The Royal College of Midwives

Submission

Submission to The People's Inquiry for London's NHS

December 2014

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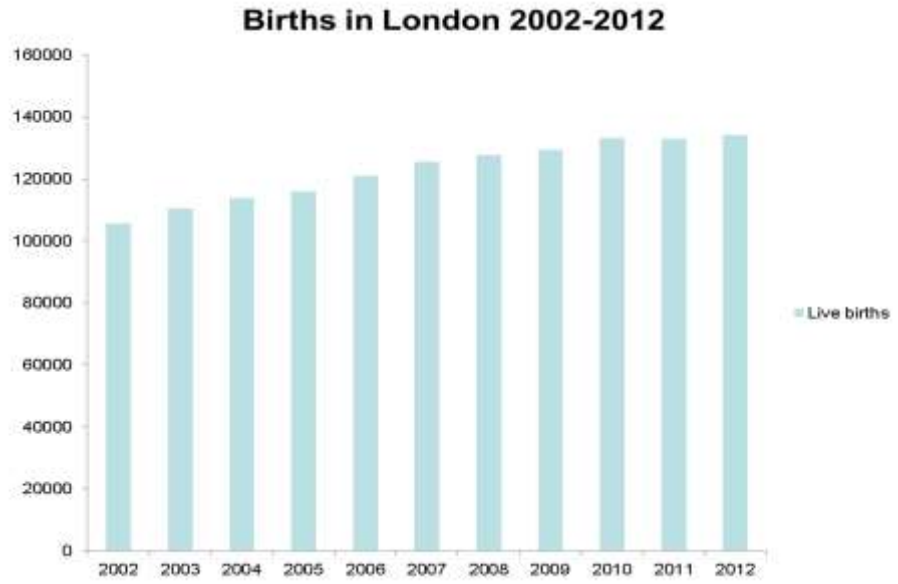
The Royal College of Midwives (RCM) is the professional and trade union membership organisation that represents the vast majority of midwives, and an increasing number of maternity support workers (MSWs) working in London's 24 maternity services, 18 alongside midwife-led units and two freestanding midwife-led units. As such, this submission is largely focused on issues that relate to maternity and midwifery services in London and how they impact on women and families and on maternity services staff.

Challenges for London's maternity services

Capacity issues

Maternity services in London face the challenge of a continuing rising birthrate: there were 134,186 births in London in 2012, an increase of 29 per cent on the number of births in 2001 (104,162); births are projected to increase by a further 2.9% in the next ten years.



Source: ONS annual birth statistics

It is not just that births have grown at a faster rate in London than anywhere else in England; it is the complexities associated with an increasing number of pregnancies and births that is placing additional pressures on maternity services. The impact of these complexities is compounded by age and by socio-economic factors such as deprivation and ethnicity.

The age at which a woman gives birth is a major influence on maternal outcomes: for example, teenage mothers tend to experience poorer health during pregnancy and are more likely to give birth to low-birth weight babies than women in their twenties and early thirties; for women aged 40 years or more, there is a higher risk of developing complications associated with conditions such as diabetes and high blood pressure. The good news in London is that the birth rate for women aged under 18 (6.3 births per 1000 women aged under 18) is the lowest in England. However, London also has the highest birth rate for women aged 45 and over (2/1000 births)[1].

There are large health inequalities in London which can have a profound impact on both maternal and long-term child health. There is, for example, a strong correlation between low birth weight and deprivation, with women in Tower Hamlets giving birth to a similar proportion of low birth weight babies as women in Botswana, whilst the proportion of low birth weight babies in Richmond is comparable to that of Switzerland[2].

A key challenge for maternity services in London is providing safe, effective and appropriate care for women from diverse ethnic and cultural backgrounds. Compared to white women, mothers from minority ethnic backgrounds:

- Have their first antenatal contact and booking later, are less likely to be aware of all possible options for place of birth and less likely to say they were given enough information about the choices for maternity care.
- Are less likely to report having confidence and trust in staff looking after them during labour and birth.
- Are less likely to say they were treated with respect by postnatal staff and reported having fewer home visits.
- Are more likely to die during childbirth and to have stillbirths and neonatal deaths.
- Are less likely to be satisfied with care during labour and delivery, and postnatal care, though more likely to be satisfied with pregnancy care[3].

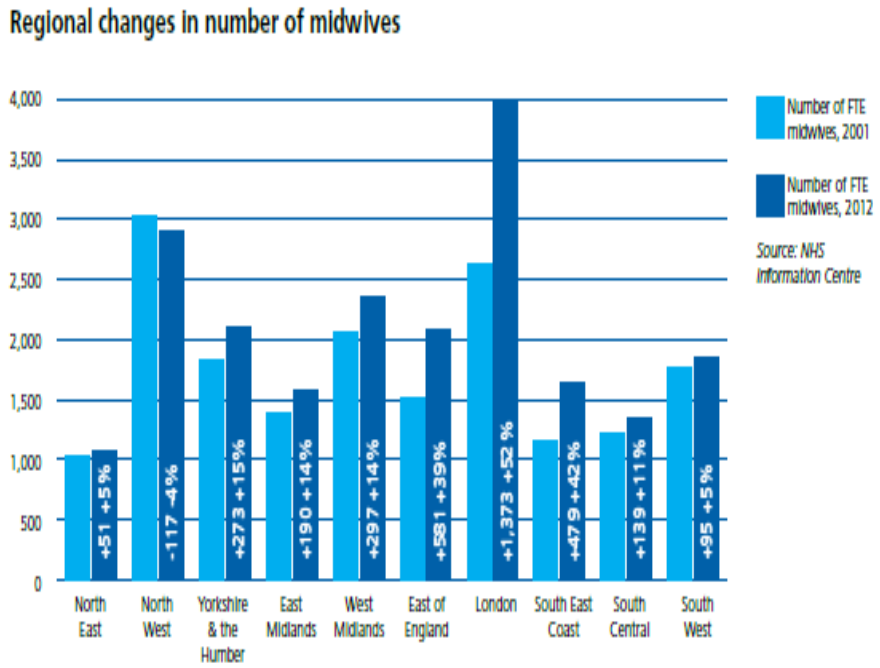
It is therefore imperative that London's maternity services improve the outcomes and experiences of BME women and families; this is given added impetus by the fact that more than 77,000 babies – 57 per cent of the total born

[1] ONS (2013) Births by usual area of residence of mother, England and Wales, 2012
[2] NHS Commissioning Support for London (2011) Improving maternity care in London: a framework for developing services.
[3] NPEU (2010) Delivered with care: a national survey of women's experience of maternity care 2010

in London in 2012 – had mothers who were born overseas. This compares to a UK average of 25 per cent. Within London there is considerable variation in the proportion of births to non-UK born women, ranging from 77 per cent in Newham to 24 per cent in Havering[4].

The midwifery workforce

Whilst London has had, over the last ten years, the fastest rising birth rate in England, it has also responded more effectively to the baby boom than any other region. Since 2001, the NHS in London has increased the number of full time midwives by more than a half, from 2,633 to 4,006.



Source: RCM (2013) State of Maternity Services Report 2013

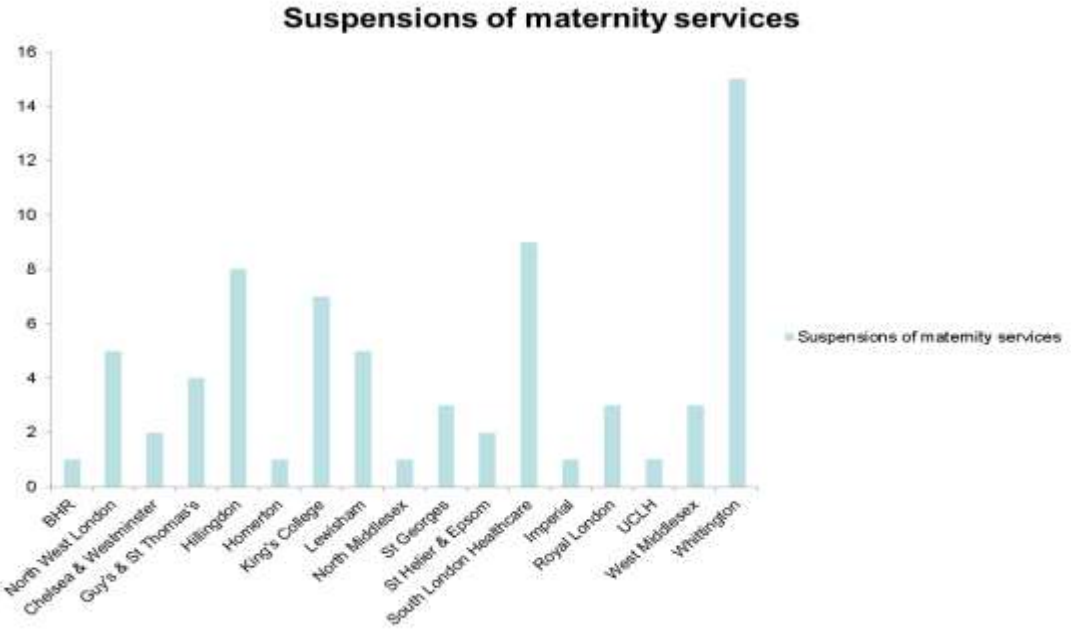
This has meant that maternity providers in London have been able to lower the ratio of births to midwives from 37:1 in 2001 to 30:1 last year. There is every prospect therefore that in the next year of so London's maternity units will meet the Birthrate Plus recommended ratio of 29.5 births to every midwife. However the births to midwife ration varies considerably between individual maternity units, with ratios ranging between 37:1 and 22:1.

Extra investment in midwifery staffing establishments is reflected in a fall in vacancy rates for midwives in London, from 16 per cent in 2009 to 8 per cent last year. Again however this masks significant variations in the vacancy rate at unit level.

[4] London Evening Standard 29th August 2013

Source: LSA Midwifery Officer Annual Report 2012-2013

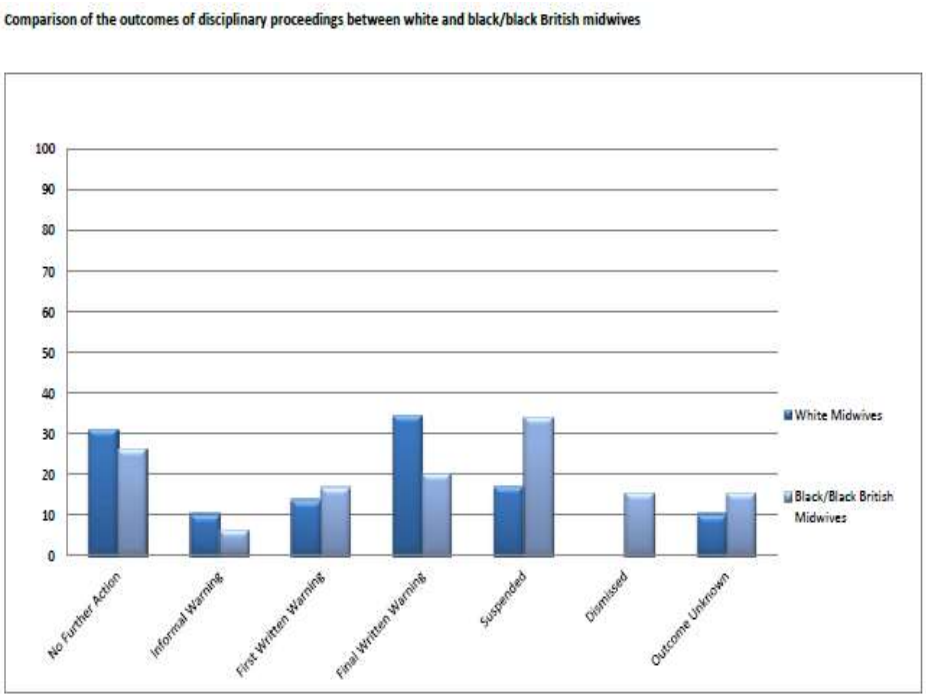
Despite the increased investment in staffing numbers in recent years it remains the case that some maternity services in London continue to struggle to meet the demands made on the service, both in terms of the baby boom and the increasing complexity of cases. This is evident from the fact that in 2012-13, there were 71 occasions on which maternity services in London had to be temporarily suspended (although this is slightly fewer than in 2011-12 when there were 76 suspensions). The main reasons for the suspensions were insufficient beds, followed by insufficient staff.



Source: LSA Midwifery Officer Annual Report 2012-2013

Regarding other workforce issues, the RCM has been concerned that a disproportionate number of BME midwives have been subject to disciplinary proceedings in London. An RCM FOI request (September 2011) to providers of maternity services in London found that:

- 60% of the midwives who were subject to disciplinary hearings were black/black British; 32% of midwives in London were black/black British
- 34% of black/black British midwives were suspended, compared to 17% of white midwives
- 31% of white midwives had no further action taken, compared to 26% of black/black British midwives
- All ten midwives dismissed in this period were black/black British.



Source: RCM (2011) analysis of response to FOI request

During 2013, the RCM has been working with the London office of NHS England and with London's maternity services to address the issues highlighted by our research. We held a joint summit in October and will be holding further events at NHS trusts across London throughout 2014. We are also working with individual units such as the maternity service at Lewisham Hospital on issues such as workplace culture, relationships and on how the treatment of the workforce impacts on the treatment that women and families receive. We will also undertake a follow-up FOI request in order to assess whether BME staff are still being disproportionately affected by disciplinary action.

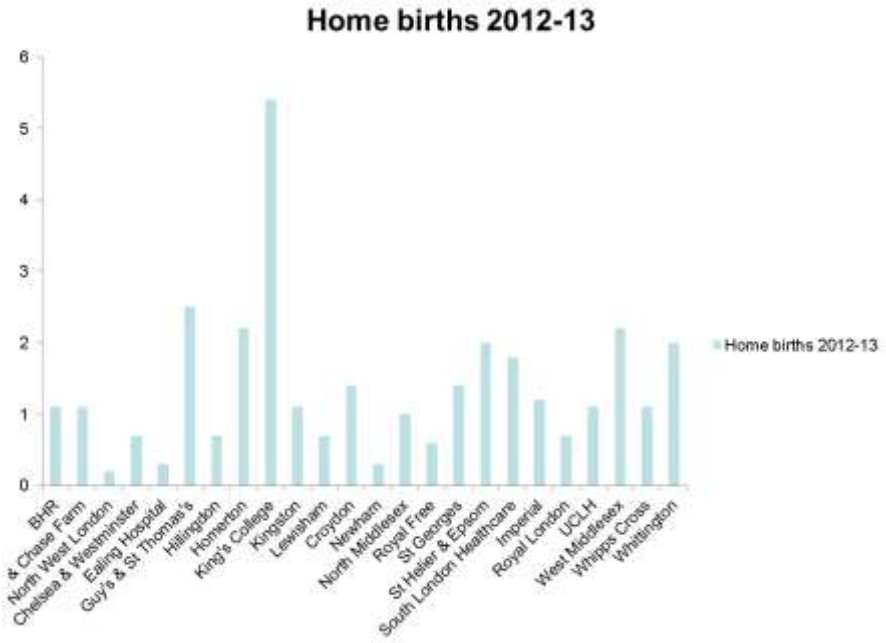
Outcomes

Outcomes for mothers and babies in London reveal a mixed picture, with progress being made in some areas but also significant challenges remaining:

- There were 19 maternal deaths in London in 2012-13 – this was four fewer than in 2011-12 and only one of the deaths was due to direct causes.

- Caesarean section rates have fallen slightly in London, from 28.9 per cent in 2011 to 28.4 per cent in 2012; however, this is still above the national average of 25 per cent. Four maternity units in London have rates at or above 30 per cent[5].

- The home birth rate in London continues to fall, year on year and one-third of maternity services have a home birth rate of less than one per cent.



Source: LSA Midwifery Officer Annual Report 2012-2013

London's maternity services have also had to address many public health issues. According to the annual report of the Local Supervising Authority Midwifery Officer for London, the capital has higher rates of early deaths from circulatory diseases, more people with diabetes and the highest level of childhood obesity in England. These complexities are all present in the

[5] LSA Midwifery Officer Annual Report 2012-2013

population of pregnant women, compounded by the number of women who have migrated to London from overseas, who often present with chronic health conditions.

Having said that, there is some evidence from some public health indicators of an improving situation for women and babies in London:

- London also has the lowest rates of maternal obesity in the UK. Whereas five per cent of the UK maternity population are classified as severely obese, the figure for London is just 3.5 per cent.

- Furthermore, fewer pregnant women smoke in London than anywhere else in England. Whereas the national average for women smoking in pregnancy is 13.4 per cent, just six per cent of pregnant women in London smoke.

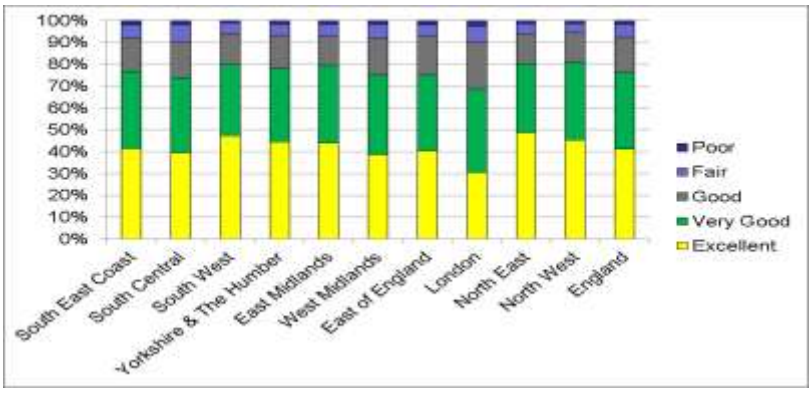
- In 2012, 87 per cent of London mothers breastfed their new-born babies. This is significantly greater than the proportion of mothers breastfeeding in England (74 per cent). The same is true of breastfeeding at six to eight weeks, with over 70 per cent of London mothers still breastfeeding, compared to a national average of just 47 per cent.

Figure 1: Breastfeeding initiation and prevalence in London and England (2011/12)

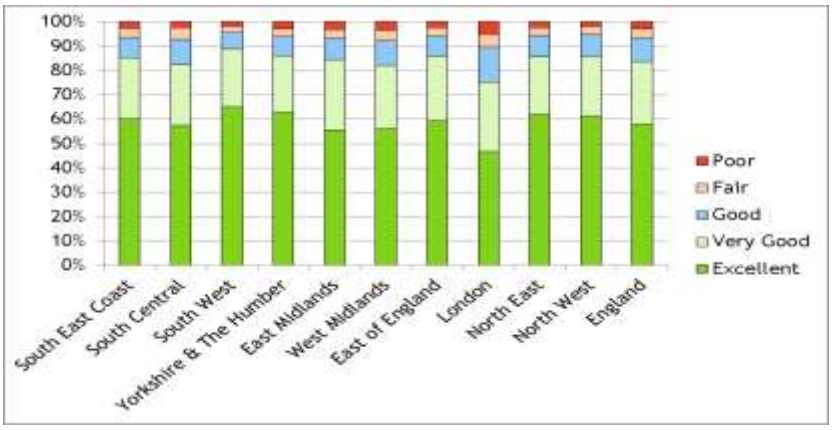
Women's experience of maternity services

The Care Quality Commission are about to release the findings from its 2013 survey of women's experience of maternity care. We have not yet been given access to the results of this survey, so for now will have to rely on the last CQC survey, conducted in 2010. Across a range of indicators, London maternity services lagged behind services elsewhere in England:

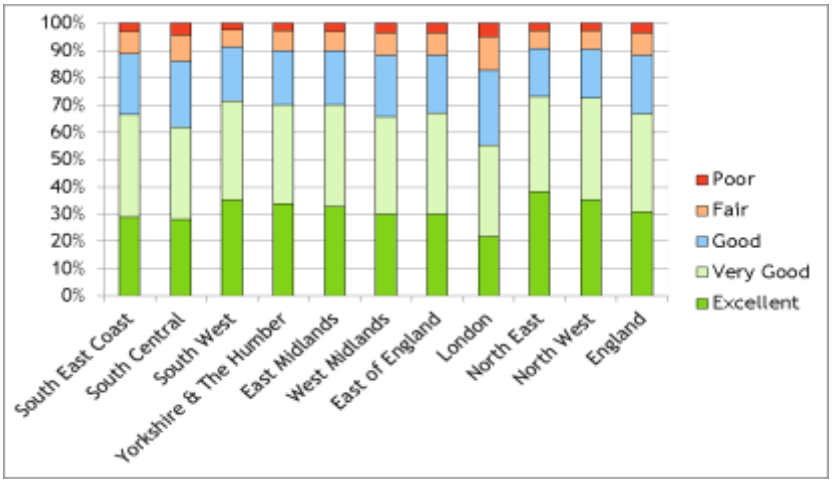
- London's maternity services were rated less well than any other region in England, with fewer women rating their antenatal care as excellent and more rating it as poor.



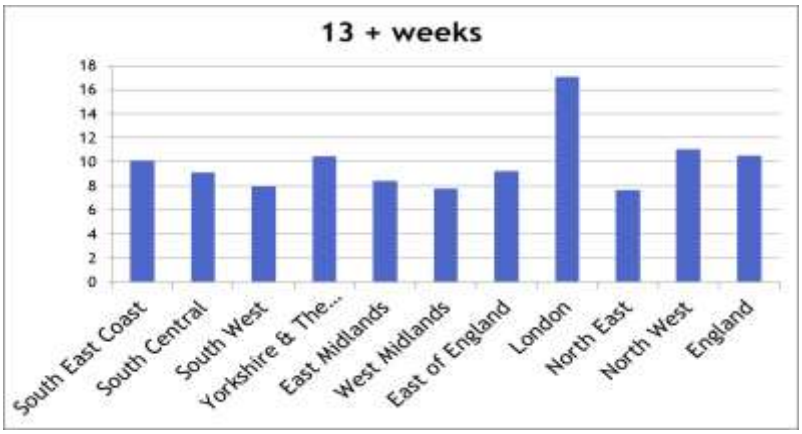
- London also lagged behind when it comes to care during labour and birth



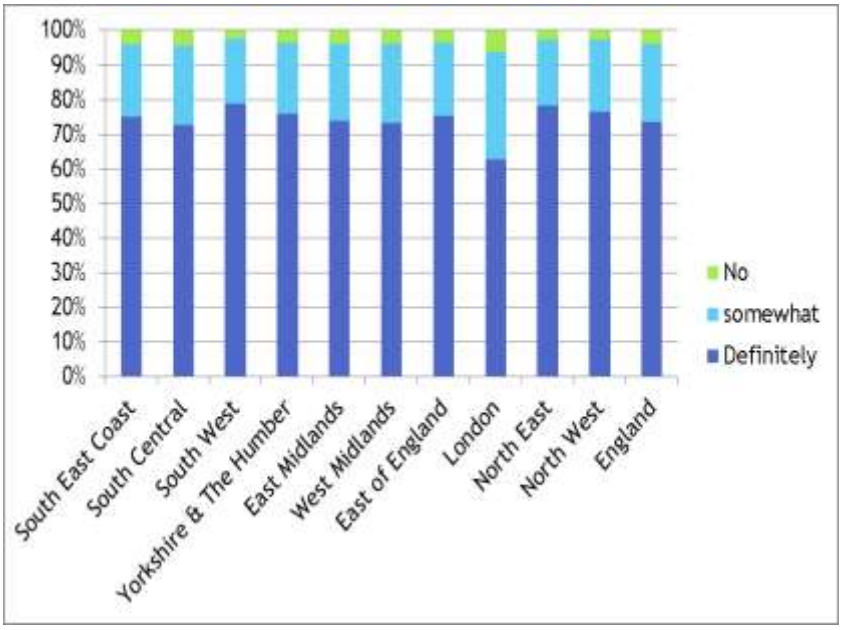
- And for postnatal care too



- More women had their antenatal booking assessment after 13 weeks in London than anywhere else in England, despite a Government target that women should have their booking appointment before the end of their twelfth week of pregnancy.

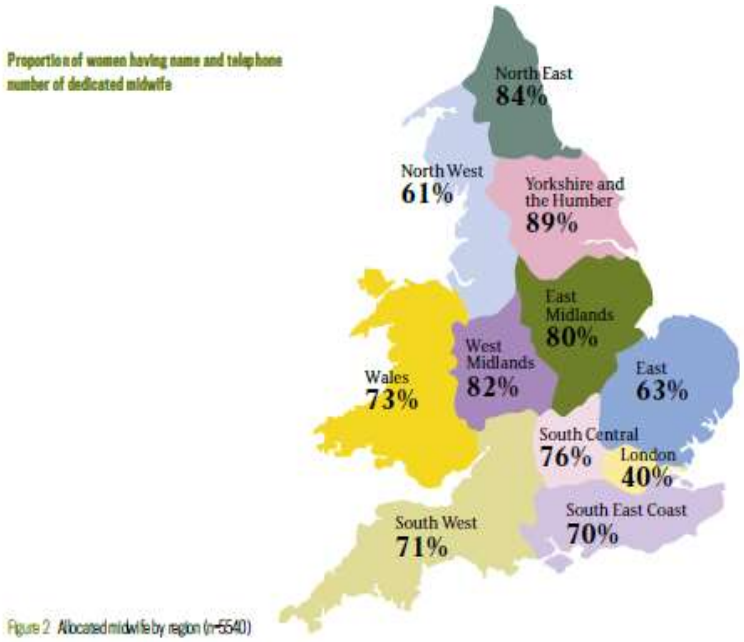


- Confidence and trust in staff was also lower in London than elsewhere



A report published earlier this year by the Women's Institute and NCT into women's experience of maternity services further areas where women in London are receiving a poorer service than women in other parts of England:

- Only 40 per cent of women in London had the name and telephone number of a dedicated midwife, compared to 89 per cent of women in the Yorkshire and Humber region and a national average of 72 per cent of women.



- Fewer women in London were made aware of the options of having a home birth (65 per cent) or birthing in a freestanding midwife-le d unit (14 per cent) than in England as a whole (69 per cent and 25 per cent respectively)
- When asked in the weeks following birth if they saw a midwife as often as they wanted to, 25 per cent of women in London said they did not, compared to 15 per cent of women nationally[6].

How maternity services are organised in London

In recent years there have been major reorganisations of maternity services in north east, south east and north west London. A reorganisation of maternity services in south west London is likely in the near future. In each case the major driver behind the reorganisation has been the centralisation of obstetric services on fewer sites in order to meet the NHS London maternity services standard which states that: "Obstetric units should be staffed to provide 168 hours a week (24/7) of consultant obstetric presence on the labour ward". In recent years, this drive to meet this standard has led or will lead to the closure of maternity units at:

- King George's Hospital, Ilford
- Ealing Hospital
- Queen Mary's Hospital, Sidcup
- Chase Farm Hospital

[6] NFWI, NCT (2013) Support Overdue: Women's experience of maternity services

Under the Trust Special Administration (TSA) proposals for south east London, the maternity unit at Lewisham was also due to close, until the judicial review overturned the decision.

The RCM acknowledges that it is desirable to provide women with equity of service provision over a 24 hour period and there are clinical benefits arising from some concentration of obstetric-led services, particularly for women and infants who require emergency or specialist care. Therefore, we would not disagree with having a long term aspiration of all obstetric units in London achieving 168 hours presence. However, the evidence for the benefit of 168 hours of consultant presence in terms of the impact on outcomes is limited, believes that due in part to the costs of 168 hours and in part to current workforce constraints the universal achievement of 168 hours is not affordable and should not therefore be the principal driving force behind the reorganisation of maternity care in London.

Recommended actions

In recent years investment in London's maternity services has increased and this is evident in the progress made in improving midwifery staffing levels. There have also been notable improvements in respect of key indicators, such as rates of maternal obesity and the number of women quitting smoking during pregnancy.

In other respects, however, progress is at best patchy and there remain notable variations in the quality of services across London's maternity units. There are still too many instances of services that are understaffed, are carrying too many vacancies and have to suspend services on too many occasions. There are too many outcomes where progress has stalled e.g. intervention rates or gone backwards, such as the number of home births in London. Evidence from the CQC and Women's Institute/NCT surveys suggest that women's experience of maternity care in London leaves a lot to be desired. Meanwhile, the reconfiguration of maternity services across London is being driven by medical staffing standards that are expensive and for which there is only very limited evidence of improved outcomes.

The RCM is concerned that without a concerted and sustained focus on raising the standard and quality of maternity services in London, there is a real risk that further progress in improving services will be jeopardised, outcomes will be compromised and women and families will be left feeling dissatisfied with the quality of care they receive.

Action is therefore needed in the following areas:

Investment in maternity services

While the demands on maternity services have increased substantially in the last decade, investment in maternity care has stagnated in London and elsewhere. According to the National Audit Office, total spending on maternity care represents 2.8 per cent of health spending, exactly what it was ten years ago. In theory the cost of providing maternity care ought to be covered by the PbR pathway tariffs; in reality, the income from tariffs is not keeping pace with rising costs and commissioners are having to provide additional funding for services that would not otherwise be financially viable[7]. This is supported by testimony to the PAC from the Foundation Trust Network which stated: "most maternity services have run at a deficit or break even at best and are cross-subsidised from other services"[8].

Indeed figures show that while NHS trusts spent £2.9bn on maternity care in 2011/12, commissioners only funded £2.6bn of activity. In London there was a shortfall of £125 million between what trusts spent on maternity care and what commissioners funded, a gap of 19 per cent. Only the NHS in north east England had a bigger funding shortfall[9].

One of the problems that the NAO identifies is that the Department of Health (DH) has never properly assessed the affordability of implementing the 2007 Maternity Matters strategy, which the Government insists is still current policy. As the NAO conclude, there are real concerns that available resources are not sufficient to meet the objectives set out in Maternity Matters.

The case for increasing investment in maternity services in London and elsewhere in England is twofold:

1. To provide maternity services with sufficient capacity to meet the ever growing demands that are being driven by the baby boom and the growing complexity of cases.
2. To ensure that adequate funding is available to implement the objectives outlined in the Government's Maternity Matters strategy.

Staffing levels

Investing in midwives is the key to ensuring that women have a safe and life-enhancing experience during their maternity care and that babies and families have the best possible start in life. The RCM would be the first to acknowledge

[7] National Audit Office (2013) Maternity services in England
[8] Uncorrected transcript of oral evidence to the Public Accounts Committee hearing 18th November 2013
[9] Department of Health annual report and accounts

that the NHS in London has done much in recent years to invest in the recruitment and retention of midwives. There is no doubt that staffing levels in London's maternity services have improved and that the gap between the number of midwives needed to provide good quality care and the number of midwives actually in post, has closed appreciably.

Nevertheless, as our evidence shows, there are significant variations across London in terms of staffing ratios and vacancy rates. Therefore, despite the progress made thus far, midwifery staffing shortfalls persist in some areas and this is impacting on the quality of care received by women and families. Whilst maternity services in London have been largely successful in ensuring that women receive one-to-one care in labour, this is sometimes being achieved at the expense of ensuring that community midwifery services are adequately staffed. The postnatal period in particular is a crucial period for the health and wellbeing of women and babies, and yet it continues to be poorly resourced. Furthermore, one of the reasons that the home birth rate has fallen in London is because there are insufficient midwives to provide this service, and this is often due to midwives in the community being called in to cover staff shortages on labour ward. It is therefore important that maternity services are properly staffed across the pathway, and not just in the hospital.

Ensuring that the right number of midwives are employed in the right places, and at the right time, is also key to meeting current maternity policies relating to choice, accessibility and quality, as set out in Maternity Matters, the NHS Mandate and the 2013/14 Choice Framework.

The reports of the Francis, Keogh and Berwick reviews, and the Government's response to the Francis report too, all make clear the importance of implementing evidence-based approaches to setting staffing levels. For maternity services, Birthrate Plus is the recognised national workforce planning tool, which is based on an understanding of the time it takes to deliver midwifery care to women across the maternity pathway, using NICE guidance and acknowledged best practice. When used correctly, Birthrate Plus will provide a specific midwifery ratio, usually within the range of 26 and 34 births to midwives, that commissioners and providers can have confidence is based on robust evidence. We therefore recommend that all maternity services in London use and implement Birthrate Plus to review their staffing levels.

Equitable care

The NHS in London clearly needs to address the needs of women from deprived communities and disadvantaged groups, who the evidence shows experience poor maternal outcomes and are less satisfied with the care they receive. Providing equitable and responsive maternity services does not mean offering the same service to everyone, regardless of individual circumstances.

What is does mean is that maternity care providers and commissioners in London should:

- Plan the provision of maternity services based on an up-to-date assessment of the needs of the local population and involving service user groups;

- Systematically take account of the reasons why women from disadvantaged and minority groups and communities find it difficult to access and maintain contact with maternity services and actively designing services to overcome these barriers.

- Strengthen services for women from disadvantaged and minority groups and communities by having a staffing profile which, as far as possible, reflects the profile of the local population.

Reorganising maternity services

As previously stated, the centralisation of maternity services across London is being largely driven by the adoption of a standard of 168 hours a week consultant obstetrician presence on delivery suites. This could well be appropriate especially if the population using a service is at high risk and the 'available' on call consultant is being called in frequently. However, as we also stated, the problem with the adoption of this standard in an unquestioning way is that there is only limited evidence as to its benefits if implemented as a routine and its implementation is unaffordable within current spending constraints unless there is major consolidation of units which may not always be the correct local solution. At the recent Public Accounts Committee hearing on maternity services in England, Catherine Calderwood, who is NHS England's Clinical Director of Women's Services said that: "there is not evidence that outcomes are improved with 24/7 resident consultants", that 24/7 consultant presence is very expensive and that it might be preferable to invest instead in different numbers of midwives or a different skill mix. At the same meeting Sir David Nicholson said that the 168 hour standard is being used as an argument for centralising more and more maternity care, "which we do not think is necessary". The RCM concurs with these comments.

The RCM is particularly concerned that the key influences shaping the provision of maternity services are i) increased consultant presence ii) proximity to accident and emergency departments and iii) the needs of the small minority of women who may require emergency or intensive care. These factors all appear to have more traction with decision-makers in London than policies such as Maternity Matters, which promote increased access to and choice of type of maternity care and which are predicated on the needs of the majority of women and families, who should be able to experience pregnancy and childbirth as a normal event. In our view, the planners of London's

maternity services have got their priorities in totally the wrong order; the way in which maternity care in London is organised should be turned on its head.

There is considerable clinical evidence that normal birth with minimal intervention has a positive impact on the long term health of women and babies through, for example, increased breastfeeding rates, reduced readmission to hospital and lower incidence of postnatal depression. Midwife-led models of care contribute to improving the safety and quality of maternity care at no additional cost. Women who receive care in these models are more likely to have effective care, a better experience, improved clinical outcomes and with some evidence of improved access to care by women who find services hard to reach and better coordination of care with specialist and obstetric services. Approximately 45 per cent of women are classified as low risk at the end of pregnancy and the challenge is to provide a choice of midwife led settings for this group of women. They are the women for whom midwife-led models of continuity of care have the potential to improve quality and safety of care.

What London's maternity services should be doing therefore, is to organise obstetric services around the needs of women who are at high risk of developing complications or who need some form of specialist medical care, while at the same time developing midwife-led models of care that will benefit those women who are at low risk. This means that appropriate centralisation of obstetric units will be accompanied by a significant expansion of midwife-led units, alongside and freestanding, and home births. In this way it should be possible to ensure that obstetric units do not expand to such an extent that they need double rotas of obstetric staff and in addition the implementation of 168 consultant presence should be limited to the larger units where the demands on the on call consultant make it sensible to have that person present all of the time.