and postnatal care. On 12 December 2002, we appointed a Maternity Services Sub-committee to undertake a series of short inquiries. This inquiry will be followed by inquiries into inequalities in access to maternity services and into choice in maternity services.

7. We were assisted in our inquiry by four specialist advisers: Dr Susan Bewley from Guy's and St Thomas's Hospital, Professor Lesley Page from the Royal Free Hospital, Professor Alison Macfarlane from City University and Professor Martin Whittle from the University of Birmingham. We wish to express our gratitude to them for their help on technical and policy points, for the benefit of their knowledge of individual maternity units and for the enthusiasm with which they assisted us at each evidence session.

8. In conducting the first of these short inquiries, we set out to look at the kind of services available to women in England today, at the variation in these services and also to seek views on issues of particular concern. We took advice from organisations such as the Maternity Alliance, the Royal College of Midwives, the National Childbirth Trust and the Royal College of Obstetricians and Gynaecologists and identified four aspects of maternity services which merited examination not only as discrete issues in themselves, but also as indicators of the variations in service provision at different maternity units. On 13 January 2003 we announced the following terms of reference for the Maternity Services Sub-committee's first inquiry, which incorporated these four aspects, into Provision of Maternity Services:

The Sub-committee will examine the provision of maternity services, and the variation in service provision, across England. In particular the sub-committee will consider:

- *The collection of data from maternity units*
- *The staffing structure of maternity care teams*
- *Caesarean section rates*
- *Provision of training for health professionals who advise pregnant women and new mothers*

The Sub-committee will investigate how staffing levels and training affect both the type of birth a woman is likely to have, and the health of her baby in early life.

9. We received over 60 memoranda from individual mothers and fathers, from practising and retired health professionals, from professional bodies and charitable organisations. We are grateful to all those who contributed and we will also look to draw on much of the written evidence as we conduct future inquiries.

10. In order to gain a ‘snapshot’ of services as they are provided at present, and to hear from those most closely involved, we decided to take evidence exclusively from health professionals and user representatives from maternity units across the country. In four evidence sessions we heard from maternity units in each of the eight NHS regions. We were keen to see how services varied within these regions and so at each evidence session we asked to hear from maternity units with different staffing configurations (such as hospital units and birthing centres), and from maternity units situated in close proximity to each other but with contrasting rates of intervention in labour (such as caesarean section and induction). We took evidence from these different units at the same time. In total 15 maternity units and 49 witnesses gave evidence. We appreciate the time taken by each of these witnesses and their colleagues at the maternity units, to arrange to speak to us.

11. The table below gives basic statistical information on each of the maternity units which gave evidence.

Maternity Unit <sup>6</sup>	Region	Type of Unit	Number of Deliveries	Induction Rate (National Average 21.5%)	Caesarean Section Rate (National Average 21.5%)	Instrumental Delivery Rate (National Average 10.9%)	normal Birth Rate (National Average 44.4%) <sup>7</sup>
St Mary's Hospital, Paddington	London	Consultant Unit	3544	n/a <sup>8</sup>	29.8% <sup>9</sup>	n/a	n/a
Edgware Birth Centre <sup>10</sup>	London	Midwifery-led Unit	250	– <sup>11</sup>	–	–	
Watford General Hospital	Eastern	Consultant unit and midwifery-led unit	2909	11.8%	18.8%	15.7%	n/a
The Rosie Hospital (Addenbrookes) Cambridge	Eastern	Consultant unit	4356	20.8%	26.4%	16.2%	n/a
Nottingham University Hospital	Trent	Consultant unit	3466	n/a	27%	15%	n/a
Derby City General Hospital	Trent	Consultant Unit	4327	n/a	18.6%	11.7%	n/a
Royal Shrewsbury Hospital	West Midlands	Consultant unit and midwifery-led unit	3761	28.4%	10.9%	13%	67.7%
Worcester Royal Infirmary <sup>12</sup>	West Midlands	Consultant unit	2969	21.8%	29.6%	10.2%	42.9% <sup>13</sup>

<sup>6</sup> Some of the maternity units represented provided their own latest available data on deliveries, included in the Appendices to the Minutes of Evidence. Some of the witnesses from consultant units (Watford General Hospital, Royal United Hospital, Bath, and St Mary's Hospital, Portsmouth) also represented community midwifery or units outside the hospital.

<sup>7</sup> A 'normal' birth is defined here as delivery without induction, caesarean, assisted delivery or regional anaesthesia.

<sup>8</sup> n/a denotes that the unit has not submitted usable information for the extension or 'maternity tail' of the Department Hospital Episode Statistics record.

<sup>9</sup> This figure was disputed by St Mary's, which provided a figure of 27%.

<sup>10</sup> See also Saunders, Dawn et al. *Evaluation of the Edgware Birth Centre*, North Thames Perinatal Public Health, 2000

<sup>11</sup> Edgware Birth Centre is a midwifery-led unit which does not provide medical interventions. Women who experience complications in labour and who require such interventions are transferred to a consultant unit. The rate of transfer from Edgware to a consultant unit was 11% in 1998–99 to 2000–01.

<sup>12</sup> Worcester Royal Infirmary closed in March 2002 and obstetrics services are now based at Worcestershire Royal Hospital.

<sup>13</sup> Normal birth rate calculated in combination with Alexandra Hospital, Redditch.

Maternity Unit <sup>6</sup>	Region	Type of Unit	Number of Deliveries	Induction Rate (National Average 21.5%)	Caesarean Section Rate (National Average 21.5%)	Instrumental Delivery Rate (National Average 10.9%)	normal Birth Rate (National Average 44.4%) <sup>7</sup>
St James's University Hospital, Leeds	Northern and Yorkshire	Consultant unit	3584	20.3%	15.7%	9.8%	n/a
Goole Midwifery Centre	Northern and Yorkshire	Midwifery-led unit	40 <sup>14</sup>	– <sup>15</sup>	–	–	–
St Mary's Hospital, Manchester	North West	Consultant unit	3953	16.6%	19.3%	10.9%	46.5%
Trafford General Hospital	North West	Consultant unit	1463	25.1%	25.9%	11.3%	35.9%
St Mary's Hospital, Portsmouth	South East	Consultant unit and GP unit	5444	23.7%	21.2%	8.7%	49%
Royal Bournemouth Hospital <sup>16</sup>	South East	Midwifery-led unit	549	1.3%	1.7%	3.3%	90.6%
Royal United Hospital, Bath	South West	Consultant unit and midwifery-led unit	4828	n/a	20.2%	n/a	n/a

Data source: Figures collated by BirthchoiceUK from NHS Maternity Statistics, England: 1998–9 to 2000–01 (Department of Health Statistical Bulletin 2002/11).<sup>17</sup>

## How is maternity care provided in England?

12. Maternity care teams work in several different settings. The Department told us that configuration of services is determined at local rather than national level:

It is for the Strategic Health Authorities and Primary Health Care Trusts to decide on the best pattern of local service provision – taking into account the needs and wishes of the local people, the local geography, the need to provide effective evidence-based care and available local resources.<sup>18</sup>

<sup>14</sup> Midwives from Goole pointed out that the unit had been closed for part of the time and so the number of births was artificially low.

<sup>15</sup> Transfer rate to consultant unit in 1998–99 to 2000–01 was 15%.

<sup>16</sup> See also Campbell R, Macfarlane AJ, Hemsall V, Hatchard K., "Evaluation of midwife-led care provided at the Royal Bournemouth Hospital," *Midwifery* 1999; 15 (3), pp 183–93.

<sup>17</sup> After the evidence sessions had taken place, the Department published figures for 2001–02 in *Statistical Bulletin* 2003/09.

<sup>18</sup> Ev 154

13. Almost all babies (96%) who are delivered within the NHS are born in ‘consultant units’.<sup>19</sup> A consultant unit is usually part of a general hospital, with medical staff (obstetricians, anaesthetists and paediatricians) and midwives making up the maternity care team. A woman is usually booked under the care of a particular consultant, but most of her care will be given by midwives unless complications arise during pregnancy or labour, when the doctors will become more involved. Interventions such as epidurals and caesarean operations are usually available in the unit. Some consultant units offer midwifery-led care or caseload midwifery,<sup>20</sup> continuity of carer<sup>21</sup> or DOMINO (Domiciliary In and Out) schemes.<sup>22</sup>

14. In ‘GP units’, a GP specialising in birth is available to provide care for women whose labour requires interventions such as forceps deliveries. In some community units, a doctor may be available to carry out caesarean sections in an emergency. In 2000-2001, 2% of deliveries were reported as having taken place on GP wards.<sup>23</sup>

15. In recent years ‘midwifery-led units’ have been established next to some consultant units. Women can give birth in these units with little or no medical intervention although if there are complications, transfer to a consultant unit is convenient. Teams of midwives in these units aim to offer women individual attention throughout labour but if the adjacent consultant unit is busy, midwifery-led units within hospitals may be understaffed at times as midwives are required to provide cover in the consultant unit. This is an issue of concern.

16. ‘Community units’ or ‘birth centres’ provide midwifery-led care in an environment designed to emulate a ‘home’ rather than a hospital. In some places these units are located near a hospital so that women with complications can be transferred quickly. In rural areas, community units, many of which used to be GP units are a place for women to give birth without travelling a long way to the nearest consultant unit. Because epidurals and caesarean sections are not usually available at these units, they tend to be suitable for women expected to have a straightforward birth (‘low-risk’ women). Concerns have been expressed with regard to the safety of units situated at a long distance from a consultant unit and the Royal College of Anaesthetists promotes the relocation of isolated maternity units to a main hospital.<sup>24</sup> However, evidence shows that this would be challenged by user groups, the midwifery-led units and the GP units who promote their safety record as being at least comparable.<sup>25</sup> The key issue must be transfer time, which may be affected by availability of transport, rather than the actual distance from a main hospital. We see no reason to qualify the conclusion of our predecessor Committee that “the policy of encouraging all women to give birth in hospitals cannot be justified on the grounds of

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<sup>19</sup> Ev 156

<sup>20</sup> A caseload is a specified number of women for whom a midwife is responsible.

<sup>21</sup> Under continuity of carer schemes, the same professional provides care throughout a woman’s contact with the maternity services.

<sup>22</sup> Under DOMINO schemes, community midwives provide the majority of care during pregnancy, intrapartum care (the woman usually goes home approximately six hours after her baby is born), and early postnatal care.

<sup>23</sup> Ev 156

<sup>24</sup> Ev 264

<sup>25</sup> Hundley, V.A. et al, “midwife managed delivery unit: a randomised controlled comparison with consultant led care.” *British Medical Journal* 1994; 309: 1400–4; Sandall J. et al, *Evaluation of the Albany Midwifery Practice: final report, March 2001*. Florence Nightingale School of Nursing and Midwifery, King’s College, London, 2001.

safety.”<sup>26</sup> The Department reported that in 2001-02, 2% of deliveries took place in midwifery-led units.<sup>27</sup>

17. Most women who choose to deliver their baby at home are cared for by midwives who are based at a local maternity unit. A small number are cared for by Independent Midwives. Antenatal appointments will usually take place in the home or in a local clinic. Once a woman goes into labour one or two midwives will provide care until the woman’s baby is born, and will then (as is the case when a woman gives birth in a maternity unit) visit the woman for between 10 and 28 days after the birth. The Department estimates that about 2% of women deliver their babies at home, although there is a wide geographical variation.<sup>28</sup> There is concern that a great many women who wish to deliver their babies at home are unable to do so.

## 2 Collection of data from maternity units

### How are data on maternity care collected at national level?

#### *How does the current system operate?*

18. Reliable data on the care provided for pregnant women and new mothers are essential to the auditing and development of maternity services at local and national level. There are three main ways in which data are collected following the birth of a baby. The first is through birth notification. All live births and stillbirths at 24 or more completed weeks of gestation must be notified by the midwife or other professional attending at the birth to the local Director of Public Health within 36 hours. This is now being achieved electronically through the NHS Numbers for Babies scheme which started in October 2002.

19. Under rules governing the civil registration of births and deaths, births, stillbirths at 24 or more completed weeks of gestation, and deaths must be registered at the local register office. Births must be notified within six weeks, live stillbirths within three months, and deaths within five days. The cause of stillbirth or death must be medically certified. These data are anonymised for statistical analysis by the Office for National Statistics which also maintains separate registers of identifiable information for legal purposes.

20. The third major source of data about maternity care given at birth is the Department’s system of Hospital Episode Statistics (HES). Statistics on maternity care are collected via items in an appendix to the standard record of care for patients admitted to hospital, known as the ‘maternity tail’.<sup>29</sup> These data are sent by trusts from their Patient Administration Systems to the Department (there are now arrangements for maternity

<sup>26</sup> Health Committee, Second Report of Session 1991–92, *Maternity Services*, HC 29-1, para 33

<sup>27</sup> Ev 156

<sup>28</sup> This ranges from 0.3% to 6.1% of maternities to residents of health authorities in 2001. *ONS Birth Statistics, England and Wales*. Series FM1 No 30, 2002.

<sup>29</sup> Maternity tail data items are: first antenatal assessment date, total previous pregnancies, delivery place (actual), delivery place (intended), delivery place change reason, gestation length, labour/delivery onset method, delivery method, status of person conducting delivery, anaesthetic given during labour/delivery/number of babies/sex (baby), birth order, live or still birth, birth weight, resuscitation method, birth date (baby), birth date (mother).

units whose systems are not linked to their hospital's patient system to send maternity data directly to the Department).<sup>30</sup>

21. Data are also collected from maternity units via the Confidential Enquiry into Maternal Deaths (a review of individual maternal deaths) and the Confidential Enquiry into Stillbirths and Deaths in Infancy (which reviews samples of events), now merged as the Confidential Enquiry into Maternal and Child Health and run by the National Institute for Clinical Excellence.

### **What are the problems with the current system?**

22. We heard throughout our inquiry, however, that there were major problems with maternity care data collection systems. One is incompleteness. Maternity tail data for nearly a third of deliveries do not reach the Department because of problems with incompatible or non-existent computer systems, or because computer systems are in the process of reconfiguration. According to the Department, since 1992–93, about 95% of deliveries in each year have at least a core record (noting the birth, and mode of delivery of each baby). However, even where HES records are sent, data may be missing. In 2000–01, out of 197 hospitals/trusts with deliveries, 52 did not submit any information for the maternity tail.<sup>31</sup>

23. Perhaps the most significant problem with maternity care data is that different units and different systems may define data items in different ways, which calls into question the validity of the statistics produced. The Maternity Care Data Project, run by the NHS Information Authority, was intended to have tackled this problem by April 2003. One of the main strands of the project was the compilation of a 'data dictionary'. This would provide standard definitions for all items of data, including the subset required by the Maternity HES. The aim was to have standardised and consistent recording of data relating to maternity and childbirth (for women and infants), within electronic patient record systems in all affected NHS organisations. However, we heard that the development of the Maternity Care Data Project has stalled owing to the lack of a 'champion'<sup>32</sup>

**24. We are concerned that the accuracy of maternity care statistics is adversely affected not only by missing data but by data submitted according to different interpretations of the terms used to define the data required by the Maternity Hospital Episode Statistics. We recommend that the NHS Information Authority clarify the progress made to date on the Maternity Care Data Project, and in particular on the compilation of the 'data dictionary'. We further recommend that work on this important area continue, overseen by a 'national champion' for maternity care data, alongside efforts to ensure that all maternity units submit data to the Maternity HES.**

25. We also heard that the data collected failed to reflect the changes in maternity care policy and practice which had taken place over the years. The British Association of Perinatal Medicine (BAPM) criticised the routine data collected in relation to childbirth as "a very limited number of items focusing on whether the mother and her baby survive"

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<sup>30</sup> Ev 144

<sup>31</sup> Ev 155

<sup>32</sup> Ev 117 (Professor Philip Steer)

and asserted that emphasis on the care of mother and baby in the selection of the data required would allow a much greater understanding of the quality of service, and of the changes in practice in maternity services.<sup>33</sup> In the past, the focus of work on maternity care data has been on the reduction of mortality levels for mothers and babies, although we note that no pregnancy-specific data are collected on care for women who have had a miscarriage.<sup>34</sup>

26. While this is still a vital component of data requirements for maternity care, many of those working in the field argued that pregnancy and childbirth should be seen as normal physiological processes which require low levels of medical intervention in the majority of cases. They felt that the medical profession and even women themselves, had lost a sense of what was normal with regard to birth, and that ‘normality’ should be defined in order for this sense to be regained. Normal or physiological birth is defined by some units as birth without any medical intervention but by others as birth without caesarean section. Helen Shallow, a consultant midwife from Derby City General Hospital told us that such definitions “could hide a multitude of interventions and things happening to a woman.”<sup>35</sup>

27. Data are also needed so that work can be done to reduce health inequalities in maternity care, both in terms of the variations in standards of care across the country and of the barriers to receiving appropriate care that some groups in society confront. The requirements for the Maternity HES do not accommodate the need to monitor inequalities in access to care, or to record normal birth statistics. Dr Soo Downe of the University of Central Lancashire told us that:

In the absence of the ability to collect data on straightforward births, the debate has become focused on caesarean sections, and on maternal and fetal/neonatal pathology. This does not allow for a full exposition of the issues in birth today.<sup>36</sup>

28. There is no central collection of data on antenatal and postnatal care outside hospital, although such data are often collected by community and General Practice systems and by the maternity records held by women themselves.<sup>37</sup> Central collection of such data might help the Government to monitor targets such as those on cessation of smoking in pregnancy. In its White Paper *Smoking Kills*, the Government set out to reduce the percentage of women who smoke during pregnancy from 23% to 15% by 2010, with a fall to 18% by 2005.<sup>38</sup> At present progress towards this target is monitored through the Infant Feeding Survey, which is conducted every five years among women who have recently given birth. The data are retrospective and cannot be validated.<sup>39</sup> Routine collection of data on cessation of smoking during pregnancy might represent a more accurate method of monitoring progress towards targets.<sup>40</sup> Lynne Pacanowski, Head of Midwifery at St Mary’s

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<sup>33</sup> Ev 130

<sup>34</sup> Ev 146

<sup>35</sup> Q 183

<sup>36</sup> Ev 188

<sup>37</sup> Ev 146

<sup>38</sup> Department of Health, *Smoking Kills: a white paper on tobacco*, Cm 4177, November 1998, Chapter 9.5

<sup>39</sup> Health Development Agency, *Cancer Prevention: a resource to support local action in delivering the NHS Cancer Plan*, October 2002, p 8

<sup>40</sup> Data on smoking cessation are now being collected at local level but concerns remain about methods of collection and duplication of effort.

Hospital, Paddington also told us about the problem of defining terms and parameters for data collection on breastfeeding rates. She pointed out that it was impossible to build a statistical base for analysing rates because data were collected at different intervals after delivery at different units.<sup>41</sup>

**29. We recommend that data on breastfeeding rates, in terms of initiation and duration, should be standardised and collected at national level.**

30. A final, but fundamental problem with the present system of national data collection is that information on child health is collected without adequate electronic links to maternity systems and so it can be very difficult to measure long-term outcomes for pregnancy and childbirth. Dr Jean Chapple, a consultant in perinatal epidemiology told us that:

Data from maternity units are important as they give a measure of the health of not only pregnant women but also their babies. Data on the mother's health plays an important part in a child's health record and maternal and child data should be linked.<sup>42</sup>

**31. We recommend that the Department take immediate action to ensure that maternity care data systems and population-based child health systems for both sick and healthy babies, should be linked together at national and local level in order that health professionals have all information relevant to mother and baby and in order that the long-term outcomes of pregnancy and childbirth for maternal and child health can be measured.**

**32. *Changing Childbirth* recommended that all women should carry their own maternity notes. We are disappointed that ten years later there are still some units where this does not happen. We recommend that the Department should insist that all units support the use of woman-held notes. We further recommend the development of a national format of these notes in preparation for the Electronic Patient Record.**

***What is being done to improve the system?***

33. The Department has introduced several measures to modify the system and method of data collection on maternity care. *Changing Childbirth* funded the National Maternity Record Project which set out to design records which would be held by the woman herself, and which explained clinical terms and gave sources for further information. However, some clinicians reported difficulty in finding data and it was later ascertained that the format of the records was not conducive to data entry in computerised maternity data systems.<sup>43</sup>

34. With effect from 29 October 2002 all babies born in England and Wales are now issued with their NHS Number at birth. The 'NHS Numbers for Babies' system is part of the NHS Information Authority's 'NHS Numbers for Life' initiative. Under this initiative, midwives request and receive a newborn baby's NHS Number as soon as possible after birth by

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<sup>41</sup> Q 78

<sup>42</sup> Ev 136

<sup>43</sup> Ev 137

connecting to the new NHS Central Issue System. The number is passed on to the Registrar of Births and Deaths. The new system has been welcomed as a way of strengthening the mechanisms necessary to collect comprehensive and accurate statistics<sup>44</sup> but some problems with the implementation of the scheme have been drawn to our attention. Professor Alison Macfarlane from City University, London, told us that technical problems have meant that some birthweights are no longer being passed from child health systems to local registrars of births and deaths, and that implementing the scheme has involved considerable duplication of effort in passing information to child health systems. She also raised the concern that the National Congenital Anomaly System operated by the Office for National Statistics could be undermined, as the minimum dataset for ‘NHS Numbers for babies’ does not contain details of congenital anomalies.<sup>45</sup>

35. The Department told us that it was acting as an intermediary in negotiations between trusts and the NHS-wide clearing service which received maternity care data, to help reduce incompatibilities between data systems. The Department also told us that the HES system was being recommissioned and that options for the collection of maternity care data were being explored.

**36. We welcome the Department’s efforts to reduce incompatibilities between data systems and to review policy on the collection of maternity care data. We recommend that this review take account of calls for a renewed focus on normal birth and of the need for accurate data on antenatal and postnatal care in order to monitor progress towards targets and reducing health inequalities. We further recommend that in reviewing the Maternity HES the Department should ensure that the figures compiled for each maternity unit take accurate account of factors such as privately-run units within hospitals, and reflect the configuration of services which take in community midwifery teams and midwifery-led units under the auspices of a hospital unit. The Department should also take steps to ensure that data are collected on births in privately-run units and on home births.**

## **How are data on maternity care collected at local level?**

### ***What systems are used by maternity units to enter and retrieve data?***

37. The data requirements of the Confidential Enquiries, the Maternity HES and the National Sentinel Audit of Caesarean Sections have led to the development of more sophisticated electronic collections than those used in other areas of health care. Professor Philip Steer, from Imperial College, London put forward this argument in terms of the Government’s plans for migration of patient records to electronic format:

The use of computers to collect and store clinical information has been extensively explored in maternity care ... electronic collection of data in the maternity services is probably nearer to being a true electronic patient record than in any other medical discipline.<sup>46</sup>

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<sup>44</sup> Ev 130

<sup>45</sup> Ev 145

<sup>46</sup> Ev 117

38. Data collected on maternity care are important not only as a means of monitoring trends at national level but also as a source of guidance for maternity units in developing local services. This means that a good maternity data system will allow retrieval as well as collection and transmission of data.

39. However, the serious problems with collection of data at national level reflect problems at maternity unit level. As part of the preliminary work for the NHS Numbers for Babies project the NHS Information Authority contacted the 184 trusts which provide maternity services (which contain a total of 269 units) and asked them to describe their maternity data systems. Some 34% of the trusts told the NHS Authority that they currently operated manual data systems, and 40% reported that the infrastructure of their current system was not sufficient to support implementation of the NHS Numbers for Babies project.<sup>47</sup>

40. Approximately 60% of the maternity units which did have electronic data systems used one of three commercially available systems but this was no guarantee of uniformity in terms of definitions for data items, or in terms of links to main hospital data systems. Other maternity units used systems developed in-house rather than those from commercial suppliers.<sup>48</sup>

41. We asked each of the maternity units giving evidence to tell us about their data systems, and about how they entered and retrieved data. Although we heard several very different kinds of system described, almost all were reported to be inefficient or inadequate.

42. Staff members from St Mary's Hospital, Paddington told us that their system, developed in-house, crashed on a regular basis and did not allow staff to retrieve useful data. Professor Lesley Regan, Consultant Obstetrician at St Mary's described attempts to use the system for this purpose:

It is an incredibly laborious process and most of it has to be hand-picked in the sense that an individual will have to extract items of data and then correct it because of inadequacies in not just the collection but in the storage of the data and missing fields. It is possible to get an annual report, but it is not the most accurate and myself and ... [the] Head of Midwifery could not go and actually plan strategy on the basis of that annual report at the present time.<sup>49</sup>

We also spoke to representatives from Edgware Birth Centre, which used the same system. Edgware staff told us that the system could not collect data which would be useful in developing and planning practice at the birth centre, and that other tools had to be devised for this purpose.<sup>50</sup>

43. Professor James Walker, a consultant obstetrician at St James's University Hospital, Leeds identified a key difficulty in retrieving data on maternity care from some computerised systems:

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<sup>47</sup> NHS Information Authority, *NHS Numbers for Babies*, Issue 1 (2000), p 2

<sup>48</sup> Ev 117 (Professor Philip Steer)

<sup>49</sup> Q 16

<sup>50</sup> Q 3

they are put into place by administrators who want administrative data, they have not been put in place by people wanting clinical data. So from our point of view it can give us information about the number of people that deliver and certain basic information, but that does not give us any clinical information that we can use for audits or care comparisons.<sup>51</sup>

44. Professor Walker described the process used to audit caesarean sections at St James's. The computer system could tell staff which patients had undergone caesareans but any further information had to be sought from case records or the delivery suite book. Another source of difficulty in collating data on mothers and babies was inadequate communication between the maternity system and other hospital computer systems such as that used for pathology.<sup>52</sup> This was another near universal problem in terms of the maternity units which provided evidence for our inquiry.

45. Karen Connolly, Head of Midwifery at St Mary's Hospital for Women and Children, Manchester described her unit's maternity data system, which had been initiated in 1987 to the design of one particular consultant and then implemented across the maternity unit ten years later. It collected specific data from the time that a woman booked her maternity care with the unit through to the postnatal period, and could generate monthly and annual statistics. Although the system itself was "comprehensive", it had only been linked to the hospital's patient administration system in the previous twelve months and even then, as Karen Connolly pointed out, "only in a minimal way, just for the demographic details. We are still having some teething problems ... trying to get combined data."<sup>53</sup>

46. Even where maternity systems were linked up with other data systems maternity care staff still struggled to achieve worthwhile returns relative to the time they devoted to entering data. The system at Trafford General Hospital was created in-house as a module of the Hospital's Patient Administration System but as Antony Nysenbaum, Clinical Director of Obstetrics and Gynaecology pointed out, lack of financial investment in maintenance of the system meant that desperate measures were needed in order to retrieve data:

We have a shortage of people in the computer department, and prioritisation I am afraid is very low. The first information we extracted off it successfully was yesterday, when I waved the sledgehammer of the Commons Select Committee at the computer department, and they managed to print off how many inductions we had last year. So there is a wealth of information, but we have no means at all of accessing it.<sup>54</sup>

47. In some areas midwives working with pregnant women and new mothers in the community had more fundamental problems of access to data in that they had no way of linking up with hospital computer systems. Cathy Rogers from Barnet and Chase Hospital spoke for midwives working in the community when she emphasised:

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<sup>51</sup> Q 359

<sup>52</sup> Qq 360-63

<sup>53</sup> Q 450

<sup>54</sup> Q 455

the importance of ensuring that all systems are available in the community setting where most of maternity care is provided and at GPs' surgeries so that midwives working in the surgeries can access the appropriate information that may be entered from the hospital setting.<sup>55</sup>

48. We were even more dismayed to hear reports from units where computer systems were useless or non-existent. Gill Smethurst, a clinical co-ordinator for midwifery and gynaecology told us about collection of maternity data at Goole Midwifery Centre:

We had a maternity information system set up for us and the chap who set it up left and nobody else knows how to get anything from it. The very sad thing is that we are still inputting on to it ... we will have a new maternity information service hopefully later on this year across the Trust ... we still decided to keep paper records of everything when the maternity information system came in about five years ago, so, thankfully, we still do have good statistics, but they are on paper. It is a register that we keep.<sup>56</sup>

49. We also heard from Worcestershire Royal Hospital and from Shrewsbury Royal Hospital, which lacked any computerised form of maternity information system. Just as at Goole, delivery records at the unit were kept on a ledger in the maternity ward, rendering any effort to generate statistics a time-consuming project: "If you are trying to look at why you are having a high Caesarean rate, if you are trying to do a retrospective audit of that, it means you pull in all the notes for the last twelve months to try and identify common reasons."<sup>57</sup>

**50. We were appalled to hear of the burden of work imposed on maternity care staff in units where maternity care data systems were inadequate or nonexistent. The dramatic variation in the reliability and availability of maternity care data systems across the country cannot be rationalised by differences in size or configuration of units. We were struck by the disparity between this unacceptable situation, where staff could not retrieve information about their patients, and in turn where reliable national statistics could not be generated, and the Government's intention to use information technology to "enable NHS professionals to have the information they need both to provide ... [the best possible] care and to play their part in improving the public's health."<sup>58</sup> We recommend that the Department of Health Statistics Division 3G liaises with other relevant parts of the Department and the NHS Information Authority to issue a direction to trusts on the provision and maintenance of maternity care data systems, and on links between these systems and other health information systems, so that maternity units can collect and retrieve accurate data in a more efficient way to meet both local and national data needs.**

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<sup>55</sup> Q 18

<sup>56</sup> Qq 372-73

<sup>57</sup> Q 269

<sup>58</sup> Department of Health, *An Information Strategy for the Modern NHS: 1998-2005*

### **Who collects and enters the data?**

51. According to the Centre for Nursing and Midwifery Research at the University of Brighton, responsibility for data collection, data entry and data reporting lies with maternity managers or heads of midwifery, who may not necessarily have the skills needed to work with data on computerised systems.<sup>59</sup> Responsibility for these tasks may be delegated, either to IT staff or, in one third of maternity services across the country, to an IT-specialist midwife. Where the IT-specialist midwife position is a full-time senior post, “the computerised systems function considerably more effectively to produce meaningful clinical data.”<sup>60</sup>

52. It became clear to us that those units which had the benefit of a team member interested or skilled in IT were able to make the best use of the computer systems available to them. Responsibility for, and a sense of ‘ownership’ of, the data collection system were crucial to successful data retrieval, as Donna Ockenden, Head of Midwifery at St Mary’s Hospital, Portsmouth told us: “we have an experienced midwife with a big interest in IT and she is responsible for a lot of the good quality detail.”<sup>61</sup> Technical support seemed to inspire more confidence in the system. Karen Connolly, from St Mary’s, Manchester was able to tell us that:

Systems don’t crash often – we have a midwife who is responsible for that overall system, and she talks with the company that are based in London. If we do have any problems, we have a helpline that staff can ring throughout the day, and also internal systems at night.<sup>62</sup>

53. In the majority of units, however, entry of data into electronic systems or ledgers was mostly undertaken by midwives without any particular expertise in IT, and often with insufficient technical support. We heard from midwives that data entry was seen as a burden which could add to the pressure already exerted by a heavy workload. Jennifer Fake, Head of Midwifery at Watford General Hospital, illustrated this point:

As a unit which is running on a huge vacancy rate, we are desperately trying to look after women, we are trying to give one-to-one care. If at the end of looking after that woman, you then have to spend a considerable amount of time inputting that information ... it is very, very time consuming.<sup>63</sup>

54. Jen Ferry from the Rosie Hospital, Cambridge suggested that IT specialists would be better placed to take responsibility for maintaining data collections:

Our problem is finding the project staff and the funding for them to be able to run the computer system rather than using midwives to do that. Midwives, whilst they

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<sup>59</sup> Ev 198

<sup>60</sup> Ev 198

<sup>61</sup> Q 547

<sup>62</sup> Q 454

<sup>63</sup> Q 125

have the clinical expertise, do not necessarily have either the project or the IT expertise and it is poor use of valuable clinical time.<sup>64</sup>

Written evidence from Dr Luk Yun Chan, a consultant paediatrician at Mayday Hospital, Croydon also argued that clerical staff should input data on the grounds that this would produce more accurate results and ease pressure on clinical staff.<sup>65</sup>

55. Given the shortage of midwives in a number of services it can be difficult to provide even the most basic care. If training is inadequate and there is poor support for IT (particularly in relation to prompt assistance when problems arise), entering data can be time consuming and frustrating for midwifery staff and can hamper the provision of good quality care.

**56. The process of entering data on maternity care must not compromise the quality of care that pregnant women, and new mothers and babies receive. Adequate managerial and systems support is vital. Maternity care teams should have access to the services of administrative staff who have been trained to use the data system. While clerical staff can help to alleviate some of the pressure on maternity staff in terms of data entry, it is essential that the ultimate responsibility for overseeing the quality and clinical accuracy of data lies with a senior member of the clinical team. We recommend that the Department ensure that maternity units have access to reliable hardware, systems which can support the handling of individual records, to software which can be used for data analysis, and to appropriate statistical and IT support. Provision should be made for midwives who wish to do so to acquire skills in data analysis for monitoring and audit.**

### **How can maternity unit data collection systems be improved?**

57. We received evidence to suggest that the implementation of computerised maternity care data systems in some units had been delayed owing to uncertainty about the future requirements of the Government's electronic patient record (EPR) initiative.<sup>66</sup> This suggestion was confirmed by one of our witnesses, Professor David James, Lead Obstetrician at University Hospital, Nottingham. Professor James felt that the drive to deliver the electronic patient record was commendable in principle but was worried that records generated in different parts of the country by different computer systems might not be transferable: "we could be investing a vast amount and developing that locally, and it could be at variance with what is being done nationally."<sup>67</sup>

58. Cathy Rogers from Barnet and Chase Farm Hospital also expressed some anxiety about the development of the EPR. Her answers to our questions reflected a general feeling of dislocation between those who collect data at maternity units and those who formulate policy on data collection at national level:

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<sup>64</sup> Q 131

<sup>65</sup> Ev 209

<sup>66</sup> Ev 139

<sup>67</sup> Q 177

You have to develop the package for EPR; it is not developed yet. There may be issues in terms of making national comparisons if we are not all inputting the same data ... It would be very useful if we had a national lead in terms of the development of the database. I can only speak for my own Trust, but in our Trust we have a group of core people working on development of the things that we want included in EPR, and it would be nice if perhaps nationally we had a group of key people developing the database.<sup>68</sup>

59. Our witnesses told us that they would value central direction on the collection of maternity care data. Some went as far as to say that all maternity units should use an identical computer system. Christopher Guyer, Clinical Director of Obstetrics, St Mary's Hospital, Portsmouth suggested that such a system "would not only be able to produce records locally but would also be able to produce records nationally across the country."<sup>69</sup> However, other witnesses pointed out that the variation in the kinds of maternity unit which operate across the country meant that exactly the same system might not be appropriate for all units. Professor James Walker from St James's, Leeds told us that:

What we need is to try and aim for a common data set that we collect around the country. Whether we use exactly the same computer system is probably less important, as long as they can communicate and be adapted accordingly. I think each individual unit has different needs, so the one-size-fits-all may not be the best way forward, as long as there is a degree of uniformity across the board.<sup>70</sup>

60. Throughout this part of our inquiry, our attention was drawn to the system of maternity care data collection in Scotland, where data relating to all admissions to maternity units have been collected on the SMR02 form for over twenty years. Several witnesses agreed with the RCOG that the form seemed to be "simple and readily completed" and also noted that annual accounts of perinatal outcomes drawn from the data were published on the website of the Scottish Perinatal Mortality and Morbidity Review.<sup>71</sup>

**61. We recommend that in reviewing policy on the collection of maternity care data, the Department consider the merits of the system used in Scotland, not only in terms of the system itself but also in terms of other factors which might contribute to its success, such as the allocation of resources and the existence of a culture which supports staff who collect, enter and analyse data.**

**62. Most of the midwives and doctors who spoke to us did not recognise the requirements of the Maternity HES as a common data set, because they had not heard of them, or because they felt that definitions of the data required were not clear, or because the Maternity HES did not correspond with the more detailed information they collected independently for the purposes of care for individual mothers and babies, and development of their service. This is an indication of the disparity between national policy on and local knowledge of, collection of maternity care data. If**

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<sup>68</sup> Qq 9–10

<sup>69</sup> Q 539

<sup>70</sup> Q 364

<sup>71</sup> Ev 192; Q 14 (Professor Regan, St Mary's, Paddington); <http://www.show.scot.nhs>

maternity unit data collection systems are to be improved, communications between the Department and individual trusts and maternity units must be strengthened. We recommend that the Department should set out the implications of the electronic patient record initiative for maternity care data systems, including agreement of data definitions for maternity care, and further that it should consult and communicate with trusts on developments relating to the minimum dataset required by the Maternity HES.

63. We believe the current state of maternity care data systems at units across the country to be so grave as to warrant specific attention by PCTs and trusts, and, where needed, the allocation of funds for the purpose of installing and maintaining adequate systems and for recruiting and training appropriate staff to undertake data entry, analysis and system support. We recommend that maternity care data systems should form part of Local Delivery Plans.

### 3 Caesarean section rates

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#### How have caesarean section rates changed?

##### *What is the current situation?*

64. Just over one in five babies in England are now delivered by caesarean section. In the 1950s 3% of births in England were by caesarean section. This figure had risen to 9% by 1980 and has since increased rapidly, reaching 12% in 1990, 21% in 2000,<sup>72</sup> and 22.3% in 2001.<sup>73</sup>

65. Caesarean section rates at individual maternity units vary widely across England. Behind the 22.3% national rate<sup>74</sup> local figures range from approximately 12% to approximately 30% and differences between the rates of neighbouring hospital trusts and even neighbouring maternity units, may be stark.<sup>75</sup>

66. Lack of consistent data on maternity care is a problem in countries other than England and so exact international comparisons of caesarean section rates are difficult to make, although an overall increase has been recognised as a global phenomenon. Estimates for France and Germany suggest that rates in these countries are broadly in line with that in England. Caesarean section rates in Norway, Finland Sweden and Denmark (countries which produce reliable maternity care data) mirrored the position in England until the 1990s but while rates rose rapidly in England in the 1990s, in Nordic countries they

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<sup>72</sup> Ev 163

<sup>73</sup> Department of Health, *Statistical Bulletin NHS Maternity Statistics, England 2001–02*. 2003/09, May 2003

<sup>74</sup> *Ibid.*

<sup>75</sup> *Caesarean Sections*, POSTnote 184, Parliamentary Office of Science and Technology, October 2002. Caesarean section rates in private hospitals are often higher than in NHS maternity units. For example, the Portland Hospital in London has a caesarean section rate of approximately 44%. However, only around 0.5% of births take place in the private sector and so this has little impact on national statistics.

remained at 12–14%. The caesarean section rate in Italy, which was comparable to that in England in 1980, had risen beyond the rate in England (to 22%) by 1995.<sup>76</sup>

67. In the United States, caesarean section rates rose steeply throughout the 1970s and 1980s, from 6% in 1970 to 17% in 1980 to 24% in 1990. However, in contrast to trends in European countries, US rates in the 1990s stabilised, falling to 22% in 1995.<sup>77</sup> In South and Central America, caesarean section rates are considerably higher than those in the US and Western Europe. It is estimated that rates in Brazil and Chile are currently around 40%.<sup>78</sup>

### ***What are the implications of rising caesarean section rates for women and babies?***

68. In 1985 the World Health Organization (WHO) undertook a study of caesarean section rates and maternal and perinatal mortality rates. A WHO conference on caesarean section rates concluded that no additional health benefits were associated with rates above the range 10–15%.<sup>79</sup> For some women and babies, caesarean section may be a life-saving procedure. However, rising caesarean section rates give cause for concern with regard to health outcomes for mothers and babies because the operation is a major surgical procedure which is associated with some immediate risks and also has some longer-term health implications.

69. A great many of those who responded to our call for evidence on this aspect of our inquiry registered their concern about rising caesarean section rates in English maternity units, and sought to make clear to us the risks involved in the procedure. The RCN set out these risks in the starkest of terms:

Although the [caesarean] procedure carries major benefits for some women and children, there are also associated risks, such as increased perinatal and maternal morbidity and mortality due to operative injury and complications of anaesthesia. Post-operative recovery can also be lengthy.<sup>80</sup>

70. An elective caesarean section carries almost a three-fold greater chance of maternal mortality over vaginal birth, if there is no emergency present.<sup>81</sup> Dr Soo Downe, from the Midwifery Studies Research Unit at the University of Central Lancashire also pointed out the “immediate but very rare” risk of maternal death, owing to a combination of the underlying reasons which indicated the need for the procedure, anaesthetic risk, and complications of surgery. Martin England recounted for us how his wife delivered triplets by caesarean section after a relatively trouble-free 36-week pregnancy but subsequently died from a rare condition associated with caesarean section (Acute Colonic Pseudo-

<sup>76</sup> Thomas, J., and Paranjothy, S. Royal College of Obstetricians and Gynaecologists Clinical Effectiveness Support Unit. *National Sentinel Caesarean Section Audit Report*. RCOG Press, 2001, p 2

<sup>77</sup> *Ibid.*

<sup>78</sup> *Caesarean Sections*, POSTnote 184, Parliamentary Office of Science and Technology, October 2002

<sup>79</sup> *Having a Baby in Europe*, World Health Organization, Copenhagen, 1985

<sup>80</sup> Ev 207

<sup>81</sup> Hall, M.H. and Bewley, S. “Maternal mortality and mode of delivery”, *Lancet* 354 (1999), pp 776–79

Obstruction or Ogilvie's syndrome) which was not identified until the inquest into her death.<sup>82</sup>

71. Professional debate continues as to whether the mortality risks inherent in caesarean section are now so small, that the only relevant issues are morbidity differences between labour and elective caesarean section, for example, differences in recovery time, infections, and incontinence. However, there is little detailed work on morbidity and longer term outcomes. There is strong evidence that immediate serious morbidity is at least 30% higher for elective caesarean section than it is for labour, including vaginal deliveries followed by emergency caesarean sections. There is also professional consensus that caesarean section risks increase with each operation, whereas labour risks decrease with each delivery.<sup>83</sup>

72. Postpartum maternal infection is also a risk associated with caesarean section. The concerns about caesareans are not only related to the immediate operation and recovery period but longer term sequelae (that include repeat caesarean, scar dehiscence and rupture, and obstetric hysterectomy), adhesions complicating further surgery, ectopic pregnancy and haemorrhage and hysterectomy following uterine evacuation. There is some evidence that women who have had a previous caesarean section are more likely to have problems with fertility.<sup>84</sup> Dr Downe told us of the possible implications of caesarean section for babies. She identified an increased risk of respiratory distress in babies delivered by elective caesarean section before 39 weeks gestation and also an adverse effect on successful breastfeeding and bonding.<sup>85</sup> It is estimated that during the procedure itself there is a 1% risk of a knife laceration to the fetus (this increases to up to 8% if the fetus is not in the cephalic, or head-first, position).<sup>86</sup>

73. Increasing caesarean section rates have cost implications for the NHS. A caesarean section was costed in the mid-1990s at an estimated £760 more than a vaginal delivery. By this calculation, every 1% increase in the national rate costs the NHS £5million.<sup>87</sup>

### **How has the Government responded to these concerns?**

74. Since the 1920s the Department has played a key role in monitoring the risks associated with pregnancy and childbirth by commissioning studies of maternal mortality. In 1952 the Department (then the Ministry of Health) established the Confidential Enquiry into Maternal Deaths in the United Kingdom in response to concerns about deaths in childbirth. The findings of the Enquiry, a centrally-directed self-audit for health professionals involved in maternity services, are incorporated into Government health policy and obstetric practice.<sup>88</sup> As mentioned above in Chapter 2, CEMACH will continue

<sup>82</sup> Memorandum from Martin England (MS6) (*not printed*)

<sup>83</sup> Hall, M.H. and Bewley, S, "Maternal mortality and mode of delivery", *Lancet* 354 (1999), pp 776–79; Hofmeyr, G.J., and Hannah, M.E. "Planned caesarean section for term breech delivery." *Cochrane Library*. Issue 4, 2001.

<sup>84</sup> Hemminiki, E. "Impact of caesarean section on future pregnancy—a review of cohort studies." *Paediatric and Perinatal Epidemiology*, 10 (1996) pp 366–79

<sup>85</sup> Ev 186

<sup>86</sup> Smith, J.F., Hernandez, C, Wax, J.R., "Fetal laceration at caesarean delivery," *Obstetrics and Gynaecology* 90 (1997), pp 344–46

<sup>87</sup> Audit Commission, *First Class Delivery: improving maternity services in England and Wales*, 1997

<sup>88</sup> *Why Mothers Die 1997–1999: The Confidential Enquiries into Maternal Death in the United Kingdom*, 2001

the work carried out since 1992 by CESDI to collect and analyse data on deaths in late fetal life and infancy and so ultimately to reduce the number of such deaths.

75. These projects have audited caesarean sections in relation to maternal and infant deaths, but while mortality rates have decreased, concerns about the rising national caesarean section rate and about the variation in rates between maternity units in light of the risks associated with the procedure, have intensified. Concerns about caesarean section rates pertain not only to the safety of the procedure itself but also to the perception that caesarean section might not be the most appropriate option for some of the women who undergo the operation; that it might represent an unnecessary intervention in the natural process of childbirth.

76. In January 2000 the Department commissioned the National Sentinel Caesarean Section Audit “to accurately determine the current caesarean section rate, factors associated with variation in the rate and quality of care.”<sup>89</sup> Data were collected from maternity units in England and Wales between 1 May and 31 July 2000. The aim of the Audit was not to judge obstetric practice but to gather the data required to inform the development of guidelines for caesarean section which the National Institute for Clinical Excellence (NICE) has been commissioned to provide.

77. NICE guidelines on caesarean section are expected in December 2003. In the mean time, the Department has commissioned NICE guidelines on two other forms of intervention in labour which might increase the likelihood of a decision to perform a caesarean section: the use of electronic fetal monitoring (EFM)<sup>90</sup> and the induction of labour. After repeat caesarean sections which contribute 29% to the overall caesarean section rate, the most common reason for performing the procedure is presumed fetal distress, diagnosed by EFM, which contributes 22% to the overall rate.<sup>91</sup> The guidelines on EFM and induction of labour are intended to support maternity unit staff in making decisions about interventions, to reduce variations in clinical practice and with particular regard to EFM, to reduce “unnecessary caesarean sections and instrumental deliveries.”<sup>92</sup>

### ***Why are caesarean sections carried out and why are rates increasing?***

78. In the evidence it provided for this part of our inquiry, the Department drew on the results of the National Sentinel Caesarean Section Audit. During the Audit over 70% of caesareans carried out were attributed to one of four factors:

- previous caesarean section(s) [29%].
- dystocia (slow birth) [20%]
- fetal distress [22%]

<sup>89</sup> Thomas, J., and Paranjothy, S. Royal College of Obstetricians and Gynaecologists Clinical Effectiveness Support Unit. *National Sentinel Caesarean Section Audit Report*. RCOG Press, 2001. p xvii

<sup>90</sup> EFM is used to monitor a baby’s heartbeat continuously during labour. Sensors are placed against the mother’s abdomen and are connected to a heart rate monitor, which produces a record of the baby’s heart rate.

<sup>91</sup> *Caesarean Sections*, POSTnote 184, Parliamentary Office of Science and Technology, October 2002, p 2

<sup>92</sup> Ev 163

- breech presentation [16%].

79. The National Caesarean Section Audit noted failures to use good practice guidelines dealing with these four indications in a substantial proportion of cases: Syntocinon was not used in dystocia or ‘failure to progress’ (in cases accounting for 2.6% of the overall caesarean section rate), fetal blood sampling which can halve the caesarean section rate for ‘fetal distress’ was not used (in cases making up 4.6% of the overall rate), external cephalic version, which turns approximately half of breech babies to head-first, was not offered (to 67% of women having elective caesarean section for breech presentation) and on the discussion of labour with women who had one previous caesarean section was highly variable across units (suggested by the wide range of vaginal birth achieved after caesarean section in 6–66% of women). Thus there is strong evidence that simply adhering to present standards should reduce unnecessary caesareans by at least 5%.

80. Around 63% of caesarean sections carried out were identified as emergency procedures, while 37% were identified as elective. The Department noted that, in the Audit, 7% of caesareans were attributed to maternal request. However, the Audit Report itself indicated that such classifications might be misleading:

Caesarean section has traditionally been divided into two groups, either elective or emergency procedures. The emergency category is broad, as it may include procedures done within minutes to save the life of a mother or baby as well as those in which mother and baby are well but where early delivery is desirable ... In some centres this has led to an ad hoc local adaptation ... This has resulted in data inconsistencies between hospitals.<sup>93</sup>

81. With regard to the ‘maternal request’ category identified by the Department, the Centre for Family Research at the University of Cambridge found that individual obstetricians used different definitions of a maternal request, with some recording this as a reason for undertaking caesarean section even if it had been recommended by clinical staff as the best course of action.<sup>94</sup>

**82. We recommend that in undertaking caesarean section audits, all hospitals should classify the degree of urgency of a caesarean section in the same way. We further recommend that the classification scheme used by the National Sentinel Caesarean Section Audit be considered as a standard scheme and that the data items needed to construct it should be included in the Maternity Care Data Dictionary.**

83. The Department told us that the reasons for the rise in caesarean rates were “complex and not well understood” but suggested the following as contributory factors:

- Technical advances have enabled obstetricians to identify complications at earlier stages [for example, through EFM], so that intervention may constitute a more appropriate option than it once did
- Increased safety of the procedure

<sup>93</sup> Thomas, J., and Paranjothy, S. Royal College of Obstetricians and Gynaecologists Clinical Effectiveness Support Unit. *National Sentinel Caesarean Section Audit Report*. RCOG Press, 2001, pp 49–50

<sup>94</sup> Ev 244

- Changes in the age profile of the obstetric population [women over 35 years old form a larger proportion of all maternities than they did twenty years ago, and the caesarean section rate increases with maternal age]<sup>95</sup>
- Women's choice<sup>96</sup>

84. Perhaps the most contentious and least understood of these factors is women's choice. The British Association of Perinatal Medicine (BAPM) told us that "greater consumer choice in choosing when and how to deliver", is a factor which contributed to rising caesarean section rates.<sup>97</sup> However, several others detected a perception, fuelled by media coverage of private practice, that the rise in caesarean rates is *largely* a consequence of maternal request for the procedure. Dr Soo Downe of the Midwifery Studies Research Unit, University of Central Lancashire, told us that:

There appears to be little evidence that the sharp rise in the rates of caesarean section can be fully explained by a rise in maternal requests for the operation. Maternal request subsequent on a traumatic first birth experience may, however, play a small part in the rise.<sup>98</sup>

85. Caesarean section rates in private hospitals are often higher than in the NHS (the Portland Hospital in London has a caesarean section rate of some 44%). As we have noted, while these rates have little impact on national statistics, the levels of public awareness of celebrities who deliver their babies by caesarean section in private hospital may have a disproportionate influence on culture and perceptions.<sup>99</sup>

86. According to the Centre for Family Research at the University of Cambridge, the RCOG and many others who provided written evidence for our inquiry, pregnant women want more information on the risks and benefits of caesarean section and wish to be involved in the decision-making process.<sup>100</sup> A survey carried out between 1999 and 2002 by the Centre for Family Research at the University found that that maternal requests for caesareans were made mainly because of fears about the health of mother or baby.<sup>101</sup> In their most extreme form, these fears constituted a phobia of giving birth (tokophobia), and a small number of seriously traumatised women may need surgery in order to avoid severe psychological problems.<sup>102</sup>

87. Another contentious issue afforded a great deal of attention in the press, is that of litigation related to maternity care. The NHS Litigation Authority (NHSLA) had potential liabilities for clinical negligence of £5.2 billion at 31 March 2002 and as the NHSLA attests: "obstetrics is responsible for a disproportionate number and cost of clinical negligence

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<sup>95</sup> Thomas, J., and Paranjothy, S. Royal College of Obstetricians and Gynaecologists Clinical Effectiveness Support Unit. *National Sentinel Caesarean Section Audit Report*. RCOG Press, 2001, p 25

<sup>96</sup> Ev 162

<sup>97</sup> Ev 130

<sup>98</sup> Ev 185

<sup>99</sup> *Caesarean Sections*, POSTnote 184, Parliamentary Office of Science and Technology, October 2002, p 3

<sup>100</sup> Ev 242; Ev 194

<sup>101</sup> Ev 242

<sup>102</sup> *Ibid.*

claims with damages awarded often exceeding £3million.”<sup>103</sup> Dr Luk Yun Chang from Mayday Hospital, Croydon, told us that the rise in caesarean section rates reflected concerns regarding the risks of litigation if a vaginal delivery is seen to be difficult or might be considered in hindsight to have been managed inappropriately.<sup>104</sup> The BAPM identified “an increasing tendency to practise defensive medicine.”<sup>105</sup> This view was supported by evidence submitted by the Centre for Family Research at the University of Cambridge.<sup>106</sup>

88. The RCOG emphasised the finding of the National Sentinel Caesarean Audit that lower caesarean section rates could be associated with aspects of staffing policy, such as continuous support for women in labour, and dedicated consultant time on labour wards.<sup>107</sup> The BAPM also argued that the staffing structure of labour wards had a bearing on caesarean section rates, stating that if less experienced staff were responsible for decisions about the mode of delivery, rates tended to rise.<sup>108</sup>

89. We were keen to hear at first hand the views of health professionals and user representatives on these issues, to explore their perceptions of caesarean rates, nationally and at their own units, and in particular to try to find out why caesarean rates varied so much among maternity units in England.

## What is the experience in maternity units?

### *What concerns do staff and users have about rising caesarean rates?*

#### *The woman’s role in the decision to undertake a caesarean section*

90. We put the various possible reasons for the increases in caesarean section rates to obstetricians, midwives and user representatives from maternity units in each region of England. Our witnesses addressed the well-publicised aspects of the maternal choice controversy but also helped us to explore in greater depth women’s perceptions of the procedure and of their role in the decision to undergo it. Although caesarean sections undertaken at maternal request make up a small proportion of the total number carried out, the issues raised by discussion of these cases in respect of provision of information and support for pregnant women relate to all aspects of maternity care.

91. Some maternity care staff told us they had noticed a change in women’s attitudes to caesarean section and to childbirth in general. Siobhan Hargreaves, a user representative from University Hospital, Nottingham said that “until the last couple of years” she had never known women to talk about undergoing a caesarean section “because of the convenience of arranging childcare and getting back to work.” Mrs Hargreaves registered

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<sup>103</sup> NHS Litigation Authority, “Key facts”, *NHSLA website*, [http://www.nhsla.com/welcome\\_to\\_NHLSA.htm](http://www.nhsla.com/welcome_to_NHLSA.htm); *NHSLA Review*, Issue 23 2002, p 6

<sup>104</sup> Ev 209

<sup>105</sup> Ev 130

<sup>106</sup> Ev 242

<sup>107</sup> Ev 194

<sup>108</sup> Ev 130

her concern for these women, asking “are they fully aware of the implications of major abdominal surgery?”<sup>109</sup>

92. We heard from maternity care staff who felt that the portrayal of maternity care in the media had had an effect on women’s aspirations and expectations with regard to childbirth. Marie Pearce, a Community Midwife working for West Hertfordshire NHS Trust told us:

People in the press make it sound so easy, you can have your section at nine o’clock on a Tuesday morning and have your visitors at three. You have your champagne afterwards and it looks so nice. Some women see it in the press and think that if they can do it and get their figures back in three days then why shouldn’t they? ... The popular press is making it worse.<sup>110</sup>

93. This image of birth does not refer at all to the health of the mother or the baby but a positive outcome is assumed. In turn, then, the portrayal of this scenario can play not only on women’s lifestyle aspirations but also on their deepest concerns about childbirth. As Elaine Parker, another user representative from University Hospital, Nottingham, told us:

Women want a perfect birth. They want a perfect outcome, and if there is any slight risk they see caesarean section as an easy option to get that birth, without always understanding the consequences of aftercare and subsequent pregnancies.<sup>111</sup>

94. Several witnesses told us about the kind of fears associated with childbirth which, while they might not constitute tokophobia, could still influence women’s attitude to caesarean section. Elaine Parker told us that many women were so anxious about the prospect of a forceps delivery that they would rather have a caesarean section.<sup>112</sup> Livia Mitson, representing women who received maternity care at the Rosie Hospital, Cambridge, summed up:

childbirth can actually be really quite scary, whereas a caesarean section is seen as an operation and it is planned and under control. You do read about caesarean section in the media and you are aware of them whereas you are not so aware of encouragement for home births.<sup>113</sup>

95. It was clear to us that women’s perceptions about caesarean section and their fears with regard to childbirth were of considerable concern to maternity care staff, who felt a sense of obligation to respect a woman’s choice but also to protect her from the risks associated with surgery if at all possible. Many maternity care team members and user representatives argued that providing women with adequate information about caesarean section represented the best way forward. As Ann Geddes, Head of Midwifery at St James’s University Hospital Leeds told us:

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<sup>109</sup> Q 209

<sup>110</sup> Q120

<sup>111</sup> Q 208

<sup>112</sup> Q 213

<sup>113</sup> Q 120

some women will require caesarean sections for some very good reasons—others perhaps not so good. I feel our role is to give the information that is required in a non-judgmental way and help them to make that decision.<sup>114</sup>

Sheena Appleby, Head of Midwifery Services at Derby City General Hospital also felt that women “need the information on which to make the choice ... they need the support”, particularly as “a lot of women’s experiences have been so poor in the last ten years that they are scared.”<sup>115</sup>

96. Several witnesses acknowledged that work was required in this area, in the first place to establish what kind of information and advice women received on caesarean section, and then to ascertain how best to provide this. Siobhan Hargreaves, as a user representative, argued that “women should be made fully aware”:

I am sure they are told about the risk to subsequent pregnancies or what-have-you, but it is not something that can be lightly undertaken because at the end of the day it is major surgery.<sup>116</sup>

97. Jennifer Fake, Head of Midwifery at Watford General Hospital, felt that women sometimes received conflicting advice and information, and that maternity care staff might be selective in imparting information. Although staff could not go through every risk with a woman, she said “I think we need to look at that again, the type of information we give them ... I think that is something we should do, look at more patient evaluation to see what their feelings are after the birth.”<sup>117</sup>

**98. The issue of women’s choice in undergoing caesarean section when there is no clinical need is a fraught one. The NHS does not generally provide other major operations for patients when there is no clinical need, nor does the NHS tend to offer choices of treatment to patients when one costs on average £760 more per patient than the alternative, since it is obliged to make the best use of NHS resources. It remains to be seen whether the National Institute for Clinical Excellence will allow choice for caesareans when in other areas of the NHS patients do not have comparable freedom. We would like to see a distinct shift in emphasis to ensure that elective caesareans as a ‘lifestyle choice’ are not supported by the NHS and that caesarean section should be a procedure undertaken only when medically or psychologically necessary and after appropriate support and counselling.**

**99. We look forward to the publication of NICE guidelines on caesarean section and recommend that these should serve to support maternity care staff not just in assessing the medical indications for caesarean, but also in giving consistent advice and information to women considering the procedure.**

**100. We share the concerns of maternity care staff who wish to protect women from the risks associated with caesarean section. We are particularly concerned for those women**

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<sup>114</sup> Q 377

<sup>115</sup> Q 220

<sup>116</sup> Q 210

<sup>117</sup> Qq 114–19

**who choose caesarean section because they are anxious about delivering their babies. While their fears about childbirth should not be compounded by new anxieties about the risks of caesarean section, these women should be made aware of the implications of surgery for women and babies and of services which help to reduce anxiety. We recommend that maternity units examine how women who request caesarean section are cared for, what kind of information and advice they receive, and how the women themselves feel about their discussion of caesarean section with midwives and consultants.**

101. Just as some women have a preference for caesarean section, so other women wish to avoid the procedure. Several of the user representatives we heard from were concerned that women did not receive sufficient information about the other interventions in labour which might render more likely the decision, not by a woman but by her obstetrician, that caesarean section was the appropriate method of delivery. Catherine Eccles, Chair of the Maternity Services Liaison Committee at St Mary's Hospital, Paddington told us that women should be advised in more detail about EFM, induction and epidural. These, she told us were all:

... very positive steps towards having a caesarean section. That information really needs to be put across more forcibly than it is at the moment. I think at the moment women see having an epidural as having pain relief and therefore having an easier time. What they do not understand is that they have a far higher chance of an instrumental delivery or a Caesarean.<sup>118</sup>

Katy Waters, a user representative from West Hertfordshire NHS Trust agreed that "there is quite a lot of misunderstanding about how intervention starts at quite a seemingly low level with an epidural."<sup>119</sup>

102. Induction and epidural, like caesarean section, are both associated with very rare, but potentially very serious risks to mother and baby. Some methods of inducing labour, such as use of synthetic versions of the hormone oxytocin to encourage contractions, may cause the uterus to contract too much. This may affect the pattern of the baby's heartbeat.<sup>120</sup> Women who receive oxytocin-type drugs in labour are more likely to have an epidural.<sup>121</sup> Epidural is associated with a small risk of a drop in blood pressure, bleeding, and an intense headache. Permanent paralysis resulting from epidural analgesia during labour is so rare that clear figures on its incidence are not available, but anaesthetists regard blood clots which could cause injury to the spinal cord, and damage to the spinal cord as a result of infection, as very rare but very serious complications of epidural.<sup>122</sup>

103. We heard it argued that information and advice about caesarean sections and other interventions should not only enable women to assess for themselves the risks of the procedure in considering a request but also empower them to question a recommendation

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<sup>118</sup> Q 44

<sup>119</sup> Q 115

<sup>120</sup> National Institute for Clinical Excellence, *Inherited Clinical Guideline D: Induction of Labour*, June 2001

<sup>121</sup> Anaesthetic is injected into the space around the spinal cord, so that the nerves are blocked below the level of the injection.

<sup>122</sup> Fellows of the Royal College of Anaesthetists, *Educational points on epidurals*, <http://www.frca.co.uk>, 2003

by maternity care staff. Thus Rosemary Connor, Head of Midwifery and Service Manager at Trafford General Hospital asserted:

I think we have to make sure that they are educated enough to know that it is not a norm, that it should only happen in exceptional circumstances; and if it is looking as though it is going to happen, that they should be challenging it, not just going along with it because it is the route of least resistance.<sup>123</sup>

Katy Waters put this case in even stronger terms, in telling us that some “women have a battle against intervention.”<sup>124</sup>

**104. We understand that in some cases interventions in labour are necessary to protect the health of mother and baby. However, women should be made aware that interventions such as EFM, epidural and induction may increase the likelihood of a caesarean delivery. Raising a woman’s awareness in these areas should not entail merely the transmission of clinical information but rather it should involve discussion with a health professional in the context of the individual woman’s background and concerns.**

#### *Maternity care staff and the decision to undertake caesarean sections*

105. We asked obstetricians how they arrived at the conclusion that caesarean section was the best course of action for a woman and her baby, and how they explained rising caesarean section rates. We heard from several obstetricians who attributed part of the increase in caesarean section rates to the advances in clinical facilities and practice which had made caesarean section a safer procedure. Professor Walker from St James’s, Leeds explained how this had altered the decision-making process:

The operation itself is now safer than it was twenty years ago, and I certainly know from my own practice that twenty years ago we strove far more not to carry out caesarean sections because of the risks to the mother. The risk to the mother is now less, therefore your threshold changes purely because the balance of risks and benefits has changed. Litigation must come into that equation.<sup>125</sup>

106. Professor Walker was among several witnesses who told us of the value of experience in weighing the balance of risks and benefits of caesarean section to women and babies. Whilst we were assured by Professor Walker and others that the prospect of litigation did not outweigh clinicians’ determination to provide the best possible care and the best possible outcome for mothers and babies, there was considerable concern that for less experienced doctors, anxiety about litigation might have some effect. Professor David James from University Hospital, Nottingham identified the threat of litigation as an influence on less experienced doctors, and in turn as a factor which may contribute to rising caesarean section rates:

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<sup>123</sup> Q 507

<sup>124</sup> Q 115

<sup>125</sup> Q 386

Nobody is going to sue you for doing an emergency caesarean section when one was justified necessarily, but they will sue you if you fail to do a caesarean section when one was justified. Experience counts for a lot in doing an operation.<sup>126</sup>

107. All of our witnesses insisted on the importance of experience in coming to a decision on caesarean section and some worried that without an experienced consultant on-site in the maternity unit, women who might otherwise deliver their babies vaginally would undergo caesarean section. These worries, we were told, had been intensified by changes in staffing levels, training and working hours. Cathy Rogers from Barnet and Chase Farm Hospital said that changes in specialist training made it important for decisions about caesarean sections to be made in the presence of a consultant rather than “just being seen by somebody who talks to the consultant on call in terms of confirming the decision or not.”<sup>127</sup>

108. Maternity care staff at all of the units we heard from took part in audit processes to review caesarean sections and the validity of the decisions which led to the procedure being undertaken. Christoph Lees from the Rosie Hospital, Cambridge described how decisions were “put under the microscope at risk management meetings and at our junior doctor meetings” and Antony Nysenbaum from Trafford General Hospital outlined a multi-faceted and multi-disciplinary caesarean section audit:

We audit in two different ways. We have had for probably a few years a regular meeting when we look at the emergency caesarean sections of the previous week, where one of the obstetricians – the labour ward lead will go through them with the middle-grade junior doctors and midwives, and discuss how appropriate they are. We do formal audits where we pull fifty out of one hundred notes, and break down the reasons and look at them very carefully.<sup>128</sup>

109. These audit processes resulted in development of guidelines for good practice as Professor Walker from Leeds explained:

we have a regular audit programme and there is a consultant in charge of the obstetric audit who will make decisions on what audit is done at any given time. Then people, usually junior members of staff, are involved in getting that audit together and putting it together. We then sit and listen to the audit, and policy decisions made as a result of that audit are then decided by the consultant body.<sup>129</sup>

110. Junior doctors played an important role in audits at the maternity units and consultants saw this as an important form of training for junior staff. However, we heard evidence that staffing issues such as the limits imposed on working hours by the European Working Time Directive, could restrict the role played by junior doctors and in turn jeopardise the audit process. We look below in Chapter Four at the implications of the Directive. Rick Porter, Clinical Director of Maternity Services at Royal United Hospital,

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<sup>126</sup> Q 197

<sup>127</sup> Q 57

<sup>128</sup> Q 99, Q 496

<sup>129</sup> Q 397

Bath explained how routine audit at Bath, which he viewed as “a very important part not only of good housekeeping but actually of training the junior staff as well” had stalled:

Our ongoing running audit is in abeyance at the moment largely because of junior staff issues. Normally, what we have been doing is having a weekly run-through of every single section that goes through the unit where we actually critically analyse the decision-making process.<sup>130</sup>

111. One of the most significant aspects of the audit process seemed to be the spirit in which it was undertaken. According to Professor Walker, this could be the factor which determined whether or not the audit yielded useful results:

I think the importance of this form of audit is that it is done in a non-judgemental, informative way. One of the problems in a lot of hospitals is that review of practice is done in a judgmental way, of blame. As soon as blame comes into it – ‘you should not have done this’ or ‘this was wrong’ – then people stop buying in to the audit. It needs to be done in a regular, no-blame way so that the information can be fed back to people so that they can learn from the information that is collected.<sup>131</sup>

Undertaken in this way, audit might represent not just an attempt to review cases where caesarean sections might have been avoided, but to “share good practice, so that we do not reinvent the wheel all the time.”<sup>132</sup>

**112. We were disappointed to hear that so few caesarean section audits involved the views of users. The woman’s experience is an important facet of the analysis of caesarean section rates and we recommend that maternity units consider this aspect of the audit process, even if women’s views can only be sought through questionnaires.**

**113. We agree with those witnesses who told us that ideally the decision to undertake a caesarean section should be made in the physical presence of a consultant. Whilst this is not practicable within current staffing levels we believe that consultants should always be consulted over the decision to undertake a caesarean section except in the rare cases where immediate section is necessary. Although caesarean section is now a much safer procedure than it once was, we are concerned that some women undergo unnecessary sections on the recommendation of doctors who lack experience owing to the time limitations imposed by the New Deal and the European Working Time Directive on their training. This situation renders the process of auditing caesarean sections at individual maternity units all the more important as a form of training for junior staff as well as a means of ensuring that decisions made by consultants have been appropriate. We recommend that the forthcoming NICE guidelines on caesarean section should be supported by advice on audit procedures.**

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<sup>130</sup> Qq 661–62

<sup>131</sup> Q 398

<sup>132</sup> Q 398

### **Why do caesarean section rates vary so much between maternity units?**

114. Beyond decisions on the individual cases subject to audit, we asked doctors and midwives to comment on what they saw as the underlying reasons for comparatively high or low caesarean section rates at their units. We heard again about the inadequacies of data collection methods as many staff members took issue with the caesarean section rates recorded by the Department of Health Statistical Bulletin, by guides based on these figures, such as those produced by *Birthchoice UK*, or by independent guides, such as those produced by *Dr Foster*.<sup>133</sup> For example, Lynne Pacanowski, Head of Midwifery at St Mary's Hospital, Paddington told us that figures for St Mary's had been artificially high as they had included caesareans undertaken at a privately-run maternity unit within the hospital.<sup>134</sup> Helen Jones, Midwifery Manager at Royal United Hospital, Bath said that rates had been skewed because the configuration of services in Bath, namely seven community units and an acute unit, could not be accommodated by the system used to generate statistics from the Maternity HES.<sup>135</sup>

115. Notwithstanding these discrepancies, the doctors, midwives, and user representatives we heard from were all aware that caesarean section rates at their units were higher or lower than the national average, and indeed than units in close proximity to their own. One reason given for high caesarean rates was the location and the nature of the population served by the maternity unit. Christoph Lees acknowledged the high caesarean section rate (26%) at the Rosie Hospital, Cambridge. He said that the rate was high because Addenbrookes Hospital (to which the Rosie Hospital is affiliated) was a tertiary referral centre, a centre of expertise for neonatology, obstetrics and fetal medicine and so "we have a much higher proportion of women who are delivering pre-term, who have severe pre-eclampsia,<sup>136</sup> who have babies with abnormalities and problems that have required help in the antenatal period."<sup>137</sup> Professor Lesley Regan, Consultant Obstetrician at St Mary's, Paddington, said that the 27% caesarean section rate at the unit could be explained in this way:

We would have in-utero transfers for a variety of complications. We have a large miscarriage service, for example. We have a lot of operative deliveries that are perhaps not commonplace to all units.<sup>138</sup>

116. We also heard from staff at other tertiary units who felt that this status might contribute to lower caesarean section rates. Dr Tracy Johnston, Clinical Director for Obstetrics at St Mary's Hospital for Women and Children, Manchester (which has a caesarean section rate of 18%) emphasised this:

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<sup>133</sup> Dr Foster is a commercial organisation which produces independent guides to health services in the public and private sectors. The Dr Foster *Good Birth Guide* was first published in 2001. Birthchoice UK is a voluntary group which maintains a website (<http://www.birthchoiceuk.com>) designed to provide women with information on what to expect from maternity care and on the options available to them.

<sup>134</sup> Q 20

<sup>135</sup> Q 651

<sup>136</sup> Pre-eclampsia is a condition that can occur in the second half of pregnancy, which can cause the blood pressure to rise, causing circulation problems for the mother and preventing adequate flow of blood to the placenta. The usual treatment for pre-eclampsia is delivery of the baby as soon as it is sufficiently developed to live outside the mother's womb. If not treated in this way, pre-eclampsia can lead to eclampsia, where a seizure occurs, putting mothers at serious risk of stroke and causing fetal distress.

<sup>137</sup> Q 96

<sup>138</sup> Q 26

We have got dedicated obstetricians that run the obstetric service, and we do not do gynaecology—and that is unusual; you will only get that in tertiary units; you are not going to get that in District General Hospitals.<sup>139</sup>

117. However, as Professor Walker from Leeds told us:

if you look at [caesarean section] rates across the country you can see differences which you can relate to hard things, like age differences, health differences, and the fact that tertiary units are different to ... district general hospitals ... but you cannot explain all the figures for the differences that way.<sup>140</sup>

118. Dr Johnston from St Mary's, Manchester went on to say that “the other reason ... that we have got such a low section rate for such a busy high-risk unit is that we have a massive consultant presence on the labour ward.”<sup>141</sup> Staffing levels at obstetric units were acknowledged as a key influence on caesarean rates, not just in terms of dedicated consultant cover on labour wards, but also in terms of the midwifery establishment. Professor Regan from St Mary's told us starkly that in her view there was a direct relationship between high vacancy rates for midwifery staff and high caesarean section rates.<sup>142</sup>

119. Caesarean section rates can be influenced by individual obstetricians. Again, we heard the concerns raised by discussion of the decision-making process which led to caesarean section. Antony Nysenbaum from Trafford General Hospital compared his hospital's caesarean section rate of over 24% to that of St Mary's, Manchester:

I think a lot of the decision-making about caesarean sections depends on the experience and confidence of the obstetrician dealing with the case. We do not have the same consultant cover that St Mary's has, and I think it is extremely difficult when you have got a crisis ... if you have junior staff or inexperienced staff, or people who are not even very confident ... they are much more likely to go to section in the first instance.<sup>143</sup>

Beyond the issues of experience and confidence, the views of individual consultants may also have an impact on caesarean section rates. Mr Nysenbaum said that the presence of “two major interventionists for some years” constituted “one of the causes” of a high caesarean section rate.<sup>144</sup>

120. Rick Porter indicated that even in areas such as Bath, where normal births in community and midwifery-led settings tended to be encouraged by clinical staff and one third of deliveries took place in the community without assistance from a consultant, individual consultants might hold very different views on caesarean section and intervention in labour:

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<sup>139</sup> Q 467

<sup>140</sup> Q380

<sup>141</sup> Q 467

<sup>142</sup> Q 24

<sup>143</sup> Q 491

<sup>144</sup> Q 476

we have one consultant who has a different view to the rest of us and certainly has a much lower threshold for caesarean sections than the rest of us. It seems to me that that is within clinical freedom. I do not agree with the position that he takes but I respect the fact that he believes deeply that he is correct.<sup>145</sup>

121. We were concerned that in planning and booking their maternity care, women might not be fully aware, or indeed might not be *made* fully aware, of this variation in clinical practice or of the effect it could have on how their baby would be delivered. Julianna Beardsmore, representing women who used maternity services in Bath confirmed that:

further away from Bath ... one consultant will visit each unit, so you do not get a lot of choice about what different consultants have as their thresholds. You do sometimes get somebody who, if they have a query, may ask to see another consultant but it is unusual.<sup>146</sup>

**122. Such variations in clinical practice, while they might not compromise a woman's safety, may affect her role in making decisions on the mode of delivery for her baby if she does not have access to information on the risks and benefits of caesarean section. We are not convinced that it can be justified for women to have a significantly increased chance of a major operation because of an individual consultant's judgement of the risks of caesarean against normal birth and we hope that the NICE guidelines will create a consistency of approach across the country. Although we recognise the sensitivity of releasing individual consultant data we believe this data should be given to all users together with national and local comparisons so that women are aware of their consultant's caesarean section rate.**

123. However, we also heard evidence that in a number of areas women were very much aware that there were different thresholds and beliefs over intervention in labour, and that they planned their care accordingly. These were the areas with maternity units in which individual consultants and their midwife colleagues seemed to work together according to a certain ethos which was apparent, and attractive, to women seeking low-intervention maternity care. Several units told us that they believed that such an ethos was the decisive factor in achieving comparatively low section rates. Professor Walker from St James's University Hospital, Leeds suggested that differences in caesarean rates could "relate to the attitude within the environment of the women themselves, the midwives and obstetricians ... because of a philosophy that comes from within the hospital. Also, to some extent, women choose which hospital fits their philosophy."<sup>147</sup>

124. Dr Tracy Johnston from St Mary's, Manchester, outlined this philosophy in terms of its direct relationship to policy on caesarean section:

it is not so much that we will not do caesareans at any cost, but it is very much a case of promoting normality, minimising unnecessary intervention, but taking the

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<sup>145</sup> Q 663

<sup>146</sup> Q 664

<sup>147</sup> Q 380

women with us and making sure that they are involved in the decisions that are made.<sup>148</sup>

Professor Walker also talked in specific terms about a collective belief that unnecessary intervention should be minimised, for example through encouragement of vaginal delivery of babies in the breech position (seen by some clinicians as an indicator for caesarean section), and through involving the women themselves by “following” their feelings.<sup>149</sup>

125. David Redford, a consultant obstetrician working for Royal Shrewsbury Hospitals NHS Trust, which had a caesarean section rate of under 11%, told us that once such a philosophy or culture was in place, it became self-perpetuating for two reasons. In relation to staff he stated “we have low intervention rates and once that is known we attract both midwives and obstetricians who like to practise in that way” and concerning the women cared for within the Trust, Mr Redford pointed out that:

The caesarean section rate this year is very largely determined by what it was last year in that the largest single contributor numerical-wise to the number of caesarean sections is repeat caesarean sections from previous years.<sup>150</sup>

126. While this trend is most encouraging for those units in which staff are trying to maintain a culture of low intervention, it presents a serious obstacle for staff trying to reduce caesarean section rates in those units in which rates have historically been high. As Antony Nysenbaum from Trafford told us, “we know where we are going wrong; it is the ability to change that that can be very, very difficult.”<sup>151</sup>

## What can be done to reduce caesarean section rates?

### *Reviewing maternity care for women who have had a previous caesarean section*

127. For staff at maternity units where the caesarean section rate is currently “probably higher than it needs to be”, a major component of the strategy to reduce caesarean section rates is a careful review of provision of care for pregnant women who have undergone a previous caesarean section.<sup>152</sup> For many years it was accepted clinical practice for women who had delivered their first child by caesarean section to deliver all of their children in this way. However, there is now strong evidence to suggest that at least 70% of women who have had a previous caesarean section can go on to have a successful vaginal delivery.<sup>153</sup> The National Sentinel Caesarean Section Audit found a direct link between low rates of vaginal birth after caesarean section and high rates of caesarean section and recommended

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<sup>148</sup> Q 467

<sup>149</sup> Q 383

<sup>150</sup> Q 264

<sup>151</sup> Q 496

<sup>152</sup> Q 195 (Professor David James)

<sup>153</sup> *Caesarean Sections*, POSTnote 184, Parliamentary Office of Science and Technology, October 2002, p 2

that in the absence of complications vaginal birth should be considered by all women who had undergone a previous caesarean section.<sup>154</sup>

128. The Audit also cited evidence that counselling after caesarean section and during subsequent pregnancy had an impact on the decisions a woman took in delivering her second child.<sup>155</sup> Christoph Lees told us that vaginal birth after a caesarean section for the first child was actively encouraged at the Rosie Hospital, Cambridge. He reported that over half of women who had one caesarean section attempted a normal delivery in their next pregnancy under the care of the unit: “we know that the risks are quite low for having a vaginal delivery after one Caesarean section and it is something we encourage and many women are very happy to do it with, of course, appropriate monitoring.”<sup>156</sup>

129. Professor David James from Derby General Hospital confirmed that women undergoing repeat caesarean sections constituted the largest group within the overall total number of caesarean sections undertaken at the maternity unit. He said that staff at the unit made special arrangements to meet women who had delivered a baby by caesarean section to discuss their concerns about vaginal delivery.<sup>157</sup>

130. Other maternity units took similar approaches to care for pregnant women who had a caesarean section. Cathy Rogers from Barnet and Chase Farm Hospital argued that helping women to consider vaginal birth after a caesarean section depended on making contact with them at an early stage:

People who have had previous sections are very late when it comes to making decisions about subsequent mode of delivery and if we want to reduce caesarean section rates, reduce second caesarean we really have to start after the woman has had her first section and meet with her, debrief her, really give her information very early in the pregnancy in relation to supporting and being more positive about the whole thing.<sup>158</sup>

Antony Nysenbaum told us that “careful discussion about mode of delivery ... does take time” but that “most women” would often then “opt for aiming for a normal birth—successfully.”<sup>159</sup>

### **Reviewing policy on intervention in labour**

131. Maternity units have used caesarean section audits to develop a number of other strategies to reduce rates. One of these strategies has been to review practice with regard to electronic fetal monitoring (EFM), which is directly associated with caesarean section. While it may be a vital aspect of care for women who have had difficult pregnancies and where there are complications in labour, use of EFM does not lead to better health

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<sup>154</sup> Thomas, J., and Paranjothy, S. Royal College of Obstetricians and Gynaecologists Clinical Effectiveness Support Unit. *National Sentinel Caesarean Section Audit Report*. RCOG Press, 2001, p 46

<sup>155</sup> Thomas, J., and Paranjothy, S. Royal College of Obstetricians and Gynaecologists Clinical Effectiveness Support Unit. *National Sentinel Caesarean Section Audit Report*. RCOG Press, 2001

<sup>156</sup> Q102

<sup>157</sup> Q 201

<sup>158</sup> Q 44

<sup>159</sup> Q 476

outcomes for women who have had low risk pregnancies and guidelines issued by the NICE in May 2001 recommended that EFM should not be used with low risk women on admission to a maternity unit.<sup>160</sup>

132. This recommendation marks a shift in policy and practice relating to fetal monitoring as until recently every woman arriving in hospital in labour was routinely monitored using EFM for 20 minutes, a practice known as the ‘admission trace’. A great many midwives doubted the benefit of EFM on admission to hospital as they saw that the monitoring equipment could restrict a woman’s choices with regard to her position and movement, and worried that the reassurance of EFM might permit doctors and midwives in busy wards to leave women unattended in labour. As Helen Shallow, Midwife Consultant at Derby City General Hospital explained, lower levels of intervention combined with higher levels of support in labour might reduce the likelihood of caesarean section becoming necessary:

If a woman is confined to bed for fetal monitoring for no real reason, her pain is worse. She requires an epidural because her pain is excruciating and there is nobody there to support her. If you change that model and encourage women to move around and be in a nicer environment, a more relaxed environment where somebody is supporting you, then we know that that makes a difference to how that woman labours.<sup>161</sup>

133. For these reasons, NICE guidelines on EFM were welcomed by members of maternity care teams who have used them to implement and support a change in policy. Catherine Eccles, Chair of the Maternity Services Liaison Committee at St Mary’s Hospital, Paddington, told us that women welcomed the change to the policy of admission trace “because it has been shown to be the first step towards intervention and therefore the first step towards possible caesarean but with no positive outcome.”<sup>162</sup>

134. Similar developments have taken place in respect of induction and augmentation of labour using drugs and in June 2001 NICE issued guidelines on induction in order to reduce the risk of stillbirth in ongoing pregnancy “without increasing the caesarean section rate.”<sup>163</sup> Once again, caesarean section audits had indicated a direct relationship between high induction rates and high caesarean section rates, and a renewed focus on induction policy was seen as a way of reducing the likelihood of caesarean section. Rosemary Connor, Head of Midwifery at Trafford General Hospital, described the rationale behind her unit’s review of induction policy:

One of the big issues when we tried to tackle our caesarean section rate was that we had a very high induction rate. Once you start intervening, you are much more likely to end up with caesarean sections, so we did address it ... we had clinicians who were

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<sup>160</sup> National Institute for Clinical Excellence, *The use and interpretation of cardiotocography in intrapartum fetal surveillance*, May 2001, p 4

<sup>161</sup> Q 204

<sup>162</sup> Q 32

<sup>163</sup> National Institute of Clinical Excellence, *Induction of Labour*, June 2001, p 4

very interventionist. We have had to address that now. We have revisited our induction policy in line with NICE, and we are seeing a falling induction rate.<sup>164</sup>

This policy has had a dramatic impact on the induction rate, which was approximately 28% in 2000–01 but has since fallen to 24.2%.<sup>165</sup>

135. Reducing induction rates involves discussion and counselling as well as revised policy on clinical procedure. At St Mary's Hospital for Women and Children in Manchester, no woman is induced until she is ten days beyond the full term of her pregnancy (term plus ten). After that, Dr Johnston told us, the woman is given "informed choice" on how to proceed: "It is a case of sitting down and giving the options ... quite a lot of women will say: 'that is fine. As long as you are monitoring it, it will be fine and I will carry on.'"<sup>166</sup> At Bath, where labour is induced at term plus 12 days, Helen Jones, Maternity Services Manager, told us of a new initiative whereby women booked inductions with a midwife rather than a consultant. The midwife's counselling, it was thought, might help women to consider all the available options.<sup>167</sup>

**136. We strongly endorse innovative approaches to reducing caesarean sections which involve women in detailed discussion about their maternity care and help to raise awareness of the risks and benefits of the different kinds of intervention in labour. We believe that this involvement is key to a positive experience of childbirth and of maternity care, and that the development of strong relationships between women and well-trained, confident midwives is crucial. The information gathered from discussion of previous experiences could be vital to the development of maternity services, particularly in relation to caesarean section. We recommend that information from women on their previous caesarean section should be incorporated into audits.**

**137. We are encouraged to hear that maternity care staff value NICE guidelines and evidence based on research commissioned by the Department as tools for developing strategies to reduce caesarean section rates and to increase 'normal' birth rates. We recommend that the Department continue to support research and evidence-gathering initiatives and in particular the work on caesarean section audit.**

### ***Increasing consultant support for women in obstetric units***

138. The key to all of these strategies for implementing policies to reduce caesarean section rates is time spent with a pregnant woman; discussing her care and advising her of her choices. Consultant input in discussions can be particularly important, both in the initial stages where women are making choices about their care, and during labour. Alex Silverstone, a user representative at St Mary's, Manchester was certain that caesarean rates at the unit were kept lower (18%) than the national average (21.5%) on account of consultant availability:

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<sup>164</sup> Q 501

<sup>165</sup> Ev 75

<sup>166</sup> Q 498

<sup>167</sup> Q 678

I think a lot of it is that they have easy access to consultants, and the consultants do sit with them and talk to them. They explain it. They do not talk them out of it. There is definitely informed choice ... if she is very worried—she might have had a very traumatic experience the time before with a caesarean—they will listen to her and will continue to listen. It is not just that one point at the beginning; when she goes back again she is listened to and supported.<sup>168</sup>

Dr Johnston, Clinical Director at the same hospital emphasised the importance of a consultant presence on the labour ward, particularly if less experienced doctors were caring for a woman:

I think couples find that very reassuring, that a more senior doctor has come in and is looking at the whole picture again ... they turn round and say: 'I have looked at this. You are doing fine. You can do this. We do not need to intervene just now. Carry on.' A lot of them take faith in that, but if the consultant is not there and does not come in, then it is very difficult for the registrar to go back and say 'I phoned him and although I said I thought you needed a section, he said that you do not so we are not going to section you now.' It is not the same as going in and talking to them.<sup>169</sup>

139. Along with all of the other consultants who spoke to us during our inquiry, Dr Johnston stated that a woman's choice with regard to caesarean section must be respected. However, she was insistent that making time to provide women with information on which to base their choices, did yield results in terms of keeping caesarean section rates under the national average rate:

We do get a lot of women requesting elective caesarean section, and with each of these women we sit and talk to them and find out what it is they are frightened of; and the vast majority of them are scared about something with labour and delivery. With good investment antenatally, with obstetric staff and midwifery staff, I would say that over three-quarters of these women will change their minds and then go for a vaginal delivery afterwards, and be very, very satisfied with that. That requires a lot of time. That would take me two hours of clinic time sometimes to talk to somebody about that, but I see that as important – as a consultant, that is what I am there for.<sup>170</sup>

### ***Increasing midwifery support in community and in obstetric units***

140. There was consensus amongst our witnesses that continuous midwifery support, antenatal and intrapartum, was just as important, if not more important, than consultant presence on a labour ward or in a clinic. Lynne Pacanowski, Head of Midwifery at St Mary's, outlined the unit's strategy to reduce caesarean section rates by creating more community-based caseload teams.<sup>171</sup> Professor Regan from St Mary's Hospital, Paddington, having linked a high midwifery vacancy rate to a high caesarean section rate said that "in an ideal world we would have one-to-one care for women in labour and I

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<sup>168</sup> Q 486

<sup>169</sup> Q 507

<sup>170</sup> Q 465

<sup>171</sup> Q 60

would anticipate a significant reduction in caesarean section rate.”<sup>172</sup> The proof of this, we were told, could be found in the results of an audit of a case load team of midwives working with women in the community. The caesarean section rate for women cared for in this way was 15%, as opposed to the 27% rate overall.<sup>173</sup> Professor Regan outlined for us the system of care which yielded such a substantial reduction in caesarean section rate:

It is continuity of care and one-to-one care in labour. These women are cared for primarily in the community with hospital input for various screening tests and investigations and reference for any complications or queries, and then when they go into labour they are seen at home by their midwife in this caseload team and then brought into hospital. They are delivered by one, two or possibly a third midwife from that team with whom they will already have developed a relationship. That midwife will stay on duty—unless some exceptional circumstance occurs—until the baby is delivered.<sup>174</sup>

141. Once again, the key to reducing caesarean section rates seems to be time spent with a pregnant woman, advising and reassuring her, supporting her from the time she makes contact with a unit to book her maternity care through to the early stages of her baby’s life. Indeed this kind of support is vital to a healthy outcome, not just in terms of mode of delivery but also in terms of the development of early bonds between a new mother who is relaxed and confident in her care, and her baby. However, as we heard from all too many maternity units, this kind of support can be difficult, or even impossible, to provide if services are blighted by staffing problems.

**142. Based on evidence we heard from maternity units, we see a relationship between high rates of caesarean section and low levels of staffing. It seems to us unacceptable that a woman should undergo a surgical procedure that might have been avoided had she been better supported during pregnancy and/or during labour. It is clear from strong evidence that one of the most important means of reducing the caesarean section rate is to provide adequate support for women in labour. The level of staffing and organisation of care should enable women to be supported at all times.**

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<sup>172</sup> Q 24

<sup>173</sup> Q 24

<sup>174</sup> Q 25

## 4 The staffing structure of maternity care teams

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### How are women and babies cared for during pregnancy and the early stages of life?

#### *What are the main staff roles within maternity care teams?*

##### *Midwives and doctors*

143. Midwives provide most of a woman's care during pregnancy, labour and in the postnatal period. The midwifery profession may be entered directly by undertaking a specialised university course leading to a midwifery qualification. The minimum academic standard for a midwifery programme is a diploma although a number of programmes are at degree level. In order to practise, midwives must be registered with the statutory body for nursing, midwifery and health visiting, the Nursing and Midwifery Council. The Council maintains a register of midwives. To remain on the Register, midwives must update their knowledge and maintain a professional portfolio as evidence of their updating. To enable the Council to know which midwives are practising, all practising midwives are required to notify their intention to practice on an annual basis.

144. There are a number of career pathways for midwives, and so they may play any of a range of roles within a maternity care team. A midwife may become a clinical specialist (known as a 'consultant midwife' or 'midwife consultant'), or work in management as a head of midwifery services or supervisor of midwives at local authority level. Some midwives pursue academic careers in education and research as 'research and development midwives' and some specialise in particular aspects of maternity care work, such as IT. The majority of midwives practice within the NHS, working with other midwives and other health care professional and support staff in a maternity care team. Midwives can also practice independently and there is a small group of midwives who do so.

145. Most midwives who work within the NHS work either in hospital or community settings, and midwifery practices can vary greatly between these settings. Hospital midwives run antenatal clinics, care for women who give birth in the hospital, and look after women who stay in the antenatal and postnatal wards of the hospital. Their work usually gives them experience of interventions such as induction, EFM and use of epidurals for pain relief and they often work closely with doctors. Hospital midwives now have a much wider role than they did ten years ago. For example, some midwives have now taken over the traditional consultant task of advising women on their choices when they first visit the unit, and women now have higher expectations of midwives with regard to information and advice on testing and screening. Midwives have also taken over some tasks usually undertaken by junior doctors such as IV cannulation (inserting the narrow tubes which allow patients to receive medication intravenously) and suturing (stitching wounds). As the caesarean section rate increases midwives spend more time providing post-natal care for women who have to stay longer in hospital after the procedure.

146. New patterns of practice, particularly caseload midwifery, have allowed midwives to bridge the community and hospital service, working in a way that allows midwives to ensure that the “woman having a baby should be seen as the focus of care” as our predecessor Committee recommended.<sup>175</sup> This pattern is unfortunately not consistent across the country.

147. ‘Community midwives’ provide maternity care outside the hospital, although they will usually be affiliated to a hospital or a GP practice. They may give antenatal care in local clinics or GP practices, or visit women in their homes. Community midwives can attend women who have chosen to deliver their baby at home, or they may accompany women to hospital to give birth. They also visit women and their new babies in their homes for up to 28 days following the birth. Working away from the hospital environment, community midwives gain experience and develop skills in supporting women who give birth without medical intervention.

148. Doctors working in obstetrics provide medical care for mother and baby. Consultants in obstetrics will have undertaken four to five years of training as Specialist Registrars, during which time they will have passed examinations set by the RCOG. Most hospitals have a team of consultants who are responsible for the patients who use their services. They train junior doctors and together with these doctors and with specialists in training, they undertake antenatal and gynaecological clinics, ward rounds and operations and they supervise the labour ward or delivery suite.

149. In 2000-01, approximately 33% of deliveries were conducted by hospital doctors and 66% by midwives, although a midwife was present at over 99% of all births. The Department told us that the “overall balance between the professions has shifted steadily” since 1989-90 when about 24% of deliveries were conducted by doctors and 76% by midwives.<sup>176</sup> This trend corresponds with the continuing rise in the number of women who deliver their babies by caesarean section.

### *Other members of the maternity care team*

150. A range of other health professionals play crucial roles in maternity care teams, particularly in those teams working at large hospitals with specialist fetal medicine or neonatal units. As Dr Griselda Cooper, Senior Lecturer in Anaesthesia at the Queen Elizabeth Hospital, Edgbaston told us: “anaesthesia is an integral part of the safe delivery of maternity services” for women who require medical intervention in labour and for pregnant women who become seriously ill either through complications in pregnancy or through pre-existing conditions.<sup>177</sup>

151. Southampton University Hospitals NHS Trust called for the expansion of the maternity care team by maintaining that a dedicated consultant nurse in Fetal Medicine departments could play an important role in educating and supporting GPs and Midwives in the management of women who experienced complications in pregnancy<sup>178</sup> and the

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<sup>175</sup> Health Committee, Second Report of Session 1991–92, *Maternity Services*, HC 29, para 384

<sup>176</sup> Ev 156

<sup>177</sup> Ev 264

<sup>178</sup> Ev 240

British Association of Perinatal Medicine suggested that in the neonatal service it was widely anticipated that many of the traditional junior medical roles would be undertaken in the future by advanced neonatal Nurse Practitioners.<sup>179</sup>

152. Obstetric physiotherapists are also key members of the maternity care team. They provide care for women before, during, and after labour, and so in busy consultant units where midwifery establishments are depleted, not only their specialist services but also their support and reassurance for women can be vital. The Chartered Society of Physiotherapy told us that the number of physiotherapists who specialised in neonatal care was rising. Obstetric physiotherapists can provide antenatal education classes, and other out-patient services in addition to in-patient work, promoting a woman's health by helping her to prepare for labour. They also play a valuable role in advising health professionals on techniques which can reduce the risk of complications such as symphysis pubis dysfunction (the over-loosening of ligaments in the pelvis, which can result in pain and loss of balance and mobility). Neonatal physiotherapy is an advanced practice sub-specialty within paediatric physiotherapy, and a minority service provided only in the larger hospitals but the Chartered Society of Physiotherapy reported how such members of the maternity team can help to improve developmental outcomes for premature and at-risk babies, and to support parents.<sup>180</sup>

153. Postnatal care should not be neglected. We recognise the importance of links to other providers of postnatal care such as health visitors.

154. Throughout our inquiry we heard evidence that maternity care staff valued, and in units with staffing shortages, very much needed, staff such as care assistants who helped women with aspects of their postnatal care. The Royal College of Nursing endorsed the health care assistant post, commenting that care assistants might be trained to support women initiating breast feeding.<sup>181</sup> The Mother and Infant Research Unit at the University of Leeds recommended to us that peer support services for pregnant women and babies should be integrated into health service care.<sup>182</sup>

**155. We recommend that the Department research further how staff, including support staff, volunteers, and staff employed by voluntary organisations, could enhance maternity services and provide important links to other providers of postnatal care, such as health visitors. In particular, the use of voluntary breastfeeding counsellors and supporters to contribute to the education of a range of healthcare professionals and other workers should be considered. We further recommend that the NHS consider funding or sub-contracting to voluntary organisations which could support the provision of specific services such as breastfeeding support.**

### *Relationships within the maternity care team*

156. Strong lines of communication and good working relationships can influence the kind of care a pregnant woman receives, particularly if the woman's point of access to maternity

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<sup>179</sup> Ev 130

<sup>180</sup> Ev 129

<sup>181</sup> Ev 206

<sup>182</sup> Ev 214

care is a GP who then refers her to a maternity unit. Even after referral the GP is part of the woman's maternity care team. In written evidence, Dr Chris McCourt at the Centre for Midwifery Practice, Thames Valley University, identified a lack of communication and trust between some GPs and midwives, and a lack of involvement of midwives in PCT developments.<sup>183</sup> Professor Jenny Hewison from the University of Leeds called for more research into how GPs and midwives worked together and determined their respective roles. She told us that based on research already undertaken, the pattern of antenatal care received by women seemed to be strongly influenced by the type of care that a GP wished to provide and that there were “variations between practices and between GPs in the same practice.”<sup>184</sup>

157. Community midwives play a pivotal role within the maternity care team. Rupert Fawdry, a consultant obstetrician and gynaecologist, argued that community midwives should always work in teams covering a particular part of a local area and that each team should liaise closely with a particular multi-disciplinary hospital team. In this way, Mr Fawdry told us, the majority of pregnant women would have the benefit of a “much more closely integrated group of health professionals.”<sup>185</sup> Health visitors also have an important role to play in this group of health professionals as they support women through the postnatal period, providing a vital link between maternity units and community and social services.

**158. Maternity care has always been a team effort but the professions involved seem to us to work together better and with more mutual respect than they did perhaps even ten years ago. However, in the majority of cases, GPs are also members of a woman's maternity care team as they presently provide a first point of contact with maternity services and offer advice on care. In some areas there is room for improvement in terms of communication and understanding between GPs and midwives who support births in the community and in the home.**

### ***How has the Government supported the development of the maternity care units and the maternity care workforce?***

159. In March 2001, the Department initiated the use of Birthrate Plus, a local workforce planning tool which was developed in collaboration with the Royal College of Midwives (RCM). Birthrate Plus helps staff at a unit assess the experience of women using a local maternity service through the use of clinical indicators connected with their care before, during and after the birth, and then links this to the clinical workload of the midwife. The outcome of this assessment is a recommendation with regard to the optimal level of staffing and way of working.

160. In February 2001 the Department established the Maternity and Neonatal Workforce Group (MNWG) to consider workforce issues, staffing for the various models of care and configuration of maternity services. The task of MNWG, on which Royal Colleges, NHS organisations and the National Childbirth Trust and Maternity Alliance are represented, is

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<sup>183</sup> Ev 190

<sup>184</sup> Ev 225

<sup>185</sup> Ev 183

to contribute to the development of the Children’s National Service Framework. The Department told us that the Children’s Care Group Workforce Team is now analysing the implications of the Children’s NSF for workforce development, and that broader workforce considerations with regard to maternity and neonatal services are “high on the priority list.”<sup>186</sup>

161. Investments have been made to increase the number of midwives, with a target of 2,000 extra midwives by 2006, to be achieved by increasing the number of midwifery training places and by encouraging qualified midwives to return to practice. The Department stated that good progress towards the target was being made, with 510 more midwives working in the NHS in 2001 than in 2000.<sup>187</sup> We note below, however, that in terms of whole-time-equivalent midwives, this increase was not evident to our witnesses.<sup>188</sup> Indeed, Department of Health figures show that the increase between 2000 and 2001 was only 371 in whole-time equivalent terms and was concentrated in only four regions, while three regions had a decrease.<sup>189</sup> More work will be required if the additional training places provided so far do not yield improved vacancy rates and the target figure of 2,000 extra midwives may itself have to be increased.

## **What are the most important workforce issues for maternity care teams?**

### ***What is the current situation with regard to recruitment and retention of midwives?***

162. Much of the evidence we received on the staffing structure of maternity care teams made reference to shortages of midwifery and nursing staff and to concern about rising vacancy rates. Information from the Department confirmed that a survey had registered a rise in the vacancy rate in midwifery – from 2.6% in March 2001 to 2.8% in March 2002. The Department attributed the increase in the vacancy rate in part to the creation of new posts ahead of the planned expansion in the workforce but we heard a more worrying account of the state of the midwifery profession from many other quarters.<sup>190</sup>

163. The RCM’s annual staffing survey found that London was the only region in which vacancy rates had not increased and that long-term vacancy rates in midwifery were currently the highest ever recorded. In England in 2002, vacancies which remained unfilled for over three months accounted for 59% of all midwifery post vacancies.<sup>191</sup> Despite the static vacancy rate in London, according to the Women’s Health Directorate at University College, the recruitment and retention of midwives in London posed a major problem for maternity services.<sup>192</sup>

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<sup>186</sup> Ev 157

<sup>187</sup> See Appendix

<sup>188</sup> Evidence from the RCM cites NMC figures showing a fall in the number of practising midwives. There were 33,165 midwives practising on 31 March 2002 (20% of whom were over 50), compared with 35,291 a year earlier (Ev 221).

<sup>189</sup> Department of Health, *2000 Non-medical workforce census; 2001 non-medical workforce census* (calculations made by Professor Alison Macfarlane)

<sup>190</sup> Ev 160

<sup>191</sup> Ev 221

<sup>192</sup> Ev 141

164. As we heard from maternity care staff themselves, two themes emerged with regard to staffing levels and recruitment and retention issues. In very general terms, recruitment and retention seemed to pose a greater problem for services in the South than they did in the North of England. Several of our witnesses attributed this to higher costs of living, particularly in areas close to London but not close enough for midwives to receive London weighting as part of their salaries.<sup>193</sup> Across the whole country, however, vacancy rates at consultant units were much higher than they were at midwifery-led units and birth centres.

165. There was consensus amongst the maternity care team representatives that midwives enjoyed practising the full range of their skills in terms of facilitating normal birth without medical intervention, and that they became disillusioned with the profession when the majority of births they attended involved high levels of intervention and when they had to divide their time between a number of women in labour. Shona Ashworth, Head of Midwifery at University Hospital, Nottingham illustrated this sense of disillusion in the most graphic of terms:

They are not able to practise as midwives. They are overstretched; they are not able to give quality of care and you often see newly qualified midwives crying because they feel devastated and they know that the care that they are giving to women on the wards in their view is substandard.<sup>194</sup>

166. Toni Martin, Head of Midwifery at Worcestershire Royal Hospital, said that many midwives now chose to work part-time as a means of coping with the pressure they experienced on labour wards.<sup>195</sup> A great many others, however, have chosen to leave the profession altogether. St Mary's Hospital, Paddington took part in a London-wide project to examine midwifery establishments by comparing ratios of births to midwives. In a range from 28:1 to 41:1 St Mary's had one of the highest ratios at 38:1.<sup>196</sup> Use of Birthrate Plus indicated a shortage of 40 midwives at St Mary's.<sup>197</sup> Professor Regan, a consultant obstetrician at St Mary's told us that the depletion of the midwifery establishment had serious consequences for the service, for the profession and most importantly, for pregnant women:

it is extraordinarily difficult to retain good experienced midwives who find themselves regularly in a situation where they are caring for three women and feel that the situation is unsafe. They are going to leave the service and then you have lost this extraordinary resource. However many people you put back into that one job you may never replace the experience.<sup>198</sup>

167. There were 20 midwifery vacancies at the Rosie Hospital, Cambridge with 105 midwives in post in a unit which, according to Birthrate Plus, needed 168.8. Mrs Jen Ferry, Head of Midwifery and Operations Manager for Women's Services at the Rosie Hospital, suggested that she had not seen evidence of the progress on workforce expansion

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<sup>193</sup> Q 144 (Marie Pearce)

<sup>194</sup> Q 257

<sup>195</sup> Q 312

<sup>196</sup> Q 43 (Lynne Pacanowski)

<sup>197</sup> Q 58 (Lynne Pacanowski)

<sup>198</sup> Q 46

announced by the Department: “For all the discussion about the lack of midwives our region will be training across Norfolk, Suffolk and Cambridgeshire thirty extra nurses and midwives by the next three years.”<sup>199</sup>

168. Those midwives who do not leave the profession must strive to provide good quality of care for women and babies, and at some units, to maintain a safe service. Mrs Ferry told us that extra work was being undertaken to “put in contingency plans and strategic measures to ensure that we keep the risk at a minimum whilst the staffing is so difficult.”<sup>200</sup> Karen Connolly, Head of Midwifery at St Mary’s Hospital for Women and Children described a similar situation in Manchester which had begun to experience staffing shortages in recent years:

it has been said that there has been an increase in places, but to my knowledge the actual number of places available is exactly the same as it was previously, and the number of midwives that have reached retirement age or have moved out of midwifery because of the pressures that everybody is aware of, means that there is still this catch-up. We know that there is going to be this generation that are retiring, and the impact of the government putting in new training places is not yet felt. My numbers for students are exactly the same as they were four years ago.<sup>201</sup>

169. Maternity unit staff from several regions spoke of strong relationships between universities and hospitals but registered their concern at the high drop-out rates from midwifery diploma and degree courses, particularly in areas such as Manchester where access to training places was limited. Some talked of student midwives becoming disillusioned with the service even before qualification, but there was consensus that funding for student midwives was the main barrier to qualification. As Karen Connolly told us “students that are training just cannot afford to live on a bursary. They may be more mature students where they come from previous jobs and have received a wage, and to go into a bursary has a big impact on their own home life.”<sup>202</sup>

170. Mrs Ferry described how staffing at the unit was configured to compensate for a shortage of midwives:

we are back-filling with all the support staff that we can, ensuring there is maximum cover so that midwives are not answering phones, seeking notes and doing the administrative chores which should be done by other staff. We are putting maternity care assistants in and generally looking at processes to see where we can make things more efficient.<sup>203</sup>

171. Miss Alison Fowlie, consultant obstetrician at Derby City General, represented a number of units which acknowledged that shortages were stretching services in the community and in hospital, but which had put in place measures to enable midwives to

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<sup>199</sup> Q 136

<sup>200</sup> Q 136

<sup>201</sup> Q 510

<sup>202</sup> Q 513

<sup>203</sup> Q 149

practise the full range of their skills as a means of alleviating problems with recruitment and retention:

I think it is reasonable to say that we have done as much as we can moving acute midwives to community, community midwives to acute, when there is a crisis. We have been very creative as far as possible to try and put people where they are needed at any one moment in time, but we do have a particularly low establishment ... we have to try and do what we can with what we have at the moment. We do try very hard to look at all different ways of running our service. Our midwife-led care at the moment is probably only running at 20% and one of the reasons for that is that our community midwives, because they have been stretched with high caseloads, have not felt quite able to take that responsibility forward. We have been trying very hard for a long period of time ... it was the main reason for considering the appointment of ... a midwife consultant to support and lead the care of normal pregnancy.<sup>204</sup>

172. Lynne Pacanowski from St Mary's Hospital, Paddington told us that despite being under-established, the unit had been more successful in recruiting and retaining staff since the introduction of an area with a birthing pool within the unit for women expected to deliver their babies without complication where midwives could facilitate normal birth:

That is not the way they are used to working, in a high-tech obstetric led unit. They have almost had to have a refresher course in using those skills and it has been wonderful. They have really enjoyed going back to practising basic normal midwifery.<sup>205</sup>

Donna Ockenden, Head of Midwifery at St Mary's Hospital, Portsmouth said that after severe staffing problems which culminated in a 22% turnover of staff, similar measures to improve working conditions and professional development for midwives had helped to create stability.<sup>206</sup>

173. Undertaking work to allow midwives to use a range of skills and to provide continuity of care was also a strategy to reduce turnover of staff at units where recruitment and retention had not been such urgent problems. Ann Geddes, Head of Midwifery at St James's University Hospital in Leeds told us that such measures could ease concerns about retaining staff:

we do not have any difficulty in Leeds in recruiting staff ... we do have a retention problem because people tend to come and stay and not move on; therefore, the opportunities for promotion are few and far between. What we have been trying to do is look at retention issues, about how we can encourage people to stay by developing new skills and extending the midwife's role.<sup>207</sup>

174. Worrying evidence was provided by the Royal College of Obstetricians and Gynaecologists (RCOG) on recent and proposed closures of consultant obstetric units. The

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<sup>204</sup> Q 252

<sup>205</sup> Q 42

<sup>206</sup> Q 608

<sup>207</sup> Q 404

RCOG surveyed all of its Regional Advisers in 1999 and found that 21 consultant units had closed in the late 1990s, that 28 units were known to be under threat of closure, that 31 other units were due to close within five years, and that a further 17 units were in danger of losing support.<sup>208</sup> We aware that the closure and merger of smaller units can lead to a loss of midwives from the profession.

**175. Depleted midwifery establishments and closures of maternity units are not conducive to the return of midwives to the profession. We recommend that the Department assess whether its strategy to encourage midwives to re-register for practice takes into account the extent to which these problems influence a midwife's decision to leave the profession in the first place. The Department also needs to understand why there is a high drop-out rate on some midwifery courses and take measures to reduce the problem.**

176. Community midwifery, and home birth support services in particular are also threatened by staffing shortages. This in turn limits the range of skills which midwives can gain and practise. Sheena Appleby told us that the home birth service at Derby continued “because of the commitment of the midwives” but that reconfiguration of staffing structures was crucial:

I think sometimes we struggle to provide that service [in the community] and sometimes they really have to come in [to the consultant unit] because we cannot cope. It depends on what is going on at the time and what the activity levels are ... It is about that interface and we are looking to change the way we work.<sup>209</sup>

177. As Sue Breslin, Women's Services Manager at the Royal Shrewsbury Hospital pointed out to us, maternity units which promoted a philosophy of low intervention in labour and allowed midwives to practise a full range of skills, had to invest extra time in their new recruits, midwives and doctors, who had no experience of such a philosophy at work:

some of them have never seen a baby born in breech, they have never been with twins who have been delivered vaginally ... what am I to do with them? They almost need retraining to be able to work in Shropshire ... we have to show them how we look after women in labour and show them how it can be a perfectly straightforward delivery and I think the consultants have a similar problem with the middle grade who come to us who trained elsewhere whose first recourse at the first blip is caesarean, get the baby out.<sup>210</sup>

**178. Evidence we heard throughout our inquiry has led us to conclude that it will be difficult to invest sufficient time to allow midwifery and medical staff to gain experience of normal birth but it is crucially important to the range of skills they practise and the quality of care they provide. We welcome the introduction of workforce planning tools and the drive to train and recruit more midwives. However, particularly in consultant units, some midwifery establishments are depleted to seriously low levels, as workforce planning tools have shown. In some units staffing**

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<sup>208</sup> Ev 193

<sup>209</sup> Qq 247–52

<sup>210</sup> Q 323

cannot be reconfigured to compensate for shortages and where unit mergers or closures are poorly handled, staffing problems are compounded. Several witnesses told us that they had seen no evidence at all of Government initiatives to increase staffing levels. We recommend that the Department take steps to ensure that every maternity unit has the opportunity to use Birthrate Plus to make an assessment of minimum and optimum staffing levels. We further recommend that the Department ask PCTs and hospital trusts to review their investment in midwifery and critically examine their caesarean rates. There needs to be adequate staffing to provide good quality maternity services. The Department also needs to review and renew its efforts to recruit, and bring back to practice, midwives.

179. Given the positive effect of midwifery-led services on recruitment and retention we would urge PCTs and hospital trusts to do all they can to develop midwifery-led services and to be aware of the possible impact of closing units on staff morale, recruitment and retention. Given the general recruitment problem in the South of England and the high cost of living in these areas, we recommend that the Government assess whether the *Agenda for Change* proposals will tackle the geographic differences in recruitment that we have seen in our inquiry.

***What effect have the European Working Time Directive and other changes to doctors' hours had on maternity care teams?***

180. The Department told us that the number of consultants working in the field of obstetrics and gynaecology had increased by 21% since 1997 but it did not provide figures for losses in numbers of junior doctors and in time spent training in obstetrics. The Department acknowledged that the vacancy rate had increased (by 0.2% since 31 March 2001 to 1.7% on 31 March 2002) but noted that it was still lower than the vacancy rate of 3.8% across all specialties.<sup>211</sup> However, we heard some worrying evidence that the number of junior doctors choosing to pursue careers in obstetrics was in decline. The intensity of out-of-hours work in obstetrics, and perhaps the comparatively restricted opportunities for private practice (while private practice in gynaecology is common throughout the country, obstetric private practice is concentrated in London and in the larger metropolitan areas), might lead doctors to specialise in gynaecology rather than obstetrics.

181. Christoph Lees, a consultant obstetrician at the Rosie Hospital in Cambridge was very much aware of a downturn in the popularity of his specialty and described a worrying scenario:

In the last five years we have seen several media debacles of badly performing doctors' units that have hit the spotlight. There is concern about litigation, about personal professional issues, about the intensity of work when you become a consultant obstetrician ... it suffered very badly among the perception of doctors and the public and many of the people who were appropriate to go into the specialty were put off because of the problems inherent in the specialty at the moment.<sup>212</sup>

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<sup>211</sup> Ev 159

<sup>212</sup> Q 163

182. David Redford, consultant obstetrician at Royal Shrewsbury Hospital also drew our attention to problems with “recruitment into obstetrics as a profession”, reporting the results of a recent study of the intentions of medical graduates one year after qualification, which showed “a halving of the medical graduates thinking of doing obstetrics and gynaecology compared with ten years ago and that is a very real worry.”<sup>213</sup>

183. The RCOG has recommended that all consultants should have set sessions devoted to labour ward or delivery suite work, providing 40 hours per week of consultant cover for the labour ward or delivery suite. Out of these hours the labour ward or delivery suite should be staffed by junior doctors with the Consultant providing cover from home. An RCOG survey found that only 16% of units were currently able to achieve this standard.<sup>214</sup>

184. In discussing caesarean section rates and decision-making with regard to delivery, we heard that increased consultant presence on labour wards was of benefit to women who faced difficult decisions in labour and we received written evidence which called for the introduction of a 24-hour consultant service in larger consultant units.<sup>215</sup> However, those maternity units which could provide the recommended 40-hour per week consultant cover found that it intensified work for staff and that it exerted pressure on some aspects of the maternity service. St Mary’s Hospital, Paddington now met the RCOG recommendation but as Professor Lesley Regan told us, the transition period was proving difficult:

I am sure it is better for patient care and it is better for staff training, but it has come at a cost to other facets of a busy department of obstetrics and gynaecology. In order to meet that demand or necessity other things have had to be put down the priorities list. The demands on consultants and...issues like ... audit, appraisal ... they all have to be fitted in in addition to the clinical work.<sup>216</sup>

185. Despite the task of reconfiguring the service to accommodate increased cover, and despite the increased demands on consultant time, maternity unit staff felt that finding the capacity to provide 40-hour consultant cover was a significant achievement for maternity units and also a necessary means of tackling other problems with medical staffing. According to Professor Walker from St James’s University Hospital, Leeds: “by having consultants present on a labour ward you can help to reduce the problems of lack of junior staff.”<sup>217</sup>

186. Professor Walker, along with all of those who represented consultant units, drew our attention to the reduction in hours worked by junior doctors which has taken place over the last decade. The ‘New Deal’ on junior doctors’ living and working conditions, including guidelines for hours of work and work intensity, was introduced in 1991. New Deal compliance was incorporated into pre-registration House Officer contracts from August 2001 and was to be a condition of Senior House Officer and Specialist Registrar contracts from August 2003. However, the New Deal guidance, which hospitals were already

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<sup>213</sup> Q 352

<sup>214</sup> Ev 194

<sup>215</sup> Ev 132 (Professor Robert Shaw), Ev 256 (Mr A.S. Binks)

<sup>216</sup> Q 64

<sup>217</sup> Q 432

struggling to implement, has been superseded by the European Working Time Directive (EWTD). The EWTD will, by law, reduce junior doctors' working hours to 48 per week, and will necessitate full shift working for all doctors resident out of hours. By 2004 resident doctors will only be allowed to work 13 hours out of 24.<sup>218</sup>

187. Dr Johnston from St Mary's Hospital for Women and Children, Manchester gave us an insight in to the kind of restructuring and reconfiguration of staff roles which compliance with EWTD entails:

you have to look at what roles medical staff are performing; and if you have less of them around, they should only be doing roles that are essential for medical staff to do; so you are then going to have to expand the role of midwives. That is something we are looking at. If you have expanded the role of midwife without a big increase in the number of midwives, you need to take things from them; and we are looking very much at the role of the healthcare support worker and trying to expand what they do, so that you free up midwives to do midwifery duties, who can do more of the stuff that doctors are doing that midwives are capable of doing, and therefore trying to concentrate the role of fewer medical staff.<sup>219</sup>

188. However, in some cases reconfiguration did not represent a solution to the problems posed by the EWTD which remained a daunting prospect for some units and threatened the existence of others. David Redford, a consultant obstetrician at Royal Shrewsbury Hospital told us that:

the practical issue for me is having six doctors in the middle tier doing a lot of the key work at night, the advice is in a year and a half's time with the EWTD I will need eight and I really do not know where those two are going to come from at the same time that every other trust is looking for two more ... the danger is that you have to rely more and more on agencies and you get into a blackmailing situation where you are paying £40 or £50 an hour for a diminishing pool of doctors who are not fully committed to a job in one hospital and you end up spending enormous sums of money just to keep your service running.<sup>220</sup>

189. Others talked in even plainer language about the threat of closure. Rick Porter, Clinical Director of Maternity Services at Royal United Hospital, Bath told us that "only one person has to be off on long-term sick and the unit is nigh unto closing, it is that close"<sup>221</sup> and Antony Nysenbaum from Trafford General Hospital said that unless more middle-grade doctors were employed, "we would not be able to provide cover, and therefore we would no longer be viable."<sup>222</sup>

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<sup>218</sup> A full shift working arrangement is one under which doctors, contracted in terms of basic hours, work a shift on a regular basis, rotating around the shift pattern, whereas a partial shift working arrangement involves doctors, contracted in terms of basic hours, principally working normal weekdays but they work a different duty in term intervals e.g. a week on nights or a weekend.

<sup>219</sup> Q 518

<sup>220</sup> Qq 352–54

<sup>221</sup> Q 713

<sup>222</sup> Q 517

190. Doctors working to become specialists in obstetrics now encounter difficulties in gaining experience as the hours they spend in training have been reduced, and as the registrar and senior registrar grades have now been merged into a single Specialist Registrar grade.<sup>223</sup> Professor Regan from St Mary's Hospital, Paddington argued that it was now difficult for trainees to follow the care of a patient:

The Registrar I did a ward round with on Monday morning will be different from the person who goes into theatre with me in the afternoon and will be different from the person who does the post-operative ward round the next day. That may be frustrating for me, it is not very good for the patient, but if we are talking about the trainees ... it cannot be the happiest way to be trained.<sup>224</sup>

191. Professor Regan commented on the longer-term implications of the EWTD for staffing in maternity units:

the need for much reduced hours, the limited number of trainees ... has had a big effect on the way the staffing structure runs in the maternity unit. It has also had a big effect on the amount of supportive care which the midwives can provide.<sup>225</sup>

She went on to say that "it has had a massive, devastating impact on the sort of standards of care we have been able to provide."<sup>226</sup>

**192. Moves to implement the New Deal and the European Working Time Directive have already had a profound impact on the levels of experience that obstetricians gather as trainees and are already threatening the viability of maternity units which currently serve as consultant obstetric units. This might create welcome opportunities for the development of midwifery-led units for women with low-risk pregnancies but we are extremely concerned that women who experience complications in pregnancy and in labour should have access to skilled, experienced and confident obstetricians. We welcome the Department's work to assess the implications of the EWTD but are concerned that any action on this work will come too late for the current generation of trainee obstetricians, and indeed for those units threatened with closure. If the EWTD is to be implemented, more investment in training and recruitment of doctors is required so that adequate levels of staffing and levels of experience can be maintained. We are very concerned that the Government is not sufficiently aware of the difficulties the professions face on account of the European Working Time Directive.**

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<sup>223</sup> This took place on the recommendation of the report of the Working Group on Specialist Medical Training (chaired by Sir Kenneth Calman), *Hospital Doctors: training for the future*, Department of Health, 1993.

<sup>224</sup> Q 75

<sup>225</sup> Q 62

<sup>226</sup> Q 74

## What impact do staffing and configuration issues have on women and babies?

### *Access to maternity care*

193. The staffing of a maternity care team affects the kind of care a woman will have from the moment she first seeks professional advice on her pregnancy. In the majority of cases a woman will seek that advice from her GP. Some GPs help to provide their patients' antenatal care and a few follow through to attend at the delivery but most will provide advice and then refer pregnant women to a maternity service. Levels of communication and working relationships between GPs and maternity services vary and this variation can influence the kind of delivery a woman envisages.

194. We heard evidence of mutual trust and respect between GPs and midwives in the community, working relationships which allowed GPs to support women in their choices, including delivery in community units or at home. For example, Gill Smethurst, representing Goole Midwifery Centre, said that GPs recognised midwives as experts in maternity care and were happy to refer women who chose home birth: "the GPs just refer to us. If a woman goes to a GP and says 'I want to have my baby at home' they will just say 'go and talk to the midwife'."<sup>227</sup> In 2002, 30 out of 434 women who were cared for by Goole midwives delivered their babies at home.

195. However, some GPs may be reluctant to support women in choosing home birth or delivery in midwifery-led units located at some distance from hospital. As Carol Burns, a user representative from St James's University Hospital, Leeds told us, although she did not think that there was a 'huge' group of women who wanted home births, "we suspect that there are more than are having them at the moment."<sup>228</sup> Mandy Grant, another user representative (from Dorset) said that "most women tell me that their GPs can often be quite off-putting about going to the low risk unit ... some GPs are a bit frightened; they think women should go where the technology is in case something goes wrong."<sup>229</sup>

196. Christopher Guyer, Clinical Director of Obstetrics at St Mary's Hospital, Portsmouth, which has a number of peripheral, midwifery-led units, explained to us why so many GPs were reluctant to support births away from consultant units, and suggested a way of changing perceptions:

there needs to be some sort of national guidance for GPs and for community midwives on who is appropriate to be managed at a peripheral centre and who should be referred to the central unit where there is obstetric, anaesthetic and paediatric support ... we have a group of GPs at the moment who have gone through a system whereby all they have seen from an obstetric perspective is the abnormal, and it must be very difficult for them to perceive what normality is like and, as a consequence, being able to support women delivering in areas where there is not obstetric, anaesthetic and paediatric support. So we come back again to offering

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<sup>227</sup> Q 422

<sup>228</sup> Q 421

<sup>229</sup> Q 633

some insight probably at undergraduate level into community-based maternity care so they have a perception as to what that is.<sup>230</sup>

197. Ann Geddes, Head of Midwifery at St James's University Hospital, Leeds (where 70 of 8,000 births took place at home in 2002) outlined a similar strategy with regard to home birth:

we worked very hard through our Maternity Services Liaison Committee to clarify the role of professionals at home births, because we found that women were experiencing a lot of conflict, in that they went to the GP, where they would never allow you to have a home birth, whereas the midwife would support that. We worked very hard to produce a document which clarified each person's role, including women who were requesting a home birth. That has gone a long way to actually breaking down a lot of these barriers.<sup>231</sup>

198. A number of witnesses suggested to us that midwives, rather than GPs should be the first point of contact for a pregnant woman. Julianna Beardsmore, representing users of maternity services in Bath, saw "the midwife as a key information giver for the woman" and felt that women should not have to confirm where they would deliver their babies until 32–36 weeks into pregnancy by which time they would have explored all of their options.<sup>232</sup>

**199. Women should be able to take time over their initial decisions on maternity care. It is important at this early stage in pregnancy that women should not be subject to any undue influence in relation to the type of maternity unit they are to choose. We recommend that national guidance be issued to support GPs in referring women for appropriate maternity care and in particular to clarify the role of the GP in relation to home birth i.e. that GPs do not need to take responsibility for this. We further recommend that the Government consider the idea of making the midwife rather than the GP the first point of contact for a discussion of maternity care choices.**

### ***Access to antenatal and postnatal care***

200. A woman is referred to a maternity service not just to 'book' care for the delivery, but also to receive care and support during pregnancy. This antenatal care can help a woman to be aware of her own health and that of her unborn baby and to reassure her if she is anxious about her pregnancy or birth. Antenatal care in the form of classes often help women to develop a support group of their peers in the class, which may endure beyond the birth of their babies. Davidica Morris, from the Maternity Services Liaison Committee at Worcestershire Royal Hospital argued that antenatal classes "are very important and they give parents the knowledge to make more informed choices ... and help them in making decisions during their pregnancy and labour."<sup>233</sup>

201. Midwives recognised the importance of antenatal care, particularly for very young mothers and for disadvantaged or socially excluded women, and worked to provide the

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<sup>230</sup> Q 634

<sup>231</sup> Q 420

<sup>232</sup> Q 675

<sup>233</sup> Q 346

models of care that women feel most comfortable with: “we have tried one-on-ones, we have tried small groups and at the moment we are trying what we call a drop-in centre where we have a room with midwives available.”<sup>234</sup> Where maternity services are integrated, with midwives working in the community and at maternity units, antenatal classes may help women to get to know the midwives they will see at the unit, and in turn to feel more familiar with the unit itself.

202. However, Toni Martin, Head of Midwifery at Worcestershire told us that when maternity units were short of staff, quality of care for women in the antenatal period could be compromised: “antenatal classes are less important than delivering the babies because the babies have to be delivered.”<sup>235</sup>

203. In the same way, staffing shortages can affect care for a woman after she has delivered her baby. As Professor Regan from St Mary’s, Paddington stated: “The postnatal ward is always the poor relation. Wherever there is a staff shortage that is where they are lost.”<sup>236</sup> The postnatal period can be a vulnerable one for a woman and her baby and even where both are healthy, professionals can give support which promotes the development of bonds between parent and child. Perhaps the most vivid example of this kind of support is breastfeeding which has proven health benefits, but which can also be difficult to initiate and sustain without help. Mandy Grant from Dorset Maternity Services Liaison Committee illustrated the importance of midwifery support to a woman’s attitude to breastfeeding:

there is no doubt that after giving birth women often need quite a lot of support with breastfeeding. I run three breastfeeding support groups so we pick up the pieces of what often happens in hospital, but the women in Bournemouth get more midwife time and the midwives are on the whole much more well-informed about breastfeeding, so they are helping women with information and it just makes a huge difference.<sup>237</sup>

204. At Edgware Birth Centre, where seven whole-time equivalent core staff deliver around 500 babies, midwives keep detailed statistics on breastfeeding. Some months see 100% breastfeeding on departure from the Birth Centre. This may be explained at least in part by the fact that no formula milk is kept on the premises, but on follow-up at three to four months, midwives found that women were usually still breastfeeding.<sup>238</sup> We heard from Selene Daly of the value of simple advice and reassurance given by midwives who have time to spend with women and their babies in a maternity unit where continuity of care is routine:

in the birth centre if you do have problems you know you can go back and call a midwife up ... and you know you will get support. You cannot always do it yourself;

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<sup>234</sup> Q 683 (Helen Jones)

<sup>235</sup> Q 347

<sup>236</sup> Q 79

<sup>237</sup> Q 598

<sup>238</sup> Q 77

you do not know how to do it. The first time I had to breastfeed I just got some quick techniques and the next day it worked.<sup>239</sup>

### ***The concepts of continuity of care and continuity of carer***

205. One of the strongest themes to emerge from our inquiry was the importance of continuity to pregnant women and new mothers; continuity in terms of the person or people who care(s) for the woman, and continuity in terms of constant support in labour. User representatives from consultant units and birth centres alike insisted that continuity was a condition of good quality care for women and babies. Catherine Eccles from St Mary's, Paddington told us:

One thing that I know women want and would produce better results in labour is one-to-one care. Continuity of care as well. Being supported all the time by a midwife ... actually having the same midwife who has seen you antenatally and then is supporting you through labour with a relationship of trust that has been evolved through pregnancy towards labour.<sup>240</sup>

Selene Daly from Edgware Birth Centre defined what she saw as the ideal for maternity services, one-to-one care:

You stay in one room; you do not get trolleyed between labour, theatre and everything else. You stay in one room and virtually the whole time you are in there through your labour, through the delivery itself and then post-delivery, your midwife is with you.<sup>241</sup>

206. This could not be further from the situation in maternity units stretched beyond capacity owing to staffing shortages:

If you have a particularly bad day and you have staff shortages, you could find one midwife looking after three labouring women in three different rooms. In that situation one of the only things that poor midwife will be able to do to facilitate safety of both mother and baby is to leave these monitors on and when she is in room two just hope that her right ear will hear the *pip, pip, pip* in room three and vice versa. I am exaggerating a little bit, but that is an issue.<sup>242</sup>

207. This kind of situation raises questions about quality of care, if not in terms of safety or even of avoiding unnecessary medical intervention which could lead to caesarean section, but in terms of a woman's feelings about her experience of childbirth. Another user representative, Davidica Morris from Worcestershire Royal Hospital, insisted that "not always having a midwife with [the woman] is a big issue."<sup>243</sup>

208. In some areas women have access both to continuity of carer, where the same midwife or midwives provide antenatal, intrapartum and postnatal care, and continuity of care,

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<sup>239</sup> Q 79

<sup>240</sup> Q 27

<sup>241</sup> Q 30

<sup>242</sup> Q 46 (Professor Lesley Regan)

<sup>243</sup> Q 351

where the woman is supported in labour at all times. At Goole Midwifery Centre, two midwives attend every birth.<sup>244</sup> The Albany Midwifery Practice in Peckham employs seven midwives, each on-call 24 hours a day, seven days a week (but with twelve weeks' holiday a year). Each woman is assigned to two midwives and in 95% of cases, one or both midwives attended at the birth.<sup>245</sup>

209. In many other areas staffing issues and team structures render continuity of carer impossible and continuity of care difficult to provide. However, it seems that in struggling to balance the needs of staff and pregnant women, continuity of care is an aim which informs all plans to develop maternity services at local level. Shona Ashworth, Head of Midwifery at University Hospital, Nottingham said that asking midwives to take on caseloads of women they would care for throughout pregnancy and the postnatal period was unlikely to yield a positive response:

most midwives are now not willing to work those kinds of shifts. They are mothers themselves. It is really difficult to offer continuity. As shifts get very fragmented, the number of carers increases; so the most we can aim for for the majority of the time is a shared philosophy and very clear guidelines and procedures. That is the way we have to go. We have to offer midwifery care where they are with a woman and can take charge of the case. I think that is creating more ownership, and I have seen midwives now wanting to stay a little longer and being less willing to hand over the care. So that brings benefits, but it is difficult with the short shifts or lengthened shifts—and midwives have choices too.<sup>246</sup>

210. Evidence from user representatives suggested that women appreciated every effort that was made to promote continuity of care, even if continuity of carer was not possible; and that women felt secure knowing that continuity was the aim and the guiding philosophy of the maternity unit. Clare Hodgson, a user representative from Trafford General Hospital, and Alex Silverstone from St Mary's Hospital for Women and Children, Manchester described women's experiences:

I had one particular midwife ... the same midwife actually stayed with me for most of the night and was going to outstay her shift, but unfortunately could not stop any longer because of her own children. The point at which I got to the delivery suite, another midwife came in and she stayed with me for the rest of the labour and I was very happy and confident that there had been continuity.

I think they do try and have continuity, but if the labour is going on for quite a long time, it is quite hard, but they are very specific and the next midwife comes along to explain to the woman ... and they explain the situation and I think the women feel confident with the next midwife coming along. It is difficult to do total continuity if it is a long labour, but usually the midwives do say, 'when I come on duty I will find

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<sup>244</sup> Q 439 (Gill Smethurst)

<sup>245</sup> Ev 132

<sup>246</sup> Q236

out what you had', and I think that is that nice little bit at the end and she feels cared for.<sup>247</sup>

211. At some units it was felt that women whose pregnancies were judged to be high risk, and who were under close medical supervision, were more likely to receive continuity of care. At other units, such as that in Royal United Hospital, Bath, special effort was made to have women with high risk pregnancies meet and get to know the midwives as well as the doctors at the unit.<sup>248</sup> Whether pregnancy was high or low risk, it was acknowledged that women needed continuity of care, and it was affirmed that midwives wanted to provide it but that they were hampered by under-establishment and staffing shortages. Helen Shallow, Midwife Consultant at Derby City General Hospital insisted that flexibility was the key element in reconfiguring services to maintain quality of care for pregnant women and job satisfaction for staff:

I do not think there is a 'one size fits all' model for midwifery but we need to engage and go back and speak to people. What is good for women is good for midwives; the two mirror each other. The issue of choice for women has to apply to choice for midwives as well to some extent. You could have a variety of different models in one service ... We can provide more variety of services instead of this utilitarian approach we have adopted over the years, where there is a 'one size fits all' model.<sup>249</sup>

**212. We agree that the issue of continuity of care is of crucial importance to women and families and we urge the Department to facilitate the sharing of good practice in configuring services to provide continuity of care-giver across the country. In particular, we recommend that the Department liaise with PCTs to promote the development of services based on one-to-one care. We would welcome the creation of midwifery networks to share examples of innovative practice in the primary care setting. We recommend that the Department issue guidance on standard definitions for one-to-one care, continuity of carer and continuity of care.**

## **5 Provision of training for health professionals who advise pregnant women and new mothers**

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213. Post-registration training for maternity care staff is essential to the maintenance of high-quality care for women and babies, and also to the professional development and job satisfaction of members of staff themselves. A great many of those who responded to our call for evidence on training for maternity care staff identified a lack of experience and skill which needed to be addressed urgently by means of specific training programmes. Dr Chris McCourt from the Centre for Midwifery Practice (at Thames Valley University) was

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<sup>247</sup> Q 521

<sup>248</sup> Q 237 (Shona Ashworth)

<sup>249</sup> Q 229

among several contributors who called for an emphasis on training midwives to assist in normal birth, as some student midwives had little or no experience in this area.<sup>250</sup>

214. The RCOG argued that medical students also needed experience of community-based obstetrics, normal pregnancy and births, and that provision of this sort of training would “enhance mutual understanding and facilitate seamless transfer between the community and hospital settings.”<sup>251</sup> John Watts from Worcestershire pointed out that for the majority of trainee obstetricians “the only time they saw a normal delivery was when they were an undergraduate and at that time they perhaps only saw a handful, let alone actually performed a vaginal delivery.”<sup>252</sup>

215. Christopher Guyer from St Mary’s, Portsmouth advocated community-based obstetric training both at undergraduate and postgraduate level as a way of promoting the ethos of low intervention in labour outlined above at Chapter 4. Mr Guyer told us that such training “is something that needs to be looked at, particularly if we are trying to promote this idea of normality and allowing our trainees to get some perspective as to what normality is, which they do not currently have.”<sup>253</sup>

216. Special training is also needed to equip staff with the skills they need to play extended roles in the maternity care unit. Marie Pearce, a community midwife from West Hertfordshire NHS Trust pointed out that midwives were now training to undertake some of the tasks traditionally performed by doctors, such as the examination of the newborn baby.<sup>254</sup> This, she told us, had “taken quite a bit of pressure off the paediatricians, and the GPs.”<sup>255</sup>

217. In common with other professionals and many women, midwives have lost the skills, science, art and confidence to support normal birth. Midwives need to get this confidence back so that they can understand how to use intervention appropriately, for example to use intermittent auscultation and provide support for water labour and birth where labour is normal. As well as the physiology of normal birth student midwives need to see confident, competent midwives working in practice. We have heard from many parts of the country where these skills are present. Midwives from these areas expressed disbelief at the lack of skills elsewhere. For example, shock was expressed by women confident in water birth that units elsewhere had birthing pools but did not allow women to use them because they had not been sufficiently trained.<sup>256</sup> We share their disappointment in this.

218. Maternity care professionals will need to be more creative and innovative in helping students and junior staff to gain experience of normal deliveries. Student midwives might attend home births, medical students might undertake placements at midwifery-led units or watch videos of women discussing home birth and delivering their babies at home. Simulators might be used to provide some experience of vaginal breech delivery. All

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<sup>250</sup> Ev 190

<sup>251</sup> Ev 194

<sup>252</sup> Q 333

<sup>253</sup> Q 625

<sup>254</sup> Midwives must achieve a qualification (N96) in order to perform this examination.

<sup>255</sup> Q 157

<sup>256</sup> Qq 444–45

midwives and obstetricians should be able to deal with breech deliveries which take place through women's choice, through prematurity, the birth of twins, during caesarean section or as emergencies presenting in the late first or second stages of labour. We are concerned that the diminishing number of vaginal breech deliveries should not lead to an erosion of skills which might increase the risks to babies who are born in the breech position.

**219. We recommend that the Government should ask the appropriate bodies to commission a review of training for health professionals in maternity services. In our view all members of the maternity care team should receive training on and gain experience of normal births in a range of settings. Midwives play a crucial role in supporting normal birth. The Nursing and Midwifery Council should ensure that curricula, and practical experience elements of training allow student midwives to develop appropriate skills in the support of normal birth. All student midwives should undertake placements within a midwifery-led unit or birth centre, and with a team of midwives who assist at home births, and the Government should also encourage the use of midwives in educating junior doctors on normal births.**

### ***Medical and technical training***

220. Much of the written evidence we received on in-post training for maternity care staff emphasised the importance of 'skills and drills' competence training for management of emergencies in maternity units. The RCN told us that in particular, all staff working in birth centres should undertake training in maternal and infant resuscitation and in the management of obstetric emergencies.<sup>257</sup>

221. Individual maternity units provided us with examples of good practice in development of training programmes in such areas. For example, Aberdeen Maternity Hospital initiated a course in neonatal resuscitation which provided a certified skills base on which maternity unit staff would then build at their own units. Dr Munro and Dr Bowring, who developed the course told us that the NHS should ensure that all maternity staff are trained to a certified level in the skills required. They suggested that 'basic life support equipment committees' be formed (to cover hospital and primary care services) in order to ensure that staff members receive training in use of the appropriate equipment.<sup>258</sup> Jen Ferry from the Rosie Hospital, Cambridge told us that all maternity care team members at the unit had the opportunity to take courses in advanced life support (46 midwives had taken the course) and that staff had also begun to take neonatal life support courses and to work with the trust's resuscitation officer.<sup>259</sup>

222. We also heard calls for training to help maternity care staff to provide early warning of, or to prevent such emergencies. The recommendation made by the Confidential Enquiry into Stillbirths and Infant Deaths, that all staff members should receive training in using and reading a cardiotocograph or CTG (an instrument for EFM) with women whose

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<sup>257</sup> Ev 208

<sup>258</sup> Ev 125

<sup>259</sup> Q 156

pregnancies have been designated high-risk, was highlighted by a number of submissions to our inquiry.<sup>260</sup>

**223. We recommend that all midwives and doctors receive training together in emergency procedures, including the use of appropriate equipment.**

### ***Communication, support and outreach training***

224. Although training in the technical and technological protocols of maternity care provision, the ‘skills and drills’ of emergency management and monitoring procedures, was acknowledged to be crucial, we heard that training for development of communications skills could also have a profound effect on the quality of maternity care. In some areas of maternity care, the two types of skills must be used together. The charity Antenatal Results and Choices (ARC) recommended specific training for professionals who care for women before, during and after antenatal screening. In particular ARC argued that health professionals should receive training, not only in performing screening and testing procedures but should also be trained to give appropriate information and advice to parents, to facilitate parents in making informed choices, to give distressing news, and to provide bereavement care.<sup>261</sup> Helen Jones from Royal United Hospital, Bath told us that antenatal screening was a particular focus for discussion of and training in giving appropriate and consistent information and advice to women and families.<sup>262</sup>

225. The Maternity Alliance emphasised the need for training for maternity staff so that they feel confident in working with minority groups such as asylum seekers, parents with learning difficulties or disabilities, and very young mothers. The Maternity Alliance also called for training specifically designed for health professionals working with women subjected to domestic violence, and for those helping the most disadvantaged groups initiate and maintain breastfeeding.<sup>263</sup> We intend further to examine these issues as part of our Maternity Services Sub-committee’s second inquiry, into inequalities in access to maternity care.

226. Health professionals have a crucial role in helping new parents to keep their babies healthy and safe through appropriate physical handling. The NSPCC told us that training for staff does not adequately reflect this responsibility, for example through giving advice to all parents on the danger of shaking babies.<sup>264</sup> We also received evidence which called for training designed to help staff promote communication between new parents and their children. The Centre for Family Research at the University of Cambridge recommended that health professionals should take courses in infant behavioural cues in order to help parents develop relationships with their newborn babies.<sup>265</sup>

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<sup>260</sup> echo: The Fetal Heart Charity also advocated sonography training for health professionals in order to improve antenatal detection rates for congenital heart disease. (Ev 212)

<sup>261</sup> Ev 256

<sup>262</sup> Q 751

<sup>263</sup> Ev 121

<sup>264</sup> Ev 261

<sup>265</sup> Ev 210

227. We recommend that a review of training programmes should emphasise the importance of skills in informing, advising and counselling mothers and families, and in promoting the development of bonds between parents and their babies. In particular, we recommend greater emphasis on support for breastfeeding. All newly-registered maternity staff should be aware of the special support needs of some families.

### *How is training delivered at maternity units?*

228. The Department outlined its approach to post-registration learning and development for health professionals in delivering the Government's modernisation agenda for the NHS:

to encourage integrated service and workforce development, with the commissioning of learning and development being more directly informed by service plans and the needs of patients. This implies less emphasis on uni-professional, nationally driven curricula, and more on multi-professional, competence-based approaches.<sup>266</sup>

229. However, the Department has gone out to tender to develop a framework for health professional learning beyond first registration (expected to be completed by July 2004), to support Workforce Development Confederations in commissioning more innovative ways of providing learning, in line with the patient-centred approach, with the maintenance of standards, and with the continuous professional development needs of health professionals.

230. In giving evidence on the training available at their maternity units, many of our witnesses concurred with the view of University College London Hospitals that training for medical staff, midwives, neonatal nurses and healthcare assistants should be integrated or multi-professional as recommended by the Department.<sup>267</sup> Professor Regan told us that St Mary's Hospital, Paddington had explored a joint model of training for midwives and doctors on courses in skills such as neo-natal resuscitation and interpretation of CTG monitoring. Specialist registrars and midwives trained together, led by a senior midwife and a consultant.<sup>268</sup>

231. Mrs Toni Martin from Worcestershire Royal Hospital expressed some doubt over the value of integrated training for midwives and obstetricians but still argued the case for training to strengthen the maternity care team:

it is a completely different training. There is no point in a budding obstetrician looking after one woman in labour and delivering one woman. That is not going to influence his practice in any way other than he has seen it. I would think that we do not have joint training other than ... the skill drills, and that is very good because it is team working. If you are going to look at training midwives and potential obstetricians together you need to completely re-look at why you are training and

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<sup>266</sup> Ev 168

<sup>267</sup> Ev 142

<sup>268</sup> Q 65

who you are training because they are very different skills, completely different skills at the end, and a lot of it should be about respect for each other's professions as well and each other's skills.<sup>269</sup>

232. Cathy Rogers of Barnet and Chase Farm Hospital told us about the approach to training taken at Edgware Birth Centre:

We have the same philosophy that it is interdisciplinary multi-profession education and the midwives at the birth centre attend educational programmes with their colleagues—both obstetricians and midwifery colleagues—on the host site ... Again, multi-disciplinary education is important not just because of the cost effectiveness, but it is also about developing the necessary collaboration and trust and respect for each other's contribution to maternity services. It is an excellent forum for that.<sup>270</sup>

233. Lynne Pacanowski from St Mary's, Paddington suggested that provision of more individualised kinds of training for members of the maternity care team could help to stabilise staff turnover: "one of the reasons we have been quite successful in recruiting and retaining staff [is] because we have a generous sort of approach to people who want to do different types of study."<sup>271</sup> Guy's and St Thomas's Hospital outlined for us their in-house continuing education programme run by professional development and consultant midwives, which made use of educational facilities at King's College, London. The programme combined integrated skills training for midwives and doctors with programmes tailored for individual staff members. Meetings, teaching sessions and demonstrations for professionals with a range of skills took place on a regular basis, and staff training was supported by the use of personal development plans and the availability of study leave.<sup>272</sup> Staff at the Rosie Hospital, Cambridge also had access to a range of different training and study programmes, according to Jen Ferry, thanks to a "fairly creative approach" to "getting scholarships and other funding and we can support people through diplomas, degrees, Master's courses, whatever." This kind of training, along with multidisciplinary training in emergency management skills, helped to retain "a highly motivated workforce."<sup>273</sup>

234. Despite consensus that training was a vital aspect of professional life and a means of improving the quality of care for women and babies, some maternity units confronted staffing shortages so severe as to prevent members of the maternity care team from undertaking the appropriate training courses. Karen Connolly from St Mary's, Manchester told us that at her unit staffing and funding levels were barriers to training:

There is a wealth of training available but there is a lack of staff to enable them to access the training. There is a willingness among professionals, for example a consultant will work and train the midwife in an area of specialty and the midwives are more than willing to be able to access training, but we do not have the means to do that. We put training programmes in place, whether it be, for example, for

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<sup>269</sup> Qq 329–35

<sup>270</sup> Q 68

<sup>271</sup> Q 67

<sup>272</sup> Ev 172

<sup>273</sup> Q 156–57

management training, customer care training and we have put sessions in place to train midwives on HIV which are multi-disciplinary sessions, but it is accessing that training and also funding the training because although the Government have again given the money for continued professional development, we do not necessarily see it in the form it is needed on the shop floor.<sup>274</sup>

**235. Current training seems to us not fully to acknowledge the changed nature of maternity care today. We therefore recommend that steps should be taken promptly to ensure that the Colleges and the Nursing and Midwifery Council develop appropriate training on a multi-disciplinary team basis, including where possible the participation of such members of the maternity care team as physiotherapists and health visitors.**

## 6 Conclusions

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236. The group of issues we identified in our terms of reference as areas which warranted examination seemed to draw together discrete or even disparate aspects of maternity services. However, although each of the issues does indeed raise specific concerns, collection of maternity care data, caesarean section rates, maternity care staffing and staff training are all closely related in terms of the causes and effects of the problems which can compromise the quality of a woman's experience of her maternity care.

237. The maintenance of a comprehensive and accurate statistical evidence base for maternity services is a vital component of work to identify trends such as rising caesarean or induction rates, and in turn to inform national guidelines and policies. The national statistical base should allow researchers, maternity service providers and service users themselves to access the information which they require; on antenatal care (smoking cessation in pregnancy, for example), on care during labour and childbirth (on 'normal birth' and levels of intervention), and on postnatal care (such as breastfeeding rates) and infant health. This kind of information is needed if access to care and quality of care for disadvantaged groups, aspects of maternity services which we intend to examine in our next inquiry, are to be monitored effectively.

238. At local level, maternity care staff need to have access to a system which facilitates the efficient collection and entry of data on care for each woman, which is compatible with other hospital *and community* information systems which keep records on antenatal and postnatal care. Maternity units should also be able to retrieve data which they can use in auditing their service and in drawing up guidelines for good practice. In terms of care for the individual woman and her baby, data systems should accommodate comprehensive health records.

239. However, the evidence we heard during this inquiry strongly suggests that data collection at local and national level is seriously impaired, not only by inadequate or nonexistent data systems and by inconsistent use of terminology, but also by a lack of IT specialist support for maternity units. Entering data into inefficient systems is an onerous task for midwives who have no specialist expertise or training, and who feel that much of

the time spent on data entry would be much better spent caring for women and their babies.

240. Caesarean section rates constitute one area of maternity care in which accurate data collection is particularly important and in which, as the National Sentinel Caesarean Section Audit showed, identification of trends and use of evidence can inform policy at local and national level to improve care for women. All of the maternity units we heard from had policies in place to reduce section rates and these policies were based on evidence of health outcomes for women undergoing different levels of intervention in labour. However, this inquiry has not allayed our concern that caesarean rates are too high, nor that they vary so dramatically between neighbouring areas and even neighbouring units. We conclude that some women are exposed to risks of surgery which are not balanced by benefits sufficient to justify caesarean section and that there is a need both for the implementation of evidence-based protocols and policies and an investment in staff establishments so that doctors and midwives can spend time giving information, advice and reassurance to women before labour, that they can support women during labour, and so that experienced doctors can make the decision to undertake a caesarean section.

241. We conclude from our examination of the staffing of maternity care teams, however, that in many units staffing levels in terms of medical and midwifery staff are not what they should be. Depleted midwifery establishments mean that a midwife may have to care for several women at a time, perhaps having to rely on electronic monitoring to check on mother and baby. In turn this means that intervention in labour starts earlier, increasing the likelihood of caesarean section. Lack of on-site consultant cover for maternity units can also contribute to rising caesarean rates in that experienced doctors are not always present when the decision to undertake a section is made. This is compounded by the implementation of the European Working Time Directive which is limiting the presence of younger doctors in maternity units.

242. The evidence we took from user representatives confirmed that there is no single model for maternity care. Some women have needs in pregnancy which can only be met at a consultant unit based in a hospital and some women who do not have such needs may well be reassured by the medical and technological back-up of the hospital setting. A great many other women however, value the opportunity to deliver their babies in the 'home-from-home' setting of a birthing centre, and some wish to deliver their babies at home, supported by community midwives. The most important factor in a positive experience of birth in any of these settings is continuity of care, where a woman is supported at all times during labour by a member of the maternity care team. Maternity staff who work in an environment where it is possible to provide this level of care seem to be happier in their jobs and in their professions. Staffing shortages at maternity units are self-perpetuating in that they lead to recruitment and retention problems. Such shortages threaten the existence of some maternity units, and closures impair women's choice in relation to maternity care (an area which we intend to examine as part of a future inquiry), and in some cases their safety and that of their babies.

243. Rising rates of intervention in labour and staffing shortages create gaps in the skills mix of maternity care teams and render post-registration training of maternity staff all the more important. As caesarean sections and other interventions become increasingly

common, midwives and doctors in training are less likely to gain experience in facilitating normal birth and some of our witnesses argued a very convincing case for doctors and midwives working in consultant units to undertake training in other settings. Midwives now take on some of the tasks traditionally performed by doctors and so they require special training and support in order to feel confident in their expanded role. Training in the use of specialist equipment and in emergency ‘skills and drills’ is essential to the safety of pregnant women and new babies. The development of other types of skill (in caring for women with specific needs, and in breastfeeding support, for example) can enrich a woman’s experience of maternity care and improve health outcomes for mother and baby. Access to in-post training at a maternity unit may improve recruitment and retention rates but this access is dependent in the first instance on the availability of staff to undertake training sessions and courses.

244. In undertaking this inquiry our intention was not to attempt an all-encompassing survey of maternity services or to appraise the services provided by individual maternity units, but rather to seek a range of views on those particular issues of concern drawn to our attention by experts in the field. This ‘snapshot’ approach afforded us the opportunity to explore specific issues in some detail, but also to engage in a wider debate which connected those issues. We also gained some degree of insight into the experience of maternity care staff and of pregnant women and mothers and this insight will inform our future inquiries into inequalities in access to maternity services and choice in maternity services.

245. Confidence appears to be a key factor in childbirth, whether it is the confidence of the woman in her innate ability to deliver her own baby, the confidence of her carers (midwives, doctors, companions) in their ability to support her, or the confidence of women in general that maternity services will be available and responsive to the social and medical needs of women during pregnancy, labour and the postnatal period. We were encouraged to hear evidence from maternity units where the confidence of women and staff was high but we found it difficult to see how this kind of confidence could be generated at units where staff struggled to attain basic minimum standards of safety in managing rising workloads. An increase in staffing, especially midwives, should lead to reduced caesarean section rates and may have cost benefits for the NHS.

246. We are very much aware that a great many of our recommendations reiterate those made by our predecessor Committee and by *Changing Childbirth*. We recognise that maternal and perinatal mortality rates have fallen since *Changing Childbirth* and we heard evidence of good practice and of a commitment to provide high-quality maternity care. However, it was clear that the principles of good maternity care as set out in *Changing Childbirth* had not been achieved throughout the country. Maternity Services are not yet “based primarily in the community.” Women themselves are not yet “sufficiently involved in the monitoring and planning of maternity services.” In all too many cases the woman still does not feel that she is “in control of what is happening to her and able to make decisions about her care, based on her needs, having discussed matters fully with the professionals involved.”<sup>275</sup> During our predecessor Committee’s inquiry, the late Audrey Wise MP often said that, as she saw it, the best way of providing the kind of appropriate and good quality maternity care subsequently described by the principles set out in

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<sup>275</sup> Department of Health, *Changing Childbirth: the report of the Expert Maternity Group*, 1993

*Changing Childbirth*, was to “staff the woman” rather than the delivery suite itself. We conclude that this standard of individualised care, expressed in *Changing Childbirth* as making the woman the “focus of care” is one which is under-resourced, under-staffed, and under-supported.<sup>276</sup>

247. A great many of those who have worked in, and indeed used, the maternity services over the last decade have been disappointed by what they see as the failure to implement the reforms announced by *Changing Childbirth*. We share this disappointment. We wholeheartedly agree with Baroness Cumberlege, the Chair of the Expert Maternity Group which produced *Changing Childbirth*, who said in January of this year that “it is time that the Government put some strong political will behind the issue and improved the lot of women and children in this country.”<sup>277</sup> We hope that this report will provide an opportunity for the present Government to respond and reflect on why so many widely-supported previous recommendations have failed to be fully implemented.

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<sup>276</sup> Health Committee, Second Report of Session 1991–92, *Maternity Services*, HC 29, para 384

<sup>277</sup> HL Deb, 15 January 2003, col. 300

## Conclusions and recommendations

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1. We are concerned that the accuracy of maternity care statistics is adversely affected not only by missing data but by data submitted according to different interpretations of the terms used to define the data required by the Maternity Hospital Episode Statistics. We recommend that the NHS Information Authority clarify the progress made to date on the Maternity Care Data Project, and in particular on the compilation of the 'data dictionary'. We further recommend that work on this important area continue, overseen by a 'national champion' for maternity care data, alongside efforts to ensure that all maternity units submit data to the Maternity HES. (Paragraph 24)
2. We recommend that data on breastfeeding rates, in terms of initiation and duration, should be standardised and collected at national level. (Paragraph 29)
3. We recommend that the Department take immediate action to ensure that maternity care data systems and population-based child health systems for both sick and healthy babies, should be linked together at national and local level in order that health professionals have all information relevant to mother and baby and in order that the long-term outcomes of pregnancy and childbirth for maternal and child health can be measured. (Paragraph 31)
4. Changing Childbirth recommended that all women should carry their own maternity notes. We are disappointed that ten years later there are still some units where this does not happen. We recommend that the Department should insist that all units support the use of woman-held notes. We further recommend the development of a national format of these notes in preparation for the Electronic Patient Record. (Paragraph 32)
5. We welcome the Department's efforts to reduce incompatibilities between data systems and to review policy on the collection of maternity care data. We recommend that this review take account of calls for a renewed focus on normal birth and of the need for accurate data on antenatal and postnatal care in order to monitor progress towards targets and reducing health inequalities. We further recommend that in reviewing the Maternity HES the Department should ensure that the figures compiled for each maternity unit take accurate account of factors such as privately-run units within hospitals, and reflect the configuration of services which take in community midwifery teams and midwifery-led units under the auspices of a hospital unit. The Department should also take steps to ensure that data are collected on births in privately-run units and on home births. (Paragraph 36)
6. We were appalled to hear of the burden of work imposed on maternity care staff in units where maternity care data systems were inadequate or nonexistent. The dramatic variation in the reliability and availability of maternity care data systems across the country cannot be rationalised by differences in size or configuration of units. We were struck by the disparity between this unacceptable situation, where staff could not retrieve information about their patients, and in turn where reliable national statistics could not be generated, and the Government's intention to use

information technology to “enable NHS professionals to have the information they need both to provide ... [the best possible] care and to play their part in improving the public’s health.” (Paragraph 50)

7. We recommend that the Department of Health Statistics Division 3G liaises with other relevant parts of the Department and the NHS Information Authority to issue a direction to trusts on the provision and maintenance of maternity care data systems, and on links between these systems and other health information systems, so that maternity units can collect and retrieve accurate data in a more efficient way to meet both local and national data needs. (Paragraph 50)
8. The process of entering data on maternity care must not compromise the quality of care that pregnant women, and new mothers and babies receive. Adequate managerial and systems support is vital. Maternity care teams should have access to the services of administrative staff who have been trained to use the data system. While clerical staff can help to alleviate some of the pressure on maternity staff in terms of data entry, it is essential that the ultimate responsibility for overseeing the quality and clinical accuracy of data lies with a senior member of the clinical team. We recommend that the Department ensure that maternity units have access to reliable hardware, systems which can support the handling of individual records, to software which can be used for data analysis, and to appropriate statistical and IT support. Provision should be made for midwives who wish to do so to acquire skills in data analysis for monitoring and audit. (Paragraph 56)
9. We recommend that in reviewing policy on the collection of maternity care data, the Department consider the merits of the system used in Scotland, not only in terms of the system itself but also in terms of other factors which might contribute to its success, such as the allocation of resources and the existence of a culture which supports staff who collect, enter and analyse data. (Paragraph 61)
10. Most of the midwives and doctors who spoke to us did not recognise the requirements of the Maternity HES as a common data set, because they had not heard of them, or because they felt that definitions of the data required were not clear, or because the Maternity HES did not correspond with the more detailed information they collected independently for the purposes of care for individual mothers and babies, and development of their service. This is an indication of the disparity between national policy on and local knowledge of, collection of maternity care data. If maternity unit data collection systems are to be improved, communications between the Department and individual trusts and maternity units must be strengthened. We recommend that the Department should set out the implications of the electronic patient record initiative for maternity care data systems, including agreement of data definitions for maternity care, and further that it should consult and communicate with trusts on developments relating to the minimum dataset required by the Maternity HES. (Paragraph 62)
11. We believe the current state of maternity care data systems at units across the country to be so grave as to warrant specific attention by PCTs and trusts, and, where needed, the allocation of funds for the purpose of installing and maintaining adequate systems and for recruiting and training appropriate staff to undertake data

entry, analysis and system support. We recommend that maternity care data systems should form part of Local Delivery Plans. (Paragraph 63)

12. We recommend that in undertaking caesarean section audits, all hospitals should classify the degree of urgency of a caesarean section in the same way. We further recommend that the classification scheme used by the National Sentinel Caesarean Section Audit be considered as a standard scheme and that the data items needed to construct it should be included in the Maternity Care Data Dictionary. (Paragraph 82)
13. The issue of women's choice in undergoing caesarean section when there is no clinical need is a fraught one. The NHS does not generally provide other major operations for patients when there is no clinical need, nor does the NHS tend to offer choices of treatment to patients when one costs on average £760 more per patient than the alternative, since it is obliged to make the best use of NHS resources. It remains to be seen whether the National Institute for Clinical Excellence will allow choice for caesareans when in other areas of the NHS patients do not have comparable freedom. We would like to see a distinct shift in emphasis to ensure that elective caesareans as a 'lifestyle choice' are not supported by the NHS and that caesarean section should be a procedure undertaken only when medically or psychologically necessary and after appropriate support and counselling. (Paragraph 98)
14. We look forward to the publication of NICE guidelines on caesarean section and recommend that these should serve to support maternity care staff not just in assessing the medical indications for caesarean, but also in giving consistent advice and information to women considering the procedure. (Paragraph 99)
15. We share the concerns of maternity care staff who wish to protect women from the risks associated with caesarean section. We are particularly concerned for those women who choose caesarean section because they are anxious about delivering their babies. While their fears about childbirth should not be compounded by new anxieties about the risks of caesarean section, these women should be made aware of the implications of surgery for women and babies and of services which help to reduce anxiety. We recommend that maternity units examine how women who request caesarean section are cared for, what kind of information and advice they receive, and how the women themselves feel about their discussion of caesarean section with midwives and consultants. (Paragraph 100)
16. We understand that in some cases interventions in labour are necessary to protect the health of mother and baby. However, women should be made aware that interventions such as EFM, epidural and induction may increase the likelihood of a caesarean delivery. Raising a woman's awareness in these areas should not entail merely the transmission of clinical information but rather it should involve discussion with a health professional in the context of the individual woman's background and concerns. (Paragraph 104)
17. We were disappointed to hear that so few caesarean section audits involved the views of users. The woman's experience is an important facet of the analysis of caesarean

section rates and we recommend that maternity units consider this aspect of the audit process, even if women's views can only be sought through questionnaires. (Paragraph 112)

18. We agree with those witnesses who told us that ideally the decision to undertake a caesarean section should be made in the physical presence of a consultant. Whilst this is not practicable within current staffing levels we believe that consultants should always be consulted over the decision to undertake a caesarean section except in the rare cases where immediate section is necessary. Although caesarean section is now a much safer procedure than it once was, we are concerned that some women undergo unnecessary sections on the recommendation of doctors who lack experience owing to the time limitations imposed by the New Deal and the European Working Time Directive on their training. This situation renders the process of auditing caesarean sections at individual maternity units all the more important as a form of training for junior staff as well as a means of ensuring that decisions made by consultants have been appropriate. We recommend that the forthcoming NICE guidelines on caesarean section should be supported by advice on audit procedures. (Paragraph 113)
19. Such variations in clinical practice, while they might not compromise a woman's safety, may affect her role in making decisions on the mode of delivery for her baby if she does not have access to information on the risks and benefits of caesarean section. We are not convinced that it can be justified for women to have a significantly increased chance of a major operation because of an individual consultant's judgement of the risks of caesarean against normal birth and we hope that the NICE guidelines will create a consistency of approach across the country. Although we recognise the sensitivity of releasing individual consultant data we believe this data should be given to all users together with national and local comparisons so that women are aware of their consultant's caesarean section rate. (Paragraph 122)
20. We strongly endorse innovative approaches to reducing caesarean sections which involve women in detailed discussion about their maternity care and help to raise awareness of the risks and benefits of the different kinds of intervention in labour. We believe that this involvement is key to a positive experience of childbirth and of maternity care, and that the development of strong relationships between women and well-trained, confident midwives is crucial. The information gathered from discussion of previous experiences could be vital to the development of maternity services, particularly in relation to caesarean section. We recommend that information from women on their previous caesarean section should be incorporated into audits. (Paragraph 136)
21. We are encouraged to hear that maternity care staff value NICE guidelines and evidence based on research commissioned by the Department as tools for developing strategies to reduce caesarean section rates and to increase 'normal' birth rates. We recommend that the Department continue to support research and evidence-gathering initiatives and in particular the work on caesarean section audit. (Paragraph 137)

22. Based on evidence we heard from maternity units, we see a relationship between high rates of caesarean section and low levels of staffing. It seems to us unacceptable that a woman should undergo a surgical procedure that might have been avoided had she been better supported during pregnancy and/or during labour. It is clear from strong evidence that one of the most important means of reducing the caesarean section rate is to provide adequate support for women in labour. The level of staffing and organisation of care should enable women to be supported at all times. (Paragraph 142)
23. We recommend that the Department research further how staff, including support staff, volunteers, and staff employed by voluntary organisations, could enhance maternity services and provide important links to other providers of postnatal care, such as health visitors. In particular, the use of voluntary breastfeeding counsellors and supporters to contribute to the education of a range of healthcare professionals and other workers should be considered. We further recommend that the NHS consider funding or sub-contracting to voluntary organisations which could support the provision of specific services such as breastfeeding support. (Paragraph 155)
24. Maternity care has always been a team effort but the professions involved seem to us to work together better and with more mutual respect than they did perhaps even ten years ago. However, in the majority of cases, GPs are also members of a woman's maternity care team as they presently provide a first point of contact with maternity services and offer advice on care. In some areas there is room for improvement in terms of communication and understanding between GPs and midwives who support births in the community and in the home. (Paragraph 158)
25. Depleted midwifery establishments and closures of maternity units are not conducive to the return of midwives to the profession. We recommend that the Department assess whether its strategy to encourage midwives to re-register for practice takes into account the extent to which these problems influence a midwife's decision to leave the profession in the first place. The Department also needs to understand why there is a high drop-out rate on some midwifery courses and take measures to reduce the problem. (Paragraph 175)
26. Evidence we heard throughout our inquiry has led us to conclude that it will be difficult to invest sufficient time to allow midwifery and medical staff to gain experience of normal birth but it is crucially important to the range of skills they practise and the quality of care they provide. We welcome the introduction of workforce planning tools and the drive to train and recruit more midwives. However, particularly in consultant units, some midwifery establishments are depleted to seriously low levels, as workforce planning tools have shown. In some units staffing cannot be reconfigured to compensate for shortages and where unit mergers or closures are poorly handled, staffing problems are compounded. Several witnesses told us that they had seen no evidence at all of Government initiatives to increase staffing levels. We recommend that the Department take steps to ensure that every maternity unit has the opportunity to use Birthrate Plus to make an assessment of minimum and optimum staffing levels. We further recommend that the Department ask PCTs and hospital trusts to review their investment in midwifery

and critically examine their caesarean rates. There needs to be adequate staffing to provide good quality maternity services. The Department also needs to review and renew its efforts to recruit, and bring back to practice, midwives. (Paragraph 178)

27. Given the positive effect of midwifery-led services on recruitment and retention we would urge PCTs and hospital trusts to do all they can to develop midwifery-led services and to be aware of the possible impact of closing units on staff morale, recruitment and retention. Given the general recruitment problem in the South of England and the high cost of living in these areas, we recommend that the Government assess whether the Agenda for Change proposals will tackle the geographic differences in recruitment that we have seen in our inquiry. (Paragraph 179)
28. Moves to implement the New Deal and the European Working Time Directive have already had a profound impact on the levels of experience that obstetricians gather as trainees and are already threatening the viability of maternity units which currently serve as consultant obstetric units. This might create welcome opportunities for the development of midwifery-led units for women with low-risk pregnancies but we are extremely concerned that women who experience complications in pregnancy and in labour should have access to skilled, experienced and confident obstetricians. We welcome the Department's work to assess the implications of the EWTG but are concerned that any action on this work will come too late for the current generation of trainee obstetricians, and indeed for those units threatened with closure. If the EWTG is to be implemented, more investment in training and recruitment of doctors is required so that adequate levels of staffing and levels of experience can be maintained. We are very concerned that the Government is not sufficiently aware of the difficulties the professions face on account of the European Working Time Directive. (Paragraph 192)
29. Women should be able to take time over their initial decisions on maternity care. It is important at this early stage in pregnancy that women should not be subject to any undue influence in relation to the type of maternity unit they are to choose. We recommend that national guidance be issued to support GPs in referring women for appropriate maternity care and in particular to clarify the role of the GP in relation to home birth i.e. that GPs do not need to take responsibility for this. We further recommend that the Government consider the idea of making the midwife rather than the GP the first point of contact for a discussion of maternity care choices. (Paragraph 199)
30. We agree that the issue of continuity of care is of crucial importance to women and families and we urge the Department to facilitate the sharing of good practice in configuring services to provide continuity of care-giver across the country. In particular, we recommend that the Department liaise with PCTs to promote the development of services based on one-to-one care. We would welcome the creation of midwifery networks to share examples of innovative practice in the primary care setting. We recommend that the Department issue guidance on standard definitions for one-to-one care, continuity of carer and continuity of care. (Paragraph 212)

31. We recommend that the Government should ask the appropriate bodies to commission a review of training for health professionals in maternity services. In our view all members of the maternity care team should receive training on and gain experience of normal births in a range of settings. Midwives play a crucial role in supporting normal birth. The Nursing and Midwifery Council should ensure that curricula, and practical experience elements of training allow student midwives to develop appropriate skills in the support of normal birth. All student midwives should undertake placements within a midwifery-led unit or birth centre, and with a team of midwives who assist at home births, and the Government should also encourage the use of midwives in educating junior doctors on normal births. (Paragraph 219)
32. We recommend that all midwives and doctors receive training together in emergency procedures, including the use of appropriate equipment. (Paragraph 223)
33. We recommend that a review of training programmes should emphasise the importance of skills in informing, advising and counselling mothers and families, and in promoting the development of bonds between parents and their babies. In particular, we recommend greater emphasis on support for breastfeeding. All newly-registered maternity staff should be aware of the special support needs of some families. (Paragraph 227)
34. Current training seems to us not fully to acknowledge the changed nature of maternity care today. We therefore recommend that steps should be taken promptly to ensure that the Colleges and the Nursing and Midwifery Council develop appropriate training on a multi-disciplinary team basis, including where possible the participation of such members of the maternity care team as physiotherapists and health visitors. (Paragraph 235)

## Appendix: Current situation in maternity services

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In March 2002 the Committee asked the Department of Health for an update on the current situation in maternity services in the context of its predecessor Committee's report (Second Report of Session 1991–92, Maternity Services, HC 29).

Information from the Department's update, on key current developments and on the main developments since 1991–92, is reproduced below.

### Key current developments

#### *Children's National Service Framework including maternity services*

The Children's National Service Framework (NSF) was announced in February 2001 in order to give children the best possible start in life and is expected to take about 2 years to develop. The aim of the NSF is to improve the lives and health of mothers, children and young people wherever they live through the delivery of appropriate, integrated, effective, evidence-based and needs-led services.

The maternity part of the NSF will help set national standards of care to cover antenatal, delivery and post natal services. To start the process a Maternity External Working Group (EWG) has been set up, and its Membership has been announced. The first meeting of the EWG was held in May 2002.

The EWG is being co-chaired by Heather Mellows the Junior Vice-President of the Royal College of Obstetricians and Gynaecologists and Meryl Thomas Vice-President of the Royal College of Midwives. The EWG members are drawn from a wide range of backgrounds including medical professionals, research experts and user group representatives.

The maternity module of the NSF will look at how to make maternity services more flexible, accessible and appropriate. We will be ensuring that general health education programmes stress the importance of contact with health services early in and throughout pregnancy. We will also be aiming to ensure more active follow-up of women who regularly fail to attend appointments and improvements in translation services. This will go a long way to address the inequality of access to services that face disadvantaged groups in society.

### ***The Maternity and Neonatal Workforce Group***

The MNWG was set up in February 2001 to consider workforce issues, staffing for the various models of care and configuration of maternity services. Its work will feed into the development of the NSF and includes representatives from:

The Royal College of Obstetrician & Gynaecologists

The Royal College of Paediatrics and Child Health

The Royal College Midwives

The Royal College GPs

The NHS Confederation

Primary Care Trust Chief Executives

The Maternity Services Liaison Committee Chairs

The National Childbirth Trust

The Maternity Alliance

### ***£100m Capital Investment***

£100m capital investment over two years (2001-02 and 2002-03) was announced last May, to modernise and refurbish over 200 maternity units across England. Every unit decided on their own local priorities for a share of this investment and bids were submitted after consultation with local parents, midwives, doctors and other staff.

This investment will help improve privacy for women and their families, provide better bereavement facilities, as well as facilities for fathers to stay if the baby is ill, and to upgrade and buy new equipment. The projects include structural alterations to some antenatal and post natal wards as well as delivery rooms to better suit local needs. Improvements are also being made to modernise showers/toilets to provide women with more home from home comforts.

A few projects have been completed and most are underway. All projects are expected to be completed around April 2003.

### ***Clinical Guidelines—National Institute for Clinical Excellence***

To order to improve the safety and well being of mother and baby the Department asked the National Institute for Clinical Excellence (NICE) to issue clinical guidance on:

*Use of electronic fetal monitoring*—these were issued in May 2001. The guidelines will help ensure that the technology is appropriately used and should result in a reduction in unnecessary caesarean sections and instrumental deliveries.

*Induction of labour*—these were issued in June 2001. The guidelines help to provide clinicians in maternity units with recommendations for safe practice and reduce variations in clinical practice.

*Anti D prophylaxis*—these were issued May 2002. NICE have recommended that pregnant rhesus negative women should be offered routine antenatal anti-D prophylaxis preventive treatment routinely (unless their blood already contains antibodies to the D antigen) This will help prevent Haemolytic disease of the newborn (HDN) which affects the fetus. HDN can range in severity from being detectable only in laboratory tests, through to stillbirth, birth of infants with severe handicaps or death of newborn children from anaemia and jaundice.

#### **Further guidelines from NICE are awaited on:**

*Use of caesarean sections*—Guidelines expected December 2003.

*Routine antenatal care*—Guidelines expected August 2003

The Department is in the process of considering the need for clinical guidelines on post natal and intra partum care in the next wave of guidelines.

#### ***Findings and recommendations of the United Kingdom Confidential Enquiry into Maternal Deaths***

Due to the development of sophisticated coding programmes with the Office for National Statistics (ONS), the latest CEMD Report published (December 2001 covering 1997-1999), has for the first time been able to more fully evaluate social and lifestyle factors that may have played a part in the woman's death.

The report shows that maternal death rates are the lowest ever, reflecting improvements in the standard of care and the implementation of recommendations made in earlier Reports. However the findings also show that maternal mortality rates amongst the socially excluded, including women from lower socio-economic classes, very young girls and minority ethnic groups, are higher than amongst the population as a whole. The findings in the Report will feed in to the development of the National Service Framework for Children

#### ***Increasing the number of midwives***

The Department is also investing to increase the number of midwives so that by 2006 there will be an extra 2000 midwives working in the NHS. There were 510 more midwives working in the NHS in 2001 than there were in 2000. We are investing in order to increase the number of training places for midwives and to encourage midwives to return to practice. From 1 April 2001 midwives undergoing return to practice training have been eligible to receive a sum of £1,500. This is in addition to the returners package of support which includes payment of course fees, and assistance with childcare support of up to £135 per week for one child and £200 for two or more children.

#### **Conclusion**

The majority of births continue to be uncomplicated, resulting in healthy outcome for mother and baby. The latest figures for infant mortality rates, perinatal mortality rates

and maternal deaths all show a continuing downward trend. It is therefore safer than ever before to have a baby. However, issues to do with the quality of women's experience of childbirth; and the conviction that more can be done within ante and post natal care and support to set new families off in a sound footing; and the need to find and resource new models of hospital obstetric care are the main drivers for the maternity module of the National Service Framework now being developed.

### **Main developments since 1991/92**

#### ***1992—Expert Maternity Group***

An Expert Maternity Group was set up in 1992, under the Chairmanship of Baroness Cumberlege, to review NHS maternity care including the role of professionals to ensure that the services offered women choice, continuity of care and control. The Group published its findings through the Changing Childbirth Report in 1993.

#### ***1994—Changing Childbirth Implementation Team***

The NHS began implementing the recommendations in the Changing Childbirth Report for a more women-centred maternity service in January 1994. The Changing Childbirth Implementation Team was set up in Cambridge by the Department to oversee implementation of the Report. It was initially set up to run for three years, but its existence was extended until it was finally disbanded in March 1998. The Changing Childbirth Team successfully promoted and supported high quality woman centred maternity care and there has since been significant progress in changing the experience of women during pregnancy and childbirth. A report detailing the progress and outcomes of the development projects funded as part of the Changing Childbirth Initiative was issued in August 1998.

#### ***1997—Audit Commission Report***

In March 1997 the Audit Commission published its Report "First Class Delivery: Improving Maternity Services—England and Wales". This was the first large-scale audit of the Maternity Services since the implementation of Changing Childbirth. The Report found that 90% of women surveyed were pleased or very pleased with the way they were treated during pregnancy and childbirth. This was a very strong endorsement of the Department's policy on maternity services.

#### ***The United Kingdom Confidential Enquiry into Maternal Deaths***

The United Kingdom Confidential Enquiry into Maternal Deaths, now in its fiftieth year was set up in 1952 by the Department of Health because of concern over deaths in childbirth. It is the longest running example of national professional self audit in the world, and it carries not only the support of all health professionals involved in maternity service provision in the UK but is held in very high regard internationally. It was run by the Department of Health until last year, but is now run by the National Institute for Clinical Excellence (NICE).

The present Director of the Enquiry is also currently helping India, South Africa and Israel to set up similar enquiries and she also acts as an expert advisor on maternal mortality for the World Health Organisation. Over the years its findings and recommendations have helped improve the health of pregnant and recently delivered women in the UK, as its findings are always incorporated into Government health policy.

The latest Report *Why Mothers Die 1997–1999* was published in December 2001 indicates a lowest ever rates. For the first time, it has also been able to access much wider data sources and undertake specific sub-enquiries, which have resulted in important messages for the wider public health. It provides a unique indicator of the impact that social exclusion, inequality and other issues may have on woman's reproductive health.

### ***Confidential Enquiry into Stillbirths and Deaths in infancy (CESDI)***

CESDI was established in 1992 with the aim of collecting and analysing data on deaths in late fetal life (involving foetuses at more than 20 weeks' gestation) and infancy (children up to one year) and to use the findings to reduce the risk of such deaths. The Report covers England, Wales and Northern Ireland (Scotland has its own confidential enquiry). CESDI is funded by the Department and managed by the Maternity and Child Health Research Consortium formed of the Royal College of Midwives, Royal College of Obstetricians and Gynaecologists, Royal College of Pathologists and Royal College of Paediatrics and Child Health. CESDI came within the overall remit of the National Institute for Clinical Excellence (NICE) from 1 April 1999

The findings of CESDI are important to both individuals and professional bodies. The messages are wide ranging and applicable to the entire spectrum of health workers, ranging from doctors, midwives, nurses and health visitors to coroners, and at times findings are particularly relevant to parents. All the professions represented on the CESDI consortium are signed up to implement its recommendations.

### ***April 1999—The National Institute of Clinical Excellence (NICE)***

In 1999 the Department issued Clinical Governance: Quality in the NHS which provides NHS organisations and health professionals with a framework for quality improvement. The National Institute for Clinical Excellence was set up to promote clinical and cost effectiveness through guidance and audit, and provide a single national focus for appraisal of significant new and existing clinical interventions.

### ***July 1999—Making a Difference: the nursing, midwifery and health visiting contribution***

Making a Difference: the nursing, midwifery and health visiting contribution was launched by the Prime Minister in July 1999. This outlines the Department's proposals to expand the role of the midwife to include more involvement with women's health and public health. This will assist with supporting women to give up smoking during pregnancy, the early identification and referral for postnatal depression or domestic violence, and the continuation of breast-feeding.

### ***January 2000 –National Sentinel Caesarean Section Audit***

To establish the reasons for the rise in Caesarean Section rates in recent years, the Department commissioned the Royal College of Obstetrics and Gynaecologists to carry out the first ever and biggest national Audit. In November 1999 Ministers asked NICE to issue clinical guidelines based on the findings of this multi-disciplinary sentinel audit. The findings of the Audit were published by the Royal College of Obstetricians and Gynaecologists in October 2001 and the NICE guidelines are expected in December 2003.

### ***The NHS Plan—July 2000***

The publication of the NHS Plan and record additional investment into the NHS by this Government since 2000 is helping to make further improvements in maternity services. The plan sets out a package of measures to modernise the NHS and includes plans to reduce long-term inequalities in child mortality and child morbidity. This involves high quality care during pregnancy and labour as well as improvements in obstetric, paediatric and midwifery services.

### ***February 2001—Children’s National Service Framework***

The Government announced in February 2001 that a Children’s National Service Framework would be developed which will include maternity service. It will set standards of care for antenatal, intrapartum and post natal care.

### ***May 2001—£100 million capital investment***

Last summer the Government announced a capital investment of £100 million during 2001/02- 2002/03 to upgrade and modernise over 200 maternity units across England to improve facilities and the environment in which maternity care is provided.

### ***May 2001—Extra midwives***

Last May the Department announced that, by the end of 2002, there will be an extra 500 midwives working in the NHS with an extra 2000 on the wards within the next five years. Latest figures show an increase of 510 in the last year and we are making very good progress towards meeting our 2002 target.

# Formal Minutes

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**Tuesday 3 June 2003**

Members present:

Julia Drown, in the Chair

Dr Doug Naysmith

Dr Richard Taylor

The Committee deliberated.

Draft Report (*Provision of Maternity Services*), proposed by the Chairman, brought up and read.

*Ordered*, That the Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 247 read and agreed to.

Summary read and agreed to.

An Appendix (*Current Situation in Maternity Services*) read and agreed to.

*Resolved*, That the Report be the Fourth Report of the Committee to the House.

*Ordered*, That the Chairman do make report to the House.

*Ordered*, That the provisions of Standing Order No. 134 (select committees (reports)) be applied to the Report.

Several papers were ordered to be appended to the Minutes of Evidence.

*Ordered*, That the Appendices to the Minutes of Evidence taken before the Maternity Services Sub-committee be reported to the House.

[Adjourned till Thursday 5 June at 10 am.]

## Witnesses

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### Thursday 6 March 2003

Page

**Professor Lesley Regan**, Consultant Obstetrician, **Ms Lynne Pacanowski**, Head of Midwifery, and **Ms Catherine Eccles**, Maternity Services Liaison Committee, St Mary's Hospital Paddington, **Ms Betty Larkin**, Midwifery Manager, **Ms Kay Barber**, Senior Midwife, and **Ms Selene Daly**, User Representative, Edgware Birth Centre, **Ms Cathy Rogers**, Consultant Midwife, Barnet and Chase Farm Hospital.

Ev 6

**Mrs Jennifer Fake**, Midwife, **Ms Marie Pearce**, Community Midwife, and **Ms Katy Waters**, User Representative, West Hertfordshire NHS Trust, **Mr Christopher Lees**, Consultant Obstetrician, **Ms Jane Hurley**, Senior Midwife, **Mrs Jen Ferry**, Head of Midwifery and Operations Manager for Women's Services, and **Ms Livia Mitson**, Patient Representative, The Rosie Hospital Addenbrookes NHS Trust

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### Thursday 11 March 2003

**Professor David James**, Fetomaternal Medicine and Lead Obstetrician, **Mrs Shona Ashworth**, Assistant Director, Nursing and Head of Midwifery, **Mrs Elaine Parker**, User Representative, and **Mrs Siobhain Hargreaves**, User Representative, University Hospital, Nottingham, **Ms Sheena Appleby**, Head of Midwifery, **Ms Helen Shallow**, Midwife Consultant, and **Miss Alison Fowlie**, Consultant Obstetrician, Derby City General Hospital.

Ev 29

**Mr David Redford**, Consultant Obstetrician, **Ms Catherine Smith**, Professional Development Midwife, **Ms Susan Breslin**, Women's Services Manager and **Ms Julie Ball**, User Representative, Royal Shrewsbury Hospital, **Mr John Watts**, Consultant Obstetrician and Clinical Director, **Mrs Toni Martin**, Head, Midwifery, and **Mrs Davidka Morris**, User Representative, Maternity Services Liaison Committee, Worcestershire Royal Hospital.

Ev 48

## Tuesday 25 March 2003

**Professor James Walker**, Obstetrician, **Mrs Ann Geddes**, Head of Midwifery, and **Ms Carol Burns**, User Representative, St James' Hospital, Leeds, **Ms Karen Fox**, Team Leader, **Ms Gill Smethurst**, Clinical Co-ordinator for Midwifery and Gynaecology, Scunthrope General Hospital and **Ms Philippa McEnroe**, User Representative, Goole Midwifery Centre

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**Ms Karen Connolly**, Head of Midwifery, **Dr Tracy Johnston** Clinical Director for Obstetrics and **Mrs Alex Silverstone**, User Representative, St Mary's Hospital for Women and Children, Manchester, **Ms Rosemary Connor** Head of Midwifery and Service Manager, **Mr Antony Nysenbaum**, Clinical Director, Obstetrics and Gynaecology, and **Ms Clare Hodgson**, User Representative, Trafford General Hospital

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## Tuesday 1 April 2003

**Mrs Donna Ockenden** Head of Midwifery, **Mr Christopher Guyer**, Clinical Director, Obstetrics, and **Ms Sue Creegan**, User Representative, St Mary's Hospital, Portsmouth, **Ms Peggy Hand**, Midwife and Clinical Leader, **Ms Margaret Wheatcroft**, Clinical Director, Maternity Services, and **Mrs Mandy Grant**, User Representative, Dorset Maternity Services Liaison Committee, Royal Bournemouth and Christchurch Hospitals NHS Trust

Ev 93

**Mr Rick Porter**, Clinical Director of Maternity Services, **Ms Helen Jones**, Maternity Services Manager, and **Ms Julianna Beardsmore**, User Representative, Royal United Hospital, Bath

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## List of written evidence

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3	West Hertfordshire Hospitals NHS Trust	Ev 16
4	Addenbrooke's NHS Trust	Ev 17
5	Queen's Medical Centre Nottingham University NHS Trust	Ev 27
6	Southern Derbyshire Acute Hospital NHS Trust	Ev 28
7	Lisa Cotton	Ev 28
8	Worcestershire Acute Hospitals NHS Trust	Ev 42
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13	Trafford Healthcare NHS Trust	Ev 74
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20	Miss Zoe Penn	Ev 126
21	Chartered Society of Physiotherapy	Ev 128
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49	Professor James Drife	Ev 219
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63	Association of Radical Midwives	Ev 258
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## List of unprinted written evidence

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Additional papers have been received from the following and have been reported to the House but to save printing costs they have not been printed and copies have been placed in the House of Commons Library where they may be inspected by Members. Other copies are in the Record Office, House of Lords and are available to the public for inspection. Requests for inspection should be addressed to the Record Office, House of Lords, London SW1. (Tel 020 7219 3074) hours of inspection are from 9:30am to 5:00pm on Mondays to Fridays.

Professor Beatrice Heuser

Mr J Halsey

Mr Martin England

Jean Hawkins

Georgina Lewis

Obstetric Anaesthetists Association

SSL International Plc

## Reports from the Health Committee since 2001

The following reports have been produced by the Committee since the start of the 2001 Parliament. The reference number of the Government's response to the Report is printed in brackets after the HC printing number.

### Session 2002–03

First Report	The Work of the Health Committee	HC 261
Second Report	Foundation Trusts	HC 395
Third Report	Sexual Health	HC 69

### Session 2001–02

First Report	The Role of the Private Sector in the NHS	HC 308 ( <i>Reply Cm 5567</i> )
Second Report	National Institute for Clinical Excellence	HC 515 ( <i>Reply Cm 5611</i> )
Third Report	Delayed Discharges	HC 617 ( <i>Reply Cm 5645</i> )





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