KING's FUND CENTRE

MATERNITY CARE

CHOICE, CONTINUITY AND CHANGE

March 1993

Consensus Statement

This statement on Britain's maternity services was drawn up by an independent panel following a consensus conference held in London on 4-5 March 1993. It was organised by the King's Fund Centre for the Department of Health.

The statement will be presented as evidence to the Expert Committee on Maternity Services set up in 1992 by Baroness Cumberlege, following the report of the Parliamentary Select Committee on Health (Winterton Report).

The panel comprised:
Niall Dickson (Chair), Chief Social Affairs Correspondent of the BBC. Akgul Baylav, Ethnic Minorities Service Manager, City and East London Family Health Services Authority; Kuldip Bharj, Senior Lecturer in Midwifery, Airedale College of Health; Sue Blennerhassett, Joint Chief Officer, Newcastle Community Health Council; Professor Richard Cooke, Professor of Paediatric Medicine, Liverpool University; Dr Lindsey Davies, Director of Public Health, Nottingham Health Authority; Catherine Griffiths, Unit General Manager, Birmingham Women's Services Unit; Rosemary Jenkins, Director of Professional Affairs, Royal College of Midwives; Dr Ann McPherson, GP, Oxford; Professor Charles Normand, Professor of Health Policy, London School of Hygiene and Tropical Medicine; Professor Gordon Stirrat, Professor of Obstetrics and Gynaecology, University of Bristol; Olivia Timbs, Editorial Director, Medicom (UK) Ltd, and mother of two children.

Invited speakers:
Margaret Anthony, Head of Women's Services, Royal London Hospital Trust; Carol Baxter, Health and Race Consultant, Manchester; Beverley Beech, Honorary Chair, Association for the Improvement of Maternity Services; Alice Coyle, Independent Midwife, London; Allan C Davidson, Consultant Obstetrician and Gynaecologist, Leicester Royal Infirmary Maternity Hospital; Karlene C Davis, Education and Midwifery Adviser, South East Thames Regional Health Authority; Ruth Evans, Director, National Consumer Council; Jo Garcia, Social Scientist, National Perinatal Epidemiology Unit, Oxford; Christine Gowdridge, Director,

Maternity Alliance; John James, Chief Executive, Parkside Health Authority; Dr David Jewell, GP, Bristol, and Senior Lecturer in General Practice, Bristol University; Debra Kroll, Senior Research Officer, Community Midwifery, Bloomsbury and Islington Health Authority; Dr John McClure, Consultant Anaesthetist, Royal Infirmary, Edinburgh; Heather Mellows, Consultant Obstetrician and Gynaecologist, Bassetlaw Hospital, Worksop, Nottinghamshire; Mary Newburn, Head of Policy Research, National Childbirth Trust; Dr John Noakes, GP, Harrow; Professor Ann Oakley, Director, Social Science Research Unit, Institute of Education, London; Professor Philip Steer, Head, Academic Department of Obstetrics and Gynaecology, Charing Cross and Westminster Medical School; Dr Jim Thornton, Senior Lecturer and Honorary Consultant Obstetrician and Gynaecologist, Leeds General Infirmary; Ann Wraight, Research Midwife, Institute of Manpower Studies.

The panel was asked to address the following questions:

1. What sort of choices are important to women and are there proper limits to women's choice as a result of clinical, organisational or financial constraints?

2. How is it possible to enhance the ability of women and their partners to make choices?

3. Women's preference is often for continuity of care and carer. Can this be described, what are the implications and how can it best be organised?

4. What are the priority actions for bringing about these changes?

A comprehensive maternity service

The overriding aims of the maternity service must be to provide the pregnant woman and her family with as safe an outcome as possible for her and her baby, to offer her choice in the type of support and care she needs and to ensure that she retains control and responsibility. Good maternity care will be built on trust between professionals and women and between the professionals themselves. It is vital that all women should have equal access to this quality of care.

It is clear, however, that there are factors beyond the scope of the maternity services, such as low incomes, poor housing and inadequate nutrition, that can have a decisive influence on a woman's experience by decreasing choice, restricting access to services and increasing risks to her and her baby. While the NHS needs to provide services which mitigate the effect of these disadvantages, there are obvious limits as to what can be done by health care alone.

1a What sort of choices are important to women?

There is considerable evidence which points to a set of universal standards that all women want from their maternity care: they have said they want a service that offers safety, that is flexible and responsive to their individual needs, which communicates effectively, and provides the information that allows informed choices. Women seek a service that is respectful, personalised and kind, gives them control and makes them feel comfortable in the sense of being at ease in the environment of childbirth and having confidence in the care that is being given.

There is also evidence that many women currently are not receiving care which meets those standards, and in particular it is clear that many are denied real choice in the types of service they are offered and in the way these are delivered. There have been many small pieces of research and observational studies in recent

years which have consistently indicated that women want greater choice over matters such as where antenatal care takes place, where they have their babies, who is involved in their care and what treatment they receive. More research, especially in the form of large scale studies, is needed to expand knowledge of the particular choices that are important to women.

It would be wrong to assume that women are a homogeneous group. What suits one will not suit another. Those who wish to hand over some decision-making to professionals should also be given that choice. Likewise, while there are women who wish to be in and out of hospital as quickly as possible, there are others who want to spend longer in hospital before returning home and others who do not want to go into hospital at all. A flexible, responsive service needs to take account of these differences.

In order to make choices we believe all women and their families need to have as full information as is available about the options open to them locally, and they need to be made aware of the benefits and risks of those options. That does present problems: the benefits and risks of many procedures are not known and, where they are, professionals are not always good at providing objective and comprehensible explanations.

There have been significant changes in maternity care in the last ten years, not least because there has been a widespread recognition that the service needs to adapt to women's needs and choices. How universal the changes have been is difficult to gauge – there are many examples of good and innovative practices but in some places the service is not yet offering real choice. Some groups of women still face formidable barriers in securing the types and level of services that others are able to take for granted. For choice to be real there needs to be a range of services.

In some places options are limited because there simply is not the range of appropriate and skilled personnel or the care settings available. There is also evidence that sometimes women do not have full access to what is available. Often this stems from

breakdowns in communication. It would be difficult to overstate the importance of providing consistent, reliable and objective information. Professional attitudes are also crucial and in some cases will need to change so that, for example, obstetric protocols are used to influence and inform good practices, and not to deny choice.

It is evident that some groups of women are offered less choice than others. Women from black and minority ethnic, disabled women, travellers and those in poor or no housing find that choice and access which is sometimes available to others is frequently not available to them. More research is needed on the choices that are important to different groups of women, although there is no doubt that more advocates and link workers, better training and greater efforts to develop services in consultation with users will help.

Much of the discussion about choice in pregnancy has focused on those women who believe that a home birth offers them the best chance of a fulfilling experience. It is possible that more women would choose this option were it made more available, with the benefits and risks spelt out objectively alongside the benefits and risks of the alternatives. However, we believe that home confinement may have come to symbolise 'real' choice because of the more personalised service that it offers and the fact that it explicitly leaves control in the hands of the woman and her family.

1b Are there proper limits to women's choice as a result of clinical, organisational, or financial constraints?

The panel took the view that there were few justifiable constraints on women's choice and that many of those that are sometimes put forward will occur only in very exceptional circumstances.

Clinical constraints

In particular there are few proper clinical constraints on women's freedom of choice. In rare instances choice might justifiably be denied but this is usually in response to a demand for intervention rather than a request to avoid it. For example, professionals might properly refuse to induce labour where there were no clinical grounds for so doing. There could also be situations where the woman is not in a position to make choices because her autonomy is impaired, for example if she is unconscious.

Professionals have the responsibility to give women and their partners advice based on their knowledge and experience; they do not have the right to impose their views even where they believe the mother's choice may increase the risk of harm to herself and her baby.

It is perhaps more relevant that women's choice can be constrained by the fact that professionals often do not have, and probably never will have, definitive answers on the implications of pursuing a particular course. In all this, professionals need the confidence and the communication skills to help users to make decisions in the face of uncertainty.

Organisation

Some of the current limitations on choice stem from the way services are organised but, as with clinical considerations, there are few which in practice can be justified. Many of the traditional barriers to choice, such as a lack of appropriately skilled personnel, duplication of effort and impersonal surroundings, can be overcome and in many places the shortcomings of the past are being tackled. It should also be possible to ensure that organisational structures are geared to providing continuity of care and maximum choice.

However, even with more flexible services there will be some limits as to what can be offered. It is not possible or even desirable

always to guarantee that the midwife who handles the bulk of the antenatal care will be present at the birth. This would require inappropriately long working hours. However, the organisation of the services should be such that, wherever possible, the woman knows the midwife who delivers her baby.

Resources

It is almost impossible to judge how far resources act as a constraint since there is a regrettable lack of information about the cost of existing provision or about how much would be involved in developing alternative arrangements to extend choice. There are examples where choice does appear to be restricted by a lack of resources and levels of service and the facilities available in different areas vary considerably. But there is also some evidence that changes will bring about resource savings, such as the better use of professional skills. Other changes, such as making delivery rooms more homely, could be introduced without significant extra spending.

2 How can you enhance the ability of women and their partners to make choices?

Choice is fundamental and all levels in the health service with responsibility for maternity care need to re-examine what choices are genuinely available to women and their families. Maximising choice should be a priority.

The Patients' Charter sets national standards in the provision of health services. In the case of maternity services, if choice is to be extended these need to be developed to meet the criteria of safety, responding to the needs and choices of individual women, good communication, respect and kindness. There will also need to be mechanisms to monitor the commissioning and provision of services against these national standards.

At local level, purchasers should maximise the choices available by specifying and commissioning a range of provision. They should ensure that local needs and circumstances are fully taken into account in the purchasing decisions and set quality standards within their contracts which meet the objectives already outlined. They also have a responsibility to ensure that women and their families are provided with full information on all the options for their care during and after pregnancy.

More needs to be done to involve users, and purchasers will need to develop a variety of methods to ensure that they are involved in setting priorities and in monitoring contracts. Effective Maternity Service Liaison Committees (MSLC) offer one mechanism for achieving this provided that they have adequate user representation, from bodies such as Community Health Councils, local voluntary organisations and consumer groups. They should also include, where possible, some individual mothers. MSLCs also offer the opportunity for collaboration across the professional groups.

While recognising that it is often hard to discover the preferences of different users and to make sure that less vocal interests are heard, purchasers and providers of maternity care should nevertheless make strenuous efforts to do so.

Full and unbiased information is essential if women and their partners are to make effective choices throughout pregnancy. It needs to be provided in appropriate, sensitive and understandable ways (written and oral) and should avoid overload. It should be available before, during and after pregnancy and provided in a variety of settings. There are examples of good practice, such as well put together information leaflets in a range of languages and imaginative use of innovative media. Information should cover all local options, women's rights, standards of care, how to gain access to appropriate services and whom women should approach if they are dissatisfied with the service. Information, in whatever form, should be open minded, non directive and where possible based on evaluated research.

The transfer of information depends on successful communication with all women. Choices for women who do not share the same language and culture as the providers must be enhanced through trained and well resourced interpreters, advocates and link workers.

Professional training needs to stress the rights of women to make informed choices, should assist in fostering appropriate attitudes to cultural diversity and should enhance communication skills. Equal opportunities policies and practices should be reinforced by training. Team working can be enhanced through the use of common modules in the training of professionals

The quality and availability of information at the point of entry into services is crucial. General practitioners are currently the most common first point of contact and therefore have particular responsibility for making women aware of choices of services and professionals available. There is evidence that this happens only in a minority of cases, particularly in relation to some dimensions of choice, such as the place of birth.

Although it may be possible to provide some enhanced choice without additional resources, in other cases it will depend on the ability to release funds currently locked into established patterns of provision. This would require pump-priming and transitional support. Facilities may need to be developed and staff training and development carried out before new services can be introduced.

Real choices in maternity services cannot be seen in isolation from other policies. There is, for example, an important overlap with the quality and availability of family planning services to try to ensure that every pregnancy is a wanted one. The Department of Health should also liaise with other government departments to consider the impact of government policies on heathy choices and outcomes, such as the impact of benefit levels on access to healthy diets, and the impact of paid maternity leave on the feasibility of breast feeding. Paternity leave could enable men to be more involved.

3 Women's preference is often for continuity of care and carer. Can this be described, what are the implications, and how can it best be organised?

Lessons from past and recent studies point to the need for greater continuity of care and for services to be flexible enough to meet women's needs.

However, it is not clear from the evidence just how important, in itself, continuity of care is for most women. Although studies have shown that women believe it is desirable, they do not necessarily rank it as highly as, for example, having a safe delivery or receiving consistent advice. In practice though, one of the most effective ways of achieving such consistency will be to reduce the number of professional staff involved in the care of each woman and to ensure that they work together as a team. For most women the midwife will be the key professional in providing continuity and, given the preference of many women for community based antenatal care, the aim should be to reorientate services so that midwives can follow women throughout and beyond their pregnancies. However,the provision of continuity of carer is not exclusive to any one professional group.

Description of 'continuity of care'

Continuity of care is most easily provided by one professional but in most cases it is unlikely to be achieved, and in practice there will be a spectrum of continuity. Within that lies the idea of continuity of carer which implies that the woman should have the chance to build a relationship based on trust with those looking after her throughout pregnancy, and that one of them should be available especially at crucial times such as the birth.

Implications of providing continuity of care

Movement towards greater continuity may not imply significant organisational change but it does have implications for practice. There will need to be agreed and consistent clinical policies, consistent advice to women, careful and consistent note keeping and the development of individual care plans.

Many of the current problems occur when communication breaks down between professionals, and between them and the women and their families. This can create difficulties for all women but it can be especially damaging for those with particular needs. One remedy that can at least reduce the potential for misunderstandings and confusion is to enable women to hold their own notes.

It is also vital that, if improvements are to be made in this aspect of care as in others, the standards, consistency and outcomes of the service are audited continually.

Implications for continuity of carer

Changing patterns of service to ensure continuity of carer will require more flexible working patterns as well as a fundamental change in the relationship between the care giver and the woman, with attendant emotional benefits and costs. There will also need to be changes in the relationships between professions with a greater recognition of each other's contributions. It will be important to provide support for professionals when things go wrong.

All this is certain to have significant implications for training as professional staff have to adapt to new roles and acquire a broader range of skills.

All those involved in setting up new approaches to care will have to take account of practical difficulties such as the sensitive deployment of trainees who can dilute and dislocate continuity.

Reliance on part-time working and the reduction in junior doctors' hours may also have an impact on continuity of care.

Greater emphasis on midwifery as the profession most likely to provide continuity of care to majority of women may have an impact on the systems of remuneration both for GPs and midwives.

Organisation

Continuity of care will probably best be provided by small teams of midwives with their own caseloads, working between hospital and the community and linked with primary health care teams.

Local services must be driven by the requirements of the woman and must be able to respond flexibly. Whether the key figure for an individual woman in the team is a midwife, GP, general obstetrician or tertiary care specialist will depend on her particular needs and choices, although each team will have midwives able to provide the woman with maternity care irrespective of her particular additional needs.

Different models of care will be suitable for different parts of the country and we do not feel it would be appropriate to be prescriptive about the pattern of service that should be adopted. There are already primary health care and obstetric care teams who provide continuity of care; tertiary obstetric services have been developed in some areas but require expansion. Midwifery teams are in their infancy and greater priority should be given to their development. However, as with all other innovations, they need to be monitored and evaluated to ensure they achieve what they set out to do.

What are the priority actions for bringing about these changes?

In order to achieve the changes outlined in this statement, action will have to be taken at all levels in the health service. The following specific measures deserve to be highlighted:

At national level

We recommend that the Government should:

- ensure that national standards for maternity care are set (see page 8.)

- review the consistency of policies across government departments that impact on the health of pregnant women and babies.

- commission research into the following: women's needs and wants; the effectiveness of routine clinical procedures; the costs and effectiveness of, and satisfaction with, different models of care.

- improve routine reporting of activity (including activity of midwives) and costs of maternity services to allow audit, comparisons between and planning for service development. Such data will need to come from GPs, community and hospital services.

- develop new payment criteria for GP, hospital, midwifery and community services which will encourage more appropriate patterns of care.

- provide pump-priming and transitional funds to facilitate a diverse range of care and the consequent training that will be needed to implement these changes.

We support the setting up of the Government's Maternity Services Task Force on good practice and hope that it will ensure the dissemination of high quality information and in particular that it will see that examples of good written information for users are widely circulated so that they can be adapted for local use.

At local level

We recommend that managers should examine the whole range of maternity services and, building on existing strengths, should set goals for new development, establish a timetable for change and evaluate the outcomes.

We recommend that purchasers, including FHSAs, should:

- undertake a fundamental review of the commissioning of maternity services against the criteria of availability of choice; local accessibility; continuity of care and diversity of need (accepting that this may result in short-term investment for long-term gain)

- provide women and their families with a full range of unbiased information on the services available.

- develop effective monitoring mechanisms which involve users.

- develop mechanisms which enable pregnant women to be referred and/or transferred from one team to another (including, where reasonable, across district boundaries) depending on their changing needs or wishes.

We recommend that providers should:

- develop and publish a service philosophy, agreed by all involved (including users themselves) placing women and their families at the centre of care.

- develop alternative models of good practice which maximise continuity of care and foster antenatal services in the community. All such changes should take into account existing good practice in their area and evaluated research. Innovative forms of care should be encouraged but only in the context of evaluated studies.

- collect feedback from users and involve them in the development of services. Training and support should be provided for users who participate in developing services.

- ensure consistency of advice from staff.

- maximise continuity of care for high risk women wherever it takes place.

- ensure that boundaries between providers do not preclude the reasonable movement of women or staff in support of continuity.

Professionals

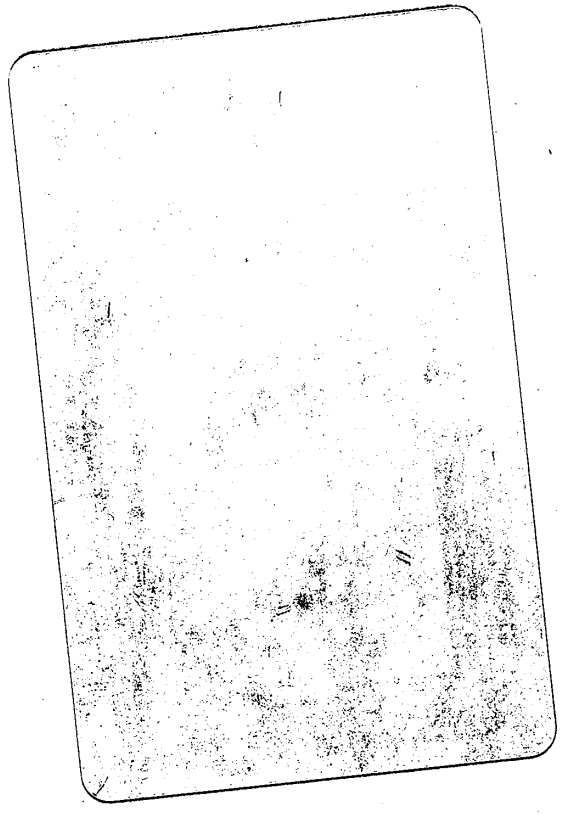
There is no place for professional rivalries which only hinder the provision of good maternity services, and it is clear that tensions do exist in some places.

We recommend that:

- professional bodies review training requirements. This would include developing the training of obstetricians in the community, and updating the training of midwives and GPs in resuscitation, examination and care of the newborn.

- training programmes should be developed for all staff to include psycho-social skills, ethics, communication (including cross-cultural), and equal opportunities. There should be shared learning involving the different professions.

There is much that is good in maternity care in this country, but it is also clear that further reform is both desirable and inevitable. The changes set out in this report represent a move towards more woman-centred care in which users will be able to take part in decision making about their own care and provide feedback about their experiences to improve the service of the future.



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