



House of Commons
Health Committee

Choice in Maternity Services

Ninth Report of Session 2002–03

Volume I



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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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Footnotes

In the footnotes of this Report, references to oral evidence are indicated by 'Q' followed by the question number. Written evidence is cited by reference to Appendices contained in volume II of this Report.

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1 Introduction

1. Introducing a House of Lords debate on maternity services in January this year, Baroness Cumberlege said:

Every woman is unique; every baby is unique; every birth experience is unique. That is why it is so important to give a woman and her partner choice: choice of place of birth; choice of style of care; and choice of professional who is going to accompany them in this unique and special journey.¹

2. The intervening years between *Changing Childbirth* and the debate in the Lords had witnessed many changes in society: more women were entering higher education; more were entering the professions; and more of them were single parents and sole wage earners. Yet, in the view of Baroness Cumberlege, choice remained “a luxury”.

3. Following the then Health Committee’s Second Report of Session 1991–92, an Expert Maternity Group chaired by Baroness Cumberlege, then Parliamentary Under-Secretary of State at the Department of Health, undertook a review of maternity services which made recommendations for reform through *Changing Childbirth* (1994). *Changing Childbirth* insisted that maternity care should be woman-centred and that choice, continuity and control should inform the development of services. One of the three main principles adopted by *Changing Childbirth* made the case for choice as an integral element of good quality maternity care:

The woman must be the focus of maternity care. She should be able to 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.²

4. The principles of *Changing Childbirth* were welcomed by many midwives, doctors and users of the service who, according to the Royal College of Midwives (RCM), had already been working towards a more woman-centred approach to care, a “remodelled maternity service based on the needs and wishes of those using it.”³ *Changing Childbirth* was adopted as Government policy in 1994, when an Implementation Team was set up, and pilot projects were established around the country. The RCM reported that some service providers responded rapidly to inform women about the choices they could make in terms of their maternity care.

5. In March 1997, the Audit Commission published its report *First Class Delivery—Improving Maternity Service—England and Wales* which was the first large-scale audit of maternity services since the implementation of *Changing Childbirth*.⁴ The Audit Commission found that national policy had focused on making maternity services more ‘woman-centred’: giving priority to information, choice and flexibility, ensuring continuity of carer, and listening to women’s views. As the Department noted, “90% of women

1 HL Deb, 15 January 2003, cols 267-68.

2 Department of Health, *Changing Childbirth: Report of the Expert Maternity Group*, 1993.

3 Royal College of Midwives Journal, vol 1 no 2, February 1998.

4 See www.audit-commission.gov.uk/publications.

surveyed were pleased or very pleased with the way they were treated during pregnancy and childbirth.”⁵

6. However, although many women were satisfied with the care that they had received, the Audit Commission reported that many women wanted more and better information about services and about options for care. The Audit Commission report indicated that information was particularly important in antenatal screening. During labour, the Audit Commission found that some women did not feel involved in key decisions. It recommended that trusts, managers and professional staff should provide the information that women needed to understand what was happening to them, including information on the options for pain relief.

7. At the RCM Conference on 2 May 2001, the then Secretary of State for Health, the Rt. Hon. Alan Milburn MP, announced a £100 million fund for maternity services which was intended to “ensure that pregnant women have more choice and access to improved maternity services.”⁶ He went on to assert that “choice for women cannot be there when there are shortages of midwives in too many parts of the country. Mr Milburn made an explicit link between choice in maternity services and the appropriate level of care which promoted healthy outcomes for babies:

Today I am setting a new ambition for the health service: modern maternity services as the foundation for giving each and every child in our country the very best start in life. Maternity services that give women and families more choice over the care they receive so that every child, regardless of background or circumstance, has the best possible start in life.⁷

8. On 12 December 2002, we appointed a Maternity Services Sub-committee, and the present inquiry into choice in maternity services is its final contribution. The Sub-committee announced this inquiry on 14 May 2003 with the following terms of reference:

The Sub-committee will examine the degree of choice and control a woman has over her maternity care.⁸

9. On 17 June we took oral evidence from representatives of the Association for Improvements in Maternity Services (AIMS), the Independent Midwives’ Association, the National Childbirth Trust (NCT), the Royal College of Obstetricians and Gynaecologists (RCOG) and the Royal College of Midwives (RCM). On 24 June, we took evidence from the Baroness Cumberlege and from Dr Stephen Ladyman MP, Parliamentary Under-Secretary of State for Community Care, Department of Health, and his officials.

10. In addition to these sessions we received 24 written memoranda from a variety of trusts, professional bodies, pressure groups and users which were invaluable in helping us form our conclusions. We are most grateful to all who presented written or oral evidence.

5 Health Committee, *Provision of Maternity Services*, Fourth Report 2002-03, HC 464, p 82.

6 Department of Health, Press Notice 2001/0212.

7 *Ibid.*

8 Health Committee Press Notice 23, Session 2002-03.

11. We also, once again, owe many thanks to our excellent advisers on this and our previous inquiries: Dr Susan Bewley from Guy's and St Thomas' Hospital, Professor Lesley Page from the Royal Free Hospital, Professor Alison Macfarlane from City University and Professor Martin Whittle from the University of Birmingham.

Defining Choice

Data on choice

12. It is extremely difficult to define the extent to which women have choice in maternity care. The Royal College of GPs noted in its submission that “little systematic data are available” about the extent to which choice is a reality.⁹ The Mother and Infant Research Unit at the University of Leeds has recently completed a survey of women's expectations and experiences of intrapartum care, focusing on issues of choice and control. The survey was based on a similar survey carried out in 1987. The survey concluded:

- There had been an overall increase since 1987 in the extent to which women felt that they had been able to make choices, in the extent to which they were involved in decision making and the extent to which they felt in control of what staff were doing to them in labour. The most important variable in feeling in control was being treated with respect and as an individual.
- Around 60% of women, however, did not feel always in control of what was being done to them.
- The general increase in feelings of choice and control had not yielded the improvement in psychological outcomes that might have been expected. This, the researchers postulated, might be because of the increased levels of obstetric interventions which were associated with poorer outcomes.
- Many women chose epidurals because they lacked confidence in their own ability to cope without. The proportion of women who were “very worried” about labour pain had increased from 16% to 26% of first time mothers.¹⁰

13. As part of its work to consider the modernisation of maternity services in the light of the *NHS Plan*, the Maternity and Neonatal Workforce Group (MNWG) commissioned a project led by Dr Tina Lavender, Reader in Midwifery at the University of Central Lancashire, to undertake a rapid assessment of women's and midwives' view of the range of options for place of antenatal care and birth. Dr Lavender's preliminary findings (from a survey of about 2,300 women) included the following indications of women's preferences in maternity care, expressed during the antenatal period:

- Little knowledge or understanding of home births. Only 8% had considered it and 50% were not offered a choice;
- 72% wanted local antenatal care;

⁹ Appendix 21, para 3.8

¹⁰ Appendix 18, para 2

- Around 68% were willing to travel for perceived higher quality of care during labour;
- Around 33% believed it was important to know in advance the midwife who helped them to give birth while 32% thought it unimportant;
- Around 64% stated that they would feel unsafe if a doctor were not immediately available during labour. After delivery, 45% of women felt this way;
- Around 75% stated that it was important to have a neonatal unit in the place where they delivered;
- 51% said they wanted 24-hour access to an epidural anaesthetic. After delivery the figure was 50%;
- 51% agreed that it was important for them to have a midwife who can support them to give birth without medical intervention.¹¹

14. Women perceived consultant-led maternity units to be busy, clinical and less personal, but they felt reassured by the availability of access to appropriate medical staff in case of an emergency. For many of the women surveyed, a midwifery-led unit on the same site as a consultant unit was believed to offer a more homely, but safe, environment. Dr Lavender attributed this to women's expectations and experience—lack of knowledge of the choices available, and perception of the safety of medical rather than midwifery-led care.

15. The MNWG, in its report to the Department of Health's Children's Taskforce, concluded that the forthcoming Children's National Service Framework (NSF) should seek further evidence on the views of women and their families about the different models of maternity care, including information on initial preferences, the 'real-life' choices which women and their families make, and how they feel about the services they receive.

16. The MNWG also called for more evidence on how women's views and preferences could be influenced by the services made available to them, by how health professionals presented alternatives to them, and by the "maternity services culture variations between NHS trusts." However, it insisted that "Good maternity care starts with the wishes of the woman herself, and her family, and aims to meet these as far as possible, whilst also ensuring the safety of both mother and baby. Different women will make different choices."¹²

17. Professor Dunlop for the RCOG told us that he "strongly supported" the idea of greater consumer research in maternity services which was an area he considered to be far too little researched.¹³

18. For most women, giving birth is a normal physiological process, not an illness. It is not clear to us that the usual methods the Department employs to measure the effectiveness of services (which must inevitably focus on clinical outcomes) are

11 The Maternity and Neonatal Workforce Group, *Report to the Department of Health Children's Taskforce*, January 2003, Annex B.

12 The Maternity and Neonatal Workforce Group, *Report to the Department of Health Children's Taskforce*, January 2003.

13 Q 66

necessarily the most appropriate for maternity services. We also note the surprising paucity of evidence in this area, given that over half a million births are recorded by the NHS each year. So we would welcome the Department commissioning some more research on the fundamental needs, wishes and concerns of women in this area to gain a better picture of what women think about maternity care but also to see how they would respond to different lead carers and different birth settings.

An illusion of choice?

19. There is a danger, as our inequalities report would suggest, that choice in maternity services is really a choice for the articulate middle classes. Maggie Elliot, Director of Midwifery and General Manager at Queen Charlotte's and Chelsea Hospital also maintained that emphasis on choice for some women created barriers to access for others:

It can be quite difficult sometimes to provide specialised services for women who cannot speak up because the women who can speak up demand them. It is sometimes going against the political climate that is going on at the time.¹⁴

20. However, the Disabled Parents Network indicated that choice and services for disadvantaged groups were not mutually exclusive concepts. The organisation argued that:

Disabled women are not always given the same choices as other parents, for example, decisions about the type of birth or anaesthesia and mode of delivery are taken by professionals without adequate discussion with the woman or her partner. Informed choice is often not an option for disabled women due to assumptions and decisions made by professionals.¹⁵

21. Diane Jones from Newham Healthcare told us that while making choices and participating in decisions was “quite an alien concept for some women” at the outset of care, it was possible to develop an understanding which would allow women to become involved in their own maternity care choices:

When you first meet with them and expect them to make choices and decisions about what tests they may want to have or how to feed their baby, it may be quite a new concept when they have never made those types of decisions for themselves in the first place ... when you do have a midwife who is part of your care all the way through, that is something that can be developed and encouraged as you go along and she might have an understanding of what we mean by wanting to empower her, to give her responsibility for her care.¹⁶

22. Even for women who are not disabled, the extent to which choice is a real choice was questioned by several of our witnesses. Asked if she thought that the opportunities for choice for women had improved over the last ten years, Beverley Beech, Chair of the Association for Improvement in Maternity Services (AIMS), replied:

¹⁴ Health Committee, *Inequalities in Access to Maternity Services*, Eighth Report 2002-03, HC 696, Q 100.

¹⁵ *Ibid.*, para 204

¹⁶ *Ibid.*, Q 129

Absolutely not. Choice is an illusion. The majority of women are conned into thinking that they have a choice. What they have is a specific menu that is offered them. If they choose within that menu, that is fine. If they choose outside that menu, they have an enormous battle to get what they want.¹⁷

23. Belinda Phipps for the NCT thought that the threat of litigation created a culture of fear and defensive medicine which made trusts “nervous” and made them fail to provide “objective” information:

From a woman’s point of view, we worry hugely when there is an apparent feeling of choice but actually the information is not being provided. I think there is some evidence that the fear of litigation may bias what is made available to women so that women have informed compliance rather than informed choice.¹⁸

24. As Louise Silverton of the RCM told us, choice can be difficult to define: “some people may say, ‘choice is you choosing what I offer you’”.¹⁹ Choice is clearly only genuine, meaningful and beneficial if women and their families have appropriate and unbiased information available to them to help them to make informed choices. At what stage they receive this information, and in what circumstances, is also crucial to the process of informed decision-making. There is an important distinction between a clinician advising one course of action and the reasons for and against it and recommending that action, and setting out a choice of actions and the advantages and disadvantages of each and leaving a woman to make the decision. Adopting the latter approach would reinforce women-centred care and might discourage legal claims because it would be clearer that any action was the choice of the woman rather than the clinician.

25. We note the Leeds University research which suggested that high levels of intervention in care had militated against better psychological outcomes being achieved as a consequence of greater choice. The Department needs to ensure that women are given a genuine and informed choice, and not the illusion of choice that some of our witnesses suggested was currently the case.

17 Q 61

18 Q 26

19 Q 8

2 Choice of who should provide care

26. As we noted in our first inquiry, maternity care teams work in a range of settings: consultant units, GP units, midwifery-led units, community units and in mother's homes.²⁰ However, the vast majority of babies (96%) are delivered in consultant units. In our earlier report we echoed our predecessor Committee who in 1991 said that "the policy of encouraging all women to give birth in hospitals cannot be justified on the grounds of safety".²¹ Those who try to shift services to other settings find themselves having to tackle huge barriers.

27. Currently, for the vast majority of pregnant women, the first point of contact for accessing maternity services is their GP. However, we were told by many witnesses that GPs, although they could play a valuable role in a woman's maternity care, were not always fully versed in the different options for care available to pregnant women, and so frequently referred women directly to a consultant unit. This, in effect, curtailed choice for women experiencing a normal pregnancy who might prefer to be cared for through an NHS midwife-led programme in the community, an option which might enable them to give birth at home or in a stand-alone birthing centre.

28. **We were also concerned to hear that some women found it hard to access maternity care without a referral from a GP. We advised the Minister that even NHS Direct was not giving correct advice to callers on how to access maternity services suggesting that the only route was via a GP. We would expect this advice to be updated.**²² If a woman wants or needs to be cared for in an acute hospital setting, she should also be offered a choice of different acute units since, as our previous inquiry demonstrated, the type of care a woman is likely to receive can vary greatly from hospital to hospital, and even between different consultants in the same unit.

29. The difficulty in effecting a culture change was encapsulated in a memorandum submitted by Elizabeth Key of Preston Lancashire. Ms Key explained to us she was writing in an individual capacity since the organisations she was representing—the North West Lancashire Maternity Service Liaison Committee (MSLC) and Preston Community Health Council (CHC)—had either been abolished or were about to be abolished. Ms Key's MSLC arranged for a local group of midwives and mothers to draft a short pamphlet setting out information on maternity services for distribution to pregnant women. The health authority would not fund its production but eventually local CHCs met the bill, which was under £400. None of the local Primary Care Trusts (PCTs), according to Ms Key, would support the leaflet. Ms Key told us they were "not happy" with the wording but were unable to supply "specific examples or alternatives".²³ Only one out of four local maternity units was prepared to issue it: this unit agreed to supply a copy of the leaflet to every mother booking there.

20 *Provision of Maternity Services*, paras 12-20.

21 *Provision of Maternity Services*, para 16.

22 Q 125

23 Appendix 10, para 2.2

30. We ourselves were supplied with copies of the leaflet, *Choices for Maternity Care*. The leaflet is short and seems to us factually accurate. We can only surmise that the units and GPs might have objected to the way the leaflet encourages home birth as a “safe” option for women with uncomplicated pregnancies, and describes consultant led care as a choice “especially suitable for women with particular health or pregnancy related problems”.

31. Clearly we have only heard one side of this story and we would not want to apportion blame to units or GPs for not circulating the pamphlet without knowing their reasons. What we can say is that the organisations supporting the choice pamphlet are now disappearing, and that whatever the rights and wrongs of the matter, it is clear that local staff and patient groups were not able to co-operate and reach a consensus. **For our part, we do think it appropriate that women should be encouraged to contact midwives as their first port of call and to at least be aware of their right to have a home birth without seeking “the GP’s permission”. This could be done by ensuring all GP receptionists and hospital units know of the appropriate midwife to refer women to, by notices in GP practices advising women on how to contact midwifery services directly and by local telephone directories having a contact for midwifery services.**

32. Witnesses told us of their concern that, with PCTs now responsible for commissioning the majority of healthcare in England, these bodies lacked representation from midwifery or obstetrics.²⁴ The RCM told us that the “limited understanding” of maternity services within PCTs was a “major concern”.²⁵ Belinda Phipps for the NCT felt that PCTs were unlikely to be orientated to dealing with maternity issues:

I wonder whether we would be better to have something like a midwifery trust, a virtual body, where the board is focused on midwifery, where there is a director of midwifery in the place of a director of nursing, looking after the services that are located out there.²⁶

33. In addition, there are few places where there is midwifery representation at Trust Board level. Thus there is very little visibility for central issues relating to maternity. Yet maternity care is different in nature to general health care. The majority of patients looked after in general acute trusts are chronically or acutely ill, whereas pregnant and labouring women are usually perfectly well. Offering care to women from a separate organisation devoted exclusively to maternity care would reinforce the message that pregnancy and birth are normal life events rather than illnesses, and may help counter the medicalisation of birth we have heard described. We would however be wary about suggesting more organisational change such as the setting up of new maternity trusts but we were attracted by the model in Bath where maternity services are run via the community PCT rather than the acute trust. In this regard, it is interesting to note the example of the Netherlands where around 40% of women give birth without ever having seen a specialist obstetrician since so much care is rooted in sophisticated systems of primary care.

34. Running services from the PCT might make an appropriate division of care between primary and secondary care more likely. They would fit well into the PCT agenda of public

24 Q 4 (Beverley Beech)

25 Appendix 3, para 4.1

26 Q 6

health and reducing inequalities. We would expect PCTs to operate a primarily community-based service, with the majority of women expected to receive their antenatal care in the community, and their intrapartum and post natal care in a birthing centre (either attached to secondary care provision, or stand-alone) or at home. It could manage secondary maternity care for women who experience complications, and have access to 24 hour cover for obstetric or paediatric emergencies.

35. Whether in an acute trust or PCT we would encourage managers to ensure sufficient attention is given to maternity issues. Our evidence suggests action is needed in many areas to achieve this. It may be that whilst maternity care is predominantly located in acute units, the community aspects of services and the voice of midwives will never be heard equally to the medical and acute parts of the service. We can see how much easier it would be for users to approach a PCT to recommend shifting beds from an acute unit to the community – or to replace beds with a home birth service, so we would recommend PCTs having the power to take over maternity services where they feel their communities’ needs are not being met.

36. In order to make an informed choice over what maternity services to use, women need to be made fully aware of the different options open to them, and be given helpful information about the advantages and disadvantages of each, from their very first contact with a health professional. They should be given written as well as verbal information, time to consider their options fully, and opportunities to discuss areas of uncertainty with health professionals and to visit units and meet staff, before making a choice. Given the time constraints most GPs work under, it does not seem realistic to expect them to provide such intensive and specialist support to pregnant women, and it seems obvious that community midwives would be better placed to provide this sort of support to women, working in conjunction with GPs and obstetricians. Women should not be under pressure to decide on where to give birth early in their pregnancy.

37. We therefore recommend that, as part of the Children’s NSF, the NHS should ensure that each pregnant woman has at least one initial ‘booking appointment’ with a community midwife who has in-depth knowledge of local services, and who has received special training to help newly pregnant women with this type of decision-making. Women whose first contact is with their GP should be referred automatically to a community midwife.

38. The Nursing and Midwifery Council observed that independent midwives found it “increasingly difficult to continue caring for a woman who has been transferred into a maternity unit”, deprecating the policy of maternity units assigning other midwives, usually unknown to the woman, to her on entry to the unit.²⁷ King’s College Hospital NHS Trust contracts with an independent midwifery practice, the Albany Practice in Peckham. The Albany Practice, which has been mentioned as a centre of excellence by witnesses in all our inquiries, does contract with independent midwives, but its practice here is very much the exception, not the rule.²⁸

27 Appendix 15, para 7

28 Q 38 (Louise Silverton)

39. The Independent Midwives Association argued that the current hegemony of the medical model of care in maternity, where the bulk of activity takes place in hospitals, involving women first referred by their GP, could only be overturned by radical measures. It suggested moving toward the model of care used in New Zealand whereby midwives operate as independent contractors, much the same way as most GPs, dentists and opticians do in the UK, and are paid a set fee per woman.²⁹ In New Zealand it is estimated that approximately half of all pregnant women use an independent midwife. The Netherlands, which has the highest home birth rate in Europe, uses a similar system of independent contracting with midwives. However, the health systems in New Zealand and the Netherlands differ substantially from that in England.

40. We feel that calls for extending the independent contractor model to encompass all NHS midwifery practice would not be so vociferous if NHS community midwives were properly supported to use their professional skills in accommodating the choices of individual women. We would expect that giving community midwives a stronger role in maternity care would share the advantages put forward by independent midwives, particularly in recruitment and retention. But achieving this stronger role may not be easy. It may be that the option of independent midwifery would work well and the Department or individual PCTs, particularly those where choice is currently limited for women, may want to pilot this approach as an addition to current services.

41. Whether or not such a model is adopted, women who choose to employ and pay for an independent midwife should not face difficulties in using a trust's facilities, and trusts and local independent midwives should be expected to forge good working arrangements. All trusts should ensure they have established arrangements for using independent midwives where they are paid for by the woman, where they face staff shortages or where they cannot meet individual women's wishes, for example for those areas which do not support homebirths, water births or a higher risk birth where a woman makes an informed choice to avoid intervention. The Department must ensure that Trusts can access appropriate insurance cover in these circumstances.

42. We recommend that the Government uses the opportunity presented by its forthcoming NSF as an opportunity to recast maternity services to the advantage of both women and their carers. We feel that the current delivery of maternity services, which is generally led by acute general hospitals, over-medicalises birth. Through the NSF, PCTs should be given a lead role in ensuring there is choice and community-led services for women, wherever they live.

29 Appendix 7, para 20

3 Choice in where care is provided

A postcode lottery?

43. According to the Association of Radical Midwives and AIMS, choice for women in maternity services depended to a large extent on where they lived. In a few areas women had access to “primary level models of care” such as the Albany Centre, or the Sheffield One to One caseload service, or the Torbay centre where a supportive manager was in charge of a team of skilled, dedicated one to one midwives.³⁰

44. Rather less than 2% of births currently take place in free-standing birth centres. In the view of the Birth Centre Network, this is partly because such centres have arisen unsystematically, meaning that coverage is very patchy. Only around 57 birth centres exist in England, and large parts of the country have no access to such centres at all. Access to such centres seems likely to reduce further, according to the Birth Centre Network UK: a number of centres are now under threat of closure, such as The Malmesbury Unit in Wiltshire or three units around the Scarborough consultant unit, those at Malton, Bridlington and Whitby.³¹ Yet a good deal of research validates the suggestion that community-based intrapartum care of healthy women results in lower rates of analgesia, lower rates of caesarean section, makes women feel more in control and generally results in a better experience of birth.³²

45. The NCT pointed out that women in London had access to only one free-standing midwifery unit, the Edgware Birth Centre in North London. While a second is planned for the Central Middlesex Hospital, which is in North West London, even in the capital most women cannot choose to give birth in a free-standing midwifery unit.³³

46. The Nursing and Midwifery Council acknowledged that the NHS had made “great strides” in meeting women’s requests for more personalized maternity services but felt that much more could be achieved by a fundamental shift in philosophy. They contended that the dominant perspective currently was one of “normality in retrospect”, that is to say an approach favouring the detection and anticipation of problems before they arose. Such an interventionist culture went hand in hand with the majority of maternity services being based in acute settings.³⁴ Midwives were trained to treat birth as a normal, physiological event for the majority of women, but such an approach was inimical to the “problem orientated” acute settings where so much care was delivered. The Council called for cost-benefit analysis to be conducted on maternity units based in acute settings as against birth centres and home births.

47. We asked the Department what steps they could take to ensure the viability of community services. Dr Ladyman told us that the configuration of services was a matter

30 Appendix 2, para 1.2; Appendix 4, para 24.1.

31 Appendix 11, para 4.3.

32 See Cochrane review cited in *Ibid.*, para 5.4.2.

33 Appendix 5, para 2.4 (ii).

34 Appendix 15, para 4.

for local trusts and Strategic Health Authorities to determine.³⁵ Catherine McCormack, midwifery adviser to the Department, explained that one of the reasons that these units closed was because they were “under-utilised”.³⁶ As part of the reconfiguring hospitals project the Department was looking at ways of marketing the service to women to ensure greater uptake. We believe that it is equally important to inform GPs about the benefits and safety of community based care.

48. The most fundamental reason for the closure of so many birth centres is that there remains broad faith in the notion of centralised services as being safer and more cost effective. Like our predecessor committee we have not seen any evidence to support such a stance. It is not only birth centres that have been under threat: a number of midwifery developments were closed, for example the BUMPS project in Leicester, despite evidence of good outcomes. One problem may be that such schemes and centres are closed because they are an identifiable part of the budget and can easily be lopped off, a point Baroness Cumberlege made in evidence to us.³⁷ **We accept that local configuration of services is a matter for local determination but given that pregnant women are not able to travel long journeys to give birth, if midwife led units are not available local choice is severely constrained.**

49. **In costing proposed closures the Department should ensure that local health services take into account the full and long term costs and benefits of the services being considered, including the likely impact on the recruitment and retention of midwives, on breastfeeding rates, postnatal depression rates and reduced intervention and caesarean rates which these units tend to achieve. We believe, as did our predecessor committee, that there should be a presumption against closure of smaller maternity units because without them the shift in attitude which they wanted and we want to see will be very much harder to deliver.**

50. **We believe that our recommendations above, calling for a shift towards midwife bookings, greater autonomy for midwives in delivering services and sufficient priority given by trusts to maternity issues would reverse the worrying medicalisation of birth reported to us.**

Home birth

51. For normal low risk women, research shows that home birth is as safe as hospital birth and results in less intervention and less morbidity for mothers and babies. At the RCM Conference on 2 May 2001, the then Secretary of State for Health, the Rt. Hon. Alan Milburn MP used the availability of home birth as an example of the iniquities which limited choice in maternity services:

In some areas home births are widely available to women; in others they are not. Our standard must be an end to the lottery in childbirth choices so that women in all

35 Q 136

36 Q 136

37 Q 106

parts of the country, not just some, have greater choice including the choice of a home birth.³⁸

52. We support the Secretary of State's policy goal of making home birth more widely available but are disappointed that nothing has been done directly by the Department to achieve this over the two years since his statement. It may be that it is expected that the NSF will achieve this and if so we would welcome that but we believe action could have been taken on this independently of the NSF.

53. Currently around 2% of births are home births. While this is broadly comparable with the figures in other socio-economically comparable countries it is hugely below the highest rate in Europe, that prevailing in the Netherlands which has for many years recorded a home birth rate of around 30%.

54. What the figure for home births in England does not reveal is the amount of unmet need amongst women who want to have home birth but feel they do not have the opportunity to do so, and those who are wrongly advised against home birth on spurious grounds. Dr Tina Lavender's study, cited in paragraph 13 above, indicated that half of the women surveyed had not even been given the option of a home birth.

55. Little robust evidence exists to quantify the extent of unmet need. Beverly Beech, Chair of AIMS, referred to a study conducted in York some time ago which suggested that around 20% of women would choose home birth if given "free choice".³⁹ She maintained that there were trusts in England who "really vigorously oppose home birth".⁴⁰ Further, she felt that many GPs were "woefully under-informed about home birth". The RCM cited a more conservative estimate from an NCT survey which indicated that around 20% of women would at least like more information so as to be able to consider the option of home birth. A further indication of the potential for greater uptake of homebirth is the very wide geographical variation in home birth statistics, which range from 0.3% to 6.1% of maternities resident to health authorities.⁴¹

56. Belinda Phipps for the NCT suggested that home births were not "well integrated" into the NHS. According to the NCT, some GPs were opposed to birth at home.⁴² While the NCT contended that, overall, booked home births involve *less* midwifery time than those in hospitals and were only half as likely to involve caesarean section, in their view home birth was still often regarded as a luxury, "add on" service. They noted that the Chelsea & Westminster Hospital had recently suspended its home birth service.⁴³

57. Some support for the notion that the Department did take the view that home birth absorbed greater resources than consultant units came in remarks that Dr Stephen Ladyman MP, the newly-appointed Minister with responsibility in this area, made to us:

38 Department of Health Press Notice 2001/0212.

39 Q 16

40 Q 16

41 *Provision of Maternity Services*, p 11.

42 Appendix 5, para 2.4 (i).

43 *Ibid.*

If I put my sort of managerial hat on—and I will be brutally honest here, so do not leap down my throat when I say this—but if I was responsible for service in one of those areas of London where we have approaching a 15 per cent vacancy rate for midwives, I might, as a manager, be thinking to myself; it is going to be pretty damn difficult to offer home births as a routine in this area and my priorities might have to be somewhere else initially until I can deal with the midwife recruitment issue in my area.⁴⁴

58. This view which is shared by some in maternity services is not backed by any evidence presented to us. Indeed promoting a home birth model may aid rather than detract from the recruitment of midwives. If one to one care is to be achieved in labour it should make little difference whether that care is provided at home or in hospital, but there does need to be a political will to give this choice for women. It may be that it is necessary to try and build up a critical mass of home birth numbers in each area by promoting this choice in order for services to become just as easy to organise for women at home as they are in hospital.

59. AIMS suggested that trusts would typically present obstacles in the path of homebirth. They would indicate to women that it might not be possible to supply a suitably trained midwife when the labour commenced:

The commonest classic ploy is to inform the woman towards the end of her pregnancy (usually around 36 weeks) that the staff cannot guarantee, or will not be able to supply, a midwife because of staff shortages, with hints that she would be “selfish” to try to take the midwife from the labour ward. It has now become a game of brinkmanship, with women supported by us hanging on and informing the Trust that they will give birth at home, come what may, and will hold them responsible if they fail to supply care. We deal with at least one such case a week and often more. In the end a midwife is invariably supplied, but by now she is seen by the woman as representing a domineering, antagonistic system, which does not understand or support normal birth.⁴⁵

60. We regard this treatment of women particularly at such an important stage of their pregnancy as wholly unacceptable. If trusts have staff shortages they should call on the services of agency staff and independent midwives so that women in hospital and at home do not have to face the prospect of not being properly supported in labour. The Department should ensure that via a fast-track complaint or other procedure women experiencing any pressure like this should have an immediate source of help for the situation to be resolved without delay.

61. In the view of AIMS, many midwives lacked the confidence or experience to carry out home births. They told us that the NHS insisted on entry to hospital for some women who were judged to be at risk. This has resulted in some very high risk women labouring and giving birth alone at home. Sometimes they have not even had their partner present for fear that he will be threatened with prosecution, even though the law does not allow for

44 Q 149

45 Appendix 4, para 22.4.

such a prosecution. This is of huge concern and emphasises the importance of providing adequate midwifery services in the place of a women's choosing, even if that is not the place of birth that the relevant professional would advise.

62. Another issue sometimes cited is the requirement of some trusts to have a second midwife in attendance for home births. Usually a second professional attends for second stage or near the time of birth: this may be a midwife or doctor so that there is at least one person who has neonatal resuscitation skills who can support the baby if needed while the other staff member supports the mother. Louise Silverton from the RCM told us that a second pair of hands would not have to be a fully trained midwife. This model is adopted in the Netherlands where a maternity care assistant supports a birth and often goes on to support a family with postnatal care.⁴⁶ Even allowing for the second person at the second stage of birth where that is needed, the well recognised workforce planning tool Birthrate Plus shows that overall booked home births involve less midwifery time than hospital births because they tend to be quicker and involve fewer interventions.⁴⁷

63. Although some independent midwives always practice in pairs, many support home births without a second midwife or assistant as they work with the woman's birth partner(s). This is consistent with Nursing and Midwifery Council rules. Where they do practice alone, independent midwives would always have a 'back-up' – a midwife who would be available, if needed, to attend a long or difficult labour.

64. Rather than perceiving home births as a potential drain on scarce resources we see them as a gateway to promoting normal birth and a spur towards midwife recruitment and retention. We endorse AIMS' recommendation that all trainee midwives should be obliged to attend a minimum of three home births as an essential part of their training. We believe that this would help tackle prejudice against home births amongst health professionals, But we also believe it would be very beneficial if GPs and consultant obstetricians attended a similar number of home births to give them insights into the process and to provide for a more informed and rational debate.

65. Home births, we believe, would be far better supported if there was a general principal of continuity of carer, an issue we raised in our first report but reiterate here.

66. There may be scope for creating the post of maternity assistant to help deliver services in the community. Such a person could also assist in the role of educating and informing pregnant women and in neonatal and postnatal support in areas such as breast feeding as happens in Hythe, Hampshire and Lymington.

Choice in consultant units

67. Many women will want to proceed with births in consultant units. Dr Lavender's study indicated that the majority of women liked to have a doctor in immediate attendance and around half wanted immediate access to epidural anaesthetic. However, a decision to opt for care in a consultant unit should not, in our view, curtail a woman's right to choose the most appropriate setting.

46 Q 21

47 For information on Birthrate Plus, see *Provision of Maternity Services*, para 159.

68. If a woman wants or needs to be cared for in an acute hospital setting, she should also be offered a choice of different acute units where this is practical. As our previous inquiry has shown, the type of care a woman is likely to receive can vary significantly from hospital to hospital, and even between different consultants in the same unit. That inquiry recommended that individual consultant data on, for example, the caesarean rates of different consultants, together with national and local comparisons, should be given to all users.⁴⁸

69. Professor Dunlop, for the RCOG, thought there would be “no problem at all” with such a recommendation provided that the data took account of the different case mix of units, and we accept that this is an important requirement.⁴⁹

48 *Provision of Maternity Services*, para 122.

49 Q 42

4 Choice in how care is provided

70. Each year over half a million women give birth in England. For most women, being pregnant and having a baby are ‘normal’ experiences, that is to say they do not involve medical procedures. The WHO estimates that between 90 and 95% of births worldwide are normal. Yet within England “only about half of women (53%) had a spontaneous labour and delivery, without induction, the use of instruments or caesarean section”.⁵⁰ What makes this last statistic even more depressing is the figure has steadily fallen from 63% in 1991-92, around the time of our predecessor Committee’s inquiry and *Changing Childbirth*.⁵¹

71. *Changing Childbirth* identified ten indicators for success, all of which can have an influence on informed choice in maternity care:

- All women should be entitled to carry their own notes;
- Every woman should know one midwife who ensures continuity of her midwifery care— the named midwife;
- At least 30% of women should have the midwife as the lead professional;
- Every woman should know the lead professional who has a key role in the planning and provision of her care;
- At least 75% of women delivered in a maternity unit should know the person who cares for them during their delivery;
- Midwives should have direct access to some beds in all maternity units;
- At least 30% of women delivered in a maternity unit should be admitted under the management of a midwife;
- The total number of antenatal visits for women with uncomplicated pregnancies should have been reviewed in the light of the available evidence and the RCOG guidelines;
- All front line ambulances should have a paramedic able to support the midwife who needs to transfer a woman to hospital in an emergency;
- All women should have access to information about the services available in their locality.

72. Of the ten indicators of success identified in *Changing Childbirth* all of which can have an influence on informed choice in maternity care, our evidence would suggest that significant but not complete success has been achieved with three of them: on women holding their own notes; on the number of women delivered in maternity units being admitted under the management of a midwife; and on reviewing the number of antenatal

⁵⁰ Appendix 3, para 3.3 (RCM).

⁵¹ *Ibid.*

visits for women with uncomplicated pregnancies. The latter is expected to be reinforced by NICE guidelines.

73. There has been some progress with another two indicators: midwives having direct access to some beds in maternity units (but certainly not in all the ways envisaged by the report); and on information available to all women about local services (but here there is still a significant way to go to achieve good practice nationally).

74. Our inquiry did not cover ambulance services which is covered by one of the indicators and the remaining four were about continuity of care and the lead professional for maternity services. There is still a long way to go to achieve the real continuity of carer envisaged by the report of ten years ago and we hope our report will help to achieve this.

75. The key issues affecting choice in the clinical delivery of care are rooted in two extremely different models of provision. The most highly medicalised pregnancies might involve a series of separate scans and tests, induction of birth, electronic monitoring of the fetus during labour, use of analgesia such as epidural anaesthetic and then, in almost a quarter of cases, a caesarean section. In contrast, the most ‘normal’ births would eschew scans and tests, avoid fetal monitoring, make no use of analgesia and favour vaginal birth wherever possible.

76. The tension between these two models of care ripples through the evidence we have received in this inquiry. While it is fair to say that the majority of the submissions we have received in this inquiry have argued for a shift away from the first model of care towards the second—and indeed such an approach was sanctioned in *Changing Childbirth*—it is equally pertinent to point out that most maternity care in England today much more closely follows the medical model of care.

Scans, tests and procedures

77. According to the Department, all women will be offered at least one ultrasound scan usually from 10 weeks onwards, “to check the size and age of the fetus”.⁵² Besides this, women are “usually offered a range of screening tests to establish whether the baby is developing normally”.⁵³ These might include:

- serum screening, used to assess the risk of Down’s syndrome and spina bifida (usually offered at 15 weeks onwards);
- amniocentesis, also offered from 15 weeks and used to detect chromosomal abnormalities such as Down’s syndrome – this test involves a risk of miscarriage so is normally offered to “those women at a higher risk of having a Down’s syndrome baby if a woman’s serum test was screen positive”; when there is a family history of chromosomal abnormalities; or when abnormal findings have been picked up on the utrascan;

⁵² Appendix 1, para 2.3 (Department of Health).

⁵³ *Ibid.*, para 2.4.

- chronic villus sampling, offered between 11-14 weeks to detect some inherited disorders such as Down’s syndrome, sickle cell anaemia and thalassemia – this has a higher risk than amniocentesis of miscarriage so “is only offered to women whose babies are at risk”.⁵⁴

78. The Department suggested “a woman can choose whether she wants the tests” but according to the NCT too little is made of their optional nature. Moreover not all tests are available through the NHS in all areas. So nuchal translucency screening for Down’s syndrome is available in some but not all areas.⁵⁵ **The NCT also told us that miscarriage rates following invasive testing are also reported to vary significantly. Echo, the fetal heart charity, also pointed to an inequality in the detection rates of congenital heart disease through ultrasound screening from 3% to 68%. The Department should investigate and take action if there is such a variation.**

79. For Caroline Flint, a former president of the RCM, former adviser to our predecessor Committee in 1991 and the Director of a Birth Centre, screening was a sign of “the desire to complicate pregnancy”:

It sometimes appears to be the role of modern antenatal care to make women anxious. A whole industry has grown up around ultrasound scanning – which has yet to be shown to have any clinical benefits at all (despite the millions of pounds we must be spending as a country on this process), women are told that there are cysts in the baby’s brain (may or may not mean anything), golf balls in the baby’s heart (may or may not mean anything) etc. etc.⁵⁶

80. Ms Flint noted that mini glucose tolerance tests are carried out on nearly all women going through London hospitals despite the fact that “this has specifically been cautioned against by the National Perinatal Epidemiology Unit”. She concluded that such screening was part of the “over-medicalisation” of birth which ultimately damaged the key relationship between mothers and midwives.⁵⁷

81. Anne Francis of the Independent Midwives’ Association offered some support for the view that tests could lead to a spiral of intervention when she reported anecdotal evidence that the removal of routine admission trace use of cardiocographs in labour at St George’s Hospital Tooting had resulted in a substantial reduction in caesarean rates.⁵⁸

82. We do not believe that simply making tests available is in itself an extension of choice. Testing and screening sometimes inhibit rational choice and sometimes encourage higher levels of intervention. We recognise that many women will want to have the tests available and support them in that choice but women do need to be fully informed of the purpose and consequence of all tests, so that tests are not treated simply as a routine part of the process of being pregnant. We recommend that the NSF

54 *Ibid.*, para 2.6.

55 *Ibid.*, para 2.2; Appendix 5, para 2.2.

56 Appendix 15.

57 *Ibid.*

58 Q 48; cardiocographs measure fetal heart rate relative to the woman’s contractions.

should specify the minimum screening services that should be available in all areas of the country.

83. The NCT reported to us that the evidence-based guidelines on the induction of labour published by the RCOG and NICE in 2001 were being interpreted in very different ways across the country. The guidelines stated that ‘women with uncomplicated pregnancies should be offered induction of labour beyond 41 weeks’. The guideline also said that ‘women must be able to make informed choices’. The NCT reported that many women were not being supported to make decisions that they felt were right for them and that professionals were not respecting women’s right to refuse unwanted treatment.⁵⁹

84. We recommend that women should receive evidence-based information on the balance of risks and benefits of induction of labour at different times, so that those whose pregnancy continues beyond term can make informed decisions about whether to accept the offer of a medical induction at around 41 weeks or at any stage thereafter. Where women refuse treatment their decision should be respected.

Birth suites

85. Several of our witnesses argued that the typical hospital delivery suite limited women’s choices and intrinsically favoured a medical model of care. According to the NCT, “the very act of immobilising women in a clinical environment to monitor them intensively to look for signs of pathology creates pathology as the flow, the hormones, and the behaviour of normal labour is disrupted.”⁶⁰

86. Caroline Flint put this most forcefully when she suggested that making women lie down to give birth was “the most crucial way in which labour is made more painful and more likely to need medical intervention”.⁶¹ She saw a prone labour position as creating a spiral of intervention: labour lying down was more painful; this made epidurals more frequent; this in turn triggered a higher rate of caesarean section. In the ten years during which her birth centre had run, she told us, only *one* woman had given birth on a bed. The issue of the design of the typical birth suite and its impact on labour seemed to Ms Flint to offer a good example of the way in which the current structure acted against informed choice. Few women were likely to question the way the hospital had set up a particular room, not least because the prone position facilitated the use of monitoring devices and pain relief. She concluded, however, that: “When women had a real choice, they do not choose to labour on a bed, it causes them too much pain”.⁶²

87. It does not require a huge sum of money to reorganize birth suites. The bed can be moved from the centre of the room, a rocking chair can be introduced, a mattress on the floor, birth balls, birth stools and birth pools can all make contributions. But we have heard from midwives who have had to battle to achieve even moving beds to the side of the room.

59 Appendix 5, para 2.3.

60 Appendix 5, para 1.

61 Appendix 14.

62 Appendix 14.

The really big issue is retraining midwives to encourage movement, and making movement within labour natural and typical behaviour.

88. If the arguments of the NCT and AIMS are soundly based, and hundreds of thousands of women are being asked to give birth in wholly inappropriately designed rooms, this would be a matter of very great concern. We are not the appropriate body to judge on such clinical matters but we suggest that the National Institute for Clinical Excellence should be able to investigate this important issue as a matter of priority.

Partners

89. The NCT pointed out that some trusts allowed several birth partners to be present during birth while others only permitted one.⁶³ Yet a woman may wish to have a relative with her as well as a partner, or an even an acupuncturist or aromatherapist. There is some evidence to suggest that a female birth supporter in addition to a partner has a positive effect on the progress of labour.

90. We asked the Department whether there was, or should be, a Department of Health policy on the issue of partner numbers. Lindsay Wilkinson, Head of Women's Health and Maternity Services at the Department, told us that user involvement was something that would be considered in the context of the forthcoming Children's NSF.⁶⁴ The Minister thought that it was important to take into account the reasons the trust gave for restricting the number of partners to one. If it was the result of a physical constraint in the building he would want to have future buildings modified to ameliorate the problem; if it was simply a matter of entrenched, conservative attitudes he hoped that more enlightened views would be brought to bear.⁶⁵

91. We do not think it appropriate that women are asked to give birth in rooms where there is deemed to be insufficient room for a second partner if they choose to have a second partner there. This seems to us to be a fundamental denial of choice: it is the mother who is giving birth and her choices here should be respected.

92. However, as our inequalities report demonstrated, the limitations placed on able-bodied people pale in comparison to many of those imposed on some people with disabilities. During the Sub-committee's inquiry into inequalities in access to maternity care, Simone Baker described this feeling of loss of control in its most extreme form: "people have their babies taken away from them before they are born."⁶⁶

93. While we acknowledge that there may be problems of space and security which might limit the overall number of partners who can be present we do not think that it is reasonable that women should be limited to a single birth partner in any circumstances. Such an attitude suggests birth is being managed for the convenience of the unit rather than the mother. We look to the Department to support the view that women should not be limited to a single birth partner.

63 Appendix 5, para 2.6.

64 Q 133

65 Q 134

66 *Inequalities in Access to Maternity Services*, Q 70.

Birth pools

94. Birthing pools are popular with women and can now be found in the great majority of maternity units. There is clear evidence to support the suggestion that many women find them a great benefit and comfort when giving birth. However, several of the submissions we received suggested that the mere existence of a birthing pool by no means guaranteed that a woman would have access to such a facility when it came to her labour or that she would be able to make as much use of the pool as she might wish.

95. The Association for Improvements in Maternity Services (AIMS) used the introduction of birthing pools as an example of where supplying women with insufficient or irrelevant information could restrict choice, arguing that although many hospitals now had a birthing pool and might advertise this as part of the ‘choices’ they offered, in many units pools were used very infrequently. AIMS reported how women who asked to use pools were too often told that the pool was unavailable (being cleaned, needing maintenance, or needing sterilisation). AIMS argued that “the crucial piece of information, therefore, was not whether the unit had a pool, but how many women gave birth in it the previous year”.⁶⁷

96. According to Beverley Beech for AIMS, another problem arose from some midwives not knowing how to deliver a woman in water and resorting to asking the woman to get out of the pool to give birth even when this was against her wishes.⁶⁸ Sarah Montagu, for the Association of Radical Midwives thought that such an attitude was completely inappropriate and symptomatic of the distortion of values in maternity care:

It struck me as quite bizarre that it seems optional for management that if midwives from a unit feel that they do not want to support women in water, they do not feel they can force the midwives to train to look after women in water. If a midwife said, “I do not feel I want to look after women having epidurals or Caesarean sections” the managers would tell them not to be stupid and that it was part of their job.⁶⁹

This assertion prompted Professor Dunlop of the RCOG to query whether a water birth could be characterised as a “normal labour” rather than, as he presumably believed, “a form of intervention”.⁷⁰ Midwives responded by saying that unlike other interventions there were no side effects or complications associated with a water birth. Such a clash of attitudes well sums up the debate about normal versus medical models of care.

97. We believe that if maternity units have pools, as most now do, a woman giving birth should have a reasonable expectation that the pool will be available for her use except in cases where demand is abnormally high. Efforts should be made to ensure that maintenance is organized so as to restrict as little as possible the hours which the pool may be accessed. We think it is unacceptable that midwives should be uncomfortable in dealing with mothers using birth pools: this is a matter that should be addressed in training and through professional development. We agree that it should not be

67 Appendix 4, para 16.2.

68 Q 79

69 Q 80

70 Q 80

acceptable for midwives to be unable or unwilling fully to support women using birth pools.

Caesarean section

98. In our first report, we discussed the issue of rising rates of caesarean sections in considerable detail.⁷¹ Around 63% of caesarean sections are classified as “emergency procedures”. Health professionals and academics vary in their explanations for the rise in numbers of emergency caesareans, which include the use of continuous electronic fetal monitoring, the use of protocols which specify that labour must proceed to a set timescale, and the de-skilling of both midwives and junior doctors in ‘normal’ birth. Given nearly all women who have no need for a caesarean section prefer not to have one and given the evidence that the current rise in caesarean sections does not improve outcomes in maternity services, the rising rate of caesarean sections suggests women are not being able to follow what would be their choice of delivery method.

99. The Department’s evidence to us suggested they wished to resist getting involved in whether the rising caesarean rate was a good or bad thing. They told us they were “well aware of the debate”, that there was “not sufficient evidence or medical consensus about the desirability and what the optimum caesarean section rate should be” and that the National Sentinel Caesarean Section Audit “did not show that caesarean section is unsafe”.⁷² However the evidence does suggest that if it is not clinically indicated vaginal births are safer than caesareans and have fewer long term adverse consequences for women. The evidence we received suggested a consensus that more needs to be done to tackle the rising rate and the variation in rates across the country and we would again urge the Department to tackle this issue.

100. Elective caesarean rates have risen, in part, perhaps, because of the increasing inclination of obstetricians to perform a caesarean for a breech or a twin birth. It is not within our remit to comment on the efficacy or safety of different clinical practices. However, many witnesses have argued compellingly that the increase in the caesarean rate reflects the effective removal of informed choice from a large number of women who would have preferred to be given the option to give birth naturally.

101. Informed choice here may be compromised in two ways. First, choice may be restricted if units implement policies effectively prohibiting certain types of clinical practice, for example vaginal breech births, or vaginal birth for twins. For example, in our first inquiry we found that around two thirds of women were not being offered the turning round of a breech baby.⁷³ Applying predetermined clinical policies will often mean that women will only receive information about that hospital policy, and finding out about possible clinical alternatives will be very difficult. Secondly, although different clinical choices may be offered to the woman during delivery (for example between opting for a caesarean section on the basis of a trace abnormality, and taking a ‘wait and see’ approach), the options may be presented in such a way that the woman feels that the only decision

71 For the Committee’s discussion of the fraught issue of choice in caesarean section, see *Provision of Maternity Services*, paras 90-104.

72 *Provision of Maternity Services*, Ev 162.

73 *Provision of Maternity Services*, Q 48.

which is ‘allowed’ is that favoured by the health professional advising her. This is clearly particularly important given the extreme vulnerability of women giving birth and given the natural tendency of many people to defer to ‘experts’. While the lead health professional, whether a midwife or an obstetrician, has a professional duty to give advice based on what he or she judges to be the most appropriate course of action, it is vitally important that the woman is able to receive clear and unbiased information about the risks and benefits of both, so that she can make an informed choice.

102. A birth story printed in the *Daily Telegraph* to coincide with the publication of our first report, illustrates well how information can contribute to positive experiences and outcomes: Jane Dawson knew that her baby was breech, and after an unsuccessful attempt to turn the baby, and discussions with her clinicians, Ms Dawson chose a planned caesarean, and reported that “Knowing all the options and being talked to as an equal partner in the birth team was crucial. I felt I was well cared for”.⁷⁴

103. The evidence we have received suggests that women-centred care would be best achieved by the Government adding to the weight of opinion we have heard in favour of an increase in normal births. We recognise that for some women—probably less than 20%—medical interventions including caesareans are desirable and will improve outcomes. But given that the national rate of interventions is now well above this we would like to see maternity service managers setting themselves objectives to increase normal births as part of an audit cycle. This could include actions to improve facilities, control and choice for women in the birth environment, to ensure women receive one to one support during labour and training to promote normal birth to all staff. NICE guidelines and the forthcoming NSF should emphasise that birth is a physiological process to be facilitated and not a medical problem and should reflect this consensus to see an increase in the normal birth rate.

Choice in neo-natal and post-natal care

104. *First Class Delivery* noted that women made more negative comments about hospital postnatal services than any other aspect of their maternity care. It recommended that trusts should have flexible policies on length of stay and that they should consult women about their postnatal care. The report also recommended that trusts should provide support, information and practical help so that parents of babies in neonatal units could be involved in their baby’s care.

105. The NCT drew our attention to a range of problems in postnatal care.⁷⁵ In their view, while the length of stay of a woman in hospital had been “cut dramatically” over the last few years, there was no evidence that there was adequate support in the community to replace in-hospital care. The NCT pointed out that some women might want more support in, for example, breast feeding in the days after birth, and that it was wrong always to assume that someone would be there to support a woman at home. They noted that in busy consultant units women were seldom offered choice as to length of hospital stay,

⁷⁴ *The Daily Telegraph*, 24 June, “Pleasure, pain and complicated deliveries”.

⁷⁵ Appendix 5, para 4.

whereas in smaller midwifery led units length of stay after birth was often four or five days, and breast feeding rates (and confidence to breast feed) were often high.

106. We hope that the NSF will include choice for women on the length of time they can stay in hospital or in a midwife-led unit after birth and allow for flexible support in the community for up to eight weeks from midwives and health visitors working as a team.

5 Choice and litigation

107. Many witnesses have drawn attention to the argument that increasing rates of litigation for birth-related adverse outcomes may be having an impact on clinical decision making, and restricting the information given to women and hence their ability to make informed choices about their clinical care:

I think there is some evidence that that fear of litigation may bias what is made available to women so that women have informed compliance rather than informed consent. That is a big issue. There are women who, for all sorts of reasons, might choose to want to have twins vaginally or a breech baby vaginally. It is very important they have the information and know the risks they are running; but ultimately it has got to be down to them.⁷⁶

108. The Chief Medical Officer's eagerly awaited consultation paper on clinical negligence and litigation, *Making Amends*, was published shortly after we completed taking evidence on this inquiry.⁷⁷ It recommends the development of an NHS Redress Scheme, the aim of which will be to provide no-fault compensation of up to £30,000 to NHS patients who suffer an adverse outcome as the result of serious shortcomings in the standard of their care. The reforms also propose that the scheme should encompass care and compensation for severely neurologically impaired babies or babies with cerebral palsy, whose condition has resulted from birth under NHS care. Payments would be capped at £100,000 per annum, but supplementary payments of up to £50,000 would also be available to cover home adaptations, and to compensate for pain and suffering.

109. *Making Amends* also proposes reforms to the complaints management process, and the introduction of a 'Duty of Candour' on all healthcare professionals and managers, obliging them to inform patients where they become aware of a possible negligent act or omission. This would be accompanied by exempting clinicians and managers from disciplinary action by employers or professional regulatory bodies, except where a criminal offence has been committed, or where it would not be safe for a healthcare professional to continue to treat patients.

110. The consultation paper does not explicitly address the issue of defensive medicine, and we are not convinced that on their own these reforms will have a significant impact on the more defensive clinical practices that have become entrenched in maternity care in recent years. It will take time to establish whether such a scheme can engender a true 'no-blame' culture in the NHS, or whether admission of responsibility for a clinical error or misjudgement would still go hand in hand with individual clinicians being singled out or stigmatised, an approach which may still be perceived as being implicitly punitive. A system of collective, team-based responsibility might be more likely to succeed in building clinicians' confidence to report adverse incidents. Our concern is that the defensive approach to medicine may particularly undermine giving women

76 Q 26 (Belinda Phipps, NCT).

77 Department of Health, *Making Amends—A Consultation Paper Setting Out Proposals for Reforming the Approach to Clinical Negligence in the NHS*, June 2003.

choice in maternity services and we urge the Government to implement and monitor any changes with this in mind.

6 Conclusion

111. The three inquiries of our Maternity Services Sub-committee should not be seen as existing in isolation from one another. A reading of our report on Provision of Maternity Services would point to many issues which have informed our inquiry. The generally poor quality of data in maternity services, for example, referred to in our first report hampers us here, just as it did in our second inquiry into Inequalities in Access to Maternity Services, and just as it must hamper the Department in forging its policy.

112. The examination of rising caesarean section rates undertaken in our first report highlighted the issue of choice, and in particular the importance of informed choice, in relation to intervention in labour. Some of the recruitment and retention issues we discussed in our first report are rooted in issues of choice: increasing choice for women might increase job satisfaction amongst midwives which might encourage retention. This in turn might enable more maternity units to provide continuity of care and carer which is the kind of maternity most women would choose if it were available to them. Similarly, the concerns over the availability of medical staff, particularly because of changes due to the European Working Time Directive may lead to less advice being available to women.⁷⁸

113. During our first inquiry we heard evidence from obstetricians, midwives, and user representatives, in order to gain a ‘snapshot’ of mainstream maternity services. As a means of building a more detailed picture of service provision we moved on in our second inquiry to hear from organisations working in the voluntary sector, and from midwives who provided specialist services for women and families from disadvantaged groups—those whose views may not fully have been represented by the service providers or by the user representatives who gave evidence as part of our first inquiry. In our inquiry into Inequalities in Access to Maternity Care we heard from some who felt that ‘choice’ was the preserve of the articulate, white, middle classes who demanded it. However, it is clear that flexible services, and also a sense of involvement in making decisions and choices about maternity care should help all women and particularly those from disadvantaged groups.

114. We note that Baroness Cumberlege herself acknowledged that women were now far better informed than when *Changing Childbirth* was produced.⁷⁹ Nevertheless, with rising caesarean rates, impending closures of birth centres, midwife shortages and an apparently relentless drive to medicalise the birth process, we believe that the time has come for the Department to revisit some of the assumptions in *Changing Childbirth*, and to revive the prevailing philosophy of that document. Much of the Government’s publicly stated policy in recent months has been to support the “choice agenda”, and we would like the Department now to take the steps to give women power to make informed and real choices.

115. We were pleased that all the units we had evidence from were keen to improve their services for families. The barriers to change often seemed to be firstly, the pressure of day

78 For the impact of the European Working Time Directive, see *Provision of Maternity Services*, p 53ff and Appendix 24 to this report (RCOG).

79 Q 96

to day work which meant they never had the time to think about change and secondly a shortage of resources for training or to release staff for training. **We therefore would urge the Government to consider allocating some one-off resources to maternity units wanting to make changes to their practise so that they could carry out this work. Unlike the £100m allocation the Government announced in 2001 for maternity services this one-off allocation might be used more to support staff than building improvements. This might be done in the form of a team of people who local units could ask to be brought in to support a service either by releasing local staff to do the work themselves and/or by helping them make changes. Independent midwives may be a particularly useful source of staffing for a part of these teams.**

116. We have talked in previous reports of the need for partnership between the health professionals caring for women in maternity services. But perhaps the most crucial partnership of all is that between the woman and her carers which we believe will work most effectively where women feel that they have control and that their wishes are respected and supported.

117. Like our predecessor committee and in keeping with the aims of Changing Childbirth we hope that in ten years midwifery led and community based services will be seen as the norm and the basis of maternity services.

Conclusions and recommendations

1. For most women, giving birth is a normal physiological process, not an illness. It is not clear to us that the usual methods the Department employs to measure the effectiveness of services (which must inevitably focus on clinical outcomes) are necessarily the most appropriate for maternity services. We also note the surprising paucity of evidence in this area, given that over half a million births are recorded by the NHS each year. So we would welcome the Department commissioning some more research on the fundamental needs, wishes and concerns of women in this area to gain a better picture of what women think about maternity care but also to see how they would respond to different lead carers and different birth settings. (Paragraph 18)
2. We note the Leeds University research which suggested that high levels of intervention in care had militated against better psychological outcomes being achieved as a consequence of greater choice. The Department needs to ensure that women are given a genuine and informed choice, and not the illusion of choice that some of our witnesses suggested was currently the case. (Paragraph 25)
3. We were concerned to hear that some women found it hard to access maternity care without a referral from a GP. We advised the Minister that even NHS Direct was not giving correct advice to callers on how to access maternity services suggesting that the only route was via a GP. We would expect this advice to be updated. (Paragraph 28)
4. For our part, we do think it appropriate that women should be encouraged to contact midwives as their first port of call and to at least be aware of their right to have a home birth without seeking “the GP’s permission”. This could be done by ensuring all GP receptionists and hospital units know of the appropriate midwife to refer women to, by notices in GP practices advising women on how to contact midwifery services directly and by local telephone directories having a contact for midwifery services. (Paragraph 31)
5. We therefore recommend that, as part of the Children’s NSF, the NHS should ensure that each pregnant woman has at least one initial ‘booking appointment’ with a community midwife who has in-depth knowledge of local services, and who has received special training to help newly pregnant women with this type of decision-making. Women whose first contact is with their GP should be referred automatically to a community midwife. (Paragraph 37)
6. We recommend that the Government uses the opportunity presented by its forthcoming NSF as an opportunity to recast maternity services to the advantage of both women and their carers. We feel that the current delivery of maternity services, which is generally led by acute general hospitals, over-medicalises birth. Through the NSF, PCTs should be given a lead role in ensuring there is choice and community-led services for women, wherever they live. (Paragraph 42)

7. We accept that local configuration of services is a matter for local determination but given that pregnant women are not able to travel long journeys to give birth, if midwife led units are not available local choice is severely constrained. (Paragraph 48)
8. In costing proposed closures the Department should ensure that local health services take into account the full and long term costs and benefits of the services being considered, including the likely impact on the recruitment and retention of midwives, on breastfeeding rates, postnatal depression rates and reduced intervention and caesarean rates which these units tend to achieve. We believe, as did our predecessor committee, that there should be a presumption against closure of smaller maternity units because without them the shift in attitude which they wanted and we want to see will be very much harder to deliver. (Paragraph 49)
9. We believe that our recommendations above, calling for a shift towards midwife bookings, greater autonomy for midwives in delivering services and sufficient priority given by trusts to maternity issues would reverse the worrying medicalisation of birth reported to us. (Paragraph 50)
10. We support the Secretary of State's policy goal of making home birth more widely available but are disappointed that nothing has been done directly by the Department to achieve this over the two years since his statement. It may be that it is expected that the NSF will achieve this and if so we would welcome that but we believe action could have been taken on this independently of the NSF. (Paragraph 52)
11. We regard this treatment of women [the introduction of barriers against home birth] particularly at such an important stage of their pregnancy as wholly unacceptable. If trusts have staff shortages they should call on the services of agency staff and independent midwives so that women in hospital and at home do not have to face the prospect of not being properly supported in labour. The Department should ensure that via a fast-track complaint or other procedure women experiencing any pressure like this should have an immediate source of help for the situation to be resolved without delay. (Paragraph 60)
12. Rather than perceiving home births as a potential drain on scarce resources we see them as a gateway to promoting normal birth and a spur towards midwife recruitment and retention. We endorse AIMS' recommendation that all trainee midwives should be obliged to attend a minimum of three home births as an essential part of their training. We believe that this would help tackle prejudice against home births amongst health professionals, But we also believe it would be very beneficial if GPs and consultant obstetricians attended a similar number of home births to give them insights into the process and to provide for a more informed and rational debate. (Paragraph 64)
13. Home births, we believe, would be far better supported if there was a general principal of continuity of carer, an issue we raised in our first report but reiterate here. (Paragraph 65)

14. There may be scope for creating the post of maternity assistant to help deliver services in the community. Such a person could also assist in the role of educating and informing pregnant women and in neonatal and postnatal support in areas such as breast feeding as happens in Hythe, Hampshire and Lymington. (Paragraph 66)
15. If a woman wants or needs to be cared for in an acute hospital setting, she should also be offered a choice of different acute units where this is practical. As our previous inquiry has shown, the type of care a woman is likely to receive can vary significantly from hospital to hospital, and even between different consultants in the same unit. That inquiry recommended that individual consultant data on, for example, the caesarean rates of different consultants, together with national and local comparisons, should be given to all users. (Paragraph 68)
16. Professor Dunlop, for the RCOG, thought there would be “no problem at all” with such a recommendation provided that the data took account of the different case mix of units, and we accept that this is an important requirement. (Paragraph 69)
17. The NCT also told us that miscarriage rates following invasive testing are also reported to vary significantly. Echo, the fetal heart charity, also pointed to an inequality in the detection rates of congenital heart disease through ultrasound screening from 3% to 68%. The Department should investigate and take action if there is such a variation. (Paragraph 78)
18. We do not believe that simply making tests available is in itself an extension of choice. Testing and screening sometimes inhibit rational choice and sometimes encourage higher levels of intervention. We recognise that many women will want to have the tests available and support them in that choice but women do need to be fully informed of the purpose and consequence of all tests, so that tests are not treated simply as a routine part of the process of being pregnant. We recommend that the NSF should specify the minimum screening services that should be available in all areas of the country. (Paragraph 82)
19. The NCT reported to us that the evidence-based guidelines on the induction of labour published by the RCOG and NICE in 2001 were being interpreted in very different ways across the country. The guidelines stated that ‘women with uncomplicated pregnancies should be offered induction of labour beyond 41 weeks’. The guideline also said that ‘women must be able to make informed choices’. The NCT reported that many women were not being supported to make decisions that they felt were right for them and that professionals were not respecting women’s right to refuse unwanted treatment. (Paragraph 83)
20. We recommend that women should receive evidence-based information on the balance of risks and benefits of induction of labour at different times, so that those whose pregnancy continues beyond term can make informed decisions about whether to accept the offer of a medical induction at around 41 weeks or at any stage thereafter. Where women refuse treatment their decision should be respected. (Paragraph 84)

21. If the arguments of the NCT and AIMS are soundly based, and hundreds of thousands of women are being asked to give birth in wholly inappropriately designed rooms, this would be a matter of very great concern. We are not the appropriate body to judge on such clinical matters but we suggest that the National Institute for Clinical Excellence should be able to investigate this important issue as a matter of priority. (Paragraph 88)
22. While we acknowledge that there may be problems of space and security which might limit the overall number of partners who can be present we do not think that it is reasonable that women should be limited to a single birth partner in any circumstances. Such an attitude suggests birth is being managed for the convenience of the unit rather than the mother. We look to the Department to support the view that women should not be limited to a single birth partner. (Paragraph 93)
23. We believe that if maternity units have pools, as most now do, a woman giving birth should have a reasonable expectation that the pool will be available for her use except in cases where demand is abnormally high. Efforts should be made to ensure that maintenance is organized so as to restrict as little as possible the hours which the pool may be accessed. We think it is unacceptable that midwives should be uncomfortable in dealing with mothers using birth pools: this is a matter that should be addressed in training and through professional development. We agree that it should not be acceptable for midwives to be unable or unwilling fully to support women using birth pools. (Paragraph 97)
24. We hope that the NSF will include choice for women on the length of time they can stay in hospital or in a midwife-led unit after birth and allow for flexible support in the community for up to eight weeks from midwives and health visitors working as a team. (Paragraph 106)
25. The consultation paper [*Making Amends*] does not explicitly address the issue of defensive medicine, and we are not convinced that on their own these reforms will have a significant impact on the more defensive clinical practices that have become entrenched in maternity care in recent years. It will take time to establish whether such a scheme can engender a true 'no-blame' culture in the NHS, or whether admission of responsibility for a clinical error or misjudgement would still go hand in hand with individual clinicians being singled out or stigmatised, an approach which may still be perceived as being implicitly punitive. A system of collective, team-based responsibility might be more likely to succeed in building clinicians' confidence to report adverse incidents. Our concern is that the defensive approach to medicine may particularly undermine giving women choice in maternity services and we urge the Government to implement and monitor any changes with this in mind. (Paragraph 110)
26. We therefore would urge the Government to consider allocating some one-off resources to maternity units wanting to make changes to their practise so that they could carry out this work. Unlike the £100m allocation the Government announced in 2001 for maternity services this one-off allocation might be used more to support staff than building improvements. This might be done in the form of a team of people who local units could ask to be brought in to support a service either by

releasing local staff to do the work themselves and/or by helping them make changes. Independent midwives may be a particularly useful source of staffing for a part of these teams. (Paragraph 115)

Formal minutes

Thursday 10 July 2003

Members present:

Mr David Hinchliffe, in the Chair

Mr David Amess
Mr John Austin
Jim Dowd
Mr Paul Burstow

Siobhain McDonagh
Dr Doug Naysmith
Dr Richard Taylor

The Committee deliberated.

* * * * *

Another draft Report (Choice in Maternity Services), proposed by the Chairman, brought up and read.

Ordered, That the Chairman's draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 117 read and agreed to.

Resolved, That the Report be the Ninth Report of the Committee to the House.

Several papers were ordered to be appended to the Minutes of Evidence—(*The Chairman.*)

Ordered, That the Appendices to the Minutes of Evidence taken before the Committee be reported to the House.—(*The Chairman.*)

[Adjourned till Thursday 17 July at 10 am.]

Witnesses

Tuesday 17 June 2003

Page

Ms Beverley Lawrence Beech, Chair, Association for Improvements in the Maternity Services, **Ms Sarah Montagu**, Association of Radical Midwives, **Ms Annie Francis**, Independent Midwives Association, **Ms Belinda Phipps**, Chief Executive, National Childbirth Trust, **Ms Louise Silverton**, Deputy General Secretary, Royal College of Midwives, and **Professor William Dunlop**, President, Royal College of Obstetricians and Gynaecologists.

Ev 1

Tuesday 24 June 2003

The Baroness Cumberlege CBE, and **Dr Stephen Ladyman MP**, Parliamentary Under-Secretary of State for Community Care, **Ms Lindsay Wilkinson**, Head, Women's Health and Maternity Section, **Ms Catherine McCormick**, Midwifery Adviser, and **David Amos**, Deputy Director of Human Resources, Department of Health

Ev 26

List of written evidence

The numbers below refer to Appendices contained in Volume II.

- 1 Department of Health
- 2 The Association of Radical Midwives
- 3 Royal College of Midwives
- 4 The Association for Improvements in the Maternity Services
- 5 The National Childbirth Trust
- 6 Royal College of Obstetricians and Gynaecologists
- 7 Independent Midwives Association
- 8 The Portland Hospital for Women and children
- 9 The Society of Homeopaths
- 10 Elizabeth Key
- 11 Birth Centre Network UK
- 12 Royal College of Anaesthetists
- 13 The Midwives Information & Resource Centre (MIDIRS)
- 14 The Birth Centre Ltd
- 15 Nursing & Midwifery Council
- 16 Southampton University
- 17 Dr S M Yentis
- 18 Mother and infant Research Unit, University of Leeds
- 19 Saint Mary's Hospital for Women and Children Manchester
- 20 North Middlesex University Hospital NHS Trust
- 21 RCGP
- 22 Alison Macfarlane and Rona Campbell
- 23 South Devon Healthcare NHS Trust
- 24 Royal College of Obstetricians and Gynaecologists (supplementary)

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 (Cm 5876)
Third Report	Sexual Health	HC 69
Fourth Report	Provision of Maternity Services	HC 464
Fifth Report	The Control of Entry Regulations and Retail Pharmacy Services in the UK	HC 571
Sixth Report	The Victoria Climbié Inquiry Report	HC 570
Seventh Report	Patient and Public Involvement in the NHS	HC 697
Eight Report	Inequalities in Access to Maternity Services	HC 696

Session 2001–02

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