AIMS For a better birth...

Editorial

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Debbie Chippington Derrick and Ruth Weston consider the NHS reorganisation situation

We are about to see big changes in the way that maternity services are commissioned. In order for services to be provided that will truly meet the needs of women, their babies and their families, those of us who understand what constitutes high-quality maternity care are going to need to make sure a clear message reaches those who will be commissioning these services.

Reorganisation within the NHS and of the way services are to be commissioned is going to happen, and although there are serious concerns about what will happen to the NHS, and what impact this may have on the standard of health care, this may present some real opportunities for change in the structure of care within maternity. In April 2012 'Any Qualified Provider' came into force, allowing services from outside of the NHS to be offered and for patients to choose from a range of services. The NHS choices website has details of current services of this type www.nhs.uk/choiceintheNHS/Yourchoices/any-qualified-provider/Pages/aqp.aspx.

Any Qualified Provider status enables non-NHS organisations to be service providers commissioned by clinical commissioning groups (CCGs). It is into this structure and policy that providers One to One Midwives and Neighbourhood Midwives are integrating themselves, and it offers a potential opportunity for a reorganisation of care that could provide women with more continuity of care and receive it based more in their community.

The Government has made clear pledges about provision for maternity services which include:

- Making sure the investment in a record 5,000 midwives currently in training means that women will have one named midwife who will oversee their care during pregnancy and after they have had their baby.
- Making sure that investment also means that every women [sic] has one-to-one midwife care during labour and birth.
- Making sure that investment means parents-to-be will get the best choice about where and how they give birth. The Government wants to see more joined-up working, so women can choose from a full range of services, meaning that choices made are delivered within an integrated, flexible service.

Further details of the pledges that were made can be seen at www.gov.uk/government/news/nhs-pledges-more-support-for-women-with-postnatal-depression. If these pledges and the changes in the

structure of the provision of care are to provide improved maternity services then women and their families are going to have to stand up and make it clear what they need and that the standard of the services currently provided to many women is not acceptable.

Women need midwives to be providing real 'with woman' midwifery care. If the current situation of so many unnecessary and damaging interventions is to change, women need their midwives to have had the opportunity to fully develop skills for supporting normal birth and keeping interventions to a minimum.

One-to-one care needs to be clearly defined and monitored to make sure that services being commissioned and paid to provide it are actually doing so Access to home birth, free-standing and alongside midwifery units needs to be available in all areas of the country; it should not be a postcode lottery. Women need to be able to make truly informed decisions about the birth of their baby, and, in order to do so, midwifery care and a choice of places of birth need to be realistic, well-supported options.

We are being sold 'centralisation is good' by the medical establishment, but the needs of women are not being properly considered in this policy. There is a failure to recognise the need for local services that provide a high standard of support for women in the antenatal and postnatal periods and access to local facilities for birth. Women will continue to go into labour where they live and they need to be able to access services locally; they need midwives readily available to attend them in their homes and in local midwifery units. If the centralisation of obstetric units occurs without these local services, more women are going to give birth or encounter labour problems in transit, and we are going to see more mothers and babies suffer or die because of the failure to provide services locally.

In this Journal we hear how Manchester services have been reconfigured, taking valuable services away from women in some areas, with the impact being particularly serious for vulnerable women. Within that service we hear of how St Mary's Birth Centre in Salford provides a service that is valued by women and gives care that avoids unnecessary interventions that are damaging to women, babies and their families. Yet the promise of further units of this sort has not been kept; leaving thousands of women every year without this evidence- based option of care which would be safer for them and cheaper for the NHS.

We need to question the basis of this kind of decision- making when it is not in the interests of women's health, nor what they actually want. Maternity services have been reviewed previously and both the Winterton Report1 and Changing Childbirth2 have made it clear that changing the service to make it more woman-centred is essential for better outcomes.

We have good evidence about the sort of care that women want and care that makes birth safe and empowering, the sort of care that enables women to be well prepared for caring for their child, through the Can we get a better deal?

Postnatal period and onwards to adulthood. We need to ensure our government and commissioners fully value what a strong midwifery service can do for society as a whole, and not just for the short-term physical outcomes of a mother and baby. Good midwifery care can improve the health, both physical and psychological, of women, their babies, whole families and the wider society to which they belong.

The recent Birth Place Study has removed any question about whether midwifery services outside obstetric units are safe and effective; we now need all commissioners of maternity services to make sure that they are providing the full range of midwifery services: home birth, free-standing midwifery units and alongside units, as well as obstetric units. Every woman in the UK should be able to obtain support for a birth that will not be subjected to unnecessary and damaging interventions. Without midwifery units and well- supported home birth services, women will continue to be damaged, at a significant cost to themselves, their babies, their families, the NHS and society in general.

We are also coming to a critical point with insurance for midwives. In October 2013 midwives will be legally required to have professional indemnity insurance if they are providing care during birth. AIMS is very concerned about what this may mean for women who have, until now, been able to opt out of NHS care by employing a midwife independently. Many women who have turned to independent midwives in the past have done so because the NHS has not been able or willing to provide the care that they need. Sometimes this is because of the high- quality antenatal and postnatal support one-to-one care provides, and because they needed a known and trusted midwife to attend the birth. However, it has also included women with more complicated situations, such as those having breech babies or twins, where the NHS has proved unable or unwilling to find confident and competent midwives to support women who are making choices outside the basic offer of care. See www.aims.org.uk/?Campaigns/independentMidwifery.htm.

Unless we engage with service commissioners we are likely to find ourselves with a selection of large obstetric units that are well suited to those who provide obstetric care, but fail to meet the needs of women and babies and that also fail to meet the needs and skills of those who wish to provide good quality midwifery support. Service commissioners need to be well informed about the benefits of local services, in terms of both outcome and cost, and about the risks that large obstetric units present to the majority of mothers and babies.

We need commissioners to understand that research has shown that midwifery services improve outcomes for mothers and babies, and that failure to provide these services will mean that those commissioning the service are causing damage to some women for whom they are funding care, and that will incur further costs to address that damage. They need to understand that women who have unnecessary interventions will cost more to care for not only in that birth but also in future births, and that they may also require additional services to overcome physical or psychological trauma.

NICE measures outcomes in terms of QALYs (quality- adjusted life years) and makes decisions about funding based on these. If the QALYs of a good birth could really be considered, and the care put in place

to make sure that services were achieving on this measure, then we would really have made a step forward, for everyone. The structure of commissioning is only emerging as this Journal goes to press and there is a glut of information being produced. The 23rd Bulletin for proposed CCGs was published on 9 November 2012 (www.commissioningboard.nhs.uk/2012/11/09/ccg-bulletin-issue-23/). However, it is clear that the government is aware that GP commissioners won't understand many areas of health care and so CCGs are busy recruiting (often from the dying PCTs) officers who will do the commissioning for them. Indeed, within some regions, CCGs may contract/delegate commissioning work to a regional enterprise (which is essentially a business set up and run by previous PCT employees). We need to make sure that they do not just replicate the current system with its current failings, by commissioning services from the very NHS Trusts that have been failing women around the country.

AIMS is working with others to investigate what it may be able to do to influence change, but we would suggest that there are four things that you could be doing:

- Find out who the local GP commissioner is, ready for when action may be needed. The CCG managers may be good contacts, but this will vary by area, and local knowledge will be essential in finding out who are the people who can take action to enable real change.
- Find out about local consultations. There is a requirement to consult with local populations; so get in there and talk about maternity. Make sure that you go armed with at least one question to ask. The more you change the agenda to maternity the more you are likely to make sure it is on their plan.
- Be ready for the first CCG AGMs. These are an opportunity for CCGs to be held publicly to account. Again, be there armed with at least one question about maternity care in the area, remembering it is not so much about the answer that you get, but about the question that you have raised.
- Register with us as a local contact so that we can make sure that we have a network in place in order to take action. Please email campaigns@aims.org.uk This Journal really highlights how much women value the personalised care that small, midwife-led units offer ; and since that is also the care that is safest for mothers and babies, and the most cost-effective form of maternity care, there is no excuse for not offering it to all women. There will also be the additional benefit of freeing up obstetric time for those who really do need it, ensuring that they also get better and more personalised care. There is really nothing to lose.

References

1. House of Commons Health Committee (1992) Second report on the maternity services (Winterton report). HMSO: London. Cited by Mr Nicholas Winterton in Hansard, 19 April 2000.
2. Department of Health (1993) Changing childbirth: report of the expert maternity group (Cumberlege report). HMSO: London.