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Continuity consensus emerging

AIMS Journal, 2014, Vol 26, No 3

Gill Boden describes progress being made towards caseloading care in London

The year 2013 was the 20th anniversary of Changing Childbirth,[1] which set out the three Cs, choice, continuity and control. These essential lelements of care often elude women in childbirth but there are some hopeful signs of a convergence of opinion, which might make continuity of care a possibility, at least in London, and enable a woman to know the midwife who will attend her birth.

In December 2013 the Care Quality Commission, (CQC), published a survey showing that women's experiences of maternity care in London needed improvement[2] and the Strategic Clinical Leadership Group (SCLG) and the Maternity Strategic Clinical Network (SCN) were set up to be driving forces behind improving the quality of care within London's maternity services.

In the same month the Royal College of Midwives, (RCM), made a submission to The People's Inquiry for London's NHS.[3] It drew attention to capacity issues; the increase in complex pregnancies; the health inequalities associated with deprivation and ethnicity and to the finding that only 40% of women in London had the name and telephone number of a dedicated midwife compared to the national average of 72%.

The RCM in its submission was concerned with the fact that the reorganisation of maternity services has beendriven by the centralisation of obstetric services on fewer sites to meet the NHS London maternity services standard. This standard states that *'obstetric services should be staffed to provide the 168 hours a week (24/7) of consultant obstetric presence on the labour ward.'* In the RCM's view, while it may be desirable to concentrate obstetric-led services, particularly for women and infants who require emergency or specialist care, there is little evidence of benefit in terms of its impact on outcomes, it is expensive, and it should not be the principal driving force behind reorganisation. Catherine Calderwood, NHS England's Clinical Director of Women's Services, echoes this view and told a Public Accounts Committee hearing that investment in midwives would be more effective: what women need is obstetric services organised around the needs of women with a high risk of complications during pregnancy, birth and/or after birth, and midwife-led models of care to benefit women who are at low risk of complications with a significant expansion of midwife-led units and home birth.

Chief Executive of the RCM, Cathy Warwick in January 2014 quoted the survey carried out by the National Federation of Women's Institutes and NCT.[4] The survey found that 88% of women had not met the midwives who were to attend them in labour and although most women did get one to one care in

labour this was managed by Heads of Midwifery redeploying staff continually away from essential services.

Continuity of carer has been shown, by Jane Sandall and others,[3] to be safer for mothers and babies, more cost effective, with fewer interventions and preterm births, and increased chances of normal birth. There is now a clear consensus, backed by the Birthplace Study[5] for a maternity service, which is arranged around the needs of women and babies and not the demands of a medically-based hospital service. The Department of Health Mandate,[6] sets out to *'ensure that every woman has a named midwife who is responsible for ensuring she has personalised one to one care throughout pregnancy, childbirth and during the postnatal period including additional support for those who have a maternal health concern'* (p19). There is much work going on now which might mean that London will lead the way to making caseloading midwifery a reality and making birth the life-affirming event it could be.

Gill Boden

References

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