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Margie Polden Memorial Lecture: *Maternity Matters*: can the Government deliver?

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Abstract

Over the past 50 years, the UK Government has issued a number of policy documents about maternity care. Most recently, *Maternity Matters: Choice, Access and Continuity of Care in a Safe Service* laid out the policy framework for future maternity services. The author reviews the evolution of maternity policy since World War II, focusing on the issue of home birth since it is a crucial area of choice that seeks to reverse the trend towards hospital delivery that occurred in almost all countries in the twentieth century. Proposals for the future are made.

Keywords: Government, home births, *Maternity Matters*, maternity services, policy framework.

Introduction

I am very honoured to be asked to give this lecture in memory of Margie Polden. I was privileged to work with her on the executive committee of the Forum on Maternity and the Newborn at the Royal Society of Medicine. This multidisciplinary forum, which was started by Dr Luke Zander, a general practitioner (GP) obstetrician, in 1980, holds regular meetings six times a year, which, I am sure, would be of interest to your members. Margie was an active and stimulating member of the committee, and we were all shocked by her unexpected and untimely death.

Maternity Matters: Choice, Access and Continuity of Care in a Safe Service was the name given to the Government policy document, issued in April 2007 by the then Secretary of State, Patricia Hewitt, laying out the policy framework for maternity services in the future (DH 2007a). It was a welcome evidence-based initiative, although this long document has a lot of 'New Labour speak' and runs to some 40 pages.

Over the past 50 years, the Government has issued a number of policy documents about maternity care, and starting from a baseline in 1946, when 46% of women gave birth at home (JCRCOGPIC 1948), these have transformed the situation. In 1958, the Cranbrook Committee suggested an increase in the number of hospital births since, with the increase in the birth rate after World War II, some women who wanted to give birth in hospital or were unsuitable for home birth were forced to deliver at home because hospital beds were in short supply (MH 1959). This sometimes led to tragedies, as portrayed in the play *A Day in the Death of Joe Egg* (Nichols 1967), which is about a child who suffered severe brain damage in a home birth. However, Cranbrook stipulated that a good domiciliary service should be retained.

The second perinatal survey was done in 1958, and this showed that women who were at low risk and were looked after by GPs had poorer outcomes than those who were looked after in hospital. This was used by obstetricians to pursue the idea of shared care between the hospital and the GP in the community. The fact that district midwives caring for a high proportion of social class 5 women, who would be expected to have poorer outcomes, did very well was, however, not commented on or used to drive policy. At this time, 36% of women had their babies at home and 12% in a GP maternity unit (GPU) (Butler & Bonham 1963).

In 1970, Sir John Peel advocated extending 'the benefits of hospital delivery to all women' without producing any evidence to show that

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this was beneficial (SMMAC 1970). By 1970, the proportion of home births had fallen to 13%, and 18% of women gave birth in a GPU, where they were usually cared for by a midwife until the end of labour, when the GP would arrive to catch the baby (Chamberlain *et al.* 1975). By 1980, this policy had resulted in the virtual outlawing of home birth, with only 1% of women having a home birth and 3.5% giving birth in a GPU (ONS 2008a). This massive transformation of such a crucial event in women's lives was followed by sociologists, and during the 1970s and 1980s, a number of papers demonstrating women's dissatisfaction with their care and then a seminal prospective study (Green *et al.* 1988) were published. The Government response was to issue a number of recommendations, mainly provided by obstetricians and civil servants, called *Maternity Care in Action* (MSAC *et al.* 1982, 1984, 1985).

In 1979–1980, a House of Commons Select Committee chaired by the late Renee Short examined the high rate of perinatal mortality in the UK and made the erroneous statement that hospital birth was now safer than home birth, a basic epidemiological error where like was not compared with like (HCSSC 1980). Rona Campbell examined the outcome of all home births in 1979 and showed that, for booked home birth, the perinatal mortality rate (PMR) was 4.1 per thousand, approximately one-third of the hospital rate (Campbell *et al.* 1984). What pushed up the PMR for all home births, only half of which were planned, were the very high rates for women without bookings (196 per thousand), and the higher rate (65.7 per thousand) of women booked for hospital birth who had an emergency delivery at home as a result of prematurity or antepartum haemorrhage. However, although this paper was published in the *British Medical Journal*, it was ignored by most doctors.

In 1991, the late Audrey Wise, Labour MP for Preston, who was on the House of Commons Health Select Committee (HCHSC), persuaded its chair, Nicholas Winterton, to examine the maternity services. Their first recommendation in the report (HCHSC 1992a, b, c) began with the words: 'On the basis of what we have heard, this Committee must draw the conclusion that the policy of encouraging all women to give birth in hospitals cannot be justified on grounds of safety' (HCHSC 1992a). For the first time, the voices of women were heard, and the evidence given by the Royal College of Midwives (RCM), the National Childbirth Trust (NCT) and the Association for Improvements in the Maternity Services was based on evidence, whereas the Royal College of Obstetricians and Gynaecologists (RCOG) gave only opinion.

The HCHSC visited Holland and units round the UK, and listened to women. They recommended that midwives should have a greater role and more autonomy, and that women should have real choice about the place of delivery. The initial Government response was positive, and a working party was set up that was chaired by Julia Cumberlege, who had had two of her three babies at home herself and did not enjoy the hospital birth.

The Committee commissioned a MORI poll, which found that almost all women (98%) were not offered a choice of where to have their baby – hospital birth was assumed to be their only option. Seventy-two per cent of women surveyed would have liked a choice of place of delivery, and of those, 22% would have chosen the option of a home birth. This is amazing when you think that there had been over 20 years of obstetric advice that home birth was not safe and almost all GPs had absorbed this view.

The HCHSC reported in August 1993 and *Changing Childbirth* was a blueprint for real change (DH 1993). The working party set targets as indicators of success that were to be reviewed in 5 years. Unfortunately, the Government said that the changes should be cost-neutral, which was, of course, unlikely to lead to change. They set up a Changing Childbirth implementation team, which issued newsletters reporting on the many pilot studies that were set up, but these were never translated into routine practice. In 1997, the Government changed: New Labour had other priorities, the implementation team was disbanded, and although there were some positive changes in attitudes towards women, the only tangible result was that the home birth rate rose marginally. By 2006, it had reached 2.69% in England, 3.63% in Wales, 1.36% in Scotland and 0.39% in Northern Ireland (BirthChoiceUK 2008).

Maternity Matters: the blueprint for the future

In April 2007, Patricia Hewitt, the then Secretary of State for Health, launched *Maternity Matters*, which set out how maternity services would develop over the next decade (DH 2007a). There was a great deal of media coverage, and

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women were told that they would now have more choices, including the options of having their babies at home, in a midwife-led maternity unit or in a hospital; only later was this modified to say that these options were for healthy women.

This announcement was greeted with some scepticism since the NCT had highlighted how many midwifery-led maternity units were under threat (NCT 2006a, b). The RCM said that this plan would require more midwives if it was to be implemented and that this would take some years to achieve, even though newly qualified midwives in Salford had been unable to get jobs the year before as hospitals and primary care trusts (PCTs) tried to keep within budget (Robotham & Hunt 2006; RCM 2007, 2008). The RCOG seemed to have retreated from their position of accepting home birth (Chamberlain & Patel 1994) with the following non-evidenced-based and rather paternalistic statement:

> 'The RCOG believes that midwives need to be supported in order for them to deliver a safe and effective service. It is also important to recognise that hospital births are still the safest option for most women and these women need the care of a maternity team who are trained to work together and who will include midwives, obstetricians, paediatricians and anaesthetists.' (RCOG 2007)

I do not believe that hospital is the safest option for most women or that most women need the care of doctors.

How will these aims be achieved?

Implementation of the changes proposed in *Maternity Matters* will be through performance management by the Department of Health (DH), via strategic health authorities (SHAs) and local delivery plans at the PCT level. Targets will be set as part of public service agreements. Reductions in infant mortality rates and under-18 conception rates are mentioned in the report, but while these are important issues, they do not increase and are not immediately relevant to women's choice. Improved commissioning using a tool kit (DH 2006), issued concurrently with *Maternity Matters* and updated on 16 September 2008, is also mentioned.

Monthly e-bulletins have been issued on the DH website (DH 2007b). Regional events were held for staff in May and June 2007. An implementation group was set up on 4 September 2007, and the North West SHA was selected to lead the project. On 16 October 2007, £15 000 was offered to PCTs who wished to be early adopters of the policy. This is enough to pay for one midwife working full-time for 6 months. In October 2007, the RCOG and the National Institute for Health and Clinical Excellence (NICE) launched their safer birth and normal labour guidelines, respectively. None of this suggests that great strides are taking place to implement the policy.

In March 2008, it was announced that £330 million would be available to PCTs to enable progress to be made, but there is nothing in the above-mentioned e-bulletins (DH 2007b) to suggest that anything has happened. Furthermore, one person whose e-mail was given did not reply and the second was on holiday.* There was a report in *The Times* that the extra money has not gone into maternity services (Rose 2008), even if it has reached the PCTs. I was informed by a midwife working on the project that there should have been about £1 million for each Trust, but she confirmed that they had received no money.

Are there enough midwives?

Shortages of midwives have been reported for years, and the birth rate has been rising since 2001, reaching 690 013 in England and Wales, and over 700 000 in the UK (ONS 2006, 2008b). In 2005 (the latest figures), there were 18 928 full-time equivalent (FTE) midwives (NMC 2006), which equated to 24 784 people, a rise of 780 FTEs from 2001. I estimated that there were 32.4 births per midwife in England in 2005 (Savage 2007); the RCM target is 36 births per midwife per year. This does not seem an excessive workload, and allowing for holidays study and sick leave, this leaves 42 working weeks, which works out as less than one birth, and 10 antenatal and 10 postnatal visits per midwife per week.

There are also significant variations by PCT, region and country. Scotland has the best staffing ratio of 21.5 births per midwife and Northern Ireland has a figure of 22.9; neither of these regions do many home births. Wales and England have staffing ratios of 22.9 and 32.4 births per midwife, with the worst ratio being in

*Since I gave this lecture, the latter has done so and said that they are working on a 'milestone review' that should come out soon.

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the East Midlands (37.7). In March 2008, a 'golden hello' of £3000, designed to encourage midwives to return to work after having had a break, was announced in the e-bulletin. The use of maternity support workers was announced in April 2008, and in July 2008, SHAs were given £1.5 million to implement return-to-work programmes for midwives. The aim is to have 4000 more midwives in post by 2012. In August 2008, a Quality of Care Committee chaired by Professor Jane Sandall was set up to report by the autumn.

The way midwives are deployed does not make full use of their skills and the hospital is always seen as the priority. My solution would be to get midwives to specialize as either community midwives or hospital midwives. This should not split the profession in the way some fear that it would (Savage 2007). After all, the British Medical Association represents GPs and hospital doctors with a vastly greater range of specialities, and doctors are not split. Community midwives would be organized into small groups and maintain continuity of care, as has been shown to work brilliantly in South East London, first by the independent midwifery group led by Nicky Leap, and now by the Albany practice at King's College, London, who achieved a 47% home birth rate and 78% breast-feeding rate at 28 days, much higher than the national average in a multi-ethnic area with high levels of deprivation (Sandall *et al*. 2001; Atkins 2007).

Women's views about care

There have been several surveys that have addressed the way that women feel about maternity care, and two further House of Commons Health Committee reports published this century have found increasing levels of satisfaction with care on the whole – from a low baseline in the 1980s – but dissatisfaction about the difficulty in having the baby at home (HCHC 2003a, b).

The latest study, which was done by the Healthcare Commission and reported in November 2007 (HC 2007), surveyed 26 000 women (the largest ever review – using tax-payer's money) in early 2007 before *Maternity Matters* was launched. Eighty-nine per cent of women rated their care good, very good or excellent in the antenatal period, 90% in labour, but only 80% postnatally. Ninety per cent said that they saw a health professional when they wanted to, but 43% were not given the choice of having their baby at home, ranging from the best area, where 8% were not offered the choice, to the worst, where this figure was 76%. Thirty per cent gave birth lying down and 27% did so in stirrups – an amazing figure when the forceps/vacuum rate was only 13%. The worst area had a 44% rate of delivery in stirrups (HC 2007).

Implementation by 2009?

Maternity Matters (DH 2007a) stated:

> 'The national choice guarantees described in this document are:
> '(1) Choice of how to access maternity care
> '(2) Choice of type of antenatal care
> '(3) Choice of place of birth – depending on their circumstances, women and their partners will be able to choose between three different options. These are:
>
> - a home birth
> - a birth in a local facility, including 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
>
> '(4) Choice of place of postnatal care
> 'As well as the choice of local options a woman may choose to access maternity services outside her area with a provider that has available capacity. In addition, *every woman will be supported by a midwife she knows and trusts throughout her pregnancy and after birth.*' [My emphasis.]

How can any Government minister *guarantee* that a woman will trust her midwife? The lack of continuity of care for my youngest son's partner led to me paying for an independent midwife so that she could have a home water birth with a midwife she knew and trusted because, sadly, the local National Health Service (NHS) midwives could not provide continuity, and without that, it is hard to build up trust.

The Government's ability to deliver these choices is debatable (BBC 2008), and I am going to concentrate on the field of home birth since, although it applies to a minority of women, it is a crucial area of choice that seeks to reverse the trend towards hospital delivery that occurred in almost all countries in the twentieth century.

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Table 1. Percentage rates of home birth and Caesarean section in the UK since 1970

	Year							
	1970	1975	1980	1985	1990	1995	2000	2005
Type of delivery								
Home birth	13.0	3.2	1.2	0.9	1.0	1.9	2.1	2.5
Caesarean section	4.5	5.8	8.8	10.4	11.3	15.5	21.5	23.4

Home Births: the 1994 Confidential Enquiry

The 1998 Confidential Enquiry on Home Births compared a group of women who were planning a home birth with those who had planned a hospital birth matched for age and parity (Chamberlain *et al.* 1997). A randomized controlled trial is impossible because you cannot allocate a woman who does not want a home birth to have one and *vice versa*; therefore, a cohort study is the next most reliable study that can be performed. This was very influential in changing the attitudes of some obstetricians, notably Professor Geoffrey Chamberlain, editor of the *British Journal of Obstetrics and Gynaecology* and an ex-president of the RCOG, who was one of the group who did the study. What they found was that there was no difference in the outcome as far as the babies were concerned and there were no ill effects on the women who delivered at home, but that the Caesarean section (CS) rate (CSR) was half that for women booked at home compared with those booked for hospital (Chamberlain *et al.* 1997). This fact is included in the 2004 NICE guidelines on CS birth, but I do not know how many obstetricians tell women this (NCCWCH 2004).

The effect of moving healthy women into hospital

As can be seen from Table 1, the CSR has increased steadily over the past 30 years, and in 2007, it reached 24% (BirthChoiceUK 2008). This cannot be right, and there is no scientific reason why the rate should be twice the 10% rate that the World Health Organization Consensus Conference in 1985 thought was appropriate for a region (WHO 1985).

One would have thought that the effect of moving the third of healthy women who had been giving birth at home into hospital would have led to a fall in the hospital CSR, but it does not even show a flattening – the rate rises inexorably so that now almost one woman in four is giving birth by CS. It is true that women are having their first babies later and obesity is rising, which may increase the rate by 1–2%, but our surveys of obstetricians in 1990 (Savage & Francome 1993) and 2005 (Savage & Francome 2007) showed that the leading reason given by obstetricians was litigation, followed in the earlier paper by better prognosis for the baby, and in the later one by women's choice, demand or pressure, and thirdly, by poor training of junior staff or newly appointed consultants (Savage & Francome 1993, 2007). We asked about the optimal CSR for the UK, and in the first period, when we found the CSR to be 12.1% (later confirmed by Government figures), two-thirds said that the rate should be below 12%, whereas, by 2005, two-thirds said that it should be 16% or above, with one interviewee saying 40%! This suggests that obstetricians have become used to these high rates and delivery by CS has become normalized.

Students are no longer required to conduct 20 normal deliveries, as they were in my day, and those training to be GPs or obstetricians have no experience of normal birth; they spend their time arranging or performing CS or assisted vaginal births, or doing foetal blood samples and looking at cardiotocograms. General practitioner trainees may also be exposed to neonatal intensive care during their hospital training, and so their negatively biased view of birth is further reinforced by exposure to premature births and term babies who have suffered problems. The idea that birth is a normal process and not an illness is hard to retain in these circumstances.

What needs to be done?

Midwives need to be divided into hospital and community branches, and the majority of women would be looked after in the community, thus giving medical students the opportunity to see normal healthy women in this setting. The home birth rate would be expected to rise based on the experience in South London. Those

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training to be obstetricians would, like GP trainees, spend the majority of their first 6 months attached to community midwives, and would be expected to assist at some normal births as well as learning about abnormal pregnancies. This would change the way that doctors approach birth, and I believe, would eventually reduce the CSR. Fully trained obstetricians would only look after women with complicated pregnancies, and removing the healthy majority would give them time to deal with those women better.

What has happened since April 2007?

Of the 152 PCTs, 12–15 applied to become early adopter sites, but what has happened is hard to ascertain. Six PCTs and boroughs in South East London are working together and a health equity audit has been conducted this year. East Lancashire has issued an interim report. Hospitals do not have the money to employ midwives, despite there being unemployed midwives in some areas. The £330 million allotted to implement the policy has not reached the maternity services, even if it has reached the PCTs.

Will this government deliver? Would the Tories deliver?

I do not think that this Government will deliver the vision that was proposed in 2007 by 2009.

Changing Childbirth (DH 1993), which was such a boost to campaigner's hopes, was the result of a House of Commons Health Committee chaired by Sir Nicholas Winterton and overseen by Baroness Julia Cumberlege, who are both Tories. David Cameron, the present Leader of the Opposition, is unusual in having experience of the NHS, so the Conservatives may take this forward if they win the next election.

But

Women's issues have a tendency to drop off the agenda and these things will not happen unless we, as women, get together to force the Government to fulfil its promises. I have always thought that there is an untapped resource of grandmothers who could unite and change the system, and in addition, we need to reactivate the All Party Parliamentary Group on Maternity.

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She has achieved much in her long and distinguished career since qualifying from Cambridge and the London Hospital Medical College in 1960. In 1977, she became a senior lecturer in obstetrics and gynaecology and honorary consultant at the London Hospital Medical College. In 1985, she was elected a fellow of the Royal College of Obstetricians and Gynaecologists and then appointed in 1986 as an honorary consultant at what is now the Royal London Hospital. From 1991 to date, she has been an honorary visiting professor at Middlesex University. In 2000, she was presented with an honorary degree of Doctor of Science at the University of Greenwich. Wendy has four children and six grandchildren, lives in London and relaxes in Cumbria.

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