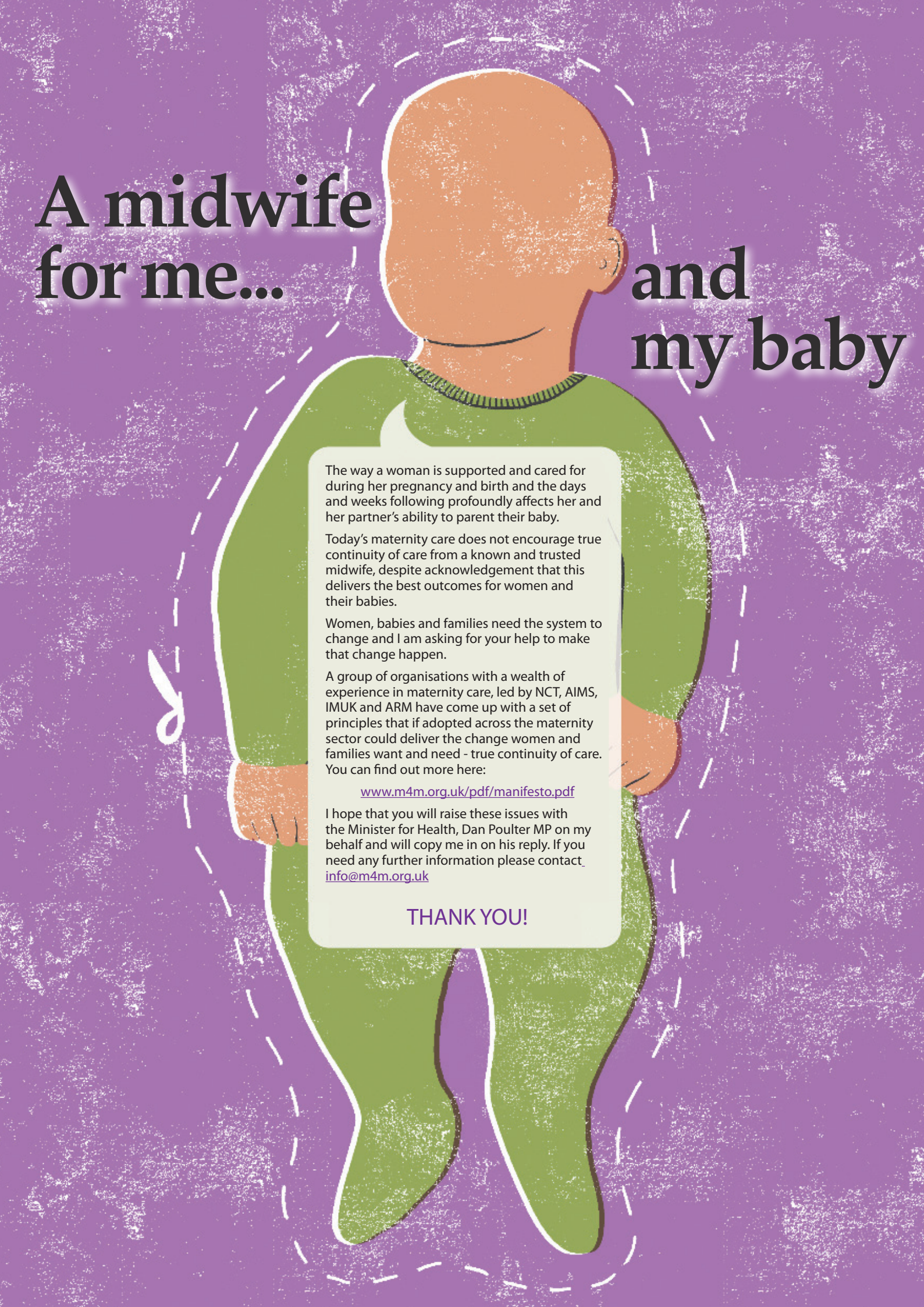
A midwife for me... and my baby



The way a woman is supported and cared for during her pregnancy and birth and the days and weeks following profoundly affects her and her partner's ability to parent their baby.

Today's maternity care does not encourage true continuity of care from a known and trusted midwife, despite acknowledgement that this delivers the best outcomes for women and their babies.

Women, babies and families need the system to change and I am asking for your help to make that change happen.

A group of organisations with a wealth of experience in maternity care, led by NCT, AIMS, IMUK and ARM have come up with a set of principles that if adopted across the maternity sector could deliver the change women and families want and need - true continuity of care. You can find out more here:

www.m4m.org.uk/pdf/manifesto.pdf

I hope that you will raise these issues with the Minister for Health, Dan Poulter MP on my behalf and will copy me in on his reply. If you need any further information please contact info@m4m.org.uk

THANK YOU!

Introduction

“I want my mummy to be able to have a midwife that she can get to know and trust, who will support her through her pregnancy, birth and beyond.”

Today more than 2000 women will give birth. Of those, only 380 will be attended at any point in their labour by a midwife they have met before.[1] In some places only one in 10 will have a midwife they have met before, while in other places nearly 1000 of them will be left alone in labour or after the birth when they are frightened.[2] More than 500 of them will have a caesarean.[3] Seventeen of them will lose their baby.[4] Afterwards, 200 will become depressed, while 600 will appraise their experience as ‘traumatic’ and 60 will develop post-traumatic stress disorder (PTSD).[5]

One in five women is left alone in labour.[13]

69% of new mothers start breastfeeding exclusively, but a week after birth, only 46% are doing so.[16]

8 in 1,000 babies die at or around the time of birth.[4]

25% of births are carried out by caesarean section.[3]

birthrights

ASSOCIATION OF RADICAL MIDWIVES

AIMS

The Birth I Want

nct

IM INDEPENDENT MIDWIVES UK

What we want for parents

We owe it to parents to give them the healthiest and best-supported start to parenthood we can, because the start in life that parents give to their baby has a profound effect on that child's:

- later health, well-being and life chances;[6]
- ability to contribute as a productive and positive member of society; and
- ability to be a parent themselves.

Giving the best-supported start to parents means making sure that the birth, and the weeks before and after it, are a positive as well as a safe experience for the new parents and their baby.

Delivering 'a midwife for me and my baby'

We want every woman to have a midwife who she can get to know and trust, who can support her through her pregnancy, birth and beyond, regardless of her circumstances or where her baby is to be born.

What midwives say

We asked midwives for their thoughts on one-to-one care. Here are some of the responses:

- 'When my clients know and trust me they are able to surrender to the birth process with less fear and the birthing occurs more easily; it is deeply rewarding for me to be part of this journey with these women and their families.'
- 'What people need is other people. You can put as much money into anything that you might care to, but people will always need people. Continuity is of the utmost importance for people needing people in midwifery, nursing, medicine, education and law enforcement.'
- 'I love working as a caseload midwife. Having journeyed through pregnancy, when it comes to the birth, the woman feels peaceful, trusting, empowered and supported, able to birth her baby usually with minimal intervention, the culmination of everything planned... celebration, equipping the new family to have the best possible start! And 99% of my clients are still breast-feeding at six weeks. I'm convinced this is mostly due to the way I work.'
- 'Giving women and their families one-to-one care, I've felt like part of the family too. Partners, grannies, best friends. . . We become one team, and that feeling of belonging is delicious.'
- 'Something that amazed me when I started working this way is that women actually started telling me the truth. Until that point, I hadn't realised how much most women keep from their midwives.'
- 'Being able to serve the women and not the system means I don't have divided loyalties between the woman and my employer, and that's how midwifery should be.'
- 'When there is so much reflection on, and discussion of, how morbidity and mortality can be reduced for mothers and babies in the UK, it is hard to see why there is not a midwife for every woman and her baby! Birth takes place on an industrial scale and women and their families talk to us about how they feel about being "processed", and what impact this has had on them. It influences everything from their health to the wellbeing of their families. What is stopping us acknowledging the benefits of having a known midwife for women, or from accepting that for us all to have a healthy and happy population, this investment in a model of care which meets the needs of women, their families and midwives is imperative?'
- 'In our city, implementing this model of care would go some way towards equalising the inequalities in health which parts of our population experience. Having a relationship with a midwife of one's own would help birth to be the positive, rewarding and empowering experience we know it could be.'

What mothers want

We asked women about their experiences of giving birth, and their views of the relationship between mother and midwife. We found that women often express unhappiness that they rarely see the same midwife twice, that midwives aren't able to spend enough time with them and that they lack the opportunity to build up a close relationship with an individual midwife.

But when each woman sees her own midwife throughout pregnancy and labour, the experience is often a much happier one:

- 'I *loved* my midwives – I have had two "lead" ones for four pregnancies, and met most of the rest of their community team either at my three homebirths or for checks before or after the birth, and their friendship, advice, support and general wonderfulness helped enormously during the birth. I have found saying goodbye to them incredibly traumatic – almost a grieving process!'

- ‘My relationship with my midwives was and is one of the most powerful relationships I have had, and I am sure that it contributed greatly to my love of pregnancy and birth – I know that their amazing humanity and wisdom had a huge impact on how I experienced my birth and in my (subconscious) emotional and psychological preparation for labour.’

- ‘I think the one-to-one experience was truly amazing. I think it made the whole experience very positive and got me through a difficult birth without intervention. It would have been very easy to go for a section but Sue gave me the confidence to have a natural birth.’

Asked for their ideal midwifery experience, women were very clear:

- ‘My ideal midwifery experience would be one midwife, who listened to me, who I knew, who would be there at my birth.’

- ‘I would love to see a system where every woman received the standard of care currently provided by independent midwives, with appointments in the woman’s home, time to really get to know the midwife and discuss even the small things and, of course, that midwife present at the birth in whatever setting is appropriate.’

- ‘My ideal midwifery experience would be to build a bond with someone who I could trust to listen to my hopes and wishes and who could support me in labour when I can’t speak for myself. Someone who I trust and someone who knows me. Not to feel out of control and unimportant.’

What do others say?

Wider society is increasingly accepting what parents and midwives have known for decades: that the way a woman is supported and cared for during her pregnancy and birth - and in the days and weeks following - profoundly affects her and her partner’s ability to parent their baby.[7,8,9]

The way that a baby develops in utero and in the weeks after birth is influenced by the quality of care that parents receive – and these early weeks and months of a child’s life affect the life chances of the resulting adult profoundly.[10] Transforming support for parents will transform the crucial care that babies receive from their parents at this developmentally influential time. A government report on the future of midwifery care says:

- ‘Women and their partners want a safe transition to parenthood and they want the experience to be positive and life enhancing. Quality maternity services should be defined by the ability to do both.’[11]

The Royal College of Obstetricians and Gynaecologists takes a similar view:

- ‘The model we are proposing focuses on the needs of the woman and her baby by providing the right care, at the right time, in the right place, provided by the right person and which enhances the woman’s experience.’[12]

What’s wrong with the current system?

The current system of maternity care, in which most women are not cared for by a midwife they know and trust, leads to numerous problems:

- emotional or mental discomfort, distress, anguish, illness in one or both parents;

- physical discomfort, pain, trauma for the mother;

- relationship breakdown between the couple or between parent and baby; and

- loneliness, isolation, exclusion, separation of the parents from a support network.

Parents experiencing these difficulties are able to offer less than optimal care for many new babies and children, and consequently there may be negative effects on life chances as parents struggle to manage their children’s needs alongside their own.

The system drives more women into consultant units than want or need to go. Women who would otherwise have a straightforward birth have a complicated or surgical birth. This inflates the total cost of maternity services.

- ‘I saw the midwives at my doctor’s surgery, and one home visit. I don’t think I saw the same midwife twice. Waiting times were long and appointments were rushed, which was stressful for both me and the midwife’

- ‘My appointments were always quite rushed due to the pressure of my midwives’ caseload, so I didn’t develop a relationship. The midwife who was at the birth, I had never met her before. If I had been particularly anxious about labour I think this would have caused problems.’

- ‘Midwives are very important people for a short time in your life and it’s a shame in bigger teams and hospitals that they are often so overworked they can’t spend more time with you and see you throughout your pregnancy.’

- ‘I would ring the bell over and over and just no one would turn up. During a time when I could hardly walk

because of the c-section and just feeling so emotionally vulnerable after the birth of my daughter – it felt like I was just deserted in the hospital. It was horrible!'

- 'I felt very traumatised for several years. The worst being for the first year or more. I had a vaginal birth, I would say it was about as far from normal as one can get, but, I avoided epidurals, c-sections etc...and felt very traumatised despite nothing "awful" happening.'

- 'I feel the sessions with my midwife were a little rushed and clinical. They only lasted 10 mins approx. All the checks were done, but I never felt I could really discuss anything.'

Why is the situation getting worse?

Several trends are exacerbating the problem:

- An increase of 22% in the UK birth rate between 2001 and 2011.[17]

- A rise in mothers with increasingly complex needs. This is partly down to an increase in the number of older first-time mothers,[18] and partly a result of an increase in the numbers with physical, social or psychological problems.[11]

- An acute shortage of midwives.[17]

- Midwives not rostered to be available when needed. Overworked midwives not having enough time to provide quality midwifery care.[19]

- No financial incentive for maternity providers to provide continuity of midwifery care[20] or to support birth in the community or provide the support to enable straightforward births.

- Centralisation of maternity care in fewer, very large obstetric units which feel impersonal and create increased travel time for women in labour. [21]

- Often-inappropriate care for low-risk women in obstetric units, with low-risk births being treated as if they were high-risk.

- High drop-out rates among midwives: 20% of student midwives drop out during their course; a further 10% leave in the first 18 months after qualification, mainly because they are unable to practise in the way that they wished.[22]

- Fewer women having the support they need to have straightforward births.[23]

- Fewer women having one-to-one midwifery care in labour in obstetric units.[24]

- The majority of women not being given a full range of choices of where to give birth.[21]

- A low ratio of midwives to women (the required ratio of one midwife to 28 women is not being met).[25]

How can we improve things?

- Each woman should have a named midwife they can get to know and trust and who they will see during their pregnancy, birth and after their baby is born.[26]

- Maternity services should be able to offer choice in line with the available evidence.

- Women should be provided with information and support to enable them to make decisions that are right for them on where and how their baby will be born and who will be with them during labour, birth and the postnatal weeks.

- There must be a financial regime and sufficient resources within the health service to support services in line with the evidence.[26]

- The maternity service must be organised to enable care in line with the evidence. This will require the establishment of maternity networks with most care based in the community.[27]

What changes do we need?

In order to effect these improvements, we need to make a number of changes:

- The acknowledged shortage of 5,000 additional midwives must be addressed urgently.

- Maternity providers should have a financial incentive to provide continuity of care from a midwife throughout a woman's pregnancy, birth and beyond. Good evidence demonstrates improved outcomes from midwifery case-loading models providing continuity, such as a decrease in the caesarean birth rate, fewer inductions, increased breastfeeding rates, fewer GP visits, fewer baby hospital admissions, etc.[28,29]

  These improved outcomes generate significant savings.[30] Even a moderate increase in breastfeeding rates, for example, would have a protective effect on the development of certain illnesses, saving the NHS £40m a year.[31] Some of these savings should be reinvested into a tariff for providers who achieve midwifery continuity who could then appropriately pay midwives who provide this level of commitment and

service (24/7 availability). This will ensure these care models grow and are sustainable.[20]

- At present in England, Payment by Results (PbR) is not well-suited to promoting continuity and co-ordination of care[32] and even the newer version may continue to create a ratcheting-up effect on caesarean section rates. PbR should also be designed to ensure there is no incentive for intervention and does not disadvantage midwifery-only maternity providers.
- Capital charges should be changed from a charge for the space to a charge for the person, so there is less incentive to pull all births into consultant units.
- NHS maternity care is being driven by the financial incentive of discounted premiums for indemnity cover from the Clinical Negligence Scheme for Trusts (CNST) for providers to implement processes that reduce litigation rather than necessarily improving care. The protocols stress the importance of ensuring that services carry out intervention safely when they intervene, which is valuable, but it is important that premiums recognise the benefits of safely not intervening, and putting in place strategies to prevent the need for intervention, rather than just demonstrating safe intervention. Premiums need to be discounted to those providers that provide evidence-based care which is designed to produce a safe and fulfilling process and outcome for mother and baby.
- Maternity networks should be established as providers to deliver maternity services.[27]
- Services should be configured so that women can be seen in a community setting where appropriate.[12]
- There should be a single leader for each maternity service rather than the current system in which three people from three disciplines have to work together to lead maternity services.
- Midwifery and obstetric training and continuing professional development (CPD) should be integrated where appropriate, and made complementary where separate. Training should be parent-focused and evidence-based.
- User-led MSLCs should continue and be supported as the strategy development body for maternity services.
- Independent midwives need to have insurance and guaranteed access rights to support women giving birth on NHS premises.[33]
- These defined principles need to be adopted both across the maternity sector and by governments and assemblies, and their achievement measured and reported on.

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