Improving maternity care in London

A framework for developing services

March 2011
# Contents

Forward 1  
Executive summary 3  
Introduction 5  

## CASE FOR CHANGE

**PART A: Responding to London’s demographics and public health trends**  
1  Public health trends 6  
1.1 The number and location of births 6  
1.2 Maternal age 8  
1.3 Increasing fertility treatment 13  
1.4 Increasing obesity 13  
2  Reducing inequalities of outcomes 15  
2.1 Decreasing mortality 15  
2.2 Low birth weight babies 17  
2.3 Pre-term babies and retarded growth 18  
2.4 Improving preconception care 20  
2.5 Improving antenatal care and early booking 20  
2.6 Smoking cessation during pregnancy 21  
2.7 Encouraging breastfeeding 22  
3  Key messages 24  

**PART B: Improving women’s experiences**  
4  Women's views 26  
4.1 Feedback from Healthcare Commission report 26  
4.2 What women say 27  
4.3 Communication 28  
4.4 Women centred care 29  
4.5 Continuity of care 30  
4.6 Choice 31  
5  Choice of location of birth 32
5.1 Normalising birth – home births and midwifery led units 32
5.2 Reducing inappropriate interventions – births in obstetric units 34
6 Key messages 40

PART C: Ensuring safety and quality
7 Meeting minimum standards 41
8 The cost of clinical negligence 43
9 Workforce and training 44
10 Key messages 45

PART D: Improving data
11 The case for collecting complete, quality data 46
12 Key messages 48

MODEL OF CARE
1 Introduction 49
1.1 The case for change 49
1.2 Overview 52
1.3 The care pathway 53
2 Guiding principles 55
3 Key recommendations 56
3.1 Targeted pre-conception advice and care 57
3.2 Accessible, timely antenatal care 58
3.3 Midwife coordinated care for all women 60
3.4 Provision of continuity of care 61
3.5 Offering choice and non-medicalised care 65
3.6 Providing safe births 68
3.7 Commission and provide for diversity 71
3.8 Improve postnatal care 75
3.9 Improve data and evidence 77
CONCLUSION

Appendix 1: Communication 80
Appendix 2: London Ambulance Service 81
Appendix 3: Acknowledgements 82
Appendix 4: Glossary 89

Linking publications

Commissioning Support for London. What women and their families need and want from a maternity service: Overview of existing data. 2010


Early pregnancy leaflet and guidance. 2010. Available from maternity@csl.nhs.uk
Foreword

London is one of the most diverse cities in the world and has experienced a rapidly growing population, with ever increasing numbers of births. Londoners need and deserve high quality, accessible maternity services. They should expect no less than an excellent service, coupled with an informed choice of how and where they have their babies. To ensure babies have the best start in life, we need to make certain we are providing appropriately targeted and informative pre-pregnancy care as well as excellent maternity services for women antenatally, during delivery and postnatally. There is good evidence that choice and high quality services for expectant mothers achieves better outcomes for both mother and baby.

The capital's maternity services do not perform uniformly, with unacceptable inequalities in maternity outcomes in areas of mortality, morbidity, access and experience. For some time, services have been struggling to meet national standards for safety, outcomes and women's experiences. There are discrepancies in performance between hospitals across London and compared with England.

This guide is an important step in the improvement journey; it aims to advise and empower commissioners to transform the way maternity services are delivered in London. It provides recommendations, which are based on national and international best practice, developed by clinicians and NHS professionals with input from women and their families. These recommendations will support the commissioning of quality services, which are innovative, cost-effective and responsive to local need.

As Senior Responsible Officer and GP Clinical Advisor leading the maternity project, we urge commissioners and service developers to use the guide to inform their future strategy and procurement decisions to improve maternity services and outcomes for women and their babies.

Sally Gorham
Chief Executive, NHS Waltham Forest
Senior Responsible Officer, Commissioning Support for London’s maternity project

Dr Mike Lane
GP in South West London
Pan-London GP Clinical Advisor
Endorsements

The Royal College of Midwives endorses London’s model of maternity care which emphasises the importance of pregnancy and childbirth as the start of family life. We concur with the issues raised in the case for change. It is essential that London’s maternity services tackle inequalities in access to services and differing standards of care. The RCM particularly supports the underpinning philosophy of ‘women centred care’ with all services expected to give priority to the wishes and needs of women.

The Royal College of Obstetrics and Gynaecology also endorse this report.
Executive summary

London’s maternity services face challenges to providing excellent, safe maternity care for the diverse needs of women and their babies in the capital. We know that London’s maternity services do not perform uniformly with unacceptable inequalities in maternity outcomes in areas of mortality, morbidity, access and experience.

The project’s multi-professional clinical expert panel developed a model of care to help address and manage the challenges set out in the case for change. The model is informed by clinical evidence and best practice, supported by national and international guidance.

Case for change

The number of births in London has been increasing and is likely to continue to increase in London in the short term. Obesity, diabetes, the age at which women give birth and the use of fertility treatment are all increasing. These factors increase the risk of medical complications, making thorough risk assessment and early management of complications essential.

Whilst birth in London is safe for the majority of women, there is still an unacceptable level of risk for a minority of women. Variation exists in relation to perinatal mortality and low birth weight, correlated with socio-economic factors. Breastfeeding is proven to improve infant health, but initiation and continuation is variable.

Pre-conception care can improve maternal and newborn health but is not usually commissioned or offered by healthcare services in London. Early booking enables early screening, health advice and management but London does not achieve the ideal standard of 90% of women seeing a maternity healthcare professional for a health, risk and social assessment by 12 completed weeks of pregnancy.

Women told us they do not always feel that maternity services communicate with them effectively and they sometime feel unsupported, especially in relation to postnatal care. Women want useful information to enable them to make informed choices about their care, in partnership with healthcare professionals. Data collection, completeness and quality is variable across London. There is a shared emphasis and professional consensus to offer women choice, empowering them and focusing on facilitating a normal birth. However, there are significant differences in intervention rates across London and when compared nationally.

Guidance issued to improve the quality of care during labour emphasises the importance of midwives, multidisciplinary team working, clinical leadership, one-to-one care during established labour and the increased presence of consultant obstetricians on labour wards. Maternity services in London do not always meet this guidance.

Model of care

Care should be organised around the following guiding principles:

- Localised and normalised care.
- Continuous risk assessment.
• Seamless care.
• Choice.
• Communication, referral and transfer.
• Women centred care.

Cathy Warwick, Co-chair Clinical Expert Panel and General Secretary Royal College of Midwives:

“The model outlines an holistic approach to providing maternity care, emphasising women’s individualised needs and reducing health inequalities. The model aims to target current issues such as increasing levels of obesity, women having babies later in life, teenage pregnancy and supporting women from ethnic minorities.”

The model of care makes the following recommendations:

1. **Targeted pre-conception advice and care.** Improving general health and promoting a healthy lifestyle before pregnancy can improve outcomes.
2. **Accessible and timely antenatal care.** Good antenatal care provides the foundation for a good pregnancy experience and birth outcome. Continuous needs and risk assessment should be predominant with early access and monitoring targeted to women at most need.
3. **Midwife coordinated care for all women.** All women’s care should be coordinated by a named midwife throughout pregnancy, birth and postnatally.
4. **Provision of continuity of care.** Women feel more comfortable and supported if they know the healthcare professionals managing their care.
5. **Offering choice and non-medicalised care.** Women should be supported to make genuine, informed choice of how and where they receive their care. Where safe, labour and birth should be seen as a normal physiological process.
6. **Providing safe births.** Maternity commissioners and service providers need to work to meet the top safety and quality standards for providing maternity care.
7. **Commission and provide for diversity.** Service development needs to be informed and shaped by the individual needs of the women in London’s diverse communities.
8. **Improve postnatal care.** Postnatal support should be based on the individual needs of women and families. Breastfeeding initiation and continuation should be a particular priority.
9. **Improve data and evidence.** Women should have access to information and data to help them make informed choices about their care. Complete and accurate data should allow clear outcomes benchmarking to monitor quality, safety and inequalities.
Introduction

As an international city, London deserves world-class maternity services. The maternity project has been clinically led by a range of professionals who are involved in the front-line provision of maternity services in London. This includes obstetricians, midwives, neonatologists, anaesthetists and GPs. Maternity service commissioners, managers, women who have used services and members of the public were also integral to forming the recommendations on how London’s maternity services should be provided in the future (Appendix 3).

Co-chairs Professor Andrew Shennan, Obstetrician, St Thomas' Hospital, and Cathy Warwick, President, Royal College of Midwives:

“The clinical working groups worked hard to review the available evidence base and recommend a model of care which can provide the best outcomes for women and their babies in London.”

In addition to London guidance, national policy perspectives on the development of maternity services emphasise the need for change and improvements in maternity services. Maternity services must strive to meet clinical guidelines set out by The National Institute for Health and Clinical Excellence (NICE). Services also receive national guidance from the Royal College of Obstetricians and Gynaecologists (RCOG), the Royal College of Midwives (RCM), the Centre for Maternal and Child Enquiries (CEMACE) and other bodies. Services have to comply with standards set by the Care Quality Commission and the NHS Litigation Authority. Maternity services integrate the above guidance, standards and advice into local protocols.

The case for change sets out London’s demographic and public health context, women’s views and evidence for developing maternity services for women and their babies in London. To tackle the challenges set out, the model of care is a proposal for developing world class maternity services from those in London’s maternity community. The clinicians, commissioners and service user groups involved in developing the model have made recommendations based on clinical evidence or best practice, supported by national and pan-London guidance.
CASE FOR CHANGE

PART A: Responding to Londoners’ needs

1 Public health trends

1.1 The number and location of births

The population in London has been increasing. There has been a steady increase in the number of births year on year (104,412 births in 2002 compared to 127,640 in 2008\(^1\)), with an overall increase of 18.2% across London from 2002-2008. This increase is predicted to level off across London with a decrease of 2.3% (2,857 births) between 2012 and 2018 and a small increase of 1.6% across the whole of London (1,956 births) predicted from 2018 to 2031 (Figure 1)\(^2\).

Maternity commissioners and service providers in London have to respond to changing birth numbers. In London there is not always the right physical capacity and staff available at the right time, in the right place to care for women and their babies. To ensure women are always provided with a safe service, there are sometimes temporary closures of units. All closures of labour wards are classified as serious incidents and are fully investigated. Services in London need to constantly review need and available capacity as well as their models of care and options for place of birth to avoid these temporary closures.

Figure 1: The number of births (solid lines) and projection of births (dotted lines) in London

Source: Greater London Authority (2010). Round Population Projections
Local commissioners will need to review and analyse local birth projection data from different sources to best determine local current and future need.

\(^2\) ibid
London has a highly transient population whose health needs are diverse. London residents usually have a choice to give birth in different hospitals all within very close proximity (0-5 miles). Teams of community midwives providing antenatal and postnatal care for the hospital a woman chooses to give birth in may not provide care where the woman lives. In these scenarios women often do not experience continuity of care.

“I didn’t expect to see so many midwives. I would have really liked to have had one midwife that I could have built a relationship with, rather than seeing different faces all the time...Because I had different midwives, it’s difficult talking about what’s going on with your body.”

London needs to plan services that can provide continuity of care across boundaries throughout London.

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3 Feedback from a Maternity Services Liaison Committee
1.2 Maternal age

Most women having babies in London are aged between 25-34 years (Figure 3). However, very young mothers (women aged 11-19 years) and older mothers (aged 40 years and over) have unique health needs and place different and often additional demands on maternity services.

Figure 3: Age groups of mothers in London PCTs


The London average is shown in the dark purple central column.
Teenage mothers

Pregnant young people are a diverse group and have differing needs. Some young people will relish the opportunity to spend time with other mums in similar situations and others will choose to take part in other antenatal care options. A recent review of evidence by the National Collaborating Centre for Women’s and Children’s Health found that young, pregnant women may feel uncomfortable using antenatal care services where the majority of service users are in older age groups. This evidence is backed up by feedback at a London Maternity Service Liaison Committee:

“This group did not want to enter traditional maternity services – and were appalled at the idea that they would have to sit in the same surgery or antenatal clinic with the pregnant friends of their mothers. They were acutely self-conscious of their situation and that they were being judged by older women and healthcare professionals.”

In addition, teenage mothers can have difficulties accessing services if they do not have their own transport and public transport is unavailable or unaffordable. Day time clinics can be problematic for young people at school or college.

In some instances teenage pregnancies and early parenthood are recognised as being associated with poor outcomes and social exclusion. Teenage mothers are a third less likely to breastfeed than older mothers and are at an increased risk of having an inadequate diet during pregnancy.

In London in 2008, 4% (4,857 babies) of births were to mothers aged 11-19 years old (Figure 4). Women aged under 20 years have one of the lowest rates of maternal mortality of all age groups (9.9 per 100,000 deliveries). However the most recent perinatal mortality report in Britain showed that babies born to women aged under 20 years experience a higher rate of stillbirths (5.6 per 1,000 deliveries), higher rate of perinatal death (8.9 per 1,000 deliveries) and higher rates of neonatal death (4.4 per 1,000 births) when compared to women aged 20-34 years.

Having babies later in life

Over the last two decades there has been a trend towards women delaying having a baby until they are in their 30s and beyond. In 2006, nearly half of all births (48%) in England and Wales were to women aged over 30, compared to 28% in 1986. The percentage of births to women over 40 has more than doubled in the last two decades.

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2 Feedback from teenagers through a London Maternity Service Liaison Committee
4 Department for Children Schools and Families, Getting maternity services right for pregnant teenagers and young fathers , 2009
5 ibid
6 The NHS Information Centre for health and social care, 2008
decades\textsuperscript{13}. The breakdown of mothers over the age of 40 by PCT in London (Figure 5) shows that some areas (such as Kensington & Chelsea, Richmond & Twickenham and Camden) have a significantly higher proportion of older mothers compared to other areas. The Royal College of Obstetricians & Gynaecologists Expert Study Group on Reproductive Ageing advised that ageing is associated with worsening reproductive outcomes.

Dr Susan Bewley, Consultant Obstetrician/ Maternal Fetal Medicine, Guy’s and St Thomas’ Hospital, Honorary Senior Lecturer, King’s Health Partners:

“We should not be surprised that pregnancy aged over 35 years, beyond the natural normal range of maternal age, is riskier. More complexity, diabetes, hypertension, IVF, multiple pregnancies and perinatal loss are all inevitable consequences that provide a challenge to providing maternity services in London.”

\textsuperscript{13} ibid
Women over the age of 35 have more antenatal tests and ultrasound scans\textsuperscript{14}. Older mothers have an increased chance of developing medical problems such as high blood pressure, gestational diabetes, low lying placenta and other complications which can cause problems in pregnancy and birth.

Dr Felicity Plaat, Obstetric Anaesthesia, Imperial College Healthcare NHS Trust:

“We are beginning to see conditions not usually associated with childbearing age such as myocardial infarcts.”

Data from a representative sample of London’s maternity hospital birth episodes from Quarter 1 (April-June) 2009/10\textsuperscript{15} (Figure 6) was analysed. Births with complications were plotted by age\textsuperscript{16}. There is a marked pattern of increased complication and/or intervention at birth with increasing maternal age. It is unknown whether this


\textsuperscript{15} Secondary User Statistics, Quarter 1 2009/10

\textsuperscript{16} All births not ‘normal without complications’ were plotted
correlation relates to an increased need (e.g. increased likelihood of fetal distress in older mothers) or whether there is a perception that because the mother is older she is high risk and thus complications and medical intervention increase. Despite this, increased interventions and complications are associated with increased use of resources and need for specialist staff in the right place at the right time.

**Figure 6: % births with complications plotted by age (from representative sample of London’s maternity hospital birth episodes Quarter 1 2009/10)**

![Graph showing percentage of births with complications plotted by age](chart.png)

Source: Output from analysis of London’s maternity hospital birth episodes from Quarter 1 (April-June) SUS 09/10 Q1

Services in London need to be prepared for women having babies later in life. Women need to be given information and be aware of the risks associated with delaying parenthood. Women should be encouraged to be as healthy as possible with early management of medical conditions before conception. Women having babies at an older age need continuous antenatal risk assessment and early management to reduce the likelihood of complications. Services need to ensure they plan to have the right equipment, facilities and staff in place to manage the increase in older pregnant women.

**1.3 Increasing fertility treatment**

The delay in childbearing has important consequences as fertility declines with age. The number of women receiving fertility treatment has increased steadily since the early 1990s. In 1992, 14,057 women received treatment at an average age of 33 years. This increased to 36,648 by 2007 with the average age shifting to 36 years¹⁷. The shift in age reflects the increasing age of women having babies in the general population.

25% of pregnancies resulting from fertility treatment in the UK lead to the birth of twins, which is around 20 times more likely than after natural conception\textsuperscript{18}. In England and Wales, multiple births were recorded as 15 per 1,000 deliveries in 2007 compared with just 9.8 per 1,000 deliveries in 1980\textsuperscript{19}. It is very likely that the increase in multiple births is due to the increase in fertility treatment. Multiple pregnancies are associated with increased risks for mothers such as hypertensive disorders, diabetes, postpartum haemorrhage, pre-eclampsia, preterm labour and complications during birth. Babies are more likely to experience risks associated with low birth weight and immaturity, admission to neonatal intensive care units and impaired development\textsuperscript{20}.

Services in London need to be able to respond to the service challenges of multiple pregnancies. Services need to ensure they have the right equipment and facilities in place to manage the potential risks and complications associated with multiple pregnancies. Staff need to have adequate competencies to manage this group of women.

1.4 Increasing obesity

Maternal obesity is recognised as a growing issue for maternity services. Joint guidelines were published in 2010 by the Centre for Maternal and Child Enquiries and the Royal College of Obstetricians and Gynaecologists in 2010\textsuperscript{21}. The prevalence of obesity in the general population in England is continuing to increase with first trimester maternal obesity doubling from 7.6% to 15.6% over 19 years\textsuperscript{22}. There is substantial evidence that obesity in pregnancy contributes to increased complications for mother and baby with increased likelihood of miscarriage, fetal congenital abnormality, diabetes, pre-eclampsia, complicated labour, postpartum haemorrhage and wound infections\textsuperscript{23}. There is a higher caesarean section rate and lower breastfeeding rates in obese women compared with those with a normal BMI\textsuperscript{24}. The increased levels of complications in pregnancy and labour represent a fivefold increase in the cost of antenatal care\textsuperscript{25}.

Dr Felicity Plaat, Obstetric Anaesthesia, Imperial College Healthcare NHS Trust:

"I have seen a marked increase in the number of obese women we care for. Any type of anaesthetic intervention carries greater risks in these women who, as a group, require anaesthetic interventions much more frequently than the non-obese population\textsuperscript{26}.”

Services need to be able to respond to the increased risks associated with obese women through thorough risk assessment and early mitigation of associated risks.

\textsuperscript{18} ibid
\textsuperscript{19} NICE. Final Scope: Multiple Pregnancy. NICE, 2009
\textsuperscript{20} NICE. Final Scope: Multiple Pregnancy. NICE, 2009
\textsuperscript{21} Centre for Maternal & Child Enquiries/ Royal College of Obstetricians & Gynaecologists. Joint Guidelines: Management of women with Obesity in Pregnancy, 2010
\textsuperscript{23} Centre for Maternal & Child Enquiries/ Royal College Obstetricians & Gynaecologists. Joint Guidelines: Management of women with Obesity in Pregnancy, 2010
\textsuperscript{24} ibid
\textsuperscript{25} ibid
\textsuperscript{26} Knight, M. et al on behalf of UKOSS. Extreme obesity in pregnancy in the UK. Obstetricians & Gynaecologists 2010; 115(5). pp.969-997
Women should be encouraged to lead a healthy lifestyle before conception through pre-pregnancy care. The maternity care pathway should involve a number of staff from multidisciplinary teams to manage women’s care holistically.
2 Reducing inequalities of outcomes

Dr Daghni Rajasingham, Consultant Obstetrician, Guy’s and St Thomas’ NHS Foundation Trust:

“We talk about developing countries and their perinatal mortality rates, when there are geographical pockets across London with the same rates. This is unacceptable variation and we are all responsible for changing it.”

On the whole, women in London are healthier than those in the rest of England and Wales, but there are large health inequalities within London, often reflecting socio-economic factors such as deprivation and ethnicity. The long-term effects of the early pregnancy environment are well accepted and therefore pre-pregnancy care provides women and healthcare professionals with a unique opportunity to impact not only on maternal health but also on long-term child health.

2.1 Decreasing mortality

Maternal deaths

Being pregnant and giving birth is now safer than for any previous generation. In the early 1950s, mothers had a 1 in 1,500 chance of dying during childbirth. Today the chances are 1 in 20,000. By world standards, the UK is in line with other developed countries. However, any preventable maternal death is unacceptable and the rate of decline in the UK has slowed in the past decade (1%) compared with that of other countries in Europe (Spain’s rate of maternity mortality has declined at a faster rate of 3%)..

Women from south Asian and Black African communities, women living in poverty, and women seeking refuge and asylum are significantly more likely to die in childbirth compared to their white British counterparts in England and Wales.

Infant mortality

A 2007 report showed that the average rate of infant mortality (deaths under 1 year old) across England and within London was 5 deaths per 1,000 live births. Data from the Office of National Statistics for 2008, published in 2009, highlights an Infant Mortality Rate (IMR) of 4.6 per 1,000 live births in England and Wales. Data showed IMR is 50% higher for mothers born in New Commonwealth countries compared with mothers born in England and Wales (6.6 and 4.4 per 1,000 live births respectively). The IMR rate for mothers born in Caribbean countries is 9.5 per 1,000 live births which is the highest rate overall and double that compared with mothers born in England and Wales. Mothers born in East Africa and ‘Rest of Africa’ had significantly higher IMR.

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31 Ibid
rates compared with mothers born in England and Wales (7.0 and 8.0 per 1,000 live births respectively)\textsuperscript{34}.

The majority of deaths (69\%) were neonatal deaths (death occurring from 0-28 days old) with just over half occurring in the first week of life. Only 31\% were post-neonatal deaths\textsuperscript{35} (deaths from 28 days to 1 year old). The major causes for deaths were immaturity related conditions, antepartum infections and congenital anomalies (these were the cause in 72.5\% of infant deaths and 85.8\% of neonatal deaths). Nearly half (42.8\%) of post neonatal deaths were related to problems during pregnancy\textsuperscript{36}.

The Confidential Enquiry into Maternal and Child Health found evidence that smoking and alcohol/substance misuse are key factors influencing stillbirth and neonatal death rates\textsuperscript{37}. There is also a strong correlation between infant mortality rates and different ethnic and socio-economic groups\textsuperscript{38}.

Perinatal mortality refers to stillbirths and deaths at 0-6 days old. In the 1960s, 30 out of 1,000 newborn babies were stillborn or died soon after delivery\textsuperscript{39}. Perinatal mortality is now much lower, however. Figure 7 shows the significant variation in perinatal mortality rates within London.

**Figure 7: Perinatal mortality rates in London boroughs**

![Perinatal Mortality Graph](image)

Source: The NHS Information Centre for health and social care. Perinatal mortality, 2006-08 (pooled), December 2009

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\textsuperscript{34} ibid
\textsuperscript{35} ibid
\textsuperscript{36} ibid
\textsuperscript{37} Confidential Enquiry into Maternal and Child Health (CEMACH,) Perinatal mortality figures, 2007
\textsuperscript{38} ibid
\textsuperscript{39} Shribman, S. Making It Better: For Mother and Baby. Department of Health, 2007
To examine these trends, it is useful to look at factors causing perinatal mortality.

2.2 Low birth weight babies

Low birth weight, defined as less than 2,500g (WHO), is a major cause of perinatal mortality and morbidity. Low birth weight increases babies’ risk of impaired immune function, heart disease, diabetes and cognitive disabilities.

8% of all babies in the UK and in London have a low birth weight. When compared internationally to developed countries with similar characteristics, London has the same rate as the United States, but higher rates than Spain, Ireland and Canada (6%) and double the proportion of Finland and Sweden (4%). It is unclear what causes these differences, however we do know there are large variations in the rates of low birth weight babies within London boroughs.

The correlation between low birth weight and deprivation in London is shown in Figure 8 (correlation coefficient of 4.9). Tower Hamlets has the highest proportion of low birth weight babies (10%) which is the same proportion as Brazil, Botswana and Bulgaria. This is probably due to factors such as poorer pre-conception and maternal nutrition, increased smoking rates, poor housing and potentially poor uptake of antenatal care in these areas of deprivation. Richmond and Twickenham (6%) in contrast has the lowest rate which puts it in line with Switzerland.

Figure 8: Correlation between PCTs (in order of deprivation) and low birth weight in London


Department of Communities and Local Government, Indices of Deprivation, 2007

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42 ibid
43 ibid
The project groups were interested in reducing the number of babies born with low birth weight and asked for analysis of the main causes of low birth weight: a short gestation period (preterm birth) or retarded fetal (intrauterine) growth\textsuperscript{45}.

### 2.3 Preterm babies and retarded growth

Preterm birth, defined as childbirth occurring at less than 37 completed weeks of gestation (WHO), is a major cause of low birth weight and a major determinant of neonatal mortality and morbidity\textsuperscript{46}. Children who are born prematurely have higher rates of cerebral palsy, sensory deficits, learning disabilities and respiratory illnesses compared with children born at term. The morbidity associated with preterm birth often extends to later life, resulting in physical, psychological and economic costs\textsuperscript{47 48}.

In addition, intrauterine growth retardation is associated with significant perinatal mortality and morbidity\textsuperscript{49} such as impaired neurological development, cerebral palsy and diabetes in adult life.

Babies of teenage mothers, mothers who smoke during pregnancy, mothers with alcohol or drug addiction problems, women from socially deprived areas, women who have poor nutrition and women within certain ethnicity groups are more likely to have children born pre-term or with restricted growth\textsuperscript{50}. Studies have also found that the rate of preterm births is increasing because of rising numbers of preterm deliveries from assisted conception multiple pregnancies\textsuperscript{51}.

European countries have an average preterm birth rate of 6.2\%\textsuperscript{52}. This compares to 11.9\% for African countries and 9.1\% in Asia. The London average is 7\% (Figure 9) but varies considerably across London, from 2\% (Bromley) to 11\% (Croydon), highlighting persisting inequalities. Despite issues with the completeness of data, Waltham Forest, Newham, Islington and Tower Hamlets all have a higher percentage of pre-term births. These boroughs are all high on the Index of Multiple Deprivation 2007.

### Reviewing data

Figure 9 highlights variations in data completeness for preterm birth (with anomalies greyed out). For example, in Greenwich only 1 in 10 deliveries have a recorded gestation age. The two boroughs with low numbers of recorded data (Croydon, 12\%; Greenwich 14\%) appear to have abnormally large proportions of women delivering at less than 37 weeks. This affects the accuracy of the proportion of births and does mean caution has to be applied when comparing and benchmarking data.

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\textsuperscript{45} ibid
\textsuperscript{47} Petrou S. The economic consequences of preterm birth during the first 10 years of life. British Journal Obstetrics & Gynaecology 2005; 112: 10-5
\textsuperscript{50} Goldberg RL, Culhane JF, Iams JD, et al., Epidemiology and causes of preterm birth. The Lancet. 2008 Jan 5;371(9606):75-84.
\textsuperscript{51} ibid
Figure 9: % mothers delivering at less than 37 weeks gestation by PCT of residence

<table>
<thead>
<tr>
<th>Area (PCT)</th>
<th>Mothers delivering under 37 weeks</th>
<th>Percentage of mothers delivering where gestation was recorded</th>
<th>Percentage of mothers delivering where gestation was recorded where gestation was &lt;37 weeks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barking &amp; Dagenham</td>
<td>219</td>
<td>98%</td>
<td>7%</td>
</tr>
<tr>
<td>Barnet</td>
<td>236</td>
<td>92%</td>
<td>5%</td>
</tr>
<tr>
<td>Bexley</td>
<td>114</td>
<td>72%</td>
<td>6%</td>
</tr>
<tr>
<td>Brent</td>
<td>212</td>
<td>88%</td>
<td>5%</td>
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<tr>
<td>Bromley</td>
<td>47</td>
<td>83%</td>
<td>2%</td>
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<td>Camden</td>
<td>164</td>
<td>93%</td>
<td>7%</td>
</tr>
<tr>
<td>City &amp; Hackney</td>
<td>286</td>
<td>94%</td>
<td>7%</td>
</tr>
<tr>
<td>Croydon</td>
<td>66</td>
<td>12%</td>
<td>11%</td>
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<tr>
<td>Ealing</td>
<td>238</td>
<td>77%</td>
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<tr>
<td>Enfield</td>
<td>289</td>
<td>88%</td>
<td>7%</td>
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<tr>
<td>Greenwich</td>
<td>56</td>
<td>14%</td>
<td>10%</td>
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<tr>
<td>Hammersmith &amp; Fulham</td>
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<td>82%</td>
<td>7%</td>
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<tr>
<td>Harrow</td>
<td>122</td>
<td>79%</td>
<td>5%</td>
</tr>
<tr>
<td>Havering</td>
<td>148</td>
<td>97%</td>
<td>6%</td>
</tr>
<tr>
<td>Hillingdon</td>
<td>52</td>
<td>27%</td>
<td>5%</td>
</tr>
<tr>
<td>Hounslow</td>
<td>241</td>
<td>95%</td>
<td>6%</td>
</tr>
<tr>
<td>Islington</td>
<td>183</td>
<td>86%</td>
<td>8%</td>
</tr>
<tr>
<td>Kensington &amp; Chelsea</td>
<td>103</td>
<td>98%</td>
<td>6%</td>
</tr>
<tr>
<td>Kingston upon Thames</td>
<td>123</td>
<td>92%</td>
<td>6%</td>
</tr>
<tr>
<td>Lambeth</td>
<td>307</td>
<td>86%</td>
<td>7%</td>
</tr>
<tr>
<td>Lewisham</td>
<td>95</td>
<td>30%</td>
<td>7%</td>
</tr>
<tr>
<td>Newham</td>
<td>413</td>
<td>96%</td>
<td>8%</td>
</tr>
<tr>
<td>Redbridge</td>
<td>239</td>
<td>97%</td>
<td>6%</td>
</tr>
<tr>
<td>Richmond &amp; Twickenham</td>
<td>145</td>
<td>95%</td>
<td>6%</td>
</tr>
<tr>
<td>Southwark</td>
<td>327</td>
<td>96%</td>
<td>7%</td>
</tr>
<tr>
<td>Sutton &amp; Merton</td>
<td>184</td>
<td>53%</td>
<td>6%</td>
</tr>
<tr>
<td>Tower Hamlets</td>
<td>188</td>
<td>67%</td>
<td>8%</td>
</tr>
<tr>
<td>Waltham Forest</td>
<td>334</td>
<td>98%</td>
<td>8%</td>
</tr>
<tr>
<td>Wandsworth</td>
<td>129</td>
<td>52%</td>
<td>5%</td>
</tr>
<tr>
<td>Westminster</td>
<td>138</td>
<td>97%</td>
<td>6%</td>
</tr>
</tbody>
</table>

Source: Information Centre. 2008/09 HES, analysis by CSL. Excludes still births.
2.4 Improving preconception care

Dr Daghni Rajasgingham, Consultant Obstetrician, Guy’s and St Thomas’ NHS Foundation Trust:

“It’s important for women to start making healthy choices before pregnancy. Before conception, people need to think about the physical, emotional and lifestyle issues they will face during pregnancy, birth and as a parent.”

Improving pre-conception care can improve maternal and newborn health through providing the foundation for a good pregnancy and birth experience. In addition, pre-conception care could lead to improvement in general public health. Such care may include advice on healthy maternal weight, smoking cessation and improving nutrition. The promotion of pre-conception care is a national recommendation aimed at stimulating improvements in maternity services. However, we know that pre-conception care does not normally appear on care pathways nor is it usually commissioned or offered by healthcare services in London.

2.5 Improving antenatal care and early booking

Equity and excellence: Liberating the NHS (2010) p17:

“Pregnancy offers a unique opportunity to engage women from all sections of society, with the right support through pregnancy and at the start of life being vital for improving life chances and tackling cycles of disadvantage.”

Health differences start before birth. For example, evidence shows that a woman’s emotional health in pregnancy has significant effects on the long-term outcomes for her child, including mood disorders later in childhood.

Early contact with maternity services after a woman discovers she is pregnant enables screening, lifestyle advice and appropriate referrals to be made early during the care pathway. In this way, achieving early booking is an important proxy measure for improving outcomes and reducing inequalities of outcomes in maternity services. Early access is defined as:

“The percentage of women who have seen a midwife or a maternity healthcare professional for a health and social care assessment of needs, risk and choices by 12 completed weeks of pregnancy.”

Ensure Better Care for all Public Service Agreement (2007)

Women living in disadvantaged or minority groups and communities are significantly less likely to access services early. This is likely to be due to inequality of access or cultural factors placing less priority on early booking and antenatal care. In London,

References:

53 Department of Health, National Service Framework: Young People and Maternity Services, 2005
55 Confidential Enquiry into Maternal and Child Health (CEMACH,) Perinatal mortality figures, 2007
56 Department of Health, Maternity Standard, National Service Framework for Children, Young People and Maternity Services, October 2004
analysis of booking data highlights trends associated with late booking and different groups of women.

Commissioners and providers are expected to work together to ensure that over 90% of women receive their first assessment before 12 completed weeks of pregnancy. However, maternity services in London are not consistently achieving this and London falls below the national average in its early booking performance (Figure 10). Women do not always understand the importance of accessing services early. Some women may not know how to access maternity services or be in a position to do so.

**Figure 10: % women booked within 12 (plus 6 days) weeks of pregnancy by PCT**

![Graph showing early bookings in Q4 2009/10 as a % women delivering in Q2 2010/11](source: Secondary User Statistics, Quarter 2 2010/11)

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### 2.6 Smoking cessation during pregnancy

Eradicating smoking during pregnancy will improve mother and infant outcomes. The percentage of mothers who are recorded as smoking at the time of delivery in London (2008/09) is significantly lower (7.4%) than the national average (14.4%). However, we know that babies born to women who smoke during pregnancy are much more likely to have a low birth weight and suffer from associated poor health outcomes.

There is significant variation in smoking rates across London (Figure 11). Bexley is the only London borough to have a higher rate of smoking at the time of delivery (15.2%) than the national average. Commissioners should aim to reduce the prevalence of smoking during pregnancy.

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smoking to the minimum levels possible among pregnant women or women planning a pregnancy. Smoking cessation programmes that are targeted at particular groups could be even more effective at reducing the number of mothers who are smoking at the time of delivery.

Figure 11: % of mothers smoking at time of delivery 2008/09 by London borough

Source: Association of Public Health Observatories

2.7 Encouraging breastfeeding

Evidence shows that breastfeeding has a major role in improving public health\textsuperscript{59}. Breastfeeding protects infants against gastroenteritis, infection, juvenile diabetes and raised blood pressure and reduces women’s chances of developing ovarian and breast cancer\textsuperscript{60}. Despite the health benefits, the UK has one of the lowest rates of breastfeeding worldwide, especially among families from disadvantaged groups, such as white young women, teenage women, first time mothers and single women\textsuperscript{61}. Statistically, London compares well to the rest of England with breastfeeding initiation

\textsuperscript{59} Dyson, L., Renfrew, M., McFadden, A., McCormick, F., Thomas, J., Promotion of breastfeeding initiation and duration: Evidence into practice briefing, July 2006, NICE


\textsuperscript{61} Ibid
averaging 84% compared with 72% in England\textsuperscript{62}. By 6-8 weeks, 65% babies in London are still totally or partially breastfed; again, this compares well to 45% in the rest of England\textsuperscript{63}. Healthcare professionals in London need to continue to encourage breastfeeding initiation and continuation to improve public health and wellbeing. Not all London maternity services are commissioned to encourage breastfeeding and not all services achieve Unicef and the World Health Organisation’s ‘Baby Friendly Status’, an initiative to improve breastfeeding rates worldwide\textsuperscript{64}.

\textsuperscript{62} Source: Department of Health, Vital Signs Monitoring Return, Initiation of breastfeeding by PCT & SHA (2009-10), Crown Copyright 2010
\textsuperscript{63} Ibid
\textsuperscript{64} Unicef and the World Health Organisation’s ‘Ten steps to successful breastfeeding’ are outlined on the model of care
3 Key messages

Evidence and data has highlighted that:

- The number of births has been increasing and is likely to continue to increase in the short term. Services need to plan their capacity and models of care to have adequate physical and staff capacity to cope with demand and prevent suspension of services.

- London is highly populated with several maternity services in close proximity to each other. Women often receive care in a different area to where they live, therefore services need to provide care across provider boundaries to ensure continuity of care. Services are not necessarily commissioned to provide this, so there will need to be a collaborative commissioning approach to achieve this.

- Obesity, diabetes, the age at which women give birth and use of fertility treatment are all increasing. These factors increase the risk of medical complications making thorough risk assessment and early management of complications essential.

- Services need to have provision available for the specific needs of individual groups such as teenage mothers, disabled women, single sex couples, travellers, drug users and other groups of seldom heard women.

- Whilst birth is safe for the majority of women, there is still an unacceptable level of risk for a minority of women. Women from south Asian and Black African ethnicities, women living in poverty and women seeking refuge and asylum are more likely to die in childbirth compared to white British women.

- Variation exists in relation to perinatal mortality and low birth weight in London. There is a correlation between these factors and socio-economic deprivation. Pre-term birth and poor intrauterine growth can cause perinatal mortality and low birth weights and are more common in teenage mothers, women who smoke, mothers with alcohol or drug addiction issues, women from socially deprived areas and women who have poor nutrition.

- Pre-conception care can improve maternal and newborn health but does not normally appear on care pathways, nor is it usually commissioned or offered by healthcare services in London.

- Early booking can improve outcomes and enables early screening, health advice and management but London is below the ideal of 90% women seeing a maternity healthcare professional for a health, risk and social assessment by 12 completed weeks of pregnancy.

- Smoking during pregnancy should be reduced as far as possible as it contributes to poor outcomes for women and their babies. Particular groups of women are more likely to smoke so targeted smoking cessation programmes will help reduce smoking rates.

- Although London compares well to the rest of England, we know that the lowest rates of breastfeeding are recorded among families from disadvantaged groups, particularly disadvantaged white young women, teenage mothers, first time
mothers and single women. Services should aim to continually improve breastfeeding rates.

The model of care should therefore:

- Be regarded within wider pre-conception and public health issues such as obesity and smoking. Information should be targeted with advice to those women most at risk. Women should be aware of risks in delaying starting a family or being overweight.

- Be suited to the individual needs of each mother and her baby e.g. teenage mothers.

- Mandate thorough risk assessment, enabling early management of potential complications.

- Emphasise meeting the needs of women whose health outcomes are less favourable when compared with the rest of the population (such as mothers born outside the UK), without diminishing support for other women.

- Ensure that women from all socio-economic, cultural and ethnic backgrounds get the same access and quality of service.

- Promote early access for all, especially targeted to groups who are less likely to book before their 12th completed week of pregnancy.

- Have systems in place capable of providing equitable outcomes for women and babies, for example through provision of support for women with complex social needs or who are at an increased clinical risk.
PART B: Improving women’s experiences

4 Women’s views

London’s healthcare community was disappointed with the Healthcare Commission’s review into maternity services in England in 2008 as it highlighted that women were not always experiencing excellent care. The report showed improvements were needed, especially in relation to patient satisfaction, postnatal care and the provision of choice. Research into women’s wants and needs and the views of seldom heard women has identified gaps in service provision and highlighted areas for improvement.

4.1 Feedback from the Healthcare Commission report

The Care Quality Commission (CQC) is the independent regulator of health and social care in England (formerly the Healthcare Commission). From 2002-2005 they conducted a detailed review of maternity services in England prompted by investigations into serious clinical incidents.

Firstly, trusts’ maternity services were assessed in three areas: clinical focus, women-centred care and efficiency and capability. 19 of the 27 trusts scored as ‘least well performing’ nationally were in London (Figure 12).

There were 25 indicators grouped into three areas. Each unit was scored 1-5 on each indicator, with three as an average. Those with a better performance scored four or five and those with a poorer performance scored one or two. The average of all indicators became the sites’ overall score.

Secondly, mothers’ experiences were assessed. The survey asked women to rate their care during pregnancy, labour and birth and following birth. Patient satisfaction in London was below the national average (Figure 13). In particular, postnatal care experience was worse than England as a whole (although this was not uniform across London). Also causing concern was the perceived lack of access to perinatal mental health services and women feeling they did not have choice of where to have their baby.

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66 Commissioning Support for London. What women and their families need and want from a maternity service, 2010
67 COI/NHS London, Qualitative research report: Satisfaction with maternity services in London amongst seldom heard audiences, June 2010
4.2 What women say

The project’s engagement group ran a rolling programme researching the wants and needs of women in London. The publication *What women and their families need and want from a maternity service*69 presents existing quantitative and qualitative published and unpublished data on what London women and their families say they need and want from maternity services. Valuable input was received from Maternity Service Liaison Committee (MSLC) chairs and the voluntary sector. Following this groundwork, NHS London’s Maternity Services Improvement Board (MSIB) commissioned qualitative research, including in-depth interviews with women, their partners and healthcare professionals to further understand the expectations, experience and needs of seldom heard groups70.

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69 Commissioning Support for London. What women and their families need and want from a maternity service, 2010
70 COI/NHS London, Qualitative research report: Satisfaction with maternity services in London amongst seldom heard audiences, June 2010
* Seldom heard groups identified were: younger women (under 30 years old); women from BMER groups; women with a self-reported disability; single women (those without a partner)
Women taking part in both sets of research identified similar issues in relation to their experiences. These have been grouped into the following themes below: communication; women-centred care; continuity of care; access to information; and choice.

**Figure 13: Care Quality Commission survey questions, 2007**

<table>
<thead>
<tr>
<th>Survey questions</th>
<th>London average</th>
<th>England average</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>H9a. Overall, how would you rate the care received during your pregnancy? Excellent/Very good/Good</td>
<td>84.74%</td>
<td>88.49%</td>
<td>3.75%</td>
</tr>
<tr>
<td>H9b. Overall, how would you rate the care received during your labour and birth? Excellent/Very good/Good</td>
<td>83.85%</td>
<td>88.55%</td>
<td>4.70%</td>
</tr>
<tr>
<td>H9c. Overall, how would you rate the care received during your care after the birth? Excellent/Very good/Good</td>
<td>70.07%</td>
<td>79.40%</td>
<td>9.32%</td>
</tr>
</tbody>
</table>

**Scored assessment for London**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Poor performing</th>
<th>Average</th>
<th>Better performing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator 10: Choice and continuity for antenatal care</td>
<td>0%</td>
<td>59%</td>
<td>41%</td>
</tr>
<tr>
<td>Indicator 15: Quality of support in caring for the baby after discharge</td>
<td>11%</td>
<td>15%</td>
<td>56%</td>
</tr>
</tbody>
</table>


4.3 Communication

"Don’t make assumptions that I want to be treated the same as everyone else – ask me what I want."71

Women do not always feel they are clearly communicated with. Women said they wanted good communication with staff who are empathic, open to questions and have sufficient time to talk through concerns. Women said they value proactive contact from maternity providers, such as by texting appointment reminders.

Services need to improve the way they communicate care pathways and the healthcare professionals who are involved. Healthcare professionals need to be aware of the importance of the tone of communication with women, with an emphasis on women-centred care which demonstrates an understanding and appreciation of each

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71 Quote from personal experience of Dr Alison Wright, Consultant Obstetrician
woman’s diverse needs. This is especially pertinent in London where local authority areas are the most diverse in the England72.

“Women in labour should be treated with respect and should be in control of, and involved in, what is happening to them…..healthcare professionals and other caregivers should establish a rapport with the labouring woman…being aware of the importance of tone and demeanour.” 73

4.4 Women-centred care

Some women said they felt unsupported during pregnancy and birth. Postnatal care in hospital was a particular cause of dissatisfaction. Women said they wanted healthcare professionals to have enough time to support their recovery and to help them gain confidence in taking care of their baby.

Women may have complex medical, social or emotional needs and this is a particular issue within some parts of London, such as services working with women from a diverse range of ethnicities and cultures and whose first language is not English. Healthcare professionals often feel ill-equipped to meet the needs of their ethnically diverse patient population. Adequate cultural competency training to prepare providers to deliver supportive and culturally sensitive care can improve this74.

One woman described how pregnant drug users can feel when using maternity services:

“Drug users are scared that their baby will be taken away by social services, and so are not likely to talk about this. They feel they have to be more perfect – i.e. more clean, no mental health issues, because they are users.”

During an engagement event, one woman explained:

“Women would like more support, e.g. a buddying system for vulnerable women with a woman that has had children before, so she knows how it feels.”75

To address women who feel like this, national policy recommends that care should be women-centred and tailored to individuals’ needs and wishes, for example, a woman living with violence may need specific information support services during pregnancy76. The Royal College of Midwives believe that women-centred care should mean that all women receive care coordinated by a midwife with services planned and delivered in communities where women live and work77. We know that in London not all women’s care is coordinated by a midwife and that women often have to travel and attend hospitals for appointments that could be provided closer to where women live and work.

72 Greater London Authority: Focus on London. A top ranking of all authorities in England and Wales, 2009
73 NICE, Intrapartum care: Care of healthy women and their babies during Childbirth: Clinical guideline 55, Developed by the National Collaborating Centre for Women’s and Children’s Health, Sept 2007, p.4
75 Commissioning Support for London. What women and their families need and want from a maternity service, 2010
76 Department of Health, Maternity Standard, National Service Framework for Children, Young People and Maternity Services, October 2004
77 Royal College of Midwives, Women centred care position statement, June 2008
4.5 Continuity of care

Women said they appreciated receiving care from known and named healthcare professionals throughout their pregnancy. This is not always provided in London with some women expressing feelings of abandonment and lack of support. Continuity of care across the maternity pathway has consistently been identified by women as an issue in the majority of London trusts. Services do not always provide continuity of care across their maternity pathway, during pregnancy, birth and, importantly, during the postnatal period. In addition, we know that women often receive care in a different area to where they live and services are not necessarily commissioned to provide care across boundaries throughout London. Women said that consistency in how information is transferred between healthcare professionals is pivotal so that professionals know a woman’s medical history and women do not have to repeat their details continually. Specifically, women want to be able to see a midwife who knows her and her baby postnatally. Women often need additional support after they have had their baby and seeing many different healthcare professionals can leave them feeling confused and overwhelmed.

“I would have preferred to have just one or two midwives looking after me whilst pregnant. Instead…I just saw whoever was on duty on the day of my appointment. It didn’t give me a chance to get to know them and vice versa, so there wasn’t one/two midwives who knew everything that was going on in my pregnancy. This isn’t a criticism of the midwives who were, in general, very good.”

“I remember in the old days, you had a personal relationship with your midwife, I’m sure that new mothers nowadays would want that kind of support.”

Most women with complex needs will benefit from continuity of care as it can significantly improve the experience and outcomes for women and their babies and women are more likely to talk openly to healthcare professionals and trust them.

4.5.1 Access to information

“We often don’t have GPs and don’t know where to find information.”

Women and their families said they did not always know what to expect from maternity services. Women wanted access to timely, accessible information about the care they could receive and what to expect. Women said they need information in a variety of formats that is accessible, comprehensive and accurate. Specifically, families wanted information such as visiting hours tailored to them. Families felt this would enable and empower them to support mother and baby.

Shared decision making is becoming the norm in healthcare and evidence-based information about factors that make a normal birth with good outcomes more likely

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78 Commissioning Support for London. What women and their families need and want from a maternity service, 2010
79 Participant in engagement work-stream event
80 Commissioning Support for London. What women and their families need and want from a maternity service, 2010
81 Commissioning Support for London. What women and their families need and want from a maternity service, 2010
should be presented in a format women understand. This information should enable shared decision making between women, their families and healthcare professionals.

It is important that maternity healthcare professionals in London have adequate competencies to facilitate informed decision making and choice.

4.6 Choice

Women said they wanted a real and informed choice of birth setting with adequate information and explanations about choices available to them.

Maternity service commissioners do not always commission services to provide different birthing environments for women. When this is commissioned, providers are not always able to implement choice:

“I wanted a home birth but I was told there weren’t enough staff or midwives who knew how to do it.”

Usually women in London access services based on where they live, who their GP usually refers to and based on the historical set up of services. However, commissioners should plan services so women in the area have a choice of how and where to access maternity care.

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82 Royal College of Midwives, Royal College of Obstetricians & Gynaecologists, National Childbirth Trust. Making normal birth a reality: Consensus statement from the Maternity Care Working Party: our shared views about the need to recognise, facilitate and audit normal birth, 2007.

83 Feedback from London service users as part of the maternity project’s patient engagement, 2009.
5 Choice of location of birth

Women receiving choice and midwife-coordinated care increase the likelihood of a normal birth with less pain and providing a better birthing experience. There is growing consensus that when it is safe for mother and baby, women should be supported to have a normal birth free from medical intervention.

The NHS Constitution states that:

“You [patients] have the right to drugs and treatments that have been recommended by NICE for use in the NHS, if your doctor says they are clinically appropriate for you.”

Government policy and NICE promote the principle that women should have a choice of birth setting and there is a current commitment to a ‘national choice guarantee’ where women and their partners should be able to have a choice of:

- A home birth supported by a midwife.
- Birth in a local facility, including a hospital, under the care of a midwife.
- Birth in a hospital supported by a local maternity care team including midwives, anaesthetists and consultant obstetricians (for some women this will be the safest option).

Women should also have a choice regarding:

- How and where to access maternity care (a woman may choose to access maternity services outside her area with a provider that has available capacity).

5.1 Normalising birth – home births and midwifery led units

The start of the 20th century saw a rise in rates of hospital delivery. In 1927, just 15% of deliveries in England and Wales took place in hospital, but by 1932 this had risen to 24%. By the 1950s, 36% of mothers gave birth at home with another 13% under the care of GPs or midwives. By the 1970s, home births had dropped to 12% and in the 1980s, policy encouraged women to have their baby in a hospital where emergency facilities were available. This increased the culture of turning birth into a medical event rather than a natural physiological process.

The Royal College of Midwives and the Royal College of Obstetricians and Gynaecologists reviewed evidence available on home births and encourage home births for women with uncomplicated pregnancies. Many argue that home births provide a familiar, relaxing and private environment where women experience less pain and use less pharmacological pain relief, lower levels of intervention, more autonomy and ultimately, increased satisfaction.
However, the rate of home births in the UK is seen as low at approximately 2%\(^91\). In London there is a significant range from 0.2% - 8% (Figure 14). When it is safe, a home birth should always be available for women who choose this.

**Figure 14: Percentages and numbers of home births per maternity service 2008/09**

<table>
<thead>
<tr>
<th>Trust maternity units</th>
<th>Total deliveries</th>
<th>Home births</th>
<th>Home births (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barking Havering &amp; Redbridge</td>
<td>9,666</td>
<td>130</td>
<td>1.30%</td>
</tr>
<tr>
<td>Barnet &amp; Chase Farm</td>
<td>6,638</td>
<td>45</td>
<td>0.70%</td>
</tr>
<tr>
<td>Central Middlesex &amp; Northwick Park</td>
<td>4,799</td>
<td>33</td>
<td>0.70%</td>
</tr>
<tr>
<td>Chelsea &amp; Westminster</td>
<td>5,205</td>
<td>28</td>
<td>0.50%</td>
</tr>
<tr>
<td>Ealing Hospital</td>
<td>2,991</td>
<td>17</td>
<td>0.60%</td>
</tr>
<tr>
<td>Guy’s and St Thomas’</td>
<td>7,190</td>
<td>64</td>
<td>2.30%</td>
</tr>
<tr>
<td>Hillingdon Hospital</td>
<td>4,250</td>
<td>65</td>
<td>1.50%</td>
</tr>
<tr>
<td>Homerton Hospital</td>
<td>4,633</td>
<td>75</td>
<td>1.60%</td>
</tr>
<tr>
<td>King’s College Hospital</td>
<td>5,474</td>
<td>456</td>
<td>8.30%</td>
</tr>
<tr>
<td>Kingston Hospital</td>
<td>5,726</td>
<td>87</td>
<td>1.50%</td>
</tr>
<tr>
<td>Lewisham Hospital</td>
<td>3,499</td>
<td>137</td>
<td>3.90%</td>
</tr>
<tr>
<td>Mayday Hospital</td>
<td>4,519</td>
<td>43</td>
<td>1.00%</td>
</tr>
<tr>
<td>Newham Hospital</td>
<td>5,066</td>
<td>13</td>
<td>0.30%</td>
</tr>
<tr>
<td>North Middlesex Hospital</td>
<td>3,453</td>
<td>58</td>
<td>1.70%</td>
</tr>
<tr>
<td>Princess Royal</td>
<td>3,735</td>
<td>173</td>
<td>4.60%</td>
</tr>
<tr>
<td>Queen Charlotte's &amp; Chelsea Hospital</td>
<td>5,198</td>
<td>8</td>
<td>0.20%</td>
</tr>
<tr>
<td>Queen Elizabeth</td>
<td>4,114</td>
<td>135</td>
<td>3.30%</td>
</tr>
<tr>
<td>Queen Mary's (Sidcup)</td>
<td>2,987</td>
<td>43</td>
<td>1.40%</td>
</tr>
<tr>
<td>Royal Free Hospital</td>
<td>3,252</td>
<td>51</td>
<td>1.60%</td>
</tr>
<tr>
<td>St George's Hospital</td>
<td>4,943</td>
<td>85</td>
<td>1.70%</td>
</tr>
<tr>
<td>St Helier and Epsom Hospitals</td>
<td>5,002</td>
<td>139</td>
<td>2.80%</td>
</tr>
<tr>
<td>St Mary's Hospital</td>
<td>4,487</td>
<td>39</td>
<td>0.90%</td>
</tr>
<tr>
<td>The Royal London Hospital</td>
<td>4,247</td>
<td>18</td>
<td>0.40%</td>
</tr>
<tr>
<td>University College Hospital</td>
<td>4,032</td>
<td>59</td>
<td>1.50%</td>
</tr>
<tr>
<td>West Middlesex Hospital</td>
<td>3,928</td>
<td>73</td>
<td>1.90%</td>
</tr>
<tr>
<td>Whipps Cross Hospital</td>
<td>5,125</td>
<td>56</td>
<td>1.10%</td>
</tr>
<tr>
<td>Whittington Hospital</td>
<td>3,683</td>
<td>110</td>
<td>3.00%</td>
</tr>
</tbody>
</table>

**Average** 1.80%


The Cochrane Review\textsuperscript{92} compared midwife-led care with obstetric-led care and found that midwife-coordinated care increases the likelihood of a normal birth\textsuperscript{93}. Secondly, the review compared midwife-led models of care to other models of care. Women receiving midwife-led care were more likely to experience: a spontaneous vaginal birth; no intrapartum analgesia/anaesthesia; attendance at birth by a known midwife; high perceptions of control during labour; higher rates of breastfeeding initiation.

About 4\% of births take place in a midwife-led unit like a birthing centre in England\textsuperscript{94}. In London, we do not have accurate data to track the number of births in midwifery-led units.

**Keeping up to date with evidence: birthplace study**

Research reviews have identified major gaps in the evidence around place of birth. The National Institute for Health Research (NIHR)* and Department of Health has awarded funding to a collaborating group led by the National Perinatal Epidemiology Unit to compare outcomes of births planned at home, in midwifery-led units and in hospital units.

The report is due to be published in 2011 and will provide women, healthcare professionals and commissioners with evidence to support choices, decisions and strategy to plan birth location.

When designing services and proposing models of care, new and emerging evidence needs to be constantly reviewed to ensure clinical practice and services operate in line with the latest evidence based knowledge.

*NIHR Service Delivery and Organisation Programme
NIHR Policy Research Programme

\section*{5.2 Reducing inappropriate interventions – births in obstetric units}

In London, most women give birth in an obstetric unit. An obstetric unit is usually part of a hospital, staffed by obstetricians and midwives with access to anaesthetists and other specialist staff. Interventions such as epidurals, caesarean section operations or forceps are available in these units. Women with high-risk pregnancies who are likely to experience complications are advised to have a hospital based birth.

There is increasing agreement that when possible, women should be supported to have a normal birth free from medical intervention.

The Maternity Care Working Party’s (MCWP) statement highlights the consensus:

\textit{“With appropriate care and support the majority of healthy women can give birth with a minimum of medical procedures and most women prefer to avoid interventions, provided that their baby is safe and they feel they can cope….Members of the

\textsuperscript{93} The Information Centre for the NHS in England has adopted a working definition for normal labour and birth which they call ‘normal delivery’. The definition is “without induction, without the use of instruments, not by caesarean section and without general, spinal or epidural anaesthetic before or during delivery”.

- 34 -
Maternity Care Working Party are concerned about rising intervention rates and wide variations between different services.95

Normal births seem more likely to occur where there is a shared positive attitude towards birth as a normal process96 and women receive one-to-one care from a known midwife97.

There are significant differences in the intervention rates (for example, assisted deliveries and caesarean section rates) in providers across London.

5.2.1 Caesarean sections

The World Health Organisation (WHO) recommends that caesarean section rates should not exceed 10-15%98. In England and Wales in 2007/08, the rate was 24.6%99 and the average in London for 2007/08 was 27.3%100. London has the highest elective and emergency caesarean section rate in the country101. This is variable across trusts (Figure 15) but nearly always higher than the recommended level102.

The rates between trusts may differ due to their case mix. However, rates above national and recommended averages should prompt questions regarding practice.

Normal births, free from intervention, reduce a woman’s hospital length of stay. This is better for women and releases capacity in maternity services, with corresponding financial savings. After a caesarean section, the average length of stay in London is three days without complications and four days with complications. After a normal birth, 74.1% of women had left the hospital after one day or less (Figure 16).

Comparing data

There are inherent issues when collecting and comparing data from London’s maternity providers. Data is not always complete or accurate and there are risk factors when comparing intervention rates with the rest of England. For example, in some areas of London a higher proportion of women, when compared with the rest of England, have their antenatal care abroad, increasing risk and the likelihood of intervention.

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99 NHS Information Centre, NHS Maternity Statistics, April 30th, 2009
100 ibid
101 ibid
Figure 15: Rate of caesarean sections by London hospital trusts


England average: HES data 2008/09

World Health Organisation recommends that caesarean section rates should not be higher than 10 – 15%

Use of data

It should be noted that the data for rates of birth interventions such as forceps and ventouse (Figure 18) should be used with caution. These interventions are usually only used when necessary for the safety of mother and baby. They are therefore not sensitive indicators for quality. More sensitive indicators would include failed forceps delivery or the extent of trauma caused by an intervention. This data is not currently available on a pan-London basis.
Some unspecified cases from the University College London Hospital and the Royal Brompton stayed fewer days after a caesarean section. These cases were not in a dedicated maternity ward and therefore, the completed episode may not have reflected the end of the recovery in hospital.

5.2.2 Epidurals

Epidural analgesia during a vaginal birth is a popular form of pain relief for women during childbirth. Because an epidural is an invasive procedure carried out by an anaesthetist, women choosing this form of pain relief must be cared for in units with on-site anaesthetic services, usually within a consultant-led unit. In NHS trusts, rates appear to differ by as much as 30% (Figure 17).
5.2.3 Forceps and ventouse

Forceps and ventouse are interventions to assist women deliver their babies. Within London hospitals, forceps are used in 4.1% births (compared with 5% in England\textsuperscript{103}). Rates in London differ by as much as 5.9%. In England, 7% of babies born were aided by ventouse with London’s average one year later showing a similar average rate 8% in 2008/09\textsuperscript{104}. 

\begin{footnotesize}
\textsuperscript{103} NHS Information Centre for health and social care, 2008/09, December 2009
\textsuperscript{104} ibid
\end{footnotesize}
Figure 18: Rate of forceps and ventouse interventions by London hospital trusts

6  **Key messages**

- London was disappointed with results from the Healthcare Commission’s 2008 assessment of maternity services. London’s health community want to improve this for women and their babies.

- Women told us they did not always feel maternity services communicated with them effectively and they wanted empathic healthcare professionals caring for them who communicate with them as an individual and have respect for them and their families.

- Women want better and more useful information to enable them to make informed choices about how and where to give birth.

- Women sometimes felt unsupported, especially in relation to post-natal care. Women said they valued continuity of care from healthcare professionals they know and trust.

- London’s maternity services do not always provide women with adequate choice or access to home births or births in a midwifery led unit. Whilst the rate of home births in London are low at 1-8%, medical interventions during pregnancy and birth within an obstetric hospital setting continue to increase.

- There is a shared emphasis and consensus on offering pregnant women choice, empowering them, focusing on facilitating a normal birth to decrease interventions.

- There are significant differences in intervention rates at providers across London. London has high caesarean section and episiotomy rates compared with the rest of England and World Health Organisation recommendations. There is high variation in the use of epidurals, ventouse and forceps obstetric units in London.

The model of care should therefore:

- Respond to what women have said and improve services in relation to communication, women-centred care, continuity of care and access to information.

- Allow parents to make informed choices supported by good provision of data.

- Promote choice in how and where women have their baby with a particular emphasis on supporting and encouraging women to see birth as a normal physiological event, to give them confidence in their ability to safely give birth and to have as normal a pregnancy and birth as possible without medical interventions.
PART C: Ensuring safety and quality

7 Meeting minimum standards

The top priority of organisations providing maternity services in London must be to provide safe, high quality care. We know that London’s maternity service providers scored poorly when assessed for clinical focus, efficiency and capability\(^\text{105}\). London’s services reported a total of 289 Serious Incidents to NHS London in 2008-09\(^\text{106}\). Increasing Serious Incidents may not be a bad thing as it may be indicative of improved reporting and openness. All maternity services in London need to ensure they have an open culture in relation to incident reporting as analysis of Serious Incidents enables shared learning and future risk management. However, the causes of Serious Incidents, poor safety or quality, should be reduced to a minimum.

Women have told us they need their basic care requirements met, for example a clean environment, provision of adequate food and to be treated with respect and dignity\(^\text{107}\). Some women said they felt abandoned during childbirth and did not always receive one-to-one care from a midwife during established labour:

“I was concerned about infection control issues. The mattress was taped together….a nurse didn’t use aseptic non-touch technique when administering medication into my epidural port”\(^\text{108}\)

\textit{Safer Childbirth} (2007)\(^\text{109}\) was published by the Royal College of Obstetricians and Gynaecologists jointly with the Royal Colleges of Midwives, Royal College of Anaesthetists and Royal College of Paediatrics and Child Health. The report responded to national concerns from the Confidential Enquiry into Maternal and Child Health (CEMACH) and the Confidential Enquiry into Maternal Deaths (CEMD), which highlighted the need for better organisation of care for women in labour. The report focused on setting out informed views about minimum staffing standards required to support women in labour. London does not always meet these minimum standards. Specifically:

- Midwives should be the main care-giver for normal labour and birth and form partnerships with obstetricians, anaesthetists and paediatricians for women with complex labours. Similarly, Midwifery 2020\(^\text{110}\) recommends that midwives are the lead professional for all healthy women with straightforward pregnancies and midwives should also be the key coordinator of care for women with complex pregnancies, within a multidisciplinary team of obstetricians, anaesthetists and paediatricians for women with complex labours. In London not all women have a named midwife. Constant leadership and supervisory support is needed to ensure midwives have these skills.

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\(^{106}\) Helleur A. Annual Report to the Nursing and Midwifery Council 1\textsuperscript{st} April 2008 – 31\textsuperscript{st} March 2009, Local Supervisory Authorities of London, NHS London, 2009

\(^{107}\) Commissioning Support for London. What women and their families need and want from a maternity service: Overview of existing data, 2010

\(^{108}\) ibid

\(^{109}\) Royal College of Anaesthetists, Royal College of Midwives, Royal College of Obstetricians and Gynaecologists, Royal College of Paediatrics and Child Health,\textit{ Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour}, 2007

\(^{110}\) http://www.midwifery2020.org/
• Multidisciplinary team working and excellent clinical leadership should be developed in all services with a team approach to improving communications between healthcare professionals themselves and when communicating with women. We know that women in London do not always feel they are communicated with effectively.

• One-to-one midwifery care should be provided for all women during established labour. Women have said this is not always the case in London.

• There should be an increased involvement of consultant obstetricians on the labour ward in the care of women with complex pregnancies and in the supervision and training of medical staff. Minimum staffing levels are recommended (Figure 19 below). London’s maternity services do not always meet these minimum requirements.

Figure 19: Obstetric staffing levels in safer childbirth\(^{111}\) p.34

<table>
<thead>
<tr>
<th>Births/year</th>
<th>Consultant presence (year of adoption)</th>
<th>Specialist trainees (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>60-hour</td>
<td>98-hour</td>
</tr>
<tr>
<td>&lt;2,500</td>
<td>Units to continually review staffing to ensure adequate based on local needs</td>
<td>1</td>
</tr>
<tr>
<td>2,500-4,000</td>
<td>2009</td>
<td>-</td>
</tr>
<tr>
<td>4,000-5,000</td>
<td>2008</td>
<td>2009</td>
</tr>
<tr>
<td>5,000-6,000</td>
<td>Immediate</td>
<td>2008</td>
</tr>
<tr>
<td>&gt;6,000</td>
<td>Immediate</td>
<td>Immediate if possible</td>
</tr>
</tbody>
</table>

• Services should have adequate equipment (for example fetal heart monitoring, ultrasound and resuscitation equipment) and laboratory facilities at all times.

• Postnatal support should be arranged in line with NICE guidance on postnatal support\(^{112}\). We know that women in London do not always receive adequate postnatal care.

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\(^{111}\) ibid

\(^{112}\) NICE. Routine postnatal care of women and their babies. NICE Clinical Guideline 37. July 2006
8 The cost of clinical negligence

The NHS Litigation Authority administers the Clinical Negligence Scheme for Trusts (CNST), providing a means for NHS organisations to fund the cost of clinical negligence claims. Maternity services in England account for a significant proportion of the number and the cost of claims reported to the Litigation Authority each year. By meeting CNST standards, trusts receive a discount on the premiums they pay to the NHS Litigation Authority as increased safety and quality reduces the risk of clinical negligence incidents. In the 2007-08 CNST assessment, 15% of London trusts scored only one out of three (the lowest mark) for risk management and compliance with standards. 54% of provider trusts in London scored two out of three.

If all trusts in London were able to achieve top accreditation in CNST standards then the hypothesis is that trusts would save large amounts of money currently paid to the NHS Litigation Authority and there could also be significant improvements in quality and safety for women and their babies to achieve the best care outcomes.

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CNST standards case study

The maternity service at Guy’s and St Thomas’ NHS Foundation Trust has achieved top accreditation from the Clinical Negligence Scheme for Trusts (CNST) which assesses quality and safety. The way the service manages high-risk conditions, the care of emergency situations and communication between staff and patients are a few of the clinical criteria considered in the assessment.

As a result of meeting the top standard, the money the trust pays to the NHS Litigation Authority has been substantially reduced. This money can then be reinvested in patient care.

Source: Guys and St Thomas’ Press Release, 12th July 2010. Maternity services awarded highest clinical safety standard

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113 We know that Trusts in London pay between £450 and £750 per birth to the Litigation Authority as part of the Clinical Negligence Scheme for Trusts (CNST)
9 Workforce and training

Maternity care commissioners and providers need to commission and develop maternity services in line with changing public health trends, reducing inequalities and improving safety, quality and experience. London is challenged with developing a workforce who can achieve this.

Maternity service providers cannot always recruit the right number of staff with the right skills to provide excellent care for women and their babies in London. Skill mix is a vital component of the maternity workforce. Teams are not just made up of midwives but with staff with appropriate competencies at various levels ranging from Maternity Support Workers (MSWs) to newly qualified midwives and consultant midwives.

It is important that maternity healthcare professionals in London have adequate competencies to facilitate shared decision making and choice for women. Similarly, staff need to have adequate training to manage high risk patients and complications. For example, this may involve providing suitable postgraduate training for midwives to enable services to care to women with high dependency needs.
10 Key messages

- Women should always feel safe during childbirth and labour and this is not always the case in London.

- The Royal Colleges have issued guidance on improving safety and quality of care for women in labour, emphasising the importance of midwives, multidisciplinary team working, clinical leadership, one-to-one care during labour and increased presence of consultant obstetricians on labour wards. London does not always achieve these recommendations.

- Insurance for clinical negligence costs is very expensive for service providers. Providers can receive substantial discounts in contributions if they meet top quality and safety standards.

The model of care should therefore:

- Ensure midwives have a central role in the care of all women, supporting the development of leadership and supervisory skills to support this.

- Aim to meet Royal College guidelines such as one-to-one care during labour.

- Ensure safety and quality is embedded in the whole pathway and encourages improvements in standards.
PART D: Improving data

11 The case for collecting complete, quality data

Information about patient care plays a vital role in the management of health services. It should be used to plan and commission services, monitor trends and measure performance. Placing information in the public domain should allow comparison and facilitate patient choice as the public can see how well services are performing. Commissioners can also be held to account for their use of public money. For these reasons, data should be robust to provide accurate and credible information.

In London, data collection is inconsistent across providers and improvements in data quality are a necessary precursor to adequately measuring and then improving outcomes. To be able to provide information which is accurate, the first challenge is to have systems that can collect and extract data on women’s care. This is not always the case in London’s maternity service providers. For example, some services have to collect data manually on spreadsheets and some trusts do not always submit data on deliveries in midwifery led standalone units as they may not be linked to patient administration systems.

Commissioners in London do not always ask or contract providers to submit similar information and data on maternity services they provide. Because of this, data collected in London cannot always be benchmarked and compared across London. Commissioners cannot see how well services are performing compared to the rest of the capital and account for the public money they are spending.

Data used in this case for change had variations in quality. Ethnic monitoring data can be poor so accessing adequate and appropriate data to inform local commissioning decisions is often a challenge. More complete and accurate data would allow clearer benchmarking and effective monitoring of the maternal health of at-risk groups.

An assessment of maternity service providers’ current dashboards (used as an internal governance tool to aid risk management) was undertaken. Between them, the maternity service dashboards in London contain almost 200 different internal indicators – 100 indicators are unique to a single trust. Four indicators appear on all dashboards – total deliveries, total caesarean section rate, intensive care unit admissions and postpartum haemorrhage. A further three indicators are on all dashboards, with the exception of one or two – serious untoward incidents\(^{114}\), third degree tears\(^{115}\), complaints\(^{116}\) and instrument deliveries\(^{117}\).

Tolerances will differ between trusts due to the different case mix of women and babies cared for. The red, amber, green thresholds (for example, what outcomes are rated green) and precise definitions (for example, what gets reported as post partum haemorrhage) vary between trusts and across indicators\(^{118}\).

\(^{114}\) Not Kingston Hospital NHS Trust
\(^{115}\) Not Barnet & Chase Farm Hospitals NHS Trust or Newham University Hospital NHS Trust
\(^{116}\) Not Kingston Hospital NHS Trust or West Middlesex University Hospital NHS Trust
\(^{117}\) Not Whittington NHS Trust or North West London Hospitals NHS Trust
\(^{118}\) Commissioning Support for London, Output from the Clinical Indicators workgroup: Maternity Service Improvement Board & Clinical Expert Panel, 2010
There is therefore a case for introducing standardised collection and threshold criteria of three to six dashboard indicators across London. The criteria can then be compared across London and clinical teams should be able to see meaningful information to assess clinical outcomes against their peers.
12 Key messages

- Data collection, completeness and quality is variable across providers in London. Providers do not always have adequate information collection systems.

- Providers are not always contracted to provide commissioners with similar data about their outcomes and safety records.

- Currently, London maternity dashboards contain almost 200 different indicators with differing definitions and benchmarking thresholds.

The model of care should therefore:

- Introduce standardised collection and threshold criteria for three to six clinical outcome indicators across London to allow pan-London benchmarking and comparison of clinical outcomes.

- Encourage providers to improve data collection, completeness and quality.
MODEL OF CARE

Equity and excellence: Liberating the NHS (2010) p8:

“Too often, patients are expected to fit around services, rather than services around patients…Our intention is to secure excellence as well as equity.”

1 Introduction

The case for change has set out the challenges for maternity services in London. Evidence has highlighted that maternity services are not always as good as they could, and should be. There are inequalities for women and their babies in maternity service access, outcomes and experiences.

1.1 The case for change

Evidence and data has highlighted that:

- The number of births has been increasing and is likely to continue to increase in the short term. Services need to plan their capacity and models of care to have adequate physical and staff capacity to cope with demand and prevent suspension of services.

- London is highly populated with several maternity services in close proximity to each other. Women often receive care in a different area to where they live, therefore services need to provide care across provider boundaries to ensure continuity of care. Services are not necessarily commissioned to provide this, so there will need to be a collaborative commissioning approach to achieve this.

- Obesity, diabetes, the age at which women give birth and use of fertility treatment are all increasing. These factors increase the risk of medical complications making thorough risk assessment and early management of complications essential.

- Services need to have provision available for the specific needs of individual groups such as teenage mothers, disabled women, single sex couples, travellers, drug users and other groups of seldom heard women.

- Whilst birth is safe for the majority of women, there is still an unacceptable level of risk for a minority of women. Women from south Asian and Black African ethnicities, women living in poverty and women seeking refuge and asylum are more likely to die in childbirth compared to white British women.

- Variation exists in relation to perinatal mortality and low birth weight in London. There is a correlation between these factors and socio-economic deprivation. Pre-term birth and poor intrauterine growth can cause perinatal mortality and low birth weights and are more common in teenage mothers, women who smoke, mothers with alcohol or drug addiction issues, women from socially deprived areas and women who have poor nutrition.

- Pre-conception care can improve maternal and newborn health but does not normally appear on care pathways, nor is it usually commissioned or offered by healthcare services in London.
• Early booking can improve outcomes and enables early screening, health advice and management but London is below the ideal of 90% women seeing a maternity healthcare professional for a health, risk and social assessment by 12 completed weeks of pregnancy.

• Smoking during pregnancy should be reduced as far as possible as it contributes to poor outcomes for women and their babies. Particular groups of women are more likely to smoke so targeted smoking cessation programmes will help reduce smoking rates.

• Although London compares well to the rest of England, we know that the lowest rates of breastfeeding are recorded among families from disadvantaged groups, particularly disadvantaged white young women, teenage mothers, first time mothers and single women. Services should aim to continually improve breastfeeding rates.

• London was disappointed with results from the Healthcare Commission’s 2008 assessment of maternity services. London’s health community want to improve this for women and their babies.

• Women told us they did not always feel maternity services communicated with them effectively and they wanted empathic healthcare professionals caring for them who communicate with them as an individual and have respect for them and their families.

• Women want better and more useful information to enable them to make informed choices about how and where to give birth.

• Women sometimes felt unsupported, especially in relation to post-natal care. Women said they valued continuity of care from healthcare professionals they know and trust.

• London’s maternity services do not always provide women with adequate choice or access to home births or births in a midwifery led unit. Whilst the rate of home births in London are low at 1-8%, medical interventions during pregnancy and birth within an obstetric hospital setting continue to increase.

• There is a shared emphasis and consensus on offering pregnant women choice, empowering them, focusing on facilitating a normal birth to decrease interventions.

• There are significant differences in intervention rates at providers across London. London has high caesarean section and episiotomy rates compared with the rest of England and World Health Organisation recommendations. There is high variation in the use of epidurals, ventouse and forceps obstetric units in London.

• Women should always feel safe during childbirth and labour and this is not always the case in London.

• The Royal Colleges have issued guidance on improving safety and quality of care for women in labour, emphasising the importance of midwives, multidisciplinary team working, clinical leadership, one-to-one care during labour and increased
presence of consultant obstetricians on labour wards. London does not always achieve these recommendations.

- Insurance for clinical negligence costs is very expensive for service providers. Providers can receive substantial discounts in contributions if they meet top quality and safety standards.

- Data collection, completeness and quality is variable across providers in London. Providers do not always have adequate information collection systems.

- Providers are not always contracted to provide commissioners with similar data about their outcomes and safety records.

- Currently, London maternity dashboards contain almost 200 different indicators with differing definitions and benchmarking thresholds.

The case for change outlined that the model of care needs to:

- Be regarded within wider pre-conception and public health issues such as obesity and smoking. Information should be targeted with advice to those women most at risk. Women should be aware of risks in delaying starting a family or being overweight.

- Be suited to the individual needs of each mother and her baby e.g. teenage mothers.

- Emphasise continuous risk assessment, enabling early management of potential complications.

- Emphasise meeting the needs of women whose health outcomes are less favourable when compared with the rest of the population (such as mothers born outside the UK), without diminishing support for other women.

- Ensure that women from all socio-economic, cultural and ethnic backgrounds get the same access and quality of service.

- Promote early access for all, especially targeted to groups who are less likely to book before their 12th completed week of pregnancy.

- Have systems in place capable of providing equitable outcomes for women and babies, for example through provision of support for women with complex social needs or who are at an increased clinical risk.

- Respond to what women have said and improve services in relation to communication, women-centred care, continuity of care and access to information.

- Allow parents to make informed choices supported by good collection of data.

- Promote genuine choice in how and where women have their baby with a particular emphasis on supporting and encouraging women to see birth as a normal physiological event, to give them confidence in their ability to safely give birth and to have as normal a pregnancy and birth as possible, without medical interventions.
• Ensure midwives have a central role in the care of all women, supporting the development of leadership and supervisory skills to support this.

• Aim to meet Royal College guidelines such as one-to-one care during labour.

• Ensure safety and quality is embedded in the whole pathway and encourages improvements in standards.

• Introduce standardised collection and threshold criteria for three to six clinical outcome indicators across London to allow pan-London benchmarking and comparison of clinical outcomes.

• Encourage providers to improve data collection, completeness and quality.

Cathy Warwick, Co-chair Clinical Expert Panel & General Secretary Royal College of Midwives:

“The model outlines an holistic approach to providing maternity care, emphasising women’s individualised needs and reducing health inequalities. The model aims to target current issues such as increasing levels of obesity, women having babies later in life, teenage pregnancy and supporting women from ethnic minorities.”

1.2 Overview

The project’s multi-professional clinical expert panel has developed the model of care to help address and manage the challenges outlined in the case for change. The model of care is a proposal for how maternity services in London could be shaped and provided. The model was informed by clinical evidence and best practice, supported by national, international and pan-London guidance. Importantly, clinicians emphasised the importance of commissioning and providing services that are sustainable within the context of London’s changing demographics, whilst being responsive to individual needs.

The clinical working groups recognised the importance of a balance between meeting the medical, social and emotional needs of women and babies. The model places maternity services within the wider public health paradigm with a targeted approach to care, accounting for individual medical, social and emotional needs. The model considers care across the continuum from pre-conception to post-natal care with targeted or outreach support provided for vulnerable women or women with specific needs. The model aims to result in greater satisfaction, improved experiences and early detection and treatment of high-risk mothers and babies, leading to long-term health and outcome improvements.

The recommendations seek to normalise birth and place the care pathway within wider support networks for women and families. Maternity services are placed within communities, integrated with primary care.

Professor Andrew Shennan, Co-Chair Clinical Expert Panel, Consultant Obstetrician, Guy’s and St Thomas’ NHS Foundation Trust:

“Midwives should always coordinate women’s care, providing personal care and a network of social and clinical support. Pregnant women should have rapid, equitable
access to specialist services when needed but our vision starts from the belief that pregnancy is a normal physiological event.”

1.3 The care pathway

The care pathway is mapped out in Figure 20, focusing on midwife coordinated care.

The supporting guidance, ‘Maternity care pathways’ sets out detailed care pathway recommendations onto map of medicine profiles.

The profiles provide maternity service commissioners with detailed guidance of the pathway so that they may safely and effectively meet the demands of their local population. The profiles also describe what women can expect on their maternity journey.
Figure 20: The care pathway

- Woman and family
  - Identified midwife
    - Assessment of needs, complexity and choices by 12 and six weeks
    - Identified midwife and back-up team, including an identified obstetrician
      - Dynamic assessment of clinical, psychological and social need
        - Discussion at 36/52 weeks on place of birth
          - Home
          - Free-standing midwifery unit
          - Alongside midwifery unit
          - Hospital delivery suite
            - Home or hospital
              - Postnatal care at woman’s choice of location
                - GP surgeries
                - Acute setting
                - Home
                - Other community healthcare settings e.g. children centres

NHS Standards
At each antenatal appointment
Supported by information and education

Referral as necessary to:
- GP
- obstetrics
- psychiatry
- substance misuse services
- domestic violence
- counselling
- specialist midwifery.
2 Guiding principles

The clinical expert panel identified five high-level guiding principles which should underpin all maternity service development. Applying the principles should facilitate the provision of high quality, safe care for mothers and babies:

Localised and normalised care

Pregnancy is a normal physiological event and maternity services should be non-medicalised where possible. Care should be delivered in the community where appropriate, in partnership with GPs and embedded within wider community provision of healthcare, social and emotional support services. This provides a focus on health and wellbeing. Pregnancy and childbirth should be a positive experience for women.

Continuous risk assessment

Continuous health (medical and social) risk and needs assessments should take place throughout the care pathway, as a woman’s needs can change throughout her pregnancy. Factors that can increase the risk of complications or poor outcomes such as obesity, smoking, poor nutrition or substance misuse should be actively managed. Continuous assessment throughout the care pathway should result in improved detection and early treatment of complications and risks for mothers and babies. It also enables identification of women who start out with risk factors which then normalise.

Seamless care

Services should be shaped around the needs of women with continuity of care provided throughout the maternity care pathway. Partnerships and cooperation should ensure coordination of care between midwives, GPs, health visitors, families, social care, voluntary organisations, private providers and all other people and agencies involved in care provision.

Choice

Women should be empowered to make genuine and informed choices throughout their pregnancy; labour and postnatal care according to their individual needs and based on the result of continuous health needs and risk assessment.

Communication, referral and transfer

Women should understand their plan of care and the ongoing continuous process of assessment. Excellent communication and clearly identified lines of responsibility between healthcare professionals, particularly across the acute and primary care sectors, should underpin referral and transfer mechanisms (see communication model, Appendix 1).

Women-centred care

Care should give priority to the needs and wishes of women. There should be a focus on pregnancy and childbirth as the start of family life, not a clinical episode. Women should have control over the key decisions affecting the progress of care and be supported to have as normal a pregnancy and childbirth experience as possible.
3  Key recommendations

The key recommendations form the basis of this model, aiming to address the issues raised in the case for change.

3.1  Targeted pre-conception advice and care

The case for change outlined that obesity, the age at which women give birth and diabetes are all increasing. These public health trends are associated with an increased risk of medical complications during pregnancy and birth. Evidence presented highlighted that pre-term birth and poor intrauterine growth are more common in mothers who smoke, women with drug or alcohol addiction and women who have poor nutrition. The risk of perinatal mortality is also increased. We know that pre-conception care is not always commissioned or offered by healthcare services in London and women are not always aware of the risks associated with their lifestyles or decisions. This makes a clear case for the role of pre-conception public health interventions to improve women’s knowledge and pre-conception care management. The joint Royal College guidance Standards for Maternity Care emphasises that improving general health and promoting healthy lifestyles should be an underlying philosophy of all health, education and social services. In this way, pre-pregnancy care is the responsibility of all healthcare professionals. Women with pre-existing medical conditions need to be aware of the need to manage their condition when planning pregnancy.

Pre-pregnancy care should be offered formally when a woman requests this. Importantly, GP practices, pharmacists and other healthcare professionals are ideally placed to provide local opportunistic pre-pregnancy care to women of childbearing age. Approaches should be targeted towards women of childbearing age who are at an increased risk of poor outcomes such as women within deprived areas or those who smoke.

Interventions to improve maternal and infant health and decrease mortality and morbidity include:

- Promotion of healthy lifestyles for both potential parents to enhance the chances of conceiving a healthy child.

- Opportunistic distribution of information and social marketing campaigns to promote pre-conception health. These can be placed within non-healthcare settings such as children’s centres and playgroups.

- Promotion of smoking cessation.

- Information about the risks to unborn babies associated with smoking.

- Pre-conception and pregnancy nutritional advice and/or supplements to address poor maternal nutrition.

• Weight loss programmes to encourage women to be a healthy weight when they conceive and information about the associated risks of pregnancy and birth when women are overweight.

• Advice and specialist support for women with alcohol and substance misuse problems.

• Advice to women delaying parenthood on the associated risks and increased likelihood of complications.

• Information about the risks associated with accessing fertility treatment abroad for older women having difficulty conceiving.

• Risk assessment through screening so potential problems or issues are spotted in advance of the pregnancy and minimised.

• Pregnancy planning for women with pre-diagnosed conditions. For example diabetes control can improve pregnancy outcomes for the mother and child.

“My GP gave me advice on folic acid, and I got some, otherwise I wouldn’t have known”

3.2 Accessible, timely antenatal care

The case for change highlighted that whilst birth is safe for the majority of women, there is still an unacceptable level of risk for a minority of women. Often these women do not present to maternity services in London in a timely manner to manage their care. In addition, as women delay motherhood and obesity, diabetes and other medical risks increase, early detection and management of risk is essential to planning women’s care.

Good antenatal care provides the foundation for a good pregnancy experience and birth outcome. There is extensive clinical guidance on all aspects of antenatal care from NICE\textsuperscript{120}. The number of antenatal appointments and their timing should be commissioned according to the best practice care pathway\textsuperscript{121} and continuous needs assessment. Services should be proactive about communicating the importance of antenatal care, for example by texting information about appointments.

Continuous needs and risk assessment

Continuous needs assessment should be predominant throughout the antenatal period and used to identify complications, develop early management strategies and facilitate informed choice. A key element of good care is the initial assessment of a woman’s health and pregnancy. NICE antenatal guidance\textsuperscript{122} states:

“The needs of each pregnant woman should be assessed at the first appointment and reassessed at each appointment throughout pregnancy because new problems can arise at any time. Additional appointments should be determined by the needs of each

\textsuperscript{120} National Institute for Health & Clinical Excellence, Antenatal care: Routine care for healthy pregnant women, 2008

\textsuperscript{121} NICE Guidance outlines best practice care and is continually updated according to the latest evidence. Section 4 outlines an overarching care pathway developed by the project’s clinicians.

\textsuperscript{122} ibid
pregnant woman, as assessed by her and her care givers, and the environment in which appointments take place should enable women to discuss sensitive issues."\textsuperscript{123}

**Early access**

The first health and social care needs assessment is an important gateway to the antenatal pathway, aiding early risk assessment and management. It should be before 12 completed weeks of pregnancy and within two weeks of referral\textsuperscript{124}. Services should be commissioned to achieve the 90% NHS standard of “women who have seen a midwife or a maternity healthcare professional for a health and social care assessment of needs, risk and choices by 12 completed weeks of pregnancy.”\textsuperscript{125}

As a woman’s entry point to the maternity pathway, early access enables women to be fully involved in their own care plans from early pregnancy. At, or prior to, their first antenatal visit and subsequently, all women should be provided with information about models of care available to them, consistent advice, clear explanations and the advantages and disadvantages associated with these. Care options should always be flexible as women may change their mind or her care needs may change. A description of the roles of carers may assist their decisions. Women’s needs should be assessed on an individual basis.

**Targeted early access and monitoring**

Women who are more likely to develop medical complications in pregnancy should receive targeted support and be encouraged to access antenatal care early and consistently. In addition, some families will require additional support. For example, women are more prone to depression in pregnancy if exposed to domestic violence, if they are living in poverty or have poor social support. All routine antenatal screening should include an assessment for depression or experience of violence.

Local booking data should be analysed with targeted interventions such as behaviour change projects to improve equitable access to maternity service.

**Location**

Antenatal care should be offered in a variety of community and primary care settings including GP surgeries, outreach clinics, community centres, midwife-led units and children’s centres, regardless of the complexity of pregnancy. Care can also be provided by a midwife in an obstetric setting for women who choose this. Local, one-stop settings should be available with appropriate communications systems in place to ensure referrals between healthcare professionals and providers are timely and appropriate. The location provided for antenatal care should be accessible to teenagers (by public transport) and groups of women identified as being more likely to access services late. This should maximise the uptake of antenatal care in these groups.

\textsuperscript{123} ibid
\textsuperscript{124} ibid
\textsuperscript{125} Ensure Better Care for all Public Service Agreement (2007)
All services in London should provide direct access and self referral. Information regarding how to access and contact the service should be easily available on the internet and within local settings.

Many GP practices provide a local setting for antenatal and postnatal care either by locating midwives in surgeries or through GPs providing direct maternity care. This is variable across London and is largely dependent on commissioning arrangement and relationships between GPs and local providers. We know that GPs can be invaluable in providing antenatal care\textsuperscript{126}. In all cases, it is important that medical and social information relating to a woman’s pregnancy, baby and family is shared between maternity services and the woman’s GP.

3.3 Midwife coordinated care for all women

The case for change highlighted that London’s maternity services do not always provide women with the right amount of support, information or choice about their care. Women said that they did not always feel services and healthcare professionals communicated with them effectively.

All women’s care should be coordinated by a named midwife throughout pregnancy, birth and the postnatal period. Midwife coordinated care plays a key role in ensuring women receive continuity of care and are cared for in a culture that promotes normalised care and facilitates communication.

Margaret Richardson, Strategic Midwife Advisor, NHS London:

“Midwives should always be involved in women’s care along the whole care pathway. This means we need to ensure that midwives are appropriately trained and educated to identify deviations from the norm and to continue to provide care for women with high-risk pregnancies, in partnership with obstetricians and multidisciplinary teams.”

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**Case study: The Deanery Road Centre, NHS Newham**

To deliver care closer to home, a new midwifery service is available at children’s centres in Newham.

Services include:

- Free pregnancy testing
- Antenatal education
- Dedicated clinics for teenagers
- Direct access to a midwife
- Late gestational booking

Audit results indicate that did not attend (DNA) rates have reduced from 18% in hospital to 7% within children’s centres. Feedback from women and their families has been positive and there has been an increase in free pregnancy testing which can support a drive towards early booking, known to improve health outcomes for woman and baby.

\textsuperscript{126} Smith, A., Shakespeare, J., Dixon, A. The role of GPs in maternity care – what does the future hold? Kings Fund. 2010
Co-morbidities should be a ‘bolt-on’ to the pathway and at no point should the woman come off the midwife coordinated pathway. Where specialist care is needed, this should be facilitated by her named midwife and planned in close discussion with the woman. The woman’s named midwife should ensure a clear care plan is developed and that all of the necessary specialist input is available. Clinical responsibility for women with complex care needs should remain with the specialist, but these women should still receive midwife coordinated care. Specialist input should not exclude women from receiving continuity of care from her midwife.

“All women will need a midwife and some need doctors too”\textsuperscript{127}

Women who choose to have care from their GP should be linked to a named midwife and/or a team of midwives so they can access midwifery support and advice. GPs delivering antenatal and postnatal care for women who choose this should regularly communicate with the woman’s midwifery team and/or named midwife.

3.4 Provision of continuity of care

Equity and excellence: Liberating the NHS:

“We can foresee a better NHS that is less insular and fragmented and works much better across boundaries, including between hospitals and practices.”

The case for change showed that women want to be able to see healthcare professionals who know them and their care needs. In London, with a concentrated population and several maternity service providers to choose from all within close proximity, there is an additional challenge as women may choose to receive care in a different area to where they live.

“Continuity of care throughout pregnancy and childbirth is an important component of women-centred maternity care and there is evidence that continuity of care in complex organisations may be associated with increased patient safety.”\textsuperscript{128}

Women should receive continuity of care throughout their care pathway. This can be provided through case loading models (as below). Commissioned care pathways should be seamless even if they are provided across different agencies and organisations. Women feel more comfortable and supported if they know the healthcare professionals managing their care, especially when they are in labour and may feel anxious or frightened.

Continuity of care includes:

- Providing support to women and her family throughout pregnancy, birth and postnatally.
- Having time and building a relationship with women to understand and help meet their needs.

\textsuperscript{127} Royal College of Anaesthetists, Royal College of Midwives, Royal College of Obstetricians and Gynaecologists, Royal College of Paediatrics and Child Health, \textit{Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour, 2007}.

\textsuperscript{128} Department of Health, Evidence to inform the National Service Framework for Children, Young People and Maternity Services, 2005, London, p.203
• Ensuring seamless handovers and referrals if women are supported by other healthcare professionals.

• Providing women with contact details so a midwife or healthcare professional she knows is easily accessible and available if a woman needs to speak with someone.

• Having in-depth knowledge of services and local support systems to provide women with information and her options.

“I remember feeling immense relief seeing my antenatal midwife for post-natal care once I was home.”

GPs, who are competent in providing maternity care, can play a key role in providing continuity of care. GPs often already have an established relationship with a woman and this can continue throughout the woman’s pregnancy and after her baby has been born. For women with complex needs, specialist healthcare professionals will be required to provide specialist care. The named midwife should continue to provide support as appropriate and ensure a seamless handover to the specialist midwife so the continuum of care is maintained.

Case loading

Continuity of care can be commissioned and provided through a variety of models. Case loading is one approach to providing continuity of care.

Some case loading teams offer one-to-one care from a named midwife for women throughout her whole pathway with one other midwife providing back-up should the named midwife be unavailable. Women like this personalised care from a midwife they can build a relationship with. In this scenario, women see the same midwife for their antenatal care, when they are in labour and postnatally. The midwife will work and travel according to the needs of the women she cares for. If a woman goes into labour in the middle of the night then her midwife will travel to support the woman.

“...We have our own midwife. She’s brilliant, you can ask her anything. She explains things really well. You can talk to her on her mobile and get your mind put at rest – it’s much better than seeing strangers.”

In other services, a team of midwives look after a caseload of women so women will always see a midwife from that team. Usually the team is arranged so women receive care from as few midwives as possible. Some of the midwives within this team might work in the community and others within a labour ward. The midwives managing the care of the woman work as a team and know the woman, her circumstances and needs.

Many factors influence how teams of midwives are set up including the working time preferences of midwives in the team, personal and family commitments and the number of staff available. It is likely that local services and commissioners will use a mixture of case loading approaches. What is important is to provide women with continuity of care from healthcare professionals she trusts, is comfortable with and who

129 Commissioning Support for London. What women and their families need and want from a maternity service, 2010

130 Commissioning Support for London. What women and their families need and want from a maternity service, 2010
know her needs. This could be through one-to-one case loading or through team midwifery.

Targeted outreach support and/or other specialised services should be available to support women with complex needs. A case loading approach should be prioritised for women in vulnerable groups or who have specific complex social or emotional needs. Commissioners should ensure they are fully informed about the needs of their resident population and plan their services flexibly to meet these.

**Midwife: women ratio**

The midwife to women ratio should be kept at an appropriate level (between 1:25 and 1:35 within London depending on case mix\(^{131}\)) so the team can manage the workload and fluctuations in capacity requirements (for example, several women may go into labour at the same time). Services should work towards providing midwife: patient ratios recommended in their Birthrate Plus individual reports\(^ {132}\).

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\(^{131}\) Ball and Washbrook. Evidence based ratios for midwifery workforce planning for London. NHS London, March 2010

\(^{132}\) ibid
Case study: Community-based one-to-one case load group practice programme in areas of high deprivation, Guy’s and St Thomas’

The caseload group practice programme at Guy’s and St Thomas’ commenced services in July 2005. Three community-based teams of six midwives are based in areas of deprivation. Each woman has a named midwife. Midwives have a personal caseload size of 36 births per annum and caseloads are mixed in terms of their level of risk. The midwives work in partnership providing out-of-hours cover. This group structure and philosophy supports continuity of carer and care.

Outcomes

- 62% of women were attended to during birth by their named midwife/partner - 90% by one of the practice midwives.
- Compared with women receiving standard care (i.e. not caseload care), women receiving caseload care had a higher vaginal birth rate (62% versus 58%); higher breastfeeding rates (82% versus 77%); lower caesarean section rates (27% versus 29%); and lower epidural anaesthesia rate (27% versus 33%).
- The antenatal missed appointment rate was lower (1.6% versus 18%) as was the pre-term birth rate (5.6% versus 8%) with Apgar scores less than seven at five minutes remaining at the same level as the rest of the trust at three per cent.

Homebirth rate

The increase in the homebirth rate was influenced by positive home birth stories and early labour assessments in the home (39% of women were assessed at home). Early labour assessment in the home can reduce anxiety while encouraging and supporting women to stay at home longer during early labour. The benefits of home birth include lower costs to midwifery and hospital resources, and more ‘normalised’ childbirth for women.

Missed appointments or ‘Did Not Attends’ (DNAs) are expensive in terms of wasted clinic time and are a patient safety issue as they reduce women’s access to care. The caseload group practices were successful in reducing DNAs by providing women with the option of home bookings and follow-up care where appropriate and desired; making personalised contact with women to organise place and time of appointments, including booking; and tailoring location of care to women’s needs.

This model of caseload care comprises:

- Personalised contact with women to organise appointments including bookings.
- Home bookings and antenatal appointments when appropriate and desired.
- Early labour assessment in the home.
- Delay choice of place of birth until early labour for low-risk women.
- Continuity throughout antenatal, intrapartum and postnatal periods.
- Partnership case loading providing labour cover 24 hours a day, seven days a week for women using week-on week-off on-call model.

Source: Florence Nightingale School of Nursing & Midwifery at King’s College London.
3.5 Offering choice and non-medicalised care

The case for change showed that women want and, through the NHS Constitution, have a right to an informed choice regarding where and how they access and use maternity services. We know there is common consensus that, where it is safe for mother and baby, women should be supported to have a normal birth free from medical intervention.

National Childbirth Trust:

“An empowering experience of birth creates positive memories and has a positive impact on families.”133

Annie Francis, Independent Midwife, Independent Midwives UK:

“I love being an independent midwife as women benefit from a strong partnership with their midwife and it can help promote normality in childbirth. Individualised care which is always coordinated by a midwife is essential to excellent maternity care.”

Labour and birth should be seen as a normal physiological process. Women’s experiences of birth can have great implications for her and her baby’s health, wellbeing and relationships. Intrapartum care should aim to make women feel as comfortable as possible. Women should always receive 1:1 care in established labour. Water as pain relief should be available to all women who want to use this in all birth settings. If the intrapartum care is not delivered by the named midwife or a member of her team, effective communication systems should be in place to ensure the transfer of care is as seamless as possible.

Choice

“It’s good to have choices because everyone wants to do things differently, especially when you have so many cultures.”134

Women should be supported to make a genuine, informed choice of where and how they want to give birth, through continuous dialogue with their primary carer (this will usually be their named midwife) and informed by continuous needs assessment. Women should be offered choice through her whole pregnancy and into early labour. The overriding requirement for pregnant women is that they are assured that the service they and their baby receive is safe, of the highest quality and in a location of their choosing. The following should be taken into account when considering birth location:

- Level of complexity: Women with an uncomplicated pregnancy should be offered choice of homebirth, midwifery-led unit (alongside or standalone) or an obstetric unit. Choice of provider, location of care and mode of birth may be limited according to individual need for women requiring complex care.135 However, a complex pregnancy should not preclude a spontaneous vaginal birth. The woman’s level of risk should be assessed near the time of birth through continuous needs assessment. If the pregnancy is low-risk or becomes low-risk, the woman should

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133 http://www.nct.org.uk. Accessed 22nd September 2010
134 Quote from personal experience of member of the Clinical Working Group
have the choice of giving birth in settings other than an obstetric unit (Risk matrix, Figure 21).

- Proximity: A key consideration for all women, but especially those with a complex pregnancy or social disadvantage, is to avoid excessive travelling. Regardless of the care setting, the distance travelled for women from their locality (such as work or home) is an important factor, especially where it becomes too onerous to travel.

“I was given a choice of location and hospital; for ease of access and so I would not have to transfer in case of complications.”

- Women’s preferences: Meeting a woman’s preferences can lead to greater user satisfaction and supports choice.

“Don’t make assumptions that I want to be treated the same as everyone else – ask me what I want.”

The same criteria should be applied to assessing appropriateness of women for a safe, midwife-coordinated birth whether the setting is at the woman’s home or in a standalone or alongside midwife-led unit. There should be no difference in exclusion criteria between home, alongside midwife-led unit and standalone midwife-led unit as there is currently no evidence that suggests one setting is safer than the other.

**Figure 21: Maternity risk matrix to determine birth setting options**

![Maternity risk matrix](image)

Source: Maternity Clinical Working Group, team analysis
The matrix demonstrates that as complexity increases, options for the location of birth reduce.

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136 Quote from personal experience of member of the Clinical Working Group
137 Quote from personal experience of member of the Clinical Working Group
Information

Women should be offered appropriate information and communication to enable them to make an informed choice on the appropriate place of birth. Information should be available in a variety of formats appropriate for varying ages, cultures, literacy levels and language contexts. Importantly, information should be evidence based and enable shared decision making. Services should ensure training is available so that staff have required competencies to enable shared decision making between women and healthcare professionals.

Dr Alison Wright, Consultant in Obstetrics & Gynaecology, Royal Free Hampstead NHS Trust:

"I genuinely enjoy talking to women about their care needs and wishes. I strongly believe in informed choice for women and I feel that can only result from adequate provision of information to women and their families. Healthcare professionals need to have an awareness and empathy of what women want, being able to listen and tailor care to individual need.

“I have worked with women from lots of different cultural backgrounds abroad in India, Pakistan and in multicultural areas in the UK. We, as healthcare professionals, must recognise the importance of respect for all cultures and individuals."

Case study: Improving access

Maternity Action – challenging inequality: promoting wellbeing

This project aimed to improve access to maternity care for marginalised women from BME communities. The Maternity Access and Advocacy Pack (MAAP) was developed by local communities. It recognises that individuals may seek information from people they trust within local communities (e.g. Imams, assistants in children’s centres).

The MAAP consists of storyboards depicting pregnancy, birth and becoming a parent with an accompanying booklet. It is a picture-based tool aimed to increase the choice agenda for people who experience marked inequalities in access and ongoing engagement with maternity services.

Feedback from participants was extremely positive, with women relating to storyboards:

“It makes maternity services visible for everyone…then there is choice…it makes you realise that nothing is set in stone.”

Women from Uganda – “Pictures speak louder than words…there has been much thought and imagination as to how pictures impact on people…the storyboards work on their own”

3.5 Providing safe births

Angela Helleur, London’s Local Supervisory Authority Midwifery Officer:

“Safety and quality should be the aim of every midwife in London. The avoidance, prevention and mitigation of adverse outcomes or incidents stemming from maternity services is integral to my role in improving standards of midwifery practice to protect the wellbeing of all women and babies born in London.”

Commissioners need to work and plan for the future to ensure that maternity services in their area are configured and designed in a way that is best for both outcomes and the experience of women and their babies to provide high quality, sustainable care.

The case for change highlights that London’s maternity services need to plan to have the right physical capacity, staffing levels and skills for the expected number of births. This is not always easy to plan given London’s transient population with highly mixed demographics and needs. The case for change also highlighted that London’s maternity services do not always meet guidance, standards or recommendations for providing excellent, safe maternity care.

London’s maternity services should aim towards meeting the detailed and comprehensive guidelines and recommendations from NICE, the Royal College of Obstetricians and Gynaecologists\textsuperscript{138}, the Royal College of Midwives and the NHS Litigation Authority’s Clinical Negligence Scheme for Trust’s (CNST) standards. If all providers met top CNST risk management and safety standards then we would expect clinical outcomes to improve and adverse incidents to decrease. In addition, by

\textsuperscript{138} For example, Royal College of Obstetricians and Gynaecologists, Royal College of Midwives, Royal College of Anaesthetists and the Royal College of Paediatrics and Child Health. Standards for Maternity Care: Report of a Working Party. 2008. RCOG Press
achieving higher standards, trusts would benefit financially from the discount on their CNST contributions to the NHS Litigation Authority.\textsuperscript{139}

All providers in London should achieve the standard of ‘90% of women see a midwife or maternity healthcare professional for a health and social care assessment of needs, risk and choices by 12 completed weeks of pregnancy’. Booking data should be used to aid maternity service providers to plan available capacity. Obstetric units need to be prepared for women with increasing risks and complications associated with increasing obesity, maternal age and multiple births. Commissioners and providers need to plan for a workforce that can support this. For example, there may be a need for more specialist staff available to manage complications.

Development of clinical leadership and dissemination of skills should be a priority in all services.

Denise Chaffer, Director of Nursing, Croydon Health Services NHS Trust (formerly Mayday Hospital):

“As a Director of Nursing, developing future nurse and midwifery leaders is a priority. Good leadership can turn visions for excellent patient care into a reality. I know many midwives aspire to work in services where women and their families are treated with dignity and respect at all times, where services are designed to benefit women’s individual needs and where the work of midwives is valued and respected.”

Services should also prioritise the development of supervisors of midwives in partnership with the London Local Supervisory Authority (LSA). Supervisors of midwives should be supported in their statutory role to make sure that all practice under their supervision is up to data and within the midwife’s sphere of competence.

Jill Demilew, Consultant Midwife, Supervisor of Midwives, King’s College Hospital NHS Foundation Trust:

“As a supervisor of midwives it is my role to act as a positive role model for midwives, guiding and supporting them in developing skills and expertise. Cooperation and consultation are some of the best ways to effect change and improve standards and supervisors of midwives hold these skills and can therefore be key to driving up quality and safety.”

One-to-one midwifery care should always be available for women in established labour. A woman giving birth should have assurance that if something goes wrong she can be transported to expertise safely and quickly. Safe transfer is essential for all women regardless of risk status. If a woman is transferred, the midwife must transfer with her. If the woman retains her midwife from the midwife-led unit, there must be midwives to backfill at the unit. It is essential that the midwife accompanies the woman during transfer to another unit, even if it means the partner has to travel separately (see Appendix 2 for information on London Ambulance Service).

Role redesign and staff mix should be considered by commissioners and service providers (see case study ‘Building capacity to care’). Some care could be undertaken

\textsuperscript{139} We know that Trusts in London pay between £450 and £750 per birth to the Litigation Authority as part of the Clinical Negligence Scheme for Trusts (CNST)
by appropriately trained MSWs to enable midwives to provide 1:1 care in labour, provide care for women with complex needs and ensure that all women have a full social and healthcare needs assessment before the 12+6 week of pregnancy.

Appropriate consultant obstetrician staffing levels are essential to providing safe labour wards. Provider organisations and commissioners should actively develop business and contingency plans to address consultant presence shortfalls. However, there is consensus that fully implementing obstetric presence in line with Safer Childbirth is an aspirational aim. The recent Kings Fund publication on the challenges of staffing maternity services highlights this, outlining: “more important than the total numbers of staff is the skill mix, experience and deployment of existing staff.” (p.ix).

Safer Childbirth recommends that all maternity services delivering between 2,500-4,000 babies per year should have a minimum 60 hour/week consultant presence by 2009. All maternity services in London delivered more than 3,000 babies in 2009-10. Therefore, 60 hours per week is deemed a sensible minimum level of consultant presence on a labour ward for maternity units in London and commissioners can set expectations for this locally.

Commissioners should set local expectations and trajectories for improving consultant presence on labour wards in line with Safer Childbirth recommendations (see Part C, case for change).

Current and future workforce requirements to meet the needs of local women should be analysed and planned.

Edwin Chandraharan, Consultant Obstetrician and Gynaecologist, Lead Clinician Labour Ward and Lead for Clinical Governance, St George’s Healthcare NHS Trust:

“Increasing consultant presence is not about having obstetricians on call or ‘being available’, it is about being present on the actual labour ward as recommended by our professional body.”

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140 These recommendations are in line with achieving level 3 CNST standards
141 Sandall, J. et al. Staffing in Maternity Units: Getting the right people in the right place at the right time. Kings Fund. March 2011
143 Royal College of Anaesthetists, Royal College of Midwives, Royal College of Obstetricians and Gynaecologists, Royal College of Paediatrics and Child Health, Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour, 2007
Figure 22: Transfer routes during labour and delivery

Examples of specialist care include: care of women with cardiac or renal complications or women with systemic lupus.

3.6 Commission and provide for diversity

Yana Richens, Consultant Midwife, University College London Hospitals NHS Trust:

"Information shows us that London is one of the most diverse cities in the world and mothers have told us that we are not always able to respond to their individual personal needs."

The case for change highlighted that services need to have provision available for the specific needs of individual groups such as teenage mothers, disabled women, single sex couples, travellers, drug users, BME women, women whose first language is not English and other groups of seldom heard women. We know that variation exists in relation to borough perinatal mortality and low birth weight in London. Pre-term birth and poor intrauterine growth can cause perinatal mortality and low birth weights and are more common in teenage mothers, women who smoke, mothers with alcohol or drug addiction issues, women from socially deprived areas and women who have poor nutrition.

Services should be designed to reduce inequalities of outcomes. Maternity services in London need to be informed and shaped by the diverse needs of the communities they service. Commissioners need to have knowledge of their local women to ensure services commissioned are appropriate to their needs. Health needs assessments should be used to forecast demands on maternity services. Commissioners and providers should work together to ensure that data on local ethnicity and cultural needs (e.g. language or interpretation needs) is collected robustly and routinely. Services
should be designed in partnership with local providers, healthcare professionals and women and families who use services.

In addressing the needs of London’s diverse population, it is imperative to recognise individual as well as group differences, treating women as individuals and placing positive value on diversity in the community as well as in the workforce. Individual and group diversity needs to be considered in order to ensure that everybody’s needs are understood and responded to within maternity service design and delivery. Commissioners and providers should develop innovative ways to respond to women’s individual needs such as peer support groups or social support networks.

“A community midwife visited us at home and informed us of other pregnant same sex parents in the area.”

Case study: addressing health inequalities

NHS Newham award for addressing health inequalities

NHS Newham staff won a National Childbirth Trust award for the Development of Service to address health inequalities. A maternity service manager and a maternity modernisation commissioner won the award for work to address significant inequalities in health for women and their babies in Newham, responding to a critical Healthcare Commission report.

NHS Newham is situated in an area of high deprivation. The project encouraged women to access maternity services easily and directly (regardless of GP registration) and brought maternity services closer to the community through:

- Listening to women’s views
- Placing community midwives in community centres
- Working with local voluntary organisations e.g. Newham’s Asian Women’s Projects
- Reinvigorating the Maternity Services Liaison Committee to truly reflect the women in the local area.

The project resulted in an increase in antenatal appointments, a reduction in still births and better recruitment and retention of midwives. The project worked in partnership with all agencies providing care and support for women and used innovative ways to resolve local issues and concerns.
Case study: Building capacity to care

Development of maternity support workers (MSWs) in London in partnership with London South Bank University

“London South Bank University, in partnership with NHS London, has developed a foundation degree programme for MSWs in response to an evaluation of the Educational Preparation of Maternity Support Workers in London (2008). The results of the evaluation demonstrated that there is a need to develop the knowledge and skills of Bands 1-4 to enable them to effectively and efficiently contribute to the maternity workforce.”

Professor Jacqueline Dunkley-Bent, Professor of Midwifery, Faculty of health and social care, London South Bank University

We know there is an increasing demand for maternity services in London, coupled with midwife labour market pressures (recruitment challenges and many midwives in London reaching retirement age).

Some of the biggest challenges in meeting maternity service reform centre on the capability and capacity of London’s maternity workforce – not just midwives but the wider multidisciplinary team. London needs to maximise staff skills at all levels.

Midwife support workers can carry out duties across care settings, undertaking duties depending on local demands and service specific requirements. For example:

- Assist with breastfeeding support and personal hygiene.
- Care of the well baby.
- Basic care of women who are postoperative.
- Contribute to data collection for clinical audit.
- Assist midwives in the assessment, planning, implementation and evaluation of care using care plans.
- Support women in their own home – particularly women or families who have high social needs and/or require assistance to support them in parenting in the early days post birth.

NHS London and the London South Bank University are developing a coherent London-wide approach to MSW workforce development. For example career pathways, NVQ qualifications and core competencies are being established.

Case study: Commissioning individualised care

The Brierley Practice, King’s College Hospital

The Brierley Practice provides individualised care to women who either have severe mental health problems or have chosen to have a home birth. Their caseload is made up of one-third of the former and two-thirds the latter. Women with mental health problems in particular benefit from ensuring their care is well planned, all relevant agencies are involved and a high level of support is provided.

To ensure continuity of care, each mother-to-be is assigned to a midwife plus two associate midwives during the birth and up to 28 days after giving birth. Women receive more visits antenatally to ensure all their needs are being met and discussed. All women are visited at home in labour and the choice of place of birth is often kept open until that time. As a result, the practice has a 60% home birth rate for women who are having their first baby and an 85% home birth rate for women who have given birth before, with a caesarean section rate of 15%.

The practice cared for 72 women with mental health problems in 2008 along with 98 other women. The midwives aim to keep birth as normal as possible in order to give these women the best start to parenthood.

Positively UK at The Whittington Hospital NHS Trust

From ‘Pregnancy to Baby and Beyond’ is a project funded by MAC make-up AIDS fund. The project is aimed at providing a comprehensive programme to support women who are HIV positive and pregnant. The project uses ‘mentor mothers’ to support HIV positive pregnant women. The mentors have personal experience and have undergone a training programme.

“Working together, clinicians in the NHS and organisations like Positively UK can make a real difference and prevent new infant HIV infections. Breaking down stigma and supporting women with HIV to access care for themselves and their unborn children”.

A local paediatrician

“To all positive mothers to be, I encourage you to celebrate your health and vitality by entering into as much of the birthing experience as you are able. For positive women, the stresses, questions and decisions are more complex and pressing.....It is important to work with medical advisors to minimise risk and uncertainty. Yet it is also important to own your experience as much as possible and to individualise it. ....Gain the support you require and enjoy the process, having made the appropriate choice for you”.

A mentor mother taking part in the peer support project to support other HIV positive pregnant women
3.7 Improve postnatal care

Dr Debra Bick, Professor of Evidence Based Midwifery Practice. Florence Nightingale School of Nursing and Midwifery, King’s College London:

“Postnatal care has continued to be the most neglected aspect of a woman’s journey through pregnancy and birth. Evidence is building on the impact that well planned, timely and appropriate postnatal care could have on a positive effect on woman’s physical and psychological health and wellbeing, with many advantages for her child and family. It is essential that this aspect of care is viewed as part of the continuum of safe, high quality, maternity care.”

We know that inadequate postnatal support, advice and management can impact considerably upon a woman's and baby’s health outcomes, her relationships with family and friends, and her parenting abilities. Effective postnatal provision can alleviate and in some instances avert poor postnatal outcomes such as low breast feeding initiation and continuation rates, physical and mental health problems.

Maternity services in London should always provide postnatal care in accordance with NICE guidance\(^\text{144}\). Support should be based on individual needs as women and their families will have different postnatal needs. Positive attachment or ‘bonding’ between a mother and baby has consistently been shown to be important for early development\(^\text{145}\). Skin to skin contact should be encouraged between mother and baby soon after the baby is born to encourage this.

The number and timing of postnatal visits should be based on individual physical, mental health and social needs of the women, baby and family, identified by the health needs assessment, and considering women’s choice. This information should be included in the postnatal transfer (discharge) plan of care. The first postnatal contact should take place at women’s homes. Subsequent postnatal care can take place either in the home or in an appropriate community setting such as a children’s centre, GP practice or community settings, based on the choice and needs of the woman.

The health and social needs of mothers and babies should be assessed at each postnatal contact, and specialist advice sought as appropriate. Importantly, continuity of care should be carried into the postnatal phase. Midwives should plan postnatal care supported by appropriately trained Midwife Support Workers (MSWs). Seamless handover to other healthcare professionals such as health visitors should always be planned with healthcare professionals communicating closely with each other.

Mothers should have access to support and advice from a known healthcare professional. Healthcare professionals should be aware of local NHS, voluntary and other services in the area. Women should be referred, guided to or given information about these as appropriate. For example, peer support programmes or a buddying service can offer invaluable support, particularly in deprived areas. Where postnatal assessment identifies isolation or depression, evidence based approaches to treatment should be commissioned and provided. Healthcare professionals, such as health visitors, should be competent in assessing mental health and be able to refer to support services. For example, psychological therapies should be available for women

\(^{144}\) NICE. Postnatal care: Routine postnatal care of women and their babies. July 2006

\(^{145}\) Department of Health. Updated child health promotion programme.
experiencing mild to moderate depression. Specialist perinatal mental health services should always be commissioned for women with more severe mental health issues. This support is part of the Healthy Child Programme\textsuperscript{146}, a universal, preventative programme tailored to the needs of the whole family. Fathers taught the skills of caring and interacting with a newborn baby (e.g. baby massage and bathing) tend to be closer to babies shortly after birth and later\textsuperscript{147} and healthcare professionals should support fathers with this.

Breastfeeding initiation should be encouraged through the implementation of evidence based interventions with a particular emphasis on population groups where breastfeeding rates are typically low in the area (nationally priority groups are disadvantaged white women, especially teenage women, first time mothers and single parents). Once breastfeeding is established continuous support should be provided to women as and when they need it through their named midwife. Handover to the health visitor should be seamless and the women should be able to continue to access breastfeeding support as required either in the home or in a community setting. Commissioners and providers need to tailor breastfeeding initiation and continuation interventions to meet the needs of local population groups.

All maternity services commissioned in London should have achieved or be working towards Unicef and the World Health Organisation’s ‘Baby Friendly Status’ through implementation of ‘ten steps to successful breastfeeding’\textsuperscript{148}. Services should:

1. Have a written breastfeeding policy that is routinely communicated to all healthcare staff.
2. Train all healthcare staff in skills necessary to implement this policy.
3. Inform all pregnant women about the benefits and management of breastfeeding.
4. Help mothers initiate breastfeeding within half an hour of birth.
5. Show mothers how to breastfeed, and how to maintain lactation even if they should be separated from their infants.
6. Give newborn infants no food or drink other than breast milk, unless medically indicated.
7. Practise rooming-in, that is, allow mothers and infants to remain together 24 hours a day.
8. Encourage breastfeeding on demand.
9. Give no artificial teats or pacifiers (also called dummies or soothers) to breastfeeding infants.
10. Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic.

\textsuperscript{146} Department of Health, \textit{Healthy Child Programme: Pregnancy and the First 5 years of Life}, 2009
\textsuperscript{147} Department of Health (2009). Updated child health promotion programme.
\textsuperscript{148} \textit{Protecting, Promoting and Supporting Breastfeeding: The Special Role of Maternity Services}, a joint WHO/UNICEF statement published by the World Health Organization.
“At home they answered all our questions, they weren’t rushed and they advised more about breastfeeding.”

“I went to breastfeeding support organised through SureStart – it was great.”

The postnatal period should also be used effectively as the pre-pregnancy period of the next pregnancy. High quality communication after delivery, particularly for women whose births have been complex, can reduce the number of interventions in future pregnancies.

3.8 Improve data and evidence

Equity and excellence: Liberating the NHS (2010):

“Information, combined with the right support, is the key to better care, better outcomes and reduced cost. Patients need and should have far more information and data on all aspects of healthcare.”

Dr Mike Lane, London GP, Pan-London GP Advisor:

“Many mothers-to-be ask me how they’re supposed to make their choice of maternity unit and where they can find information on quality. Often, women rely on anecdotal information about maternity services from friends, family or the media. Reliable, interpretable data available in a single place will provide women and GPs with an information source to enable decision making about maternity care.”

The case for change highlighted that information about patient care and outcomes plays a vital role in the management of maternity services. However in London, data collection, completeness, quality and reporting is inconsistent. Providers do not always have systems in place to collect data. The way data is collected is inconsistent and therefore cannot always be compared or benchmarked. Commissioners are unable to monitor trends, measure outcomes and justify their use of public money.

Commissioners and providers in London need to maximise the use of data to monitor outcomes and access. Service providers need to have information systems in place to collect, extract and monitor data for commissioners and clinicians. Information systems and staff need to be able to collect and extract data even if they are working in the community, in GP practices or within a midwifery-led unit. There may need to be development of information systems, for example, to enable remote access.

Commissioners and providers need to develop a data and audit driven culture with clinicians as data champions to audit their practice, inform evidence and provide best practice. Clinicians need to be committed to collecting and recording accurate data and know why this is important. Complete and accurate data should allow clear benchmarking and effective monitoring of quality, safety and inequalities. This information should be placed in the public domain. Outcomes from evidence-based interventions should be monitored by ethnic groups to ensure equality of outcomes for all.

As information is placed in the public domain, providers and commissioners need to work to ensure data is accurate and up to date. In London, there is a clear case for introducing standardised collection and threshold criteria for three to six indicators to appear on all provider dashboards to allow benchmarking and assessment of
outcomes across the capital. Trusts would, of course, still have as many additional local indicators as desired for internal governance and risk management. These are likely to have their own tolerances dependent on case mix. Standard indicators will enable local commissioners to be provided with assurance that maternity services at local providers are of similar quality and obtain the best outcomes when compared to those elsewhere in London. This will provide assurance to the public, local authorities and the NHS community.
Conclusion

The maternity case for change highlighted considerable scope for improving maternity services in London. The NHS in London has shown its commitment to improving quality, safety, equity of access, experiences and ultimately, clinical outcomes.

The recommendations in the model of care aim to address issues raised in the case for change. The model of care is presented as a series of recommendations to commissioners, clinicians, managers and people shaping maternity service development at a local, borough or regional level. Commissioners and providers are urged to develop services in line with the vision outlined in these recommendations.

The model proposes placing maternity services within the wider public health paradigm with an individualised and targeted approach to all care. The pathway considers care from pre-conception to postnatal care with targeted support prioritised for vulnerable women, women with specific needs and women who have been identified as being at a higher risk of poor outcomes. Central to the model is the provision of accessible, timely antenatal care so that all women receive their first health and social care assessment by the end of their 12th week of pregnancy. Early antenatal care provides the foundation of a good pregnancy and allows early detection and management of risks. Implementing recommendations to provide all women with midwife-coordinated care, continuity of care throughout the pathway and the provision of choice should raise satisfaction and women’s experience of care. Providing excellent care and support to mothers, families and the wider networks of support can help give babies the best possible start in life.

The collection and publication of high quality performance information is at the heart of the model of care. It is vital that commissioners and clinicians have access to accurate, contextualised data in order to make effective commissioning and service development decisions. This information should also be made available to the public, to enable them to make informed choices, and to providers, to allow them to benchmark themselves against others.

Some recommendations have already been taken forward and are being used by commissioners to develop local services in 2011/12. There are key challenges for implementing the recommendations. For providers and people who work in maternity services, implementing the recommendations may result in a new way of delivering care. Success will depend on strong clinical leadership, willingness of organisations and innovative ideas. Ultimately, implementing the recommendations should result in safer care, improved experiences for women and their families, improved clinical outcomes and a decrease in provider contributions to the Litigation Authority, providing much needed finance to re-invest in service improvement.
Appendix 1

Communication

Effective communication between different healthcare professionals and the women they care for is vital to the success of this model. This is especially pertinent when women first make contact with services, usually through a GP or direct access to a midwifery team, where the potential for getting lost in the system is greater. Effective communication is also a key factor to ensuring timely and appropriate referrals to specialist services are made for women whose pregnancies require specialist input, such as women with existing medical pre-conditions or women who develop complications. Figure 23 describes the communication points required for delivering the maternity care pathway.

Figure 23: Communications requirements for delivering the maternity care pathway

Source: Clinical Working Group, team analysis
Appendix 2

London Ambulance Service

In 2008, the London Ambulance Service attended over 24,000 maternity events, 7,000 birth imminent events and 1,000 births. The London Ambulance Service is closely involved in safe and effective transfer and supports these maternity service guiding principles.

The London Ambulance Service sends its own first responders to incidents by different modes of transport such as bicycle, motorbike and car as it often arrives quicker to scene. This includes attending maternity events, but relies on who is nearest to an incident, for example a first responder, emergency medical technician, or paramedic crew. The London Ambulance Service tries to send paramedics to a maternity event with a higher skill set if responding to a red (high code emergency) dispatch.

The service supports home birth community units – King’s College Hospital has a 6-8% home birth with 25% transfer rate – and has separate transfer policies with standalone units in London, such as the Barkantine Birth Centre and Edgware Birthing Unit.

Appropriate emergency ambulance usage is paramount. The London Ambulance Service actively discourages women from using the service for transport in uncomplicated labour and has developed a maternity care pathway to assess women’s transport needs when a call is received. Normal labour is a low priority for ambulance dispatch. The London Ambulance Service is also working with maternity units, midwives and user representatives to explore and plan alternative transport for women in normal labour. Currently obstetric calls account for approximately 2.5% of their total emergency calls per annum. They have 76 dispatch locations to serve 26 units in London. Consequently, the London Ambulance Service is supportive of any move towards midwife-led units, and home birth can be absorbed into their existing plans if calls to the service for women in normal labour are reduced.
Appendix 3: Acknowledgements

CSL would like to thank the following people who have provided input and time into this model of care.

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Appendix 4: Glossary

Active labour: Contractions women experience in early labour become stronger and more intense. Active labour is the longest part of labour as the body is preparing for the baby to be born.

Antenatal: This period covers conception until the beginning of labour. It is also called prenatal.

Antenatal care: Medical care for a pregnant woman and her developing baby for the duration of the pregnancy.

Caesarean section (or C-Section): Delivery of the baby through a surgical incision in the mother’s abdominal wall and uterus.

Cervix: The lower end or neck of the uterus which leads into the vagina, and gradually opens during labour.

Eclampsia: Convulsions associated with hypertension in pregnancy.

Elective: A planned procedure, not undertaken as an emergency.

Embryo: From conception to the eighth week of pregnancy.

Epidural: A common method for administering pain relief in labour. A local anaesthetic injected into the space around the spinal cord, causing loss of sensation to the lower part of the body.

Episiotomy: Surgical cut through the perineum performed at the end of labour immediately before a vaginal birth to facilitate delivery of the baby.

Fetal distress: Changes in the condition of the fetus which might indicate a potentially harmful environment in the womb.

Fetus: The name given to a growing baby after eight weeks of development; before eight weeks, the developing baby is called an embryo.

Forceps: Instrument applied to the baby’s head to assist in delivery.

General fertility rate: Rate of live births per 1,000 resident women aged 15-44 years.

Gestation: The length of pregnancy. Full-term gestation is between 38 and 42 weeks.

Induction: Process by which contractions of the womb are initiated artificially, either by breaking the membranous sac around the baby, or by drugs, or both.

Infant mortality rate: Deaths under age of 1 year after live birth, rate per 1,000 live births.

Intrapartum: During labour.

Labour: The process of childbirth, from the dilation of the cervix to the delivery of the baby and the placenta.
Maternal mortality: The death of a mother directly related to a pregnancy, either from the birth, a miscarriage, or an abortion.

Perinatal: Perinatal refers to the period just before, during, and immediately after birth. Specifically from 22 completed weeks (154 days) of gestation (the time when birth weight is normally 500g) to 7 completed weeks after birth. Legal regulations in different countries include gestation age beginning from 16 to 22 weeks (5 months) before birth.

Perinatal mortality rate: Stillbirths and deaths at 0-6 days, rate per 1,000 live and stillbirths.

Placenta: An organ which develops in the uterus during pregnancy, providing nutrients for the fetus and eliminating its waste products. It is also referred to as the afterbirth because it's delivered after the baby in a vaginal birth.

Postnatal: Postnatal is the period beginning immediately after the birth and extending for about six weeks. Another term would be postpartum period, as it refers to the mother (whereas postnatal refers to the infant).

Postneonatal death: Death from 28 days to less than one year of age (28-364 days).

Premature baby: A premature baby is one who is born before 37 weeks of gestation.

Neonatal: The period from birth to 28 days.

Neonatal mortality rate: Deaths at 0-27 days after birth, rate per 1,000 live births.

Parity: Total number of previous live births and still births. This does not include abortions or miscarriages.

Still birth: If a fetus dies in the uterus before delivery, after the 24th week, it is called a stillbirth. The loss of a pregnancy before 24 weeks of gestation is called a miscarriage.

Triage: Triage is the process of assessment to determine the mother's care needs to make appropriate referrals.

Vacuum extraction: This is also known as ventouse delivery. It is a method increasingly used as an alternative to forceps to assist delivery. A suction cup attached to a machine is placed on the baby's head to assist the baby's passage through the birth canal.

Ventouse: Equipment used for vacuum extraction.

1:1 care in established labour: A women in established labour receives care from a designated midwife for the whole of that labour, or the midwife’s whole shift, whichever is the shorter. The midwife will be available to care for the women 100% of that time. At the end of the shift, if necessary, care will be handed over to another designated midwife, who will continue the one-to-one care of that woman.