AIMS For a better birth...

Personalised maternity care?

AIMS Journal, 2014 Vol26, No 1

Emma Ashworth reports on the Health Education England meeting, 28 February 2014, Leeds

Personalised maternity care stakeholder events, hosted by NHS Health Education England, are being held around the country in response to a request from the Permanent Secretary for Health, Dr Dan Poulter, to explore the ambitions for future maternity services and what they might look like by 2022.

I came home with a headache, partly due to immense blood pressure spikes from time to time, not least listening to an obstetrician using the phrase 'rescuing women' TWICE in his talk, and calling obstetric services 'rescue services'.

I sat with One to One midwives and the two consultant midwives from Wakefield, plus someone from the RCM, and on the whole found the meeting to be very enlightening in terms of understanding some of the future of maternity care in England.

Lisa Bayliss-Pratt, Director of Nursing, Health Education England
Lisa talked briefly about success criteria for change being improvements in clinical outcomes. I thought that solely looking at clinical outcomes was really missing the point, given that, as we all know so well, there are so many other outcomes which are non-clinical, but just as important to the longer-term mental and physical health of mums and babies.

Unfortunately there was no opportunity for questions so I was unable to make this point, although fortunately it was clearly raised in later presentations. Lisa said that most NHS maternity funding goes into the training of obstetricians.

Birte Harlev-Lam, Head of Maternity and Children's Services, NHS England
Birte did make the point that there were lots of new midwives being trained, but not enough jobs for them.

Every time Dan Poulter is interviewed about the shortage of midwives, his answer is that there are 5,000 midwives in training, yet he consistently fails to mention that in fact there will be few jobs for those midwives once qualified, so it is a weasel answer.

Birte said that there was an exclusion from the legal right of a patient to any other provider within maternity, mental health and cancer ser vices. However, a representative from One to One Midwives said to me that they have had some clarity on that and it wasn't legally supportable. Birte said that, according to some research they'd done, 'On the whole, women are "reasonably happy".' A delegate

queried this at the end, pointing out that in the private sector companies would not feel that customers, on the whole, being reasonably happy, would be acceptable.

The analogy that came to me too late was of parachute-packing companies which at least wouldn't have customers left to complain if they were only 'reasonably happy'! Brenda from Independent Midwives UK (IMUK) pointed out that Clinical Commissioning Groups (CCGs) can still commission Any Qualified Provider (AQP), even if they're not legally obliged to.

Lesley Page, Royal College of Midwives (RCM)
Lesley claimed that we are 'hugely privileged' within the UK. She talked about the Birthplace Study, and gave some good information on homebirth and midwifery-led units (MLUs) having a lower risk of caesarean section and other interventions. She said that the RCM 'still wants to support normal birth' but wants to look at models for women who have complex pregnancies. There was no clarity about what this meant, exactly, and it will be interesting to see what choices the RCM makes over the next months.

Lesley went on to talk about how Middlesex Hospital gives out gold stars to midwives and doctors who receive good feedback from the friends and family rating. I was personally disappointed that this was the best example of best practice she could come up with, although it did seem to be something that those involved in the trial felt was valuable. While 'ever y little helps', the general consensus on our table was that we had expected examples with more substance.

Only 12% of women know their midwife in labour, and, she said, access to MLUs should be widened. Perhaps that is what she means about looking at models for women who have complex pregnancies? This could be brilliant if the RCM is going to actively support it. She also said that any maternity improvements must respect the contribution of midwives – such as improve working practices and management practices. If only! Lesley said that the Birthplace Study said that low risk women should have a choice of place of birth. This, it was pointed out in the questions, was not accurate, and aside from access to Trust proper ty such as birth centres, women of any 'risk' have the choice, enshrined in law, to birth where they want to. Lesley conceded that this was so, but then went on to say that while this is true, in her experience with the right care, women will do 'what is best for them'. Another questioner pointed out that some women are not given the choice and end up having to birth alone, and Lesley again said, 'sometimes women need help to make their choice'. A third questioner made the excellent point that commissioning is fragmented and the tariff doesn't reward continuity, and this was discussed and agreed.

Barbara Kuypers, project lead for the day, then said that women need to understand that when they are asking for care outside of midwifer y-led care it's out of the midwife's remit.

James Walker, Royal College of Obstetricians and Gynaecologists (RCOG)
I was not the only person to find this speaker ver y difficult to listen to. He spoke a lot about 'rescue services' (obstetrics) and how they must not be taken away, which is an absolutely pointless straw-man argument as no one is for a moment suggesting that we should be taking obstetric care out of the equation for those women who need it. He used the phrase 'rescuing women' several times. He also said

that midwives need to understand abnormality, not just normality, as though midwives were not highly skilled and experienced in both. All of the midwives on my table bridled strongly at this.

He went on to AQPs and said that it's important that they're regulated and that the problem is that it's cheaper for them to run their businesses without training their staff. I believe that he was intentionally undermining the idea of AQP to the commissioners. A representative from One to One said that AQPs have to be registered with the same bodies as the Trust providers, and regulated the same, and trained the same.

Sheena Byrom, Midwife and author
Sheena spoke next, about the lack of evidence base in maternity care and how change is long overdue. I enjoyed her talk so much that I made few notes, apart from the comment that I agreed with her! Fortunately Sheena has summarised the talk she gave on her website, sheenabyrom.com.

Carmel McCalmont, Associate Director of Nursing and Head of Midwifery, Coventry
I really struggled to understand what point Carmel was making because she talked a lot about non-evidence-based care they'd done (something about turning a woman on her head to avoid miscarriage?) and then she said that when the woman got to the end of her pregnancy she [Carmel] went in to birth her baby. She mentioned this a few times: how other midwives on her ward birthed babies for women, 'This is a photo of Alison, with the baby she's just birthed'. This is a personal bugbear, as of course women birth their babies, not their care givers! I think the point she was trying to make was that woman-centred care (a phrase I detest, given that the entire purpose of maternity ser vices is to give care to women) wasn't necessarily going to be to guidelines, which I absolutely agree with, but I felt that her point was poorly made, unfortunately.

Belinda Phipps, CEO, NCT
Belinda discussed how it was a real problem in labour wards to staff appropriately, and therefore it made sense to staff the women, not the ward (continuation of carer/ community midwife coming into the labour ward). She talked a lot about continuation of carer, and a questioner at the end asked, 'Given that the biggest campaign at the moment on this area is M4M, is the NCT going to support it?' She replied that they had supported it, signed up to it and funded it. She was then asked if the NCT was going to actually share the information with its members (as there has been virtually no use of NCT members or branches to support this vital campaign, despite that being the huge value of NCT to the campaign, thus losing a massive opportunity for change). She replied that M4M was an organisation run by mums and it was more appropriate for NCT to be in the background, and anyway M4M had probably done its job and will likely be no longer needed. I was extremely disappointed in this answer. M4M is an active and essential campaign. Whilst I would be delighted for it to no longer be needed, I felt that this was Belinda stepping the NCT away from the campaign rather than an accurate reflection of the fact that we now have a 'Midwife 4 Me and My Baby'. In my opinion the NCT lost a great opportunity to support this vital campaign through its networks which it never did in any meaningful way.

I chatted a bit, in the break, with a couple of consultant obstetricians who were talking freely about

defensive 'care' (isn't that an oxymoron?) being essential in their work. I think this is something that we in AIMS really urgently need to address: firstly, making sure that it is very clear to women who we communicate with that this is happening, and secondly trying to see if we can come up with suggestions of how clinicians can protect themselves without causing more damage. So for instance, instead of putting the fear of God into people, perhaps coming up with ways that they can word information so that it's true information sharing.

Emma Ashworth

The Twitter hash tag from the day is #pmcare2014

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